State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board and Committee Meetings
May 1-2, 2014

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MEDICAL BOARD OF CALIFORNIA
PANEL A MEETING AGENDA

MEMBERS OF PANEL A
Barbara Yaroslavsky, Chair
Michael Bishop, M.D.
Silvia Diego, M.D.
Ronald Lewis, M.D., Vice Chair
David Serrano Sewell, J.D.
Jamie Wright, Esq.
Felix Yip, M.D.

Sheraton Gateway LAX
6101 West Century Boulevard
Los Angeles, CA 90045
310.642.1111 (directions only)

Thursday, May 1, 2014
Santa Catalina Room
9:00 a.m. – 11:30 a.m.
(or until completion of business)

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

1. Call to order/Roll Call

2. ***CLOSED SESSION**

   Deliberation on disciplinary matters, including proposed decisions and stipulations (Government Code §11126(c)(3))

3. **OPEN SESSION**

   Adjournment

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.

****The Panel of the Board will convene in Closed Session, as authorized by Government Code Section 11126(c)(3),to deliberate on disciplinary decisions and stipulations. For additional information, call A. Renee Threadgill, Chief of Enforcement, at (916) 263-2389. Listed times are approximate and may be changed at the discretion of the President/Chair.***

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

For additional information call (916) 263-2389.

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

MEDICAL BOARD OF CALIFORNIA
PANEL B MEETING AGENDA

MEMBERS OF PANEL B
Dev GnanaDev, M.D., Chair
Howard Krauss, M.D.
Sharon Levine, M.D.
Elwood Lui
Denise Pines, Vice Chair
Gerrie Schipske, R.N.P., J.D.

Sheraton Gateway LAX
6101 West Century Boulevard
Los Angeles, CA 90045
310.642.1111 (directions only)

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

Thursday, May 1, 2014
Gateway Ballroom
10:30 a.m. – 11:30 a.m.
(or until completion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

10:30 a.m. OPEN SESSION

1. Call to Order / Roll Call

2. ***CLOSED SESSION**

   Deliberation on disciplinary matters, including proposed decisions and stipulations (Government Code §11126(c)(3))

3. **OPEN SESSION**

   Adjournment

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MEDICAL BOARD OF CALIFORNIA

EXECUTIVE COMMITTEE MEETING AGENDA

MEMBERS OF THE 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

Sheraton Gateway LAX
6101 W. Century Blvd.
Los Angeles, CA 90045
310-642-1111 (directions only)

Thursday May 1, 2014

1:00 pm – 2:15 pm
(or until the completion of business)

Teleconference – See Attached
Meeting Information

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order / Roll Call

2. Public Comment of Items Not on the Agenda
Note: The Committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code §§11125, 11125.7(a)]

3. Approval of Minutes from October 23, 2013 Meeting

4. Discussion on and Approval of Revisions to the Strategic Plan - Ms. Kirchmeyer

5. Adjournment

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

Meeting Information

This meeting will be available via teleconference. Individuals listening to the meeting will have an opportunity to provide public comment as outlined below.

The call-in number for teleconference comments is: (800) 230-1059.

Please wait until the operator has introduced you before you make your comments.

To request to make a comment during the public comment period, press *1; you will hear a tone indicating you are in the queue for comment. If you change your mind and do not want to make a comment, press #. Assistance is available throughout the teleconference meeting. To request a specialist, press *0.

Each person will be limited to two minutes per agenda item. However, during Agenda Item 2 and 3 – Public Comments on Items Not on the Agenda, the Board/Committee has limited the public comment period for individuals on the teleconference to 20 minutes. Therefore, after 20 minutes no further comments will be accepted. During public comment on any other agenda item 10 minutes will be allowed for comments from individuals on the teleconference line. After 10 minutes, no further comments will be accepted.

Comments for those in attendance at the meeting will have the same time limitations as those identified above for individuals on the teleconference line.

Agenda Item 3

MEDICAL BOARD OF CALIFORNIA

Executive Committee
Historic Mission Inn
3649 Mission Inn Avenue
Riverside, CA 92501

October 23, 2013

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Executive Committee of the Medical Board of California (Board) was called to order by Dr. Levine at 2:05 p.m. A quorum was present and notice had been sent to interested parties.

Committee Members Present:
Sharon Levine, M.D., President
David Serrano Sewell, J.D., Vice President
Dev GnanaDev, M.D.
Barbara Yaroslavsky

Committee Members Absent:
Silvia Diego, M.D., Secretary

Staff Present:
Susan Cady, Staff Services Manager II
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs'
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Interim Executive Director
Valerie Moore, Staff Services Manager I
Dino Pierini, Business Services Analyst
Regina Rao, Business Services Analyst
Kevin Schunke, Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant
See Vang, Business Services Assistant
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Gloria Castro, Senior Assistant Attorney General, Department of Justice
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Julie D'Angelo Fellmeth, Center for Public Interest Law
Victoria Edwards, California Citizens for Health Freedom

Karen Ehrlich, Licensed Midwife, Midwifery Advisory Council
G.V. Ayers, Consultant, Senate Business, Professions and Economic Development Committee
Tom Roy, Department of Consumer Affairs

Before formally starting the meeting, Dr. Levine announced that tomorrow at the Full Board Meeting she will acknowledge Dr. Janet Salomonson who passed away unexpectedly and ask for a moment of silence in her honor. Dr. Salomonson was a woman with enormous capabilities, a giant heart, and someone who has contributed tremendously to the Board and her patients.

Agenda Item 2 Public Comment on Items Not on the Agenda

Karen Ehrlich, Midwifery Advisory Council, stated that she is thrilled with the passage of AB 1308 and thanked the Board for the help in getting it passed through the Legislature. It was brought to her attention that at some point during the past year, as the bill was going through the legislative process, an Executive Committee discussed some of the provisions in that bill. When that discussion took place, there was no licensed midwife in the room and she feels that if there had been a licensed midwife present, the Board would have had more accurate information. She asked that the Board do everything they can to be sure there is a licensed midwife in the room to fill in any gaps in the discussion.

Agenda Item 3 Approval of Minutes from April 5, 2013 Meeting

Ms. Yaroslavsky made a motion to approve the meeting minutes from the April 5, 2013 meeting; s/Mr. Serrano Sewell. Motion carried.

Agenda Item 4 Discussion on and Approval of Revisions to the Strategic Plan, Goals, and Objectives – Dr. Levine/Mr. Roy

Dr. Levine stated the Board had adopted the Strategic Plan back in early 2012, the same year that the Sunset Review Report was completed. Since the completion of that report, the Board felt that the Strategic Plan needed to be reviewed again to make certain that it is line with what Members feel are the current important goals and objectives of the Board and where the Board ought to be spending its time. It is important that the plan capture what the Board's intent is and communicate to all stakeholders and constituents where the Board's resources will be used. The determination was made after working with the Department of Consumer Affairs (DCA) that the plan should not capture items that are within the scope of normal operation of the Board.

Dr. Levine met with Ms. Kirchmeyer to discuss a proposal to review the plan. Mr. Tagami and Dr. Levine worked as the Operational Effectiveness Committee to bring forward revisions to the Committee. They sought consultation with Mr. Tom Roy, DCA, who will be leading the Board through the process. Mr. Roy has been with the DCA since 2010 and has facilitated successful planning and implementation of over 20 strategic plans for a variety of boards, bureaus and programs within State Government. Mr. Roy will walk the Board through the revisions and lead them through the thinking and process behind creation of a strategic plan that accurately reflects the goals and objectives of the Board.

Mr. Roy thanked the Committee for inviting him to join the meeting today. He stated that he met with Ms. Kirchmeyer to discuss what the Board needed and then met with the Operational Effectiveness Committee to discuss augmentations to the Board's Strategic Plan, as well as review staff's suggestions and edits. Today will consist of reviewing the action statements and after each objective, discuss any areas that may be missing and need to be added or modified. In addition, the Committee will assign a priority to each. It is very important in strategic planning to determine what objectives need to be accomplished first. After this is completed, the next steps will involve working with staff to determine the specific actions that will accomplish the overall objectives. Following that, a final plan will be delivered to the Board at the February 2014 Board Meeting.

Mr. Roy went through each new goal and objective and asked Committee Members for their thoughts and input on any additional changes they feel should be included and/or made. The outcome of these discussions is as follows (changes were made to the documents that were presented in the Board packet, which in turn changed the objective numbers as shown in the presentation):

- Approved the six goals as recommended by the Operational Effectiveness Committee.
- Goal 1: Approved additions/deletions to objectives as recommended by the Operational Effectiveness Committee with the following additional edits:
    - Objective 1.1: added the words "in California"; gave the objective a high priority with a #2 standing
    - Objective 1.3: added the words "demonstrate competency and", "current", and "for retraining for"; deleted the words "licensure"; gave the objective a high priority with a #1 standing
- Goal 2: Approved additions/deletions to objectives as recommended by the Operational Effectiveness Committee with the following additional edits:
    - Objective 2.1 (2.5 in packet): gave the objective a medium priority with a #7 standing
    - Objective 2.2 (2.6 in packet): gave the objective a high priority with a #5 standing
    - Objective 2.3 (2.7 in packet): gave the objective a high priority with a #6 standing
    - Objective 2.4 (2.8 in packet): deleted the words "if necessary"; gave the objective a high priority with a #2 standing
    - Objective 2.5 (2.9 in packet): gave the objective a high priority with a #4 standing
    - Objective 2.6 (2.10 in packet): replaced the words "the required" with "all mandated" and deleted the words "pursuant to Business and Professions Code section 805"; gave the objective a high priority with a #3 standing
    - Requested the addition of a new objective for the transition of the investigators to the Division of Investigation and a continuation of measuring timelines to ensure effectiveness; gave the objective a high priority with a #1 standing
- Goal 3: Approved additions/deletions to objectives as recommended by Operational Effectiveness Committee with the following priorities/standings:
    - Objective 3.X (first): gave the objective a high priority with a #2 standing
    - Objective 3.X (second): gave the objective a medium priority with a #4 standing
    - Objective 3.3 (3.7 in packet): gave the objective a high priority with a #3 standing

  - Objective 3.4 (3.8 in packet): gave the objective a medium priority with a #5 standing
  - Objective 3.5 (3.X (third in packet): gave the objective a high priority with a #1 standing
- Goal 4: Approved additions/deletions to objectives as recommended by Operational Effectiveness Committee with the following additional edits:
  - Objective 4.1: deleted the words "relationships with elected officials and their staffs. Build and strengthen" and added the words "with elected officials and their staff" after the word relationships; gave the objective a high priority with a #1 standing
  - Objective 4.2 (4.3 in packet): added the words "consumer organizations" and requested to categorize the groups differently; gave the objective a high priority with a #3 standing
  - Objective 4.3 (4.4 in packet): gave the objective a high priority with a #2 standing
- Goal 5: Approved additions/deletions to objectives as recommended by Operational Effectiveness Committee with the following additional edits:
  - Objective 5.1 and 5.2: requested these two objectives be combined; ensure the word "median" was added when talking about timelines and added the words "from prior year" after 10-20% in objective 5.2; gave the objective a high priority with a #1 standing
  - Objective 5.3 (5.4 in packet): gave the objective a medium priority with a #4 standing
  - Objective 5.4 (5.6 in packet): added the words "and Board Member attendance at staff meetings" at the end of the objective; gave the objective a medium priority with a #3 standing
  - Objective 5.5 (5.8 in packet): replaced the words "our users about" with "those who access"; gave the objective a high priority with a #2 standing
- Goal 6: Approved additions/deletions to objective as recommended by Operational Effectiveness Committee with the following priorities/standings:
  - Objective 6.1: gave the objective a high priority with a #1 standing

Mr. Roy stated that the next steps will be to take these edits back to Ms. Kirchmeyer and work with staff to assign tasks to each of the objectives. The revised draft will then be submitted to the Board for adoption at the February 2014 Board Meeting.

Agenda Item 5 **Adjournment**

Ms. Schipske made a motion to adjourn; s/Ms. Yaroslavsky. Motion carried.

Meeting adjourned at 3:27 p.m.

Agenda Item 4

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 15, 2014
ATTENTION:	Members, Executive Committee
SUBJECT:	Strategic Plan Revisions
STAFF CONTACT:	Kimberly Kirchmeyer, Executive Director

RECOMMENDED ACTION:

Review and approve the Board's Strategic Plan and make a recommendation to the full Board for final approval.

BACKGROUND AND ANALYSIS:

The Board's Executive Committee (Committee) revised the goals and objectives of the Board's 2012 Strategic Plan due to the need to incorporate issues from the Sunset Review Report and to bring it in line with the direction of the Board. Board staff and the Department of Consumer Affairs' Solid Planning Solutions team met and identified tasks or activities to meet those goals and objectives.

The final draft of the Strategic Plan is attached. The second attachment is a version that identifies the Committee's final recommended changes with text ~~strikeouts~~ for deletions and text underlined for additions. The Committee should review the final draft to determine if any edits are necessary. If approved, the Committee will need to make a recommendation to the Board for final approval of the Board's 2014 Strategic Plan.

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	Goal 1: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and examination. demonstrated competence.		
1.1	**Define what is necessary to demonstrate competency and promote safe re-entry into medical practice after extended absences, including looking at the current difference between the requirement for retraining for re-entry (5 years) and the disciplinary re-entry (18 months).**	**HIGH - 1**	
a.	Examine and identify other states' definitions and requirements for re-entry into practice.	Jan-2015	Licensing Outreach Manager
b.	Compare the elements with California's existing practices for re-entry and determine if there are differences.	Jan-2015	Licensing Outreach Manager
c.	Consult with experts in the field of professional skills and competency.	May-2015	Licensing Outreach Manager
d.	Draft a report based upon this research, then propose appropriate length of non-practice to Board for review and approval.	Oct-2015	Chief of Legislation
e.	Make recommendations to the Business and Professions Committees and seek legislation.	Nov-2015	Chief of Legislation

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
1.2	**Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure (MOL) and the American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) initiatives to determine if changes are needed to existing requirements in California (continuing medical education) in order to ensure maintenance of competency of California physicians.**	**HIGH - 2**	
a.	Review the FSMB MOL and the ABMS MOC documents and identify the various components.	Jan-2015	Licensing Outreach Manager
b.	Compare the elements with California's laws and regulations regarding continuing medical education and determine if there are differences.	Apr-2015	Licensing Outreach Manager
c.	Staff will draft changes to laws and regulations as necessary.	May-2015	Licensing Outreach Manager
d.	Hold an interested parties meeting to discuss the proposed changes.	Jun-2015	Chief of Legislation
e.	Present the final changes to the laws and regulations to the Board for consideration.	Jul-2015	Chief of Legislation
f.	Based on the discussion by the Board, if legislative changes are needed, find an author and initiate the legislative process.	Oct-2015	Chief of Legislation
g.	Based on the discussion by the Board, if regulatory changes are needed, have staff initiate the rule-making process.	Oct-2015	Licensing Outreach Manager

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	effectively enforcing laws and standards.		
2.1	**Effectively transition the investigators from the Board to Department of Consumer Affairs in order to improve investigative time frames.**	**High - 1**	
a.	Identify existing investigative timeframes.	Dec-2013	Executive Director and Chief of Enforcement
b.	Hold regular meetings with DCA to discuss the transition of the investigators.	Oct-2013 and ongoing	Executive Director and Chief of Enforcement
c.	Review and approve the Memorandum of Understanding to identify how the transition will be implemented and DCA/Board responsibilities.	Mar-2014	Executive Director, Chief of Enforcement, and Senior Staff Counsel
d.	Update the Board on the transition of staff.	Quarterly	Executive Director and Chief of Enforcement
e.	Meet with labor relations to discuss transition issues.	Apr-2014	Executive Director and Chief of Enforcement
f.	Meet with staff to discuss the transition.	Ongoing	Executive Director and Chief of Enforcement
g.	Finalize the transition and movement of staff.	Jul-2014	Executive Director and Chief of Enforcement
h.	Gather and review investigative timeframes.	Monthly	Executive Director and Enforcement Manager
i.	Report investigative timeframes to the Board.	Quarterly	Executive Director and Enforcement Manager

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
2.2	**Review the laws and regulations pertaining to the Board's responsibility to regulate outpatient surgery centers and suggest amendments.**	**High - 2**	
a.	Review existing laws to determine which laws/regulations need to be revised to meet the current needs for consumer protection and medical education.	Oct-2013	Chief of Licensing
b.	Provide a summary of the proposed changes to the interested parties.	Jan-2014	Chief of Licensing
c.	Determine which changes can be done with regulations versus legislation.	Jan-2014	Senior Staff Counsel
d.	Hold an interested parties meeting to discuss the proposed changes.	Jan-2014	Chief of Licensing
e.	Present the proposed changes to the Board to initiate the legislative process, if needed.	Oct-2014	Chief of Legislation
f.	Initiate the rule-making process.	May-2014	Chief of Licensing and Senior Staff Counsel
g.	Work with the stakeholders to facilitate implementation of regulatory and statutory changes.	Jan-2015 and Jan-2016	Chief of Licensing and Senior Staff Counsel

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
2.3	**Identify methods to help ensure the Board is receiving all the mandated reports.**	**High - 3**	
a.	Send individual notifications to all mandated reporters regarding the reporting requirements.	Annually	Enforcement Manager
b.	Obtain a list of reports from the National Practitioner Databank to cross check with the Board's information.	May annually	Research Program Specialist
c.	Identify opportunities for placement of articles on mandatory reporting in professional newsletters/publications and provide content to be used.	July-2014 and ongoing	Public Information Officer
d.	Conduct outreach on reporting requirements to all mandated reporters, as resources allow.	July-2014 and ongoing	Public Information Officer
2.4	**Determine whether the Registered Dispensing Optician Program should remain within the authority of the Board.**	**High - 4**	
a.	Initiate discussions with the DCA, Board of Optometry, stakeholders, professional groups, and consumer representatives to discuss the potential transfer of the RDO program.	Aug-2014	Chief of Legislation and Executive Director
b.	Write a summary report of the discussions for the Board's review and approval.	Oct-2014	Chief of Legislation and Executive Director
c.	Make recommendations to the Business and Professions Committees and seek legislation if necessary.	Nov-2014	Chief of Legislation and Executive Director

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
2.5	**Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.**	**High - 5**	
a.	Continue to evaluate, revise, and update the training program and materials for experts.	Ongoing	Enforcement Manager
b.	Require the Deputies Attorney General who use the experts to provide evaluations on each expert report and each expert that testifies.	Within 30 days of completion of each expert task	Enforcement Manager
c.	Examine the evaluations to determine if there is a need for remediation or elimination of the experts.	Within 30 days of the evaluation	Enforcement Manager
d.	Continue to provide statewide trainings for the expert reviewers.	Provide two trainings	Enforcement Manager
e.	Provide a status report to the Board on the Expert Reviewer Program.	Quarterly	Enforcement Manager

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
2.6	**Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.**	**Med - 6**	
a.	Examine recent disciplinary decisions to identify any training needed for the Administrative Law Judges.	Monthly	Enforcement Manager
b.	Identify subject matter experts and arrange OAH training at least every other month.	Six times annually	Enforcement Manager
c.	Provide OAH with updates on the Board issues and changes to disciplinary guidelines.	Annually	Executive Director and Enforcement Manager
2.7	**Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks.**	**Med - 7**	
a.	Identify the metrics to be used to examine disciplinary cases within last five years.	Aug-2014	Research Program Specialist
b.	Identify the red flags that could be used to predict patterns before serious harm occurs.	Nov-2014	Research Program Specialist
c.	Draft a report based upon the findings to present to the Board for possible action.	Jan-2015	Research Program Specialist

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.		
3.1	**Review the Board's public disclosure laws regarding posting postgraduate information and move forward with rescinding the 10-year time limit for posting disciplinary information/documents.**	**High - 1**	
a.	Seek legislation to rescind the 10-year time limit for posting disciplinary information/documents.	Feb-2014	Chief of Legislation
b.	Discuss the proposal to remove the posting of postgraduate training information with interested parties, specifically consumer interest groups.	Aug-2014	Chief of Legislation and Chief of Licensing
c.	Provide the recommendation on postgraduate training information to the Board for approval.	Oct-2014	Chief of Legislation and Chief of Licensing
d.	Make recommendations to the Business and Professions Committees and seek legislation.	Nov-2014	Chief of Legislation
3.2	**Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.**	**High - 2**	
a.	Engage in at least two consumer outreach events with area organizations, as travel permits.	Quarterly	Public Information Officer
b.	Continue to provide articles and information in the Newsletter regarding potential violations to assist physicians in understanding the laws and regulations.	Quarterly	Public Information Officer
c.	Launch a Twitter account to provide stakeholders with updates on best practices, changes in laws and regulations, and recent Board activities.	Apr-2014	Public Information Officer
d.	Provide at least two articles to appropriate media outlets regarding laws and regulations and what they mean to stakeholders.	Quarterly	Public Information Officer

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
3.3	**Examine opportunities for the Board to provide training to licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.**	**High - 3**	
a.	Work with DCA to establish webinar protocol and the tools needed to hold successful webinars.	Jun-2014	Public Information Officer
b.	Work with healthcare agencies and organizations regarding topics of interest for training purposes.	Sep-2014	Public Information Officer
c.	Develop interactive webinar content for licensees to promote public protection.	Jan-2015	Public Information Officer
d.	Conduct webinars to promote public protection.	Apr-2015 and bi-annually	Public Information Officer

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
3.4	**Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.**	**Med - 4**	
a.	Expand and continue to cultivate relationships with various ethnic communities through their individual media outlets by providing information and education on the Board's role and responsibilities. Provide update to Board.	Quarterly	Public Information Officer
b.	Engage in television and radio interviews promoting transparency and providing needed information as requested.	Ongoing	Public Information Officer
c.	Create PSAs and videos that can be placed online for viewing that address topics of interest as well as educate stakeholders.	Aug-2014 and ongoing	Public Information Officer

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
3.5	**Establish a method for hosting public seminars taught by legal or enforcement personnel on disciplinary cases, laws violated, and other issues of importance to the profession and the public.**	**Med - 5**	
a.	Develop a list of groups who have shown interest for Board speakers in the past, in order to identify similar groups that the Board can reach out to for potential seminars.	Sep-2014	Public Information Officer
b.	Cultivate relationships with groups, not previously engaged, in order to provide seminars.	Sep-2014	Public Information Officer
c.	Revise and update presentations already developed for the purpose of providing seminars.	Jan-2015	Public Information Officer, Senior Staff Counsel, and Enforcement Manager
d.	Conduct and record the seminar and post it on the Board's website.	Mar-2015 and ongoing	Public Information Officer, Senior Staff Counsel, and Enforcement Manager

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	Goal 4: Organizational Relationships: Improve effectiveness of Build relationships with related organizations to further the Board's mission and goals.		
4.1	**Build collaborative relationships with elected officials and their staffs to work toward shared interests in consumer protection and advancing the profession.**	**High - 1**	
a.	Develop a plan to visit Senate and Assembly Business and Professions Committee members and staff with Board members.	May-2014	Chief of Legislation
b.	Invite Legislative members and staff to Board meetings.	Quarterly	Chief of Legislation
c.	Continue to reach out to new Legislative members to inform them of the Board's roles and responsibilities.	Ongoing	Chief of Legislation
4.2	**Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.**	**High - 2**	
a.	Arrange licensing fairs and orientations at teaching facilities to educate applicants on the Board and its application and licensing processes.	Monthly	Licensing Outreach Manager
b.	Provide presentations on the Board's roles, responsibilities, mandatory reporting requirements, and processes at hospitals, health systems, and similar organizations, as travel permits.	Quarterly	Public Information Officer and Appropiate Subject Matter Expert

DRAFT

Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
4.3	**Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, consumer organizations, professional associations and societies, the Federation of State Medical Boards, federal government agencies, and other state agencies, including the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency.**	**High - 3**	
a.	Develop a contact list of representatives for stakeholder organizations.	Mar-2014 and update annually	Public Information Officer
b.	Offer to make presentations to all stakeholder organizations to provide educational information and updates on the Board's current activities, as travel permits.	May-2014 and ongoing	Public Information Officer
c.	Maintain regular communication with stakeholders, including attending stakeholder meetings as appropriate, as travel permits.	Ongoing	Public Information Officer
d.	Invite stakeholders to participate in the Board's Newsletter with articles and information, approved by the Editorial Committee, pertinent to licensees.	March-2014 and ongoing	Public Information Officer
e.	Provide activity reports to the Education and Wellness Committee.	At each committee meeting	Public Information Officer

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.		
5.1	**Review licensing applications within 45 days. Reduce complaint processing, investigations, and discipline timelines by 10% from prior fiscal year; reduce complaint processing median to less than 70 days, with 50-60% less than 50 days.**	**High - 1**	
a.	Gather and evaluate statistics regarding the Board's application review timeframes.	Quarterly	Chief of Licensing
b.	Determine if the Board is reviewing applications within 45 days, and if not, identify possible problems and solutions.	Quarterly	Chief of Licensing
c.	Implement the possible solutions for licensing process enhancement.	As Necessary	Chief of Licensing
d.	Gather and evaluate statistics regarding the Board's enforcement timeframes.	Quarterly	Enforcement Manager
e.	Determine if the Board is meeting enforcement timeframes goals, and if not, identify possible problems and solutions.	Quarterly	Enforcement Manager
f.	Implement the possible solutions for enforcement process enhancements.	As Necessary	Enforcement Manager
5.2	**Obtain and monitor feedback from those who access Board services and provide a report to Board.**	**High - 2**	
a.	Evaluate consumer satisfaction statistics.	Quarterly	Research Program Specialist
b.	Evaluate applicant satisfaction statistics.	Quarterly	Research Program Specialist
c.	Evaluate web user satisfaction statistics.	Quarterly	Research Program Specialist
d.	Evaluate Newsletter reader satisfaction statistics.	Quarterly	Research Program Specialist
e.	Create a summary report of satisfaction statistics and present them to the Board.	Quarterly	Research Program Specialist and Executive Director
f.	Implement changes as needed based upon the feedback received.	As Necessary	Research Program Specialist and Executive Director

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
5.3	**Establish a consistent approach to educating staff about the Board's activities and priorities set by Board Members, including but not limited to facilitating staff attendance at meetings and Board Member attendance at staff meetings.**	**Med - 3**	
a.	Send an email to all staff after each Board Meeting indicating the action taken by the Board and any projects that will need to be completed.	Quarterly	Executive Director
b.	Send emails to all staff updating them on projects of the Board.	Monthly	Executive Director
c.	Hold regular staff meetings and provide a Q and A time for staff.	Quarterly	Executive Director
d.	Send an email to staff notifying them of upcoming meetings where they could attend.	Quarterly	Executive Director
e.	Invite Board Members to all staff meetings.	Quarterly	Executive Director

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
5.4	**Conduct a review every two years of each of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose for which they were established, and determine if they should continue, be reconfigured, or eliminated.**	**Med - 4**	
a.	Add an agenda item to the Board's October meeting to review the Committees.	Oct-2014 and Biennially	Executive Director
b.	Review the Committee Roster in October and identify Committees that may no longer be needed or may need reconfigured.	Oct-2014 and Biennially	Executive Director
c.	Prepare a memo for the Board Meeting Packet identifying the purpose of every committee and making staff recommendations.	Oct-2014 and Biennially	Executive Director
d.	Discuss the Committee Roster at the Board Meeting.	Oct-2014 and Biennially	Executive Director
e.	Update the Committee Roster as approved by the Board.	Oct-2014 and Biennially	Executive Director

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Medical Board of California

2014 Strategic Plan

	Goals and Objectives	Priority/Date	Responsible Parties
	Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.		
6.1	**Educate the Board on the Affordable Care Act (ACA) and how it will impact physician practice, workforce, and utilization of allied healthcare professionals.**	**High**	
a.	Continue to invite appropriate speakers to inform the Board about the ACA.	Bi-annually	Chief of Legislation and Executive Director
b.	Identify and obtain ACA articles to print in the Board's Newsletter.	Bi-annually	Public Information Officer

***Goal 1: Professional Qualifications*: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and ~~examination~~. demonstrated competence.**

Objective 1.X
Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure (MOL) and the American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) initiatives to determine if changes are needed to existing requirements in California (continuing medical education) in order to ensure maintenance of competency of California physicians.

~~**Objective 1.1: Examine current continuing medical education (CME) structure, its effectiveness, the current California requirements, and opportunities for improvement.**~~

~~**Objective 1.2: Examine and identify methods available to the Medical Board to ensure physicians remain current in knowledge and skills**~~

Objective 1.3: Define what is necessary to demonstrate competency and promote safe re-entry into medical practice after extended absences, including looking at the current difference between the requirement for retraining for re-entry (5 years) and the disciplinary re-entry (18 months).

~~**Objective 1.4: The Licensing Committee (or subcommittee) will examine the FSMB Maintenance of Licensure (MOL) and ABMS Maintenance of Certification (MOC) initiatives and study what should be adopted in California, and determine how it can collaborate with the FSMB and ABMS certifying boards.**~~

~~**Objective 1.5: Conduct a comprehensive review of international schools.**~~

~~**Objective 1.6: Conduct a literature review and internal study of the performance of physicians in training and how it may predict later performance in practice. (See objective 2.5)**~~

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.

~~Objective 2.1: Develop a plan to conduct a complete review of all laws and regulations relating to licensing to identify those no longer relevant and what needs to be added or eliminated. Identify requirements that are not necessary to the safety of practice but may be serving as barriers for qualified applicants, as well as simply updating requirements to be congruent with current educational environments. (To be done in conjunction with Objective 2.2)~~

~~Objective 2.2: Develop a plan to conduct a complete review of all laws and regulations relating to enforcement. Identify those laws /regulations that are no longer useful and augment those that are needed for public protection. Identify the Board's regulatory authority for promulgating new regulations and also identify those issues that require legislation. (To be done in conjunction with Objective 2.1)~~

~~Objective 2.3: Conduct a review of the Vertical Enforcement/Prosecution (VEP) model to assure uniform implementation in all offices and identify any aspects of the model that are increasing cost without producing benefits.~~

~~Objective 2.4: Examine complaint handling priorities. Educate Board members on how complaints are prioritized, as well as the legislatively mandated priorities. Determine if there is a need to change the priorities.~~ (Completed)

Objective 2.X: Effectively transition the investigators from the Board to Department of Consumer Affairs in order to improve investigative time frames.

Objective 2.5: Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks. ~~(Done in conjunction with Objective 1.6)~~

Objective 2.6: Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.

Objective 2.7: ~~Identify opportunities to better educate judges/hearing officers.~~ Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.

Objective 2.8: **Review the laws and regulations pertaining to** ~~**Work to clarify**~~ **the Board's responsibility to regulate outpatient surgery centers**~~**, and obtain the resources to be effective**~~ **and suggest amendments**.

Objective 2.9: ~~**Examine Board responsibilities that could be eliminated or moved to a more appropriate board, bureau, or program. (Midwives, Registered Dispensing Opticians, Spectacle Lens Dispensers, Research Psychoanalysts, approval of non-ABMS specialty boards, etc.)**~~ **Determine whether the Registered Dispensing Optician Program should remain within the authority of the Board.**

Objective 2.10: ~~**Examine the decline of the number of reports received pursuant to Business and Professions Code section 805 (reporting peer review actions).**~~ **Identify methods to help ensure the Board is receiving all the mandated reports.**

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.

Objective 3.X: Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.

Objective 3.X: Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.

~~**Objective 3.1: Improve and expand professional educational outreach, including outreach to students and new graduates, about the laws and regulations that govern medical practice.**~~

~~**Objective 3.2: Improve public education by expanding current outreach efforts and initiating more outreach programs to educate the public on the board's programs, the rights of patients, and how to file complaints.**~~

~~**Objective 3.3: Identify more effective methods to promote the Expert Review Program to recruit qualified physicians.**~~

~~**Objective 3.4: Establish a more proactive approach in communicating with the media to educate consumers and publicize disciplinary cases and criminal investigations, including those done in cooperation with other agencies.**~~

~~**Objective 3.5: Expand the Newsletter to better inform physicians, medical students, and the public.**~~

~~**Objective 3.6: Expand the Web site capabilities to create a portal to provide intuitive and searchable web experience. Develop more online services and surveys to help improve Board's program (see Objective 3.2)**~~

Objective 3.7: Examine ~~how the~~ opportunities for the Board ~~might~~ to provide training to ~~the profession~~ licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.

Objective 3.8: Establish a method of ~~holding~~ hosting public seminars taught by legal or enforcement personnel on disciplinary cases, ~~the~~ laws violated, and other issues of importance to the profession and public.

~~**Objective 3.9: Conduct outreach to ethnic and other language publications and groups.**~~

Objective 3.X: Review the Board's public disclosure laws regarding posting postgraduate information and move forward with rescinding the 10-year time limit for posting disciplinary information/documents.

Goal 4: Organizational Relationships: ~~Improve effectiveness of~~ Build relationships with related organizations to further the Board's mission and goals.

Objective 4.1: ~~Improve~~ Build collaborative relationships with elected officials and their staffs~~. Build and strengthen collaborative relationships~~ to work toward ~~common goals create partnerships on areas of common interests~~ shared interest in consumer protection and advancing the profession.

~~Objective 4.2: Work with California medical schools and training programs on common needs and goals. Create a better partnership with them on educational issues beyond licensing requirements, such as those relating to professionalism, ethics, unprofessional behavior, etc.~~

Objective 4.3: ~~Work to establish better~~ Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, consumer organizations, professional associations and societies, the Federation of State Medical Boards, ~~F~~federal government agencies, and other state agencies, including Department of Consumer Affairs and ~~State and Consumer Services Agency~~ Business, Consumer Services and Housing Agency.

Objective 4.4: Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.~~ Educate the health care profession not only about the Medical Board, but all the health boards in the Department of Consumer Affairs. Re-establish a speakers' bureau or some other outreach for this purpose.~~

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.

~~Objective 5.1: Licensing applications to be reviewed within 45 days.~~

~~Objective 5.2: Reduce discipline, complaint processing, and investigation timelines by 10-20%; reduce complaint processing average to less than 70 days, with 50-60% less than 50 days.~~

Objective 5.X: Review licensing applications within 45 days. Reduce complaint processing, investigations, and discipline timelines by 10% from prior fiscal year; reduce complaint processing median to less than 70 days, with 50-60% less than 50 days.

~~Objective 5.3: Conduct a review of all outside agencies' billing (Department of Consumer Affairs, Attorney General, Office of Administrative Hearings, etc.) to identify redundancies, cost savings, and promote efficiency.~~

Objective 5.4: Conduct a review every two years of ~~all~~ each of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose ~~of~~ for which they were established, and determine if they should continue, be reconfigured, or eliminated~~, or be merged with other committees~~.

~~Objective 5.5: Establish and conduct an annual self-evaluation.~~

Objective 5.6: Establish a ~~means of better~~ consistent approach to educating staff about the Board's activities and priorities set by ~~the membership~~ Board Members, including but not limited to ~~encouraging staff to attend meetings~~. facilitating staff attendance at meetings and Board Member attendance at staff meetings.

~~Objective 5.7: Establish a means of better educating the Board membership about operational activities by providing tours of headquarters, district or regional offices when they are at or near the location for Board meetings.~~

Objective 5.8: ~~Establish a method of obtaining feedback from our users about services.~~
Obtain and monitor feedback from those who access Board services and provide a report to Board.

***Goal 6: Access to Care, Workforce, and Public Health*: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.**

Objective 6.1: Educate the Board on the ~~new healthcare reform law~~ Affordable Care Act (ACA) and how it ~~may~~ will impact physician~~s'~~ practice, workforce ~~(possible shortages)~~, and utilization of allied healthcare professionals.

MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE MEETING AGENDA

MEMBERS OF THE ENFORCEMENT COMMITTEE
Dev GnanaDev, M.D., Chair
Howard Krauss, M.D.
Elwood Lui
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Sheraton Gateway LAX
6101 Century Blvd.
Los Angeles, CA 92501
(310) 642-1111(directions Only)

Teleconference – see attached
Meeting information

Thursday, May 1, 2014
2:30 p.m. – 4:00 p.m.
(or until the conclusion of business)

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

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

Please see Meeting Information Section for additional information on public participation.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE
If a quorum of the Board is present, members of the Board who are not members of the Committee may attend only as observers.

1. Call to Order / Roll Call

2. Public Comment 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 and 11125.7(a)]

3. Approval of Minutes from October 23, 2013 Meeting

4. Discussion on the Memorandum of Understanding Between Medical Board of California and Department of Consumer Affairs Resulting from SB 304 – Ms. Kirchmeyer

5. Update on Transition of Staff to Department of Consumer Affairs Pursuant to SB 304 – Mr. Gomez, Mr. Kidane, Ms. Kirchmeyer and Ms. Threadgill

6. Presentation and Discussion on Enforcement Statistical Reports – Ms. Cady and Ms. Kirchmeyer

7. Presentation on Interim Suspension Order Statistics – Ms. Kirchmeyer

8. Clarification of Expert Reviewer and Medical Consultant Responsibilities – Ms. Sweet

9. Future Agenda Items

10. Adjournment

Meeting Information

This meeting will be available via teleconference. Individuals listening to the meeting will have an opportunity to provide public comment as outlined below.

The call-in number for teleconference comments is: (800) 230-1059

Please wait until the operator has introduced you before you make your comments.

To request to make a comment during the public comment period, press*1; you will hear a tone indicating you are in the queue for comment. If you change your mind and do not want to make a comment, press #. Assistance is available throughout the teleconference meeting. To request a specialist, press *0.

Each person will be limited to two minutes per agenda item. However, during Agenda Item 2 – Public Comments on Items Not on the Agenda, the Board/Committee has limited the public comment period for individuals on the teleconference to 20 minutes. Therefore, after 20 minutes no further comments will be accepted. During public comment on any other agenda item 10 minutes will be allowed for comments from individuals on the teleconference line. After 10 minutes, no further comments will be accepted.

Comments for those in attendance at the meeting will have the same time limitations as those identified above for individuals on the teleconference line.

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

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

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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 Ms. Toof. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE

Agenda Item 3

Historic Mission Inn
3649 Mission Inn Avenue
5711 W. Century Boulevard
Riverside, CA 92501

Wednesday, October 23, 2013

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Enforcement Committee of the Medical Board of California was called to order by Dr. GnanaDev, Chair. With due notice having been mailed to all interested parties, the meeting was called to order at 4:10 p.m.

Members Present:
Dev GnanaDev, M.D., Chair
Sharon Levine, M.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

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

Staff Present:
Susan Cady, Staff Services Manager II
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Kimberly Kirchmeyer, Interim Executive Director
Valerie Moore, Staff Services Manager I
Dino Pierini, Business Services Analyst
Regina Rao, Business Services Analyst
Marie Russell, M.D.
Kevin Schunke, Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Rachel Wachholz-LaSota, Inspector III
Kerrie Webb, Staff Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Gloria Castro, Senior Assistant Attorney General, Department of Justice
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Michael Gomez, Deputy Director, Department of Consumer Affairs
Awet Kidane, Chief Deputy Director, Department of Consumer Affairs

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were provided.

Agenda Item 3 Approval of Minutes from April 25, 2013 meeting
Ms. Yaroslavsky made a motion to approve the minutes from the April 25, 2013 meeting; s/Dr. Yip, motion carried.

Agenda Item 4 Update on Implementation Plans for the Transition of Staff Pursuant to SB 304
Ms. Kirchmeyer introduced the representatives from the Department of Consumer Affairs (DCA). Mr. Kidane, Chief Deputy Director at DCA, and Mr. Gomez, Deputy Director of the Division of Investigation and Enforcement Programs at DCA were both in attendance.

Ms. Kirchmeyer reviewed the plan on the transition of the Investigators to the newly formed unit entitled the Health Quality Investigation Unit (HQIU) within the DCA, Division of Investigation. She stated that documentation of administrative specifics will be provided at the February meeting.

Ms. Kirchmeyer asked the Board members to turn to tab 4, ENF 4-1. She pointed out the written analysis of the transition and stated the following information:

- The bill has changes that will move the Board's investigators, medical consultants and all support staff to a new unit (HQIU) within the DCA.
- It will take place no later than July 1, 2014.
- All civil service employees will retain their position status and rights as employees.
- The bill specifically states that the Board cannot be charged an hourly rate by the HQIU.
- The bill retains the vertical enforcement prosecution model (VE). VE transitions to the Division of Investigation to work with the Attorney General's office during the investigation process.

Ms. Kirchmeyer guided the Committee through the new enforcement process explaining in detail the changes that came with the passage of SB 304.

Mr. Kidane commented that it is the DCA's intent to make the changes in the processes and timelines without disrupting the current functions.

Mr. Gomez clarified for Ms. Yaroslavsky that employees will not be moved to the Division of Investigations field offices and that most people will have the same phone numbers. It is the reporting line that will change.

Mr. Kidane spoke about using the Medical Board's current statistics as recommended by the transition team to hold everyone accountable. Mr. Kidane also spoke on SB 304 saying that this law is not intended to disrupt or remove any services from the consumer. The DCA's transition committee members are in place to have as many eyes as possible looking at the transition, in order to identify any problems or challenges before they occur. This is simply two offices merging together for the best interest of the consumers.

Mr. Gomez spoke on the transition plan stating that DCA is not part of the VE model but is willing to embrace it and figure out how to make it work better. Mr. Gomez guided the Committee through the transition plan using charts and handouts.

Ms. Castro discussed what part the Health Quality Enforcement Section (HQES) plays in the transition. Ms. Castro suggested that HQES does more than make suggestions to the Board, they provide feedback and follow-up, they direct investigations to get them to the logical conclusion of closure, filing, or otherwise and throughout this process they participate in critical junctures of the cases, such as evaluating expert reports, choosing the experts and approving subpoenas. She stated that some of the results already obtained due to the VE model were HQES' ability to produce serious discipline and to close cases earlier brought against physicians that may be innocent. HQES has also focused on more serious cases bringing them to resolution and to the public's attention quicker, plus identifying interim suspensions. This has avoided withdrawals and dismissals of cases and has identified other resolutions that might include public letters of reprimand, citations and fines.

Ms. Kirchmeyer commented that SB 304 extended the time to file an accusation after an interim suspension order is issued from 15 days to 30 days, and explained how the extra time to file the accusation will be of assistance to the investigation.

Karen Ehrlich, licensed midwife and vice chair of the Midwifery Advisory Council, stated that she believes medical consultants have been asked to weigh in on professions where they do not necessarily have training or experience. Ms. Ehrlich stated she would like to see the team approach capitalized by making sure when there are cases against providers other than physicians that a representative of said profession be included in all levels of the deliberations when deciding if a case should be brought against a practitioner.

Agenda Item 5 Presentation Regarding Enforcement Program Accomplishments

Ms. Sweet highlighted the accomplishments of the enforcement program. She spoke about the impact from furloughs, vacancies and other challenges in investigations. She stated that the unique thing about the Medical Board is that the investigation unit handles the cases from beginning to end.

Dr. GnanaDev asked Ms. Sweet which changes in SB 304 will improve the enforcement process, such as timelines for interviews.

Ms. Sweet suggested there are opportunities to review some of these things and there are opportunities to tighten up some things in the manuals that the Enforcement Program shares with the Attorney General. Ms. Sweet suggested some items may not be resolved, and challenges such as subpoenas are going to continue to exist, just by the nature of the work.

Ms. Yaroslavsky thanked Ms. Sweet for the report saying that things may not be as bad as the media says. Ms. Yaroslavsky suggested that staff find a way to tell the Board's story, saying the public needs to know that the Board is paying attention, doing a better job and the results are in the details. She also encouraged the Committee to find a way to tell the story.

Dr. GnanaDev concurred with Ms. Yaroslavsky.

Dr. Yip asked if the expert training is still scheduled and who is the target audience.

Ms. Sweet stated the training is scheduled for November 2, 2013, at UC San Diego in the Met Building and everyone is invited to attend. The Medical Board experts are the target audience. Ms. Sweet went on to explain that the experts will complete sample opinions that will be graded and feedback will be provided. This will help generate a better product. The training is interactive and the experts are all assigned a clicker so they can participate and vote on different scenarios. The experts will be given ten continuing medical education (CME) credits.

Agenda Item 6 Discussion on Suggested Improvements to the Enforcement Program and Review of Member Survey Results

Dr. GnanaDev suggested deferring this agenda item to a future Committee meeting, after SB 304 has been established and implemented.

Agenda Item 7 Update on Operation Rx (Prescribing Strike Force)

Ms. Sweet noted that the prescribing strike force has been working exclusively on over prescribing investigations. Ms. Sweet said there is a unique aspect relating to these cases, which is the need to coordinate with other interested law enforcement agencies such as the Drug Enforcement Agency, the Department of Justice, the Office of the Inspector General, the Federal Bureau of Investigations and a variety of prosecuting agencies including the United States Attorney's office.

Ms. Sweet stated four physicians and one physician's assistant have been arrested or self-surrendered with criminal charges pending. Three search warrants have been executed, one of which resulted in the seizure of 250 boxes of evidence. Since its inception Operation Rx has conducted 15 undercover operations and has procured about 2000 physician prescriptions. Numerous search warrants are in the planning stages. Currently the unit has a case load of 27.

Agenda Item 8 Update on Expert Reviewer Training

Ms. Sweet noted the next training is scheduled for November 2, 2013 at UC San Diego and invited all to attend. Ms. Sweet also noted that ten hours of CME credit will be provided to the participants who attend the training and complete the sample expert opinion. Dr. GnanaDev encouraged the Committee Members to attend.

Agenda Item 9 Probation Monitoring Presentation

Ms. Cady reported background information regarding the Probation Monitoring Unit and how this program monitors the physicians' compliance with the terms and conditions ordered by the Board in its disciplinary orders. She presented a breakdown on how many physicians are on probation (561), how many are practicing while on probation (444), how many are not practicing or are out of state while on probation (117), and how they are all monitored. Ms. Cady explained the inspectors' duties from intake to quarterly updates and stated that most physicians on probation are ordered to take various educational courses and/or a PACE assessment. She answered various questions from the Committee Members regarding these areas.

Ms. Cady continued by stating that the goal set in statute is to rehabilitate and remediate physicians while ensuring adequate protection for the public and that the conditions identified in the disciplinary orders are designed to meet this goal. She continued stating the role of the Probation Unit is to give the physicians the tools and the information necessary to meet the conditions that have been ordered and to ensure adherence to the patient protection components. The inspectors are also charged with monitoring the physicians' practices.

Agenda Item 10 Agenda Items for February 2014 Meeting

- Update on Expert Reviewer Training
- Update on the Transition of Staff Pursuant to SB 304
- Update on Operation Rx (Prescribing Strike Force)

Agenda Item 11 Adjournment

There being no further business, the meeting was adjourned at 6:24 p.m.

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

Agenda Item 4

Medical Board of California and Department of Consumer Affairs Memorandum of Understanding

What is a Memorandum of Understanding

- A document that outlines the agreement between two parties [Medical Board of California (MBC) and the Department of Consumer Affairs (DCA)] and defines the relationship between those parties
- A document that establishes mutually agreed upon protocols and specific roles and responsibilities of each party

Department of Consumer Affairs Duties and Responsibilities

- Provide monthly financial reports and budget projections to the MBC
- Charge MBC for all costs incurred by the Health Quality Investigation Unit (HQIU)
- Will not exceed the allocated amount for HQIU each fiscal year
- Procure equipment and services for HQIU (with the exception of IT equipment and services)

Department of Consumer Affairs Duties and Responsibilities (cont.)

- Create a new Asset Forfeiture Account (current funds in the MBC account will only be used for HQIU until funds are exhausted)
- Pay all invoices received by MBC for costs resulting from HQIU services
- HQIU staff will provide investigative services to HQIU clients only
- Investigate using the vertical enforcement model

Department of Consumer Affairs Duties and Responsibilities (cont.)

- Review Attorney General billings for accuracy
- Return all investigatory files to MBC
- Follow the established IT implementation plan
- Utilize BreEZe as its primary database and enter all data necessary for case tracking
- HQIU staff will assist MBC in the development and presentation of enforcement information
- HQIU staff will assist MBC with expert training

Department of Consumer Affairs Duties and Responsibilities (cont.)

- HQIU staff will collect the same data markers (statistics) as collected prior to the transition
- Notify MBC of any media or legislative inquiry and assist in any necessary response
- Will not provide any press releases regarding MBC cases without approval
- Forward all subpoenas or requests for investigation case records to MBC
- Keep all HQIU case records/information confidential

Medical Board of California Duties and Responsibilities

- Pay all HQIU costs
- Provide existing Asset Forfeiture Account funds for HQIU use
- Follow the IT implementation plan
- Provide IT support services to HQIU staff
- Send all cases referred for investigation by HQIU to the field offices

Medical Board of California Duties and Responsibilities (cont.)

- Incorporate all data marker information (statistics) collected by DCA into MBC documents
- Provide DCA with advance notice of any public presentation of enforcement-related document or information concerning HQIU to Board Members
- Notify DCA of any media or legislative inquiries regarding HQIU and work with DCA on response

UPDATED SB 304 Implementation Plan

October 2013

1. Appear at the Medical Board of California's (MBC) next board meeting and jointly present a proposed transition plan. **(COMPLETE)**
2. Establish with MBC and Department of Consumer Affairs (DCA) budget staff the details of the budget in implementing SB 304. **(COMPLETE – See attached Budget Fact Sheet)**
3. Transition Team is created (DCA Exec staff and MBC). **(COMPLETE)**

November 2013

1. Begin joint meetings with MBC, Health Quality Enforcement Section of the Attorney General's (AG) Office (HQES) and the Division of Investigation (DOI) Re: briefing on Vertical Enforcement Prosecution (VEP). **(COMPLETE)**
2. Identify Transaction areas: **(COMPLETE)**
   - Facilities (if any)
   - Human Resources (HR)/Personnel
   - Budgets and Contracts
   - Expectations of AG's Office/HQES
   - Review current organization charts and begin discussion on proposed charts
   - Information Technology (IT) needs (databases, case management)
   - Internal and external communication
3. Begin informal meet and greets with MBC staff transitioning to DOI-HQIU. **(COMPLETE)**

December 2013

1. Continue discussions on VEP manual. **(IN PROCESS)**
2. Request delegation from California Department of Human Resources (CalHR) to meet and confer with affected labor groups. **(COMPLETE)**
3. Hold meetings between DCA, DOI and MBC staff regarding specific transaction areas. **(COMPLETE)**

January 2014

1. SB 304 becomes law (transfers the MBC peace officers, medical consultants and support staff to D of I effective July 1, 2014). **(COMPLETE)**
2. Governor's Budget for FY 2014/15 is introduced. **(COMPLETE)**
3. Finish meet and greets with MBC staff. **(COMPLETE)**
4. Transition team continues to meet with HQES to define implementation of VEP in the SB 304 model. **(IN PROCESS)**
5. Begin information sharing meetings with unions. **(COMPLETE)**
6. Begin drafting Memorandum of Understanding between DCA and MBC re: Transition of MBC Investigators. **(COMPLETE)**
7. Begin regular meetings among DCA and MBC staff on specific issue areas. **(COMPLETE)**

February 2014

1. Attend MBC's regular meeting to provide update. **(COMPLETE)**
2. Develop plan for the transition of IT, facilities, contracts and other administrative support components. **(COMPLETE)**
3. Initiate joint (DOI/MBC) senior management introductions and facilitate internal communication meetings. **(IN PROCESS)**
4. Complete MOU between DCA and MBC. **(IN PROCESS)**

March 2014

1. Continue implementation of IT, facilities, contracts, and other administrative support components. This includes regular meetings and updates between MBC and DCA staff. **(IN PROCESS)**
2. Continue information sharing meetings with unions. **(IN PROCESS)**

April 2014

1. Review and determine need for revisions or amendments to the current VEP manuals of the MBC and HQES. **(IN PROCESS)**

May 2014

1. Implement IT system access for DOI's management (case management systems). **(IN PROCESS)**
2. Attend MBC's regular meeting and provide update. **(IN PROCESS)**
3. Hold Townhall for MBC and DOI staff regarding the Transition. **(IN PROCESS)**
4. Formal Meet and Confer (after Governor's Budget). **(IN PROCESS)**

June 2014

1. FY 2014/15 Budget Bill enacted to reflect appropriate budget authority.
2. Continue information sharing meetings with unions, if necessary.

July 2014

1. MBC investigators, support staff and medical consultants become employees of the DOI.
2. Initiate a plan to have monthly conference calls or quarterly meetings with HQES leadership.
3. Report to MBC on the Transition.

October 2014

1. Provide enforcement statistics to MBC at regular meeting.

Health Quality Investigation Unit
Budget Fact Sheet

Senate Bill 304 (Lieu, Chapter 515, Statutes of 2013) requires all peace officers, field office medical consultants, and their support positions to be transferred from the Medical Board of California (MBC) to the Health Quality Investigation Unit (HQIU) within the Division of Investigation no later than July 1, 2014.

- FY 2014/15 Appropriation: $15.628 million
  - $12.896 million for personal services.
  - $2.732 million for operating expenses and equipment (Includes one-time costs for equipment).
- FY 2014/15 Authorized Positions: 117.0
  - 98.0 sworn peace offices and 19.0 non-sworn positions.
  - 12.0 positions will report to 1747 N. Market Blvd instead of 2005 Evergreen St.
  - Remaining positions will continue to report to existing offices.
- FY 2014/15 Investigative Services
  - HQIU will track investigative hours for the allied health programs (excludes MBC).
  - Allied health programs will be billed at the existing MBC hourly rate.
  - MBC will fully reimburse HQIU for all costs incurred.
  - Allied health programs will reimburse MBC for their costs (HQIU will handle the accounting process).
- Potential Changes to Investigative Services
  - HQIU, MBC, and the allied health programs will work in conjunction to update the investigative services cost methodology for the HQIU. Any change to this methodology would become effective in FY 2015-16.

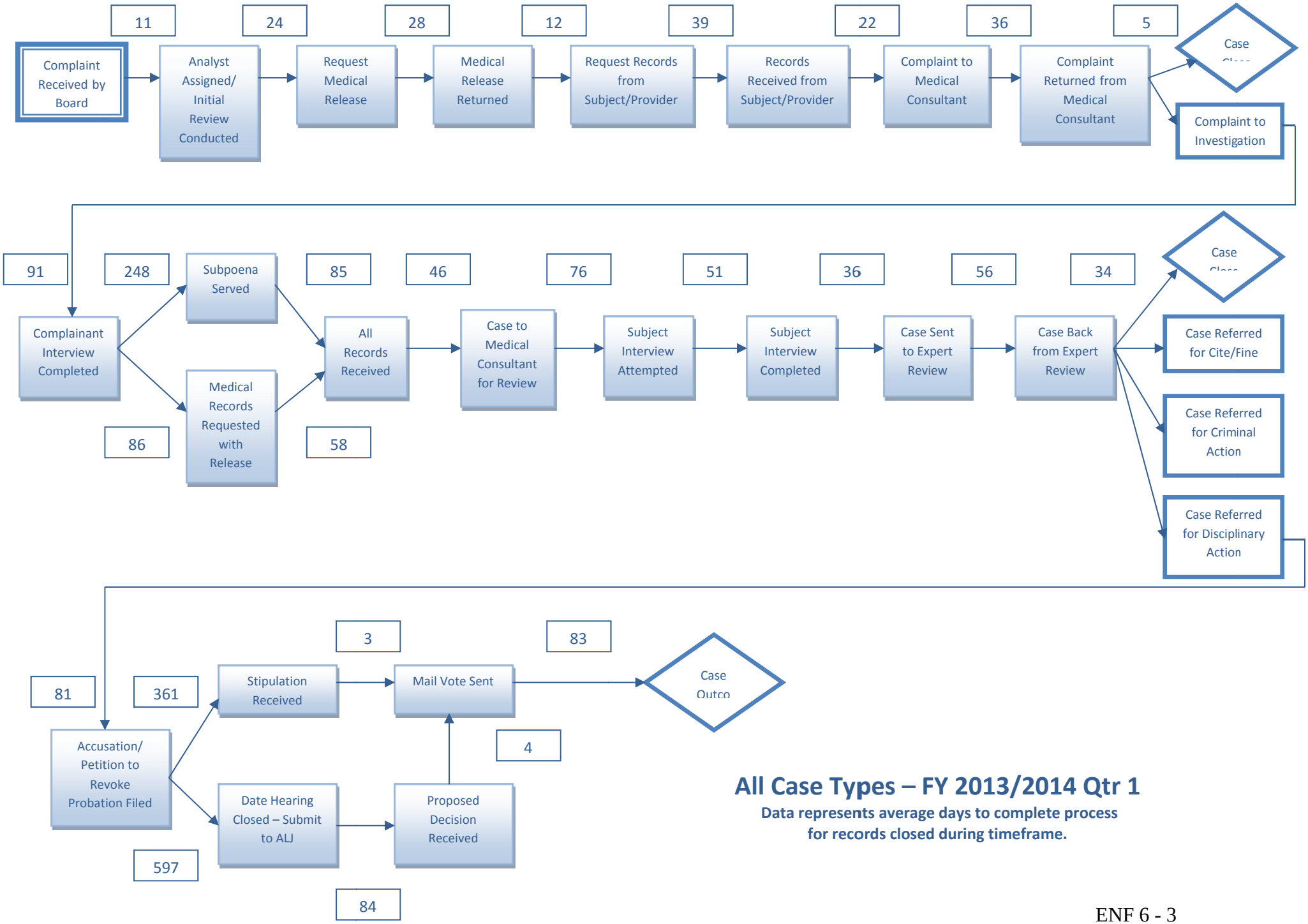
Enforcement Data Markers
All Case Types

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


Complaint Received by Board
11
Analyst Assigned/ Initial Review Conducted
24
Request Medical Release
28
Medical Release Returned
12
Request Records from Subject/Provider
39
Records Received from Subject/Provider
22
Complaint to Medical Consultant
36
Complaint Returned from Medical Consultant
5
Case
Complaint to Investigation
91
Complainant Interview Completed
248
Subpoena Served
86
Medical Records Requested with Release
85
58
All Records Received
46
Case to Medical Consultant for Review
76
Subject Interview Attempted
51
Subject Interview Completed
36
Case Sent to Expert Review
56
Case Back from Expert Review
34
Case
Case Referred for Cite/Fine
Case Referred for Criminal Action
Case Referred for Disciplinary Action
81
Accusation/ Petition to Revoke Probation Filed
361
Stipulation Received
3
Mail Vote Sent
83
Case
597
Date Hearing Closed – Submit to ALJ
84
Proposed Decision Received
4
All Case Types – FY 2013/2014 Qtr 1
Data represents average days to complete process
for records closed during timeframe.

ENFORCEMENT TIMEFRAMES

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
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)**

	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

Enforcement Program Action Summary
Physicians & Surgeons

	FY 11-12	**FY 12-13**
Complaints/Investigations[1]		
Complaints received	6,923	**7,459**
Complaints closed by Complaint Unit	5,662	**5,840**
Investigations		
Cases opened	1,577	**1,502**
Cases closed	1,544	**1,564**
Cases referred to the Attorney General (AG)	610	**566**
Cases referred for criminal action	89	**122**
Number of probation violation reports referred to the AG	33	**24**
Consumer Inquiries		
Consumer inquiries	14,411	**11,243**
Jurisdictional inquiries	7,926	**6,184**

1 Some cases closed were opened in a prior fiscal year

Enforcement Field Operations Caseload[2]

	FY 12-13[6]	
	Statewide	**Per Investigator**
Active investigations	1,219	15
AG assigned cases[3]	540	7
Probation Unit Caseload[4]	**Statewide**	**Per Inspector**
Monitoring Cases[5]	498	29

2 Includes physicians and surgeons, licensed midwives, research psychoanalysts, dispensing opticians, outpatient surgery settings, polysomnographic program, doctors of podiatric medicine, physician assistants, psychologists, and osteopathic physicians and surgeons
3 These cases are at various stages of AG processing and may require supplemental investigative work, such as subpoena services, interviewing new victims or witnesses, testifying at hearings, etc.
4 Includes physicians and surgeons, licensed midwives, research psychoanalysts, and dispensing opticians
5 88 additional monitoring cases were inactive because the probationer was out of state as of June 30, 2013
6 Average is determined by using the total number of authorized positions, including vacant positions

Enforcement Processing Time Frames

Average and median 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:

	FY 11-12		**FY 12-13**	
	AVG	MED	**AVG**	**MED**
Complaint Unit processing	**83 days**	**64 days**	**67 days**	**54 days**
Investigation	**264 days**	**225 days**	**268 days**	**245 days**
AG Processing to preparation of an accusation	**104 days**	**78 days**	**90 days**	**75 days**
Other stages of the legal process (e.g., after charges filed)	**396 days**	**350 days**	**435 days**	**366 days**

Complaints Received by Type & Source

	Fraud	**Health & Safety[1]**	**Non-Jurisdictional[2]**	**Gross Negligence/ Incompetence[3]**	**Other Category**	**Personal Conduct[4]**	**Unprofessional Conduct[5]**	**Unlicensed/ Unregistered**	**Total**
Public	24	113	1,189	2,497	0	41	909	129	4,902
B&P Code[6]	0	6	0	827	0	113	24	0	970
Licensee/ Prof. Group[7]	7	18	26	45	0	30	156	25	307
Government Agency[8]	14	53	13	70	59	280	452	132	1,073
Misc./ Anonymous	2	12	12	32	0	19	42	88	207
Totals	47	202	1,240	3,471	59	483	1,583	374	7,459

1 Health and Safety complaints, e.g., excessive prescribing, sale of dangerous drugs, etc.
2 Non-jurisdictional complaints are not under the authority of the Board and are referred to other agencies such as the Department of Health Care Services, Department of Managed Health Care, etc.
3 Gross Negligence/Incompetence complaints are related to the quality of care provided by licensees
4 Personal Conduct complaints, e.g., licensee self-abuse of drugs/alcohol, conviction of a crime, etc.
5 Unprofessional Conduct complaints include sexual misconduct with patients, discipline by another state, failure to release medical records, etc.
6 Reference is to B&P Code §§800 and 2240(a) and includes complaints initiated based upon reports submitted to the Medical Board by hospitals, insurance companies and others, as required by law, regarding instances of health facility discipline, malpractice judgments/settlements, or other reportable activities
7 Licensee/Professional Group includes the following complaint sources: other Licensee, Society/Trade Organization, and Industry
8 Governmental Agency includes the following complaint sources: Internal, Law Enforcement Agency, other California State Agency, other State, other Unit of Consumer Affairs, and Federal or other Governmental Agency

Reports Received Based Upon Legal Requirements

	FY 11-12	**FY 12-13**
Medical Malpractice		
Insurers: B&P Code §801.01	497	**556**
Attorneys or Self-Reported or Employers: B&P Code §801.01	240	**181**
Courts: B&P Code §803	4	**6**
Total Malpractice Reports	741	**743**
Coroners' Reports: B&P Code §802.5	4	**8**
Criminal Charges & Convictions: B&P Code §§802.1 & 803.5	68	**98**
Health Facility Discipline Reports Medical Cause or Reason: B&P Code §805	114	**107**
Health Facility Reports: B&P Code §805.01	16	**9**
Outpatient Surgery Settings Reports Patient Death: B&P Code §2240(a)	7	**12**

Enforcement Program Action Summary

	FY 11-12	**FY 12-13**
Administrative Actions		
Accusation	312	**291**
Petition to Revoke Probation	34	**28**
Amended Accusation/Petition to Revoke Probation	60	**78**
Number of completed investigations referred to the AG awaiting the filing of an Accusation as of June 30, 2013	155	**160**
Number of cases over 6 months old that resulted in the filing of an Accusation	251	**227**
Administrative Outcomes		
Revocation	46	**58**
Surrender (in lieu of Accusation or with Accusation pending)	71	**80**
Suspension	0	**4**
Probation with Suspension	13	**19**
Probation	117	**119**
Probationary License Issued	24	**27**
Public Reprimand	121	**80**
Other Actions (e.g., exam required, educational course, etc.)	1	**7**
Accusation Withdrawn[1]	12	**18**
Accusation Dismissed	9	**9**
Dispositions of Probation Filings		
Probation Revoked or License Surrendered	21	**11**
Additional Suspension and Probation	1	**2**
Additional Suspension or Probation	8	**8**
Public Reprimand	0	**1**
Other	0	**0**
Petition Withdrawn/Dismissed	3	**5**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	139	**157**

[1] Accusations withdrawn for the following reasons: physician passed a competency exam; physician met stipulated terms and conditions; physician was issued a citation/fine instead; physician died, etc.

[2] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation

	FY 11-12	**FY 12-13**
Petition Activity		
Petition for Reinstatement of License Filed	20	**15**
Petition for Reinstatement of License Granted	6	**7**
Petition for Reinstatement of License Denied	11	**13**
Petition for Penalty Relief[2] Granted	36	**30**
Petition for Penalty Relief[2] Denied	10	**5**
Petition to Compel Exam Filed	20	**5**
Petition to Compel Exam Granted	18	**5**
Petition to Compel Exam Denied	0	**0**
License Restrictions/Suspensions Imposed While Administrative Action Pending		
Interim Suspension Orders	28	**27[3]**
Temporary Restraining Orders	0	**0**
Other Suspension Orders	36	**33[4]**
License Restrictions/Suspensions/Temporary Restraining Orders Sought and Granted by Case Type		
Note: *Some orders granted were sought in prior fiscal year.*	**Sought**	**Granted**
Gross Negligence/Incompetence	9	**6**
Inappropriate Prescribing	5	**12**
Unlicensed Activity	10	**5**
Sexual Misconduct	12	**8**
Mental/Physical Illness	9	**11**
Self-Abuse of Drugs or Alcohol	4	**4**
Fraud	2	**3**
Criminal Charges/Conviction of a Crime	12	**4**
Unprofessional Conduct	5	**7**
Total	68	**60**

[3] Pursuant to B&P Code §2220.05(c), ISOs and TROs were granted in the following priority categories: 2 - gross negligence/incompetence resulting in death or serious bodily injury, 0 - drug or alcohol abuse involving death or serious bodily injury, 2 - excessive prescribing, 3 - sexual misconduct with a patient, and 0 - practicing under the influence of drugs/alcohol

[4] Includes 4 - Automatic Suspension Orders per B&P Code §2236, 14 - license restrictions per Penal Code §23, 8 - out-of-state suspension orders per B&P Code §2310, 0 - stipulated agreement to suspend or restrict the practice of medicine, and 7 - suspension/cease practice orders issued by the Chief of Enforcement for violation of probation condition

Administrative Outcomes by Case Type[1]

	Revocation	Surrender	Suspension Only	Probation with Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	**Total Actions**
Gross Negligence/ Incompetence	11	23	1	6	41	0	47	1	**130**
Inappropriate Prescribing	8	10	0	2	19	0	5	1	**45**
Unlicensed Activity	0	1	0	0	7	0	9	0	**17**
Sexual Misconduct	6	10	0	1	5	0	2	0	**24**
Mental/Physical Illness	6	15	1	0	3	0	0	0	**25**
Self-Abuse of Drugs/Alcohol	8	9	1	4	21	0	1	2	**46**
Fraud	10	4	0	1	1	0	2	0	**18**
Conviction of a Crime	4	3	0	4	10	0	1	0	**22**
Unprofessional Conduct	5	5	1	1	7	27	13	2	**61**
Miscellaneous Violations	0	0	0	0	5	0	0	1	**6**
Totals by Discipline Type	**58**	**80**	**4**	**19**	**119**	**27**	**80**	**7**	**394**

[1] Pursuant to B&P Code §2220.05(c), disciplinary actions were taken in the following priority categories: 49 - gross negligence/incompetence resulting in death or serious bodily injury, 0 - practicing under the influence resulting in death or serious bodily injury, 26 - excessive prescribing, 17 - sexual misconduct with a patient, and 2 - practicing under the influence of drugs/alcohol

Agenda Item 7

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Members, Enforcement Committee
SUBJECT: Interim Suspension Order Statistics
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

BACKGROUND AND ANALYSIS:

At the October 24, 2013 Board meeting the Board requested statistical information on the number of Petitions for an ISO filed and the numbers for those granted and denied. Board staff worked with the Attorney General's Office to obtain the requested information. The following chart identifies the statistics for the last four complete fiscal years and as of April 1, 2014 in fiscal year 2014/2015.

Interim Suspension Orders (Government Code Section 11529)					
	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14*
Petitions Filed	19	23	28	31	16
Petitions Granted (ISO Issued)	19	21	28	27	15
Petitions Denied	0	2	0	4	1
Percentage of ISOs Issued	100%	91.3%	100%	87.1%	93.8%

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

Sheraton Gateway LAX
6101 W. Century Blvd.
Los Angeles, CA 90045
(310) 642-1111 (directions only)

Thursday May 1, 2014
4:15 p.m. – 6:00 p.m.
(or until the conclusion of Business)

Friday, May 2, 2014
9:00 a.m. – 3:00 p.m.
(or until the conclusion of Business)

Teleconference – See Attached
Meeting Information

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.
Elwood Lui
Denise Pines
Gerrie Schipske, R.N.P, J.D.
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.

ORDER OF ITEMS IS SUBJECT TO CHANGE.

Thursday, May 1, 2014

1. 4:15 p.m. Call to Order/Roll Call

2. Public Comments on Items not on the Agenda

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

3. Approval of Minutes from the February 6-7, 2014 Meeting

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

5. Discussion and Consideration of Medical University of the Americas Medical School Application for Recognition – Dr. Servis

6. Update on the Executive Committee and Consideration of Recommendation – Mr. Serrano Sewell
   A. Approval of Strategic Plan

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

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

9. Board Member Communications with Interested Parties – Mr. Serrano Sewell

10. President's Report – Mr. Serrano Sewell
    A. Committee Appointments

11. Executive Management Reports – Ms. Kirchmeyer
    A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
    B. Administrative Summary
    C. Enforcement Program Summary
    D. Licensing Program Summary
    E. Federation of State Medical Boards Summary

Friday, May 2, 2014

12. 9:00 a.m. Call to Order/Roll Call

13. 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)].

14. Update on the Enforcement Committee – Dr. GnanaDev

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

16. Update on the Prescribing Task Force – Ms. Yaroslavsky and Dr. Bishop

17. Review of Responses to Public Comments and Consideration of Revised Regulatory Language Amending Section 1399.541 of Title 16, California Code of Regulations - Physician Assistant Scope of Practice – Medical Services Performable – Ms. Webb and Ms. Dobbs

18. Update on Physician Assistant Board – Dr. Bishop

19. Review of Responses to Public Comments and Consideration of Revised Regulatory Language Amending Section 1361 and Adding Sections 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 to Title 16, California Code of Regulations - Uniform Standards for Substance-Abusing Licensees – Ms. Webb

20. Consideration of Legislation/Regulations – Ms. Simoes
    A. 2014 Legislation
    B. Status of Regulatory Actions

21. Special Faculty Permit Committee Recommendation; Approval of Applicant – Dr. Yip

22. Update on and Consideration of Recommendations from the Midwifery Advisory Council – Ms. Sparrevohn
    A. Approval of Future Agenda Items
    B. Approval of Licensed Midwifery Practice Guidelines

23. Agenda Items for July 24-25, 2014 Meeting in Sacramento Area

24. Adjournment

Meeting Information

This meeting will be available via teleconference. Individuals listening to the meeting will have an opportunity to provide public comment as outlined below.

The call-in number for teleconference comments is: (800) 230-1074.

Please wait until the operator has introduced you before you make your comments.

To request to make a comment during the public comment period, press *1; you will hear a tone indicating you are in the queue for comment. If you change your mind and do not want to make a comment, press #. Assistance is available throughout the teleconference meeting. To request a specialist, press *0.

Each person will be limited to two minutes per agenda item. However, during Agenda Item 2 and 13 – Public Comments on Items Not on the Agenda, the Board/Committee has limited the public comment period for individuals on the teleconference to 20 minutes. Therefore, after 20 minutes no further comments will be accepted. During public comment on any other agenda item 10 minutes will be allowed for comments from individuals on the teleconference line. After 10 minutes, no further comments will be accepted.

Comments for those in attendance at the meeting will have the same time limitations as those identified above for individuals on the teleconference line.

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.

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.

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING
Embassy Suites
150 Anza Boulevard
Burlingame, CA 94010

Agenda Item 3

Thursday, February 6, 2014
2:30 pm – 6:00pm

Friday, February 7, 2014
9:00 a.m. – 4:00 p.m.

MEETING MINUTES

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

Members Present:

Sharon Levine, M.D., President
Michael Bishop, M.D.
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Denise Pines
David Serrano Sewell, J.D., Vice President
Jamie Wright, Esq.
Felix Yip, M.D.
Barbara Yaroslavsky

Members Absent:

Howard Krauss, M.D.
Gerrie Schipske, R.N.P., J.D.

Staff Present:

Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Information Officer
Kimberly Kirchmeyer, Interim Executive Director
Armando Melendez, Business Services Analyst
Regina Rao, Associate Governmental Program Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II

See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:

Theresa Anderson, California Academy of Physician Assistants.
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Long Do, California Medical Association
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
William Ferguson, Center for Public Interest Law
Jack French, Consumer's Union
Faith Gibson, California College of Midwives
Mike Gomez, Department of Consumer Affairs
Donna Gray-Bowersox, Department of Health Care Services
Anne Heard, M.D., Department of Health Care Services
Gail Jara, California Public Protection and Physician Health
Christine Lally, Department of Consumer Affairs
Mona Maggio, Board of Optometry
Carole Moss, Niles Project and California Safe Patient Project
Ty Moss, Niles Project and California Safe Patient Project
Katrina Peters, M.D, Golden State Medical Association
Michelle Monseratt Ramos, Consumers Union Safe Patient Project
Harrison Robbins, M.D., California Academy of Cosmetic Surgeons
Bruce Tarzy, M.D., Department of Health Care Services
Rick Waltman, Center for Public Interest Law

Agenda Item 1 Call to Order/Roll Call

Dr. Levine called the meeting of the Medical Board of California (Board) to order on February 6, 2014, at 2:40 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Introduction and Swearing in of New Board Member

Dr. Levine introduced, welcomed, and swore in Mr. Elwood Lui.

Mr. Lui stated that it was his pleasure to be a part of the Board and to serve the public and is happy to have been appointed by the Governor.

Agenda Item 3 Public Comments on Items not on the Agenda

Public comment was heard on this agenda item.

Dr. Katrina Peters, President of the Golden State Medical Association, stated that her association is part of the National Medical Association which is one of the largest and oldest organizations organized of primarily African-American physicians in the country. She stated a number of their members around the state have expressed concerns that African-American physicians have been targeted and have received discipline from the Board in higher numbers than other comparable physicians in the state. The organization wants to address this issue, but has no effective way of doing so without the assistance of the Board. The organization is not certain if these concerns are fact or perception. Dr. Peters is hoping to get some assistance from the Board to answer that question. She added even if the organization's physicians are not being treated differently, it is important to have as many working and active physicians as possible and if there is anything the organization can do to help keep and return as many physicians to active duty, the organization is willing to work with the Board to help that take place.

Faith Gibson, a licensed California midwife, stated there is an item that should be added to the next Midwifery Advisory Council (MAC) meeting. The item has to do with the newly passed law that took effect on January 1, 2014, that includes the ability for the MAC to move the current licensed midwifery reporting system to the Midwives Alliance of North America system. There is a peer review publication that was recently released from the Journal of Midwifery and Women's Health. There are statistics from 2004 through 2009 all of which include prospectively logged information and includes all of the California midwives.

Yvonne Choong, California Medical Association (CMA), stated that the CMA recognizes the important role that medical consultants and expert reviewers serve in working quality of care complaints and acting as clinical experts to assess whether a licensee has acted with negligence or incompetence in the provision of patient care. The Board has routinely requested assistance from CMA in recruiting reviewers and consultants and CMA has provided that assistance. In that process, there have been some issues that have emerged which require clarification from the Board, and she asked this be placed on a future meeting agenda.

She specifically asked for information on the extent to which an expert witness opinion can be revised by the Board staff and whether there is a requirement that the expert concur with those changes before the report is finalized and used as evidence in a disciplinary case.

She also asked if a physician relinquishes his/her future ability, upon termination of an employment or consulting relationship with the Board, to serve as an expert witness for the defense in cases that appear before the Board. She inquired as to whether physicians who serve as expert witnesses for the defense are expected to disclose past work on behalf of the Board.

She asked for clarification on if a former medical consultant or expert reviewer is retained as an expert on behalf of a licensee, can action be taken against the physician's license if the Board disagrees with or believes that the physician has provided improper expert witness testimony.

Finally, she inquired if prospective consultants and expert reviewers are being made aware of these issues, prior to agreeing to provide services to the Board. If not, CMA believes that this should be included as part of the expert reviewer training under development.

Ty Moss, co-founder of Niles Project, speaking on behalf of the Consumers Union California Safe Patient Project stated they are pleased to see that the Board has begun offering teleconferencing to allow all public participation at meetings. The agenda for the Education and Wellness meeting held earlier today had instructions on how to participate via teleconference. There is some concern that those instructions can serve to reduce public participation at the Board meetings. The instructions stated that there would be a limited amount of time available for those on the teleconference line. After that time limit, no further comments would be allowed. Consumers Union feels that these restrictions are extreme and can run counter to the intentions of the Bagley-Keene Act. Mr. Moss stated that it is believed that with these limitations there will not be an overwhelming amount of teleconference participation.

Agenda Item 4 Approval of Minutes from the October 24-25, 2013 Meeting

Dr. Lewis made a motion to approve the October Meeting Minutes as submitted; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 5 Presentation on Health Care Fraud and Abuse: Preventative Strategies in Program Integrity

Dr. Tarzy, Dr. Heard, and Ms. Gray-Bowersox, from the Department of Healthcare Services (DHCS), shared with the Board a presentation regarding preventative strategies to avoid health care fraud and abuse. The presentation offered examples of issues such as errors, inefficiencies, abuse and fraud. The presentation also provided examples of how “con artists” work and what physicians can do on a regular basis to prevent being a target of fraud.

Dr. Levine asked if DHCS offers an advice line or a place for physicians who are contemplating accepting an offer to call for advice to see if it is legitimate or if it is a red flag.

Dr. Heard stated that there is not an actual advice line to call, however, DHCS’s provider enrollment unit has online information that can assist physicians with certain situations and certain specific issues.

Dr. Lewis thanked the DHCS staff for the presentation and asked about their pre-enrollment review. He understood that DHCS goes out to the site and inspects the facility and asked if the DHCS has any information that could be provided to physicians as an educational tool.

Dr. Heard stated that this is a change for the DHCS and it would like to be able to offer the continuing medical education (CME) credit for the DHCS web-based training so that physicians could receive credit for the education.

Dr. Yip stated that most Medi-Cal enrollees are already enrolled in an HMO plan, and asked if that would switch the target audience in the future, as most of those would be under a similar HMO/IPA plan, their expenditures face capitation and the room for abuse is probably less in Medi-Cal.

Ms. Gray-Bowersox stated that when deciding to do a review or an audit, DHCS uses a number of analytics. Some of the issues will be addressed by the new training modules that cross all payment types and reach all payer sources. DHCS started module two first specifically to include information about prescribing and some of the problems and red flags that physicians need to be aware of. DHCS is not trying to teach physicians how to practice, but to help them understand what the problems and pitfalls are.

Dr. Tarzy stated that the problems in managed care are different and DHCS will eventually have a managed care module.

Dr. Levine asked if the training modules will be live webinars or self-study modules.

Dr. Tarzy responded stating that the modules will be videotaped so that each individual would be able to go through it at his/her own pace. There will be questions that they have to answer before they can move on to the next part of the video, similar to the CME method.

Agenda Item 6 Board Member Communications with Interested Parties

Dr. Bishop stated that he worked with DHCS in regards to the presentation that was provided.

Ms. Yaroslavsky stated that she met with the Los Angeles County Medical Association.

Agenda Item 7 President's Report – Dr. Levine

Dr. Levine gave an update on the status of the Board's Strategic Plan stating that it will be finalized and brought back to the board at the next Executive Committee Meeting, which will be held sometime in late March or early April. The Strategic Plan will then be brought to the full board at the May Board meeting. Staff is working with Department of Consumer Affairs' (DCA) staff to finalize the tasks that need to be completed.

Dr. Levine stated that she has continued to meet with Board staff every two weeks to discuss projects and to provide any assistance she can to insure that things move smoothly. As Vice President of the Board, Mr. Serrano Sewell has agreed to participate in these calls as his schedule allows.

Dr. Levine stated that the American Board of Internal Medicine is now the second of the American Board of Medical Specialties (ABMS) boards to have eliminated any date on board certification. In addition, those who hold certification will be required to participate every year in a certain set of activities in four separate categories to maintain their board status as certified. If those who are board certified do not complete those activities within a year's time, the

certification is not lost, but one cannot be considered "board certified" until the courses are completed. Per the ABMS, all boards will be moving in this direction. Dr. Levine also stated that the Federation of State Medical Boards (FSMB) is beginning a process to look at Maintenance of Licensure's, which is a framework for continuous professional development (CPD) for those physicians who are not otherwise engaged in their CPD through their board certification. There is a pilot program being worked on in Colorado. The idea is for those physicians who have never been board certified or never will be in the future to participate in CPD.

Dr. Levine then referred the members to page 7A-1 and 7A-2 in their packets. Those pages consist of an updated Committee Roster. Dr. Lewis and Ms. Wright have agreed to join the Licensing Committee, Dr. Krauss has joined the Enforcement Committee and Dr. Lewis has joined the Application Review Committee. Dr. Yip is now chair of the Special Faculty Permit Review Committee, Mr. Lui has joined the Access to Care Committee/Cultural and Linguistic Competency Committee, and Dr. Krauss joined the Education and Wellness Committee. Dr. Levine is no longer on the Education and Wellness Committee. Mr. Lui has also been added to Panel B.

Dr. Levine proposed to the Board that a two-member Editorial Committee be established to review the non-recurring articles that are placed in the Newsletter to ensure articles are appropriate for what the Board wants to be promulgating. The two Members that will make up this committee are Dr. Levine and Ms. Pines. Board staff has expressed concern that they do not have sufficient clinical knowledge to ensure the articles are appropriate for the Newsletters.

Dr. Levine suggested that she and Ms. Pines work with staff on developing some policy guidelines around what goes in the Newsletter.

Dr. Levine reminded the Members that if anyone is interested in joining any particular committee to let Ms. Kirchmeyer or herself know.

Dr. Levine then asked for a motion to create an Editorial Committee.

Dr. Diego made a motion to create an Editorial Committee; s/Yaroslavsky. Motion carried.

Agenda Item 8A Interim Executive Director's Report

Ms. Kirchmeyer referred the Members to page BRD 8A-1 through 8A-13 to find a report that includes a staffing report, administrative update, BreEZe update, budget update and the attached documents for those items.

Ms. Kirchmeyer stated that at the end of the fiscal year, the Board is projected to be at 4.3 months reserve. This number is close to the Board's mandated limit for its fund condition, which is between two and four months. The Board's vacancy rate is currently at eight percent, however, taking into consideration those that are in background or pending hiring dates, the Board's vacancy rate is five percent.

Ms. Kirchmeyer noted that during a recent call with the DCA executive management team it was stated that the Business, Consumer Services, and Housing Agency is requesting a monthly report identifying the vacancy rate for all boards under the DCA. The Board is in line with what is expected for all state agencies.

In regards to budget change proposals (BCP), Ms. Kirchmeyer announced that the Governor's Budget that was released on January 10, 2014. The Board's BCP for five additional positions in enforcement, the BCP for BreEZe costs for next year, and the BCP for the transfer of the funding to DCA for investigators were all placed in the Governor's Budget.

The Board had also requested an additional position in the enforcement unit to perform the duties by Ms. Threadgill and to be the liaison between the DCA, Division of Investigations (DOI) and the Attorney General's Office. That position was also placed in the Governor's Budget. Ms. Kirchmeyer recently met with the Legislative Analyst's Office to discuss the BCPs. After explaining the need for them and the Board's workload, there were no concerns. The BCP's should move forward to budget hearings in March or April.

In regards to the BreEZe project, as expected, the learning curve for staff has impacted both the licensing and enforcement units. Staff has found several defects that will need to be fixed in the future, however, at this time, staff is using several workarounds in the system. As a result, the processing time in both licensing and enforcement has increased. One important issue right now is that reports cannot be run to show workload and processing times. This is a priority at this point to be sure that licensing and enforcement functions are working properly. Another issue that has come up is the fact that staff cannot provide an FTP file to organizations that request this information. Staff has written the interface report for the license verification system, but it needs to be put into production. The goal is to have it completed by the end of February 2014.

Ms. Kirchmeyer thanked the Information Systems Branch (ISB) for assisting with taking calls, making address changes, and assisting licensees in renewing their licenses. ISB is also writing up the change requests that are needed for submission to DCA while also launching the Board's new website. Ms. Kirchmeyer recommended that everyone take a look at the new site and offer input.

Since there are new Board Members and current members that will be up for reappointment within the next few months, Ms. Kirchmeyer explained the differences between a Governor's appointment and a Senate or Assembly appointment. A Governor's appointment must be confirmed by the Senate within one year of the date of the first Oath of Office and one year from the expiration date of reappointment. The Senate confirmation usually begins with a list of questions from the Senate Rules Committee staff regarding Board activities and personal opinions and goals pertaining to the position on the Board. Each member must answer these questions and submit them to Senate Rules Committee by the deadline noted. The next step is, the Member will be contacted to set up an interview. Those interviews will either take place in person or via teleconference. After the interview, the appointment will be set to be heard at the next Senate Rules Committee meeting where most often the Member is not required to appear, but can be asked to do so. Once the appointment passes through the Senate Rules Committee it then goes to the Senate floor. The appointment will then be taken up on the floor of the Senate, and then be officially confirmed upon passage from the floor. Ms. Simoes monitors all of these steps, provides information to the

Members, and works with the Senate Rules Committee staff should questions arise or to determine the status of a Member's confirmation.

In addition to the Senate process, a member has to go through a reappointment process. The Member only has 60 days from the expiration date to be reappointed if he or she is a Governor appointment. If a member is not reappointed by that time, the member can no longer serve on the Board. The Member may want to contact the Governor's Appointments Office to inform them of his or her desire to be reappointed. Members can serve two full terms on the Board.

For Senate and Assembly appointees, there is no Senate confirmation process, but there is a reappointment process through each of the appointing authorities, Senate Pro Tem and the Speaker of the Assembly. If a Member would like to be reappointed, the Member should contact those offices directly and make them aware of his or her interest in reappointment. The difference between these two processes is that the Senate and Assembly appointees have one year from their expiration date to be reappointed, or can no longer serve on the Board.

Ms. Kirchmeyer then gave a brief update on the outcome of the teleconferencing that was used at the two meetings prior to the Board meeting. She stated that it went very well and even had someone on the phone the day before that offered some good feedback on what could make it better for today's teleconference meeting. However, as stated in Ms. Kirchmeyer's written summary, the cost to do the teleconferencing that was provided previously was not accurate. For the two meetings, the Board ended up with nine callers on the phone; five yesterday and four today. With the cost that was quoted, these nine calls cost the Board approximately $1,089.00 as each reserved line that is not used costs $5.00 per line.

Public comment was heard on this agenda item.

Yvonne Choong, California Medical Association (CMA) commended the Board staff for coming up with a quick fix for the license verification system. It has been a problem for CMA, as an association, to verify that their members are in good standing with the BreEZe system. CMA looks forward to seeing the emergency release at the end of the month.

Dr. Peters, President of the Golden State Medical Association, thanked the Board for opening the meetings to teleconferencing for those who would like to comment but cannot participate in person.

Michelle Monserrat-Ramos stated that she participated in the prior meeting via teleconference and felt it worked and was handled very well. Ms. Ramos said she promoted the teleconference via social media with a lot of interest and a lot of positive responses.

Agenda Item 9A Federation of State Medical Boards

Ms. Kirchmeyer noted that the Board has been providing a lot of feedback to the FSMB on its draft policies and reports. Feedback was provided, based on Member's comments and some subject matter expert's comments, to the FSMB report on the electronic health records and its policy on telemedicine. Feedback was also provided on the National Practitioners databank guidebook, which was forwarded to the Board by the FSMB. The most recent document that the

Board provided feedback on was a draft document on the interstate medical licensure compact. There have been several federal bills introduced that lead to national licensure or removing the fact that the physician has to be licensed in the state where the care is happening. In an effort to keep state licensure, the FSMB, at its last meeting, approved a plan to look into the feasibility of doing an interstate compact to assist in expediting licensure. A task force was initiated and they recently finalized their draft report of what an interstate compact would look like. At this time, the report was just to determine if an interstate compact is feasible, which based upon the report, it is. This will be a topic of discussion at the FSMB meeting in April. Ms. Kirchmeyer offered to forward the report to any Member who requested a copy.

Overall, the biggest concern in the report was the approval process for medical education. The Board only recognizes and approves certain schools. The information for the compact is not at the same standard as California. Also, although the report reads that a physician cannot have a conviction, it does not require fingerprints to ensure there has not been a conviction. There is no requirement for a state board to enter into a state compact. If that was something the Board decided to do, it would have to go through the legislative process. Ms. Kirchmeyer will continue to follow this and keep the Board Members updated on the status as it proceeds.

The FSMB also notified boards of a risk evaluation and mitigation strategy (REMS) grant to provide educational programming and extended release on long acting opioid analgesic prescribing. The FSMB will award grants to state medical boards to conduct free live seminars for licensees in their respective states. The grant program will provide funding to award up to 25 grants in the amount of $10,000 to individual boards who complete the application process. The curriculum will be provided to the boards to support the programs that will be offered free to the physicians. In order to receive a grant, the Board will need to secure a minimum of 250 prescribers to participate in the program and has to provide the three-hour training between April 1st and December 31st. Ms. Kirchmeyer would like to apply for a grant in California and in order to do so would need approval from the Board. The Board would also have to work with the DCA to determine if there are any restrictions for the Board receiving this type of grant. Ms. Kirchmeyer requested a motion to move forward with this process.

Ms. Yaroslavsky made a motion to move forward with the grant application process; s/Dr. Lewis. Motion carried.

Agenda Item 9B Approval of Recommendation for FSMB Committee

Dr. Levine noted that Ms. Wright requested to be considered for the Editorial Committee of the FSMB. Her nomination had to be submitted by February 1, 2014. Dr. Levine stated she felt comfortable nominating Ms. Wright on behalf of the Board, contingent on taking a vote of the full board at this Board meeting.

Ms. Yaroslavsky made a motion to nominate Ms. Wright for the FSMB's Editorial Committee; s/Dr. Yip. Motion carried.

Agenda Item 10 Update on Transition of Investigators to the DCA Pursuant to Senate Bill 304

Ms. Kirchmeyer gave a brief update on the transition from the Board's perspective side. She noted that since the last Board meeting, Board and DCA staff have held eight formal meetings and several informal meetings regarding the transition of investigators to the DCA. Board and DCA staff have had a meeting with Ms. Castro regarding the transition and vertical enforcement. The items that have been discussed at these meetings have been: Information Technology (IT) issues, a memorandum of understanding (MOU) between the Board and the DCA, contracts, space, purchasing, billing for the affiliating healing arts boards and other topics that need to be discussed for the transition. The DCA is working on an MOU that will cover the issues that have been discussed and should be included in an MOU. Once the draft MOU is completed, it will be sent to Board staff for review. Some of the areas that Ms. Kirchmeyer requested be placed in the MOU include: the cost, how payment or reimbursement will be made, how the Board is billed, IT equipment and services that will be retained at the Board, information regarding assistance from the new unit on Board matters such as presentations, expert reviewer programs, etc., identification of statistics that will need to be provided by DCA, that Board staff will be able to obtain statistics from the BreEZe system based upon information entered by investigators, agreement that the work being performed by all individuals transferring will only be for Medical Board work or work within the affiliated healing arts boards that the Medical Board currently performs investigations for, sharing of expenditure information, information on the asset forfeiture account, and the process of sending cases. Ms. Kirchmeyer stated that Mr. Gomez and Ms. Threadgill have been visiting district offices to meet with staff.

Mr. Gomez provided an update on the SB 304 transition plan that was provided to the Board at the October Board Meeting. At that time, the plan was a high level milestone process that was identified for the implementation of SB 304 and the transition of the Board investigators to the newly created Health Quality Investigations Unit (HQIU) at the DOI. Discussions in October and November were setting the foundation for the transition plan. He stated there is a two year moratorium on the co-location of the HQIU and DCA offices until an assessment can be made on the coordination of the lease expirations, the work and case load areas and which area would be best to serve the consumers of California. Mr. Gomez stated that when the documents read "complete," it does not mean finished, but means that the milestone planning has been met for that component.

In the current month, the DOI and DCA introductions have begun at the Deputy Chief level to begin identifying areas of operational gaps, equipment needs, etc. Mr. Gomez stated that he took it upon himself to learn the work of the Board investigators, by meeting with the investigators, reading the Vertical Enforcement (VE) manual, and attending the four-day long narcotics and pharmaceutical investigation training course that the Board provided. Mr. Gomez stated that these opportunities gave him a chance to meet almost all of the Boards investigators.

Mr. Gomez stated that the talent and passion that these investigators have for the work they do and protecting consumers is by far unequal to any other law enforcement he has seen. He stated that the transition planning is going well and thanked Ms. Kirchmeyer and Ms. Threadgill for helping him to understand the nuances of the work that the investigators do.

Ms. Threadgill thanked Mr. Gomez for taking the time to visit each of the district offices in Southern California and for answering the questions from the staff in each office.

Ms. Yaroslavsky asked Mr. Gomez how often the Board will be getting updates on how this program is progressing and what type of information the Board will be receiving in those updates.

Mr. Gomez responded stating that in the first meeting, the discussion was about what they hope is going to happen. Mr. Gomez offered to report back to the Board as often as Ms. Kirchmeyer and/or the Board requested.

Ms. Kirchmeyer noted that knowing exactly how often and what to report may be a bit premature and believes there needs to be an Enforcement Committee meeting to identify what type of information is needed.

Ms. Yaroslavsky stated her concern is that the Board needs something specific to look at to say whether this is a better system or not. The Board needs to be able to check the metrics on that.

Dr. Lewis requested that at the next Board meeting Mr. Gomez provide the Board with some benchmarks/deliverables.

Mr. Gomez stated that those cannot be provided at the next Board meeting as the transition does not take effect until July, but there will be some updates at the July Board meeting.

Dr. Lewis asked Mr. Gomez if there has been a meeting in regards to staff and titles, etc.

Mr. Gomez stated that is something that CalHR handles and he has no say in those matters.

Mr. Serrano Sewell confirmed that the Enforcement Committee will take these issues up at its next meeting, and report back to the Board.

Agenda Item 11 Enforcement Chief's Report

Ms. Threadgill asked for a motion to approve seven orders, restoring licenses to clear status following completion of probation.

Ms. Yaroslavsky made a motion to approve seven orders to restore licenses; s/Dr. Levine. Motion carried.

Ms. Threadgill directed the Members to page 11B-1 and asked if there were any questions regarding the executive summary.

Ms. Threadgill continued stating the Enforcement Program continues to be extremely busy. Although staff has been unable to extract reports from the BreEZe system, workarounds are being done and staff is manually tracking case load inventory and case age which is time consuming and a challenge.

Operation Safe Medicine saw quite a bit of press on a case where an unlicensed practitioner was convicted of ten felonies, including the unlicensed practice of medicine, grand theft, false impersonation and attempted grand theft. This was a complicated investigation in that the

subject claimed to be able to treat terminal illnesses, such as AIDS and cancer. Investigators performed an undercover operation where the Board's operative presented a history of cancer and recurrence of cancer. The unlicensed person was arrested and a search warrant was executed.

In another case, an investigator from the Sacramento District Office was responsible for the arrest of another unlicensed person who operated an ultrasound business called "Med-Ex Express Diagnostics." This individual used the ultrasound to make the diagnosis of a medical condition. Meanwhile, Operation Rx arrested another individual and conducted three more search warrants since the last Board meeting.

Ms. Threadgill stated staff had another successful expert reviewer training. Dr. Yip and Mr. Gomez also attended this training.

In November, members of the Enforcement staff conducted an Enforcement boot camp in response to inquiries from the Legislature regarding what the Board's investigator's do. This boot camp provided an overview of the investigation process, and then presented several case studies from the inception of the case to the conclusion including the challenges that arose during the course of the case.

In January, the Board's training unit put together twenty-four hours of POST approved training for investigators state wide. Even the most seasoned investigators found the training to be very informative.

Agenda Item 12 Vertical Enforcement Program Report

Ms. Castro announced that a new Deputy Attorney General (DAG), Mr. John Hatchet, was hired from the Fresno AG's District Office. He will be working in the Board's Sacramento Office.

Ms. Castro stated that her staff continues to be called upon by Ms. Kirchmeyer on a regular basis to attend the Board's trainings. Supervising Deputy Attorney General Mr. Robert Bell presented at the medical expert reviewer training in November, 2013. Deputy Attorney General Edward Kim from the Los Angeles office attended the Prescribing Task Force meeting.

The newest Supervising DAG, Judith Alvarado will be participating in Medical Consultant interview training.

Ms. Castro reminded the Board that she meets with Ms. Kirchmeyer bi-weekly to discuss cases. Several of the recent conversations have been in regard to the transition of the investigators. On a monthly basis, Ms. Castro's staff supplies reports to the Board.

Ms. Castro reported on two significant legal cases and stated these cases are in the court of appeal and involve subpoena enforcement matters.

In the first case, *Whitney vs. Montegut*, the Attorney General petitioned the Los Angeles Superior Court for an order compelling compliance of a subpoena seeking medical records of several patients based on evidence of overprescribing. The Superior Court agreed, but the

physician appealed the court decision and challenged the sufficiency of the declaration of good cause and the Los Angeles County Superior Court's jurisdiction over the physician. This decision will assist when physicians do not want to provide records, as there is now a published decision.

The second case is also a subpoena enforcement case that was at the trial court. Dr. Chiarottino is questioning the Board's ability to review CURES absent good cause. The Board is being defended on that issue and advocating for public protection and the government's right to look at these important records.

Ms. Castro stated that the reason she brings these cases to the Board's attention today is to show that they are working very hard on subpoena enforcement cases. As mentioned prior, vertical enforcement stops if they cannot get the documents needed in a case.

Ms. Castro reported that they continue to find efficiencies in the process of reviewing their cases for prosecution and are trying to prepare for the transition as best as possible. She stated that she would like to continue the conversations on how they will be interfacing with the Executive Office upon the transition.

Ms. Castro reminded the Board that the Attorney General's Office gets involved in investigation at three critical junctures: first, when the subject is interviewed; second, when the expert package is sent to the expert reviewer to quickly make decisions based on the report; and third, when they make the final recommendation to the Board as to what should be done with the case.

Public comment was heard on this agenda item.

Long Do, CMA, responded to the two cases that were discussed by Ms. Castro. He noted that both cases involved the use of the CURES database and CMA did file amicus briefs in both cases in favor of positions taken by the physicians. They filed the briefs because they believe that, though the CURES database can be used for very good purposes, the way it was used in those particular cases posed a threat to patient privacy. Mr. Do wanted to be sure the Board understood that there was another side to those cases.

Ms. Castro indicated that her office has responded to both of the filed amicus briefs and that CMA has been very prolific in all of the court of appeal cases lately.

Agenda Item 13 Review of Responses to Public Comments and Consideration of Revised Regulatory Language Regarding Uniform Standard for Substance-Abusing Licensees

Ms. Webb referred the Members to agenda item 13 in their packets and thanked everyone for their comments and noted that many constructive comments were received.

Ms. Webb stated that the reporting requirements under SB 1441 have now been included, but under new regulatory sections so that they are not part of the disciplinary order; however, this makes it clear that the Board will be complying with the reporting requirements. There are additional parts of the standards that are now in separate regulations, as they are directives to the

Board about what to do. There are other Uniform Standards that are not appropriate for the Board to include at this time, such as the section that refers to vendors, except for specimen collectors.

Ms. Webb noted that since the changes have gone up on the website, a comment was received from Ms. Fellmeth that included a request for two modifications. The first pointed out that the beginning of the regulations included the phrase "if ordered," giving the impression there was some flexibility in all of the requirements. Ms. Fellmeth's request was to strike the phrase "if ordered" which appears on page BRD 13-4 section (c). Ms. Webb stated she felt that was an appropriate recommendation. The other area that Ms. Fellmeth asked the Board to consider changing is in regard to the major violation consequences of a licensee. This language is on page BRD 13-16 section (8) (b). Ms. Fellmeth asked that rather than lay out the penalties as a number of options, that it be rewritten to combine (8)(b)(1) and (8)(b)(2) to read as one action. Ms. Webb again felt that was an appropriate change, consistent with the Uniform Standards, and suggested that change be approved.

Ms. Yaroslavsky made a motion to direct staff to take all steps necessary to complete the rulemaking process, including noticing the modified text approved here today for an additional 15-day public comment period. If after the 15-day public comment period no adverse comments are received, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopt them at California Code of Regulations, Title 16, Division 13, Article 4, sections 1361, 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 of the proposed regulations with the modified text. Dr. Lewis seconded the motion.

Public comment was heard on this agenda item.

Ms. Fellmeth, Center for Public Interest Law, stated that Ms. Webb and Ms. Dobbs have done a terrific job of revising the regulations substantially so as to vastly reduce the omissions and inconsistencies between this regulation and the uniform standards.

Michelle Monserrat Ramos, Consumers Union Safe Patient Network, thanked the Board staff for all the work that has been done and stated many of the concerns that she had listed as part of her comments have already been addressed. She added concern that uniform standard number four gives the Board discretion to reestablish a testing cycle, or taking any other disciplinary action, if the Board finds or has suspicion that a licensee has committed a violation of a Board's testing program who has committed a major violation. While the current draft regulation gives the Board broad discretion to require testing and impose disciplinary action, Consumers Union believes it is important that language be included to assure that the Board and physicians fully understand that even in the event of suspicion, the Board has these powers. The Consumers Union feels this is a consumer protection provision.

Ms. Monseratt Ramos stated that in describing major violations, Uniform Standard 10 does not include failure to complete a Board-ordered program. Board staff argued that it is not necessary to include this in the regulations because the Board no longer has a diversion program. However, the Board will be requiring that licensees participate in certain programs, for example, the language that reads "if the Board requires the licensee to participate in group support

meetings." Since the draft regulations contemplate the Board requiring participation in certain activities, the regulations should be clear that failure to participate is a major violation as described in the Uniform Standards.

Christine Lally, DCA read a brief statement stating that the DCA acknowledges the Board's efforts in modifying its regulations to fully comply with the Uniform Standards. She stated the rewrite is well organized, and thanked the Board and staff for taking the time to rewrite it. She specifically commented on Uniform Standards 13, 14 and 15. Most of the provisions in Uniform Standard number 13, pertaining to requirements for lab testing locations and specimen collectors have been reflected in this rewrite. DCA agrees that because the Board does not have a diversion program, none of the provisions of Uniform Standard numbers 14 and 15, pertaining to private diversion vendor program requirements, apply to the Board at this time.

Ms. Webb responded to Ms. Monseratt Ramos's comments stating that her first suggestion was not understood and requested some clarification.

Ms. Monseratt Ramos reiterated her concern in regards to if the Board finds or has suspicion that a licensee has committed a violation of a Board's testing program it is a major violation.

Ms. Webb stated that concern is already covered in the current language and referred Ms. Monseratt Ramos to the proper section of the standards.

Dr. Levine then restated the current motion including the amendments that Ms. Webb read in response to Ms. Fellmeth's comments.

Dr. Levine called the vote. Motion carried.

Agenda Item 14 Update on Health Professions Education

Ms. Yaroslavsky stated that the Health Professions Education Foundation (HPEF) had a very successful year with a new Executive Director. In 2013, out of 153 applications, approximately one-third of the applicants received awards. To put that into perspective, out of the $27 million dollars that was requested, they awarded $9 million dollars.

In 2012, they had 87 applicants, 30 were awarded. HPEF has gone to an on-line application in an effort to assist with outreach. The cost of medical tuition is not going down so HPEF is doing all that it can to partner with the state and stakeholders in the underserved communities.

Agenda Item 15 Update on the Committee on Physician Supervisory Responsibility

Dr. Bishop stated that he chaired the meeting in Ms. Schipske's absence and the first item that was discussed was regarding medi spas or medical spas. This item was brought to the Committee to allow for discussion whether or not the term med spa, medi spa, medical spa or other like names should be defined in statute. Ms. Simoes provided the Committee with background information that is currently available on the Board's website. A medical or medi spa is not a facility that is currently licensed and regulated in California; however, individuals who work in medical or medi spas that perform procedures are licensed and regulated in

California. The purpose of defining a medical spa in law would be to license and regulate this type of facility. The Committee took public comment on this item and discussed the many issues surrounding medical or medi spas. The Committee decided not to go forward with recommending that the Board pursue a statute change at this time, but directed staff to research possible advertising language and what other states are doing in relation to defining a medical or medi spa. The Committee Members were uniformly in agreement that any facility that has medi or something of similar nature in its name should be subject to licensure and regulation in California. The Committee believes that the term medical, medi, medEx, etc., has a connotation that the public may confuse with providing medical care and they feel strongly that this should be pursued aggressively. The Committee also had a presentation on Fictitious Name Permits (FNP) which was given by Mr. Worden. Mr. Worden went over the purpose of an FNP, related laws and regulations, and the FNP requirements and process. Mr. Worden also provided the Committee with FNP program information and statistics. The Committee found the presentation very informative.

Ms. Webb discussed the outcome of a case on the supervision of Certified Registered Nurse Anesthetists. Ms. Webb explained that federal regulations provide a state's Governor to have discretion to make a determination, on behalf of the state, to opt out of the physician supervision requirement, for Medicare purposes, if it is consistent with state law among other things. Ms. Webb explained the process that must completed for the state's Governor to opt out of the supervision requirements. Ms. Webb then explained that in June 2009 Governor Schwarzenegger exercised his discretion under federal law and opted California out of the federal physician supervision requirement. Ms. Webb went over the subsequent lawsuits challenging this matter which were not successful.

The Committee then discussed future agenda items and put the following items on the agenda for the next Committee meeting: 1) Directed staff to collect data on how many medi spas there are in California and how many of those have FNP. 2) Have a presentation by a liability carrier on medi spas. 3) Directed staff to draft language regarding advertising by medi spas, possibly in the corporations' code. Board staff will work with the Chair and Committee Members for the date and location of the next meeting.

Agenda Item 16 Update on the Education and Wellness Committee

Ms. Yaroslavsky stated there was very positive feedback from the Consumers Union, Safe Patient Project with regard to the Board's effort to teleconference the meeting. Ms. Simoes presented an action plan for SB 380. This bill was signed into law in 2011and was sponsored by the California Academy of Preventative Medicine. At the July 17, 2013 Education and Wellness Committee meeting, informational presentations were made by a working group of interested parties on nutrition and lifestyle behavior for prevention and treatment of chronic disease. At that time, staff was directed to draft an action plan that would identify the best vehicle to provide this information to physicians and to identify available resources and an evaluation tool for physicians to use regarding this information. The proposed action plan included designing and maintaining a web page that could be a clearing house of information for physicians and consumers related to chronic disease prevention. The Board would work with other state agencies to promote this web page on their websites to get the information out. At least two articles on this subject per year will appear in the Board's Newsletter, and survey monkey will

be set up as an evaluation tool. This action plan was approved. The following goals and mission statement of the Education and Wellness Committee were approved:

1. Educate the public on the Board's mission, so they can play an active role in their own health care.
2. Educate physicians on the Board's current laws and regulations, and how they impact their practice.
3. Educate physicians and the public on maintaining an overall healthier lifestyle, including the prevention and treatment of disease.
4. Inform stakeholders regarding changes in the delivery model of health care.
5. Review and monitor the Public Affairs' Office strategic plan to ensure goals and objectives are being met.

The Board's Public Affairs Manager, Ms. Hockenson, presented a report that included outreach and media inquiries and upcoming events that the Public Information Office will be participating in. Ms. Hockenson also presented a proposal that the Board engage in social media, specifically starting with a Twitter account. FAQs were provided that included information on other state boards that engage in Twitter, as well as a copy of social media guidelines that are currently used by DCA. The Committee approved the Board to begin engaging in a Twitter account.

The next committee meeting will include a presentation by California Department of Public Health (CDPH) on the California wellness plan that is being released soon.

Dr. Levine asked for a motion to adjourn the meeting.

Dr. Lewis made a motion to adjourn the meeting; s/Dr. Bishop. Motion carried.

Meeting adjourned at 5:25 p.m.

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Friday February 7, 2014

Members Present:

Sharon Levine, M.D., President
Michael Bishop, M.D.
Silvia Diego, M.D.
Dev GnanaDev, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Denise Pines
David Serrano Sewell, J.D., Vice President
Jamie Wright, Esq.
Felix Yip, M.D.
Barbara Yaroslavsky

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

Staff Present:

Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Information Officer
Kimberly Kirchmeyer, Interim Executive Director
Armando Melendez, Business Services Analyst
Regina Rao, Associate Governmental Program Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Theresa Anderson, California Academy of Physician Assistants
GV Ayers, Senate Business and Professions
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul
Alicia Cole, Consumers Union, Safe Patient Project
Phillip Coffman, San Francisco Department of Public Health
Zennie Coughlin, Kaiser Permanente
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Julie D'Angelo Fellmeth, Center for Public Interest Law
Long Do, California Medical Association
Karen Ehrlich, L.M., Midwifery Advisory Council
Jack French, Consumer's Union Safe Patient Project
Faith Gibson, CA College of Midwives
Michael Gomez, Department of Consumer Affairs
Patricia A. Gonzalez, UC Davis
Virginia Herold, Board of Pharmacy
Steven Kelly-Reit, Kaiser Permanente
Kim Kreifeldt, California Academy Physician Assistants
Christine Lally, Department of Consumer Affairs
Khadijah Lang, M.D., Charles Drew Medical Society
Mona Maggio, Board of Optometry
Lisa McGiffert, Consumer's Union
Greg Mennie, California Academy Physician Assistants
Tina Minasian, Consumers Union Safe Patient Project

Michele Monserratt-Ramos, Consumer's Union Safe Patient Project
Carol Moss, Consumers Union Safe Patient Project
Cathryn Nation, M.D., University of California
Alison E. Price, Licensed Midwife
Debra N. Puterbaugh, Institute of Feminine Arts
Harrison Robbins, M.D., California Academy of Cosmetic Surgeons
Deborah Rotenberg, Planned Parenthood Affiliates of California
Bob Sachs, P.A., Physician Assistant Board
Suzan Shinazy, Consumer's Union Safe Patient Project
Carrie Sparrevohn, L.M., Midwifery Advisory Council
Taryn Smith, Senate Office of Research
Laura Thomas, Drug Policy Alliance
Roderick Vitangaul, Kaiser Permanente
Rick Waltman, Center for Public Law
Brian Warren, California Pharmacists Association
Mary Helen Ybarra, Health Professions Education Foundation

Agenda Item 17 Call to Order / Roll Call

Dr. Levine called the meeting of the Medical Board of California (Board) to order on February 7, 2014, at 9:10 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 18 Public Comments on Items not on the Agenda

Alicia Cole, Consumer's Union Safe Patient Project, stated she feels that the Board should make the investigative process more transparent to patients. Patients are at a disadvantage currently when the Board informs a complainant that their case does not constitute a violation, but fails to provide the expert consult report and the investigative file to the patient. Physicians are offered the opportunity to appeal the case to an outside entity, but patients are offered no such opportunity. The Board should consider patients who have submitted complaints as a valued resource for important information. When the Board feels that relevant information is missing from a case file, the Board should reach out to and consult with the patient complainant to determine whether the patient can share further information that would be helpful to fully understand a case. The Board is urged, prior to closing a case to notify the patient as to why the Board feels their case does not constitute a violation. If the patient is still not satisfied and wishes to pursue the case, they ask that the Board offer the opportunity for the patient to appeal to an outside entity. Consumers would like the Board to require a report from staff regarding the criteria used for deciding to close the case, as well as the type of information the medical board expert consultants give the Board when they recommend closing a case. Consumers Union would also like to know how often physicians are late in submitting medical records and how often they are fined.

Agenda Item 19 Regulations – Public Hearing

Dr. Sharon Levine opened the public hearing on the proposed regulations to amend Section 1399.541 in Article 4 of Division 13.8 of Title 16, California Code of Regulations, as described in the noticed published in the California Regulatory Notice Register and sent by mail to those on the Board's mailing list.

Current law permits a physician assistant to act as a first or second assistant in surgery under the supervision of an approved supervising physician. This rulemaking will permit a physician assistant to act as a first or second assistant in surgery without the personal presence of a supervising physician, if the supervising physician is immediately available to the physician assistant.

Immediately available is defined as able to return to the patient without delay upon request of the physician assistant or to address any situation requiring the supervising physician services. Dr. Levine stated that the date was February 7, 2014 and the hearing began at approximately 9:15 am.

Dr. Levine stated that the purpose of this hearing is to receive oral testimony concerning the regulatory proposal just described and as described in the notice.

Dr. Levine informed the Board that two letters and one email were received and provided to the Members. She then asked Ms. Webb to continue with discussion on the items that were received.

Ms. Webb began with the email from Ms. Ruth A. Fox, M.D. Ms. Fox's issue was that the physician assistant can perform procedures without the physical presence of a physician. Ms. Webb stated that her recommendation is that the Board not accept this comment nor make changes based on this comment.

The next comment was received from the California Hospital Association asking the language be amended to match the definition of Centers for Medicare/Medicaid Services (CMS) where immediately available means physically present, interruptible, and able to furnish assistance and direction throughout the performance of the procedure.

Ms. Webb feels the Board's definition of immediately available and interruptible is sufficient to describe the relationship that needs to occur between the physician and the physician's assistant and would not recommend accepting this comment.

The next letter was from the California Academy of Physician Assistants, which was a letter of support.

Dr. Levine called on those persons who wished to testify concerning this proposed regulation.

Greg Mennie representing the California Academy of Physician Assistants spoke in support of the proposed regulation. He was asked to join a surgical team because of a decline in the general surgeon work force. Over the last few years, the PAs have tried to help out in the surgery aspect. Today's surgeons are feeling the increasing demand of workload. His

experience over the past 20 years is that PAs are very capable of working with all physicians in all settings, across all spectrums of the health care system. The clarification in this regulation really will help create better availability of the supervising surgeons and more flexibility in their work day. It would be very helpful for PAs to have clear direction as far as supervision and allow them to serve surgeons in a fashion that can be beneficial to everyone in the system.

Teresa Anderson, Public Policy Director from the California Academy of Physician Assistants, spoke in support of these regulations. She stated the clarification will enhance patient safety.

Kim Kreifeldt, a practicing physician assistant in San Diego, stated she is in full support of the updated and clarifying changes to section 1399.541. She requested that this language be adopted as it would end the differing interpretations among the facilities concerning the personal presence of the supervising physician. By adopting the new language and clearly defining "immediately available," this resolves the ambiguity while maintaining patient safety. She thanked the Board for the opportunity to voice her strong support to amend section 1399.541 and for bringing regulations in line with the current medical community standards.

Dr. Levine stated that since there were no further public comments, the hearing was officially closed and was then opened for Board Member discussion.

Mr. Serrano Sewell asked for some clarity on "immediately available". Ms. Webb read the language directly from the proposed regulation which identifies "immediately available" as: "able to return to the patient without delay upon the request of the physician assistant or to address any situation requiring the supervising physicians' services."

Dr. Levine stated that this definition does not include telephonically available.

Dr. Diego expressed her concerns about the definition of the word "or" in the language. She was concerned that during surgery, the physician may instruct the PA on what to do, rather than physically return to the patient.

Ms. Yaroslavsky suggested replacing "or" with "in order to."

Dr. Bishop stated there are times where the PA may just have a simple question that can be addressed without the physician physically returning to the patient. Dr. Bishop noted that if the language is changed to try and strengthen it, it could create more confusion.

Ms. Yaroslavsky expressed her concerns with the two different perspectives, one from the medical side and the other from the legal side.

Dr. Levine asked if replacing the word "or" with the word "and" would solve this issue without changing the intent of the language.

Mr. Lui noted he feels that adding the word "and" would not be helpful, as the way this language now reads, it means the PA can request the physician return, which overrides the physicians decision. He believes the language is better without the "and".

Dr. Bishop agreed with Mr. Lui's statement and believes the language as it reads now is acceptable.

Dr. Levine suggested taking the word "or" out entirely.

Mr. Lui stated he believed that would work well.

Dr. Yip noted that he has no problem with the removal of the word "or," but would like to hear public comment in the future on how to enforce the language.

Dr. Levine then asked for a motion.

Ms. Yaroslavsky made a motion to direct staff to take all steps necessary to complete the rulemaking process, including preparing the modified text with the deletion of the word "or," for an additional 15-day comment period. If after the 15-day comment period, if no adverse comments are received, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rulemaking process and adopt California Code of Regulations, Title 16, Division 13.8, Article 4, Section 1399.541.

Dr. Lewis Seconded the Motion. Motion carried.

Agenda Item 20 Update on Physician Assistant Board

Dr. Bishop stated that at the last Physician Assistant Board (PAB) meeting, Mr. Sachs was re-elected as the President and Charles Alexander was elected as Vice President for 2014.

Dr. Bishop stated that mandatory reporting requirements for physician assistants (PAs) were discussed at the meeting. There are several types of professional reporting requirements for PAs and the employer such as Business and Professions Code Section 800 series, hospital suspensions and discipline, self-reporting convictions, etc. Reporting certain medical conditions of patients such as abuse or diseases also needs to be reported. The PAB requested that staff develop a fact sheet to include PA mandatory reporting requirements and update the PAB's website to show this information. Dr. Bishop stated the current voluntary exam regarding PA laws and regulations is available on the PAB's website. The current voluntary on-line examination contains 10 questions. These questions have not changed since it was placed on the website several years ago. The DCA Office of Professional Examination Services has identified approximately 20 additional questions.

The PAB is scheduled for on-line applications in April 2014 and on-line renewals in August 2014. The PAB spent much of the meeting reviewing and updating the strategic plan. The PAB's strategic plan was last updated in November, 2009. The PAB has developed new objectives for the plan. A draft plan of the PAB will be presented at the February 24, 2014

meeting. At this same meeting, the PAB will review and possibly update the current vision, mission, and values.

Dr. Bishop stated that the most important issue at this point is to respect and maintain the number of PAs available in California.

Agenda Item 21 Update from the Department of Consumer Affairs

Ms. Lally gave an update on three projects that DCA is working on. One being the implementation of SB 304 and the transition of the Board's investigators. Another is the BreEZe system and correcting some of the defects that have been discovered in the system, including the inability to produce reports. DCA is also working with Ms. Kirchmeyer on the CURES system implementation, which is the California Prescription Drug Monitoring program. Ms. Lally stated that DCA staff is in correspondence with Ms. Kirchmeyer and Board staff on a daily basis working on these issues. All three projects have their challenges, but the close working relationships that have been established have created a good flow of communication.

Ms. Lally announced that on behalf of DCA's Director, Denise Brown, she was asked to convey to the Board today her appreciation to Ms. Kirchmeyer for her extreme dedication and great leadership on all three of these projects, especially on SB 304, assisting in making that transition as smooth as possible. Ms. Lally stated that it is a pleasure to work with Ms. Kirchmeyer and the staff of the Board with the free flow of information and the willingness to share with DCA.

Ms. Lally welcomed Mr. Elwood Lui to the Board and congratulated him on his recent appointment. She reminded all Members that there is required training that needs to be taken as a new Board Member and also particular forms that are required as well, such as the Form 700.

Dr. Levine noted that the Board is also aware of the efforts and hard work that Ms. Kirchmeyer and the Executive Staff have done and appreciates it as well.

Ms. Kirchmeyer then thanked Ms. Lally for her assistance and willingness to meet with her and staff to help with those same issues.

Dr. Levine asked Ms. Lally how long DCA anticipates the design phase of the CURES system. She stated she understands that DOJ is responsible for this phase. Ms. Lally confirmed that this is a DOJ responsibility and that DCA is assisting with the Feasibility Study Report. This is a report that gets put forward to the Department of Technology showing what the project looks like, the timelines, etc.

Dr. Levine asked if the CURES system and the BreEZe system will funnel into the same IT department.

Ms. Lally stated that they will not this early in the game.

Ms. Kirchmeyer noted that with the way the legislation was written, it states that the Board has to allow the process of applying to the Board or renewing a license, to also be able to tie into the CURES system. At some point in the future, that is going to have to be addressed.

Dr. Levine thanked Ms. Lally for always attending the Board's meetings.

Agenda Item 22 Update on Activities of the Board of Pharmacy

Ms. Herold announced that the Board of Pharmacy will be working closely with the Medical Board on SB 493, which requires both Boards to work together on protocols. There is one on hormonal contraception and one for nicotine replacement products. She was hoping to have a draft protocol for the Medical Board Members before the next Board Meeting, but it does not look like that is going to happen. The new target is July, as those protocols also have to be approved by the Board of Pharmacy Members, too. The first meeting on this is scheduled for February 12, 2014. Ms. Herold and Ms. Kirchmeyer will work together so that the Medical Board Members can be kept updated during the development stage, not just at the final stage.

The Board of Pharmacy will be discussing the CURES system during their next Drug Abuse Committee meeting since the Board of Pharmacy has the same mandate that requires all licensees be signed up with CURES by January 1, 2016. The Board of Pharmacy is going to work with the DOJ on an interim measure to try and help get pharmacists signed up, so they can access the data from CURES. The Board plans to start at the Senior Pharmacist level in each pharmacy and get them enrolled and put in the system. They can then access the reports from CURES. The goal is to have some kind of cross over in the future.

Ms. Herold noted that they are working on implementing SB 294 which deals with sterile compounding, where a pharmacy does high risk compounding with an inhalation product, an eye administration product, or an injectable. It is now required that the pharmacy is specifically licensed by the Board of Pharmacy, and they are subject to an unannounced inspection, if they are buying outside of California or in California. The implementation date for this is July 1, 2014, but they are doing the hospital inspections now.

Ms. Herold added that federally, there is a new track and trace law that will be tracking prescription drugs as they move through the supply chain. The law preempts the legislation that California has. The FDA is developing a new outsource structure for large compounders that are neither manufacturers nor pharmacies. This is a three-year trial project after which legislation will be needed to make it permanent.

The Board of Pharmacy has approved a pilot study with University California San Diego (UCSD) to experiment with a method of drug delivery to patients where they can pick up their prescriptions from a vending like machine after they have been counseled. This is available in the employees' workplace at the Sharp Hospital in San Diego. The protocol for the research study is being completed and it is believed that the Board of Pharmacy will approve the protocol at the next meeting.

Dr. Yip asked Ms. Herold what is the current procedure for a Worker's Compensation claim doctor's office dispensing medication, and whether they have to be licensed by the Board of Pharmacy.

Ms. Herold stated that physicians under Business and Professions Code Section 4170 have the right to dispense to their own patients from their office.

Ms. Yaroslavsky asked if there is anything taking place to promote that March is Prescription Abuse Awareness Month.

Ms. Herold stated one of their Board Members offered some radio time for a Public Service Announcement and they will be taking advantage of that opportunity.

Agenda Item 23 Update on Prescribing Task Force

Dr. Bishop announced that the next task force meeting is scheduled to take place on February 19, 2014, at DCA headquarters in Sacramento. Due to the efforts of Ms. Kirchmeyer, there are both national and international experts who have agreed to attend. The task force will be looking into changing the prescribing practice guidelines for California physicians.

Dr. Yip asked for clarification on under what circumstances a pain management contract is required.

Ms. Webb stated that it is on a case specific evaluation basis. The medical experts look at the totality of the circumstances and determine if there was a departure.

Dr. Levine noted that under the new prescribing guidelines, there will be some information about when a contract is appropriate.

Agenda Item 28 Update on and Consideration of Recommendations from the Midwifery Advisory Council (MAC)

Ms. Sparrevohn stated that the last MAC meeting was December 5, 2013. Discussed at that meeting was the impending changes brought about by AB 1308. There was also an interested parties meeting that same day, and it was clear after those two meetings that there are issues that will require the Board to create regulations. One issue is creating a list of conditions that will require a physician referral from a licensed midwife, and the second is creating a form for hospital transfers. They are both expected to be agreed upon by interested parties.

Since that meeting, the working group for the creation of the reporting form is identifying the components and the form should be available to submit to Board staff by the end of February. The working group for creation of the list of conditions for referral has agreed to use the list that is already contained in the standard of care, with the exception of vaginal birth of cesarean which is still in negotiation between the parties and it is hopeful that an

agreement will be made before the next interested parties meeting. Also at the last meeting, Karen Ehrlich gave a report on statistics of the past 5 years for licensed midwives, which essentially have remained the same over the years. The amount of hospital births the licensed midwives are attending has had a significant rise and the caesarean section rate has remained less than 10%, which is significantly less than the national average of over 30%.

Faith Gibson, LM, and James Byrne, M.D. have agreed to work on creating an information packet that can be presented to new Board Members explaining what licensed midwives are, what they do and how the Members can best support their work.

Ms. Sparrevohn asked for approval for future MAC agenda items for the next meeting. She stated an update is needed from the California Association of Midwives on how midwives are doing with their ability to obtain drugs and devices as dictated by AB 1308. A report from staff is expected on the issue of midwife assistants and what services can be performed by an unlicensed person. The Office of Statewide Health Planning and Development (OSHPD) will give an update on reporting statistics and how the system is working. A task force will be set up to possibly change the data set as dictated by AB 1308 to become more in line with what is being collected nationally by the Midwives Alliance of North America. A staff report is needed on how the challenge mechanism will look going forward after 2015. There needs to be an update on moving forward with regulatory changes and how that process is proceeding. A staff report is requested on how midwives can accept certified nurse midwifery schools as schools that are accepted for midwifery licensure.

Ms. Yaroslavsky made a motion to approve the request for agenda items for the next MAC meeting; s/Lewis. Motion carried.

Agenda Item 24 Presentation on the *National Association of Optometrists & Opticians (NAOO) v. Harris* Litigation

Dr. Levine stated that the Board is responsible for the oversight of registered dispensing opticians.

Mr. Lui announced for the record that he represented Lenscrafters affiliations in the Supreme Court of California prior to becoming a Board Member.

Mr. Terrazas and Ms. Schneider, DOJ, thanked the Board for inviting them to provide an update on the *NAOO v. Harris* litigation.

Mr. Terrazas stated that this update is in regards to a case that does impact one of the Board's programs which is the Registered Dispensing Opticians (RDO) Program. This program was involved in litigation that challenged the regulatory schematic dealing with the allowable and prohibited relationships between RDOs and optometrists. The core issue happens to be whether or not there is any element of commercial control over the clinical judgment of the optometrists, since it is the optometrists that write the prescription, which is the pathway for eye glasses. Mr. Terrazas and Ms. Schneider have prepared a history of the litigation to help the Members understand where the case is. They are actively engaged with most of the major stakeholders in the industry to make sure they understand the business

operation models and are reviewing those for compliance and non-compliance with California's regulatory scheme.

Ms. Schneider began the presentation with a historical recap of eye care in California, beginning in 1903 when optometry became a profession in California. The history portion of the presentation included goals, commercial practice restrictions, legislation and regulations that have come to be over the years. It also included the history of the litigation.

Mr. Terrazas stated that they wanted to provide Members the background since litigation has been going on for so long. The bottom line is that the state regulatory scheme that outlines allowable and disallowable relationships between the retail commercial side and the clinician has been upheld. The US Supreme Court is now declining to exercise jurisdiction leaving intact the Ninth Circuit District Court of Appeals decision that says California laws are constitutional. This places a lot of operational business models at risk in California. These companies are now in discussions with DOJ in regards to demonstrating what their operational business models are and if they are not in compliance, how they are going to bring them into compliance. If these companies do not bring their models into compliance, the Board will be involved in any enforcement activity if needed for those RDOs in violation. If the optometrists do not bring their models into compliance, the enforcement then falls to the Board of Optometry.

Dr. Levine asked Mr. Terrazas if DOJ is certain, at this point, that the practices of the companies described are all illegal. Mr. Terrazas stated that they are in discussion with these companies presently and they have been very forthcoming in providing proprietary information for an in depth analysis to be done on how they actually operate.

Dr. Levine asked Mr. Terrazas if the Board will receive the results of their determinations. Mr. Terrazas stated that the Board will eventually, as they will be involved in any enforcement action needed.

Ms. Yaroslavsky asked if a national organization can own a free standing place where a consumer can go to receive an eye check-up and glasses and what is the current law for this type of situation.

Mr. Terrazas stated that the law does not allow an RDO to hire or control an optometrist.

Ms. Yaroslavsky asked if independent optometrists have the ability to examine and dispense in the same location if they own the business.

Mr. Terrazas stated that optometrists can do that today.

Ms. Yaroslavsky asked what the new model is that people are looking to achieve.

Mr. Terrazas stated that the goal is to have co-habitation between the optometrist and the RDO and to have the relationships between the two be appropriate and not prohibited, so there is no undue influence by the commercial interest to the optometrist.

Ms. Wright asked Mr. Terrazas for clarification as to what their process is going to be. She understands it to be that they will conduct an investigation, but will they then ask that a consent decree be entered into, or does it come before the Board for the Board to enforce.

Mr. Terrazas stated that it would only come to the Board for enforcement if they have reached an impasse where it has been determined that there is a violation of the law; then DOJ will ask the Board to step in for enforcement.

Ms. Kirchmeyer stated that for the past several years, the Board has received complaints regarding RDOs that were in violation of the law in that they had an optometrist and RDO co-joined. With this particular litigation, the Board was enjoined from taking any action against this complaint. Since this litigation has resolved, the Board is now allowed to take action, but it gave a limited amount of time for the RDOs who had been in violation, to meet with the AG's Office and try to come into compliance with their practice models, the AG's Office is now working with those entities and the Board can now begin to pursue cases that are in violation of the law as the enjoinment has been lifted. However the AG's Office is continuing to work with entities to help bring the practice models into compliance. However, if RDOs are not in compliance, the Board will go through the disciplinary process and the Board could revoke the registration. These cases will come to the Members through their voting and Panels as usual.

Dr. GnanaDev asked who actually licenses the Opticians who work in these entities.

Ms. Kirchmeyer stated that there are different types of licenses under the RDO program. There is the Registered Dispensing Optician (RDO), the bricks and mortar building, which is basically like an establishment license. There is also the Spectacle Lens Dispenser (SLD), the Contact Lens Dispenser (CLD), and the Non Resident Contact Lens Dispenser (NRCLD). All of those fall under the Board's jurisdiction.

Dr. Levine stated that the reason this item was put on the agenda is because several of the Members were unaware that this was part of the Board's purview.

Dr. Yip thanked Mr. Terrazas and Ms. Schneider for the very informative presentation and asked that staff create a detailed memo showing the history, the background and the stats for education for when one of these cases does show up for voting.

Dr. Levine requested that the Board Members get a copy of the presentation after the meeting.

Agenda Item 25 Update on Licensing Outreach/Education Program

Mr. Schunke announced that he participated in an event at Kaiser in the Los Angeles area at the main hospital, which brings together all the residents from Kaiser Facilities in Los Angeles. He also participated in an event at UCLA due to a request from the residents asking for a licensing fair.

Mr. Schunke stated that he has made most of his travel plans for 2014 for the events scheduled through November. He will be meeting with approximately 2200 unlicensed residents as they begin the licensing process. Much of his time during the last couple of months has been spent helping hospitals and applicants navigate through the BreEZe system and getting them information that is no longer available online.

Ms. Yaroslavsky asked what kind of feedback he was getting from those at the events in regards to the new BreEZe system. Mr. Schunke stated that the licensing part of the system is working well, but the rest of the system for the hospitals and applicants is a bit challenging.

Ms. Kirchmeyer stated that the individuals do not have the ability, at this time to get in and check the status of their application like they used to be able to do. This is something that Mr. Worden and his staff are working on with DCA to get the look up working. The other issue is, in the past, the applicant would be able to provide their ATS number and their passwords to the hospitals to enter the system. That is no longer going to be available to them.

Ms. Yaroslavsky expressed her concerns regarding how long it is going to take to get the new system to work accordingly.

Dr. Levine asked staff to prepare a catalog from a functionality perspective identifying where the gaps are and what the anticipated date of release is for the fixes of those gaps. She asked that this be brought back to the next Board Meeting.

Ms. Yaroslavsky stated that she would like to know when it will be working as originally planned and what the implication is on staff. She liked the idea of a unique identifier number and stated this should be examined.

Ms. Kirchmeyer stated it was originally anticipated to take about six months before staff would be processing applications in the time frame as they were before BreEZe.

Dr. GnanaDev suggested to Mr. Schunke that when he spends time with thousands of residents during the licensing fairs that he also spend some of that time sharing enforcement information as well, such as what to do to stay out of trouble.

Mr. Schunke reported that there have been several times where he has taken the opportunity to have a sit down with several students at one time, and discuss all parts of what the Board does in a Question and Answer type session.

Ms. Yaroslavsky suggested that the Board Members get a list of Mr. Schunke's travel dates and locations and recommended Board Members in that area attend a licensing fair.

Public comment was heard on this agenda item.

Karen Ehrlich suggested doing a You Tube video of the things that Mr. Schunke assists applicants with at the licensing fairs. It would be a great public source of information.

Agenda Item 26 Licensing Chief's Report

Mr. Worden stated the licensing program has faced some challenges in the second quarter of the fiscal year as licensing has had staff out for various reasons, including extended leaves, and position vacancies. However, the most challenging has been the implementation of the new BreEZe system. Part of that challenge is that staff is having to enter additional information that did not have to be added before.

Mr. Worden then referred members to pages BRD 26A-4 and BRD 26A-5 for the licensing program statistics. Many of the statistics are not available at this time due to not being able to obtain reports from the new system. He then pointed out some statistics that were reported by manual count: the consumer information unit/call center received 8,542 call back requests which is 2.2 times higher than the previous quarter; the number of physician licenses issued was 849 for the quarter which is a decrease of 598 licenses from the previous quarter; and a decrease of 415 licenses compared to last year at this time.

Mr. Worden gave a brief update on the BreEZe system stating that prior to BreEZe, the Board had a system that allowed applicants to check the status of their application. This option is not currently available which has added to the large increase in phone calls. Staff is working with DCA to get that resolved. Currently, with the learning curve, the additional information required in the system, and workarounds, it is taking twice as long to process applications in BreEZe than into the previous system. With a lot of staff ingenuity and lots of overtime, staff has been able to review applications for both the US and IMGs within forty-five days. Their next challenge is the backlog of the incoming mail.

Mr. Worden stated that BreEZe has been a challenge and one thing that has been determined to help is for each staff person to have two monitors. Some information being entered into BreEZe is taken from the Accredited Council for Graduate Medical Education (ACGME) website, which can be cut and pasted, but having to switch back and forth between screens is confusing and time consuming. They are also looking into having one touch screen monitor for each staff member.

Mr. Worden stated there is currently a resolution the Board approved identifying a passing score for the United State Medical Licensing Examination (USMLE) exams. The USMLE used to provide a scaled two digit score. The USMLE now provides a three digit passing score. Therefore, a resolution is needed from the Board to accept the FSMB's and USMLE's determined passing score as the Board's. Mr. Worden also requested that staff be permitted to begin the regulatory process to correct this issue.

Mr. Worden asked for a motion for a resolution to adopt the FSMB and USMLE minimum passing score as the Board's passing score for all steps of USMLE's physician and surgeon licensing exam.

Dr. GnanaDev made a motion to adopt a resolution accepting the FSMB and USMLE minimum passing score as the Board's passing score for all steps of the USMLE; s/Ms. Yaroslavsky. Motion carried.

The second motion is for the Board to authorize staff to proceed with the rulemaking process to either amend an existing regulation or to add a new regulation to address the minimum score for licensing examinations.

Dr. Lewis made a motion to authorize staff to proceed with the rulemaking process to either amend an existing regulation or to add a new regulation to address the minimum score for licensing exams; s/Ms. Wright. Motion carried.

Ms. Yaroslavsky expressed her concerns about staff burn-out with so many hours being worked.

Ms. Kirchmeyer stated that the deadline for concept papers is coming up, so she will see how much staff is needed with the new system, taking into consideration that much of it is a learning curve. She will determine if a Budget Change Proposal (BCP) needs to be put forward for additional licensing staff or maybe temporary help in the interim time.

Ms. Yaroslavsky suggested seeing if there was any additional information that could be put on the website as far as BreEZe is concerned to assist in maybe cutting down the high volume of calls.

Mr. Worden stated that is being looked into already.

Ms. Kirchmeyer stated that ISB staff have taken a lot of the calls, and they are looking at what can be put together for FAQs. Staff recently posted some helpful hints on the website to assist people through the BreEZe system. These hints are mostly for lookups and renewals.

Agenda Item 27 Update on the Outpatient Surgery Setting Task Force and Consideration of Recommendations

Dr. GnanaDev reported that on January 22, 2014, the Outpatient Surgery Setting (OSS) Task Force held an interested parties meeting regarding the proposed amendments to the OSS statutes and regulations. This meeting was held at the Board's headquarters in Sacramento and was video conferenced with three Board offices. Mr. Serrano Sewell participated from the San Jose office. The OSS task force provided interested parties with language and reasons for the recommended changes to the statutes and regulations and requested input on these changes. At the October, 2013, Board Meeting, the task force was authorized to move forward with its recommended changes after receiving and considering input from the interested parties at the January 22nd meeting. Based upon the comments from the interested parties, the OSS task force determined that the legislative changes could move forward. Therefore, the language for these changes was provided to Senate Business and Professions (B&P) Committee and Senator Lieu. Due to a very tight deadline to get the changes into the B&P, the task force was unable to submit all the changes, but will continue to work on getting the other changes made in the future. The task force recommended changes were as follows: 1) providing some clean up language to section 1248.15 (a)(2)(d); 2) changing section 1248.3(a), to require initial certification accreditation to be valid for only two years

instead of three; 3) section 1248.35 (b)(2) requiring inspections, after the initial inspection, to be unannounced. This language has been provided to the B&P Committee staff. In addition to the above changes, the task force determined that the Board needed to make some conforming changes to the regulations based upon the recent legislative changes, specifically those needed to be made to section 1314.4 of the California Code of Regulations, Title 16. No comments requiring modification of these adjusted changes were received at the interested parties meeting; therefore staff will begin the regulatory process to make these conforming changes. The specifics of these changes can be found in the Board Packet, page BRD 27-9.

Dr. GnanaDev added that at the interested parties meeting, there were two of the suggested amendments that received a significant amount of comments. The suggested amendment that received the largest number of comments was the deletion of section 1248.15(a)(2)(c)(3). This deletion would have removed one of the methods under which an OSS can be accredited. Based upon the comments received, the task force has determined that more discussion is needed. The other amendment that received significant input was a change to the section 1248.15(a)(6)(b)(i), which requires peer review for all physicians in an OSS, even if there is only one physician performing procedures in that OSS. The interested parties requested the Board provide more clarification and also provide a definition of peer review. The task force discussed the comments received and modified that section based on those comments. Dr. GnanaDev stated those changes were listed on page BRD 27-4 in the Board Packet.

Dr. GnanaDev indicated the new requirement would state all physicians who perform procedures for which accreditation is required in an outpatient surgery setting are required to have peer review evaluations as defined in the Business and Professions Code Section 805(a)(1)(a) including outpatient settings that only have one physician. He further added for the purpose of this section, a peer review party consists of a California licensed physician who is qualified by education and experience in performing the same type of procedures, who may or may not have privileges at that outpatient setting.

Dr. GnanaDev asked for a motion to approve the proposed amendment regarding peer review requirements for physicians in OSS.

Ms. Yaroslavsky made a motion to approve the proposed amendment; s/Dr. Yip. Motion carried.

Public comment was heard on this agenda item.

Tina Minasian, Consumers Union Safe Patient Project, stated that Consumers Union is disappointed and concerned about how few and minor the proposed changes are by the OSS task force. They urge the Board to apply rigorous oversight, maximum transparency and wise policy direction in the case of these surgery settings and their accrediting agencies. She specifically requested: 1) full disclosure of information to support informed patient decisions; and 2) maximum protection through high accreditation standards. At the October 2013 Board Meeting, it was asserted that requiring peer review at OSSs would make unnecessary a Consumers Union Safe Patient Project recommendation requirement that

physicians performing surgeries that require general anesthesia in OSS's be board certified and also have hospital privileges for the specialty surgical procedures they are performing in OSSs. According to a side by side, distributed at the Board's July meeting, only one of the four Accrediting Agencies (AA) required board certification. Apparently the other agencies allow the physician owners to create their own rules regarding who can perform which surgeries. Consumers Union urges the Board to add as requirements a board certification and hospital privileges. The Board should be aware that the peer review system does not do a good job in protecting consumers and should not be relied upon to ensure patient safety in OSSs. At the interested parties meeting, Board Member Serrano Sewell raised questions regarding what the Board could undertake to have confidence that AAs are doing their job conscientiously.

Carol Moss representing Consumer's Union stated that lapses in infection control at OSSs put patients at risk. The Board should ensure that AAs are required to ensure that OSSs are following prevention standards as established by the national experts, such as the CDC and CMS. Additionally, the law should require all OSSs to report on health care acquired infections that occur in patients. This could require a 30 to 90 day follow-up with patients. Several states already have laws requiring OSS's to report their infection rate.

Dr. Levine reminded everyone that the OSS task force will continue to meet and work on other aspects of amendments that were not able to be put into the most current version of the bill.

Agenda Item 29 Consideration of Legislation/Regulations

Ms. Simoes referred the members to page BRD 29A-1in their packets, which is the status of regulatory actions, and asked if Members had any questions. Ms. Simoes moved to 2014 legislation. Ms. Simoes stated that the 2014 legislative session has started and the introduction deadline is February 21, 2014. A 2014 legislative calendar was included in the packets. Ms. Simoes stated that this calendar shows the legislative deadlines for the year. The two-year bills are in blue on the tracker list, and will not be discussed at this meeting. Ms. Simoes stated that only two bills will be discussed at this meeting, AB 1535 – Bloom and SB 500 – Lieu.

AB 1535 (Bloom) allows pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures developed by the pharmacist and an authorized prescriber acting within the scope of his or her practice or in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy and the Board. This bill would require a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing it.

Ms. Yaroslavsky made a motion to support this bill; s/Dr. Lewis. Motion failed. (4-5)

Dr. GnanaDev asked about the protocols that are to be approved by both the Board and the Board of Pharmacy.

Ms. Simoes stated this requirement is similar to the bill that Ms. Herold had mentioned earlier in her report. Protocols would have to be approved by the Board and the Board of Pharmacy. The two boards would create those protocols together and then they would come to the Board for review and approval.

Dr. GnanaDev asked if there was any opposition to this bill.

Ms. Simoes stated there is no opposition at this point, and that there is generally support for bills that increase access to naloxone hydrochloride because of the lives that it has saved.

Ms. Yaroslavsky mentioned there was some great media recently in the Los Angeles media markets supporting this drug. It is getting a lot of positive feedback.

Public comment was heard on this agenda item.

Yvonne Choong, CMA, stated that CMA has not taken a position on this bill but is concerned that this bill currently lacks language that would provide safeguards against it being construed to allow pharmacists to dispense prescription drugs without a prescription.

Brian Warren, California Pharmacists Association, one of the Co-Sponsors of this bill, stated that they have received support from the Health Officers Association of California, which is a group of physician health officers from various jurisdictions throughout the state, as well as the California Society of Addiction Medicine. The association is scheduled to meet with CMA to discuss their concerns.

Dr. GnanaDev stated that this drug is a less dangerous drug, but how and when it is administered is a big concern. Details really need to be worked out because it can have serious side effects, but can also be a miracle drug if administered appropriately.

Dr. Bishop stated concerns because this is not necessarily a safe drug. He does not want anyone to get the impression that this drug is easy and safe to administer. It requires significant training and understanding of how the drug works.

Dr. Lewis stated that it is a safe drug and he supports the bill in principal but has concerns that even with proper training that pharmacists may be giving this drug out to people who may share it with others. He felt there should be a lot more thought process put into this before moving ahead with it.

Laura Thomas, Deputy State Director, Drug Policy Alliance, thanked the Board for considering this bill, as they are one of the sponsors. She stated it is part of their effort to be sure that California does a better job of addressing the significant epidemic of accidental drug overdose. It is the leading cause of accidental death. This type of pharmacy access is a program that is currently in place in Washington State and Rhode Island where they have developed protocols for it.

Dr. Phillip Coffman, an internist and infectious disease clinician at the University California of San Francisco and the San Francisco Department of Public Health stated he has been

doing work on opioid overdose prevention and the role of naloxone for quite some time. This drug has been distributed for over 20 years to people who might witness an opioid overdose in various places around the world. It use started in the United States around 1996 it really started picking up in the 2000's and in San Francisco since 2003 under the Department of Public Health. There was a publication a couple of years ago that documented 50,000 people trained in using naloxone and over 10,000 reversals, which means about 99.5% are successful.

He stated the safety concerns around this drug are minimal with the doses that tend to be used today. The withdrawal effects are pretty mild and most distribution programs collect data on what the side effects are after administering it. They are finding that the withdrawals are not as violent and/or severe as they were when being administered by paramedics where the doses were much higher. Most use an intranasal formula that has a much lower dosage than the intravenous dosage. He has helped clinics start up prescribing naloxone and one of the barriers is the time that physicians have to demonstrate how to administer it, etc. He feels that pharmacists are in a better position to do that, and he supports this bill, as it takes the pressure off the physicians and helps pharmacists contribute to the discussion and service.

Dr. Robbins stated his concerns about this drug possibly becoming an over-the-counter drug as it would then not have any type of follow-up care required.

Karen Ehrlich, a grandmother whose grandson died of an accidental overdose two years ago, appreciated the Board's concerns about the safety of this drug, but this drug is a benefit to the people and their loved ones who might suffer because of these accidental overdoses.

Dr. Lewis made a motion to support this bill in concept pending interested parties meetings and further discussion on the bill; s/Ms. Wright. Motion carried.

Ms. Simoes moved to the next bill, SB 500 (Lieu) and stated this bill would require the Board to update its pain management guidelines every five years, beginning July 1, 2015. It would require the Board to convene a task force to develop and recommend the revised guidelines to the Board and would allow the task force to consult with specified entities when developing the revisions to the pain management guidelines.

Ms. Simoes stated at the April 25, 2013 Enforcement Committee Meeting, the committee established a prescribing task force. This task force was convened to define best practices related to prescribing controlled substances and to revisit the pain management guidelines to address the serious problem of inappropriate prescribing. The task force had its first meeting on September 23, 2013, and discussed corresponding responsibilities of physicians and pharmacists for prescribing and dispensing. The next prescribing task force is scheduled for February 19, 2014. At that meeting the discussion will focus on revisions to the pain management guidelines. This bill would quantify the work that the Board has already begun to address the important consumer protection issue of inappropriate prescribing. The Board has identified revising these guidelines as an important tool to help combat inappropriate prescribing.

Ms. Simoes pointed out this bill will ensure that the pain management guidelines are revised and reviewed in a consistent, on-going manner to provide appropriate guidance to physicians who are prescribing pain medication.

Ms. Yaroslavsky made a motion to support this bill; s/Dr. Lewis. Motion carried.

Ms. Simoes gave a brief update of the legislative proposals that had already been approved by the Board. There are three bills that will be included in the B&P Committee omnibus bill. The first proposal is to include the American Osteopathic Association Healthcare Facilities accreditation program as an approved accreditation agency for hospitals offering accredited postgraduate training programs. The second proposal is to strike the word "scheduled" from existing law in B&P code section 2240. Lastly a proposal related to physician availability that would allow the Board to adopt regulations for all clinical settings, not just those performing elective cosmetic procedures using laser and impulse light devices.

The Board also approved going forward with legislation that would eliminate the 10-year posting requirement in existing law in order to ensure transparency to the public. In the Senate B&P's background paper it was recommended that this change be made. However, SB 304 did not include that language. Assembly Member Eggman, member of the B&P Committee, has agreed to carry this legislation.

Ms. Simoes stated that language will also be included in Senator Lieu's bill SB 500 that will reverse the *Capen vs. Shewry* decision and will allow OSSs to obtain clinical licensure from the California Department of Public Health (CDPH). This will not be a mandate or requirement, but an option. This bill will include some language that is sponsored by the Board and some language that will be sponsored by CDPH. Ms. Simoes also stated she will be working with Senate B&P staff, G.V. Ayers, on the peer review language that the Board approved; to see if that can possibly go into that bill as well.

Dr. GnanaDev stated that he is concerned with the language that states that physicians would be able to choose to either be licensed by the CDPH or accredited by the Board. He is concerned that this will cause more confusion for the consumer in regard to whom they need to contact with a complaint.

Dr. Levine stated that the long term goal is independent of whom owns it, the standards will be the same, whether they are licensed by CDPH or accredited by the Board.

Dr. Bishop stated that he agrees with Dr. GnanaDev that the Board hears from consumer groups that when they have a complaint, they have no idea who to go to and this will add another level of confusion.

G.V. Ayers, Senate B&P Committee, stated that it is an issue of concern for them as well. They understand the issue of clarity and are seeking to resolve those concerns. Amendments and new language may be needed.

Dr. Bishop stated that Dr. GnanaDev and Board staff has done a lot of work looking at all of the accreditation agencies and hopes that work has not been a waste of time and would like to have the work join with this new possible language.

Tina Minasian, Consumers Union Safe Patient Project, has concerns that if a physician is turned down for licensure by CDPH, he will apply for accreditation at the Board and may be accepted. This type of situation is very concerning to consumers.

Ms. Simoes continued with her update stating that the Board approved going forward with legislation that would require a respondent to provide the full expert reviewer report and to clarify the time frames in existing law for providing the report. This is an issue that was brought up in the sunset review report and SB 304 did originally include language that would have addressed this. However, after many meetings with CMA and the legislature on amendments, the language was pulled from SB 304. Ms. Simoes has been unable to find an author for this bill, since CMA stated that there are no amendments that they feel are appropriate.

Yvonne Choong, CMA, stated she would like to address two parts of the legislative proposal. It is their belief that in last year's negotiations with the Board on the expert witness issue, they made their concerns clearly known with respect to the changes that were being made to the expert witness proposal. CMA feels that it skews the balance towards the prosecution rather than the physician and believes the time frame that a physician has to prepare the expert witness defense is inconsistent with the Board's burden of proof as required under the Medical Practice Act for due process. They also have concerns about removing the 10-year posting requirement, since that language was put in as part of a prior sunset review process, where concerns were about leaving information up on the website that is potentially ambiguous to consumers about the competency of their physician.

Dr. Robbins, a member of the Board's Physician Supervisory Committee, stated that the Board is in the process of omitting a huge segment of OSS facilities and that segment is responsible for a good percentage of surgical procedures. The exception to the requirement for accreditation that is given to OSSs is only to those that operate under local anesthesia. They are not required to be accredited at the present time and there has been no discussion on how these will be included.

Ms. Simoes continued her report stating that the Board raised the issue of accelerated three-year, competency based medical school as a new issue in its sunset report. In an effort to reduce nationwide shortage of primary care doctors, there is a movement toward accelerated three-year curriculum. This curriculum would allow medical students to receive the same amount of education in a concentrated, modified year round education schedule. There are some California medical school programs that are proposing and/or considering competency based tracks for students that excel and progress at a faster rate. Some of these accelerated programs will not meet the requirements of existing law, and legislative changes are needed in order to accommodate changes in medical education to license graduates from the accelerated curriculum programs. All of these proposed programs are going through review and approval for accreditation through the Liaison Committee on Medical Education (LCME), which accredits all U.S. Medical Schools, or the Committee on Accreditation of

Canadian Medical Schools, which accredits Canadian medical schools. Board staff has met with staff from the University of California, Office of the President and discussed the need for legislation to accommodate the accelerated three-year medical school programs. Board staff has drafted language that would allow for these programs to meet the licensing requirements only if they are accredited by the LCME or the CACMS. These applicants would then meet the minimum medical education requirements. Staff is requesting approval from the Board to co-sponsor legislation with the UC to allow for the accelerated three-year competency based medical school programs if the UC also co-sponsors this legislation. Assembly Member Bonilla has expressed interest in authoring this legislation.

Ms. Yaroslavsky made a motion to approve this legislative proposal; s/Ms. Wright.

Dr. Levine clarified that current California law requires a specific number of weeks to qualify in a curriculum based program.

Ms. Yaroslavsky expressed her concerns about not wanting this legislation to push California's institutions to go to a shorter period of time.

Public comment was heard on this agenda item.

Catherine Nation, M.D., Associate Vice President of Health Sciences with the University of California, Office of the President, responded by stating that within California and within the U.S. medical school community, the four-year curriculum that is overseen by the LCME will remain as it is currently. This three-year curriculum is attractive for those students who wish to go into primary care, for example, which offers them the opportunity to miss a year of school and fees. Dr. Nation stated that these programs would be small, but attractive to many.

Dr. Diego asked if the core of the education continues, and that the things that are elective or maybe can be bypassed are the things being shaved off to shorten to curriculum.

Dr. Nation said that was part of the way these programs work for most schools. She stated an assessment process is conducted, for example, the UC Davis proposed program is looking to admit a small number of students, who are interested in primary care. Students at UC Davis who know they want to go into primary care would be allowed to essentially save them a year of school as well as a year of fees.

Dr. Diego asked if the students would still be eligible to be licensed in other states as well.

Dr. Nation stated that it is for the graduates of LCME-accredited medical schools across the US and would give them the path to residency training and licensure in California provided they have graduated from an LCME-accredited medical school.

Ms. Kirchmeyer stated that this is not just for the individuals in California, as there is a program in Texas and one in New York. This legislative change would allow a graduate pf a approved accelerated program at an LCME- accredited medical school to be able to apply for licensure in California, which is the goal.

Sarah Brady, Ph.D., Assembly Member Bonilla's office, stated that Assembly Member Bonilla urges the Board to support the three-year competency based medical school programs and is very interested in authoring the bill.

Dr. Levine called the vote. Motion carried.

Agenda Item 31 Presentation on Postgraduate Training/Residency Programs

Dr. Nation began her presentation by comparing context in terms of state needs. California, by comparison to the rest of the country, was part of the focus. The presentation discussed existing workforce challenges, medical education and residency training, Graduate Medical Education (GME) financing along with some budgetary and workforce challenges.

Dr. Nation stated that estimates suggest that California will face growing shortages of physicians in the coming years. The demand for doctors and health care services will increase as the population ages, as more consumers become insured, and as growing numbers of providers retire.

Dr. Nation reported that California is ranked as the 13th fastest growing state in the nation and the state's population is increasing in age and diversity. Our workforce is aging with more than 30% of California physicians at age 60 or older, which is the second highest percentage in the country.

Dr. Nation reported that California has a small medical education system in comparison to its population. There are approximately 6,500 students enrolled in California's 11 medical schools. On a per capita basis, California has a statewide medical school enrollment of 18 students per 100,000 population, which ranks third lowest in the nation.

Dr. Nation stated that in 1997, Congress capped the number of residency slots for which teaching hospitals could receive Medicare GME funding. Those limits have not been changed since then, with only a few exceptions.

Dr. Lewis asked if there are any types of advocacy groups that have partnered with UC that could assist in mentoring these residents and act as supervising physicians for these programs.

Dr. Nation stated that this is becoming a crisis as the reliance on clinical preceptors increases. The pressures in terms of practice are squeezing out the opportunities for students across the state. Supervising a medical student will slow down a physician's practice. Mentoring is the heart and soul of their PRIME program and mentorship by community-based physicians.

Dr. Levine reminded the Board that what prompted this conversation is the 30% increase in medical education slots over that last 10 years, however a much smaller increase in graduate medical education slots due to the cap put on the training programs in 1997 and Medicare

not having the funds to change that. So, the gap is growing and squeezing out IMGs. Alternative sources of funding are going to be necessary to close that gap.

Ms. Yaroslavsky asked if there is any expectation or national initiative going forward that will require Medicare to increase funding.

Dr. GnanaDev responded, stating that it is an initiative of AMA to increase the GME slots, but congressional resistance is stating that Medicare should not be the only one who funds medical education. One solution is to work with the community hospitals to create primary care residency programs and do it in such a way that one can get to the maximum in five years so that the Medicare cap is reached.

Dr. Bishop stated that the crisis that is currently taking place is not something that was unknown for years, yet somehow, has now become a crisis. He stated he is concerned that the quality part of things is missing and that caution needs to be taken.

Ms. Wright asked Dr. Nation what UC is doing in the area of there not being enough doctors per capita for high density, lower income areas.

Dr. Nation stated that this issue is the prime focus of their Urban Underserved PRIME Program. This program is small, but focuses on the needs of the poor, the homeless, the drug addicted etc., who are in urban locations, but where physicians may be concentrated in the suburbs and there may not be a path to care offered. Their residents rotate through several different facility sites such as county facilities, Veterans Affairs (VA) facilities, and student clinics in underserved, underfunded, and underinsured areas. Dr. Nation added that there is a cultural competency element for all medical school programs and a requirement of the LCME.

Agenda Item 30 Agenda Items for May 1-2, 2014 Meeting in Los Angeles Area.

Dr. Levine asked Board Members and members of the public if there were any agenda items they would like added to the May meeting agenda. Seeing none, Dr. Levine stated that if anyone thinks of anything within the next month to communicate with Ms. Kirchmeyer. Dr. Levine then asked for a motion to adjourn into closed session.

Ms. Yaroslavky made a motion to adjourn into closed session; s/Dr. Lewis. Motion carried.

Meeting was adjourned into closed session at 1:20 pm.

Agenda Item 32 Closed Session

Agenda Item 33 Open Session

Meeting reconvened from closed session at 4:15 pm, with Dr. Levine announcing that the Board had concluded the interviews for the permanent Executive Director for the Board. The Board offered the position of the Executive Director to Ms. Kirchmeyer who has been

serving as the Interim Executive Director since June 2013. This offer is pending the approval of the Director of DCA, Ms. Brown per SB 304.

Dr. Levine thanked all of the candidates for their patience in the process and congratulated Ms. Kirchmeyer stating that the Board Members look forward to working with her for at least the next five years.

Dr. Levine adjourned the meeting at 4:18 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

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 16, 2014
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School University of Queensland Ochsner School of Medicine/Clinical School Program
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

After review and discussion, recognize the University of Queensland School of Medicine/Ochsner Clinical School Program (UQO), deem it to be in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1, and extend that recognition to those who matriculate at UQO on or after January 1, 2009.

BACKGROUND AND ANALYSIS:

The University of Queensland School of Medicine, located in Brisbane, Australia, was founded in 1936 to train physicians to practice medicine primarily in Australia. It is the largest medical school in Australia and is currently recognized by the Medical Board of California (Board). Students graduate with the MBBS degree, which is the equivalent of the M.D. degree in the United States. Geographically, the school extends throughout Queensland with major sites in Brisbane, the outer metropolitan areas, and a number of rural and remote area facilities throughout the rest of Queensland.

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

The Ochsner Clinical School Program in Louisiana is conducted in partnership with the Ochsner Health System which includes eight hospitals throughout southeast Louisiana, primarily in New Orleans and Baton Rouge. Ochsner has full institutional accreditation from the Accreditation Council for Graduate Medical Education (ACGME), as does its 27 Graduate Medical Education

programs through the respective Residency Review Committees. The Ochsner Health System is also formally affiliated with both Louisiana State University School of Medicine and Tulane University School of Medicine. The UQO admits one class of students each year, with the academic year running from January to late November. The first class of students was admitted in January 2009 with an enrollment of 12 students. The UQO is aiming for a total enrollment of 480 students (120 students admitted into the program each year).

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

At the Board's Quarterly Meeting on July 19, 2013, the Board authorized a site visit to UQO's site in New Orleans. The site visit was conducted March 18-21, 2014. The Board's site visit team consisted of the following team members:

Curtis Worden, Board Chief of Licensing
Dev GnanaDev, M.D., Board Member
Kerrie Webb, Board Senior Staff Counsel
Jim Nuovo, MD, Board Licensing Medical Consultant

The site visit included meeting with administration, faculty, and students at the Ochsner Clinical School in New Orleans, Louisiana. Video conference meetings were conducted with Darrell Crawford, MBBS, FRACP, MD, Professor, Head of School, University of Queensland School of Medicine (UQ); Jennifer Schafer, MBBS, DRANZCOG, FRACGP, Head of Academic Discipline of Medical Education, Director of MBBS Program; UQ faculty; and students (both UQO and UQ cohorts).

Staff requests that Board members review the Medical Consultant's report dated April 7, 2014, (pages BRD 4 – 4 through BRD 4 – 11) and determine whether to recognize the medical education provided to students by UQO who matriculated on or after January 1, 2009.

Professor William W. Pinsky, M.D., Head, Ochsner Clinical School from the UQO, has advised staff that he plans to attend the May 1, 2014 Board meeting to be available during the meeting to answer any questions the Board may have concerning the school's educational program.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs

include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the reimbursement of the Board Member's per diem of $100.00 per day for four days. Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit. UQO prepaid the estimated cost of the site visit and Board staff is in the process of auditing the final costs of the Site Visit Team. The Board will prepare a request for a refund to UQO of any overpayments if appropriate.

April 7, 2014

To: Members
Medical Board of California

From: Jim Nuovo, MD
Professor & Associate Dean of Graduate Medical Education
UC Davis School of Medicine
4860 Y Street; Suite 2300
Sacramento, CA 95817

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

Background

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

This report is based on my review of the documents initially provided to the Board by the University of Queensland, from a response by the School to additional questions posed after review of the Self-Assessment Report, as well as additional information reviewed by the Board's Site Visit Team.

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

Site Visit Team

The Site Visit Team included:

Curtis J. Worden, Chief of Licensing

Dev GnanaDev, MD, Medical Board of California

Kerrie Webb, JD, Staff Counsel

Jim Nuovo, MD, Medical Board of California, Licensing Medical Consultant

Site Visit Process

An agenda for the site visit was developed by the team. The team arrived in New Orleans on the evening of March 18, 2014. There was an initial meeting with Dr. William Pinsky to review the agenda and discuss the goals of the site visit; specifically, that the intent of the site visit was a comprehensive review of the UQO Program as it relates to the requirements of Business and

Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1. On the following day, the Site Visit Team met with the leadership of the UQO Clinical School Program to include: Leonardo Seoane, MD, Senior Deputy Head-Curriculum, Richard Deichman, MD, Deputy Head-Student Affairs, Sohail Rao, MD, Deputy Head-Research, Shelly Monks, MBA, System Vice President, Education, Chief Administrative Officer, and Carl Tholen, MEd, Undergraduate Medical Education, Program Director. The content of the discussion included an overview of the relationship between the University of Queensland and the UQO Clinical School Program. Specific topics of discussion included the following: governance and administration, academic environment, educational objectives, admissions and promotions standards, curriculum management and educational resources. We also discussed the process by which academic problems with students are assessed and managed.

The Site Visit Team had a series of 45-minute meetings with the key clinical faculty for each clerkship; i.e. Internal Medicine, Pediatrics, Family Medicine, Psychiatry, Obstetrics and Gynecology and Surgery. In these meetings we discussed the goals and objectives of the service, how the instructors determine if the students met these educational objectives, how the faculty monitor each student's performance, how the faculty communicate with the University of Queensland, the faculty's perception of how well the students are prepared when they start their clinical rotations, and the capacity of the program to ensure adequate support for the full complement of students.

We had a tour of the Ochsner Medical Center campus. The tour included visiting some of the clinical facilities, conference rooms, student workrooms, classrooms and the library.

Afterwards, we met via video teleconference with faculty at the University of Queensland in Australia to discuss the first two years of medical education; known as Phase 1 of the curriculum. We had a 1-hour discussion of the Basic Sciences Curriculum with James Fraser, MBBS, Clinical Lead Educator and Tammy Smith, MBBS, Clinical Lead Educator. This was followed with a 1-hour discussion with Mary Kelleher, MBBS, Clinical Lead Educator and Margo Lane, MBBS, Clinical Skills Coordinator on how students are trained to become clinically prepared. Included in our discussion was the capacity of the program to ensure adequate support for the full complement of students.

This ended the first day of the site visit.

The following day the Site Visit Team started with a series of 45-minute meetings with student groups who had just completed one of the six core clerkship rotations. In these meetings we asked students to describe how they came to be at the UQO Clinical School Program, how they were informed of the goals and objectives of the rotation, the expectations for the clerkship, how performance feedback is given and how they evaluate the rotation and faculty. A total of 56 students were interviewed; 52 were from the UQO cohort and 4 were from the UQ cohort.

We followed these meetings with a tour of the Ochsner Baptist Medical Center Campus, which represents a major site of training. The tour included the Labor & Delivery suite, conference rooms, call rooms, workrooms, and simulation facilities.

Afterwards, we met via video teleconference for 1-hour with the Head of the Medical School, Darrell Crawford, MD, FRACP. The conversation included an overview of the goals of the

UQO Clinical School Program and a discussion of the Site Visit Team's concerns regarding the admissions process.

We had a 1-hour meeting via video teleconference with the Dean of Medical Education, Jennifer Schafer, MBBS, DRANZCOG, FRACGP. Among the topics discussed included a review of the disciplinary process for students who failed to meet the academic requirements during Phase 1 and Phase 2.

We had a 1-hour meeting via video teleconference with 10 students currently in their first year of training; 7 from the UQO cohort and 3 from the UQ cohort. The topics included the academic environment, curriculum, teaching and evaluation, academic and career counseling, health services and financial aid.

Finally, we had a 1-hour meeting via video teleconference with 11 students currently in their second year of training; 6 from the UQO cohort and 5 from the UQ cohort. The topics discussed were the same as we had with the first year students.

During the site visit we had the opportunity to review additional materials provided by the UQO Clinical School Program. These documents included the following: 1. The organization charts for the University of Queensland, the UQO Clinical School Program, and the Ochsner Health System. 2. Representative samples of the Medical Student Performance Evaluation (also known as the "Dean's Letter"). This is the final summative letter prepared for all graduates. 3. Copies of the evaluation forms used to assess student performance on the 3rd year clerkships. 4. The student's "Patient Clinical Log." These are used to document completion of the clerkship training requirements. 5. The GPA and MCAT data for the UQO classes from 2014-2017. 6. Demographic information to include the USMLE and Match outcomes for the students who have been in the UQO Clinical School Program. 7. The 2013 "Enrollment and Academic Progression Rules" which were requested by the Site Visit Team to better understand the process to address students in academic difficulty.

On March 21st, we had a closing meeting with Dr. Pinsky and the UQO Clinical School Program Leadership to discuss the preliminary findings of the Site Visit Team. The discussion focused on the admissions process; specifically, the lack of involvement of the UQO faculty and medical students in the selection process and the lack of an interview.

The School provided a document titled "University of Queensland/Ochsner Clinical School Proposed Interview Process." We were informed that further clarification of the interview process would be forthcoming.

We received a letter dated April 4, 2014, from Dr. Crawford. In this letter Dr. Crawford states that "The School of Medicine at The University of Queensland supports an initiative to introduce an interview into the selection process for students into the UQ-Ochsner program" and that the interview will be "added to the selection criteria for the Ochsner cohort."

Dr. Pinsky also provided the specifics of the interview process which included the following: 1. The UQO Program will institute a semi-structured interview process weighted along with the MCAT score and GPA. 2. The interviews will be performed by the "Ochsner Interviewing Committee." The committee consists of "diversified staff by gender, race, and specialty." Two 4th year students will also be part of the committee. The interviews will be conducted either in

person or via videoconference. The applicants will be rated on measures of interpersonal communication, skills and teamwork, practice-based learning and improvement, professionalism, motivation and commitment to medicine and to a global medical education with the UQ/UQO School, and resilience and adaptability. A scoring system has been developed to determine which of the applicants will be offered admission.

Recommendations

After review of all of the information described above, it is the opinion of the Site Visit Team that the UQO Clinical School Program is in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1.

General Overview of the Program

The University of Queensland (UQ) School of Medicine

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

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

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

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

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

The Ochsner Health System

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

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

The University of Queensland Ochsner (UQO) Clinical School Program

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

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

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

During the site visit we discovered that UQ is moving towards the implementation of an MD degree for all of its students.

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

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

Business and Professions Code Sections 2089

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

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

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

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

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

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

Business and Professions Code Sections 2089.5

The documents provided by UQO indicate that the instruction in the clinical courses meets or exceeds the minimum requirements in Section 2089.5. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. UQO requires 80 weeks of clinical coursework.

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

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

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

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

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

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

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

The organization and governance of the UQO "matches that of the other Clinical Schools within the School of Medicine." UQO has the "same structures, functions, and responsibilities as the onshore Clinical Schools. All Clinical School Heads report to the Deputy Head of the School."

UQ acknowledges the challenges it faces in operating the offshore clinical schools due to the geographic separation and describes a plan to ensure effective communication. Based on our findings during the site visit, the team felt that there was sufficient evidence that UQ and the UQO Clinical School Program had an effective communication plan. Additionally, we found evidence that the UQO Clinical School Program had substantive input into curricular changes and student assessment.

UQ provided a description of the facilities and faculty for each preclinical course. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content. It was the impression of the Site Visit Team that the School has sufficient resources to manage the proposed increase in the complement of students for the UQO Program at the UQ and OHS campuses.

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

Prior to the site visit an interview was not part of the selection process. Students who are interested in applying to the MBBS program are directed to a website led by International Pathways Incorporated at http://www.mededpath.org. This organization managed all aspects of the selection process including a background check.

As noted above, the Site Visit Team informed the School that under these conditions the UQO Clinical School Program did not meet the entrance requirements of the California Code of Regulations, Title 16, Division 13, Section 1314.1 (8); specifically, that "its admitted students generally meet entrance requirements equivalent to those utilized by US and Canadian medical schools, including an appropriate background check."

The additional information provided by Drs. Crawford and Pinsky which now includes an interview process as part of the selection criteria, indicates that the UQO Clinical School Program meets the requirements of the California Code of Regulations, Title 16, Division 13, Section 1314.1 (8).

There are defined promotion standards for each phase of training. These are encoded in the 2013 "Enrollment and Academic Progression Rules."

The School does not accept transfers from other medical schools.

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

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

Summary

Again, the summary recommendation by the site visit team is that the UQO Clinical School Program is in substantial compliance with the applicable statutes and regulations. It is also our recommendation that recognition be retroactive to the prior graduating classes. In our assessment of the program there haven't been any substantive curricular changes and therefore those trainees who successfully completed the program should also be eligible.

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

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 16, 2014
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School Medical University of the Americas
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

After review and discussion of the initial evaluation of the Medical University of the Americas (MUA):

1. Determine if the admission process at MUA, which does not include a minimum G.P.A. or MCAT scores, is equivalent to those utilized by US and Canadian medical schools as required by the California Code of Regulations, Title 16, Division 13, section 1314.1 (b)(8).

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

    a. Authorize a site team to conduct a site inspection of MUA in Nevis and several representative teaching hospitals in the US where MUA students receive clinical training.

    b. Approve the composition of the site team, which usually includes at least one Board executive staff member, one legal counsel, one Board Member and a medical consultant.

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

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

BACKGROUND AND ANALYSIS:

The Medical University of the Americas is a private, for-profit medical school chartered by the Government of St. Christopher's and Nevis, West Indies since 1998 and is located on a 10-acre campus on the island of Nevis. Since MUA's inception over 600 physicians have earned their M.D. at MUA. The Accreditation Commission on Colleges of Medicine (ACCM) accredited the school in 2010.

The Board is aware of two organizations that offer medical school accreditation to medical schools in the Caribbean:

- Accreditation Commission on Colleges of Medicine (ACCM)
- Caribbean Accreditation Authority for Education in Medicine and other Health Professions (CAAM-HP)

ACCM and CAAM-HP both state that their standards and processes are aligned with the Liaison Committee on Medical Education (LCME) and the US Department of Education's National Committee on Foreign Medical Education and Accreditation (NCFMEA).

The Board does not recognize either of these medical school accreditation organizations.

The Board received MUA's Self-Assessment Report in March 2012. Board staff requested additional information from MUA on two occasions. MUA provided the Board with the additional information for each request.

The Board's Medical Consultant, Mark Servis, M.D.'s initial review identified nine areas of concern (BRD 5 - 4 through BRD 5 - 5). MUA provided additional information to address the concerns. Dr. Servis' review of the additional information provided by MUA provides some evidence that MUA potentially meets the minimum requirements. However, Dr. Servis identified five (5) areas of concern (BRD 5 – 8).

Board staff is of the opinion that in order for the Board to ensure consumer protection and actual compliance with the California Business and Professions Code Sections 2089 – 2091.2, and California Code of Regulations, Title 16, Division 13, section 1314.1, site visits to MUA's basic science campus and to at least a sufficient number of the hospitals where MUA students receive clinical clerkship instruction must be conducted before the Board has sufficient information to make a final determination of MUA's request for recognition by the Board. In addition, Board staff requests that Board members review the Medical Consultant's report dated April 5, 2014, (pages BRD 5 – 4 through BRD 5 – 11) to determine if the Board believes the information provide to the Board in MUA's Self-Assessment Report is sufficient enough to authorize staff to move forward with an out-of-state travel request to conduct a site visit at MUA

It is the understanding that a representative(s) from MUA plans to attend the May 1, 2014 Board meeting to be available during the meeting to answer any questions the Board may have concerning the school's educational program.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code Section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' air and ground travel costs within the guidelines allowed by the State, the consultant's daily per diem expense, and the Board Member's daily per diem expense.

Subsection (e) of Section 1314.1 of the regulations requires the medical school to reimburse the Board for the team's estimated travel expenses in advance of the site visit.

April 5, 2014

To: Kimberly Kirchmeyer
Executive Director
Medical Board of California

From: Mark Servis, MD
Professor and Senior Associate Dean for Medical Education
UC Davis School of Medicine
2230 Stockton Blvd.
Sacramento, CA 95817

Re: Evaluation of the Medical University of the Americas Self-Assessment Report; Application for Recognition in California

BACKGROUND

The Medical Board of California requested a review of the Self-Assessment Report submitted by the Medical University of the Americas (MUA) in March 2012, whose mission is to "educate tomorrow's healthcare leaders and the advancement of patient-centered care."

Medical University of the Americas is a private, for-profit medical school chartered by the Government of St. Christopher's and Nevis, West Indies since 1998, and is located on a 10-acre campus on the island of Nevis. MUA is operated in accordance with its by-laws, which establish a Board of Trustees, their powers and duties. The Board of Trustees are empowered to supervise the academic affairs of the university and are the governing academic authority. Since its inception, over 600 physicians have earned their M.D. at MUA. The Accreditation Commission on Colleges of Medicine (ACCM) accredited the school in 2010. The school's program of study is principally designed to meet the guidelines for medical education set forth by the Liaison Committee on Medical Education (LCME) and graduates aspire to residency training and practice in the United States and Canada.

The originally submitted Self-Assessment Report from MUA was missing information in some areas, and Board staff subsequently requested missing and clarifying information from MUA, which was provided for review on April 8, 2013. Upon review of the Self-Assessment Report and the subsequently submitted information from April 8 by this consultant, further clarifying information was requested to respond to the following questions, addressing areas of potential concern:

1. In addition to the academic assistance and support services for students…have there been other efforts to address the high rates of (student dismissal, dropout and leave of absence) the last three years (i.e. financial aid, more formative assessments of students in the curriculum, raising admissions requirements such as establishing a minimum GPA, more effective screening of applicants)?

2. How are the functions of student affairs managed during the clinical years – i.e. who is responsible for student counseling, support, career advising, etc.?

3. …lecture is the primary teaching method in every course in the five semester pre-clinical curriculum, and there is very limited small group teaching…Are there plans to increase small group teaching and engaged learning in the curriculum? If so, is there faculty development planned for such efforts and faculty resources available to staff small group teaching sessions?

4. …there are 17 "recommended" electives of 4-8 weeks in the fourth year and only one fourth year requirement of 4 weeks (primary care medicine). With so much elective time and so many recommended offerings, how are students assisted in selecting a fourth year curriculum? How does the school monitor the fourth year selections of students to ensure depth and breadth in their curriculum"

5. …there is a high failure rate on USMLE Step 2 CK and Step 2 CS exams compared to the total pool of all medical students taking these exams annually. Has MUA done an analysis of this high failure rate to establish possible causes and taken any steps to address it?

6. Please provide more detail regarding the simulation/lab/small group experiences in the longitudinal Foundations of Clinical Medicine course. Do students learn physical exams on each other? What about pelvic and other sensitive elements of the physical exam? Are there standardized patients? What is the nature of the simulation component of the course? What is the experience with actual patients at Nevis hospital?

7. How are the school's institutional objectives/competencies used in student assessment, particularly in the clinical curriculum? Are students specifically evaluated using these objectives as a framework? How does the school determine that graduates have met the institutional objectives/competencies?

8. MUA uses multiple and geographically distributed clinical affiliates for the third and fourth year clinical curriculum. How does the school ensure comparable clinical experiences and student assessment methods across sites that provide the same core clinical rotations? There is a reference to a logbook of patients, but no detail as to how this is implemented or monitored. Are there any formalized clinical skills assessments during the third and fourth year clinical curriculum?

9. Is there outcome data, besides residency placement, regarding the performance of graduates? Are there any evaluations done by students of the medical education program as a whole (not just courses)? Are there any evaluations done by faculty of the medical education program? If so, please provide samples of the evaluations forms used and the relevant outcome data.

MUA provided clarifying information addressing these nine areas on December 13, 2013, and this material was analyzed and incorporated in this consultant's report and recommendations.

This report is based entirely on my review of the documents submitted by MUA. The goal of the review was to determine if the medical education at MUA meets the requirements of current California statutes and regulations for recognition by the Medical Board of California.

RECOMMENDATIONS

The MUA has provided sufficient documentation to satisfy the criteria in Sections 2089 and 2089.5 of the Business and Professions Code and section 1314.1 of Title 16, California Code of Regulations. The program is designed to meet the standards of medical education from the LCME, however it may not meet all 130 LCME accreditation standards. While the program is in substantial compliance with the requirements of current California statutes and regulations, there are five areas of concern that remain, and further evaluation, including site visits to MUA's basic science campus and to some of the affiliated hospitals where MUA students receive clinical clerkship courses are recommended to provide the Board with a full evaluation of MUA.

REVIEW

The following is a detailed assessment of MUA based on the relevant California statutes and regulations.

Business and Professions Code Section 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. MUA has a full four-year program that consists of 155 weeks of instruction, with the first five semesters on Nevis where students are trained in the Basic Sciences, introduced to clinical skills, and provided limited direct patient experience. These preclinical hours total 2,248 hours of direct classroom instruction. This is followed by an 80-week clinical medicine component consisting of an 8-week research module and 72 weeks of clinical clerkships. The estimated total hours of instruction over four years exceed 6,780, including over 1,000 "required assignment hours" in the preclinical curriculum that are not classroom based. Even if these non-classroom hours are subtracted, MUA meets the Section 2089 requirement for a minimum of 4,000 hours of course instruction.

Students are required to attend 80% of classes in the first two years, with higher thresholds of 85% attendance required in Neuroscience and 90% in Genetics. 100% full attendance is mandatory for students in the third and fourth clinical years. Attendance is monitored by students signing into classes in the preclinical years or by roll call, at least twice during each class session. Attendance in the clinical years is monitored by Clinical Medicine Preceptors and is part of the evaluation of students in the clinical years. This meets the Section 2089 requirement for 80% actual attendance in all courses. Instruction in pain management and end-of-life care is included in the Foundations of Clinical Medicine course in the second year, and in core clinical rotations and an online case during rotations in the third and fourth year.

Business and Professions Code Section 2089.5

The documents provided by MUA demonstrate that instruction in the clinical courses meets or exceeds the minimum requirements of Section 2089.5. For example, Section 2089.5 requires a minimum of 72 weeks of clinical coursework. MUA requires exactly 72 weeks of clinical coursework and includes all of the required minimums of surgery, internal medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry stipulated in Section 2089.5. The family medicine requirement is met through a fourth year 4 week requirement in primary care medicine.

Clinical rotations are in established teaching hospitals with formal affiliation agreements with MUA. All of the MUA affiliated teaching hospitals are located in the United States and are accredited by the Joint Commission on the Accreditation of Hospitals (JCAHO). In addition, each is affiliated with an ACGME accredited residency program. There are a total of 10 hospitals used by MUA for required clinical rotations in seven different states from New York to Oklahoma. MUA has sufficient numbers of clinical faculty in its teaching hospitals to provide experiences in all major specialties. MUA students have pursued fourth year elective rotations in over 90 different hospitals affiliated with other schools and residency programs.

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

The stated mission of the MUA is to "educate tomorrow's healthcare leaders and the advancement of patient-centered care. The recognition of the importance of primary care and a commitment to underserved populations is critical to this mission. Ethical conduct in all of its activities is also key to its achievement of success."

As a result of a recent review MUA adopted a comprehensive set of graduation competencies to serve as the basis for the medical education program. These competencies provide the foundation for pedagogy, curricular content and student assessment in the institution and establish future priorities for curricular and programmatic change.

As required in section 1314.1, the administration and governance system allows the institution to accomplish its objectives and the faculty have a formal role in curriculum oversight and evaluation of student progress. There are faculty on the Curriculum Committee, Clinical Curriculum Committee, and Student Promotions Committee. There is an adequate number of faculty on the Nevis campus for the preclinical curriculum consisting of 31 full time professors each of whom hold an MD and/or PhD in their field of specialty. There are clinical department chairs for each of five major specialties (not family medicine) and all are board certified in their specialty. They work with the Associate Dean of Clinical Medicine and the 10 teaching hospitals on the assignment and monitoring of clinical preceptors for each rotation. The majority of clinical instructors are hospital based with only 16% from private practice settings. MUA has recognized the challenge of teaching students research and lifelong learning skills and has worked with faculty and modified the curriculum to ensure students acquire these competencies, including an eight-week research module during the third year.

The structure and content of the educational program provides an adequate foundation in the basic and clinical sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care. The MUA curriculum makes limited use of active and engaged learning methods such as problem-based learning and small group teaching in the preclinical years, and most of the content in the first five semesters is taught by lecture. MUA is currently working on a comprehensive curricular revision that will substantially increase content integration and active learning pedagogies in the curriculum, and recent faculty development efforts have addressed the need for more active and engaged learning in the classroom. Given the geographically distributed teaching hospitals in the third year, efforts have also been made to standardize the clerkship experiences across the teaching hospitals, including a core set of assigned cases that all students are required to complete.

MUA has organized central oversight of the curriculum. Courses and faculty are systematically and regularly evaluated by students to ensure they are meeting objectives and to ensure quality. Faculty define the types of patients and clinical conditions that students must encounter and the expected level of student responsibility in clinical courses. The student's experiences in courses can be modified to ensure that the objectives are being met. Students are comprehensively evaluated in all courses and a broad range of evaluation instruments are used including OSCEs, simulations, and the USMLE examinations. Student performance on USMLE exams has been variable, and there is a high failure rate on the USMLE Step 2 CK and CS exams compared to national norms. MUA has added NBME shelf exams to the core clinical rotations to improve USMLE Step 2 CK performance and recently introduced in February 2014 a comprehensive clinical skills examination for fourth year students to improve USMLE Step 2 CS performance.

MUA has clear admission and promotion standards and a rolling admissions process with entry at three different points during the academic year. There is a clear and transparent description of admissions criteria, student selection and promotion criteria. Admissions oversight with faculty input is provided from an Admissions Committee. Admissions standards are consistent with those utilized by U.S. and Canadian medical schools, though there are no minimum GPA or MCAT scores, which may contribute to the high drop out and failure rate of students. MUA has recently enhanced their screening and admissions process to better evaluate applicants, including hiring a new Director of Admissions and new Director of Enrollment Services. Students having difficulty are comprehensively assessed and remediation plans are determined by the Student Promotions Committee co-chaired by two course directors, with four additional faculty as members of the committee. The school has very limited assessment and feedback regarding the performance of its graduates, besides their placement in residency programs. MUA recently established an Office of Graduate Affairs to improve contact with alumni and acquire more meaningful outcome data and surveys from their graduates.

There are no branch campuses. Records and student transcripts are kept permanently on a secure database. There are established quality assurance programs for patient care in the affiliated teaching hospitals. Facilities at MUA are adequate and include all needed

physical, laboratory, library and academic resources, classroom space, and technology needed to fulfill its mission and objectives, including a new Student Center that opened in November 2013.

MUA presented information on its financial resources in the form of the Department budgets for the fiscal year ending in April 2012. MUA maintains a reserve of approximately 25% of its earnings in the event of a tuition shortfall. Tuition for MUA students is approximately $104,050 over four years and student cost of living is $116,040 for four years, for a total cost of education of over $220,000 per student. All of the MUA property and facilities are owned free and clear and there is $6 million in insurance to cover operating expenses in the event of unplanned disruptions.

SUMMARY

In summary, MUA may not currently be meeting a few of the LCME accreditation standards such as: (1) An over reliance on lecture in the preclinical curriculum and insufficient active learning pedagogies; (2) Widely geographically distributed clinical rotations within core specialties with insufficient measures to ensure comparable clinical experiences between students and alignment with stated clinical competencies; (3) Unacceptably high failure and dropout rates of students; (4) Inadequate monitoring of the learning environment of students, particularly in the clinical years and; (5) Regular and comprehensive evaluation of the curriculum as a whole, tied to outcomes and assessments from graduates. However, MUA has active, organized, and well-designed plans to address these issues, including a thoughtful and comprehensive curricular revision with anticipated implementation after completion of planning in 12-18 months. Further evaluation is warranted to confirm the information provided in the MUA Self-Assessment Report and the additional documentation provided by MUA. Site visits to MUA and some of its affiliated hospitals where students receive clinical clerkship courses are recommended to provide the Board with a full evaluation of MUA.

Thank you for the opportunity to review the materials from Medical University of the Americas.

Standing Committees, Task Forces and Councils of the Medical Board of California April 2014

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 Ronald Lewis, M.D. Jamie Wright, Esq.
Enforcement Committee	**Dev GnanaDev, M.D., Chair** Howard Krauss, M.D. Elwood Lui Gerrie Schipske, R.N.P., J.D. David Serrano Sewell, J.D. Barbara Yaroslavsky Felix Yip, M.D.
Application Review Committee	**Gerrie Schipske, R.N.P., J.D., Chair** Silvia Diego, M.D. Ronald Lewis, M.D.
Special Faculty Permit Review Committee	**Felix Yip, M.D., Chair** Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) John A. Heydt, M.D. (UCR) Laurence Katznelson, M.D. (Stanford) Wadie Najm, M.D. (UCI) James Nuovo, M.D. (UCD) Neil Parker, M.D. (UCLA) Andrew Ries, M.D. (UCSD) Frank Sinatra, M.D. (USC) Barbara Yaroslavsky
Special Programs Committee	**Chair (Vacant)**
Access to Care Committee/Cultural and Linguistic Competency Committee ********** **Subcommittee Members**	Barbara Yaroslavsky, Chair Elwood Lui ********** David Hayes-Bautista, Ph.D. Sergio Aguilar-Gaxiola, M.D., Ph.D

Education and Wellness Committee ********** **Subcommittee Members**	**Barbara Yaroslavsky, Chair** Silvia Diego, M.D. Howard Krauss, 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.
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Midwifery Advisory Council	**Carrie Sparrevohn, L.M., Chair** James Byrne, M.D. Karen Ehrlich, L.M. Tosi Marceline, L.M. Monique Webster Barbara Yaroslavsky
Panel A	**Barbara Yaroslavsky, Chair** Ronald Lewis, M.D., Vice Chair Michael Bishop, M.D. Silvia Diego, M.D. David Serrano Sewell, J.D. Jamie Wright, Esq. Felix Yip, M.D.
Panel B	**Dev GnanaDev, M.D. Chair** Denise Pines, Vice Chair Howard Krauss, M.D. Sharon Levine, M.D. Elwood Lui Gerrie Schipske, R.N.P., J.D.
Organizational Effectiveness Committee	Sharon Levine, M.D.
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

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: April 2014

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Administrative Summary
STAFF CONTACT: Kimberly Kirchmeyer, 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 has had several meetings with interested parties regarding the Board.

- Dr. Levine, David Serrano Sewell 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 of 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) and other DCA Executive staff.
- Regular meetings continue to be held with Gloria Castro, Senior Assistant Attorney General.
- On March 12, 2014 the Executive Director met with the Anna Caballero, Secretary of the Business, Consumer Services, and Housing Agency regarding the Board's activities.
- Board staff and DCA staff have met numerous times to discuss the transition of the Board's investigators to the DCA.
- Board staff have been meeting with the DCA and the Department of Justice to discuss requirements for the new CURES database.
- Board staff have been meeting with Legislative Members and Staff regarding the Board's sponsored bills that are impacting the Board.
- Board staff met with representatives from the California Department of Public Health, the Board of Pharmacy, the Department of Health Care Services, the Department of Justice, the Emergency Medical Services Authority, and the Department of Consumer Affairs regarding prescription opioid misuse and overdose. This group wants to partner together to educate physicians and patients regarding issues of serious concern.
- Board staff met with Linda Cabatic, the Director and Chief Administrative Law Judge (ALJ) at the Office of Administrative Hearings (OAH); Melissa Crowell, Deputy Director, OAH; and Alan Alvord, Division Presiding ALJ, OAH. The meeting was held to discuss several issues, including the timeframes at OAH, continued training opportunities for the ALJs, requests for hearing continuances, and requests to set hearings. The transition of the investigators to the DCA was also discussed. Board staff plans to hold quarterly meetings with OAH to update them on the activities of the Board and to bring forward any issues.
- Dr. Levine and the Executive Director met with the Board of Chiropractic Examiners to discuss issues of mutual concern.
- Dr. Krauss testified at an Office of Statewide Health Planning and Development public meeting regarding proposed Healthcare Workforce Pilot Project #173. This pilot project would expand the scope of paramedics, in limited areas, to determine if legislation should be enacted for community paramedicine. Dr. Krauss raised consumer protection concerns with the pilot project proposal.

Teleconferencing Project Update:
The Board will be teleconferencing every meeting at the May 1-2, 2014 Quarterly Board meeting. After this meeting, the Board can evaluate the effectiveness of this project, the cost to the Board, and its continued use at future meetings.

Staffing Update:

The Board is at an 8% vacancy rate which equates to 22 vacant positions. However, of those 22 vacant positions, the Board has 9 individuals either in background, pending a start date, or pending verification of eligibility. Therefore, the Board only has 13 positions that do not have an individual identified for the position. This equates to a **5% vacancy rate** for the Board. Board staff is making every effort to fill these positions as quickly as possible.

The Board has hired one Supervising Special Investigator and one Special Investigator for the Complaint Investigative Unit. These positions were a result of the Consumer Protection Enforcement Initiative (CPEI). Although these positions are unfunded in the Board's budget, the Board is using savings from vacant positions to be able to fill these positions. By the end of May, the Board plans to hire five more Special Investigators. This will provide the Board with a unit of six Special Investigators and a Supervisor. The goal of this unit is to be able to investigate some of the less complex cases, whereby reducing the caseload for the sworn investigators in the district offices. The Board will not be filling additional unfunded positions until the Board has an opportunity to assess the impact of Senate Bill 304 and the transfer of the investigators to the DCA.

Budget Update:

As stated at the last Board meeting, the Board had four Budget Change Proposals (BCP) included in the Governor's budget released January 9, 2014. The BCPs included: 1) five additional employees to enhance the Board's Enforcement Program, 2) funding for the BreEZe system for fiscal year (FY) 2014/2015, 3) reimbursement authority for the Licensed Midwifery Program to reimburse the Board for services provided to this Program, and 4) the transition of the investigators to the DCA pursuant to Senate Bill 304, including a position for the Chief of Enforcement. The Board's BCPs have been approved by the Senate and Assembly Budget Subcommittees (with the exception of the BCP for the Enforcement Enhancements, which did not make it onto the Senate Budget Subcommittee agenda, but will be taken up in a future hearing). The Board believes that these BCPs will be successful and on July 1, 2014 these BCPs will be put into the Board's budget.

The Board's budget documents are attached, beginning on page BRD 11B-4 and continuing to page BRD 11B-14. The Board's fund condition on page BRD 11B-4 projects the Board's fund reserve, at the end of FY 2013/2014, to be at 4.3 months.

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 11B-5 shows partial 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.

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 will continue to monitor its fund to determine any needed changes.

The Board's overall actual expenditures for FY 2013/2014, as of February 28, 2014, can be found on page BRD 11B-6, and pages BRD 11B-7 to 11B-11 show the budget report specifically for enforcement, the AG expenditures, and licensing. Page BRD 11B-14 provides the Board Members' expenditure report as of April 4, 2014.

BreEZe Update:

Board staff continue to submit requests for changes/fixes to DCA for the BreEZe system. While several of the Board's issues have been resolved, the Board continues to have a significant number of outstanding requests

for changes that were identified prior to implementation but were not fixed prior to the release of BreEZe because they were deemed not detrimental to the Board being able to go live, as well as those requests identified since go live. Some fixes were completed with the system release in April 2014. DCA is working to amend the contract to get more releases so these fixes can be made and put into the system. However, at this time there is only a release scheduled for late May and then another scheduled release in August 2014. At this time, all other issues will be fixed after this date. As these items are fixed, Board staff must test to ensure that the fix resolved the Board's issue. The system will not meet the Board's requirements until all of the fixes have been completed.

The continued problem for Board Management is that Board staff cannot run the reports that are used as management tools to determine work productivity/timeframes. Neither the Licensing Chief's nor the Enforcement Chief's report will include statistics, as they are not available from the BreEZe system. At this time Board staff is focusing on correcting defects in the system to assist the core functions of licensing and enforcement. The current reports that are in the BreEZe system are not capturing all of the data correctly, or do not meet the needs of the Board. However, Board staff have been working with DCA to test some new reports that have been developed and hope to be able to obtain more data in the near future.

Prescription Drug Abuse Awareness/Outreach:
March was Prescription Drug Awareness Month, and the Board launched a campaign to reach out to both physicians and consumers regarding the epidemic of prescription drug abuse. The Board produced a video, with the assistance of DCA, that was designed to reach out to physicians regarding this epidemic and provide guidance on what they can do. Dr. Bishop, a member of the Board's Prescribing Task Force, was the narrator and spokesman for the Board. A press release was issued to all Medical Board subscribers and media outlets and included a link to the video. In addition, it is posted on You Tube and on the Board's website.

As a result of the video, April Rovero, founder and CEO of the National Coalition Against Prescription Drug Abuse, invited the Board to participate in the ENOUGH! Rally on March 24, 2014 at the State Capitol. The Board's Executive Director spoke at the rally and provided information on what the Board is doing to assist in resolving this epidemic. The Board had a table set up with information on the Board's roles and responsibilities and staff was available to answer questions.

Prior Board Member, Jorge Carreon, M.D., recorded two PSAs in Spanish. The Board is in the process of editing the PSAs and they will be posted to You Tube and placed on the Board's website. Although March is over, the issue of prescription drug abuse will not end and these PSAs can be used in perpetuity to reach out to the Hispanic community regarding this problem. The Board is also looking to film some PSAs with a celebrity host to further address the issue.

The US Attorney's Office is holding a Bay Area Prescription Drug Abuse Summit on May 7, 2014. The Summit is an effort to bring together senior policymakers, medical professionals, educators, and local, state and federal law enforcement to seek solutions to the problem of prescription drug abuse and to raise awareness of the issue. Board President Sharon Levine, M.D. will be providing an update on the activities of the Board in this area.

Board of Pharmacy Update:
Virginia Herold, Executive Officer of the Board of Pharmacy, has provided a written summary of the activities of the Board of Pharmacy (please see BRD 11B-15 and 16). The Board and the Board of Pharmacy continue to work together on issues of similar interest.

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

		ACTUAL 2012-13	CURRENT YEAR 2013-14	BY 2014-15	BY+1 2015-16	BY+2 2016-17
BEGINNING BALANCE		$ 24,612	$ 26,498	$ 21,141	$ 14,944	$ 7,607
Prior Year Adjustment		$ (38)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 24,574	$ 26,498	$ 21,141	$ 14,944	$ 7,607
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 365	$ 330	$ 331	$ 331	$ 331
125700	Other regulatory licenses and permits	$ 6,174	$ 5,961	$ 5,961	$ 5,961	$ 5,961
125800	Renewal fees	$ 46,107	$ 45,687	$ 45,727	$ 45,727	$ 45,727
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	$ 75	$ 65	$ 63	$ 40
160400	Sale of fixed assets	$ 4	$ 3	$ 3	$ 3	$ 3
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	$ 53,100	$ 53,131	$ 53,129	$ 53,106
Transfers:						
TOTALS, REVENUES AND TRANSFERS		$ 52,895	$ 53,100	$ 53,131	$ 53,129	$ 53,106
TOTAL RESOURCES		$ 77,469	$ 79,598	$ 74,272	$ 68,073	$ 60,713
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 34	$ 3	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 278	$ 259	$ 48	$ -	$ -
1110 Program Expenditures (State Operations)		$ 50,659	$ 56,167	$ 56,354	$ 58,415	$ 59,625
2013-2014 and 2014-15 Approved Costs						
BreEZe Costs			$ 1,209			
CURES			$ 819	$ 819		
Anticipated Future Costs						
SB 304				$ 118	$ 118	$ 118
Anticipated BreEZe Cost				$ 1,531	$ 1,531	$ 1,531
Establish Spending Authority for Midwifery				$ (13)	$ (13)	$ (13)
Enforcement Enhancements				$ 471	$ 415	$ 415
Totals, Disbursements		$ 50,971	$ 58,457	$ 59,328	$ 60,466	$ 61,676
FUND BALANCE						
Reserve for economic uncertainties		$ 26,498	$ 21,141	$ 14,944	$ 7,607	$ (963)
Months in Reserve		5.4	4.3	3.0	1.5	-0.2

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.

4/7/2014

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)
With General Fund Loan repayment

		ACTUAL 2012-13	CURRENT YEAR 2013-14	BY 2014-15	BY+1 2015-16	BY+2 2016-17
BEGINNING BALANCE		$ 24,612	$ 26,498	$ 21,141	$ 14,944	$ 13,607
Prior Year Adjustment		$ (38)	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 24,574	$ 26,498	$ 21,141	$ 14,944	$ 13,607
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 365	$ 330	$ 331	$ 331	$ 331
125700	Other regulatory licenses and permits	$ 6,174	$ 5,961	$ 5,961	$ 5,961	$ 5,961
125800	Renewal fees	$ 46,107	$ 45,687	$ 45,727	$ 45,727	$ 45,727
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	$ 75	$ 65	$ 63	$ 40
160400	Sale of fixed assets	$ 4	$ 3	$ 3	$ 3	$ 3
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	$ 53,100	$ 53,131	$ 53,129	$ 53,106
Transfers:						
	Proposed GF Loan Repayment				$ 6,000	$ 7,000
TOTALS, REVENUES AND TRANSFERS		$ 52,895	$ 53,100	$ 53,131	$ 59,129	$ 60,106
TOTAL RESOURCES		$ 77,469	$ 79,598	$ 74,272	$ 74,073	$ 73,713
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 34	$ 3	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 278	$ 259	$ 48	$ -	$ -
1110 Program Expenditures (State Operations)		$ 50,659	$ 56,167	$ 56,354	$ 58,415	$ 59,625
	2013-2014 and 2014-15 Approved Costs					
	BreEZe Costs		$ 1,209			
	CURES		$ 819	$ 819		
	Anticipated Future Costs					
	SB 304			$ 118	$ 118	$ 118
	Anticipated BreEZe Cost			$ 1,531	$ 1,531	$ 1,531
	Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
	Enforcement Enhancements			$ 471	$ 415	$ 415
Totals, Disbursements		$ 50,971	$ 58,457	$ 59,328	$ 60,466	$ 61,676
FUND BALANCE						
Reserve for economic uncertainties		$ 26,498	$ 21,141	$ 14,944	$ 13,607	$ 12,037
Months in Reserve		5.4	4.3	3.0	2.6	2.4

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.

4/7/2014

Medical Board of California
FY 13/14
Budget Expenditure Report
(As of February 28, 2014)
(67% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	16,540,850	10,403,326	62.9	6,137,524
Board Members	31,500	50,800	161.3	(19,300)
Phy Fitness Incentive Pay	29,623	6,275	21.2	23,348
Temp Help	1,800,000	791,632	44.0	1,008,368
Overtime	50,000	65,857	131.7	(15,857)
Staff Benefits	8,328,522	5,170,370	62.1	3,158,152
BL 12-03 Blanket	0	46,039		0
TOTALS, PERS SERVICES	26,780,495	16,534,299	61.7	10,292,235
OPERATING EXP & EQUIP				
General Expense	300,535	443,163	147.5	(142,628)
Fingerprint Reports	333,448	175,346	52.6	158,102
Minor Equipment	24,300	67,000	275.7	(42,700)
Printing	435,755	166,160	38.1	269,595
Communications	257,190	137,376	53.4	119,814
Postage	182,511	102,377	56.1	80,134
Insurance	41,053	16,100	39.2	24,953
Travel In-State	361,298	245,462	67.9	115,836
Travel Out-of-State	7,000	6,872	98.2	128
Training	78,895	58,663	74.4	20,232
Facilities Operation (Rent)	2,490,025	2,435,502	97.8	54,523
Consult/Prof Services	2,198,594	1,383,309	62.9	815,285
Departmental Prorata	5,034,442	3,775,838	75.0	1,258,604
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	334,841	51.5	315,389
Data Processing	129,492	260,581	201.2	(131,089)
Central Admin Svcs (Statewide Prorata)	2,417,774	1,813,331	75.0	604,443
Attorney General Services	13,347,280	8,561,450	64.1	4,785,830
Office of Administrative Hearings	1,525,080	689,566	45.2	835,514
Evidence/Witness	1,893,439	1,103,628	58.3	789,811
Court Reporter Services	225,000	226,433	100.6	(1,433)
Major Equipment	392,120	143,263	36.5	248,857
Other Items of Expense	81	34,489	42,579.0	(34,408)
Vehicle Operations	247,925	168,128	67.8	79,797
Court-ordered Payments	0	0		0
Board of Control Claim	0	992		(992)
TOTALS, OE&E	32,578,609	22,349,870	68.6	10,228,739
TOTALS, EXPENDITURES	59,359,104	38,884,169	65.5	20,474,935
Scheduled Reimbursements	(384,000)	(1,057,554)	275.4	673,554
Distributed Costs	(780,000)	(350,118)	44.9	(429,882)
NET TOTAL, EXPENDITURES	58,195,105	37,476,497	64.4	20,718,607
Unscheduled Reimbursements		(213,404)		
		37,263,093		

Budget Expenditure Report.xls
Date:4/7/14

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2013- FEBRUARY 28, 2014

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,926,314	6,801,436	current
Staff Benefits	4,869,104	3,037,585	current
TOTAL PERSONAL SERVICES	15,795,418	9,839,021	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	144,768	327,386	1-2
Printing	157,926	89,860	1-2
Communications	127,358	92,593	1-2
Postage	69,500	37,831	1-2
Insurance	38,235	13,864	current
Travel In-State	229,018	189,612	1-2
Travel Out-State	7,000	6,872	1-2
Training	31,000	45,049	1-2
Facililties Operations	1,922,825	1,737,073	current
Consultant/Professional Services	300,000	249,420	1-2
Departmental Services	3,440,033	2,663,853	current
Interagency Services	3,629	0	1-2
Data Processing	18,000	43,965	1-2
Statewide Pro Rata	1,652,065	1,278,942	current
Attorney General 1/	13,157,280	8,538,319	current
OAH	1,525,080	689,566	1
Evidence/Witness Fees	1,820,939	1,052,537	1-2
Court Reporter Services	224,750	226,433	1-2
Major Equipment	0	128,827	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	34,061	1-2
Vehicle Operations	206,925	141,877	1-2
Minor Equipment	0	33,188	1-2
Court-Ordered Payments	0	0	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,076,412	17,621,128	
DISTRIBUTED COSTS	(744,054)	(332,008)	
TOTAL BUDGET/EXPENDITURES	**40,127,776**	**27,128,141**	
Unscheduled Reimbursements		(45,232)	
		27,082,909	

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	6,177.00	170.00	1,050,090.00
	Paralegal Services	289.25	120.00	34,710.00
	Auditor/Analyst Services	273.75	99.00	27,101.25
	Cost of Suit			0.00
				1,111,901.25
August	Attorney Services	5,997.25	170.00	1,019,532.50
	Paralegal Services	302.00	120.00	36,240.00
	Auditor/Analyst Services	233.75	99.00	23,141.25
	Cost of Suit			5,311.65
				1,084,225.40
September	Attorney Services	5,722.50	170.00	972,825.00
	Paralegal Services	294.50	120.00	35,340.00
	Auditor/Analyst Services	167.25	99.00	16,557.75
	Cost of Suit			1,885.50
				1,026,608.25
October	Attorney Services	7,128.00	170.00	1,211,760.00
	Paralegal Services	323.00	120.00	38,760.00
	Auditor/Analyst Services	224.50	99.00	22,225.50
	Special Agent	2.00	120.00	240.00
	Cost of Suit			2,035.55
				1,275,021.05
November	Attorney Services	5,474.00	170.00	930,580.00
	Paralegal Services	174.25	120.00	20,910.00
	Auditor/Analyst	169.25	99.00	16,755.75
	Cost of Suit			11,674.85
				979,920.60
December	Attorney Services	5,591.00	170.00	950,470.00
	Paralegal Services	111.75	120.00	13,410.00
	Auditor/Analyst	153.75	99.00	15,221.25
	Cost of Suit			1,828.29
				980,929.54
			Total July-Dec =	**6,458,606.09**
			FY 13/14 Budget =	**13,157,280.00**

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

January				
	Attorney Services	6,218.00	170.00	1,057,060.00
	Paralegal Services	4.25	120.00	510.00
	Auditor/Analyst	210.75	99.00	20,864.25
	Cost of Suit			51.50
				1,078,485.75
February				
	Attorney Services	5,671.25	170.00	964,112.50
	Paralegal Services	163.00	120.00	19,560.00
	Auditor/Analyst	153.75	99.00	15,221.25
	Cost of Suit			2,333.47
				1,001,227.22
March				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
April				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
May				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
June				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00

Revised 04/7/2014

FYTD Total =	**8,538,319.06**
FY 13/14 Budget =	**13,157,280.00**

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2011 - JUNE 2014

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

	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	FYTD Total
Invest Cost Recovery	250	300	650	2,349	750	700	4,527	600	2,595	6,888	600	500	20,709
Criminal Cost Recovery	1,409	705	619	5,136	964	10,914	2,411	1,198	676	489	39,422	2,871	66,814
Probation Monitoring	38,879	47,871	26,432	65,999	45,648	146,950	434,545	319,499	52,448	55,458	29,123	33,854	1,296,706
Exam	1,848	3,456	6,563	2,666	5,212	975	3,074	1,625	4,725	12,262	138	1,881	44,424
Cite/Fine	2,800	1,900	4,750	6,268	8,586	12,300	8,700	4,059	3,850	1,650	3,100	7,300	65,263
MONTHLY TOTAL	45,186	54,232	39,014	82,418	61,160	171,839	453,257	326,981	64,294	76,747	72,382	46,406	1,493,916
FYTD TOTAL	45,186	99,418	138,432	220,850	282,010	453,849	907,106	1,234,087	1,298,381	1,375,128	1,447,510	1,493,916	

	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	FYTD Total
Invest Cost Recovery	650	550	550	0	0	50	1,050	50					2,900
Criminal Cost Recovery	499	698	1,050	3,127	8,857	204	2,824	9,707					26,966
Probation Monitoring	69,560	54,598	28,303	0	100,901	115,137	439,694	161,273					969,466
Exam	7,232	6,164	4,537	0	5,568	1,500	7,328	3,075					35,404
Cite/Fine	2,850	5,450	2,000	4,925	2,975	2,850	1,100	1,100					23,250
MONTHLY TOTAL	80,791	67,460	36,440	8,052	118,301	119,741	451,996	175,205	0	0	0	0	1,057,985
FYTD TOTAL	80,791	148,251	184,691	192,743	311,044	430,784	882,780	1,057,985	1,057,985	1,057,985	1,057,985	1,057,985	

excel:enfreceiptsmonthlyprofile.xls.revised 3/18/2014

NOTE: Beginning with October 2013, payment amounts reflect payments made directly to MBC; they do not include payments made through BreEZe online system. Online payment information is unavailable.

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2013 - FEBRUARY 28, 2014

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,776,800	1,696,371	current
Staff Benefits	1,303,330	812,010	current
TOTAL PERSONAL SERVICES	4,080,130	2,508,381	
OPERATING EXPENSES & EQUIPMENT			
General Expense	47,000	9,366	1-2
Fingerprint Reports*	333,448	174,651	1-2
Printing	99,876	51,523	1-2
Communications	32,246	11,415	1-2
Postage	100,000	62,817	1-2
Travel In-State	9,758	7,085	1-2
Training	8,500	897	1-2
Facilities Operation	226,000	248,716	current
Consult/Professional Services	1,810,873	1,128,521	1-2
Departmental Services	697,774	431,956	current
Interagency Services	587	0	current
Data Processing	4,000	2,290	1-2
Statewide Pro Rata	335,103	207,444	current
Attorney General	190,000	23,131	current
Evidence/Witness Fees	7,500	0	1-2
Court Reporter Services	250	0	1-2
Major Equipment	0	0	1-2
Minor Equipment	0	10,494	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,902,915	2,370,306	
SCHEDULED REIMBURSEMENTS	(384,000)	(1,057,455)	
DISTRIBUTED COSTS	(31,131)	(12,591)	
TOTAL BUDGET/EXPENDITURES	**7,567,914**	**3,808,641** **	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports
** Includes Polysom
4/7/2014

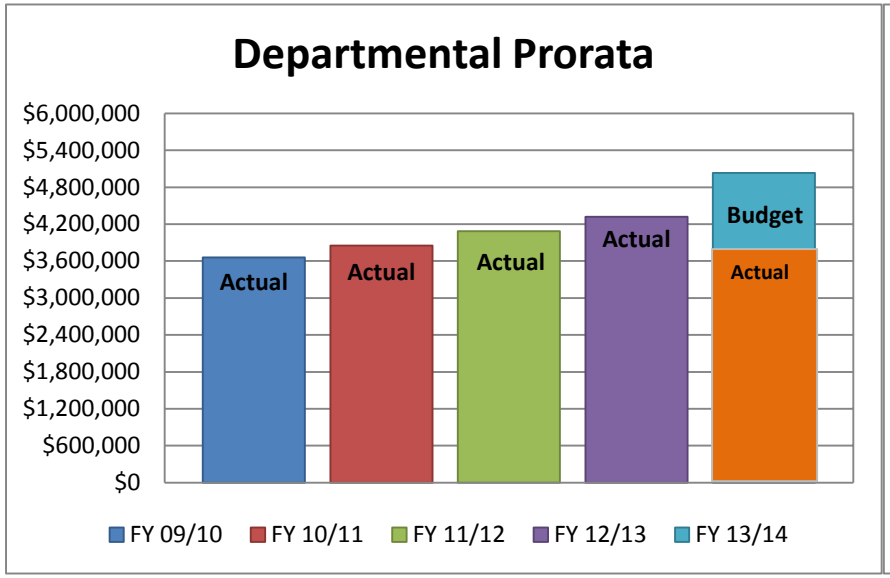
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

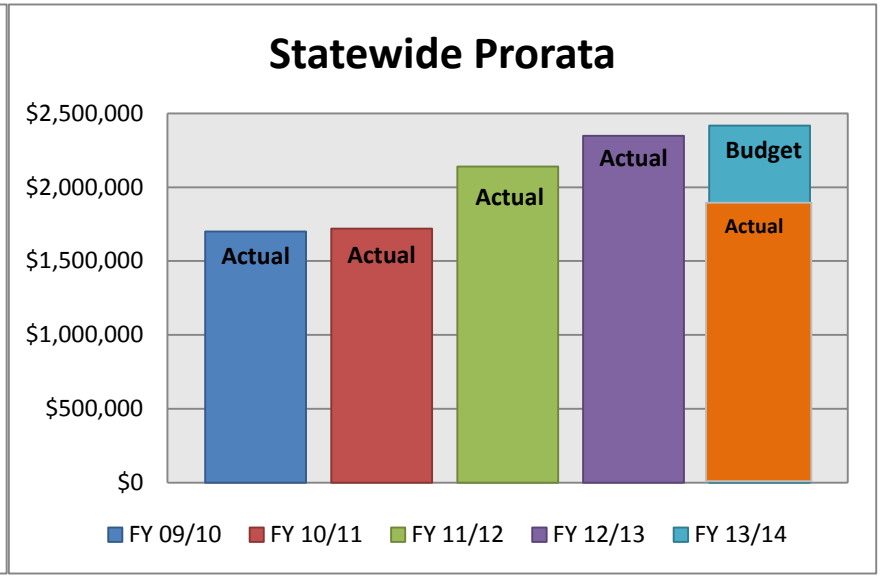
	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent *	1,771,000	34,420,000	651,000	5,061,000	1,564,000	2,948,000	487,000	46,902,000 *
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*	1,762,058	37,058,493	672,700	5,770,689	1,671,010	3,001,574	720,484	50,657,008 *
Positions								
Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 13/14								
$ Budgeted	2,304,466	40,127,776	716,147	7,567,914	1,833,855	3,363,720	2,281,227	58,195,105
$ Spent thru 02/28*	987,108	27,082,909	615,404	3,808,641	1,128,852	2,282,457	1,357,722	37,263,093 *
Positions								
Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1

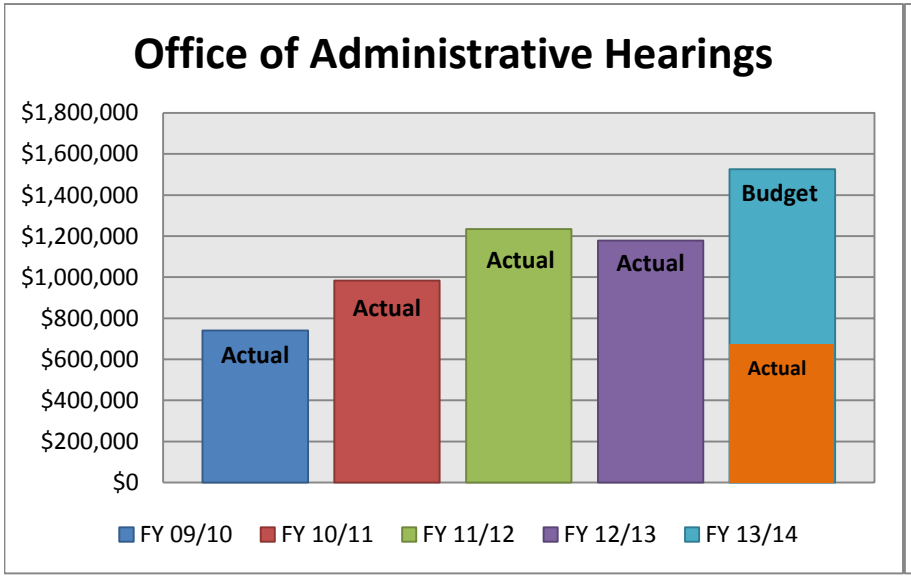
* net expenditures (includes unscheduled reimbursements)

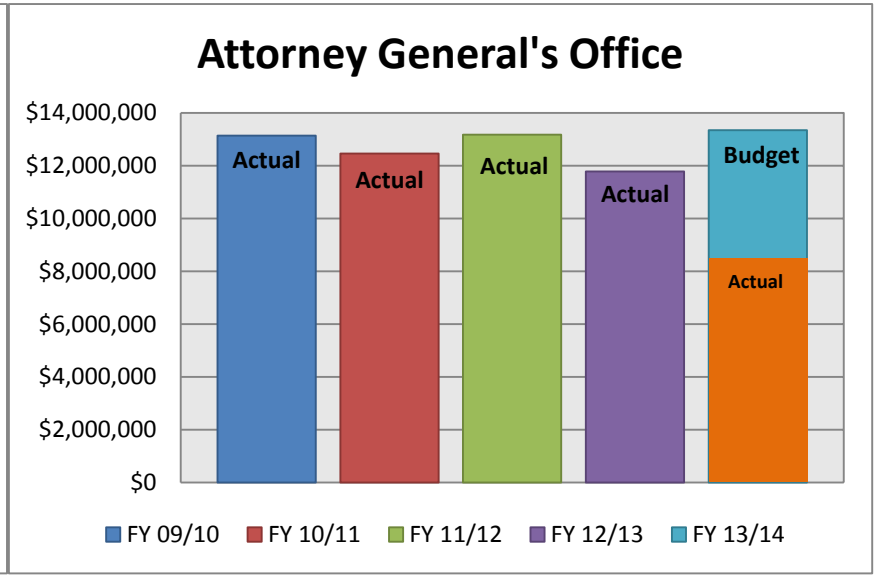
4/7/2014
Budget Overview by Program.xls

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	$ 600.00	$ 400.00	$ 600.00	$ 600.00	$ 500.00	$ 500.00	$ 300.00	$ 1,000.00	$ -	$ -	$ -	$ -	$ 4,500.00
Travel	$ 799.36		$ 698.96	$ 464.02	$ -		$ -	$ 1,836.96	$ -	$ -	$ -	$ -	$ 3,799.30
	$ 1,399.36	$ 400.00	$ 1,298.96	$ 1,064.02	$ 500.00	$ 500.00	$ 300.00	$ 2,836.96	$ -	$ -	$ -	$ -	**$ 8,299.30**
DR. DIEGO - Per diem	$ 500.00	$ 1,700.00	$ -	$ 1,700.00	$ 1,400.00	$ 1,300.00	$ 400.00	$ 900.00	$ -	$ -	$ -	$ -	$ 7,900.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 503.35	$ -	$ -	$ -	$ -	$ 503.35
	$ 500.00	$ 1,700.00	$ -	$ 1,700.00	$ 1,400.00	$ 1,300.00	$ 400.00	$ 1,403.35	$ -	$ -	$ -	$ -	**$ 8,403.35**
DR GNANADEV - Per diem	$ 900.00	$ 1,300.00	$ 1,100.00	$ 900.00	$ 800.00	$ 1,200.00	$ -	$ -	$ -	$ -			$ 6,200.00
Travel	$ 521.96			$ 46.86	$ 475.38	$ -	$ -	$ -					$ 1,044.20
	$ 1,421.96	$ 1,300.00	$ 1,100.00	$ 946.86	$ 1,275.38	$ 1,200.00	$ -	$ -	$ -	$ -	$ -	$ -	**$ 7,244.20**
DR. KRAUSS - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LEVINE - Per diem	$ -	$ -	$ -			$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ 477.16		$ -		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 477.16
	$ 477.16	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 477.16**
DR. LEWIS - Per diem	$ -	$ -	$ -	$ 1,000.00	$ 700.00	$ 1,300.00	$ 1,600.00	$ 1,400.00	$ -	$ -	$ -	$ -	$ 6,000.00
Travel	$ -	$ -	$ 416.26	$ 389.08	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 805.34
	$ -	$ -	$ 416.26	$ 1,389.08	$ 700.00	$ 1,300.00	$ 1,600.00	$ 1,400.00	$ -	$ -	$ -	$ -	**$ 6,805.34**
MR. LUI - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 200.00	$ -	$ -	$ -	$ -	$ 200.00
Travel	$ -	$ -	$ -	$ -	$ 564.87	$ -	$ -	$ 502.50	$ -	$ -	$ -	$ -	$ 1,067.37
	$ -	$ -	$ -	$ -	$ 564.87	$ -	$ -	$ 702.50	$ -	$ -	$ -	$ -	**$ 1,267.37**
MS. PINES - Per diem	$ 1,500.00	$ 1,400.00	$ 1,200.00	$ 1,500.00	$ 1,200.00	$ 1,000.00	$ 1,300.00	$ 1,300.00	$ -	$ -	$ -	$ -	$ 10,400.00
Travel	$ 771.58	$ -	$ -	$ 254.32		$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,025.90
	$ 2,271.58	$ 1,400.00	$ 1,200.00	$ 1,754.32	$ 1,200.00	$ 1,000.00	$ 1,300.00	$ 1,300.00	$ -	$ -	$ -	$ -	**$ 11,425.90**
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	$ 1,200.00	$ 1,200.00	$ -	$ 900.00	$ 900.00	$ -	$ -	$ -	$ -		$ 6,300.00
Travel	$ 742.37	$ -	$ -	$ 277.41	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,019.78
	$ 1,842.37	$ 1,000.00	$ 1,200.00	$ 1,477.41	$ -	$ 900.00	$ 900.00	$ -	$ -	$ -	$ -	$ -	**$ 7,319.78**
MR. SERRANO SWELL- Per diem	$ 800.00	$ 500.00	$ 700.00	$ 800.00	$ 500.00	$ 600.00	$ 600.00	$ 800.00	$ -	$ -	$ -	$ -	$ 5,300.00
	$ -	$ -	$ -	$ 783.34	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 783.34
	$ 800.00	$ 500.00	$ 700.00	$ 1,583.34	$ 500.00	$ 600.00	$ 600.00	$ 800.00	$ -	$ -	$ -	$ -	**$ 6,083.34**
MS.WRIGHT - Per diem	$ -	$ -	$ 300.00	$ 1,200.00	$ 900.00	$ 1,000.00	$ 1,400.00	$ 1,300.00	$ -	$ -	$ -	$ -	$ 6,100.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 954.28	$ -	$ -	$ -	$ -	$ 954.28
													$ 7,054.28
MS. YAROSLAVSKY - Per diem	$ 1,300.00	$ 600.00	$ 800.00	$ -	$ -	$ 1,000.00	$ 800.00	$ -	$ -	$ -	$ -	$ -	$ 4,500.00
Travel	$ 764.12	$ -	$ -	$ 352.58	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,116.70
	$ 2,064.12	$ 600.00	$ 800.00	$ 352.58	$ -	$ 1,000.00	$ 800.00	$ -	$ -	$ -	$ -	$ -	**$ 5,616.70**
DR. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 4/04/2014

TOTAL PER DIEM $57,600.00
TOTAL TRAVEL $ 13,276.08

TOTAL **$ 70,876.08**

California State Board of Pharmacy
1625 N. Market Blvd, N219, Sacramento, CA 95834
Phone: (916) 574-7900
Fax: (916) 574-8618
www.pharmacy.ca.gov

BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

April 15, 2014

To: Medical Board of California

From: Virginia Herold, Executive Officer, California State Board of Pharmacy

Subject: Board of Pharmacy Update

The Board of Pharmacy has the following update to the Medical Board of California.

Prescription Drug Abuse:

The board's Prescription Drug Abuse Subcommittee met in late February. During this meeting, the subcommittee heard reports on local community efforts to combat prescription drug abuse, and reviewed materials developed by several Southern California communities. A drug manufacturer provided a presentation on educational materials prepared by the company to educate students and community leaders. There also was a lengthy discussion on CURES with the CURES project manager, and the need to for pharmacists to secure faster registration to access CURES reports. Approximately 17 percent of the state's 40,000 licensed pharmacists are registered to obtain reports. Board staff will begin aiding DOJ in collecting registration packets from pharmacists.

The board developed three written public service announcements on prescription drug abuse and released them in March. Later in the month, the board filmed two video public service announcements (30 second and 60 seconds) that have been edited and are ready for release and posting on the board's website. They address teen access to medication in home medicine cabinets

Patient-Centered Prescription Container Label Requirements:

The board's requirements for patient-centered prescription container labels took effect in January 2011. These requirements, developed under statutory mandate, resulted in 50 percent of a prescription container label being dedicated to the five elements most important to patient understanding of how to take their medications – patient name, drug name and strength, directions for use, and purpose (if it appears on the prescription document). The board reviewed the requirements in 2013, and based upon widespread consumer request and pharmacy readiness to meet requirements for 12 point font labeling of the five elements, moved to regulation hearing modifications to require 12 point font as the minimum font size. The 45-day initial comment period for the regulation is now underway.

Development of Joint Protocols by Our Two Boards for California Pharmacists

Last year, SB 493 (Hernandez, Chapter 469) made a number of changes in Pharmacy Law. Among them are requirements that our two boards jointly develop state protocols for 1. Self-administered hormonal contraception and 2. Use of nicotine replacement products.

Work on these two protocols has not yet begun. We hope to begin work on these protocols with designated and interested parties later in the year. Medical board staff will be part of the process as well.

Sterile Compounding Pharmacies

The board is continuing work on implementing SB 294 (Emmerson, Chapter 565, Statutes of 2013) that requires any pharmacy that compounds sterile drug preparations for administration to patients in California to be specially licensed with the Board of Pharmacy and subject to annual, unannounced inspections, even if the pharmacy is located out of state. The board is currently performing inspections of these pharmacies and doing a major revision to California's compounding regulations for medication.

Thank you for this opportunity to continue our collaboration between our two boards.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Enforcement Program Summary
STAFF CONTACT: A. Renee Threadgill, Chief of Enforcement

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.

Expert Reviewer Program Update:
There are currently 947 experts in the Medical Board of California's expert database. 111 experts were utilized to review 122 cases in the first quarter of calendar year 2014. Attachment A provides the Expert Reviewer Program statistics. Additional experts are needed in the following specialties:

- Pain Medicine
- Addiction Medicine
- Psychiatry
- Neurosurgery

Vacancy Rate:
There are currently 6 sworn investigator vacancies (8% vacancy rate). However, 4 of these positions have individuals who are in background for the vacancy, which reduces the vacancy rate to 3%. There are 3 Supervisor vacancies (14% vacancy rate). One Supervisor vacancy has a candidate in background (which reduces the vacancy rate to 10%). The overall vacancy rate for all sworn staff is 9% or 4%, if the vacancies with candidates in background are eliminated.

Training:
In January, the investigators received superb training that was organized by the Board's Enforcement training unit and focused on various aspects of prescription drug investigations (search warrants, undercover operations, pharmacy records, and drug profiles). The training was approved by POST for 24 hours of training credits. Mr. Gomez was invited and attended this training. Course content included presentations from John Niedermann, Deputy District Attorney, Los Angeles County, regarding Tips for Testifying in a Criminal Case and Investigating and Prosecuting a Prescription Drug Case. Additionally, Tia L. Quick, Deputy District Attorney, San Diego County, presented Search Warrant training.

Special Recognition:
Board Investigator, Jon Genens, was honored this year with two awards from the United States Attorney's Office, Central District of California. On March 14, 2014, Mr. Genens was presented with a Law Enforcement Award. On April 8, 2014, Mr. Genens was presented with a Crime Victims' Service Award. Both awards stem from the admirable work completed by Investigator Genens while pursuing the Board's mission of public protection. Photos from the awards ceremony are attached (Attachment B).

During the February 2014 Quarterly Board Meeting, Senior Assistant Attorney General Gloria Castro reported information regarding the appeal of a case which raised the issue of the Board violating patients' right to privacy by accessing a computerized database of controlled substance prescription records

(CURES) prior to issuing the subpoenas. Additionally, a representative from the California Medical Association (CMA) reported that CMA had filed an Amicus Curiae Brief on behalf of the Defendant/Appellant in this matter. Attachment C is the First Appellate District, Division One Opinion, which is certified for publication. The Court concluded that the Board's actions in accessing and compiling data from the CURES database did not violate patients' constitutional right to privacy. Thanks and appreciation to Deputy Attorney General Esther La for an exceptional job of advocacy on behalf of the Medical Board and for the great result!

Operation Rx Update:
Operation Rx (ORX) was instituted June 15, 2013, in response to the epidemic of overprescribing cases and accidental overdose deaths. Four investigators and one supervising investigator were re-directed from their regular assignments to handle only overprescribing cases. By having reduced, dedicated caseloads, they were able to be remarkably productive in a short period of time. Due to current workload needs, the unit will be disbanding on May 1, 2014 and the staff will be returning to their original assignments. However, the investigators will continue to work on the ORX cases currently assigned to them.

In Northern California, during the first month, the team conducted a search warrant at a physician's office and ultimately, two months later, the physician and his physician assistant were arrested for prescribing without a legitimate medical purpose and prescribing to an addict (all felonies). An ISO suspending the physician's license remains in effect pending the outcome of the criminal matter.

Another significant Northern California case resulted in search warrants being executed in two counties and three felony charges being filed. A stipulated suspension order was immediately put in place. The physician died prior to the case being resolved.

Three felony charges were filed against a Bay Area physician and more are anticipated after evaluating the evidence seized during the search warrant. The physician's license is suspended pursuant to a Penal Code (PC) 23 order pending the outcome of the criminal case.

ORX conducted a search warrant in Riverside County and arrested a physician for prescribing to an addict, prescribing without a medical indication and sexual battery. That case is pending.

Most recently, the team conducted two search warrants in southern California and the evidence is being analyzed. On a side note, when an ORX investigator accompanied the Drug Enforcement Administration on an audit, the subject's husband, who was a convicted felon, admitted to having weapons in the home, so he was arrested.

ORX handled approximately forty investigations during its existence. Of those, fourteen cases were closed insufficient evidence, two were referred for a citation and fine, two were referred to the Office of the Attorney General and eight were referred for criminal prosecution.

As seen from the chart on the next page, ORX made significant profess in some of the most concerning overprescribing cases. The ORX deserves special thanks for their phenomenal productivity. ORX provided excellent work and tireless dedication to the Board's mission of public protection.

Subject	**Search Warrant Date**	**Arrest Date**	**Suspension**	**Outcome**	**County**
1. Physician	6-20-13	8-28-13	ISO	Pending	Shasta
2. Physician Assistant	6-20-13	8-28-13	DEA surrendered	Pending	Shasta
3. Physician		9-19-13		Convicted (3 felonies: 1-7-14)	Los Angeles
4. Physician	8-28-13	8-28-13	PC23 (stip)	Deceased	Santa Clara
5. Physician	12-2-13	12-2-13	PC23	Pending	Santa Clara
6. Physician	11-13-13	11-13-13		Pending	Riverside
7. Physician	8-1-13			Pending	Calaveras
8. Physician	3-26-14			Pending	Orange
9. Physician	3-25-14			Pending	Orange

Medical Board of California
Expert Reviewer Program Report

Attachment A

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
First Quarter, 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-March)	Number of Experts Utilized (January-March)	Active List Experts 947↑
ADDICTION	1	**1 EXPERT** 1 LIST EXPERT	15 ↓
ALLERGY & IMMUNOLOGY (A&I)			4
ANESTHESIOLOGY (Anes)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	66 ↓
COLON & RECTAL SURGERY (CRS)			3
COMPLEMENTARY/ALTERNATIVE MEDICINE	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	20
CORRECTIONAL MEDICINE			27
DERMATOLOGY (D)	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	10 ↓
EMERGENCY (EM)	7	**6 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	49 ↑
FAMILY (FM)	12	**11 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	74 ↑
INTERNAL (General Internal Med)	14	**13 EXPERTS** 12 LIST EXPERTS REIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	182 ↓
Cardiovascular Disease (Cv)	4	**4 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	33
Endocrinology, Diabetes and Metabolism (EDM)	1	**1 EXPERT** 1 LIST EXPERT	7
Gastroenterology (Ge)			19

Medical Board of California
Expert Reviewer Program Report

Attachment A

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
First Quarter, 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-March)	Number of Experts Utilized (January-March)	Active List Experts 947↑
Infectious Disease (Inf)	1	**1 EXPERT** 1 LIST EXPERT	10
Medical Oncology (Onc)			12
Nephrology (Nep)			9
Rheumatology (Rhu)			8
MIDWIFE REVIEWER			6
NEUROLOGICAL SURGERY (NS)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	9
NEUROLOGY (N)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	22 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	11	**12 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES	71 ↓
OCCUPATIONAL MEDICINE			8
OPHTHALMOLOGY (Oph)	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	30
ORAL & MAXILLOFACIAL SURGERY			1

Medical Board of California
Expert Reviewer Program Report

Attachment A

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
First Quarter, 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-March)	Number of Experts Utilized (January-March)	Active List Experts 947↑
ORTHOPAEDIC SURGERY (OrS)	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	29 ↑
OTOLARYNGOLOGY (Oto)			19
PAIN MEDICINE (PM)	12	**9 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES	18 ↑
PATHOLOGY (Path)			9
PEDIATRICS (Ped)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	48 ↑
PHYSICAL MEDICINE & REHABILITATION (PMR)	1	**1 EXPERT** 1 LIST EXPERT	9 ↑
PLASTIC SURGERY (PIS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	52
PSYCHIATRY (Psyc)	21	**20 EXPERTS** 16 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	80 ↓
RADIOLOGY (Rad)	2	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	35
RADIATION ONCOLOGY			4
SLEEP MEDICINE (S)			8

Medical Board of California
Expert Reviewer Program Report

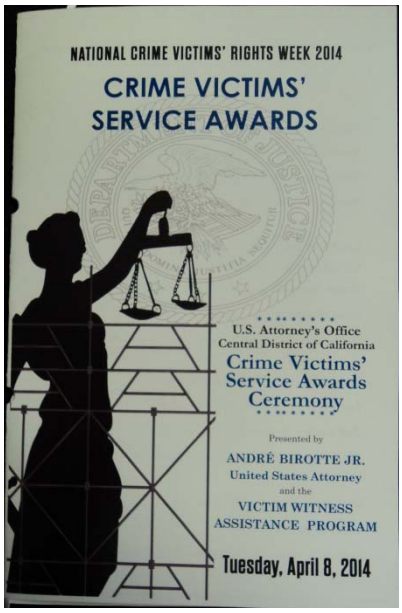
Attachment A

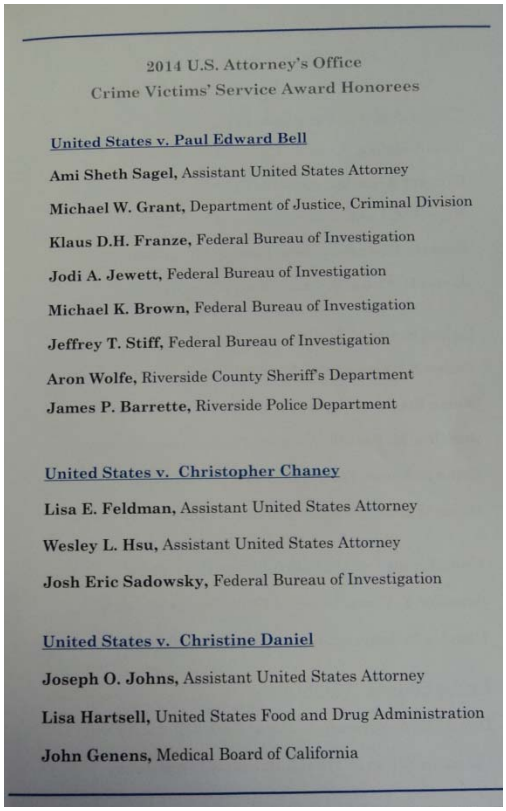
CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
First Quarter, 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-March)	Number of Experts Utilized (January-March)	Active List Experts 947↑
SURGERY (S)	11	**8 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES	40 ↓
Vascular Surgery (VascS)	1	**1 EXPERT** 1 LIST EXPERT	8
THORACIC SURGERY (TS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↑
(MEDICAL) TOXICOLOGY			3
UROLOGY (U)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	17

TOTAL CASES SENT: FIRST QUARTER 2014	**122**
TOTAL LIST EXPERTS UTILIZED: FIRST QUARTER 2014	**111**
TOTAL ACTIVE LIST EXPERTS MARCH,2014	**947**

Expert Program/sg (3.2014)





2014 U.S. Attorney's Office
Crime Victims' Service Award Honorees

United States v. Paul Edward Bell

Ami Sheth Sagel, Assistant United States Attorney

Michael W. Grant, Department of Justice, Criminal Division

Klaus D.H. Franze, Federal Bureau of Investigation

Jodi A. Jewett, Federal Bureau of Investigation

Michael K. Brown, Federal Bureau of Investigation

Jeffrey T. Stiff, Federal Bureau of Investigation

Aron Wolfe, Riverside County Sheriff's Department

James P. Barrette, Riverside Police Department

United States v. Christopher Chaney

Lisa E. Feldman, Assistant United States Attorney

Wesley L. Hsu, Assistant United States Attorney

Josh Eric Sadowsky, Federal Bureau of Investigation

United States v. Christine Daniel

Joseph O. Johns, Assistant United States Attorney

Lisa Hartsell, United States Food and Drug Administration

John Genens, Medical Board of California

Filed 4/15/14

CERTIFIED FOR PUBLICATION

IN THE COURT OF APPEAL OF THE STATE OF CALIFORNIA

FIRST APPELLATE DISTRICT

DIVISION ONE

MEDICAL BOARD OF CALIFORNIA, Plaintiff and Respondent, v. MICHAEL CHIAROTTINO, Defendant and Appellant.	A138420 (Contra Costa County Super. Ct. No. MSN121932)

Defendant Michael Chiarottino, a physician licensed to practice in California, appeals from the trial court's order to comply with investigative subpoenas issued by plaintiff Medical Board of California (Board). The Board issued the subpoenas in connection with an investigation into defendant's prescribing activities as they pertain to controlled substances. On appeal, defendant contends the court erred in rejecting his argument that the Board violated his patients' right to privacy by accessing a computerized database of controlled substance prescription records prior to issuing the subpoenas. We affirm.

FACTUAL BACKGROUND AND PROCEDURAL HISTORY

In August 2011, the Board obtained information that defendant was possibly prescribing excessive medications to patients in violation of the Medical Practice Act. (Bus. & Prof. Code, § 2000 et seq.) A Board investigator obtained a Controlled Substance Utilization Review and Evaluation System (CURES)[1] report of defendant's prescribing history between August 22, 2009 and February 22, 2012. The investigator

[1] The Controlled Substance Utilization Review and Evaluation System was established pursuant to Health and Safety Code section 11165. This section was made operative on January 1, 2005.

also obtained CURES reports of the prescription histories for five of defendant's patients over a 12-month period between 2011 and 2012, and the corresponding pharmacy records for these same patients.

The Board's medical expert Rick Chavez, M.D., conducted an independent review of the CURES reports and the patients' pharmacy records. He identified significant concerns and irregularities in defendant's prescribing of controlled substances to these patients, including prescribing large quantities of highly addictive and dangerous narcotics, prescribing highly unusual combinations of drugs, prescribing buprenorphine (a drug used to resolve opiate addiction) to patients who were concurrently receiving opioids from several other physicians, prescribing at irregular time intervals, and prescribing highly addictive drugs for lengthy periods of time. Chavez concluded defendant's conduct was alarming and difficult to justify.

On February 7, 2012, the Board's investigator sent letters to the five patients requesting authorization for the release of their medical records with respect to the treatment they received from defendant. Defendant was subsequently served with subpoenas directing him to produce the patients' medical records. After the patients were notified of the subpoenas, they informed the investigator that they objected. Defendant's counsel indicated to the investigator that defendant would not produce the requested information because the patients had objected to the release of their medical records.

On December 26, 2012, the Board filed a petition for an order compelling compliance with the investigative subpoenas. (Gov. Code, § 11180 et seq.)[2] In its supporting papers, it argued that the five patients' medical records were needed to properly assess whether the narcotics and controlled substances defendant had prescribed were or were not warranted, and whether he was in compliance with standards of care

[2] Trial courts are authorized to enforce investigative subpoenas that are "regularly issued." (Gov. Code, § 11188.) "The term 'regularly issued' means in accordance with the provisions of sections 11180, 11181, 11182, 11184 and 11185 of the Government Code providing for the matters which may be investigated, the acts authorized in connection with investigations, and the service of process." (*Fielder v. Berkeley Properties Co.* (1972) 23 Cal.App.3d 30, 39.)

and practice. The Board asserted these records were necessary to allow it to "fulfill its monitoring responsibilities of public protection as mandated by California law." It claimed the subpoenas were "reasonably tailored to seek only the records that are necessary and material to the Board's investigation."

On January 2, 2013, the trial court issued an order to show cause regarding the Board's petition.

On January 31, 2013, defendant filed his opposition to the Board's petition. He claimed his refusal was based on protecting the privacy rights of his patients, as well as their rights not to be subjected to unwarranted search and seizure.

On April 18, 2013, the trial court granted the Board's petition to compel defendant's compliance with the subpoenas. The court found the Board had set forth sufficient facts to support a finding of good cause. The court limited the disclosure to records that "are relevant and material to the pending investigation," by setting forth certain substantive and time-based limitations. This appeal followed.

DISCUSSION

I. Standard Of Review

The standard of review generally applicable to review of a trial court's order involving discovery matters or other matters where the trial court has discretionary power is abuse of discretion. (See *Britts v. Superior Court* (2006) 145 Cal.App.4th 1112, 1123.) An abuse of discretion is found where a court exceeds the bounds of reason in light of the circumstances under consideration. (*Loomis v. Loomis* (1960) 181 Cal.App.2d 345, 348.) Unless there has been a clear miscarriage of justice, a reviewing court will not substitute its opinion for that of the trial court so as to avoid divesting the trial court of its discretionary power. (*Id.* at p. 349.)

Issues of law are reviewed de novo. (*Szold v. Medical Bd. of California* (2005) 127 Cal.App.4th 591, 596.) Construction of a statute is a question of law and, as such, is subject to de novo review. (*Ibid*.)

II. Contentions On Appeal

As noted above, the trial court found the Board had established good cause to support the issuance of the subpoenas. Defendant's sole basis for challenging the trial court's good cause finding is his claim that the CURES reports themselves were obtained in violation of his patients' rights to privacy under article I, section 1, of the California Constitution. More specifically, he contends their rights were violated when the Board was given "unfettered and extensive access to two-and-a-half years' worth of all of his patients' CURES prescription information." As will be demonstrated, the Board's actions were entirely authorized under Health and Safety Code section 11165 (the CURES statute). Thus, defendant is implicitly attacking the constitutionality of the statute itself. The weight of authority supports the Board's position that the statute, and its actions taken pursuant thereto, pass constitutional muster.

III. The CURES Statute

The prescribing and dispensing of controlled substances in California are strictly regulated and are monitored by the Department of Justice (DOJ). (See Health & Saf. Code, § 11150 et seq.) The CURES statute provides for the reporting of prescription records to the DOJ, and specifically authorizes the DOJ to disclose such records to state enforcement and regulatory agencies. (Health & Saf. Code, § 11165, subd. (c).) The DOJ maintains a database for the electronic monitoring of, and Internet access to, information regarding the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. The primary purpose of the CURES statute is to "assist . . . law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of . . . controlled substances." (Health & Saf. Code, § 11165, subd. (a).) It is undisputed that the Board qualifies for authorization under the CURES statute to access and review prescription records for controlled substances that pharmacists and other dispensing providers are required to report.

The CURES statute does not require the Board to obtain either patient consent or judicial approval prior to accessing CURES data. The statute does, however, contain its

own confidentiality requirements. Specifically, it provides that the database system "shall operate under existing provision of law to safeguard the privacy and confidentiality of patients." (Health & Saf. Code, § 11165, subd. (c).) The statute further prohibits the disclosure, sale, or transfer of patient data to any third party. (*Ibid*.)

IV. The Medical Board of California

In *Arnett v. Dal Cielo* (1996) 14 Cal.4th 4 (*Arnett*), our Supreme Court provided a useful overview of the Board's role in protecting the health and safety of the public. As the court observed, California has long regulated the practice of medicine as an exercise of the State's police power. (*Id*. at p. 7.) "A key instrument of that regulation has been the statewide agency authorized to license and discipline medical practitioners," now known as the Medical Board of California. (*Ibid.*; see Bus. & Prof. Code, § 101, subd. (b).) "A primary power exercised by the Board in carrying out its enforcement responsibilities is the power to *investigate*: the statute broadly vests the Board with the power of 'Investigating complaints from the public, from other licensees, from health care facilities, or from a division of the board that a physician and surgeon may be guilty of unprofessional conduct.' [Citation.]" (*Arnett, supra,* at pp. 7-8.)

"The Board's investigators have the status of peace officers [citation], and possess a wide range of investigative powers. In addition to interviewing and taking statements from witnesses, the Board's investigators are authorized to exercise delegated powers [citation] to 'Inspect books and records' and to 'Issue subpoenas for the attendance of witnesses and the production of papers, books, accounts, documents and testimony in any inquiry [or] investigation . . . in any part of the state.' [Citations.]" (*Arnett, supra,* at p. 8.) Further, because the Board is authorized "to issue a subpoena 'in any inquiry [or] investigation' [citation], the Board may do so for purely investigative purposes; it is not necessary that a formal accusation be on file or a formal adjudicative hearing be pending. [Citation.]" (*Ibid.*) The Court in *Arnett* further observed " 'the power to make administrative inquiry is not derived from a judicial function but is more analogous to the power of a grand jury, which does not depend on a case or controversy to get evidence

but can investigate "merely on suspicion that the law is being violated, or even just because it wants assurance that it is not." ' [Citation.]" (*Ibid*.)

The Board is specifically charged with enforcement of the Medical Practices Act, and many of the Act's provisions focus particularly on the use and misuse of prescription drugs, as illustrated by the following statutes: Business and Professions Code section 2238 (violation of state or federal statute regulating dangerous drugs and controlled substances), sections 2241 and 2241.5 (furnishing prescription drugs to an addict), and section 2242 (furnishing prescription drugs without an appropriate prior examination and medical indication).

In the present case, defendant does not challenge Board's investigative powers directly. Instead, he repeatedly asserts the Board violated his patients' privacy rights when it obtained "unfettered access" to the CURES data, data the Board subsequently relied on to justify the issuance of the five subpoenas.[3]

IV. The Board's Actions Taken Pursuant to the CURES Statute Did Not Violate Patients' Privacy Rights

A. The State Constitutional Right to Privacy

"In 1972, Californians, by initiative, added an explicit right to privacy in the state's Constitution: 'All people are by nature free and independent and have inalienable rights. Among these are enjoying and defending life and liberty, acquiring, possessing, and protecting property, and pursuing and obtaining safety, happiness, *and privacy*.' (Cal. Const., art. I, § 1, italics added.)" (*County of Los Angeles v. Los Angeles County Employee Relations Com.* (2013) 56 Cal.4th 905, 926 (*County of Los Angeles*).)

In *Hill v. National Collegiate Athletic Assn.* (1994) 7 Cal.4th 1 (*Hill*), our Supreme Court "established a framework for analyzing constitutional invasion of privacy claims. An actionable claim requires three essential elements: (1) the claimant must possess a legally protected privacy interest [citation]; (2) the claimant's expectation of privacy

[3] A physician has the right to assert the privacy interests of his patients who have not consented to the disclosure of their medical records. (*Wood v. Superior Court* (1985) 166 Cal.App.3d 1138, 1145.)

must be objectively reasonable[4] [citation]; and (3) the invasion of privacy complained of must be serious in both its nature and scope [citation]. If the claimant establishes all three required elements, the strength of that privacy interest is balanced against countervailing interests. [Citation.] In general, the court should not proceed to balancing unless a satisfactory threshold showing is made. A defendant is entitled to prevail if it negates any of the three required elements. [Citations.] A defendant can also prevail at the balancing stage. An otherwise actionable invasion of privacy may be legally justified if it substantively furthers one or more legitimate competing interests. [Citation.] Conversely, the invasion may be unjustified if the claimant can point to 'feasible and effective alternatives' with 'a lesser impact on privacy interests.' [Citation.]" (*County of Los Angeles, supra,* 56 Cal.4th at p. 926, fn. added.)

It is established that patients do have a right to privacy in their medical information under our state Constitution.[5] (See, e.g., *Gross v. Recabaren* (1988) 206 Cal.App.3d 771, 782-783 [substantial privacy concerns are raised whenever there is an intrusion into a patient's confidential relationship with a physician.]; *Ruiz v. Podolsky* (2010) 50 Cal.4th 838, 851 [the same with respect to disclosure of confidential medical information regarding the condition a patient seeks to treat].) This right would appear to extend to prescription records.[6] However, it is also well settled that an individual's constitutional right to privacy is not absolute. (*Hill, supra,* 7 Cal.4th at p. 37.)

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[4] "A 'reasonable' expectation of privacy is an objective entitlement founded on broadly based and widely accepted community norms." (*Hill, supra,* 7 Cal.4th at p. 37.) The reasonableness of a privacy expectation depends on the surrounding context. The Supreme Court has "stressed that 'customs, practices, and physical settings surrounding particular activities may create or inhibit reasonable expectations of privacy.' [Citation.])" (*County of Los Angeles, supra,* 56 Cal.4th at p. 927.)

[5] "Legally recognized privacy interests include 'interests in precluding the dissemination or misuse of sensitive and confidential information,' which *Hill* described under the umbrella term ' "informational privacy." ' [Citation.]" (*County of Los Angeles, supra,* 56 Cal.4th at p. 927.)

[6] The Connecticut Supreme Court has noted that a person may reasonably expect his or her prescription records or information contained therein will not be disseminated publicly "[b]ecause prescription records may contain information of a private nature

Even assuming defendant has satisfied the three-prong prima facie elements under *Hill*, we conclude any invasion of his patients' privacy rights with respect to the Board's review of information obtained from the CURES database is justified by a compelling competing interest: "Invasion of a privacy interest is not a violation of the state constitutional right to privacy if the invasion is justified by a competing interest. Legitimate interests derive from the legally authorized and socially beneficial activities of government and private entities. Their relative importance is determined by their proximity to the central functions of a particular public or private enterprise. Conduct alleged to be an invasion of privacy is to be evaluated based on the extent to which it furthers legitimate and important competing interests." (*Hill, supra,* 7 Cal.4th at p. 38.) Here, the balance favors disclosure.

B. Defendant Does Not Challenge the CURES Statute on Its Face

As the Board correctly notes, to the extent defendant is contending on appeal that the CURES statute is facially unconstitutional, he did not raise this argument in the proceeding below; thus, this argument may be deemed waived. (*Ochoa v. Pacific Gas & Electric Co.* (1998) 61 Cal.App.4th 1480, 1488, fn. 3 ["arguments not asserted below are waived and will not be considered for the first time on appeal"].) We also observe he has not cited to any legal authority to support an argument that the CURES statute is facially unconstitutional. Accordingly, we deem the argument waived and abandoned.[7] (*Ibid*.)

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regarding a person's physical or mental health." (*State of Connecticut v. Russo* (2002) 259 Conn. 436, 460.)

[7] Amicus curiae the California Medical Association (CMA) asserts the CURES statute fails to comply with privacy statutes requiring heightened protection of highly sensitive medical information. Specifically, the CMA asserts that access to the prescription information contained in the CURES database can lead to the disclosure of information as to an individual's HIV status, treatment for drug and alcohol abuse, or participation in outpatient psychotherapy. The CMA finds fault with the provision in the statute that allows the DOJ to unilaterally determine whether "to share private prescription information with any third party as determined by the DOJ." Notably, the CMA does not argue that the DOJ abused its discretion in sharing CURES database information concerning defendant's patients with the Board. The CMA further asserts that while CURES "can serve a needed purpose to help control drug diversion in the state

C. The Board Did Not Violate Defendant's Patients' Right to Privacy

Defendant concedes that the CURES statute "appears to authorize the [Board] to obtain CURES data in its investigation of doctors for potential disciplinary purposes, as in the instant case." Our research has not disclosed a California case directly addressing an invasion of privacy claim with respect to activities undertaken pursuant to the CURES statute. However, a recent case lends support for the proposition that the Board's conduct can be justified by a compelling governmental interest. In *420 Caregivers, LLC v. City of Los Angeles* (2012) 219 Cal.App.4th 1316 (*420 Caregivers*), the Court of Appeal reversed an order granting a preliminary injunction against the enforcement of an ordinance regulating the number and geographic distribution of medical marijuana collectives and requiring their registration. Among its conclusions, the appellate court found the collectives did not have a reasonable expectation of privacy in the limited information sought by the ordinance. (*Id.* at p. 1350.) Alternatively, it found any invasion of a reasonable expectation of privacy to be justified by a legitimate and competing state interest. (*Id.* at p. 1349.) Because the collectives did not demonstrate a likelihood of prevailing on the merits at trial, the appellate panel concluded the trial court had erred in granting the request for a preliminary injunction. (*Id.* at p. 1350.)

In arriving at its holding, the appellate court observed "statutes already allow the disclosure of patient contact information by traditional health care providers upon demand. . . . Insofar as schedules II, III, and IV controlled substances (drugs which may be legally prescribed) are concerned, pharmacies are already required weekly to provide the state Department of Justice with the names, addresses, and phone numbers of prescribed users. [Citation.] This information, in turn, may be given to state, local, or federal agencies for purposes of criminal *or disciplinary investigations*. [Citation.]" (*420 Caregivers, supra,* 219 Cal.App.4th at p. 1350, italics added.) The reviewing court

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and assist physicians in making informed prescribing decisions," the privacy protections of the system "are outdated and unregulated." In light of the fact that defendant has not raised a direct challenge the CURES statute, such concerns are more properly addressed to the Legislature.

concluded: "In short, even where the privacy rights of individual collective members are concerned, the information sought is extremely limited and nonintimate in nature and the information—plus more—is typically *already subject to disclosure in the context of more traditional health care treatments and providers.* . . . [W]e see no reason to give medical marijuana users greater privacy rights than patients utilizing more traditional health care providers and more traditional prescription drugs. Indeed, given the continued illegal nature of marijuana under most circumstances, even more substantial invasions of privacy would likely be justified under the current state of the law. Whether analyzed as an unreasonable expectation of privacy or a reasonably justified invasion of a reasonable expectation of privacy, we find no violation of the Collectives' members' individual privacy rights." (*Ibid.*, italics added.)

In rejecting defendant's unreasonable search and seizure claim, the trial court in the present case specifically rejected his right-to-privacy arguments, concluding that, under the circumstances of this case, neither defendant nor his patients have a reasonable expectation of privacy in the records maintained in the CURES database. Several other jurisdictions have addressed this issue more directly and have found that a state law enforcement official's access to controlled substance prescription records does not violate the patient's right of privacy under federal law or under applicable local privacy statutes. We find those opinions to be persuasive.

Significantly, in *Whalen v. Roe* (1977) 429 U.S. 589 (*Whalen*), the United States Supreme Court addressed a statute similar to the CURES statute. In *Whalen*, a group of patients and physicians, among others, challenged the constitutionality of a New York statutory scheme requiring physicians to forward records of prescriptions for Schedule II drugs, which contained detailed patient information, to a centralized database maintained by that state's department of health. (*Id*. at pp. 593-595.) Although, like the CURES statute at issue here, public disclosure of the identity of the patient was prohibited under New York law, certain state regulatory employees and personnel responsible for investigating violations of that state's controlled substance statutes were afforded access to that information. (*Id.* at pp. 594-595.) After finding that the statute furthered the

state's "vital interest in controlling the distribution of dangerous drugs," the Court concluded that the challenged statutory scheme, by mandating the disclosure of the prescription information to representatives of the state having responsibility for the health and welfare of the community, did not create an impermissible invasion of privacy. (*Id*. at pp. 603-604.) As more recent cases demonstrate, other jurisdictions are in accord.

In *State of Nebraska v. Wiedeman* (2013) 286 Neb. 193, a criminal defendant argued that state law enforcement officers violated her due process privacy rights through their warrantless, investigatory access to her prescription records. As in the present case, she did not challenge the statute that authorized the access. (*Id.* at p. 203.) The state's high court found *Whalen* to be dispositive of her privacy arguments under the federal Constitution. (*Id.* at pp. 204-205.) The Nebraska Court observed "there is a long history of governmental scrutiny in the area of narcotics and other controlled substances. All states highly regulate prescription narcotics, and many state statutes specifically allow for law enforcement investigatory access to those records without a warrant. This well-known and long-established regulatory history significantly diminishes any societal expectation of privacy against governmental investigation of narcotics prescriptions." (*Id*. at p. 209, fn. omitted.) The Court concluded the defendant had no legitimate expectation that governmental inquiries would not occur with respect to a pharmacy's prescription records. (*Id.* at p. 212.)

In *State of Connecticut v. Russo* (2002) 259 Conn. 436 (*Russo*), the Supreme Court of Connecticut held a patient's privacy rights were not violated under a state statute that allowed government officials with the duty to enforce state and federal controlled substance statutes to inspect prescription records. (*Id.* at p. 457.) The local police department was investigating a defendant accused of multiple counts of forgery and obtaining controlled substances by forging a prescription. Pursuant to the challenged statute, an authorized law enforcement agent had obtained, with the pharmacists' consent, records of the defendant's prescriptions for controlled substances. The Court, largely relying on *Whalen*, found the defendant's privacy rights had not been violated. (*Id*. at pp. 471-472.)

The Court in *Russo* noted that the Connecticut statutory scheme was indistinguishable from the statutes at issue in *Whalen.* (*Russo, supra,* 259 Conn. at p. 464.) Specifically, both schemes safeguarded the privacy interest of the affected patients by restricting access to those records to a limited class of persons, and by prohibiting the dissemination of such information to the general public. (*Id*. at pp. 464-465.) The Court further observed that nothing in the court records in either case suggested that the law enforcement officials involved had failed to abide by the nondisclosure provisions, or that they would likely flout those provisions in the future. (*Id*. at p. 465.)

In *State of Vermont v. Welch* (1992) 160 Vt. 70, the Supreme Court of Vermont held that a criminal defendant had a privacy interest in her pharmaceutical records, based on a reasonable expectation that those records would not be arbitrarily disclosed. (*Id*. at p. 78.) The court concluded, however, that the "pervasively regulated industry" exception to the warrant requirement allowed for the warrantless inspection of her records in furtherance of the enforcement of statutes pertaining to closely regulated businesses such as pharmacies. (*Id.* at pp. 79-81.) The court specifically noted the state interest in the regulation of dangerous drugs (*id.* at p. 81), and concluded the warrantless inspection of pharmacy records undertaken in compliance with statutory procedures was reasonable. (*Id.* at pp. 83-84.)

Finally, in *Stone v. City of Stow* (1992) 64 Ohio St.3d 156, a contingent of doctors, patients, and a pharmacist sued several municipalities contending that Ohio statutes providing for the inspection of pharmacy prescription records without a warrant violated the right of privacy and the prohibition against unreasonable searches and seizures found in the United States and Ohio Constitutions. (*Id.* at pp. 159-160.) The Court found *Whalen* dispositive of the privacy issue, declining to apply a balancing test that would weigh the need for access to prescription records against the deprivation of privacy caused by the regulatory provisions. The Court noted that, on the state of the record before it, there was no basis for speculating that any unauthorized disclosure of the prescription records would occur. (*Id.* at pp. 162-163.)

In the present case, defendant argues that the Board violated the privacy rights of *all* of his patients by, essentially, conducting a fishing expedition into records of his prescribing activities as reflected in the CURES database. However, there is no evidence that the Board acted outside the scope of its investigative mandate. For example, defendant does not contend the Board used its authority to investigate the records of individuals who were not his patients, or that the Board improperly disclosed any CURES information to third parties. Nor does he contend that the Board had any improper motive in deciding to investigate his own prescribing activities. Thus, it is undisputed that the Board acted within the scope of its authority and in compliance with all relevant statutory law.

Further, the cases defendant relies on are inapposite in that they concern subpoena requests for medical records made by the Board in the absence of good cause. For example, in *Bearman v. Superior Court* (2004) 117 Cal.App.4th 463, the appellate court held that the Board "must demonstrate through competent evidence that the particular records it seeks are relevant and material to its inquiry sufficient for a trial court to independently make a finding of good cause to order the materials disclosed." (*Id.* at p. 469.) The appellate court concluded the Board had failed to set forth facts suggesting that the prescribing physician had engaged in any unethical conduct with respect to his prescribing medical marijuana to a patient. Further, the court found the request was overbroad. (*Id.* at pp. 471-472.) Here, defendant does not challenge the adequacy of the Board's good cause showing to the trial court. Instead, he challenges the legitimacy of the Board's conduct in compiling the factual justification that enabled the court to make an independent assessment of good cause.

For purposes of our decision here, we assume patients have a reasonable expectation that their prescription records will not be disclosed to persons who are not actively involved in their care. Balancing society's substantial interest in reducing the illegitimate use of dangerously addictive prescription drugs against the relatively minor intrusion upon a patient's reasonable expectations of privacy when he or she is given a prescription by a treating physician, we conclude that, as applied to such patients, the

Board's actions here in accessing and compiling data from the CURES database did not violate article I, section 1 of the state Constitution. This is particularly so in light of the fact that the Board is prohibited by law from disclosing this data to third parties. Further, even a reasonable expectation of privacy is somewhat diminished as it is widely known that such investigative actions are possible with respect to controlled substances. In this setting, we conclude that the limited incremental intrusion upon a patient's privacy is justified by the state's countervailing interest in preventing the abuse of controlled substances. Accordingly, we hold the trial court correctly found there was good cause to enforce the subpoenas of the five patients' medical records.

DISPOSITION

The order is affirmed.

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Dondero, J.

We concur:

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Margulies, Acting P.J.

_____
Banke, J.

Trial Court:	Contra Costa County Superior Court
Trial Judge:	Hon. Steven K. Austin
Counsel for Defendant and Appellant:	Pacific West Law Group LLP: Brock Phillips and Gregory Abrams
Counsel for California Medical Association as Amicus Curiae on behalf of Defendant and Appellant:	Francisco J. Silva Long X. Do Lisa Matsubara and Melanie S. Neumeyer of Center for Legal Affairs, California Medical Association
Counsel for Plaintiff and Respondent:	Esther H. La Deputy Attorney General Kamala D. Harris Attorney General of California Gloria Castro Senior Assistant Attorney General Jose R. Guerrero Supervising Deputy Attorney General

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Board Members
SUBJECT: Licensing Program Summary
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
The Licensing Program staff, continue to work hard in the third quarter of FY 13/14. Licensing has filled some vacancies and several staff have been out for various reasons. The BreEZe system requires more information to be inputted and it takes longer to process application files.

Licensing currently has the following vacancies:

- 2 - SSAs - IMG Physicians and Surgeons (P&S) Applications – Interviews will be schedule in the next few weeks.

STATISTICS:
The statistics are on pages BRD 11D - 5 through BRD 11D - 6. Please note that most of the statistics normally provided are unavailable at this time due to the implementation of BreEZe. The statistics that have been provided have been obtained either by a manual count or are not part of the BreEZe system.

Notable statistics include:

- Consumer Information Unit, telephone calls answered - 19,896 (BRD 11D - 5)
- Consumer Information Unit, telephone calls abandoned - **9,585** (BRD 11D - 5)
  - 1527 more abandon calls than the previous quarter
- Consumer Information Unit, telephone calls requesting a call back - **10,625** (BRD 11D - 4)
  - 2,083 more than the previous quarter
- The following statistics are for the work ISB staff did to assist Licensing:
  - Address changes completed by ISB staff – **1,895**
  - Answered 5,810 calls regarding BreEZe questions

- P&S applications initial review completed – *1,552* This was gathered by other means than BreEZe and has a margin of error
- P&S applications not reviewed – *675* This was gathered by other means than BreEZe and has a margin of error
- P&S applications pending – *6,683* This was gathered by other means than BreEZe and has a margin of error
- P&S licenses issued – **1,257**
  - This number is an increase of 408 licenses issued from the previous quarter and a decrease of 34 licenses issued, compared to the same timeframe in FY 12/13

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 five (5) of the 13 weeks in the third quarter of FY 13/14. BreEZe has increased the amount of time to process applications and has significantly impacted staffs' ability to meet the goal. The Licensing management will continue to monitor the review dates closely and is working with staff to reach the Board's goals in the future.

INTERNATIONAL MEDICAL SCHOOLS:
The statistics for the International Medical School Reviews are on page BRD 11D - 6.
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:
Unfortunately, the language for the changes that was provided to the Senate Business, Professions, and Economic Development Committee Staff and Senator Lieu, who previously planned on authoring a bill for these changes, was not put in any bills this year.

Specifically, the OSS Task Force recommended changes to:

1) HSC Section 1248.15(a)(2)(D) – providing some clean up language;
2) HSC Sections 1248.3(a) – requiring initial certifications of accreditation to be valid for only two years, instead of three; and
3) HSC Section 1248.35(b)(2) – requiring inspections, after the initial inspection, to be unannounced.
4) Peer review

SPONSORED FREE HEALTHCARE EVENTS:
The Board received three applications from physicians and surgeons licensed in another state to participate in the Pacific Union Adventist Laymen's Services and Industries Sponsored Free Healthcare Event:

April 23-24, 2014
The Armory Community Center
333 14th Street
San Francisco CA 94103

and

April 25, 2014
Oracle Arena East Side Club
7000 Coliseum Way
Oakland, CA 94629

The Board has not received the required fingerprint criminal record check responses for two of these applicants. The third application was received on April 15, 2014, and is being reviewed.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:
The Board has two pending applications from physician specialty boards requesting approval by the Board.

LICENSING – BREEZE UPDATE:
Prior to BreEZe the Board had an online lookup (WAAS) that P&S applicants could use to determine what documents the Board received and if the documents had been reviewed. At this time, BreEZe currently does not have a similar feature that works as requested by the Board and is useful to applicants at this time. This has resulted in a large number of telephone calls regarding application status and if the Board has received specific documents.

The Consumer Information Unit (CIU) is attempting to answer as many calls as possible. However, many of the telephone calls are taking up to 20 minutes each due to questions regarding BreEZe and needing to assist physicians who are trying to renew their licenses. The CIU is experiencing more calls than the Board is staffed to handle for the length of time each call needs. Therefore, callers are experiencing longer wait times.

The Board's Information Systems Branch (ISB) staff has and continues to provide outstanding service and assistance to the Licensing staff during the BreEZe project. The ISB staff is handling all of the calls related to technical problems regarding BreEZe and recently started taking calls from applicants regarding application information. ISB's assistance is greatly appreciated by Licensing.

As the Board has been using the new BreEZe system, the Licensing managers and the lead analysts have been identifying areas to assist staff with new procedures and additional training as needed on an ongoing basis. Staff have been working overtime in order to keep the initial review timeframes down within the Board's goal of 45 days.

OUTREACH:
The Licensing Outreach Manager has attended the following licensing workshops and, when appropriate, residents from affiliated hospitals are invited to attend:

- March 7: UCD
- March 13-14: UCSD
- March 19: Methodist Hospital (Sacramento)
- April 4: Kaiser Northern California (all SF Bay Area hospitals)
- April 9: Mercy (Merced) and Kaweah Delta (Visalia)
- April 10: UCSF-Fresno

The following licensing workshops have been planned. Additional, licensing workshops may be added if there is a need for more licensing workshops and, when appropriate, residents from affiliated hospitals are invited to attend:

- April 15-16: UCLA
- April 23: Children's Hospital Oakland
- April 29: Mercy Redding

- Aug 6: UCSF (Day 1)
- Sept 11-12: UCSD
- Sept 17: Arrowhead Regional
- Sept 18: LAC+USC
- Sept 25: UCSF (Day 2)
- Sept 29-30: UCI School Of Medicine and UCI Medical Center
- Oct 7-8: UCLA
- Oct 17: Children's Hospital Los Angeles
- Nov 13: Loma Linda
- Nov 14: Kaiser Southern California (all LA area hospitals)

Staff has been invited to participate in new resident orientation at the following teaching hospitals: UCLA, UCSF, UCI, Loma Linda, California Hospital (Los Angeles), St Mary's (Long Beach).

Staff continues to reach out to smaller hospitals, that a separate trip cannot be warranted, but which might be geographically close to other nearby hospitals. For example, staff has visited California Pacific and St. Mary's hospitals, both in San Francisco, and will attempt to coordinate visits to these smaller hospitals into one day or coordinate visits with the licensing workshops being held at UCSF. Several hospitals along the Central Coast (Ventura County Medical Center, Cottage Hospital-Santa Barbara, etc.) have for many years been active participants in the Licensing Program's matrix; this year, both have invited staff to a licensing workshop for the first time and visits will be coordinated.

All trips are planned in consideration of the Governor's Executive Order to limit and condense travel to reduce costs.

WORKLOAD REPORT
as of March 31, 2014

CONSUMER INFORMATION UNIT FY 13/14					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**46,818**	24,897	21,921	19,896	
Calls Requesting Call Back	**12,403**	3,861	8,542	10,625	
Calls Abandoned	**11,205**	3,147	8,058	9,585	
Address Changes Completed	**1,674**	1,674	1,140	2,387	

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

SR 2 - CATEGORIES FY 13/14					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**5**	5	0	4	
PG/Medical Knowledge	**28**	19	9	18	
Convictions	**16**	11	5	4	
Other	**45**	29	16	24	

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

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 13/14					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	98	102	104	
Pending Self-Assessment Reports (included above)	**N/A**	9	10	9	
New Self-Assessment Reports Received	**1**	1	0	1	
New Unrecognized Schools Received	**46**	21	25	10	
School Recognized Pursuant to CCR 1314(a)(1)	**41**	18	23	7	
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0	0*	
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	102	104	108	

*One CCR 1314.1(a)(2) school file was closed on 3/4/2014 due to lack of response to Board's requests for information.

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

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Federation of State Medical Boards Summary
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:
This report is intended to provide the Members with an update on the Federation of State Medical Boards (FSMB). No action is needed at this time.

FSMB Annual Meeting:
The FSMB will hold its annual meeting April 24 – 26, 2014. The theme of this meeting is "From Policy to Action: Resources for Medical Regulators." The goal of the meeting will be to provide state boards with the information and tools to succeed in a challenging medical regulatory environment. Highlights will include a presentation on The Future of Patient-Centered Health Care; Self-assessment, Self-direction, Self-regulation, and Other Myths; and a session on the Model Interstate Compact for Medical Licensure and Trends in Assessing Professional Competency.

FSMB's Foundation Grants:
At the February 2014 Quarterly Board Meeting it was announced that the FSMB had notified Boards that the FSMB's Foundation and several of its partners received a Risk Evaluation and Mitigation Strategy (REMS) grant to provide educational programming on extended-release and long-acting opioid analgesic prescribing to healthcare professionals. Under the grant, the FSMB Foundation would award grants to state medical boards to conduct free live seminars on extended-release and long-acting opioid analgesic prescribing for licensees in their respective states. The grant program provided funding to award up to 25 grants in the amount of $10,000 to individual state medical boards who completed the application process. The curriculum would be provided to boards to support the programs that will be offered free to the learners and would provide physicians with continuing medical education credit. In order to receive a grant, a board would need to secure a minimum of 250 prescribers to participate in the program and provide the training between April 1 to December 31, 2014. The training is for 3 hours.

At the last meeting, the Board approved moving forward with applying for one of the grants in California. On March 17, 2014, the Board was notified that it was chosen to receive one of the $10,000 grants. The Board has worked with the Department of Consumer Affairs (DCA) and will be completing the appropriate forms to obtain this funding for this educational programs. Board staff will begin working on this project within the next two months in order to meet the December deadline to provide the education. The Board will have to do outreach to ensure we meet the minimum number of attendees. This training will be very helpful for physicians. More information regarding this training will be provided at future meetings.

FCVS 2020:
The FSMB has a Program called the Federation Credentials Verification Service (FCVS), which establishes a permanent, lifetime repository of primary-source verified core credentials for physicians and physician assistants. The FCVS keeps a record of everything from medical diplomas to identification documents so physicians do not have to go through the time and effort of assembling and forwarding this information every time they need to be licensed or credentialed. In California, an applicant may use the FCVS to assist in gathering the documents necessary for licensure. However, the Board ensures that the documents are primary-source and meet all of the necessary requirements. The FSMB is looking to upgrade and enhance the FCVS by the year 2020. The Board's Chief of Licensing and the Executive Director have been a part of the work groups to provide information and suggestions to the FSMB. Several telephone conferences have been held regarding the FCVS and input has been provided. The suggestions from the work groups will be provided at the April FSMB Annual Meeting.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Board Members
SUBJECT: Physician Assistant Regulation, 16 CCR 1399.541
FROM: Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the attached proposed language modifying Title 16, California Code of Regulations (CCR) section 1399.541 (Attachment A), make a motion to approve the modified language, and refer the matter back to the Physician Assistant Board for consideration. If the language is approved without substantive changes, authorize the modified language to be noticed for another 15-day comment period.

BACKGROUND:

At the February 2014 meeting of the Medical Board of California (Board), Board Members held a hearing and reviewed the comments received during the 45-day comment period on the proposed modifications to 16 CCR 1399.541, addressing physician supervision of physician assistants acting as first or second surgery assistants. Members voted to make a small modification to the language by striking an "or" from the last sentence. The proposed modification was noticed for a 15-day comment period on March 13, 2014 (see Attachment B).

The comments received during this 15-day period, included herewith as Attachment C, are not related to the specific modification prompting the re-notice. Nonetheless, the Board has the discretion to reopen and reconsider the language. Following consideration of the comments received and discussions with counsel from the Department of Consumer Affairs and Health Quality Enforcement Section, staff recommends further clarifying the definition of "immediately available," and submits the attached proposed language (see Attachment A).

If the Board Members vote to support this further modification, the proposed regulation should be referred back the Physician Assistant Board for review and approval. If the Physician Assistant Board approves the modified language, it will be noticed for another 15-day comment period. If no adverse comments are received, the Executive Director will submit the regulation to the Office of Administrative Law and complete the rulemaking process.

MEDICAL BOARD OF CALIFORNIA
SPECIFIC LANGUAGE OF PROPOSED CHANGES
MEDICAL SERVICES PEFORMABLE

AMENDED MODIFIED TEXT

Legend

Underlined	Indicates proposed amendments or additions to the existing regulation
Red underlined	Indicates additional proposed amendments to the originally proposed language.
~~Strikeout~~	Indicates proposed deletions to the existing regulation.
~~Double strikeout~~	Indicates additional deletions to the originally proposed language

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 a~~n 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 the physician is physically accessible and able to return to the patient, without any 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.

AVAILABILITY OF MODIFIED TEXT

NOTICE IS HEREBY GIVEN that Medical Board of California has proposed modifications to the text of section 1399.541 in Title 16 Cal. Code Reg. which was the subject of a regulatory hearing on February 7, 2014. A copy of the modified text is enclosed. Any person who wishes to comment on the proposed modifications may do so by submitting written comments on or before March 28, 2014, to the following:

Glenn L. Mitchell, Jr.
Physician Assistant Board
2005 Evergreen Street, Suite 1100
Sacramento, CA 95815

Telephone Number: 916. 561.8783
Fax Number: 916.261.2671
E-Mail Address: glenn.mitchell@mbc.ca.gov

DATED: 3/13/14

Christine Valine

Christine Valine, Regulations Coordinator

MEDICAL BOARD OF CALIFORNIA
SPECIFIC LANGUAGE OF PROPOSED CHANGES
MEDICAL SERVICES PEFORMABLE

MODIFIED TEXT

Legend

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~~Strikeout~~	Indicates proposed deletions to the existing regulation.
~~Double strikeout~~	Indicates additional deletions to the originally proposed language

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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 a~~n~~ ~~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.

From: Troy Lair [mailto:troylair@thecompliancedoctor.com]
Sent: Thursday, March 13, 2014 7:55 PM
To: glen.mitchell@mbc.ca.gov
Subject: regulation changes regarding physician assistants comment

Mr. Mitchell:

As always, I appreciate anyone in a position such as yourself in that the task of trying to please many paralleled with the task of protecting the integrity of professional credentials is most challenging.

In so much as I understand the importance of the clarification of this regulatory suggested change, I still feel that there is too much interpretive conclusions that are being left up to a many that may exercise poor judgement in their understanding of what "immediately available" should mean.

We have seen this over the years with post operative patients and their surgeons and anesthesia providers wishing to vacate the premises post PACU transfer and report. Likewise, the same issue the CRNAs and Anesthesiologist and the Governorship involvement in the matter.

My suggestion is simple, immediately available could be interpreted into telephonic or face to face. With telephonic, immediately available should never pose a threat nor problem. But, with face to face- it is a dreaded and obvious failure. In California alone, traffic would be the underlying issue for anyone trying to reach a destination with the sense of urgency. So I think there should be more clarity in defining the term immediate leaving less chance for multiple interpretations of the physicians being they are the ones that will see their roles compromised by the ethical definition of being immediately available. Lives could be saved by adding just this simple two part clarity.

Best to you.

Troy Lair, PhD

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR.

PHYSICIAN ASSISTANT BOARD
2005 Evergreen Street, Suite 1100, Sacramento, CA 95815
P (916) 561-8780 Fax(916) 263-2671 web www.pac.ca.gov

2014 MAR 13 PM 1:30

LICENSING
PROGRAM

March 14, 2014

Medical Board of California
The Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Dear Board Members:

I am writing to you regarding the regulatory proposal to amend Title 16, California Code of Regulations (CCR) Section 1399.541, which seeks to update and clarify physician assistant supervision requirements.

Following the regulatory hearing held on February 7, 2014, members of the Medical Board of California, after public comment and discussion, modified the language by deleting the word "or" from the originally proposed text. The Board voted to approve the proposed amendment to the text. Because of this amendment, a 15-day comment period will take place to allow for further public comment regarding this change.

At the Physician Assistant Board meeting on February 24, 2014, Physician Assistant Board members reviewed the modified text of Title 16, CCR Section 1399.541 as approved by the Medical Board of California. The Physician Assistant Board asked that I inform you that it supports this suggested amendment to the proposed text of the regulation.

I would like to thank the Medical Board of California for their support of this regulatory proposal to amend Title 16, California Code of Regulations Section 1399.541.

Thank you.

Sincerely,

Glenn L. Mitchell, Jr.
Executive Officer

cc: Members, Physician Assistant Board

From: S. Ross [mailto:qrsw@comcast.net]
Sent: Friday, March 21, 2014 3:36 PM
To: Mitchell, Glenn@MBC
Cc: bjohnson@cmanet.org
Subject: Modified PA Supervision Language

Dear Mr. Mitchell:
I am concerned that the modified text of Sec. 1399.541 in title 16 CA. Code Reg. loosens the supervisory responsibilities of the physician. In (i) 1 it clearly states that a PA can only perform "surgical procedures" in the "***personal presence*** of a supervising physician" when the patient is under any form of anesthetic other than procedures that are ***customarily*** performed under local anesthetic (incidentally that would NOT include wound closure for open procedures conducted under general or regional anesthesia). This mean that the ***supervising physician*** must be ***right there*** i.e. in the ***same*** operating/procedure suite with eyes on the procedure and the PA.
In (i)2 the language now states that the PA can do exactly the same procedures under the same anesthetic conditions with the supervising physician ONLY "immediately available" (which could of course mean a delay), and only when the PA requests h/er, which is clearly intended to mean that s/he is not in the "personal presence" of the now unsupervised PA as required by (i)1.
Any language change as it relates to patient care should always err in the patients favor. This is clearly not the case here. A physician assistant is exactly that - an assistant - and when the physician is away from the patient the PA now becomes the ***de facto*** surgeon. Surely this not the intent of the modified language. Please reconsider this language change. Thank you

Stephen Ross, M.D.
P.O.Box 222335
Carmel, CA 93922
Ph. 510-9957773

AVAILABILITY OF MODIFIED TEXT

NOTICE IS HEREBY GIVEN that Medical Board of California has proposed modifications to the text of sections 1361 et seq. in Title 16 Cal. Code Reg. which was the subject of a regulatory hearing on October 25, 2013. A copy of the modified text is enclosed. Any person who wishes to comment on the proposed modifications may do so by submitting written comments on or before April 18, 2014, to the following:

Christine Valine
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Telephone Number: 916. 263-2466
Fax Number: 916.263-2387
E-Mail Address: chris.valine@mbc.ca.gov

DATED: 4/2/14

Christine Valine

Christine Valine, Regulations Coordinator

TITLE 16. MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS

Modified Text

Proposed amendments are shown by ~~strikethrough~~ for deleted text and underline for new text.

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

(1) Amend title of Article 4, Chapter 2, 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 Article 4, Chapter 2, 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 ~~Medical~~ Board ~~of California~~ in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such 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~~Uniform ~~s~~Standards for ~~s~~Substance-~~a~~Abusing ~~l~~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: Sections 315, 315.2, 315.4, and 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 Article 4, Chapter 2, 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 use of another prohibited substance as defined herein, the licensee shall be presumed to be a substance-abusing licensee for purposes of ~~s~~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 ~~S~~section 1361 in any order that the Board determines ~~would provide greater~~ is necessary for public protection or to 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.~~

(1) Clinical Diagnostic Evaluations and Reports; Temporary Removal From Practice.

(A) If the Board orders a licensee who is on probation due to a substance abuse problem to undergo a clinical diagnostic evaluation, the following applies:

1. The clinical diagnostic evaluation shall be conducted by a licensed physician and surgeon who holds a valid, unrestricted license, has three (3) years' experience in providing evaluations of physicians and surgeons with substance abuse disorders, and is approved by the Board.

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

3. The 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.

4. 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 ability to practice safely. 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.

5. In formulating his or her opinion as to 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:

a. License type;
b. Licensee's history;
c. Documented length of sobriety/time that has elapsed since substance use;
d. Scope and pattern of substance abuse;
e. Treatment history;
f. Medical history;
g. Current medical condition;
h. Nature, duration and severity of substance abuse problem; and
i. Whether the licensee is a threat to himself or herself or the public.

6. The cost of an evaluation shall be borne by the licensee.

7. 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. If the evaluator requests additional information or time to complete the evaluation and report, an extension may be granted, but shall not exceed 30 days from the date the evaluator was originally assigned the matter.

(B) Whenever the Board orders a licensee to undergo a clinical diagnostic evaluation, the Board shall order the licensee to cease practice 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 undergo random biological fluid testing at least two (2) times per week.

(D) The Board shall review the clinical diagnostic evaluation report within five (5) business days of receipt 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.

~~(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.~~

(2) Notice of Employer or Supervisor Information. If a licensee whose license is on probation has an employer or supervisor, 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, the worksite monitor, and his or her employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring. For purposes of this section, "supervisors" shall include the Chief of Staff and the Health or Well Being Committee Chair, or equivalent, if applicable, when the licensee has medical staff privileges.

~~(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.~~

(3) Biological Fluid Testing.

(A) The Board shall require biological fluid testing of substance-abusing licensees.

(B) For the purposes of this section, the terms “biological fluid testing” and “testing” mean the acquisition and chemical analysis of a licensee’s urine, blood, breath, or hair.

(C) The Board may order a licensee to undergo a biological fluid test on any day, at any time, including weekends and holidays. Additionally, the licensee shall be subject to 52 - 104 random tests per year within the first year of probation, and 36 - 104 random tests per year for the duration of the probationary term, up to five (5) years. If there has been no positive biological fluid tests in the previous five (5) consecutive years of probation, testing may be reduced to one (1) time per month.

(D) Nothing precludes the Board from increasing the number of random tests for any reason, in addition to ordering any other disciplinary action that may be warranted.

(E) 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 or its designee.

(F) The licensee shall be required to make daily contact with the Board or its designee to determine if biological fluid testing is required. The licensee shall be tested on the date of the notification as directed by the Board or its designee.

(G) Prior to changing testing locations for any reason, including during vacation or other travel, alternative testing locations must be approved by the Board, and meet the requirements set forth in section 1361.52.

(H) The cost of biological fluid testing shall be borne by the licensee.

(I) Exceptions to Testing Frequency Schedule.

1. Previous Testing Orders/Sobriety. In cases where the Board has evidence that a licensee has participated in a treatment or monitoring program requiring random testing prior to being subject

to testing by the Board, the Board may give consideration to that testing in altering the Board's own testing schedule so that the combined testing is equivalent to the requirements of this section.

2. Violation(s) Outside of Employment. A licensee whose license is placed on probation for a single conviction or incident or two convictions or incidents, spanning greater than seven years from each other, where those violations did not occur at work or while on the licensee's way to work, where alcohol or drugs were a contributing factor, may bypass the first-year testing frequency requirements.

3. Not Employed in Health Care Field. The Board may reduce the testing frequency to a minimum of 12 times per year for any licensee who is not practicing or working in any health care field. If a reduced testing frequency schedule is established for this reason, and if a licensee wants to return to practice or work in a health care field, the licensee shall notify and secure the approval of the Board. Prior to returning to any health care employment, the licensee shall be required to test at the first-year testing frequency requirement for a period of at least 60 days. At such time the person returns to employment in a health care field, if the licensee has not previously met the first-year testing frequency requirement, the licensee shall be required to test at the first-year testing frequency requirement for a full year before he or she may be reduced to testing frequency of at least 36 tests per year.

4. Tolling. A Board may postpone all testing for any licensee whose probation is placed in a tolling status while the licensee is not residing in California, provided the overall length of the probationary period is also tolled. A licensee shall notify the Board upon the licensee's return to California and shall be subject to biological fluid testing as provided in this section.

5. Substance Abuse Disorder Not Diagnosed. In cases where no current substance abuse disorder diagnosis is made, a lesser period of monitoring and biological fluid testing may be adopted by the Board, but not shall not be less than 24 times per year.

(J) Reinstatement of License or Reduction of Penalty. Nothing herein shall limit the Board's authority to reduce or eliminate the penalties herein pursuant to a petition for reinstatement or reduction of penalty filed pursuant to Government Code Section 11522.

(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.~~ If the Board requires a licensee to participate in group support meetings, the following shall apply:

~~(B)~~ A. When determining the frequency of group support meetings to be attended, the Board or the evaluator shall give consideration to the following:

1. The licensee's history;
2. The documented length of sobriety /time that has elapsed since substance use;
3. The recommendation of the clinical evaluator;

4. The scope and pattern of use;
5. The licensee's treatment history; and
6. The nature, duration, and severity of substance abuse.

~~(C)~~ B. The facilitator of a group support meeting shall conform to the following requirements:

~~(i)~~ 1. 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)~~ 2. He or she shall not have a current or former financial, personal, or business relationship with the licensee within the last five (5) years. A licensee's previous participation in a group support meeting led by the same facilitator does not constitute a current or former financial, personal, or business relationship.

~~(iii)~~ 3. 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)~~ 4. He or she shall report a licensee's unexcused absence to the Board within 24 hours.

C. Any costs associated with attending and reporting on group support meetings shall be borne by the licensee.

~~(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.~~

(5) Worksite Monitor Requirements and Responsibilities.

(A) The Board may require the use of worksite monitors. 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 name of a worksite monitor. The worksite monitor shall meet the following criteria to be approved by the Board:

1. 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.

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

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

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

(B) The worksite monitor shall adhere to the following required methods of monitoring the licensee:

1. 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.

2. Interview other staff in the office regarding the licensee's behavior, if requested by the Board.

3. Review the licensee's work attendance.

(C) Reporting by the worksite monitor to the Board shall comply with the following:

1. The worksite monitor shall verbally report any suspected substance abuse to the Board and the licensee's employer or supervisor as defined in subsection (c)(2) 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 occurrence, or the next business day.

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

a. The licensee's name and license number;
b. The worksite monitor's name and signature;
c. The worksite monitor's license number, if applicable;
d. The worksite location(s);
e. The dates the licensee had face-to-face contact with the monitor;
f. The names of worksite staff interviewed, if applicable;
g. An attendance report;
h. Any change in behavior and/or personal habits; and
i. Any indicators that can lead to suspected substance abuse.

(D) The licensee shall complete any required consent forms and execute agreements with the approved worksite monitor(s) and the Board authorizing the Board and worksite monitor to exchange information.

(E) If the monitor resigns or is no longer available, the licensee shall, within five (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 the licensee fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, the 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. The licensee shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

(F) Worksite monitoring costs shall be borne by the licensee.

(6) The licensee must remain in compliance with all terms and conditions of probation. If the licensee commits a major or minor violation, as defined in section 1361.52, the Board will execute the disciplinary actions required by that section, and impose any additional terms or conditions necessary for public protection or to enhance the rehabilitation of the licensee.

NOTE: Authority cited: Sections 315, 315.2, 315.4, and 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.

~~(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.~~

(4) Section 1361.51 is added to Article 4, Chapter 2, Division 13 of Title 16 of the California Code of Regulations to read:

§ 1361.51. Results of Biological Fluid Tests of Substance-Abusing Licensees.

(a) If the results of a biological fluid test indicate 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 work where he or she is practicing medicine or providing medical services. The Board shall also immediately notify all of the licensee's employers, and supervisors as defined under section 1361.5(c)(2), if any, and work site monitor, if any, that the licensee may not provide medical services or practice medicine while the cease-practice order is in effect.

(b) A biological fluid test will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance.

(c) After the issuance of a cease-practice order, the Board shall determine whether the positive biological fluid 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.

(d) If no prohibited substance use exists, the Board shall lift the cease-practice order within one (1) business day.

(e) For the purposes of this Article, "prohibited substance" means an illegal 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 the licensee has been instructed by the Board not to use, consume, ingest, or administer to himself or herself.

(f) If the Board confirms that a positive biological fluid test is evidence of use of a prohibited substance, the licensee has committed a major violation, as defined in section 1361.52, and the Board shall impose any or all of the consequences set forth in section 1361.52, in addition to any other terms or conditions the Board determines are necessary for public protection or to enhance the rehabilitation of the licensee.

NOTE: Authority cited: Sections 315, 315.2, 315.4, and 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.

(5) Section 1361.52 is added to Article 4, Chapter 2, Division 13 of Title 16 of the California Code of Regulations to read:

§ 1361.52. Actions by Substance-Abusing 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:

(1) Fails to undergo a required clinical diagnostic evaluation;

(2) Commits multiple minor violations of probation conditions and terms;

(3) Treats a patient or patients while under the influence of a prohibited substance;

(4) Engage in any drug or alcohol related act that is a violation of state or federal law or regulation;

(5) Fails to undergo biological fluid testing when ordered;

(6) Uses, consumes, ingests, or administers to himself or herself a prohibited substance;

(7) Knowingly uses, makes, alters or possesses any object or product in such a way as to defraud, or attempt to defraud, a biological fluid test designed to detect the presence of a prohibited substance; or

(8) Fails to comply with any term or condition of his or her probation that impairs public safety.

(b) If a licensee commits a major violation, the Board will take one or more of the following actions:

(1) Issue an immediate cease-practice order, and 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 shall state that the licensee must test negative for at least a month of continuous biological fluid testing before being allowed to resume practice.

(2) Increase the frequency of biological fluid testing.

(3) Refer the licensee for further disciplinary action, such as suspension, revocation, or other action as determined by the Board.

(c) A licensee who does any of the following shall be deemed to have committed a minor violation of his or her probation:

(1) Fails to submit required documentation to the Board in a timely manner;

(2) Has an unexcused absence at a required meeting;

(3) Fails to contact a worksite monitor as required; or

(4) Fails to comply with any term or condition of his or her probation that does not impair public safety.

(d) If a licensee commits a minor violation, the Board will take one or more of the following actions:

(1) Issue a cease-practice order;

(2) Order practice limitations;

(3) Order or increase supervision of licensee;

(4) Order increased documentation;

(5) Issue a citation and fine, or a warning letter;

(6) Order the licensee to undergo a clinical diagnostic evaluation at the expense of the licensee;

(7) Take any other action as determined by the Board.

(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.

NOTE: Authority cited: Sections 315, 315.2, 315.4, and 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.

(6) Section 1361.53 is added to Article 4, Chapter 2, Division 13 of Title 16 of the California Code of Regulations to read:

§ 1361.53. Request by a Substance-Abusing Licensee to Return to Practice.

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:

(a) A demonstration of sustained compliance with his or her current treatment or recovery program, as applicable;

(b) A demonstration of the capability to practice medicine safely as evidenced by current worksite monitor reports (if currently being monitored), evaluations conducted by licensed health care practitioners, and any other information relating to the licensee's substance abuse and recovery therefrom; and

(c) Negative biological fluid testing reports for at least six (6) months, two (2) positive worksite monitor reports (if currently being monitored), and complete compliance with other terms and conditions of probation.

NOTE: Authority cited: Sections 315, 315.2, 315.4, and 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.

(7) Section 1361.54 is added to Article 4, Chapter 2, Division 13 of Title 16 of the California Code of Regulations to read:

§ 1361.54. Requirements for Laboratories/Testing Locations and Specimen Collectors for Testing Substance-Abusing Licensees.

Licensees shall contract with a laboratory or service approved in advance by the Board, provided that the laboratory or service meets all the following standards:

(a) Its specimen collectors shall 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.

(b) Its specimen collectors shall conform to the current United States Department of Transportation Specimen Collection Guidelines.

(c) Its testing locations shall comply with the Urine Specimen Collection Guidelines published by the United States Department of Transportation without regard to the type of test administered.

(d) Its specimen collectors shall observe the collection of testing specimens.

(e) Its laboratories shall be certified and accredited by the U.S. Department of Health and Human Services.

(f) Its testing locations shall submit a specimen to a laboratory within one (1) business day of receipt and all specimens collected shall be handled pursuant to chain of custody procedures. The laboratory 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.

(g) Its testing locations shall possess all the materials, equipment and technical expertise necessary in order to test every licensee for which it is responsible on any day of the week.

(h) Its testing locations shall be able to scientifically test for urine, blood, and hair specimens for the detection of alcohol, illegal, and controlled substances.

(i) It must have testing sites that are located throughout California.

(j) It must have an automated 24-hour toll-free telephone system and/or a secure on-line computer database that allows the licensee to check in daily for testing.

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

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

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

NOTE: Authority cited: Sections 315, 315.2, 315.4, and 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.

(8) Section 1361.55 is added to Article 4, Chapter 2, Division 13 of Title 16 of the California Code of Regulations to read:

§ 1361.55. Reporting Requirements Relating to Substance-Abusing Licensees.

(a) The Board shall report the following information on a yearly basis to the Department of Consumer Affairs and the Legislature as it relates to licensees with substance abuse problems who are on probation:

(1) Number of probationers whose conduct was related to a substance abuse problem;
(2) Number of relapses (break in sobriety);
(3) Number of cease-practice orders;
(4) Number of suspensions;
(5) Number of major violations; nature of violation and action taken;
(6) Number of petitions to revoke probation filed; and
(7) Number of licensees who successfully completed probation.

(b) For each reporting category described in subsection (a), the Board shall identify the licensing category, and the specific substance abuse problem (i.e., cocaine, alcohol, Demerol, etc.).

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

(d) The Board shall use the following criteria to determine if its terms and conditions of probation protects patients from harm and is effective in assisting its licensees in recovering from substance abuse problems in the long term:

(1) One hundred percent of licensees whose licenses were placed on probation as a result of a substance abuse problem successfully completed probation, or had their licenses to practice revoked or surrendered on a timely basis based on noncompliance with terms and conditions of probation.

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

(e) For purposes of measuring outcomes and effectiveness relating to biological fluid testing as described in section 1361.5(c)(3), the Board shall collect and report historical data (as available) and post-implementation data as follows:

(1) Historical Data. The Board should collect the following historical data (as available) for a period of two years prior to implementation of the Uniform Standards for Substance-Abusing Licensees, for each person subject to testing for banned substances, who has done any of the following:

(A) Tested positive for a banned substance;
(B) Failed to appear or call in for testing on more than three occasions;
(C) Failed to pay testing costs; or
(D) Given a diluted or invalid specimen.

(2) Post-Implementation Data – Three Years

The Board shall collect data annually for a period of three years following implementation of the Uniform Standards for Substance-Abusing Licensees for every licensee subject to testing for banned substances pursuant to section 1361.5(c)(3). The data collected shall be reported to the Department of Consumer Affairs and the Legislature, upon request, and shall include, but may not be limited to:

(A) Licensee identification;
(B) License type;
(C) Probation effective date;
(D) General range of testing frequency for each licensee;
(E) Dates testing requested;
(F) Dates tested;
(G) Identity of the entity that performed each test;
(H) Date(s) licensee tested positive;
(I) Date(s) Board was informed of positive test(s);
(J) Date(s) of questionable tests (e.g. dilute, high levels);
(K) Date(s) Board was notified of questionable test(s);
(L) Identification of substances detected or questionably detected;
(M) Date(s) licensee failed to appear for testing;
(N) Date(s) Board notified of licensee's failure to appear;
(O) Date(s) licensee failed to call in for testing;
(P) Date(s) Board was notified that licensee failed to call in for testing;
(Q) Date(s) licensee failed to pay for testing;
(R) Date(s) licensee was removed/suspended from practice (identify which); and
(S) Final outcome and effective date (if applicable).

Note: Authority cited: Sections 315, 315.2, 315.4, and 2018 of the Business and Professions Code. Reference: Sections 315, 315.2, and 315.4 of the Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 21, 2014
ATTENTION:	Board Members
SUBJECT:	SB 1441 – Proposed Regulations to Implement the Uniform Standards for Substance-Abusing Licensees
FROM:	Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the public comments received during the 15-day comment period, make a motion to approve the recommended changes to the attached proposed language to implement the Uniform Standards for Substance-Abusing Licensees (Attachment A). Further direct staff to notice the modified language for a second 15-day comment period. If no negative comments are received during the 15-day comment period, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rulemaking process, and adopting Title 16 California Code of Regulations (CCR) section 1361, and adding sections 1361.5, 1361.51, 1631.52, 1361.53, 1361.54, and 1361.55 with the modified text.

BACKGROUND:

At the February 2014 meeting of the Medical Board of California (Board), Board Members reviewed and considered public comments directed to the modified language on the proposed regulations to implement the Uniform Standards for Substance-Abusing Licensees. Following the discussion, the Board authorized staff to notice the modified language for a 15-day comment period. This 15-day comment period ended at 5:00 p.m. on Friday, April 18, 2014. Two comments were received during this time, one from Consumers Union, and one from the California Medical Association (CMA) (Attachment B).

Comment by Consumers Union, dated April 10, 2014

Consumers Union has asked that section 1361.5(c)(3) dealing with biological fluid testing be amended to specify that the Board may reestablish a testing cycle or take any other disciplinary action if the Board has suspicion that a licensee has committed a violation of a Board's testing program, pursuant to Uniform Standard No. 4.

The current proposed language states the following under 1361.5(c)(3)(D): Nothing precludes the Board from increasing the number of random tests for any reason, in addition to ordering any other disciplinary action that may be warranted.

Moreover, under 1361.5(c)(3)(C), the proposed language indicates the following, in pertinent part: The Board may order a licensee to undergo a biological fluid test on any day, at any time, including weekends and holidays.

While the previously-noticed language gives the Board broad discretion to order and increase biological fluid testing for any reason, Consumers Union asks the language be modified to include additional language found under Uniform Standard No. 4.

The language under Uniform Standard No. 4 is bulky, would create inconsistencies, and necessitate further definition if the Board were to adopt it as it is written. Nonetheless, the Board may wish to consider the following modification under 1361.5(c)(3)(D), by adding the language in red:

> (D) Nothing precludes the Board from increasing the number of random tests, or returning the licensee to the first-year testing frequency requirements, in addition to ordering any other disciplinary action that may be warranted, for any reason, including, but not limited to, any suspicion that a licensee has committed a major violation as defined under 1361.52(a).

Comment by CMA, dated April 16, 2014

In order to harmonize the use of "negative biological fluid tests" and "prohibited substance," under the proposed regulations, CMA has asked for the following amendment to the proposed language under 1361.5(c)(1)(D):

> (D) The Board shall review the clinical diagnostic evaluation report within five (5) business days of receipt 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 or biological fluid tests indicating that a licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in section 1361.51(e).

I recommend that the Board adopt this proposed language, as it accounts for the situation where a licensee has a positive biological fluid test, but has a valid prescription for the substance.

Similarly, CMA asks for the following amendment under section 1361.53(c), addressing a request by a substance-abusing licensee to return to practice:

> (c) Negative biological fluid testing reports or negative biological fluid testing reports for a prohibited substance, indicating that a licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in section 1361.51(e), for at least six (6) months, two (2)

> positive worksite monitor reports (if currently being monitored), and complete compliance with other terms and conditions of probation.

I recommend that the Board adopt this proposed language in concept, but recommend a slight modification, so that the language is consistent with the proposed change to 1361.5(c)(1)(D), above. Thus, I recommend the following change be made to 1361.53(c):

> (c) Negative biological fluid tests~~ing~~ ~~reports~~ or biological fluid tests indicating that a licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in section 1361.51(e), for at least six (6) months, two (2) positive worksite monitor reports (if currently being monitored), and complete compliance with other terms and conditions of probation.

If the Board Members vote to support these modifications, the motion identified under Requested Action above should be made.

ConsumersUnion®
POLICY & ACTION FROM CONSUMER REPORTS

Attachment A

Sharon Levine, M.D.
President, Medical Board of California
Sacramento, California
April 10, 2014

Regarding: Regulations regarding SB 1441 Uniform Standards Regarding Substance-Abusing Healing Arts Licensees

Dear Dr. Levine:

As the manager of Consumers Union's Safe Patient Project (SPP),[1] I wanted to follow up with you regarding an issue that came up during the testimony of Michele Monserratt Ramos at the MBC quarterly board meeting on February 6, 2014 regarding regulations on the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees.

During her testimony, which was given on behalf of the SPP CA Network, Ms. Monserratt Ramos raised that concern that the proposed regulations did not explicitly incorporate Uniform Standard #4, which gives *the Board discretion to reestablish a testing cycle or take any other disciplinary action if the Board has suspicion that a licensee has committed a violation of a Board's testing program.*

Clearly, based on the discussion at the meeting, the MBC staff and members believe the current draft of the regulations gives the Board broad discretion to require testing and impose disciplinary action, for any reason. We support that. However, we are concerned that failing to include this specificity in the regulatory language (as is required in Uniform Standard #4) may cause several problems: (1) future Medical Boards may be unaware of their authority to act based on their "suspicion" and (2) physicians who fall under the Board's scrutiny may legally object to the Board taking action based on its "suspicion" since the regulations are not specific regarding this authority.

These are our concerns and we are sending this letter to confirm with you that the Medical Board intends to interpret this section of the regulations to give the MBC authority to act even when it has suspicion, without proof, that a licensee has committed a violation of the Board's testing program or some other major violation. We urge the Board to make an affirmative statement regarding this, for the record, to prevent resistance to its authority in the future.

We are otherwise pleased that the new regulations mostly incorporate the full Uniform Standards, which we believe are essential tools for the Board and staff to respond to these often difficult and

[1] Consumers Union's Safe Patient Project (SPP) is a nationwide campaign that organizes patient safety advocates from across the state of California on issues relating to hospital safety (hospital-acquired infections and medical errors) and physician safety. Our California Safe Patient Network ("CA Network") is working on issues related to the Medical Board of California (MBC).

contentious cases. We appreciate the attention you and the other members of the Medical Board have given this issue in recent months.

Sincerely,

Lisa McGiffert
Director
Consumers Union Safe Patient Project
www.SafePatientProject.org
lmcgiffert@consumer.org
512-477-4431 ext 115

CC:
Members, Medical Board of California
Kimberly Kirchmeyer, MBC Executive Director
Kerrie Webb, MBC Senior Staff Counsel
Betsy Imholz, Director of Special Projects, Consumers Union

California Medical Association
Physicians dedicated to the health of Californians

April 16, 2014

Christine Valine
Medical Board of California
2005 Evergreen St., Suite 1200
Sacramento, CA 95815

Subject: Implementation of SB 1441 — Notice File No. Z2013–0827–11

Dear Ms. Valine:

The California Medical Association (CMA) respectfully submits the following comments for consideration related to the proposed adoption of regulations on the "Implementation of SB 1441".

CMA is an advocacy organization that represents more than 39,000 California physicians. Dedicated to the health of Californians, CMA is active in the legal, legislative, reimbursement and regulatory areas on behalf of California physicians and their patients.

I. BACKGROUND

SB 1441 (Chapter 548, Statutes of 2008) authored by Senator Ridley-Thomas Chair of the Senate Business, Professions and Economic Development Committee, created the Substance Abuse Coordination Committee (SACC or Committee). The law required the Committee, by January 1, 2010, to formulate uniform and specific standards in specified areas that each healing arts board must use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal diversion program.[1] The final version of these standards was approved on April 6, 2009.

These standards, while approved by SACC, do not have the force of law of regulations and as such, full implementation requires each licensing board to promulgate regulations to adopt these standards pursuant to any applicable requirements under California's Administrative Procedure Act (APA), Government Code sections 11500 *et seq*. To date, other licensing boards have implemented the standards to varying degrees. A proposal to implement SB 1441 was heard on July 19, 2013, at the Medical Board of California's (Board) 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."

[1] Business & Professions Code §315(c).

II. SUMMARY OF CONCERNS

Our comments pertain primarily to the inconsistent use of the terms "negative biological fluid tests" and "prohibited substances".

Section 1361.5 (c)(1)(D) of Division 13 of Title 16: Clinical Diagnostic Evaluations and Reports

We recommend the following amendment (proposed amendment is underlined) to Section 1361.5 (c)(1)(D) of Division 13 of Title 16:

> "(D) The Board shall review the clinical diagnostic evaluation report within five (5) business days of receipt 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 <u>or biological fluid tests indicating that a licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in Section 1361.51(e).</u>"

The provision as proposed currently does not allow for the scenario in which a licensee has a positive biological fluid test result, but has a valid prescription for that substance. Not only is such a scenario reasonably likely to occur, the Board has expressly recognized and accepted the possibility of a permissible positive biological fluid test result. Section 1361.51 (b) provides that "[a] biological fluid test will not be considered negative if a positive result is obtained while practicing, even if the practitioner holds a valid prescription for the substance." The proposed amendment to Section 1361.5(c)(1)(D) harmonizes the section with Section 1361.51(b) and clarifies the intent of the regulations to impose disciplinary action for the use of prohibited substances, not for all positive biological test results.

Section 1361.53 (c) of Division 13 of Title 16: Request by a Substance-Abusing Licensee to Return to Practice.

We recommend the following amendment (proposed amendment is underlined) to Section 1361.53 (c) of Division 13 of Title 16:

Section 1361.53 (c) states that before determining whether to authorize the return to practice after the issuance of a cease-practice order, one of the criteria that a licensee must meet is:

> "(c) Negative biological fluid testing reports <u>or negative biological fluid testing reports for a prohibited substance, indicating that a licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in Section 1361.51(e),</u> for at least six (6) months, two (2) positive worksite monitor reports (if currently being monitored), and complete compliance with other terms and conditions of probation."

Again, this provision does not allow for the scenario in which a licensee has a positive biological fluid test result, but has a valid prescription for that substance. The proposed amendment to Section 1361.53(c) harmonizes the section with Section 1361.5(b) and clarifies the intent of the regulations to impose disciplinary action for the use of prohibited substances, not for all positive biological test results.

In conclusion, CMA supports and encourages appropriate monitoring and disciplinary measures for physicians. Thank you in advance for your consideration of our comments on the proposed regulations. California's physicians look forward to working with you to develop regulations on disciplining physicians with substance abuse issues, while keeping patient care and safety a top priority.

Sincerely,

Yvonne Choong
Senior Director, Center for Medical and Regulatory Policy
California Medical Association

State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board Meeting

May 2, 2014

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2014 Legislation

Agenda Item 20

Consideration of Legislation/Regulations

MEDICAL BOARD OF CALIFORNIA - 2014 TRACKER LIST
April 23, 2014

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. B&P	Support – 2-year Bill	6/24/13
AB 496	Gordon	Task Force: LGBTI Cultural Competency	Inactive File	Support – 2-year Bill	6/25/13
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Support – 2-year Bill	6/25/13
AB 916	Eggman	Healing Arts: False or Misleading Advertising	Sen. B&P	Support – 2-year Bill	Intro.
AB 1535	Bloom	Pharmacists: Naloxone Hydrochloride	Asm. Approps	Support in Concept Reco: Support	4/1/14
AB 1838	Bonilla	Accelerated Medical School Programs	Sen. B&P	Sponsor/Support	3/5/14
AB 1841	Mullin	Medical Assistants	Asm. B&P	Reco: Neutral	4/21/14
AB 1886	Eggman	Medical Board Internet Posting: 10-year Restriction	Asm. B&P	Sponsor/Support	4/22/14
AB 2139	Eggman	End-of-Life Care: Patient Notification	Asm. Health	Reco: Neutral	4/2/14
AB 2214	Fox	Emergency Room Physicians: CME	Asm. B&P	Reco: Neutral	4/21/14
AB 2232	Gray	UC: Medical Education	Asm. Approps	SPOT	
AB 2346	Gonzalez	NPs, CNMs, and PAs: Supervision	Asm. B&P	Reco: Neutral	
AB 2458	Bonilla	Medical Residency Training Program Grants	Asm. Approps	Reco: Support	4/10/14
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 500	Lieu	Medical Practice: Pain Management	Assembly	Support	1/9/14
SB 841	Cannella	UC: Medical Education	Sen. Approps	SPOT	3/27/14
SB 966	Lieu	Outpatient Settings: Surgical Clinics	Sen. Health	Reco: Support	4/21/14
SB 1083	Pavley	Physician Assistants:	Senate Floor	Reco: Neutral	

Pink – Sponsored Bill, Green & Orange – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA - 2014 TRACKER LIST
April 23, 2014

		Disability Certifications			
SB 1116	Torres	Physicians & Surgeons: STLRP	Sen. Approps	Reco: Support	
SB 1258	DeSaulnier	Controlled Substances: Prescriptions: Reporting	Sen. Public Safety	Reco: Support in Concept	3/25/14
SB 1262	Correa	Medical Marijuana	Sen. Health	Reco: Oppose Unless Amended	4/21/14
SB 1466	Sen. B&P	Omnibus	Sen. B&P	Sponsor/Support MBC Provisions	

Pink – Sponsored Bill, Green & Orange – For Discussion , Blue – No Discussion Needed

AB 1838 - BONILLA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1838
Author: Bonilla
Bill Date: March 5, 2014, Amended
Subject: Accelerated Medical School Programs
Sponsor: Medical Board of California and University of California
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

AB 1838 would allow graduates of accelerated and competency-based medical school programs to be eligible for licensure in California, if the program is accredited by the Liaison Committee on Medical Education (LCME) or the Committee on Accreditation of Canadian Medical Schools (CACMS).

BACKGROUND

The Medical Board of California (Board) raised the issue of accelerated three-year and competency-based medical school programs as a new issue in its Sunset Report. A nationwide physician shortage is projected to reach 90,000+ physicians by the year 2020. Nearly half of that shortage is projected for primary care doctors (family physicians, pediatricians, and family practitioners). The federal Affordable Care Act (ACA) contains provisions to relieve the projected shortage of primary care professionals. Combined with the Prevention and Public Health Fund and the American Recovery and Reinvestment Act, the ACA will provide for the training, development and placement of more than 16,000 primary care providers, including physicians, over the next five years. A significant deterrent to becoming a physician is the substantial cost of medical education. At an estimated cost of $80,000 per year, a medical student can easily accrue a debt of up to $400,000 upon graduation.

In an effort to reduce the nationwide shortage of primary care doctors, as well as lessen burdens on medical students, there is a movement toward an accelerated three-year curriculum. This curriculum would allow medical students to receive the same amount of education in a concentrated, modified year-round education schedule, by eliminating the existing summer breaks, which occur currently in the standard four-year program. Reducing or eliminating the summer breaks allows for an accelerated curriculum completion date.

One such example is the Texas Tech University Health Sciences Center School of Medicine that offers a Family Medicine Accelerated Track (F-MAT) curriculum that provides 10-12 medical students the opportunity to obtain a medical degree in 3 years with 149 contact weeks, as opposed to a traditional four-year program of 160 weeks. In addition, the F-MAT does not require the medical school student to pass USMLE Step 2CS prior to graduation,

unlike most Liaison Committee on Medical Education (LCME) accredited medical schools.

However, the F-MAT students will be required to pass USMLE Step 2CS during their first year of postgraduate training. Normally, LCME accredited medical school graduates are required to pass USMLE Step 2CS as a graduation requirement and must pass USMLE Step 3 during residency training. F-MAT graduates must also pass USMLE Step 3 during residency and successfully complete residency to be eligible for licensure. The F-MAT also has an incentive program where students are given a scholarship in their first year. It is estimated that approximately $50,000 can be saved by the student in an accelerated 3-year program. This is a substantial economic incentive to a potential medical student.

There are also some California Medical School Programs that are proposing or considering competency-based tracks for students that excel and can progress at a faster rate than the standard four-year program. Some accelerated programs will not meet the requirements of Business and Professions Code Sections 2089 – 2091.2, and legislative changes are needed in order to accommodate changes in medical education and to license graduates from the accelerated curriculum programs.

Specifically:

- Section 2089(a) provides "a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction . . . the total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80% of actual attendance shall be required."
- Section 2089.5(b) provides "instruction in the clinical courses shall total a minimum of 72 weeks in length."
- Section 2089.5(c) provides "instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length, with a minimum of eight weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine and four weeks in psychiatry."
- Section 2089.5(d) provides "of the instruction . . . 54 weeks shall be performed in a hospital that sponsors the instruction . . ."

ANALYSIS

AB 1838 would allow graduates of accelerated and competency-based medical school programs to be eligible for licensure in California, if the program is accredited by the LCME or the CACMS. This curriculum would allow medical students to receive the same medical education as that received in standard medical programs, but in a concentrated, modified year-round education schedule by eliminating the existing summer breaks, which occur currently in standard medical school programs. Providing this additional pathway for physicians that would like to practice in California will allow more physicians to be eligible for licensure, as

well as reduce debt for medical school students. This bill supports the Board's mission of promoting access to quality medical care.

FISCAL: None

SUPPORT: The Board (Co-Sponsor), University of California (Co-Sponsor), Association of California Healthcare Districts, and Kaiser Permanente

OPPOSITION: None on file

AMENDED IN ASSEMBLY MARCH 5, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1838

Introduced by Assembly Member Bonilla

February 18, 2014

An act to ~~amend Section 901 of~~ *add Section 2084.5 to* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1838, as amended, Bonilla. Healing arts: ~~exemption from licensure.~~ *medical school accreditation.*

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires each applicant for a physician's and surgeon's certificate to show by official transcript or other official evidence satisfactory to the Division of Licensing that he or she has successfully completed a specified medical curriculum that meets certain clinical instruction requirements extending over a period of at least 4 academic years, or 32 months of actual instruction, in a medical school, as specified.

This bill, notwithstanding any other law, would provide that a medical school or medical school program accredited by the Liaison Committee on Medical Education or the Committee on Accreditation of Canadian Medical Schools is deemed to meet the requirements described above.

~~Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law, until January 1, 2018, provides an exemption from the licensure requirement for a health care practitioner licensed or certified and in good standing in another state, district, or territory~~

~~of the United States, when certain requirements are satisfied and health care services are provided under specified circumstances, including that the health care services are provided to uninsured or underinsured persons at a sponsored event not exceeding 10 days.~~

~~This bill would increase the period during which a health care practitioner is exempt from licensure pursuant to these provisions from 10 days to 15 days.~~

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

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

1 *SECTION 1. Section 2084.5 is added to the Business and*
2 *Professions Code, to read:*
3 *2084.5. Notwithstanding any other law, a medical school or*
4 *medical school program accredited by the Liaison Committee on*
5 *Medical Education or the Committee on Accreditation of Canadian*
6 *Medical Schools shall be deemed to meet the requirements of*
7 *Sections 2089 and 2089.5.*
8 ~~SECTION 1. Section 901 of the Business and Professions Code~~
9 ~~is amended to read:~~
10 ~~901. (a) For purposes of this section, the following provisions~~
11 ~~apply:~~
12 ~~(1) "Board" means the applicable healing arts board, under this~~
13 ~~division or an initiative act referred to in this division, responsible~~
14 ~~for the licensure or regulation in this state of the respective health~~
15 ~~care practitioners.~~
16 ~~(2) "Health care practitioner" means any person who engages~~
17 ~~in acts that are subject to licensure or regulation under this division~~
18 ~~or under any initiative act referred to in this division.~~
19 ~~(3) "Sponsored event" means an event, not to exceed 15 calendar~~
20 ~~days, administered by either a sponsoring entity or a local~~
21 ~~government, or both, through which health care is provided to the~~
22 ~~public without compensation to the health care practitioner.~~
23 ~~(4) "Sponsoring entity" means a nonprofit organization~~
24 ~~organized pursuant to Section 501(c)(3) of the Internal Revenue~~
25 ~~Code or a community-based organization.~~
26 ~~(5) "Uninsured or underinsured person" means a person who~~
27 ~~does not have health care coverage, including private coverage or~~
28 ~~coverage through a program funded in whole or in part by a~~

~~governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the health care practitioner under this section.~~

~~(b) A health care practitioner licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified is exempt from the requirement for licensure if all of the following requirements are met:~~

~~(1) Prior to providing those services, he or she does all of the following:~~

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

~~(B) Satisfies the following requirements:~~

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

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

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

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

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

~~(A) To uninsured or underinsured persons.~~

~~(B) On a short-term voluntary basis, not to exceed a 15-calendar-day period per sponsored event.~~

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

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

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

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

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

~~(A) The name of the sponsoring entity.~~

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

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

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

~~(E) Any additional information required by the board.~~

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

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

~~(f) Within 15 calendar days of the provision of health care services pursuant to this section, the sponsoring entity shall file a report with the board and the county health department of the~~

~~county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the health care practitioners who participated in providing that care.~~

~~(g) The sponsoring entity shall maintain a list of health care practitioners associated with the provision of health care services under this section. The sponsoring entity shall maintain a copy of each health care practitioner's current license or certification and shall require each health care practitioner to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The sponsoring entity shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.~~

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

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

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

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

~~(3) A health care practitioner whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless~~

~~and until a subsequent request for authorization has been approved by the board. A health care practitioner who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of the applicable provisions of this division, and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.~~

~~(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.~~

~~(l) This section shall remain in effect only until January 1, 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.~~

O

AB 1886 - EGGMAN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1886
Author: Eggman
Bill Date: April 22, 2014, Amended
Subject: Medical Board Internet Posting: 10-Year Restriction
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

Currently, public disciplinary information for licensed physicians can only be posted on the Board's website for 10 years. AB 1886 would allow the Board to post this public information on the Board's website for as long as it remains public, with the exception of current accusations, interim suspension orders, temporary restraining orders, and public letters of reprimand; these items would continue to only be posted on the Board's website for 10 years. In addition, if a licensee's hospital staff privileges are restored and the Board is notified, this information would only remain posted on the Board's website for 10 years from the restoration date.

BACKGROUND

The Board raised the 10-year posting restriction as a new issue in its 2012 Sunset Report. Business and Professions Code Section (BPC) 2027 was amended effective January 1, 2003 to require the Board to remove certain public disclosure information from its website. Specifically, the amendment stated:

"From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Website. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003."

The information contained in these subsections pertaining to a physician's license, that would require removal, include: any license or practice suspension/restriction; any enforcement actions (e.g. revocation, probation, public reprimand, etc.); any disciplinary action in California or any other state as described in BPC § 803.1; any current accusations; any malpractice judgment or arbitration award; any misdemeanor conviction that resulted in disciplinary action; and any information required pursuant to 803.1. The only items that would remain on a physician's profile on the Board's website after ten years would be a felony conviction and hospital disciplinary action that resulted in termination or revocation of a physician's hospital staff privileges (unless those privileges were reinstated and then the

information will only remain posted for 10 years from the date of restoration).

ANALYSIS

AB 1886 would allow the Board to post public information on its website for as long as the information is public, with the exception of current accusations, interim suspension orders, temporary restraining orders, and public letters of reprimand; these items would continue to only be posted on the Board's website for 10 years. In addition, if a licensee's hospital staff privileges are restored and the Board is notified, this information would only remain posted on the Board's website for 10 years from the restoration date.

The Board believes that this bill is needed to increase transparency and allow consumers to access public records. This bill does not change what information is available to the public, it simply allows consumers to more easily access information that is already public. Currently, a consumer can call or come to Board offices and request any public documents that have been removed from the Board's website due to the 10-year restriction. However, requiring consumers to call or physically come to the Board's office is burdensome to consumers. The Board believes that not posting these public documents can be misleading to consumers, as they may believe that the physician has no history of discipline, when in fact the public documents have only been removed from the Board's website. In addition, if a consumer were to look up a physician, if the record is removed the website says there are no public documents found. To increase transparency and accessibility, the Board feels it is very important, in the interest of consumer protection, to have all public information available for consumers on the Board's website. This bill will further the Board's mission of consumer protection.

FISCAL: None

SUPPORT: The Board (Sponsor), Center for Public Interest Law, and Consumers Union

OPPOSITION: Association of Northern California Oncologists; California Academy of Cosmetic Surgery; California Academy of Family Physicians; California Medical Association; California Radiological Society; Medical Oncology of Southern Ca, Inc.; Osteopathic Physicians and Surgeons of CA; and Union of American Physicians and Dentists

AMENDED IN ASSEMBLY APRIL 22, 2014

AMENDED IN ASSEMBLY APRIL 2, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1886

Introduced by Assembly Member Eggman

February 19, 2014

An act to amend Sections 2027 and 2233 of the Business and Professions Code, relating to physicians and surgeons.

LEGISLATIVE COUNSEL'S DIGEST

AB 1886, as amended, Eggman. Medical Board of California.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law requires the board to post certain information on the Internet *indefinitely* regarding licensed physicians and surgeons and requires specified information, including any malpractice judgements, arbitration awards, and settlement information, to be posted for a period of 10 years.

This bill would ~~remove the requirement that the specified information be posted on the Internet for a period of 10 years, thereby requiring that information to~~ *require specified information, including enforcement actions, disciplinary actions, malpractice judgments, arbitration awards, and certain misdemeanor convictions, to* be posted indefinitely *on the board's Internet Web site.*

Existing law authorizes the board, by stipulation or settlement with the affected physician and surgeon, to issue a public letter of reprimand after it has conducted an investigation or inspection as specified, rather than filing or prosecuting a formal accusation.

Existing law requires the board to disclose information regarding any enforcement actions taken against a licensee, including, among other things, public letters of reprimand issued, to an inquiring member of the public, as specified.

This bill would make a clarifying and conforming change regarding the disclosure of public letters of reprimand to an inquiring member of the public by deleting a conflicting provision that authorizes, rather than requires, the board to disclose those public letters of reprimand.

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

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

1 SECTION 1. Section 2027 of the Business and Professions
2 Code is amended to read:
3 2027. (a) The board shall post on the Internet the following
4 information in its possession, custody, or control regarding licensed
5 physicians and surgeons:
6 (1) With regard to the status of the license, whether or not the
7 licensee is in good standing, subject to a temporary restraining
8 order (TRO), subject to an interim suspension order (ISO), or
9 subject to any of the enforcement actions set forth in Section 803.1.
10 (2) With regard to prior discipline, whether or not the licensee
11 has been subject to discipline by the board or by the board of
12 another state or jurisdiction, as described in Section 803.1.
13 (3) Any felony convictions reported to the board after January
14 3, 1991.
15 (4) All current accusations filed by the Attorney General,
16 including those accusations that are on appeal. For purposes of
17 this paragraph, "current accusation" shall mean an accusation that
18 has not been dismissed, withdrawn, or settled, and has not been
19 finally decided upon by an administrative law judge and the
20 Medical Board of California unless an appeal of that decision is
21 pending.
22 (5) Any malpractice judgment or arbitration award reported to
23 the board after January 1, 1993.
24 (6) Any hospital disciplinary actions that resulted in the
25 termination or revocation of a licensee's hospital staff privileges
26 for a medical disciplinary cause or reason. The posting shall also
27 provide a link to any additional explanatory or exculpatory

information submitted electronically by the licensee pursuant to subdivision (f) of Section 805.

(7) Any misdemeanor conviction that results in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed.

(8) Appropriate disclaimers and explanatory statements to accompany the above information, including an explanation of what types of information are not disclosed. These disclaimers and statements shall be developed by the board and shall be adopted by regulation.

(9) Any information required to be disclosed pursuant to Section 803.1.

(10) Settlement information, which shall be posted as described in paragraph (2) of subdivision (b) of Section 803.1.

(b) Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its Internet Web site.

~~(c) If~~

(c) (1) From January 1, 2003, the information described in paragraph (1) of subdivision (a) regarding whether a licensee is subject to a temporary restraining order (TRO) or an interim suspension order (ISO), the information in paragraph (4) of subdivision (a), and information on public letters of reprimand shall remain posted on the board's Internet Web site for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period the information shall be removed from the board's Internet Web site.

(2) Except as provided in paragraph (3), if a licensee's hospital staff privileges are restored and the licensee notifies the board of the restoration, the information pertaining to the termination or revocation of those privileges, as described in paragraph (6) of subdivision (a), shall remain posted on the board's Internet Web site for a period of 10 years from the restoration date of the privileges, and at the end of that period the information shall be removed from the board's Internet Web site.

(3) If a court finds, in a final judgment, that peer review resulting in a hospital disciplinary action was conducted in bad faith and the licensee notifies the board of that finding, the information

concerning that hospital disciplinary action posted pursuant to paragraph (6) of subdivision (a) shall be immediately removed from the board's Internet Web site. For purposes of this paragraph, "peer review" has the same meaning as defined in Section 805.

(d) The board shall also post on the Internet a factsheet that explains and provides information on the reporting requirements under Section 805.

(e) The board shall provide links to other Web sites on the Internet that provide information on board certifications that meet the requirements of subdivision (b) of Section 651. The board may provide links to other Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities. The board may also provide links to any other sites that would provide information on the affiliations of licensed physicians and surgeons.

SEC. 2. Section 2233 of the Business and Professions Code is amended to read:

2233. The board may, by stipulation or settlement with the affected physician and surgeon, issue a public letter of reprimand after it has conducted an investigation or inspection as provided in this article, rather than filing or prosecuting a formal accusation. The public letter of reprimand may, at the discretion of the board, include a requirement for specified training or education. The affected physician and surgeon shall indicate agreement or nonagreement in writing within 30 days of formal notification by the board of its intention to issue the letter. The board, at its option, may extend the response time. Use of a public reprimand shall be limited to minor violations and shall be issued under guidelines established by regulations of the board.

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AB 1535 - BLOOM

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1535
Author:	Bloom
Bill Date:	April 1, 2014, Amended
Subject:	Pharmacists: Naloxone Hydrochloride
Sponsor:	Drug Policy Alliance California Pharmacists Association
Position:	Support in Concept

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Medical Board of California (Board), in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. This bill would specify that a pharmacist furnishing naloxone hydrochloride shall not permit the person to whom the drug is being furnished to waive the consultation required by the Board and the BOP. This bill would require a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing naloxone hydrochloride.

BACKGROUND

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

According to the fact sheet, public health experts agree that increasing access to naloxone is a key strategy in preventing drug overdose deaths. The American Medical Association, the White House Office of National Drug Control Policy, the Director of the National Institutes of Drug Abuse, among others, have called for providing naloxone to at-risk patients, first responders, and persons likely to witness a potentially fatal opioid overdose.

ANALYSIS

AB 635 (Ammiano, Chapter 707, Statutes of 2013) was signed into law by the Governor and was supported by the Board. This new law 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 law 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.

This bill would increase access to naloxone by allowing community pharmacists to provide naloxone to at-risk patients in accordance with standardized procedures or protocols developed and approved by BOP and the Board, and in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. The Board and the BOP must include the following when developing the standardized procedures or protocols:

- Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition and response, safe administration of naloxone hydrochloride, potential side effect or adverse events, and the importance of seeking emergency medical care for the patient.
- Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

This bill would specify that a pharmacist furnishing naloxone hydrochloride shall not permit the person to whom the drug is being furnished to waive the consultation required by the Board and the BOP. This bill would require a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing naloxone hydrochloride. This bill would authorize BOP and the Board to ensure compliance with this bill by the Boards' respective licensees.

Drug overdoses are now the leading cause of injury death in the United States, surpassing motor vehicle crash deaths. The Board supported AB 635 because it encourages licensed healthcare providers to begin prescribing naloxone to patients on chronic opioid pain medications in order to help address the prescription drug overdose epidemic, furthering the Board's mission of consumer protection.

This bill was amended to address concerns raised by the California Medical Association and now would require the BOP and the Board to include specific procedures in the standardized procedures and protocols to ensure education of the person to whom the naloxone hydrochloride is furnished and would also require procedures to be included for the notification of the patient's primary care provider with patient consent. The amendments require that the patient receive consultation from the pharmacist, and would not allow it to be waived.

This bill will increase at-risk patient's access to naloxone, while at the same time ensuring standardized procedures and protocols are in place. This bill was amended to add requirements that will further consumer protection and address many of the concerns previously raised by the Board. Board staff is suggesting that the Board now take a support position on this bill.

FISCAL: Minimal and absorbable fiscal to develop standardized procedures and protocols with the BOP.

SUPPORT: California Pharmacists Association (Co-Sponsor); Drug Policy Alliance (Co-Sponsor); A New PATH; Addiction Research and Treatment Amity Foundation; Behind the Orange Curtain; Broadway Treatment Center; Broken No More; California Hospital Association; California Mental Health Directors Association; California Narcotic Officers' Association; California Opioid Maintenance Providers; California Retailers Association; California Society of Addiction Medicine; Center for Living and Learning; CRI-HELP, Inc.; Drug and Alcohol Addiction Awareness and Prevention Program; Families ACT!; Fred Brown Recovery Services; Gateways Hospital and Mental Health Center; Grief Recovery After a Substance Passing; Health Officers Association of California; Health Right 360; Hillview Mental Health Center; Hope of the Valley Rescue Mission; In Depth; Legal Services for Prisoners with Children; Los Angeles Centers for Alcohol and Drug Abuse; Los Angeles Community Action Network; Medical Board of California (in concept); Motion Picture Association of America; Not One More; Paving the Way Foundation; Phoenix House of Los Angeles; Primary Purpose Sober Living Homes; SHIELDS For Families; Soberspace; Solace; The County Alcohol and Drug Program Administrators Association of California; The Mary Magdalene Project; and three individuals

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 1, 2014

AMENDED IN ASSEMBLY MARCH 18, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1535

Introduced by Assembly Member Bloom
(Coauthor: Senator Pavley)

January 21, 2014

An act to add Section 4052.01 to the Business and Professions Code, relating to pharmacists.

LEGISLATIVE COUNSEL'S DIGEST

AB 1535, as amended, Bloom. Pharmacists: naloxone hydrochloride.

Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy. Existing law, generally, authorizes a pharmacist to dispense or furnish drugs only pursuant to a valid prescription. Existing law authorizes a pharmacist to furnish emergency contraceptives and hormonal contraceptives pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified, or developed by the pharmacist and an authorized prescriber. Existing law also authorizes a pharmacist to furnish nicotine replacement products pursuant to standardized procedures or protocols developed and approved by both the board and the Medical Board of California, as specified. Existing law authorizes a licensed health care provider who is permitted to prescribe an opioid antagonist and is acting with reasonable care to prescribe and dispense or distribute an opioid antagonist for the treatment of an opioid overdose to a person at risk of an opioid-related overdose or a family member,

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

This bill would authorize a pharmacist to furnish naloxone hydrochloride in accordance with standardized procedures or protocols ~~developed by the pharmacist and an authorized prescriber or~~ developed and approved by both the board and the Medical Board of California, *in consultation with specified entities*. The bill would require the board and the Medical Board of California, in developing those procedures and protocols, to ~~consider~~ *include* procedures *requiring the pharmacist to provide a consultation* to ensure *the* education of the person to whom the drug is furnished, as specified, *and notification of the patient's primary care provider of drugs or devices furnished to the patient, as specified. The bill would prohibit a pharmacist furnishing naloxone hydrochloride pursuant to its provisions from permitting the person to whom the drug is furnished to waive the consultation described above.* The bill would require a pharmacist to complete a training program on the use of opioid antagonists prior to performing this procedure. The bill would require each board to enforce these provisions with respect to its respective licensees.

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

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

1 SECTION 1. Section 4052.01 is added to the Business and
2 Professions Code, to read:
3 4052.01. (a) Notwithstanding any other provision of law, a
4 pharmacist may furnish naloxone hydrochloride in accordance
5 with ~~either of the following:~~
6 ~~(1) Standardized procedures or protocols developed by the~~
7 ~~pharmacist and an authorized prescriber who is acting within his~~
8 ~~or her scope of practice.~~
9 ~~(2) Standardized~~ *standardized* procedures or protocols developed
10 and approved by both the board and the Medical Board of
11 California, *in consultation with the California Society of Addiction*
12 *Medicine, the California Pharmacists Association, and other*
13 *appropriate entities*. In developing *those* standardized procedures
14 or ~~protocols pursuant to this paragraph,~~ *protocols,* the board and
15 the Medical Board of California shall ~~consider procedures~~ *include*
16 *the following:*

(1) Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition, and response, safe administration of naloxone hydrochloride, potential side effects or adverse events, and the imperative to seek emergency medical care for the patient.

(2) Procedures to ensure the education of the person to whom the drug is furnished regarding the availability of drug treatment programs.

(3) Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

(b) A pharmacist furnishing naloxone hydrochloride pursuant to this section shall not permit the person to whom the drug is furnished to waive the consultation required by the board and the Medical Board of California.

~~(b)~~

(c) Prior to performing a procedure authorized under this section, a pharmacist shall complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride.

~~(c)~~

(d) The board and the Medical Board of California are each authorized to ensure compliance with this section. Each board is specifically charged with enforcing this section with respect to its respective licensees. This section ~~shall~~ *does* not ~~be construed to~~ expand the authority of a pharmacist to prescribe any ~~other drug~~ *prescription medication.*

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AB 1841 - MULLIN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1841
Author: Mullin
Bill Date: April 21, 2014, Amended
Subject: Medical Assistants
Sponsor: Planned Parenthood

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow medical assistants (MAs) to hand to patients properly labeled and pre-packaged prescription drugs, that have been ordered by a licensed physician, podiatrist, physician assistant (PA), nurse practitioner (NP), or a certified nurse-midwife (CNM). This bill would require the properly labeled and pre-packaged prescription drug to have the patient's name affixed to the package and for the physician, PA, NP, or CNM to verify that it is the correct medication and dosage for that specific patient, prior to the MA handing medication to a patient. This bill would exclude controlled substances.

ANALYSIS

Existing law allows MAs to administer medication (including narcotics) orally, topically or through injection; perform skin tests; apply bandages; remove casts and stitches; perform simple lab/screening tests; and perform technical supportive services upon training and authorization of a licensed physician. However, MAs are not allowed to physically hand over medication to patients. This bill would allow MAs to hand over properly labeled and pre-packaged medication to patients when ordered by a physician or clinician. This bill was also recently amended to require the medication to have the specific patient's name affixed to the package and for the physician or clinician to verify that it is the correct medication and dosage for that specific patient, before the MA can hand over the medication to the patient. These amendments address concerns raised by the California Nurses Association.

According to the author's office, current practice in community health centers relies on the use of MAs to support clinicians. Allowing MAs to hand over medication to patients will increase efficiency and streamline and improve operations, which will allow clinicians to focus on patient care and expand and improve access to care for patients.

Existing law already allows MAs to administer medication orally, topically, or through injection. Allowing MAs to hand over properly labeled, pre-packaged medication seems to be a minor increase in the MAs duties, and one that does not compromise consumer protection, as the physician would have to label the medication for the patient and package the medication. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: Planned Parenthood (Sponsor)
California Family Health Council

OPPOSITION: Service Employees International Union

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 21, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 1841

Introduced by Assembly Member Mullin
(Coauthor: Senator Hernandez)

February 18, 2014

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

LEGISLATIVE COUNSEL'S DIGEST

AB 1841, as amended, Mullin. Medical assistants.

Existing law, the Medical Practice Act, provides for the licensure and regulation of the practice of medicine by the Medical Board of California. The act authorizes a medical assistant to administer medication only by intradermal, subcutaneous, or intramuscular injections and to perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law defines the term "technical supportive services" to mean 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, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife. Existing law, the Pharmacy Law, prohibits a prescriber, as defined, from dispensing drugs to patients in his or her office unless specified conditions are satisfied, and authorizes a certified nurse-midwife, a nurse practitioner, a physician assistant, or a naturopathic doctor who functions pursuant to a specified protocol or procedure to hand to a

patient of his or her supervising physician a properly labeled and prepackaged prescription drug.

This bill would specify that the "technical supportive services" a medical assistant may perform also includes handing to a patient a properly labeled and prepackaged prescription drug, other than a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife, *as specified.*

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

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

1 SECTION 1. Section 2069 of the Business and Professions
2 Code is amended to read:
3 2069. (a) (1) Notwithstanding any other law, a medical
4 assistant may administer medication only by intradermal,
5 subcutaneous, or intramuscular injections and perform skin tests
6 and additional technical supportive services upon the specific
7 authorization and supervision of a licensed physician and surgeon
8 or a licensed podiatrist. A medical assistant may also perform all
9 these tasks and services upon the specific authorization of a
10 physician assistant, a nurse practitioner, or a certified
11 nurse-midwife.
12 (2) The supervising physician and surgeon may, at his or her
13 discretion, in consultation with the nurse practitioner, certified
14 nurse-midwife, or physician assistant, provide written instructions
15 to be followed by a medical assistant in the performance of tasks
16 or supportive services. These written instructions may provide that
17 the supervisory function for the medical assistant for these tasks
18 or supportive services may be delegated to the nurse practitioner,
19 certified nurse-midwife, or physician assistant within the
20 standardized procedures or protocol, and that tasks may be
21 performed when the supervising physician and surgeon is not
22 onsite, if either of the following apply:
23 (A) The nurse practitioner or certified nurse-midwife is
24 functioning pursuant to standardized procedures, as defined by
25 Section 2725, or protocol. The standardized procedures or protocol,
26 including instructions for specific authorizations, shall be

1 developed and approved by the supervising physician and surgeon
2 and the nurse practitioner or certified nurse-midwife.
3 (B) The physician assistant is functioning pursuant to regulated
4 services defined in Section 3502, including instructions for specific
5 authorizations, and is approved to do so by the supervising
6 physician and surgeon.
7 (b) As used in this section and Sections 2070 and 2071, the
8 following definitions apply:
9 (1) "Medical assistant" means a person who may be unlicensed,
10 who performs basic administrative, clerical, and technical
11 supportive services in compliance with this section and Section
12 2070 for a licensed physician and surgeon or a licensed podiatrist,
13 or group thereof, for a medical or podiatry corporation, for a
14 physician assistant, a nurse practitioner, or a certified
15 nurse-midwife as provided in subdivision (a), or for a health care
16 service plan, who is at least 18 years of age, and who has had at
17 least the minimum amount of hours of appropriate training pursuant
18 to standards established by the board. The medical assistant shall
19 be issued a certificate by the training institution or instructor
20 indicating satisfactory completion of the required training. A copy
21 of the certificate shall be retained as a record by each employer of
22 the medical assistant.
23 (2) "Specific authorization" means a specific written order
24 prepared by the supervising physician and surgeon or the
25 supervising podiatrist, or the physician assistant, the nurse
26 practitioner, or the certified nurse-midwife as provided in
27 subdivision (a), authorizing the procedures to be performed on a
28 patient, which shall be placed in the patient's medical record, or
29 a standing order prepared by the supervising physician and surgeon
30 or the supervising podiatrist, or the physician assistant, the nurse
31 practitioner, or the certified nurse-midwife as provided in
32 subdivision (a), authorizing the procedures to be performed, the
33 duration of which shall be consistent with accepted medical
34 practice. A notation of the standing order shall be placed on the
35 patient's medical record.
36 (3) "Supervision" means the supervision of procedures
37 authorized by this section by the following practitioners, within
38 the scope of their respective practices, who shall be physically
39 present in the treatment facility during the performance of those
40 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) (A) "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).

(B) Notwithstanding any other law, "technical supportive services" includes handing to a patient a properly labeled and prepackaged prescription drug, excluding a controlled substance, ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife ~~operative~~ in accordance with subdivision (a). *In every instance, prior to handing the medication to a patient, the properly labeled and prepackaged prescription drug shall have the patient's name affixed to the package and a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife shall verify that it is the correct medication and dosage for that specific patient.*

(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.

~~(6) A medical assistant to dispense dangerous drugs or devices to a patient, except as may be authorized by subdivision (a) or by the board in regulations adopted pursuant to Section 2071.~~

1 (d) A nurse practitioner, certified nurse-midwife, or physician
2 assistant shall not authorize a medical assistant to perform any
3 clinical laboratory test or examination for which the medical
4 assistant is not authorized by Chapter 3 (commencing with Section
5 1200). A violation of this subdivision constitutes unprofessional
6 conduct.
7 (e) Notwithstanding any other law, a medical assistant shall not
8 be employed for inpatient care in a licensed general acute care
9 hospital, as defined in subdivision (a) of Section 1250 of the Health
10 and Safety Code.

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AB 2139 - EGGMAN

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2139
Author: Eggman
Bill Date: April 2, 2014, Amended
Subject: End-of-Life Care: Patient Notification
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require a health care provider that makes a diagnosis that a patient has a terminal illness, to notify the patient, or when applicable, the patient's agent, of the patient's right to comprehensive information and counseling regarding legal end-of-life options pursuant to existing law.

This bill would define an agent as an individual designated in a power of attorney for health care to make a health care decision for the patient who has been diagnosed with a terminal illness. This bill would define terminal illness as a medical condition resulting in a prognosis of a life expectancy of one year or less, if the disease follows it normal course.

ANALYSIS

Existing law, Business and Professions Code Section 442.5 requires that a health care provider provide a patient diagnosed with a terminal illness, upon request of the patient, with comprehensive information or counseling regarding their end-of-life options, or make other arrangements to accommodate the patient's request. The information required to be provided in law includes information about prognosis, availability of hospice and palliative care, the right to refuse or withdraw from life-sustaining treatment, and the right to provide written health care instructions or appoint a decision maker.

According to the author's office, a recent report from the California Health Care Foundation (CHCF) found that Californians frequently do not receive the care they would prefer at the end of life. According to the CHCF Report, 80% of Californians say they definitely, or probably would, like to talk with a doctor about end-of-life care, yet less than 1 in 10 have had this conversation. Existing law only requires health care providers to give patients this information on end-of-life care if the patient requests this information. According to the author's office, this bill would ensure that all California patients diagnosed with a terminal illness are notified of their right to receive comprehensive information or counseling regarding their end-of-life options.

Existing law already requires health care providers to provide comprehensive information and counseling regarding end-of-life options if the patient requests this information. Requiring a health care provider to notify a patient or the patient's agent of the

patient's right to request this information seems reasonable, as the patient should know that these resources are available. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 2, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2139

Introduced by Assembly Member Eggman

February 20, 2014

An act to ~~add Section 442.4 to~~ *amend Sections 442, 442.5, and 442.7 of* the Health and Safety Code, relating to terminal illness.

LEGISLATIVE COUNSEL'S DIGEST

AB 2139, as amended, Eggman. End-of-life care: patient notification.

Under existing law, the State Department of Public Health licenses and regulates health facilities, including hospice facilities, and the provision of hospice services. Existing law establishes the Medical Practice Act, which provides for the regulation and licensure of physicians and surgeons by the Medical Board of California. *Existing law authorizes an adult to give an individual, known as an agent, authority to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.*

When a health care provider, as defined, makes a diagnosis that a patient has a terminal illness, existing law requires the health care provider to provide the patient, upon the patient's request, with comprehensive information and counseling regarding legal end-of-life options, as specified, and provide for the referral or transfer of a patient, as provided, if the patient's health care provider does not wish to comply with the patient's request for information on end-of-life options.

~~This~~ *This bill would apply these provisions to an agent under a power of attorney for health care for a patient with a terminal illness diagnosis. The* bill would *additionally* require ~~a~~ *the* health care provider~~, as defined,~~ to notify the patient *or, when applicable, the agent*, when the health

care provider makes a diagnosis that a patient has a terminal illness, of the patient's right to comprehensive information and counseling regarding legal end-of-life care options. *The bill would define the term "terminal illness" for these purposes.*

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

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

1 *SECTION 1. Section 442 of the Health and Safety Code is*
2 *amended to read:*
3 442. For the purposes of this part, the following definitions
4 shall apply:
5 (a) "Actively dying" means the phase of terminal illness when
6 death is imminent.
7 *(b) "Agent" means an individual designated in a power of*
8 *attorney for health care, as provided in Article 1 (commencing*
9 *with Section 4670) and Article 2 (commencing with Section 4680)*
10 *of Chapter 1 of Part 2 of Division 4.7 of the Probate Code, to make*
11 *a health care decision for the patient who has been diagnosed with*
12 *a terminal illness, regardless of whether the person is known as*
13 *an agent or attorney in fact, or by some other term.*
14 ~~(b)~~
15 *(c)* "Disease-targeted treatment" means treatment directed at
16 the underlying disease or condition that is intended to alter its
17 natural history or progression, irrespective of whether or not a cure
18 is a possibility.
19 ~~(c)~~
20 *(d)* "Health care provider" means an attending physician and
21 surgeon. It also means a nurse practitioner or physician assistant
22 practicing in accordance with standardized procedures or protocols
23 developed and approved by the supervising physician and surgeon
24 and the nurse practitioner or physician assistant.
25 ~~(d)~~
26 *(e)* "Hospice" means a specialized form of interdisciplinary
27 health care that is designed to provide palliative care, alleviate the
28 physical, emotional, social, and spiritual discomforts of an
29 individual who is experiencing the last phases of life due to the
30 existence of a terminal disease, and provide supportive care to the
31 primary caregiver and the family of the hospice patient, and that

meets all of the criteria specified in subdivision (b) of Section 1746.

~~(e)~~

(f) "Palliative care" means medical treatment, interdisciplinary care, or consultation provided to a patient or family members, or both, that has as its primary purpose the prevention of, or relief from, suffering and the enhancement of the quality of life, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life as described in subdivision (b) of Section 1339.31. In some cases, disease-targeted treatment may be used in palliative care.

~~(f)~~

(g) "Refusal or withdrawal of life-sustaining treatment" means forgoing treatment or medical procedures that replace or support an essential bodily function, including, but not limited to, cardiopulmonary resuscitation, mechanical ventilation, artificial nutrition and hydration, dialysis, and any other treatment or discontinuing any or all of those treatments after they have been used for a reasonable time.

(h) "Terminal illness" means a medical condition resulting in a prognosis of a life expectancy of one year or less, if the disease follows its normal course.

SEC. 2. Section 442.5 of the Health and Safety Code is amended to read:

442.5. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall *notify the patient of his or her right to, or when applicable, the agent of the patient's right to, comprehensive information and counseling regarding legal end-of-life options and*, upon the ~~patient's~~ *patient or agent's* request, provide the patient *or agent* with comprehensive information and counseling regarding legal end-of-life care options pursuant to this section. When a terminally ill patient is in a health facility, as defined in Section 1250, the health care provider, or medical director of the health facility if the patient's health care provider is not available, may refer the patient *or agent* to a hospice provider or private or public agencies and community-based organizations that specialize in end-of-life care case management and consultation to receive comprehensive information and counseling regarding legal end-of-life care options.

(a) If the patient *or agent* indicates a desire to receive the information and counseling, the comprehensive information shall include, but not be limited to, the following:

(1) Hospice care at home or in a health care setting.

(2) A prognosis with and without the continuation of disease-targeted treatment.

(3) The patient's right to refusal of or withdrawal from life-sustaining treatment.

(4) The patient's right to continue to pursue disease-targeted treatment, with or without concurrent palliative care.

(5) The patient's right to comprehensive pain and symptom management at the end of life, including, but not limited to, adequate pain medication, treatment of nausea, palliative chemotherapy, relief of shortness of breath and fatigue, and other clinical treatments useful when a patient is actively dying.

(6) ~~The~~ *If the patient has not appointed an agent under a power of attorney for health care, the* patient's right to give individual health care instruction pursuant to Section 4670 of the Probate Code, which provides the means by which a patient may provide written health care instruction, such as an advance health care directive, and the patient's right to appoint a legally recognized health care decisionmaker.

(b) The information described in subdivision (a) may, but is not required to, be in writing. Health care providers may utilize information from organizations specializing in end-of-life care that provide information on factsheets and Internet Web sites to convey the information described in subdivision (a).

(c) Counseling may include, but is not limited to, discussions about the outcomes for the patient and his or her family, based on the interest of the patient. Information and counseling, as described in subdivision (a), may occur over a series of meetings with the health care provider or others who may be providing the information and counseling based on the patient's needs.

(d) The information and counseling sessions may include a discussion of treatment options in a manner that the patient and his or her family, *or, when applicable, the agent,* can easily understand. If the patient *or agent* requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient *or agent* shall be referred to the appropriate entity for that information.

SEC. 3. Section 442.7 of the Health and Safety Code is amended to read:

442.7. If a health care provider does not wish to comply with his or her patient's request *or, when applicable, the agent's request* for information on end-of-life options, the health care provider shall do both of the following:

(a) Refer or transfer a patient to another health care provider that shall provide the requested information.

(b) Provide the patient *or agent* with information on procedures to transfer to another health care provider that shall provide the requested information.

~~SECTION 1. Section 442.4 is added to the Health and Safety Code, to read:~~

~~442.4. When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall notify the patient of his or her right to comprehensive information and counseling regarding legal end-of-life options pursuant to Section 442.5.~~

O

AB 2214 - FOX

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2214
Author: Fox
Bill Date: April 21, 2014, Amended
Subject: Continuing Medical Education: Geriatric Care
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Board, when determining continuing education requirements, to consider including a course in geriatric care for emergency room physicians.

ANALYSIS

Existing law requires physicians and surgeons to complete at least 50 hours of approved continuing medical education (CME) during each two year license renewal cycle. Currently, physicians and surgeons only have a mandatory one-time CME requirement of 12 credit hours in the subject of pain management and the treatment of the terminally ill. There is also a mandate in existing law that requires general internists and family physicians who have a patient population of which over 25 percent are 65 years of age or older to complete at least 20 percent of all mandatory CME in a course in the field of geriatric medicine or the care of older patients.

Existing CME courses approved by the Board's Licensing Program include:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME) that qualify for AMA PRA Category 1 Credit(s)™;
- Programs which qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and
- Other programs offered by other organizations and institutions acceptable to the Board.

CME courses approved by the Board's Licensing Program for CME include programs that are approved by the California Medical Association and the American Medical Association and programs that qualify for prescribed credit from the American Academy of Family Physicians.

This bill would require the Board, when determining continuing education requirements, to consider including a course in geriatric care for emergency room physicians. Although the Board has historically opposed mandated CME, this bill would not mandate particular CME for physicians. This bill would only require the Board to consider a course on

geriatric care for emergency room physicians. The Board does not track employment information for physicians, so the Board would not know which physicians are emergency room physicians. However, if the Board decides that it is important to get out information to physicians on this particular type of CME to encourage attendance in these CME courses, it could include an article in its Newsletter or put information out on the Board's website. Board staff suggests that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 21, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2214

Introduced by Assembly Member Fox

February 20, 2014

An act to amend Section 2191 of the Business and Professions Code, relating to physicians *and surgeons*.

LEGISLATIVE COUNSEL'S DIGEST

AB 2214, as amended, Fox. Emergency room ~~physicians:~~ *physicians and surgeons:* continuing medical education: geriatric care.

Existing law, *the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law* requires the Division of Licensing of the Medical Board of California to establish continuing education requirements for physicians and surgeons.

This bill~~, the Dolores H. Fox Act,~~ would require the division, in determining continuing education requirements, to ~~include~~ *consider including* a course in geriatric care for emergency room physicians *and surgeons*.

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

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

1 SECTION 1. This act shall be known and may be cited as the
2 Dolores H. Fox Act.
3 SEC. 2. Section 2191 of the Business and Professions Code is
4 amended to read:

2191. (a) In determining its continuing education requirements, the Division of Licensing shall consider including a course in human sexuality as defined in Section 2090 and nutrition to be taken by those licensees whose practices may require knowledge in those areas.

(b) The division shall consider including a course in child abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected children.

(c) The division shall consider including a course in acupuncture to be taken by those licensees whose practices may require knowledge in the area of acupuncture and whose education has not included instruction in acupuncture.

(d) The division shall encourage every physician and surgeon to take nutrition as part of his or her continuing education, particularly a physician and surgeon involved in primary care.

(e) The division shall consider including a course in elder abuse detection and treatment to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with abused or neglected persons 65 years of age and older.

(f) In determining its continuing education requirements, the division shall consider including a course in the early detection and treatment of substance abusing pregnant women to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these women.

(g) In determining its continuing education requirements, the division shall consider including a course in the special care needs of drug addicted infants to be taken by those licensees whose practices are of a nature that there is a likelihood of contact with these infants.

(h) In determining its continuing education requirements, the division shall consider including a course providing training and guidelines on how to routinely screen for signs exhibited by abused women, particularly for physicians and surgeons in emergency, surgical, primary care, pediatric, prenatal, and mental health settings. In the event the division establishes a requirement for continuing education coursework in spousal or partner abuse detection or treatment, that requirement shall be met by each licensee within no more than four years from the date the requirement is imposed.

(i) In determining its continuing education requirements, the division shall consider including a course in the special care needs of individuals and their families facing end-of-life issues, including, but not limited to, all of the following:

(1) Pain and symptom management.

(2) The psycho-social dynamics of death.

(3) Dying and bereavement.

(4) Hospice care.

(j) In determining its ~~continuation~~ *continuing* education requirements, the division shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the division shall ~~include~~ *consider including* a course in geriatric care for emergency room physicians *and surgeons*.

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AB 2346 - GONZALEZ

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2346
Author: Gonzalez
Bill Date: February 21, 2014, Introduced
Subject: Physician Supervision Ratios: Mid-Level Practitioners
Sponsor: California Medical Association (CMA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would increase the ratios of physician supervision from 1:4 to 1:6 for physician assistants (PAs), nurse practitioners (NPs), and Certified Nurse-Midwifes (CNMs).

ANALYSIS

Existing law sets the physician supervision ratio at one physician supervising up to four of each type of mid-level practitioner. This bill would increase the ratio and allow a physician to supervise up to six of each type of mid-level practitioner.

According to the author's office, AB 2346 is intended to increase access to medical care and enable an increase in the medical workforce, while also acting as a cost containing measure. The number of mid-level practitioners is limited by the number of physicians available to provide supervision. The author's office states that by increasing the supervision ratio, more medical professionals will be able to enter the health care field, which will help to solve the workforce shortage and the increased demand for access to care. The author's office also believes that with the higher level of PAs, NPs, and CNMs providing care, hospitals and clinics will see reduced average costs of providing care and fewer physicians will be needed to supervise these professionals.

This bill will increase the total number of mid-level practitioners that a physician can supervise by six. This seems like a modest increase that may help to expand access to care, without significantly compromising consumer protection. Board staff is suggesting that the Board take a Neutral position on this bill.

FISCAL: None

SUPPORT: CMA (Sponsor)

OPPOSITION: None on file

POSITION: Recommendation: Neutral

ASSEMBLY BILL No. 2346

Introduced by Assembly Member Gonzalez

February 21, 2014

An act to amend Sections 2746.51, 2836.1, and 3516 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2346, as introduced, Gonzalez. Nurse practitioners, certified nurse-midwives, and physician assistants: supervision.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing. Existing law authorizes a nurse practitioner and a certified nurse-midwife to furnish or order drugs or devices under specified circumstances subject to physician and surgeon supervision. Existing law prohibits a physician and surgeon from supervising more than 4 nurse practitioners and certified nurse-midwives at one time for purposes of furnishing drugs or devices. A violation of the Nursing Practice Act is a crime.

This bill would prohibit a physician and surgeon from supervising more than 6 nurse practitioners and certified nurse-midwives at one time for purposes of furnishing drugs or devices.

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. Existing law authorizes a physician assistant to perform certain health care activities subject to physician and surgeon supervision. Existing law prohibits a physician and surgeon from supervising more than 4 physician assistants at one time, except as specified.

This bill would prohibit a physician and surgeon from supervising more than 6 physician assistants at one time, except as specified.

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

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

1 SECTION 1. Section 2746.51 of the Business and Professions
2 Code is amended to read:
3 2746.51. (a) Neither this chapter nor any other provision of
4 law shall be construed to prohibit a certified nurse-midwife from
5 furnishing or ordering drugs or devices, including controlled
6 substances classified in Schedule II, III, IV, or V under the
7 California Uniform Controlled Substances Act (Division 10
8 (commencing with Section 11000) of the Health and Safety Code),
9 when all of the following apply:
10 (1) The drugs or devices are furnished or ordered incidentally
11 to the provision of any of the following:
12 (A) Family planning services, as defined in Section 14503 of
13 the Welfare and Institutions Code.
14 (B) Routine health care or perinatal care, as defined in
15 subdivision (d) of Section 123485 of the Health and Safety Code.
16 (C) Care rendered, consistent with the certified nurse-midwife's
17 educational preparation or for which clinical competency has been
18 established and maintained, to persons within a facility specified
19 in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the
20 Health and Safety Code, a clinic as specified in Section 1204 of
21 the Health and Safety Code, a general acute care hospital as defined
22 in subdivision (a) of Section 1250 of the Health and Safety Code,
23 a licensed *alternative* birth center as defined in Section 1204.3 of
24 the Health and Safety Code, or a special hospital specified as a
25 maternity hospital in subdivision (f) of Section 1250 of the Health
26 and Safety Code.
27 (2) The drugs or devices are furnished or ordered by a certified
28 nurse-midwife in accordance with standardized procedures or
29 protocols. For purposes of this section, standardized procedure
30 means a document, including protocols, developed and approved
31 by the supervising physician and surgeon, the certified
32 nurse-midwife, and the facility administrator or his or her designee.

The standardized procedure covering the furnishing or ordering of drugs or devices shall specify all of the following:

(A) Which certified nurse-midwife may furnish or order drugs or devices.

(B) Which drugs or devices may be furnished or ordered and under what circumstances.

(C) The extent of physician and surgeon supervision.

(D) The method of periodic review of the certified nurse-midwife's competence, including peer review, and review of the provisions of the standardized procedure.

(3) If Schedule II or III controlled substances, as defined in Sections 11055 and 11056 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician and surgeon. For Schedule II controlled substance protocols, the provision for furnishing the Schedule II controlled substance shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(4) The furnishing or ordering of drugs or devices by a certified nurse-midwife occurs under physician and surgeon supervision. For purposes of this section, ~~no~~ *a* physician and surgeon shall *not* supervise more than ~~four~~ *six* certified nurse-midwives at one time. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(A) Collaboration on the development of the standardized procedure or protocol.

(B) Approval of the standardized procedure or protocol.

(C) Availability by telephonic contact at the time of patient examination by the certified nurse-midwife.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list

available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(4) A copy of the standardized procedure or protocol relating to the furnishing or ordering of controlled substances by a certified nurse-midwife shall be provided upon request to any licensed pharmacist who is uncertain of the authority of the certified nurse-midwife to perform these functions.

(5) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) under the following conditions:

(1) The drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (2) to (4), inclusive, of subdivision (a) and in paragraphs (1) to (3), inclusive, of subdivision (b).

(2) When Schedule II controlled substances, as defined in Section 11055 of the Health and Safety Code, are furnished or ordered by a certified nurse-midwife, the controlled substances shall be furnished or ordered in accordance with a patient-specific

protocol approved by the treating or supervising physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient in strict accordance with a standardized procedure or protocol. Use of the term "furnishing" in this section shall include the following:

(1) The ordering of a drug or device in accordance with the standardized procedure or protocol.

(2) Transmitting an order of a supervising physician and surgeon.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 2. Section 2836.1 of the Business and Professions Code is amended to read:

2836.1. Neither this chapter nor any other provision of law shall be construed to prohibit a nurse practitioner from furnishing or ordering drugs or devices when all of the following apply:

(a) The drugs or devices are furnished or ordered by a nurse practitioner in accordance with standardized procedures or protocols developed by the nurse practitioner and the supervising physician and surgeon when the drugs or devices furnished or ordered are consistent with the practitioner's educational preparation or for which clinical competency has been established and maintained.

(b) The nurse practitioner is functioning pursuant to standardized procedure, as defined by Section 2725, or protocol. The standardized procedure or protocol shall be developed and

approved by the supervising physician and surgeon, the nurse practitioner, and the facility administrator or the designee.

(c) (1) The standardized procedure or protocol covering the furnishing of drugs or devices shall specify which nurse practitioners may furnish or order drugs or devices, which drugs or devices may be furnished or ordered, under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the nurse practitioner's competence, including peer review, and review of the provisions of the standardized procedure.

(2) In addition to the requirements in paragraph (1), for Schedule II controlled substance protocols, the provision for furnishing Schedule II controlled substances shall address the diagnosis of the illness, injury, or condition for which the Schedule II controlled substance is to be furnished.

(d) The furnishing or ordering of drugs or devices by a nurse practitioner occurs under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include (1) collaboration on the development of the standardized procedure, (2) approval of the standardized procedure, and (3) availability by telephonic contact at the time of patient examination by the nurse practitioner.

(e) For purposes of this section, ~~no~~ *a* physician and surgeon shall *not* supervise more than ~~four~~ *six* nurse practitioners at one time.

(f) (1) Drugs or devices furnished or ordered by a nurse practitioner may include Schedule II through Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and shall be further limited to those drugs agreed upon by the nurse practitioner and physician and surgeon and specified in the standardized procedure.

(2) When Schedule II or III controlled substances, as defined in Sections 11055 and 11056, respectively, of the Health and Safety Code, are furnished or ordered by a nurse practitioner, the controlled substances shall be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the nurse practitioner's standardized procedure relating to controlled

substances shall be provided, upon request, to any licensed pharmacist who dispenses drugs or devices, when there is uncertainty about the nurse practitioner furnishing the order.

(g) (1) The board has certified in accordance with Section 2836.3 that the nurse practitioner has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section.

(2) A physician and surgeon may determine the extent of supervision necessary pursuant to this section in the furnishing or ordering of drugs and devices.

(3) Nurse practitioners who are certified by the board and hold an active furnishing number, who are authorized through standardized procedures or protocols to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration, shall complete, as part of their continuing education requirements, a course including Schedule II controlled substances based on the standards developed by the board. The board shall establish the requirements for satisfactory completion of this subdivision.

(h) Use of the term "furnishing" in this section, in health facilities defined in Section 1250 of the Health and Safety Code, shall include (1) the ordering of a drug or device in accordance with the standardized procedure and (2) transmitting an order of a supervising physician and surgeon.

(i) "Drug order" or "order" for purposes of this section means an order for medication which is dispensed to or for an ultimate user, issued by a nurse practitioner as an individual practitioner, within the meaning of Section ~~1306.02~~ *1306.03* of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by nurse practitioners; and (3) the signature of a nurse practitioner on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

SEC. 3. Section 3516 of the Business and Professions Code is amended to read:

3516. (a) Notwithstanding any other provision of law, a physician assistant licensed by the board shall be eligible for employment or supervision by any physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that employment or supervision.

(b) ~~No~~ *A* physician and surgeon shall *not* supervise more than ~~four~~ *six* physician assistants at ~~any~~ one time, except as provided in Section 3502.5.

(c) The Medical Board of California may restrict a physician and surgeon to supervising specific types of physician assistants including, but not limited to, restricting a physician and surgeon from supervising physician assistants outside of the field of specialty of the physician and surgeon.

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AB 2458 - BONILLA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2458
Author: Bonilla
Bill Date: April 10, 2014, Amended
Subject: Medical Residency Training Program Grants
Sponsor: California Academy of Family Physicians (CAFP, Co-Sponsor)
California Medical Association (CMA, Co-Sponsor)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Graduate Medical Education Fund (GMEF) to finance additional positions at residency programs in California hospitals and teaching health centers. This bill would appropriate $2,840,000 per year for three years from the California Health Data and Planning Fund into the GMEF. This bill would also appropriate $25,000,000 from the General Fund in 2014/15 into the GMEF.

ANALYSIS

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

According to the author's office, California has a shortage of primary care physicians and one large challenge in California is providing residency slots. Having residency positions in California is important because after residency is concluded, physicians tend to settle in areas where they complete their training. According to the author's office, nearly 70% of residents who train in California remain here to practice after graduation. The Governor's 2014-15 proposed budget includes an allocation of $2.84 million dollars for a term of three years to expand the Song-Brown Primary Care Residency Program. This bill would build on this proposed investment by providing funding for additional GME positions.

Specifically, this bill would do the following: establish the GMEF; direct the Office of Statewide Health, Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for the distribution of available monies in the GMEF; specify that monies from the GMEF will be used for new GME residency positions; appropriate $2.84 million dollars annually for a period of three years, starting in the 2014/15 fiscal year, from the California Health Data and Planning Fund to

the GMEF; and appropriate $25 million in the 2014/15 fiscal year from the general fund into the GMEF.

This bill would increase funding for residency slots in California, which will help promote the Board's mission of increasing access to care for consumers. This bill would also allow more physicians to receive residency training and potentially end up practicing in California. Board staff is suggesting that the Board take a support position on this bill.

FISCAL: None

SUPPORT: CAFP (Co-Sponsor); CMA (Co-Sponsor); American Academy of Pediatrics, California District IX; American Congress of Obstetricians and Gynecologists, District IX (California); American Federation of State, County and Municipal Employees, AFL-CIO; American Osteopathic Association; Association of California Healthcare Districts; California Chapter of the American College of Emergency Physicians; California Children's Hospital Association; California Hospital Association; California Primary Care Association; and Osteopathic Physicians and Surgeons of California

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 10, 2014

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 2458

Introduced by Assembly Member Bonilla

February 21, 2014

An act to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to medical care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2458, as amended, Bonilla. Medical residency training program grants.

Existing law, the Song-Brown Health Care Workforce Training Act, provides for specified training programs for certain health care workers, including family physicians, registered nurses, nurse practitioners, and physician's assistants.

This bill would establish the Graduate Medical Education Fund, to be used to administer and fund grants to graduate medical education residency programs located in California hospitals or teaching health centers, as specified. The bill would appropriate ~~an unspecified amount of money~~ *twenty-five million dollars ($25,000,000)* from the General Fund in the 2014–15 fiscal year for this purpose and $2,840,000 per year for 3 years, commencing with the 2014–15 fiscal year, from the California Health Data and Planning Fund for this purpose.

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

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

SECTION 1. Article 4 (commencing with Section 128310) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 4. Medical Residency Training Program Grants

128310. (a) The Graduate Medical Education Fund is hereby established in the State Treasury.

(b) Moneys in the fund shall, upon appropriation by the Legislature, be used solely for the purpose of administering and funding grants to graduate medical education residency programs located in California hospitals or teaching health centers.

(c) (1) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(2) One-time, ongoing, or administrative costs incurred or generated by the implementation of this article, including those that might be incurred by the Office of Statewide Health Planning and Development (OSHPD), shall come directly from the Graduate Medical Education Fund.

(d) The fund shall consist of both of the following:

(1) All assessments, transfers, and appropriations received pursuant to Section 128311.

(2) Interest that accrues on amounts in the fund.

(e) OSHPD, in consultation with the California Healthcare Workforce Policy Commission, shall develop criteria for distribution of available moneys in the fund.

(f) Moneys appropriated from the fund shall be used to fund new graduate medical education residency positions.

(g) Whenever applicable, OSHPD shall utilize moneys appropriated from the fund to provide a match for available federal funds for graduate medical education.

(h) For purposes of this article, the following definitions shall apply:

(1) "Commission" means the California Healthcare Workforce Policy Commission, established pursuant to Section 128215.

(2) "OSHPD" means the Office of Statewide Health Planning and Development.

(3) "Primary care physician" means an allopathic or osteopathic physician who has the responsibility for providing initial and primary care to patients, maintaining the continuity of patient care, and initiating referral for specialist care. A primary care physician shall be either a physician who has limited his or her practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

128311. (a) In the 2014–15 fiscal year, the sum of ~~——~~ *twenty-five million* dollars ~~($——)~~ *($25,000,000)* is hereby appropriated from the General Fund to the Graduate Medical Education Fund established in Section 128310.

(b) Commencing with the 2014–15 fiscal year, the sum of two million eight hundred forty thousand dollars ($2,840,000) per year for three years is hereby appropriated from the California Health Data and Planning Fund ~~into~~ *to* the Graduate Medical Education Fund established in Section 128310.

128312. Funding of this article shall not affect the existing funding for the Song-Brown Health Care Workforce Training Act (Article 1 (commencing with Section 128200)) for family medicine residency or physician assistant, family nurse practitioner, and registered nurse training programs.

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SB 966 - LIEU

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 966
Author: Lieu
Bill Date: April 21, 2014, Amended
Subject: Outpatient Settings: Surgical Clinics
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow outpatient settings owned by physicians or dentists to be licensed by the California Department of Public Health (CDPH) as a surgical clinic. This bill would also subject accredited outpatient settings to data reporting requirements in Health and Safety Code (HSC) Sections 1216, 127280, and 128787; this data would be reported to the Office of Statewide Health Planning and Development (OSHPD). This bill would state that initial certificates of accreditation issued to outpatient settings are valid for two years, and inspections after the initial inspection for accreditation shall be unannounced.

OUTPATIENT SETTINGS BACKGROUND

The Medical Board of California's (Board) role related to outpatient settings is that the Board approves the accreditation agencies (AAs) that accredit outpatient settings. In the Health and Safety Code, there is a distinction between clinics licensed by the CDPH and outpatient settings that are accredited by an outside accrediting agency approved by the Board. Clinics licensed by the CDPH are non-physician owned, while clinics accredited by an AA approved by the Board are owned by a physician, association, corporation, firm, partnership, or individual.

California law prohibits physicians from performing some levels of outpatient surgery, unless it is performed in an accredited or licensed setting. Section 2216 of the Business and Professions Code (B&P) specifies that on or after, July 1, 1996, no physician and surgeon shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Health and Safety Code Section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

As outlined in Health and Safety Code (H&S) Section 1248.1, certain outpatient surgery settings are excluded from the accreditation requirement, such as ambulatory surgical

centers certified to participate in the Medicare program under Title XVIII, health facilities licensed as general acute care hospitals, federally operated clinics, facilities on recognized tribal reservations, and facilities used by dentists or physicians in compliance with Article 2.7 or Article 2.8 of Chapter 4 of Division 2 of the B&P Code.

Existing law's distinction on which clinics are licensed by CDPH and which fall under the jurisdiction of AAs approved by the Board has been the subject of litigation. In Capen v. Shewry (2007) 147 Cal.App.4th 680, the issue before the court was whether a surgical clinic that is wholly owned and operated by a licensed physician, in which non-owner, non-licensee, physicians will practice, is required to obtain a license from CDPH. The Court concluded that physician-owned-and-operated surgical clinics are not subject to licensing by CDPH and are to be regulated by the Board. In an effort to clarify the Board's authority over outpatient settings after Capen, the Board submitted a letter on October 18, 2007 to Judge Coleman Blease, who issued the opinion in the Capen case. The Board stated that "the law does not give the MBC the authority to regulate clinics owned and operated by physicians. It just gives the MBC the authority to approve accrediting agencies that are in compliance with the standards set forth in Health and Safety Code Section 1248 et.seq."

OUTPATIENT SURGERY SETTINGS (OSS) TASK FORCE BACKGROUND

At the October 2013 Board Meeting, the OSS Task Force was authorized to move forward with its recommended changes after receiving and considering input from the interested parties at the January 22, 2014 meeting. Based upon the comments from the interested parties on January 22, 2014, the OSS Task Force determined three legislative changes could move forward.

Specifically, the OSS Task Force recommended changes to:

1) HSC Section 1248.15(a)(2)(D) – providing some clean up language;
2) HSC Sections 1248.3(a) – requiring initial certifications of accreditation to be valid for only two years, instead of three; and
3) HSC Section 1248.35(b)(2) – requiring inspections, after the initial inspection, to be unannounced.

Also, at the October 2013 Board Meeting, the Board approved staff to move forward with legislation to require accredited outpatient settings to report utilization and patient encounter data to OSHPD. Health and Safety Code Section 1216 requires clinics licensed by CDPH, including surgical clinics, to report aggregate data to 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 solely under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data.

ANALYSIS

This bill includes the Board's data reporting language and the language that came out of the OSS Task force regarding initial two-year inspections and subsequent unannounced inspections. The Board has already voted to support or sponsor these provisions. The Board also has language on peer review reporting for outpatient settings that Board staff will work with the author's office on the possibility of incorporating this language into this bill.

In addition, this bill would allow outpatient settings owned by physicians or dentists to be licensed by CDPH as a surgical clinic. As stated in the outpatient settings background information above, this is how the laws existed before the Capen V. Shewry decision in 2007. This bill would not require outpatient settings to be licensed by CDPH, but would simply give these facilities the option to be licensed by CDPH as a surgical clinic or be accredited by an AA approved by the Board.

Board staff is suggesting that the Board support this bill, it would further consumer protection and the Board has already voted to support the data reporting to OSHPD, and the language that resulted from the OSS Task Force. The other provision in the bill would go back to the outpatient setting structure as it was prior to 2007, and simply allow outpatient settings the option to become accredited or licensed.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 966

Introduced by Senator Lieu

February 10, 2014

~~An act to amend Section 14124.24 of the Welfare and Institutions Code, relating to Medi-Cal.~~ *An act to add Section 2216.5 to the Business and Professions Code, and to amend Sections 1204, 1248.15, 1248.3, and 1248.35 of the Health and Safety Code, relating to outpatient settings.*

LEGISLATIVE COUNSEL'S DIGEST

SB 966, as amended, Lieu. ~~Drug Medi-Cal.~~ *Outpatient settings: surgical clinics.*

Existing law provides for the licensure and regulation of clinics by the State Department of Public Health. A violation of those provisions is a misdemeanor. Existing law provides that certain types of specialty clinics, including surgical clinics, as defined, are eligible for licensure.

This bill would clarify that surgical clinics are eligible for licensure by the department regardless of physician or dentist ownership.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law provides that it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with specified provisions. Existing law prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting in the state unless the setting is one of the specified settings, which includes, among others, a surgical clinic licensed by the State Department of Public Health or an outpatient setting accredited by an accreditation agency

approved by the Division of Licensing of the Medical Board of California.

Existing law provides that an outpatient setting that is accredited shall be inspected by the accreditation agency and may be inspected by the Medical Board of California. Existing law requires that the inspections be conducted no less often than once every 3 years by the accreditation agency and as often as necessary by the Medical Board of California to ensure quality of care provided. Existing law requires that certificates for accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than 3 years.

This bill would require that all subsequent inspections after the initial inspection for accreditation be unannounced. This bill would require an outpatient setting accredited by the division to pay certain fees and to comply with certain data submission requirements. The bill would also instead require that initial certificates of accreditation by an accreditation agency be valid for not more than 2 years and that renewal certificates be valid for not more than 3 years.

~~Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law establishes the Drug Medi-Cal Treatment Program (Drug Medi-Cal) under which the department is authorized to enter into contracts with counties for the provision of various drug treatment services to Medi-Cal recipients, or is required to directly arrange for the provision of these services if a county elects not to do so. Existing law defines Drug Medi-Cal reimbursable services for purposes of these provisions.~~

~~This bill would make technical, nonsubstantive changes to that definition.~~

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

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

1 *SECTION 1. Section 2216.5 is added to the Business and*
2 *Professions Code, to read:*
3 *2216.5. An outpatient setting accredited pursuant to Section*
4 *1248.1 of the Health and Safety Code is subject to the requirements*

of Section 1216, subdivision (f) of Section 127280, and Section 128737 of the Health and Safety Code.

SEC. 2. Section 1204 of the Health and Safety Code is amended to read:

1204. Clinics eligible for licensure pursuant to this chapter are primary care clinics and specialty clinics.

(a) (1) Only the following defined classes of primary care clinics shall be eligible for licensure:

(A) A "community clinic" means a clinic operated by a tax-exempt nonprofit corporation that is supported and maintained in whole or in part by donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a community clinic, any charges to the patient shall be based on the patient's ability to pay, utilizing a sliding fee scale. No corporation other than a nonprofit corporation, exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a community clinic; provided, that the licensee of any community clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a community clinic.

(B) A "free clinic" means a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions, that may be in the form of money, goods, or services. In a free clinic there shall be no charges directly to the patient for services rendered or for drugs, medicines, appliances, or apparatuses furnished. No corporation other than a nonprofit corporation exempt from federal income taxation under paragraph (3) of subsection (c) of Section 501 of the Internal Revenue Code of 1954 as amended, or a statutory successor thereof, shall operate a free clinic; provided, that the licensee of any free clinic so licensed on the effective date of this section shall not be required to obtain tax-exempt status under either federal or state law in order to be eligible for, or as a condition of, renewal of its license. No natural person or persons shall operate a free clinic.

(2) Nothing in this subdivision shall prohibit a community clinic or a free clinic from providing services to patients whose

services are reimbursed by third-party payers, or from entering into managed care contracts for services provided to private or public health plan subscribers, as long as the clinic meets the requirements identified in subparagraphs (A) and (B). For purposes of this subdivision, any payments made to a community clinic by a third-party payer, including, but not limited to, a health care service plan, shall not constitute a charge to the patient. This paragraph is a clarification of existing law.

(b) The following types of specialty clinics shall be eligible for licensure as specialty clinics pursuant to this chapter:

(1) *(A)* A "surgical clinic" means a clinic that is not part of a hospital and that provides ambulatory surgical care for patients who remain less than 24 hours. A surgical clinic does not include any place or establishment owned or leased and operated as a clinic or office by one or more physicians or dentists in individual or group practice, regardless of the name used publicly to identify the place or ~~establishment, provided, however, that physicians or dentists may, at their option, apply for licensure.~~ *establishment.*

(B) Physicians or dentists may, at their option, apply for licensure. Surgical clinics shall be eligible for licensure by the department regardless of physician or dentist ownership.

(2) A "chronic dialysis clinic" means a clinic that provides less than 24-hour care for the treatment of patients with end-stage renal disease, including renal dialysis services.

(3) A "rehabilitation clinic" means a clinic that, in addition to providing medical services directly, also provides physical rehabilitation services for patients who remain less than 24 hours. Rehabilitation clinics shall provide at least two of the following rehabilitation services: physical therapy, occupational therapy, social, speech pathology, and audiology services. A rehabilitation clinic does not include the offices of a private physician in individual or group practice.

(4) An "alternative birth center" means a clinic that is not part of a hospital and that provides comprehensive perinatal services and delivery care to pregnant women who remain less than 24 hours at the facility.

SEC. 3. 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~~ *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. 4. Section 1248.3 of the Health and Safety Code is amended to read:

1248.3. (a) ~~Certificates~~ *Initial certificates* of accreditation issued to outpatient settings by an accreditation agency shall be valid for not more than *two years and renewal certificates shall be valid for not more than* three years.

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

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

disclosures of information to an outpatient setting pertaining to the accreditation of that outpatient setting.

SEC. 5. Section 1248.35 of the Health and Safety Code is amended to read:

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

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

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

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided. *After the initial inspection for accreditation, all subsequent inspections shall be unannounced.*

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

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

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

(2) Issue a reprimand.

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

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

(d) (1) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient setting. During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board and to the California State Board of Pharmacy if an outpatient setting is licensed pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code. The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

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

(e) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. If an outpatient setting has been issued a license by the California State Board of Pharmacy pursuant to Article 14

(commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code, the accreditation agency shall also send this report to the California State Board of Pharmacy within 24 hours.

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

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

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

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

(1) Notify the board of the action.

(2) Send a notification letter to the outpatient setting of the action. The notification letter shall state that the setting is no longer allowed to perform procedures that require outpatient setting accreditation.

(3) Require the outpatient setting to remove its accreditation certification and to post the notification letter in a conspicuous location, accessible to public view.

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

~~SECTION 1. Section 14124.24 of the Welfare and Institutions Code is amended to read:~~

~~14124.24. (a) For purposes of this section, "Drug Medi-Cal reimbursable services" means the substance use disorder services described in the California State Medicaid Plan and includes, but is not limited to, all of the following services, administered by the department, and to the extent consistent with state and federal law:~~

~~(1) Narcotic treatment program services, as set forth in Section 14021.51.~~

~~(2) Day care rehabilitative services.~~

~~(3) Perinatal residential services for pregnant women and women in the postpartum period.~~

~~(4) Naltrexone services.~~

~~(5) Outpatient drug-free services.~~

~~(6) Other services upon approval of a federal Medicaid state plan amendment or waiver authorizing federal financial participation.~~

~~(b) (1) While seeking federal approval for any federal Medicaid state plan amendment or waiver associated with Drug Medi-Cal services, the department shall consult with the counties and stakeholders in the development of the state plan amendment or waiver.~~

~~(2) Upon federal approval of a federal Medicaid state plan amendment authorizing federal financial participation in the following services, and subject to appropriation of funds, "Drug Medi-Cal reimbursable services" shall also include the following services, administered by the department, and to the extent consistent with state and federal law:~~

~~(A) Notwithstanding subdivision (a) of Section 14132.90, day care habilitative services, which, for purposes of this paragraph, are outpatient counseling and rehabilitation services provided to persons with alcohol or other drug abuse diagnoses.~~

~~(B) Case management services, including supportive services to assist persons with alcohol or other drug abuse diagnoses in gaining access to medical, social, educational, and other needed services.~~

~~(C) Aftercare services.~~

~~(c) (1) The nonfederal share for Drug Medi-Cal services shall be funded through a county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011, and any other available county funds eligible under federal law for federal Medicaid reimbursement. The funds contained in each county's Behavioral Health Subaccount of the Support Services Account of the Local Revenue Fund 2011 shall be considered state funds distributed by the principal state agency for the purposes of receipt of the federal block grant funds for prevention and treatment of substance abuse found at Subchapter XVII of Chapter 6A of Title 42 of the United States Code. Pursuant to applicable federal Medicaid law and regulations including Section 433.51 of Title 42 of the Code of Federal Regulations, counties may claim allowable Medicaid federal financial participation for Drug Medi-Cal services based on the counties certifying their actual total funds expenditures for eligible Drug Medi-Cal services to the department.~~

~~(2) (A) If the director determines that a county's provision of Drug Medi-Cal treatment services are disallowed by the federal government or by state or federal audit or review, the impacted county shall be responsible for repayment of all disallowed federal funds. In addition to any other recovery methods available, including, but not limited to, offset of Medicaid federal financial participation funds owed to the impacted county, the director may offset these amounts in accordance with Section 12419.5 of the Government Code.~~

~~(B) A county subject to an action by the director pursuant to subparagraph (A) may challenge that action by requesting a hearing in writing no later than 30 days from receipt of notice of the department's action. The proceeding shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director has all the powers granted therein. Upon a county's timely request for hearing, the county's obligation to make payment as determined by the director shall be stayed pending the county's~~

~~exhaustion of administrative remedies provided herein but no longer than will ensure the department's compliance with Section 1903(d)(2)(C) of the federal Social Security Act (42 U.S.C. Sec. 1396b).~~

~~(d) Drug Medi-Cal services are only reimbursable to Drug Medi-Cal providers with an approved Drug Medi-Cal contract.~~

~~(e) Counties shall negotiate contracts only with providers certified to provide Drug Medi-Cal services.~~

~~(f) The department shall develop methods to ensure timely payment of Drug Medi-Cal claims.~~

~~(g) (1) A county or a contracted provider, except for a provider to whom subdivision (h) applies, shall submit accurate and complete cost reports for the previous fiscal year by November 1, following the end of the fiscal year. The department may settle Drug Medi-Cal reimbursable services, based on the cost report as the final amendment to the approved county Drug Medi-Cal contract.~~

~~(2) Amounts paid for services provided to Drug Medi-Cal beneficiaries shall be audited by the department in the manner and form described in Section 14170.~~

~~(3) Administrative appeals to review grievances or complaints arising from the findings of an audit or examination made pursuant to this section shall be subject to Section 14171.~~

~~(h) Certified narcotic treatment program providers that are exclusively billing the state or the county for services rendered to persons subject to Section 1210.1 or 3063.1 of the Penal Code or Section 14021.52 of this code shall submit accurate and complete performance reports for the previous state fiscal year by November 1 following the end of that fiscal year. A provider to which this subdivision applies shall estimate its budgets using the uniform state daily reimbursement rate. The format and content of the performance reports shall be mutually agreed to by the department, the County Alcohol and Drug Program Administrators' Association of California, and representatives of the treatment providers.~~

~~(i) Contracts entered into pursuant to this section shall be exempt from the requirements of Chapter 1 (commencing with Section 10100) and Chapter 2 (commencing with Section 10290) of Part 2 of Division 2 of the Public Contract Code.~~

~~(j) Annually, the department shall publish procedures for contracting for Drug Medi-Cal services with certified providers~~

1 ~~and for claiming payments, including procedures and specifications~~
2 ~~for electronic data submission for services rendered.~~

O

SB 1083 - PAVLEY

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1083
Author: Pavley
Bill Date: February 19, 2014, Introduced
Subject: Physician Assistants: Disability Certifications
Sponsor: California Academy of Physician Assistants (CAPA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize physician assistants (PAs) to certify claims for disability insurance (DI) with the Employment Development Department (EDD). The PA would first have to perform a physical exam under the supervision of a physician, pursuant to existing law.

ANALYSIS

Existing law does not authorize PAs to certify claims for DI with EDD. Current law authorizes the following practitioners to certify claims for DI: licensed medical or osteopathic physicians; authorized medical officers of a U.S. Government facility; chiropractors; podiatrists; optometrists; dentists; psychologists; nurse practitioners (after examination and collaboration with a physician); licensed midwives; certified nurse midwives; nurse practitioners (for normal pregnancy or child-birth); or accredited religious practitioners.

Existing law allows PAs to perform a variety of medical services under physician supervision, including the following: order medication; conduct physical exams; diagnose and treat illnesses; order and interpret tests; instruct and counsel patient on matters pertaining to their physical and mental health; assist in surgery; and conduct medical exams and sign corresponding certificates or forms for the purposed of issuing disabled person placards.

This bill would allow PAs to certify claims for DI with EDD, if a physical exam is performed by the PA under the supervision of a physician. PAs are already allowed to certify temporary disability and issue disabled person placards. It seems reasonable to also allow PAs to certify claims for DI with EDD and in alignment with the PA scope of practice. The PA is still under a delegated services agreement with a physician, as such, this bill will not compromise consumer protection. Board staff is suggesting that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: CAPA (sponsor) and Kaiser Permanente

OPPOSITION: None on file

POSITION: Recommendation: Neutral

SENATE BILL No. 1083

Introduced by Senator Pavley

February 19, 2014

An act to amend Section 3502.3 of the Business and Professions Code, and to amend Section 2708 of the Unemployment Insurance Code, relating to physician assistants.

LEGISLATIVE COUNSEL'S DIGEST

SB 1083, as introduced, Pavley. Physician assistants: disability certifications.

The Physician Assistant Practice Act authorizes a delegation of services agreement to authorize a physician assistant to engage in specified activities.

Existing law requires a claimant for unemployment compensation disability benefits to establish medical eligibility for each uninterrupted period of disability by filing a first claim for disability benefits supported by the certificate of a treating physician or practitioner that establishes the sickness, injury, or pregnancy of the employee, or the condition of the family member that warrants the care of the employee. Existing law defines the term "practitioner" to mean a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, or a nurse practitioner, as prescribed.

This bill would amend the Physician Assistant Practice Act to authorize a physician assistant to certify disability, after performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with the act. The bill would correspondingly expand the definition of practitioner to include a physician assistant.

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

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

1 SECTION 1. Section 3502.3 of the Business and Professions
2 Code is amended to read:
3 3502.3. (a) Notwithstanding any other provision of law, in
4 addition to any other practices that meet the general criteria set
5 forth in this chapter or the Medical Board of California's
6 regulations for inclusion in a delegation of services agreement, a
7 delegation of services agreement may authorize a physician
8 assistant to do any of the following:
9 (1) Order durable medical equipment, subject to any limitations
10 set forth in Section 3502 or the delegation of services agreement.
11 Notwithstanding that authority, nothing in this paragraph shall
12 operate to limit the ability of a third-party payer to require prior
13 approval.
14 (2) For individuals receiving home health services or personal
15 care services, after consultation with the supervising physician,
16 approve, sign, modify, or add to a plan of treatment or plan of care.
17 *(3) After performance of a physical examination by the physician*
18 *assistant under the supervision of a physician and surgeon*
19 *consistent with this chapter, certify disability pursuant to Section*
20 *2708 of the Unemployment Insurance Code.*
21 (b) Nothing in this section shall be construed to affect the
22 validity of any delegation of services agreement in effect prior to
23 the enactment of this section or those adopted subsequent to
24 enactment.
25 SEC. 2. Section 2708 of the Unemployment Insurance Code,
26 as added by Section 2 of Chapter 350 of the Statutes of 2013, is
27 amended to read:
28 2708. (a) (1) In accordance with the director's authorized
29 regulations, and except as provided in subdivision (c) and Sections
30 2708.1 and 2709, a claimant shall establish medical eligibility for
31 each uninterrupted period of disability by filing a first claim for
32 disability benefits supported by the certificate of a treating
33 physician or practitioner that establishes the sickness, injury, or
34 pregnancy of the employee, or the condition of the family member
35 that warrants the care of the employee. For subsequent periods of

uninterrupted disability after the period covered by the initial certificate or any preceding continued claim, a claimant shall file a continued claim for those benefits supported by the certificate of a treating physician or practitioner. A certificate filed to establish medical eligibility for the employee's own sickness, injury, or pregnancy shall contain a diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, if no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) A certificate filed to establish medical eligibility of the employee's own sickness, injury, or pregnancy shall also contain a statement of medical facts, including secondary diagnoses when applicable, within the physician's or practitioner's knowledge, based on a physical examination and a documented medical history of the claimant by the physician or practitioner, indicating the physician's or practitioner's conclusion as to the claimant's disability, and a statement of the physician's or practitioner's opinion as to the expected duration of the disability.

(b) An employee shall be required to file a certificate to establish eligibility when taking leave to care for a family member with a serious health condition. The certificate shall be developed by the department. In order to establish medical eligibility of the serious health condition of the family member that warrants the care of the employee, the information shall be within the physician's or practitioner's knowledge and shall be based on a physical examination and documented medical history of the family member and shall contain all of the following:

(1) A diagnosis and diagnostic code prescribed in the International Classification of Diseases, or, if no diagnosis has yet been obtained, a detailed statement of symptoms.

(2) The date, if known, on which the condition commenced.

(3) The probable duration of the condition.

(4) An estimate of the amount of time that the physician or practitioner believes the employee needs to care for the child, parent, grandparent, grandchild, sibling, spouse, or domestic partner.

(5) (A) A statement that the serious health condition warrants the participation of the employee to provide care for his or her child, parent, grandparent, grandchild, sibling, spouse, or domestic partner.

(B) "Warrants the participation of the employee" includes, but is not limited to, providing psychological comfort, and arranging "third party" care for the child, parent, grandparent, grandchild, sibling, spouse, or domestic partner, as well as directly providing, or participating in, the medical care.

(c) The department shall develop a certification form for bonding that is separate and distinct from the certificate required in subdivision (a) for an employee taking leave to bond with a minor child within the first year of the child's birth or placement in connection with foster care or adoption.

(d) The first and any continuing claim of an individual who obtains care and treatment outside this state shall be supported by a certificate of a treating physician or practitioner duly licensed or certified by the state or foreign country in which the claimant is receiving the care and treatment. If a physician or practitioner licensed by and practicing in a foreign country is under investigation by the department for filing false claims and the department does not have legal remedies to conduct a criminal investigation or prosecution in that country, the department may suspend the processing of all further certifications until the physician or practitioner fully cooperates, and continues to cooperate, with the investigation. A physician or practitioner licensed by, and practicing in, a foreign country who has been convicted of filing false claims with the department may not file a certificate in support of a claim for disability benefits for a period of five years.

(e) For purposes of this part:

(1) "Physician" has the same meaning as defined in Section 3209.3 of the Labor Code.

(2) "Practitioner" means a person duly licensed or certified in California acting within the scope of his or her license or certification who is a dentist, podiatrist, *physician assistant who has performed a physical examination under the supervision of a physician and surgeon,* or a nurse practitioner, and in the case of a nurse practitioner, after performance of a physical examination by a nurse practitioner and collaboration with a physician and surgeon, or as to normal pregnancy or childbirth, a midwife or nurse midwife, or nurse practitioner.

(f) For a claimant who is hospitalized in or under the authority of a county hospital in this state, a certificate of initial and

continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by the hospital's registrar. For a claimant hospitalized in or under the care of a medical facility of the United States government, a certificate of initial and continuing medical disability, if any, shall satisfy the requirements of this section if the disability is shown by the claimant's hospital chart, and the certificate is signed by a medical officer of the facility duly authorized to do so.

(g) Nothing in this section shall be construed to preclude the department from requesting additional medical evidence to supplement the first or any continued claim if the additional evidence can be procured without additional cost to the claimant. The department may require that the additional evidence include any or all of the following:

(1) Identification of diagnoses.

(2) Identification of symptoms.

(3) A statement setting forth the facts of the claimant's disability. The statement shall be completed by any of the following individuals:

(A) The physician or practitioner treating the claimant.

(B) The registrar, authorized medical officer, or other duly authorized official of the hospital or health facility treating the claimant.

(C) An examining physician or other representative of the department.

(h) This section shall become operative on July 1, 2014.

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SB 1116 - TORRES

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1116
Author: Torres
Bill Date: February 19, 2014, Introduced
Subject: Steven M. Thompson Loan Repayment Program
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill allows physicians to donate an additional $75 to the Medical Board of California (Board), for the purposes of funding the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP).

ANALYSIS:

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

Currently, a physician could donate more than the mandatory $25 to the STLRP, however, this information is not included on the initial licensing or renewal application. This bill would allow physicians to donate an additional $75 to the Board to help fund the STLRP, but this does not mean a physician could not donate more than $75, a physician could still donate any amount they would like to the STLRP. If this bill becomes law, the Board would include specific information on the ability of a physician to donate to the STLRP in any amount and would also include a check box for an additional $75 donation on the initial and renewal application so physicians are aware of their ability to donate additional funding to the STLRP. This bill will allow for additional funding for the STLRP, which will help allow for more loans for the STLRP and more physicians to serve in underserved areas. This bill would further the Board's mission of promoting access to care and staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: California Primary Care Association

OPPOSITION: California Medical Association (Unless Amended)

POSITION: Recommendation: Support

SENATE BILL No. 1116

Introduced by Senator Torres

February 19, 2014

An act to amend Sections 2436.5 and 2455.1 of the Business and Professions Code, relating to physicians and surgeons, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1116, as introduced, Torres. Physicians and surgeons.

Under existing law, the Medical Board of California licenses and regulates physicians and surgeons and imposes various fees on those licensees. Under existing law, the Osteopathic Medical Board of California licenses and regulates osteopathic physicians and surgeons and imposes various fees on those licensees. Existing law establishes the Medically Underserved Account for Physicians within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development. Under existing law, the primary purpose of the account is to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides for the repayment of educational loans, as specified, obtained by a physician and surgeon who practices in a medically underserved area of the state, as defined. Under existing law, funds placed in the account for those purposes are continuously appropriated for the repayment of loans and may be used for any other authorized purpose. Physicians and surgeons and osteopathic physicians and surgeons are eligible for the loan repayment program and the board assesses an additional $25 license fee for purposes of the loan repayment program.

This bill would authorize a physician and surgeon and an osteopathic physician and surgeon to pay an additional $75 to the board for those

purposes. By increasing the amount of revenue in a continuously appropriated fund, the bill would make an appropriation.

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

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

1 SECTION 1. Section 2436.5 of the Business and Professions
2 Code is amended to read:
3 2436.5. (a) *(1)* In addition to the fees charged for the initial
4 issuance or biennial renewal of a physician and surgeon's certificate
5 pursuant to Section 2435, and at the time those fees are charged,
6 the board shall charge each applicant or renewing licensee an
7 additional twenty-five-dollar ($25) fee for the purposes of this
8 section.
9 ~~The~~
10 *(2) The* twenty-five-dollar ($25) fee shall be paid at the time of
11 application for initial licensure or biennial renewal and shall be
12 due and payable along with the fee for the initial certificate or
13 biennial renewal.
14 *(3) A physician and surgeon may pay an additional seventy-five*
15 *dollars ($75) to the board for the purposes of this section.*
16 (b) The board shall transfer all funds collected pursuant to this
17 section, on a monthly basis, to the Medically Underserved Account
18 for Physicians created by Section 128555 of the Health and Safety
19 Code for the Steven M. Thompson Physician Corps Loan
20 Repayment Program. Notwithstanding Section 128555 of the
21 Health and Safety Code, these funds shall not be used to provide
22 funding for the Physician Volunteer Program.
23 (c) Up to 15 percent of the funds collected pursuant to this
24 section shall be dedicated to loan assistance for physicians and
25 surgeons who agree to practice in geriatric care settings or settings
26 that primarily serve adults over the age of 65 years or adults with
27 disabilities. Priority consideration shall be given to those physicians
28 and surgeons who are trained in, and practice, geriatrics and who
29 can meet the cultural and linguistic needs and demands of diverse
30 populations of older Californians.
31 SEC. 2. Section 2455.1 of the Business and Professions Code
32 is amended to read:

2455.1. (a) In addition to the fees charged pursuant to Section 2455, and at the time those fees are charged, the board shall charge each applicant for an original or reciprocity certificate or for a biennial license an additional twenty-five-dollar ($25) fee for the purposes of this section. This twenty-five-dollar ($25) fee shall be due and payable along with the fee for the original or reciprocity certificate or the biennial license.

(b) An osteopathic physician and surgeon may pay an additional seventy-five dollars ($75) to the board for the purposes of this section.

~~(b)~~

(c) The board shall transfer all funds collected pursuant to this section, on a monthly basis, to the Medically Underserved Account for Physicians created by Section 128555 of the Health and Safety Code for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Notwithstanding Section 128555 of the Health and Safety Code, these funds shall not be used to provide funding for the Physician Volunteer Program.

O

SB 1258 - DESAULNIER

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1258
Author: DeSaulnier
Bill Date: March 25, 2014, Amended
Subject: Controlled Substances: Prescriptions: Reporting
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would do the following: require controlled substance prescriptions to be made electronically; add Schedule V controlled substances to the Controlled Substance Utilization Review and Evaluation System (CURES) database; establish dispensing limits; and allow an individual designed by a board, bureau, or program within the Department of Consumer Affairs (DCA) to access CURES data for investigation purposes.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (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 website.

Last year, the 2013/14 Budget Bill and SB 809 (DeSaulnier and Steinberg, Chapter 400) were both signed into law. The Budget Bill required all health boards in DCA to provide funding to upgrade the CURES system. The Medical Board of California (Board) provided $1.638 million. The Budget Bill required, before the funds are appropriated for CURES, for the Feasibility Study Report (FSR) 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. The FSR and Interagency Agreement are currently being drafted and the Board participates in regular meetings with DCA, other boards, and DOJ.

SB 809 established the CURES Fund, which is funded by an annual $6 flat fee for licensees of the boards in DCA that are authorized to prescribe or dispense Schedule II, III, or IV controlled substances, including the Board. 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 specified that the fee

increase shall be due at time of renewal and shall not exceed the reasonable costs associated with maintaining CURES. This bill required 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 also required 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 allowed 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 required DOJ to consult with prescribers, regulatory boards, and other stakeholders to identify desirable capabilities and upgrades to the CURES system. This bill required 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 are required to 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 required 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.

It is important to note that both bills affecting CURES were just signed into law last year, so the upgraded CURES system is still in the process of being developed, and almost all of the requirements in SB 809 are dependent on the upgraded system being developed and operational.

ANALYSIS:

SB 1258 would require all prescriptions for Schedule II, III, IV, and V controlled substances to be submitted electronically and to comply with the Drug Enforcement Agency (DEA) regulations. The electronic prescription must meet the following requirements:

- Contain the prescriber's address and telephone number; the name 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; refill information, such as the number of refills ordered and whether the prescription is a first-time request or refill; and the name, quantity, strength, and directions for use of the controlled substance.
- Contain the address for the person being prescribed the controlled substance. If the prescriber does not specify the address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist must include the address on the prescription or maintain the information in a readily retrievable form in the pharmacy.

This bill would provide an exception to the electronic prescribing requirement if technological failure prevents the electronic transmission of the prescription or if the prescription will be filled by a pharmacist located outside California, but the oral (only for Schedule III, IV, or V) or written prescription must contain all the required

information above and if the prescription is written, it must be signed and dated by the prescriber in ink. This bill would allow an agent of the prescriber, if authorized by the prescriber, to orally transmit a prescription for a controlled substance, if the written record specifies the name of the agent transmitting the prescription.

This bill adds Schedule V controlled substances to those that have to be reported to CURES. According to the DEA's website, Schedule V drugs, substances, or chemicals are defined as drugs with lower potential for abuse than Schedule IV and consist of preparations containing limited quantities of certain narcotics. Schedule V drugs are generally used for antidiarrheal, antitussive, and analgesic purposes. Some examples of Schedule V drugs are: cough preparations with less than 200 milligrams of codeine or per 100 milliliters (Robitussin AC), Lomotil, Motofen, Lyrica, and Parepectolin.

This bill would allow an individual designated by a board, bureau, or program within DCA to access CURES data for investigation purposes if an application is submitted to DOJ to obtain approval to access this information. According to the author's office, this provision would allow designated DCA investigators to access CURES information.

Lastly, this bill would establish controlled substances dispensing limits. This bill would not allow a person to prescribe, fill, compound, or dispense a prescription for a controlled substance in a quantity exceeding a 30-day supply. This bill would provide an exception to this limit and allow for a 90-day supply if the prescription is issued in the treatment of one of the following:

- A panic disorder.
- Attention deficit disorder.
- A chronic debilitating neurologic condition characterized as a movement disorder or exhibiting seizure, convulsive, or spasm activity.
- Pain in patients with conditions or diseases known to be chronic or incurable.
- Narcolepsy.

This bill would not allow a prescription for a controlled substance to be prescribed, filled, compounded or dispensed if another prescription for a controlled substance was issued within the immediate preceding 30 days, until the patient has exhausted all but a seven-day supply of the controlled substance from the previous prescription. This bill would also not allow a prescription for a Schedule II drug to be refilled.

Electronic prescribing is a goal that California should be moving towards in the future. However, this bill may be premature as the upgraded CURES system is not yet up and running. In addition, adding reporting of Schedule V drugs to CURES may be overly inclusive and burdensome to both physicians and the CURES system at this point in time. Although this bill attempts to limit the quantity of controlled substances being dispensed, it does provide many exceptions to the 30-day limit, and may result in an unintended consequence of creating difficulties for both physicians and patients. Board staff suggests that the Board support the concept of electronic prescribing and dispensing limits on controlled substances, but work with the author's office and

interested parties to make the requirements in this bill manageable and workable with the implementation of the requirements that were contained in SB 809 and the upgraded CURES system.

FISCAL: Unknown, but no direct costs to the Board

SUPPORT: California Statewide Law Enforcement Association; National Coalition Against Prescription Drug Abuse; and Troy and Alana Pack Foundation

OPPOSITION: California Hospital Association and California Medical Association

POSITION: Recommendation: Support in Concept

AMENDED IN SENATE MARCH 25, 2014

SENATE BILL No. 1258

Introduced by Senator DeSaulnier

February 21, 2014

An act to amend ~~Section 11165~~ *Sections 4071 and 4072 of the Business and Professions Code, and to amend Sections 11151, 11158, 11164, 11164.1, 11164.5, 11165, 11165.1, 11165.5, 11166, and 11200* of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 1258, as amended, DeSaulnier. Controlled substances: *prescriptions:* 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 specified information regarding prescriptions for Schedule II, Schedule III, and Schedule IV controlled substances, including the ultimate user of the prescribed controlled substance and the National Drug Control number of the controlled substance dispensed, to be reported to the Department of Justice.

This bill would additionally require the prescribing and dispensing of Schedule V controlled substances to be monitored in CURES and would require specified information regarding prescriptions for Schedule V controlled substances to be reported to the Department of Justice.

(2) Existing law requires licensed health care practitioners, as specified, and pharmacists to apply to the Department of Justice to obtain approval to access information contained in the CURES Prescription Drug Monitoring System (PDMP) regarding the controlled substance history of a patient under his or her care. Existing law requires the Department of Justice, upon approval of that application, to provide to that health care practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care.

This bill would also authorize an individual designated to investigate an applicant for, or a holder of, a professional license to apply to the Department of Justice to obtain approval to access information contained in the CURES PDMP regarding the controlled substance history of an applicant or a licensee for the purpose of investigating the alleged substance abuse of an applicant or a licensee. The bill would, upon approval of that application, require the department to provide to that individual the history of controlled substances dispensed to the applicant or licensee.

(3) Existing law generally requires, subject to specified exceptions, that a prescription for Schedule II, Schedule III, Schedule IV, or Schedule V controlled substances be made on a certain controlled substance prescription form and meet several requirements, including that the prescription be signed and dated by the prescriber in ink. Existing law authorizes, as an exception to that requirement, a Schedule III, Schedule IV, or Schedule V controlled substance to be dispensed upon an oral or electronically transmitted prescription, which must be produced in hard copy form and signed and dated by the pharmacist filling the prescription or another authorized person.

This bill would instead require, subject to specified exceptions, that a prescription for a controlled substance be made by an electronically transmitted prescription that complies with regulations promulgated by the Drug Enforcement Agency, which, except as specified, must be produced in hard copy form and signed and dated by the pharmacist filling the prescription or another authorized person.

(4) Existing law prohibits a prescription for a Schedule II controlled substance from being refilled and prohibits a prescription for a Schedule III or IV controlled substance from being refilled more than 5 times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

This bill would prohibit, subject to specified exceptions, a person from prescribing a controlled substance, or filling, compounding, or

dispensing a prescription for a controlled substance, in a quantity exceeding a 30 day supply. The bill would also prohibit a person from issuing a prescription for a controlled substance, or from filling, compounding, or dispensing a prescription for a controlled substance, for an ultimate user for whom a previous prescription for a controlled substance was issued within the immediately preceding 30 days until the ultimate user has exhausted all but a 7-day supply of the controlled substance filled, compounded, or dispensed from the previous prescription.

~~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 authorizes the Department of Justice to seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES and requires that the operation of CURES comply with all applicable federal and state privacy and security laws and regulations.~~

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

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

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

1 *SECTION 1. Section 4071 of the Business and Professions*
2 *Code is amended to read:*
3 4071. Notwithstanding any other provision of law, a prescriber
4 may authorize his or her agent on his or her behalf to orally or
5 electronically transmit a prescription to the furnisher. The furnisher
6 shall make a reasonable effort to determine ~~that~~ *whether* the person
7 who transmits the prescription is authorized to do so and shall
8 record the name of the authorized agent of the prescriber who
9 transmits the order.
10 ~~This section shall not apply to orders for Schedule II controlled~~
11 ~~substances.~~
12 *SEC. 2. Section 4072 of the Business and Professions Code is*
13 *amended to read:*

4072. (a) Notwithstanding any other ~~provision of~~ law, a pharmacist, registered nurse, licensed vocational nurse, licensed psychiatric technician, or other healing arts licentiate, if so authorized by administrative regulation, who is employed by or serves as a consultant for a licensed skilled nursing, intermediate care, or other health care facility, may orally or electronically transmit to the furnisher a prescription lawfully ordered by a person authorized to prescribe drugs or devices pursuant to Sections 4040 and 4070. The furnisher shall take appropriate steps to determine ~~that~~ *whether* the person who transmits the prescription is authorized to do so and shall record the name of the person who transmits the order. This section ~~shall~~ *does* not apply to *oral* orders for Schedule II controlled substances.

(b) In enacting this section, the Legislature recognizes and affirms the role of the State Department of Public Health in regulating drug order processing requirements for licensed health care facilities as set forth in Title 22 of the California Code of Regulations as they may be amended from time to time.

SEC. 3. Section 11151 of the Health and Safety Code is amended to read:

11151. A prescription ~~written~~ *issued* by an unlicensed person lawfully practicing medicine pursuant to Section 2065 of the Business and Professions Code, shall be filled only at a pharmacy maintained in the hospital which employs such unlicensed person.

SEC. 4. Section 11158 of the Health and Safety Code is amended to read:

11158. (a) Except as provided in Section ~~11159~~ *11159, 11159.1, 11159.2, 11167, or 11167.5,* or in subdivision (b) of this section, ~~no~~ *a* controlled substance classified in Schedule II shall *not* be dispensed without a prescription meeting the requirements of this chapter. Except as provided in Section ~~11159~~ *11159, 11159.1, 11159.2, 11167, or 11167.5,* or when dispensed directly to an ultimate user by a practitioner, other than a pharmacist or pharmacy, ~~no~~ *a* controlled substance classified in Schedule III, IV, or V ~~may~~ *shall not* be dispensed without a prescription meeting the requirements of this chapter.

(b) A practitioner specified in Section 11150 may dispense directly to an ultimate user a controlled substance classified in Schedule II in an amount not to exceed a 72-hour supply for the patient in accordance with directions for use given by the

dispensing practitioner only ~~where~~ *if* the patient is not expected to require any additional amount of the controlled substance beyond the 72 hours. ~~Practitioners dispensing drugs pursuant to this subdivision shall meet the requirements of subdivision (f) of Section 11164.~~

(c) Except as otherwise prohibited or limited by law, a practitioner specified in Section 11150, may administer controlled substances in the regular practice of his or her profession.

SEC. 5. Section 11164 of the Health and Safety Code is amended to read:

11164. Except as provided in Section *11158, 11159, 11159.1, 11159.2,* 11167, ~~no~~ *or 11167.5, a* person shall *not* prescribe a controlled substance, nor shall any person fill, compound, or dispense a prescription for a controlled substance, unless it complies with the requirements of this section.

~~(a) Each prescription for a controlled substance classified in Schedule II, III, IV, or V, except as authorized by subdivision (b), shall be made on a controlled substance prescription form as specified in Section 11162.1 and shall meet the following requirements:~~

~~(1) The prescription shall be signed and dated by the prescriber in ink and shall contain the prescriber's address and telephone number; the name 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; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.~~

~~(2) The prescription shall also contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall write or type the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.~~

~~(b)~~

(a) (1) ~~Notwithstanding paragraph (1) of subdivision (a) of Section 11162.1, any~~ *A prescription for a* controlled substance classified in Schedule *II,* III, IV, or V ~~be dispensed upon an oral~~

~~or electronically transmitted prescription,~~ *shall be made by an electronically transmitted prescription that complies with regulations promulgated by the Drug Enforcement Agency,* which shall be produced in hard copy form and signed and dated by the pharmacist filling the prescription or by any other person expressly authorized by provisions of the Business and Professions Code. Any person who transmits, maintains, or receives any electronically transmitted prescription shall ensure the security, integrity, authority, and confidentiality of the prescription.

~~(2) The date of issue of the prescription and all the information required for a written prescription by subdivision (a) shall be included in the written record of the prescription; the pharmacist need not include the address, telephone number, license classification, or federal registry number of the prescriber or the address of the patient on the hard copy, if that information is readily retrievable in the pharmacy.~~

(2) A prescription issued pursuant to this subdivision shall meet the following requirements:

(A) The prescription shall contain the prescriber's address and telephone number; the name 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; refill information, such as the number of refills ordered and whether the prescription is a first-time request or a refill; and the name, quantity, strength, and directions for use of the controlled substance prescribed.

(B) The prescription shall contain the address of the person for whom the controlled substance is prescribed. If the prescriber does not specify this address on the prescription, the pharmacist filling the prescription or an employee acting under the direction of the pharmacist shall include the address on the prescription or maintain this information in a readily retrievable form in the pharmacy.

(3) Pursuant to an authorization of the prescriber, ~~any~~ *an* agent of the prescriber on behalf of the prescriber may ~~orally or~~ electronically transmit a prescription for a controlled substance classified in Schedule *II,* III, IV, or V, if ~~in these cases the written record of~~ the prescription ~~required by this subdivision~~ specifies the name of the agent of the prescriber transmitting the prescription.

(b) (1) A prescription for a controlled substance classified in Schedule II, III, IV, or V, may be written on a controlled substance prescription form as specified in Section 11162.1, or for a controlled substance classified in Schedule III, IV, or V, may be made orally, if technological failure prevents the electronic transmission of a prescription pursuant to subdivision (a) or if the prescription will be filled by a pharmacist located outside of California, provided that the order contains all information required by subdivision (a) and, if the prescription is written on a controlled substance prescription form, is signed and dated by the prescriber in ink.

(2) If a prescriber is permitted to make an oral prescription pursuant to this section, pursuant to an authorization of the prescriber, an agent of the prescriber on behalf of the prescriber may orally transmit a prescription for a controlled substance classified in Schedule II, III, IV, or V, if the written record of the prescription specifies the name of the agent of the prescriber transmitting the prescription.

(c) The use of commonly used abbreviations shall not invalidate an otherwise valid prescription.

(d) Notwithstanding any provision of subdivisions (a) and (b), prescriptions for a controlled substance classified in Schedule V may be for more than one person in the same family with the same medical need.

~~(e) This section shall become operative on January 1, 2005.~~

SEC. 6. 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~~ *IV, and Schedule V* 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. 7. Section 11164.5 of the Health and Safety Code is amended to read:

11164.5. (a) ~~Notwithstanding Section 11164, with the approval of the California State Board of Pharmacy and the Department of Justice, a~~ *A* pharmacy or hospital ~~may~~ *shall* receive electronic data transmission prescriptions or computer entry prescriptions or orders as specified in Section 4071.1 of the Business and Professions Code, for controlled substances in Schedule II, III, IV, or V ~~if authorized by federal law and~~ in accordance with regulations promulgated by the Drug Enforcement Administration. ~~The California State Board of Pharmacy shall maintain a list of all requests and approvals granted pursuant to this subdivision.~~

(b) Notwithstanding *paragraph (1) of subdivision (a) of* Section 11164, ~~if approved pursuant to subdivision (a),~~ a pharmacy or hospital receiving an electronic transmission prescription or a computer entry prescription or order for a controlled substance classified in Schedule II, III, IV, or V ~~shall~~ *is* not ~~be~~ required to reduce that prescription or order to writing or to hard copy form, if for three years from the last day of dispensing that prescription, the pharmacy or hospital is able, upon request of the board or the Department of Justice, to immediately produce a hard copy report that includes for each date of dispensing of a controlled substance in Schedules II, III, IV, and V pursuant to the prescription all of the information described in subparagraphs (A) to (E), inclusive, of paragraph (1) of subdivision (a) of Section 4040 of the Business and Professions Code and the name or identifier of the pharmacist who dispensed the controlled substance.

(c) ~~Notwithstanding Section 11164, if~~ *If* only recorded and stored electronically, on magnetic media, or in any other computerized form, the pharmacy's or hospital's computer system shall not permit the received information or the controlled substance dispensing information required by this section to be changed, obliterated, destroyed, or disposed of, for the record maintenance period required by law, once the information has been received by the pharmacy or the hospital and once the controlled substance has been dispensed, respectively. Once the controlled substance has been dispensed, if the previously created record is

determined to be incorrect, a correcting addition may be made only by or with the approval of a pharmacist. After a pharmacist enters the change or enters his or her approval of the change into the computer, the resulting record shall include the correcting addition and the date it was made to the record, the identity of the person or pharmacist making the correction, and the identity of the pharmacist approving the correction.

(d) Nothing in this section shall be construed to exempt any pharmacy or hospital dispensing Schedule II controlled substances pursuant to electronic transmission prescriptions from existing reporting requirements.

~~SECTION 1.~~

SEC. 8. 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~~ *IV, and Schedule V* 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~~ *IV, and Schedule V* 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 the 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 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 an individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to a 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~~ *IV, or Schedule V* controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, ~~and~~ 1308.14, *and 1308.15,* 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. 9. 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~~ *IV, or Schedule V* 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.

(iii) An individual designated by a board, bureau, or program within the Department of Consumer Affairs to investigate an applicant for, or a holder of, a professional license may, for the purpose of investigating the alleged substance abuse of an applicant or a licensee, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of an applicant or a licensee that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that individual the electronic history of controlled substances dispensed to the applicant or licensee 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~~ *IV, or Schedule V* 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~~ *IV, or Schedule V* 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~~ *an authorized subscriber* 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~~ *an authorized subscriber* pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, ~~and 1308.14~~ *1308.14, and 1308.15* of Title 21 of the Code of Federal Regulations.

SEC. 10. Section 11165.5 of the Health and Safety Code is amended 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~~ *11057, or 11058* 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.

SEC. 11. Section 11166 of the Health and Safety Code is amended to read:

11166. ~~No~~ *A* person shall *not* fill a prescription for a controlled substance after six months has elapsed from the date ~~written on~~ the prescription *was issued* by the prescriber. ~~No~~ *A* person shall *not* knowingly fill a mutilated or forged or altered prescription for a controlled substance except for the addition of the address of the person for whom the controlled substance is prescribed as provided by paragraph ~~(3)~~ *(2)* of subdivision (b) of Section 11164.

SEC. 12. Section 11200 of the Health and Safety Code is amended to read:

11200. (a) ~~No~~ *A* person shall *not* dispense or refill a controlled substance prescription more than six months after the date thereof.

(b) (1) Except as provided in paragraph (2), a person shall not prescribe a controlled substance, nor shall a person fill, compound, or dispense a prescription for a controlled substance, in a quantity exceeding a 30-day supply.

(2) A person may prescribe a controlled substance, and a person may fill, compound, or dispense a prescription for a controlled substance, in a quantity not exceeding a 90-day supply if the prescription is issued in the treatment of one of the following:

(A) A panic disorder.

(B) Attention deficit disorder.

(C) A chronic debilitating neurologic condition characterized as a movement disorder or exhibiting seizure, convulsive, or spasm activity.

(D) Pain in patients with conditions or diseases known to be chronic or incurable.

(E) Narcolepsy.

~~(b) No~~

(c) (1) A prescription for a Schedule III or IV substance ~~may~~ *shall not* be refilled more than five times and in an amount, for all refills of that prescription taken together, exceeding a 120-day supply.

~~(c) No~~

(2) A prescription for a Schedule II substance ~~may~~ *shall not* be refilled.

(d) A person shall not issue a prescription for a controlled substance, nor shall a person fill, compound, or dispense a prescription for a controlled substance, for an ultimate user for whom a previous prescription for a controlled substance was issued within the immediately preceding 30 days until the ultimate user has exhausted all but a seven-day supply of the controlled substance filled, compounded, or dispensed from the previous prescription.

O

SB 1262 - CORREA

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1262
Author: Correa
Bill Date: April 21, 2014, Amended
Subject: Medical Marijuana Regulation
Sponsor: California Police Chiefs Association (Co-Sponsor)
League of California Cities (Co-Sponsor)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would put various licensing and enforcement requirements on medical marijuana dispensaries and cultivation facilities and would also put requirements on physicians recommending medical marijuana and on the Medical Board of California (Board). However, this analysis will only cover the portion of the bill related to the requirements on physicians recommending medical marijuana and the Board.

This bill would require physicians to meet specified requirements before recommending medical marijuana and would require the recommendations to include specified information. This bill would require physicians recommending medical marijuana to adhere to financial anti-kickback and advertising requirements. This bill would state that violation of the recommendation and advertising requirements in the bill constitutes unprofessional conduct. Lastly, this bill would require the Board to convene a task force of experts in the use of medical marijuana and to update the Board's statement/guidelines on medical marijuana.

BACKGROUND:

In 1996, California voters approved the Compassionate Use Act (Proposition 215), which allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making medical marijuana recommendations. SB 420 (Vasconcellos, Chapter 875, Statutes of 2003), the Medical Marijuana Program Act, included issuance of identification cards for qualified patients, and allowed patients and their primary caregivers to collectively or cooperatively cultivate medical marijuana. According to the author's office, no feasible, broad regulatory structure has been established for medical marijuana, and the implementation of the Compassionate Use Act has resulted in conflicting authorities, regulatory chaos, intermittent federal action, and a series of lawsuits. According to the author's office, the purpose of this bill is to put a framework around medical marijuana regulation and address the many associated public safety concerns.

ANALYSIS:

SB 1262 would require physicians, prior to recommending medical marijuana, to meet the following requirements:

- Have a doctor-patient relationship.

- Conduct an appropriate prior examination of the patient to establish that medical use of marijuana is appropriate.
- Consult with the patient as necessary and periodically review the treatment's efficacy.

A physician that recommends marijuana would be required to do all of the following:

- Include a discussion of the side effects.
- Address, in the recommendation, what kind of marijuana to obtain, including high tetrahydrocannabinol (THC) levels, low THC levels, high cannabidiol (CBD) levels, low CBD levels, and explain the reason for recommending that particular strain. Under no circumstances shall a physician recommend butane hash oil.
- Maintain a system of recordkeeping that supports the decision to recommend the use of medical marijuana for individual patients.
- If recommending medical marijuana to a minor (under 21 years of age), the recommendation must be approved by a board-certified pediatrician and must be for high CBD marijuana and for non-smoking delivery.

This bill would make it unprofessional conduct if a physician recommends medical marijuana without an appropriate prior examination and a medical indication, or recommends marijuana for non-medical purposes.

This bill would also subject physicians recommending medical marijuana to the laws in Business and Professions Code Section (BPC) 650.01 and would not allow a physician to accept, solicit, or offer any form of remuneration from or to a licensed dispenser, producer, or processor of cannabis products in which the licensee or his or her immediate family has a financial interest. This bill would not allow a physician to advertise for medical marijuana physician recommendations unless the advertisement contains the following notice and meets the requirements of BPC 651:

> "NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use marijuana for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. Physicians arrive at the decision to make this recommendation in accordance with the accepted standards of medical responsibility and are licensed and regulated by the Medical Board of California. California law prohibits advertising that includes statements of bait, discount, premiums, gifts, or any statements of a similar nature."

Lastly, this bill would require the Board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana, to review and update as necessary physician guidelines for recommending medical marijuana to ensure the competent review in cases concerning the recommendation of marijuana for medical purposes.

This bill would give the Board some needed enforcement tools to more efficiently regulate physicians who recommend medical marijuana. This bill expressly spells out

what a physician must do before medical marijuana is recommended, what a physician must do if a medical marijuana recommendation is issued, places appropriate anti-kick back and advertising restrictions on physicians who recommend medical marijuana, and directly ties non-compliance with some of these requirements to unprofessional conduct. These are all tools that will make the Board's enforcement more efficient. However, Board staff does have some concerns with some of the provisions in this bill.

The bill would require a physician to address, in the recommendation, what kind of marijuana to obtain, including high THC levels, low THC levels, high CBD levels, low CBD levels, and explain the reason for recommending that particular strain. Board staff is concerned that until medical marijuana is regulated by the Food and Drug Administration (FDA), physicians may not know the appropriate type of marijuana to recommend, or be able to explain the reason for recommending a particular strain. In addition, the Board's physician experts that review enforcement cases may also not be knowledgeable in the appropriate, particular strain a physician should be recommending, as the FDA does not regulate marijuana at this time.

This bill would require the Board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana, to review and update as necessary physician guidelines for recommending medical marijuana to ensure the competent review in cases concerning the recommendation of marijuana for medical purposes. The Board could convene a task force to look at the current statement adopted by the Board related to medical marijuana, and update that statement with information that will be contained in the revised pain management guidelines and with information on the new laws that are contained in this bill; however, Board staff strongly believes that the guidelines are there to guide physicians recommending marijuana. Board staff believes the competent review portion of this provision should be removed.

Board staff is suggesting the Board oppose this bill unless the portion regarding the recommendation containing a particular strain be amended out of the bill, and the portion that states the purpose of the guidelines is to ensure competent review of cases by the Board.

FISCAL: Minor and absorbable costs related to convening the task force and updating the statement/guidelines for physicians recommending medical marijuana.

SUPPORT: California Police Chiefs Association (Co-Sponsor); League of California Cities (Co-Sponsor); Association for Los Angeles Deputy Sheriffs; Association of Orange County Deputy Sheriffs; California Association of Code Enforcement Officers; California Fraternal Order of Police; City of Adelanto; City of Beaumont; City of Canyon Lake; City of Chowchilla; City of Covina; City of Encinitas; City of Etna; City of Fortuna; City of Gardena; City of Glendora; City of Hemet; City of Highland; City of La Palma; City of Lathrop; City of Lodi; City of Merced; City of Norwalk; City of Rancho Cordova; City of Rancho Cucamonga; City of Rancho Mirage; City of Rosemead; City of Sacramento; City of

San Carlos; City of Woodland; Covina Police Department; El Monte, South El Monte Chamber of Commerce; International Faith Based Coalition; Long Beach Police Officers Association; Los Angeles County Police Professional Peace Officers Association; Los Angeles Police Protective League; Mammoth Lakes Police Department; Riverside Sheriffs Association; Sacramento County Deputy Sheriffs Association; San Diego County District Attorney; San Diego District Attorney; Santa Ana Police Officers Association; Smart Approaches to Marijuana (Project SAM); Town of Colma Police Department; Town of Danville; and Patient Advocacy Network (if amended)

OPPOSITION: Butte County Board of Supervisors

OPPOSE UNLESS AMENDED: American Academy of Cannabinoid Medicine; Americans for Safe Access; California Medical Association; California National Organization for Reform of Marijuana Laws; California National Organization for the Reform of Marijuana Laws (Cal NORML); Drug Policy Alliance; Law Enforcement Against Prohibition; Rural County Representatives of California; The Greater Los Angeles Collective Alliance; and Yolo County

POSITION: Recommendation: Oppose Unless Amended

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 1262

Introduced by Senator Correa

February 21, 2014

An act to add Article 25 (commencing with Section 2525) to Chapter 5 of Division 2 of the Business and Professions Code, and to add Article 7 (commencing with Section 111657) to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, relating to medical marijuana.

LEGISLATIVE COUNSEL'S DIGEST

SB 1262, as amended, Correa. Medical marijuana: regulation of physicians, dispensaries, and cultivation sites.

(1) Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use.

This bill would require the State Department of Public Health to license dispensing facilities and cultivation sites that provide, process, and grow marijuana for medical use, as specified, and would make these licenses subject to the restrictions of the local jurisdiction in which the facility operates or proposes to operate. The bill would require the department to establish standards for quality assurance testing of medical marijuana and would prohibit the use of nonorganic pesticides in any marijuana cultivation site. The bill would require licensed dispensing facilities and licensed cultivation sites to implement sufficient security

measures to both deter and prevent unauthorized entrance into areas containing marijuana and theft of marijuana at those facilities, including establishing limited access areas accessible only to authorized facility personnel, and would require these facilities to notify appropriate law enforcement authorities within 24 hours after discovering specified breaches in security. *The bill would require licensed dispensing facilities to verify that the recommending physician and surgeon is licensed to practice medicine in California before providing a marijuana product to a patient. This bill would prohibit the distribution of any form of advertising for physician recommendations for medical marijuana unless the advertisement bears a specified notice and requires that the advertisement meet specified requirements and not be fraudulent, deceitful, or misleading, as specified.* The bill would make enforcement of these provisions the responsibility of the county health departments, with oversight by the department. Violation of these provisions would be punishable by a civil fine of up to $35,000 for each individual violation. By expanding the duties of local health officers, this bill would impose a state-mandated local program.

(2) Existing law, the Medical Practice Act, provides for licensure and regulation of physicians and surgeons by the Medical Board of California.

This bill would establish requirements for a physician and surgeon to recommend medical marijuana, including prescribed procedural and recordkeeping requirements, and would require a recommendation for medical marijuana for a ~~minor~~ *person under 21 years of age* to include a specific justification for the recommendation and why the benefit of use is more important than the possible neurological damage that could be caused by the ~~minor~~ *person* using marijuana and to be approved by a board certified pediatrician. ~~The bill would require a physician and surgeon that recommends medical marijuana to report to the board the number of recommendations issued, with supporting documentation on patient medical need.~~

~~This bill would require the board to audit a physician and surgeon who recommends medical marijuana more than 100 times in a year to ensure compliance with existing law and would require the board to establish a certification process for physicians who wish to issue medical marijuana recommendations, including a mandatory training in identifying signs of addiction and ongoing substance abuse.~~

This bill would require the board, by January 1, 2016, to convene a task force of experts in the use of medical marijuana to review and

update, as necessary, guidelines for recommending medical marijuana, as specified.

Violation of these provisions would be punishable by a civil fine not to exceed $5,000. *The bill would make the recommendation of medical marijuana without a prior examination and medical indication and recommendation of medical marijuana for nonmedical purposes unprofessional conduct, to be punished as provided. The bill would also make it a misdemeanor for a physician and surgeon who recommends marijuana to a patient for a medical purpose to accept, solicit, or offer any remuneration from or to a licensed dispensing facility in which the physician and surgeon or his or her immediate family has a financial interest. By creating a new crime, this bill would impose a state-mandated local program.*

~~(3) 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 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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

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

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

1 SECTION 1. The Legislature finds and declares all of the
2 following:
3 (a) The California Constitution grants cities and counties the
4 authority to make and enforce, within their borders, "all local
5 police, sanitary, and other ordinances and regulations not in conflict

with the general laws." This inherent local police power includes broad authority to determine, for purposes of public health, safety, and welfare, the appropriate uses of land within the local jurisdiction's borders. The police power, therefore, allows each city and county to determine whether or not a medical marijuana dispensary or other facility that makes medical marijuana available may operate within its borders. This authority has been upheld by City of Riverside v. Inland Empire Patients Health & Wellness, Inc. (2013) 56 Cal.4th 729 and County of Los Angeles v. Hill (2011) 192 Cal.App.4th 861.

(b) If, pursuant to this authority, a city or county determines that a dispensary or other facility that makes medical marijuana available may operate within its borders, then there is a need for the state to license these dispensaries and other facilities for the purpose of adopting and enforcing protocols for training and certification of physicians who recommend the use of medical marijuana and for agricultural cultivation practices. This licensing requirement is not intended in any way nor shall it be construed to preempt local ordinances regarding the sale and use of medical marijuana, including, but not limited to, security, signage, lighting, and inspections.

~~(c) Given that the current system of all-cash transactions within the medical marijuana industry is unsustainable in the long term, there is a need to provide a monetary structure, as an alternative to the federal banking system, for the operation, regulation, and taxation of medical marijuana dispensaries.~~

~~(d)~~

(c) All of the following elements are necessary to uphold important state goals:

(1) Strict provisions to prevent the potential diversion of marijuana for recreational use.

(2) Audits to accurately track the volume of both product movement and sales.

(3) An effective means of restricting access to medical marijuana by ~~minors,~~ *persons under 21 years of age* ~~given the medical studies documenting marijuana's harmful and permanent effects on the brain development of youth~~.

~~(4) Stricter provisions relating to physicians and their recommendation procedures in order to address widespread problems of questionable medical marijuana recommendations by~~

~~physicians without a bona-fide doctor-patient relationship with the person to whom they are issuing the recommendation.~~

~~(c)~~

(d) Nothing in this act shall be construed to promote or facilitate the nonmedical, recreational possession, sale, or use of marijuana.

SEC. 2. Article 25 (commencing with Section 2525) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 25. Recommending Medical Marijuana

2525. (a) Prior to recommending marijuana to a patient pursuant to Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code, a physician and surgeon shall meet all of the following requirements:

(1) Have a ~~bona fide~~ doctor-patient ~~relationship, with medical marijuana recommendations to be made by a patient's primary care physician or by a physician and surgeon to whom the patient is referred by their primary care physician~~ *relationship*.

(2) Conduct an ~~in-person~~ *appropriate prior* examination *of the patient* to establish ~~the patient's need for medical marijuana~~ *that medical use of marijuana is appropriate*.

(3) Consult with the patient as necessary and periodically review the treatment's efficacy.

(b) A physician and surgeon that recommends medical marijuana shall do all of the following:

(1) ~~Address, in the recommendation, the quantity of use and method of delivery, including~~ *Include* a discussion of side effects. ~~If the recommended method of delivery is smoking, the recommendation shall state the reasons for selecting this method of delivery in the context of health issues created by smoking.~~

(2) Address, in the recommendation, what kind of marijuana to obtain, including high tetrahydrocannabinol (THC) levels, low THC levels, high cannabidiol (CBD) levels, low CBD levels, and explain the reason for recommending the particular strain. Under no circumstances shall a physician and surgeon recommend butane hash oil.

(3) Maintain a system of recordkeeping that supports the decision to recommend the use of medical marijuana for individual patients.

(c) A recommendation for medical marijuana provided to a ~~minor~~ *person under 21 years of age* shall ~~include a specific justification for the recommendation and why the benefit of use is more important than the possible neurological damage that could be caused by the minor using marijuana. A recommendation for a minor shall~~ be approved by a board certified pediatrician. A recommendation for a ~~minor~~ *person under 21 years of age* shall be for high CBD marijuana and all recommendations for ~~minors must~~ *persons under 21 years of age shall* be for nonsmoking delivery.

~~2525.1. (a) A physician and surgeon who recommends medical marijuana shall report to the California Medical Board the number of recommendations issued, with supporting documentation on patient medical need. The board shall forward these reports to the State Department of Public Health.~~

~~(b) A physician and surgeon who makes more than 100 recommendations in a calendar year shall be audited by the California Medical Board to determine compliance with Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code.~~

~~2525.2. The California Medical Board shall establish a certification process for physicians who wish to issue medical marijuana recommendations, including a mandatory training in identifying signs of addiction and ongoing substance abuse.~~

2525.1. (a) It is unlawful for a physician and surgeon who recommends marijuana to a patient for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility licensed pursuant to Article 7 (commencing with Section 111657) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code if the physician and surgeon or his or her immediate family have a financial interest in that facility.

(b) For the purposes of this section, "financial interest" shall have the same meaning as in Section 650.01.

(c) A violation of this section shall be a misdemeanor.

2525.2. The board, by January 1, 2016, shall convene a task force of experts in the use of medical marijuana to review and update, as necessary, guidelines for recommending medical marijuana to ensure competent review in cases concerning the recommendation of marijuana for medical purposes.

2525.3. *(a)* In addition to all other remedies available pursuant to this chapter, violation of any provision of this article shall be punishable by a civil fine of up to five thousand dollars ($5,000).

(b) Recommending marijuana to a patient for a medical purpose without an appropriate prior examination and a medical indication, or recommending marijuana for a nonmedical purpose shall constitute unprofessional conduct and may be punished pursuant to Article 12 (commencing with Section 2220).

SEC. 3. Article 7 (commencing with Section 111657) is added to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, to read:

Article 7. Medical Marijuana

111657. For purposes of this article, the following definitions shall apply:

(a) "Department" means the State Department of Public Health.

(b) "Licensed cultivation site" means a facility that grows or grows and processes marijuana for medical use and that is licensed pursuant to Section 111657.1.

(c) "Licensed dispensing facility" means a dispensary, mobile dispensary, marijuana processing facility, or other facility that provides marijuana for medical use that is licensed pursuant to Section 111657.1.

111657.1. (a) Except as provided in Section 11362.5 of, and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of, the Health and Safety Code, a person shall not sell or provide marijuana other than at a licensed dispensing facility.

(b) Except as provided in Section 11362.5 of, and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of, the Health and Safety Code, a person shall not grow or process marijuana other than at a licensed cultivation site.

(c) The department shall require, prior to issuing a license to a dispensing facility or a cultivation site, all of the following:

(1) The name of the owner or owners of the proposed facility.

(2) The address and telephone number of the proposed facility.

(3) A description of the scope of business of the proposed facility.

(4) A certified copy of the local jurisdiction's approval to operate within its borders.

(5) A completed application, as required by the department.

(6) Payment of a fee, in an amount to be determined by the department not to exceed the amount necessary, but that is sufficient to cover, the actual costs of the administration of this article.

(7) Any other information as required by the department.

111657.2. The department shall, after consulting with outside entities as needed, establish standards for quality assurance testing of medical marijuana, to ensure protection against microbiological contaminants. Nonorganic pesticides shall not be used in any marijuana cultivation site, irrespective of size or location.

111657.3. (a) A licensed dispensing facility shall not acquire, possess, cultivate, deliver, transfer, transport, or dispense marijuana for any purpose other than those authorized by Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10.

(b) A licensed dispensing facility shall not acquire marijuana plants or products except through the cultivation of marijuana by that facility, if the facility is a licensed cultivation site, or another licensed cultivation site.

111657.4. A licensed dispensing facility shall not provide a marijuana product to a patient until it verifies that the recommending physician and surgeon is licensed to practice medicine in California.

111657.5. (a) A person shall not distribute any form of advertising for physician recommendations for medical marijuana in California unless the advertisement bears the following notice to consumers:

NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use marijuana for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana. Physicians are licensed and regulated by the Medical Board of California and arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. California law prohibits advertising that includes statements of bait, discount, premiums, gifts, or any statements of a similar nature.

(b) Advertising for physician recommendations for medical marijuana shall meet all requirements of Section 651 of the Business and Professions Code. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discount, premiums, gifts, or statements of a similar nature.

~~111657.4.~~

111657.6. (a) A facility licensed pursuant to this article shall implement sufficient security measures to both deter and prevent unauthorized entrance into areas containing marijuana and theft of marijuana at those facilities. These security measures shall include, but not be limited to, all of the following:

(1) Allow only registered qualifying patients, personal caregivers, and facility agents access to the facility.

(2) Prevent individuals from remaining on the premises of the facility if they are not engaging in activity expressly related to the operations of the facility.

(3) Establish limited access areas accessible only to authorized facility personnel.

(4) Store all finished marijuana in a secure, locked safe or vault and in a manner as to prevent diversion, theft, and loss.

(b) A facility licensed pursuant to this article shall notify appropriate law enforcement authorities within 24 hours after discovering any of the following:

(1) Discrepancies identified during inventory.

(2) Diversion, theft, loss, or any criminal activity involving the facility or a facility agent.

(3) The loss or unauthorized alteration of records related to marijuana, registered qualifying patients, personal caregivers, or facility agents.

(4) Any other breach of security.

(c) A licensed cultivation site shall weigh, inventory, and account for on video, all medical marijuana to be transported prior to its leaving its origination location. Within eight hours after arrival at the destination, the licensed dispensing facility shall re-weigh, re-inventory, and account for on video, all transported marijuana.

~~111657.5.~~

111657.7. (a) Enforcement of this article shall be the responsibility of the county health departments, with oversight by the department.

(b) An enforcement officer may enter a facility licensed pursuant to this article during the facility's hours of operation and other reasonable times to do either of the following:

(1) Conduct inspections, issue citations, and secure samples, photographs, or other evidence from the facility, or a facility suspected of being a dispensing facility or cultivation site.

(2) Secure as evidence documents, or copies of documents, including inventories required pursuant to subdivision (c) of Section ~~111657.4~~ *111657.6*, or any record, file, paper, process, invoice, video, or receipt for the purpose of determining compliance with this chapter.

(c) A written report shall be made and a copy shall be supplied or mailed to the owner of the facility at the completion of an inspection or investigation.

(d) Upon request by the department, local governments shall provide the department with reports on the number and types of facilities operating within their jurisdiction.

~~111657.6.~~

111657.8. In addition to the provisions of this article, a license granted pursuant to this article shall be subject to the restrictions of the local jurisdiction in which the facility operates or proposes to operate. Even if a license has been granted pursuant to this article, a facility shall not operate in a local jurisdiction that prohibits the establishment of that type of business.

~~111657.7.~~

111657.9. Violation of this provision shall be punishable by a civil fine of up to thirty-five thousand dollars ($35,000) for each individual violation.

111657.10. Nothing in this article shall prevent a city or other local governing body from doing any of the following:

(a) Adopting and enforcing local ordinances that regulate the location, operation, or establishment of medical marijuana cooperatives or collectives.

(b) The civil and criminal enforcement of local ordinances described in subdivision (a).

(c) Enacting other laws consistent with this article.

1 ~~SEC. 4. If the Commission on State Mandates determines that~~
2 ~~this act contains costs mandated by the state, reimbursement to~~
3 ~~local agencies and school districts for those costs shall be made~~
4 ~~pursuant to Part 7 (commencing with Section 17500) of Division~~
5 ~~4 of Title 2 of the Government Code.~~
6 *SEC. 4. No reimbursement is required by this act pursuant to*
7 *Section 6 of Article XIII B of the California Constitution for certain*
8 *costs that may be incurred by a local agency or school district*
9 *because, in that regard, this act creates a new crime or infraction,*
10 *eliminates a crime or infraction, or changes the penalty for a crime*
11 *or infraction, within the meaning of Section 17556 of the*
12 *Government Code, or changes the definition of a crime within the*
13 *meaning of Section 6 of Article XIII B of the California*
14 *Constitution.*
15 *However, if the Commission on State Mandates determines that*
16 *this act contains other costs mandated by the state, reimbursement*
17 *to local agencies and school districts for those costs shall be made*
18 *pursuant to Part 7 (commencing with Section 17500) of Division*
19 *4 of Title 2 of the Government Code.*

O

SB 1466 – SEN. B&P

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	SB 1466
Author:	Committee on Business, Professions, and Economic Development
Bill Date:	March 25, 2014, introduced
Subject:	Omnibus
Sponsor:	Committee, Medical Board of California (Board) and other affected regulatory health boards
Position:	Support provisions related to the Board

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis will only include the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). The omnibus language would include the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP) as an approved accreditation agency for hospitals offering accredited postgraduate training programs. This bill would also strike "scheduled" from existing law that requires physicians who perform a "scheduled" medical procedure outside of a hospital, that results in a death, to report the occurrence to the Board within 15 days.

ANALYSIS:

BPC Section 2089.5 – AOA-HFAP

Currently, the Board recognizes Accreditation Council Graduate for Medical Education (ACGME) accredited postgraduate training for the purposes of allopathic medical school students' clinical clerkship training and for the required postgraduate training for licensure as a physician and surgeon. ACGME accredited postgraduate training programs are at institutions that are accredited by the Joint Commission. Recently, ACGME has accredited postgraduate training programs in hospitals that are accredited by the AOA-HFAP. However, existing law (B&P Code Section 2089.5) specifically references the "Joint Commission on Accreditation of Hospitals" as the hospital accreditation agency for ACGME postgraduate training programs.

American Osteopathic Association (AOA) accredits postgraduate training for licensure purposes for osteopathic medical school graduates. AOA accredited postgraduate training programs are usually obtained in hospitals that are accredited by the AOA-HFAP. ACGME and AOA have reached an agreement for ACGME to approve all postgraduate training programs for both allopathic medical school (M.D. degrees awarded) and osteopathic medical school (D.O. degrees awarded) graduates.

The language included in the omnibus bill would amend BPC Section 2089.5 to include the AOA-HFAP as an approved accreditation agency for hospitals offering ACGME accredited postgraduate training programs.

BPC Section 2240 – Striking "Scheduled"

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. As such, the language included in the omnibus bill would strike "scheduled" from this provision.

Both of these proposals have already been approved by the Board to be included in the omnibus bill.

FISCAL: None to the Board

SUPPORT: Medical Board of California and other affected regulatory health boards.

OPPOSITION: None on file

SENATE BILL No. 1466

Introduced by Committee on Business, Professions and Economic Development (Senators Lieu (Chair), Berryhill, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, Wyland, and Yee)

March 25, 2014

An act to amend Sections 27, 2089.5, 2240, 2530.5, 2532.2, 2532.7, 4021.5, 4053, 4980, 4980.36, 4980.37, 4980.399, 4980.41, 4980.43, 4980.55, 4980.72, 4980.78, 4987.5, 4992.09, 4996.23, 4998, 4999.55, 4999.58, 4999.59, 4999.60, and 4999.123 of, and to amend the heading of Chapter 13 (commencing with Section 4980) of Division 2 of, the Business and Professions Code, and to amend Section 14132.55 of the Welfare and Institutions Code, relating to health care professionals.

LEGISLATIVE COUNSEL'S DIGEST

SB 1466, as introduced, Committee on Business, Professions and Economic Development. Health care professionals.

(1) Existing law requires a physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, to report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence. A person who violates this requirement is guilty of a misdemeanor.

This bill would make that provision applicable without regard to whether the procedure was scheduled. By expanding the scope of a crime, the bill would impose a state-mandated local program.

(2) Existing law provides for the licensing and regulation of persons who are engaged in the practice of speech-language pathology or audiology, as specified, and vests the enforcement of these provisions

in the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board. Among other requirements, an applicant for licensure as a speech-language pathologist or audiologist is required to submit transcripts from an educational institution approved by the board evidencing completion of specified coursework, and submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. Existing law requires the board to establish by regulation the required number of clock hours, not to exceed 300 clock hours, of supervised clinical practice necessary for the applicant.

This bill would delete the requirement that the applicant submit transcripts from an educational institution approved by the board evidencing completion of specified coursework and would increase the maximum number of clock hours that the board may establish by regulation to 375.

(3) Existing law, the Pharmacy Law, governs the regulation of the practice of pharmacy and establishes the California State Board of Pharmacy to administer and enforce these provisions. The law authorizes the board to issue a license to an individual to serve as a designated representative to provide sufficient and qualified supervision in a wholesaler or veterinary food-animal drug retailer, as specified, and requires the licensee to protect the public health and safety in the handling, storage, and shipment of dangerous drugs and dangerous devices in the wholesaler or veterinary food-animal drug retailer. The law also defines a correctional pharmacy to mean a pharmacy, licensed by the board, located within a state correctional facility, as specified.

This bill would require an individual who applies for designated representative license to be at least 18 years of age. The bill would also revise the definition of a correctional pharmacy to mean a pharmacy, licensed by the board, located within a correctional facility, without regard to whether the facility is a state or local correctional facility.

(4) Existing law requires an applicant for a license as marriage and family therapist, social worker, or professional clinical counselor, to participate in and obtain a passing score on a board-administered California law and ethics examination in order to qualify for a license or renewal of a license.

This bill would permit an applicant who holds a registration eligible for renewal, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, if eligible, to renew the registration without first participating in the California law and ethics examination.

The bill would require the applicant to pass that examination prior to lincensure or issuance of a subsequent registration number. The bill would also permit an applicant who holds or has held a registration, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, if eligible, to obtain the subsequent registration number without first passing the California law and ethics examination, if he or she passes the law and ethics examination at the next renewal period or prior to licensure, whichever occurs first.

This bill would make other changes relating to licensed marriage and family therapists and licensed professional clinical counselors.

The bill would also make other technical, conforming, and clarifying changes.

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

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

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

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

1 SECTION 1. Section 27 of the Business and Professions Code
2 is amended to read:
3 27. (a) Each entity specified in subdivisions (c), (d), and (e)
4 shall provide on the Internet information regarding the status of
5 every license issued by that entity in accordance with the California
6 Public Records Act (Chapter 3.5 (commencing with Section 6250)
7 of Division 7 of Title 1 of the Government Code) and the
8 Information Practices Act of 1977 (Chapter 1 (commencing with
9 Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code).
10 The public information to be provided on the Internet shall include
11 information on suspensions and revocations of licenses issued by
12 the entity and other related enforcement action, including
13 accusations filed pursuant to the Administrative Procedure Act
14 (Chapter 3.5 (commencing with Section 11340) of Part 1 of
15 Division 3 of Title 2 of the Government Code) taken by the entity
16 relative to persons, businesses, or facilities subject to licensure or
17 regulation by the entity. The information may not include personal
18 information, including home telephone number, date of birth, or

(f) "Internet" for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 2. Section 2089.5 of the Business and Professions Code is amended to read:

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, *or the American Osteopathic Association's Healthcare Facilities Accreditation Program,* and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the

clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

SEC. 3. Section 2240 of the Business and Professions Code is amended to read:

2240. (a) ~~Any~~ *A* physician and surgeon who performs a ~~scheduled~~ medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence.

(b) ~~Any~~ *A* physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, that results in the transfer to a hospital or emergency center for medical treatment for a period exceeding 24 hours, of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing, on a form prescribed by the board that occurrence, within 15 days after the occurrence. The form shall contain all of the following information:

(1) Name of the patient's physician in the outpatient setting.

(2) Name of the physician with hospital privileges.

(3) Name of the patient and patient identifying information.

(4) Name of the hospital or emergency center where the patient was transferred.

(5) Type of outpatient procedures being performed.

(6) Events triggering the transfer.

(7) Duration of the hospital stay.

(8) Final disposition or status, if not released from the hospital, of the patient.

(9) Physician's practice specialty and ABMS certification, if applicable.

(c) The form described in subdivision (b) shall be constructed in a format to enable the physician and surgeon to transmit the information in paragraphs (5) to (9), inclusive, to the board in a manner that the physician and surgeon and the patient are anonymous and their identifying information is not transmitted to the board. The entire form containing information described in paragraphs (1) to (9), inclusive, shall be placed in the patient's medical record.

(d) The board shall aggregate the data and publish an annual report on the information collected pursuant to subdivisions (a) and (b).

(e) On and after January 1, 2002, the data required in subdivision (b) shall be sent to the Office of Statewide Health Planning and Development (OSHPD) instead of the board. OSHPD may revise the reporting requirements to fit state and national standards, as applicable. The board shall work with OSHPD in developing the reporting mechanism to satisfy the data collection requirements of this section.

(f) The failure to comply with this section constitutes unprofessional conduct.

SEC. 4. Section 2530.5 of the Business and Professions Code is amended to read:

2530.5. (a) Nothing in this chapter shall be construed as restricting hearing testing conducted by licensed physicians and surgeons or by persons conducting hearing tests under the direct supervision of a physician and surgeon.

(b) Nothing in this chapter shall be construed to prevent a licensed hearing aid dispenser from engaging in testing of hearing and other practices and procedures used solely for the fitting and selling of hearing aids nor does this chapter restrict persons practicing their licensed profession and operating within the scope of their licensed profession or employed by someone operating within the scope of their licensed professions, including persons fitting and selling hearing aids who are properly licensed or registered under the laws of the State of California.

(c) Nothing in this chapter shall be construed as restricting or preventing the practice of speech-language pathology or audiology by personnel holding the appropriate credential from the

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 357	Pan	California Healthy Child Advisory Task Force	2-year	01/16/14
AB 369	Pan	Continuity of Care	Chaptered, #4	02/18/14
AB 395	Fox	Alcoholism and Drug Abuse Treatment Facilities	2-year	07/10/13
AB 467	Stone	Prescription Drugs: Collection and Distribution Program	Chaptered, #10	03/11/14
AB 604	Ammiano	Medical Cannabis: State Regulation and Enforcement	2-year	09/11/13
AB 678	Gordon	Health Care Districts: Community Health Needs Assessment	2-year	04/15/13
AB 889	Frazier	Health Care Coverage: Prescription Drugs	2-year	05/02/13
AB 1153	Eggman	Master Esthetician: License	2-year	01/06/14
AB 1310	Brown	Medi-Cal: Pediatric Subacute Care	2-year	05/24/13
AB 1558	Hernandez	California Health Data Organization	Introduced	
AB 1575	Pan	Public Contracts for Services	Senate	03/20/14
AB 1592	Gaines	California Diabetes Program	Asm. Health	04/02/14
AB 1612	Donnelly	State Government: Regulations	Asm. Account. & Admin. Review	04/02/14
AB 1621	Lowenthal	Emergency Medical Services: Data and Informaiton System	Asm. Health	04/21/14
AB 1650	Jones-Sawyer	Public Contracts: Bidders	Asm. Approps	04/01/14
AB 1683	Jones	Ken Maddy California Cancer Registry	Asm. Approps	04/10/14
AB 1702	Maienschein	Professions and Vocations: Incarceration	Asm. B&P	
AB 1727	Rodriguez	Prescription Drugs: Collection and Distribution Program	Asm. Health	
AB 1743	Ting	Hypodermic Needles and Syringes	Senate	
AB 1755	Gomez	Medical Information	Asm. Health	03/28/14
AB 1758	Patterson	Healing Arts: Initial License Fees: Proration	Asm. B&P	04/03/14
AB 1812	Pan	Health Facilities: Information: Disclosure	Assembly	
AB 1822	Bonta	Tissue Banks	Asm. Approps	
AB 1868	Gomez	Medi-Cal: Optional Benefits: Podiatric Medicine	Asm. Approps	
AB 1890	Chau	Athletic Trainers	Asm. B&P	04/21/14

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1898	Brown	Public Health Records: Reporting: HIV/AIDS	Asm. Judiciary	
AB 1903	Donnelly	Department of Consumer Affairs: Boards: Meetings	Assembly	
AB 1917	Gordon	Outpatient Prescription Drugs: Cost Sharing	Asm. Health	
AB 1921	Holden	Public Contracts for Services: Access to Records	Asm. Account. & Admin. Review	
AB 1923	Daly	State Government: Contracts: Public Records	Asm. Judiciary	
AB 2015	Chau	Health Care Coverage: Discrimination	Asm. Approps	
AB 2058	Wilk	Open Meetings	Asm. Approps	04/09/14
AB 2059	Muratsuchi	Medical Records: Electronic Delivery	Asm. Health	
AB 2062	Hernandez	Health Facilities: Surgical Technologists	Asm. Health	04/10/14
AB 2069	Maienschein	Immunizations: Influenza	Asm. Health	04/21/14
AB 2102	Ting	Licensees: Data Collection	Asm. Approps	03/28/14
AB 2143	Williams	Clinical Laboratories: Chiropractors	Asm. Health	03/28/14
AB 2144	Yamada	Staff-To-Patient Ratios	Asm. Health	4/1014
AB 2165	Patterson	Professions and Vocations: Licenses	Asm. B&P	04/10/14
AB 2198	Levine	Mental Health Professionals: Suicide Prevention Training	Asm. B&P	04/21/14
AB 2278		State Agency Contracts	Assembly	
AB 2336	Grove	Abortion: Gender Selection	Asm. Health	03/28/14
AB 2340	Garcia	State Department of Public Health: Office of Health Equity	Asm. Health	03/28/14
AB 2374	Mansoor	Substance Abuse: Recovery and Treatment Services	Asm. Health	04/08/14
AB 2387	Pan	Commission on Peace Officer Standards and Training	Assembly	04/21/14
AB 2396	Bonta	Convictions: Expungement: Licenses	Asm. B&P	04/21/14
AB 2400	Ridley-Thomas	Health Care Coverage: Physician Contracts	Asm. Health	
AB 2418	Bonilla	Health Care Coverage: Prescription Drug Refills	Asm. Health	
AB 2452	Pan	Advance Health Care Directive Registry	Asm. Health	04/08/14
AB 2482	Wilk	Workers Compensation: Utilization Review	Asm. Insurance	

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2484	Gordon	Healing Arts: Telehealth	Asm. B&P	
AB 2491	Nestande	Alcohol and Drug Abuse Treatment Facilities: Sober Living Homes	Asm. Health	03/28/14
AB 2507	Bocanegra	Public Records Act: Exemptions: Pending Litigation	Asm. Judiciary	04/10/14
AB 2514	Pan	Income Taxes: Credits: Rural Health Care Professionals	Asm. Rev. & Tax	04/01/14
AB 2580	Fox	Medical Licenses	Spot	
AB 2598	Hagman	Department of Consumer Affairs: Administrative Expenses	Asm. B&P	
AB 2605	Bonilla	Pharmacy: Sterile Drug Products	Asm. B&P	03/18/14
AB 2616	Skinner	Workers Compensation: Hospital Employers	Asm. Insurance	04/03/14
AB 2638	Chau	Department of Consumer Affairs	Assembly	
AB 2675	Lowenthal	State Agency: Public Contracts	Asm. Approps	
AB 2720	Ting	State Agencies: Meetings: Record of Action Taken	Asm. Gov. Org.	04/02/14
AB 2723	Medina	Administrative Procedure: Small Business	Assembly	04/09/14
ACA 5	Grove	Abortion: Parental Notification	2-year	01/07/14
ACR 93	Buchanan	Prescription Drug Abuse Awareness Month	Sen. 3rd Reading	03/24/14
ACR 107	Bloom	Year of the Family Physician	Asm. Health	
ACR 110	Fox	Health Care District Month	Asm. 3rd Reading	
ACR 111	Levine	Colorectal Cancer Awareness Month	Sen. 3rd Reading	03/20/14
ACR 125	Perez	Donate Life California Day: Driver's License	Sen. 3rd Reading	04/07/14
SB 18	Hernandez	California Health Benefits Review Program	2-year	04/17/13
SB 20	Hernandez	Health Care Coverage	2-year	04/09/14
SB 22	Beall	Health Care Coverage: Mental Health Parity	2-year	07/02/13
SB 176	Galgiani	Administrative Procedures	2-year	08/07/13
SB 204	Corbett	Prescription Drugs: Labeling	2-year	06/27/13
SB 218	Yee	Healing Arts: Ca Traditional Chinese Medicine Traumatologist	2-year	08/05/13
SB 306	Torres	Nursing: Licensing Criteria	Asm. B&P	01/13/14

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	2-year	01/06/14
SB 830	Galgiani	Health Care: Health Facility Data	Sen. Health	04/07/14
SB 906	Correa	Elective Percutaneous Coronary Intervention Offsite Program	Sen. Health	04/07/14
SB 909	Pavley	Dependent Children: Health Screenings	Sen. Judiciary	04/10/14
SB 973	Hernandez	Narcotic Treatment Programs	Sen. Health	03/28/14
SB 981	Huff	Regulations: Review Process	Sen. Gov. Org.	04/10/14
SB 1014	Jackson	Pharmaceutical Waste: Home Generated	Sen. B&P	04/21/14
SB 1039	Hernandez	Pharmacies: Furnishing Drugs	Sen. Health	04/10/14
SB 1053	Mitchell	Health Care Coverage: Contraceptives	Sen. Health	04/09/14
SB 1135	Jackson	Inmates: Sterilization	Sen. Public Safety	03/24/14
SB 1159	Lara	Professions and Vocations: Federal Tax ID Number	Sen. Approps	04/07/14
SB 1176	Steinberg	Health Care Coverage: Cost Sharing: Tracking	Sen. Health	04/07/14
SB 1215	Hernandez	Heatlhing Arts Licensees: Referrals	Sen. B&P	04/10/14
SB 1238	Hernandez	Health Facilities: Outpatient Care and Patient Assessment	Sen. Health	04/10/14
SB 1241	Leno	Health Care Coverage: Marketplace Transparency	Senate	
SB 1256	Mitchell	Medical Services: Credit	Sen. Judiciary	
SB 1266	Huff	Pupil Health: Epinephrine Auto-Injectors	Sen. Health	04/21/14
SB 1297	Hueso	Hospital Safety and Transparency Act of 2014	Sen. Health	04/02/14
SB 1303	Torres	Public Health: Hepatitis C	Sen. Health	04/02/14
SB 1322	Hernandez	Califonria Health Care Quality Improvement and Cost Containment Commission	Sen. Health	04/01/14
SB 1337	DeSaulnier	Public Records and Reports	Sen. Gov. Org.	04/21/14
SB 1340	Hernandez	Health Care Coverage: Provider Contracts	Sen. 3rd Reading	03/24/14
SB 1357	Wolk	Physician Orders for Life Sustaining Treatment Form: Registry	Sen. Health	04/21/14
SB 1426	De Leon	Breast and Cervical Cancer Treatment Program	Senate	
SB 1429	Steinberg	Civil Damages: Medical Malpractice	Senate	

MBC TRACKER II BILLS
4/23/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1438	Pavley	Controlled Substances: Opioid Antagonists	Sen. Health	04/10/14
SB 1457	Evans	Medical Care: Electronic Treatment Authorization Requests	Sen. Approps	03/28/14
SR 36	Walters	Relative to Prescription Drug Abuse Awareness	Adopted	03/25/14

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	Modified text mailed on 4/02/14; the15-day comment period ended 4/18/14.	7/19/13	9/06/13	10/25/13		8/30/13 to DCA for review and approval		
PA – Supervision Requirements	Modified text mailed on 3/13/14. The 15-day comment period ended 3/28/14.	10/25/13	12/13/13	2/07/14		12/03/13 to DCA for review and approval		

Prepared by Chris Valine
Updated April 16, 2014
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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 15, 2014
ATTENTION:	Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee Recommendation
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve the recommendations of the Special Faculty Permit Review Committee (SFPRC) for appointment of Maria-Grazia Roncarolo, M.D., pursuant to Section 2168.1 of the California Business and Professions Code.

BACKGROUND AND ANALYSIS:

The Medical Board of California (Board) is authorized to issue a Special Faculty Permit (SFP) to a person who is academically eminent and meets all of the other requirements pursuant to Section 2168.1 of the California Business and Professions Code (B&P).

An individual who holds a valid SFP is authorized to practice medicine only within the medical school itself and any affiliated institutions in which the SFP holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility.

The SFPRC is comprised of two Board members, one who is a physician and one who is a public member, and one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to Section 2168.1 of the B&P.

At the SFPRC's March 27, 2014 meeting, the SFPRC reviewed the qualifications of one applicant from the Stanford University School of Medicine (Stanford).

Maria-Grazia Roncarolo, M.D., Stanford - SFP APPLICANT:

Laurence Katznelson, M.D., Professor of Neurosurgery and Medicine, Associate Dean of Graduate Medical Education, presented Stanford's request for Maria-Grazia Roncarolo, M.D., to receive a SFP and to be the Division Chief of Pediatric Translational and Regenerative Medicine. Dr. Katznelson also presented the qualifications of Dr. Roncarolo. Dr. Katznelson indicated that Dr. Roncarolo has been offered a position as Professor in the Stanford Tenure Line, with tenure. Stanford's Provost granted an extremely rare waiver of a faculty search because of Dr. Roncarolo's highly regarded international reputation in the field of stem cell research, gene therapy and autoimmune diseases and it would be very difficult to find another clinician – scientist of her caliber.

Dr. Roncarolo was appointed to Chief of the Pediatric Immunology and Hematology Division at San Raffaele Scientific University in Milan in 2003. In 2008, Dr. Roncarolo was appointed to Scientific

Director of San Raffaele Scientific University where she still holds this position. Dr. Roncarolo has been awarded several awards, such as the Eurodis Scientific Award for outstanding contributions to the cure of genetic disease, Outstanding Achievement Award from the European Society of Gene and Cell Therapy, and is an elected member of the Academia Dupaea of Sciences. Dr. Roncarolo has 100 out of more than 280 papers published in internationally scientific peer review journals, contributed 22 chapters to books, and is an exceptionally distinguished individual who is recognized as a world leading clinical scientist conducting fundamental immunologic research. Her expertise, training, and passion for translational research will be a great benefit to the Stanford research program.

Dr. Roncarolo will hold a full time faculty appointment as a Professor of Pediatrics at Stanford, if approved for a SFP appointment by the Board. In addition, Dr. Minor the Dean of Stanford University School of Medicine is requesting that the Board approve Dr. Roncarolo to be appointed as the Division Chief of the Pediatric Translational and Regenerative Medicine (a new program at Stanford), pending approval of Stanford's SFP request for Dr. Roncarolo by the Board. Dr. Roncarolo will be training physician-scientists and graduate students in the Institute of Stem Cell Biology and Regenerative Medicine, Immunology, Cancer Biology, and Developmental Biology. Dr. Roncarolo will also mentor pediatric residents and pediatric hematology oncology fellows.

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Roncarolo for an SFP at Stanford pursuant to Business and Professions Code Section 2168.1 (a)(1)(A).

In addition, the SFPRC recommended approval of Dr. Roncarolo to be the Division Chief of the Pediatric Translational and Regenerative Medicine pursuant to Business and Professions Code Section 2168(c).

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: April 15, 2014
ATTENTION: Board Members
SUBJECT: Midwifery Advisory Council
CONTACT: Carrie Sparrevohn, L.M., Chair

REQUESTED ACTION:

Approval of the following Agenda Items is requested for the August 14, 2014 MAC meeting:

- Task Force Updates:
  - Midwife Assistant
  - Board Information Packet
  - Licensed Midwife Annual Report Data Collection Tool

- Update on regulatory changes required by AB 1308

BACKGROUND:

The last MAC meeting was held on March 27, 2014. The MAC continued its discussion surrounding the changes for licensed midwives (LM) mandated by Assembly Bill 1308 (AB1308) (Bonilla, Chapter 665, Statutes of 2013).

The MAC was presented with the final version of the hospital reporting form, as developed by staff. Staff also presented a report from LMs on their ability to obtain necessary testing and lifesaving drugs. It was found that there were few LMs who were still experiencing difficulty in this area.

Ms. Ehrlich provided a final update on the comparison of data over the past six years of collection via the Licensed Midwife Annual Report. Ms. Ehrlich reported that while changes need to be made to the data collection tool, overall the statistics have been consistent over the course of the last six years. Ms. Ehrlich's findings have been provided in the packet for reference (Attachment 1). Because of the needed changes to the collection tool, a task force was formed of Ms. Ehrlich and Ms. Sparrevohn, to identify what changes would be optimal, and then to work with staff to create those changes on the electronic data collection tool.

As had been discussed at prior MAC meetings, there is a need for LMs to have an assistant at births, and because it is not always possible for that assistant to be either another LM or a student, statutory changes are necessary to define the roles of an LM assistant. A task force was formed of Dr. Byrne and Ms. Sparrevohn to identify language that could be presented to the Board in October, outlining the roles and responsibilities related to an LM assistant.

The task force for the creation of an information packet for new Board Members is still in process. Upon completion of the document, and approval by the MAC and the Board, it will be provided to new Board members as part of the orientation packet.

The former Licensed Midwife Standard of Care document was presented to the MAC by the Board's legal counsel with the changes necessitated by AB 1308. Pursuant to AB 1308 the Standards of Care document is no longer recognized. Board staff and legal counsel edited the existing Standards of Care document to incorporate the changes necessitated by AB 1308, which resulted in the updated document: Practice Guidelines for California Licensed Midwives. The new document has been provided in the packet for reference. It is important to note that the only changes made to the document were directly related to those required by AB 1308. The Practice Guidelines were adopted by the MAC and will be provided to the public upon Board approval. The Practice Guidelines will be used by LMs to follow, while formal regulations are being drafted and approved.

LICENSED MIDWIFE ANNUAL REPORT: 2007-2012 OVERVIEW SUMMARY

EXPLANATION AND DISCLAIMER

The first page of data details outcomes of planned out-of-hospital births attended by licensed midwives (LMs) over a period of six years. The next four pages detail the reasons why mothers and/or babies were transferred to the hospital after the onset of labor.

The annual reports upon which this summary is based were developed only to follow trends in out-of-hospital maternity care provided by licensed midwives within California, as directed by law. Data listed in this summary are raw, aggregated numbers that have not been verified, validated for correct input, or subjected to epidemiological analysis. They are not to be quoted as definitive statistics or research.

The reporting tool was developed without oversight by maternity-care epidemiology professionals, and has elicited discrepant information. For example:

- The numbers listed (e.g. in sections E, O, and P of the annual report) for maternal and perinatal mortality do not tally properly, so reliable information about these mortality rates cannot be determined.
- The questionnaire does not classify where fetal, perinatal, and neonatal demises took place – out-of-hospital while under the care of the LM, during transfer of care, or in the hospital after transfer of care.
- The report does not distinguish whether the perinate had anomalies or other conditions incompatible with life.
- Mortality information is elicited in more than one section of the questionnaire. This could have led to inadvertent errors in submission, including possible doubling of some entries, thus skewing results.

In 2008 a California LM reported a maternal mortality that actually took place outside of California. Since 2009 all data for all categories come from care that was provided only within the state of California.

Prepared and submitted by Karen Ehrlich, LM – March 2014

OUTCOMES OF PLANNED OUT-OF-HOSPITAL BIRTHS WITH LICENSED MIDWIVES

	2007	2008	2009	2010	2011	2012
Planned Out of Hospital Births at Onset of Labor	1687	2278	1974	2245	2611	2784
Completed Births in Out-of-Hospital Setting	1438	1885	1621	1840	2123	2316
Percentage of Births Completed Out-of-Hospital	85.24%	82.75%	82.12%	81.96%	81.31%	83.12%
Intrapartum Elective Transfer	226	317	282	333	388	397
Intrapartum Urgent/Emergency Transfer	23	33	42	53	64	44
Total Intrapartum Transfer	249	350	324	386	452	441
Postpartum Elective Transfer	30	51	32	28	52	38
Postpartum Urgent/Emergency Transfer	17	29	27	21	34	21
Total Postpartum Transfer	47	80	59	49	86	59
Intrapartum plus Postpartum Transfer Rate	17.50%	18.90%	19.40%	19.30%	20.60%	18.00%
Newborn Elective Transfer	17	16	21	22	25	29
Newborn Urgent/Emergency Transfer	26	29	24	37	31	26
Total Newborn Transfer	43	55	45	59	56	55
Newborn Transfer Rate	2.60%	2.40%	2.30%	2.60%	2.10%	2.00%
C/S rate	7.7% (130)	8.8% (200)	9.4% (187)	8.7% (195)	7.1% (184)	7.0% (196)
Maternal Mortality	0	1	ā transfer - 0 p trānsfer - 1	0	0	0
Fetal Demise - section E, column C - fetal deaths from 20 weeks through labor	12	7	8	15	6	6
Infant Deaths - section E, column D - undefined	not asked	not asked	not asked	0	1	0
Fetal Demise diagnosed prior to labor - section 0, line 126 (line 122 in 2007 & 2008)	7	5	6	4	3	1
Fetal Demise dx during labor or at delivery - sect O, line 127 (line 123 in 2007 & 2008)	3	3	3	6	6	3
Live Born Infant who subsequently died - sect O, line 128 (line 124 in 2007 & 2008)	5	4	2	2	5	2
Complications leading to infant mortality - Section P	6	4	4	2	6	2
Perinatal/Neonatal Mortality -	5	4	4	7	9	4

Please note: The data in the reports for fetal, perinatal, and neonatal mortality are not congruent. Thus it is not possible to calculate an accurate mortality rate for the six years of this overview.

REASONS FOR HOSPITAL TRANSFER

Please note: The numbers in parantheses correspond to the lines in the 2009-2012 LMARs. A few of the line numbers for 2007 & 2008 differ from the rest.

On this page, the number in each year's column preceded by "n" refers to the number of planned out-of-hospital births at onset of CARE with LM.

		2007 n 2277	2008 n 2774	2009 n 3023	2010 n 3115	2011 n 3934	2012 n 4370
	Client request (43)	160	26	32	37	39	40
	Non vertex @ term (40)	16	48	29	31	32	43
	AB: spon & termin (34)	39	59	27	27	34	50
Antepartum	Hypertension dev in pg (26)	12	12	12	22	22	27
Elective	IUGR/fetal anomaly (36,37)	6	6	11	10	12	18
section G	Fetal heart irregularity (39)	4	2	4	4	2	6
	Multiple gestation (41)	3	12	10	11	9	10
	Abnorm fluid volume (38)	5	12	12	28	13	9
	Placental problems (33)	4	9	8	7	6	8
	Gestational DM (31)	4	3	6	7	7	9
	Vaginal bleeding (32)	4	5	2	3	3	2
	MW clinical judgment (42)	12	19	26	12	38	16
	All other (25,27,28,29,30,35,44)	32	31	30	41	32	31

	Preterm labor or ROM (50)	16	33	26	26	30	44
	Headache/PIH/Preeclam (46)	3	5	10	8	13	13
	Significant vaginal bleed (49)	1	1	0	1	5	3
Antepartum	Decr fetal mvmt/NST (51)	8	6	7	8	7	6
Urgent/	Fetal demise (52)	5	5	6	5	4	2
Emergent	MW clinical judgment (53)	2	1	5	0	0	2
section H	Non-preg med condition (45)	3	1	1	0	1	2
	All other (47,48,54)	6	3	1	1	3	4

On next 3 pages, the "n" in each year's column refers to the number of planned out-of-hospital births at onset of LABOR.

		2007 n 1687	2008 n 2278	2009 n 1974	2010 n 2245	2011 n 2611	2012 n 2784
Intrapartum Elective section I	Lack progress/exhaustion/ dehydration (60)	125	188	164	179	240	248
	Pt request pain meds (66)	36	46	38	50	44	46
	Prolonged ROM (59)	18	31	23	31	34	27
	Thickmec w/o fet distres (61)	9	14	10	16	14	23
	Non-vertex presentation (62)	9	11	16	18	11	11
	Malposition/unstable lie (63)	7	10	11	7	7	6
	Hypertension/headache (55)	3	5	3	6	8	8
	Abnormal bleeding (57)	3	2	2	4	2	3
	Signs of infection (58)	1	1	4	4	6	7
	MW clinical judgment (65)	10	4	8	14	18	11
	All other (56,64,67)	5	5	3	4	4	7

Intrapartum Urgent/ Emergency section J	Non-reassur FHT/distress (73)	14	23	16	32	46	32
	Vaginal bleeding/suspected placental abruption (69)	3	2	3	4	5	3
	Preeclampsia (68)	2	1	1	1	1	5
	Cord prolapse (72)	1	2	0	1	0	1
	MW clinical judgment (74)	3	4	21	13	11	3
	All other (70,71,75,76)	0	0	1	2	1	0

		2007 n 1687	2008 n 2278	2009 n 1974	2010 n 2245	2011 n 2611	2012 n 2784
Postpartum Elective section K	Laceration beyond MW (78)	14	24	14	10	25	14
	Adherent placenta w/o significant bleeding (77)	6	13	7	7	8	11
	Signs of infection (82)	3	1	5	3	5	1
	Excessive bleeding in later postpartum (81)	2	4	1	3	7	4
	MW clinical judgment (83)	2	2	0	0	4	1
	Client request (84)	1	3	3	2	0	1
	All other (79,80,85)	2	4	2	3	3	6

Postpartum Urgent/ Emergency section L	Adherent placenta with signif bleeding (90)	9	10	8	10	17	11
	Uncontrolled hemorrh (88)	4	7	5	4	6	5
	Signs of infection (92)	1	2	1	0	0	0
	Seizures, shock or unconsciousness (89)	1	0	3	1	2	0
	Abnorm/unstable vitals (86)	0	3	1	1	3	5
	MW clinical judgment (93)	1	2	4	1	4	0
	All other (87,91,94)	1	5	5	4	2	0

		2007 n 1687	2008 n 2278	2009 n 1974	2010 n 2245	2011 n 2611	2012 n 2784
Infant Elective section M	Poor transition (98)	4	6	6	6	9	13
	Congenital anomalies (96)	3	4	0	9	2	5
	Birth injury (97)	incl w/anomalies	incl w/anomalies	1	0	0	0
	Low birth weight (95)	2	1	1	1	0	0
	Insuffic urine/mec (99)	0	0	2	0	0	1
	Parental request (100)	0	1	3	1	0	2
	MW clinical judgment (101)	7	0	7	4	10	5
	Other (102)	1	4	1	1	4	3

Infant Urgent/ Emergency section N	Abnorm vitals, color, tone lethargy, not nursing (103)	5	16	8	11	12	8
	Significant cardiac or respiratory issues (111)	9	7	8	9	7	10
	10 min Apgar 6 or less (112)	3	6	0	3	3	0
	Congenital anomalies (108)	4	2	1	2	0	0
	Birth injury (109)	incl w/anomalies	incl w/anomalies	0	1	0	1
	Signs of infection (104)	0	1	2	6	2	2
	Signif dehydr or depression of fontanelles (110)	0	0	2	0	1	0
	Abnorm bulg fontanelles (113)	0	0	0	0	0	0
	Abnorm cry, seizures, or loss of conscious (105)	1	0	0	2	0	0
	Significant jaundice w/in 30 hours (106)	2	3	2	1	2	0
	MW clinical judgment (114)	0	3	0	2	1	3
	All other (107,115)	2	1	1	0	3	2

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	April 15, 2014
ATTENTION:	Board Members
SUBJECT:	Midwifery Practice Guidelines
FROM:	Curt Worden, Chief of Licensing Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the proposed changes, make a motion to approve the Practice Guidelines for California Licensed Midwives for posting on the Medical Board of California's website.

BACKGROUND:

In 2005, the Medical Board of California (Board) approved the Standards of Care for California Licensed Midwives. This document was crafted through the collaborative efforts of representatives from the midwifery community, the American Congress of Obstetricians and Gynecologists (ACOG), Board members and staff, and other interested parties.

The passage of AB 1308 (Bonilla) last year brought about several significant changes to the practice of midwifery in California. For example, under Business and Professions Code (B & P) Section 2507, physician supervision was removed as a requirement for licensed midwives to practice, however, new limitations have been placed on client selection. Moreover, a midwife may not provide or continue to provide care to a woman with a risk factor that will significantly affect the course of pregnancy and childbirth, regardless of whether the woman has refused to consult with a physician. Additionally, under B & P Section 2507(f) licensed midwives are authorized to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports consistent with the practice of midwifery.

AB 1308 also removed the authority for Title 16 California Code of Regulations section 1379.19, which incorporated the Standards of Care for California Licensed Midwives by reference into the Board's regulations. Accordingly, this regulation will be repealed. However, given the time and effort invested into creating the Standards of Care, and the usefulness of this document in offering guidance to licensed midwives, Board staff and interested parties have updated the document to bring it into compliance with the provisions of AB 1308, and to reword it as practice guidelines. The guidelines were approved by the Midwifery Advisory Council on March 27, 2014, following a review and discussion with interested parties, and reflect the modifications deemed necessary by the change in the law pursuant to AB 1308.

Significantly, few modifications were required to bring the Board-approved document into compliance with AB 1308. The attached document has incorporated the necessary modifications, indicated via ~~strikethrough~~ for deletions, and <u>underline</u> for additions.

MEDICAL BOARD OF CALIFORNIA

~~**DIVISION OF LICENSING**~~

~~STANDARD OF~~ ~~CARE~~ PRACTICE GUIDELINES FOR CALIFORNIA LICENSED MIDWIVES

~~September 15, 2005~~ March 2014

MIDWIFERY ~~STANDARDS OF CARE~~ PRACTICE GUIDELINES

The California licensed midwife is a professional health care practitioner who offers primary care to healthy women and their normal unborn and newborn babies throughout normal pregnancy, labor, birth, postpartum, the neonatal and inter-conceptional periods.

I. PURPOSE, DEFINITIONS & GENERAL PROVISIONS

A. This document provides a framework to identify the professional responsibilities of licensed midwives and permit an individual midwife's practice to be rationally evaluated, to ensure that it is safe, ethical and consistent with the professional practice of licensed midwifery in California. However, ~~this standard of care is~~ these practice guidelines are not intended to replace the clinical judgment of the licensed midwife.

Sources and documentation used to define and judge professional practice include but are not limited to the following:

1. The international definition of a midwife and the midwifery scope of practice
2. Customary definitions of the midwifery model of care by state and national midwifery organizations, including the Licensed Midwifery Practice Act of 1993 and all it amendments (Business and Professions Code Sections 2505, et seq.)
3. Standards of practice for community midwives as published by state and national midwifery organizations
4. Philosophy of care, code of ethics, and informed consent policies as published by state and national midwifery organizations
5. Educational competencies published by state and national direct-entry midwifery organizations

B. The California licensed midwife ~~shall~~ maintains all requirements of state and, where applicable, national certification, while keeping current with evidence-based and ethical midwifery practice in accordance with:

1. The body of professional knowledge, clinical skills, and clinical judgments described in the **Midwives Alliance of North America** (MANA) Core Competencies for Basic Midwifery Practice
2. The statutory requirements as set forth in the **Licensed Midwifery Practice Act of 1993** ("LMPA"), all amendments to LMPA and the Health and Safety Code on birth registration.
3. The generally accepted guidelines for community-based midwifery practice as published by state and national direct-entry midwifery organizations

C. The California licensed midwife provides care in private offices, physician offices, clinics, client homes, maternity homes, birth centers and hospitals. The licensed midwife provides well-women health services and maternity care to essentially healthy women who are experiencing a normal pregnancy. An essentially healthy woman is without serious pre-existing medical or mental conditions affecting major body organs, biological systems or competent mental function. An essentially normal pregnancy is without serious medical complications affecting either mother or fetus, and is consistent with the definition set forth under Business and Professions Code Section 2507(b)(1).

D. The California licensed midwife provides the necessary supervision, care and advice to women prior to and during pregnancy, labor and the postpartum period, conducts deliveries and cares for the newborn infant during the postnatal period. This includes preventative measures, protocols for variations and deviations from norm, detection of complications in the mother and child, the procurement of medical assistance when necessary and the execution of emergency measures in the absence of medical help.

E. The California licensed midwife's fundamental accountability is to the women in her care. This includes a responsibility to uphold professional standards and avoid compromise based on personal or institutional expediency.

F. The California licensed midwife is also accountable to peers, the regulatory body and to the public for safe, competent, ethical practice. It is the responsibility of the licensed midwife to incorporate ongoing evaluation of her/his practice, including formal or informal sources of community input. This includes but is not limited to the licensed midwife's participation in the peer review process and any required mortality and morbidity reporting. The results of these individual evaluations can be distributed to influence professional policy development, education, and practice.

G. The California licensed midwife is responsible to the client, the community and the midwifery profession for evidence-based practice. This includes but is not limited to continuing education and on-going evaluation and application of new information and improved practices as recommended in the scientific literature. It may also include developing and dispersing midwifery knowledge and participating in research regarding midwifery outcomes.

H. The California licensed midwife ~~shall~~ uses evidence-based policies and practice guidelines for the management of routine care and unusual circumstances by establishing, reviewing, updating, and adhering to individualized practice policies,

guidelines and protocols~~. This shall be~~ appropriate to the specific setting for a client's labor and birth and geographical characteristics of the licensed midwife's practice. Practice-specific guidelines and protocols are customarily implemented through standard or customized chart forms, informed consent and informed refusal documents (including the consent required in Business and Professions Code Section 2508) ~~and treatment waivers~~, other formal and informal documents used routinely for each area of clinical practice, including but not limited to the antepartum intrapartum, postpartum, newborn periods and inter-conceptional period.

I. The licensed midwife's policies, guidelines and protocols ~~shall be~~ are consistent with standard midwifery management as described in standard midwifery textbooks or a combination of standard textbooks and references, including research published in peer-review journals. Any textbook or reference which is also an approved textbook or reference for a midwifery educational program or school ~~shall~~ will be considered an acceptable textbook or reference for use in developing a midwife's individual policies and practice guidelines. When appropriate or requested, citations of scientific source should be made available for client review.

J. The licensed midwife may expand her skill level beyond the core competencies of her training program by incorporating new procedures into the individual midwife's practice that improve care for women and their families. It is the responsibility of the licensed midwife to:

1. Identify the need for a new procedure by taking into consideration consumer demand, standards for safe practice, and availability of other qualified personnel.
2. Ensure that there are no institutional, state, federal statutes or regulations that would constrain the midwife from incorporation of the procedure into her practice.
3. Be able to demonstrate knowledge and competency, including:
   a) Knowledge of risks, benefits, and client selection criteria.
   b) Having a process for acquisition of required skills.
   c) Identifying and managing complications.
   d) Employing a process to evaluate outcomes and maintain professional competency.
4. Identify a mechanism ~~to~~ for obtaining medical consultation, collaboration, and referral related to each new procedure.

II. A BRIEF OVERVIEW OF THE LICENSED MIDWIFE'S DUTIES AND SPECIFIC RESPONSIBILITIES TO CHILDBEARING WOMEN AND THEIR UNBORN AND NEWBORN BABIES

A. The California licensed midwife engages in an ongoing process of risk assessment that begins with the initial consultation and continues throughout the provision of care. This includes continuously assessing for normalcy and, if necessary, initiating appropriate interventions including consultation, referral, transfer, first-responder emergency care and/or emergency transport.

B. Within the midwifery model of care, the licensed midwife's duties to women and babies ~~shall~~ include the following individualized forms of maternity care:

1. Antepartum care and education, preparation for childbirth, breastfeeding and parenthood.
2. Risk assessment, risk prevention and risk reduction.
3. Identifying and assessing variations and deviations from normal and detection of abnormal conditions and subsequently communicating that information to the ~~childbearing~~ woman and, when appropriate, to other health care providers and emergency responders.
4. Maintaining an individual plan for consultation, referral, transfer of care and emergencies.
5. Evidence-based physiological management to facilitate spontaneous progress in labor and normal vaginal birth while minimizing the need for medical interventions.
6. Procurement of medical assistance when indicated.
7. Execution of appropriate emergency measures in the absence of medical help
8. Postpartum care to mother and baby, including counseling and education.
9. Maintaining up-to-date knowledge in evidence-based practice and proficiency in life-saving measures by regular review and practice.
10. Maintenance of all necessary equipment and supplies, and preparation of documents including educational handouts, charts, informed consent & informed refusal documents (including the consent required in Business and Professions Code Section 2508) ~~and treatment waivers~~, birth registration forms, newborn screening, practice policies, guidelines, protocols, and, ~~if required by law~~ morbidity and mortality reports and annual statistics.

III. ~~STANDARD OF PRACTICE~~ GUIDELINES FOR COMMUNITY-BASED MIDWIFERY

~~**STANDARD**~~ **ONE:** The licensed midwife ~~shall be~~ is accountable to the client, the midwifery profession and the public for safe, competent, and ethical care.

~~**STANDARD**~~ **TWO:** The licensed midwife ~~shall~~ ensures that no act or omission places the client at unnecessary risk.

~~**STANDARD**~~ **THREE:** The licensed midwife ~~shall~~, within realistic limits, provides continuity of care to the client throughout the childbearing experience according to the midwifery model of care.

~~**STANDARD**~~ **FOUR:** The licensed midwife ~~shall~~ respects the autonomy of the mentally competent adult woman by working in partnership with her and recognizing individual and shared responsibilities. The midwife recognizes the healthy woman as the primary decision maker throughout the childbearing experience.

~~**STANDARD**~~ **FIVE:** The licensed midwife ~~shall~~ upholds the client's right to make informed choices about the manner and circumstance of ~~normal~~ pregnancy and childbirth, and facilitates this process by providing complete, relevant, objective information in a non-authoritarian and supportive manner, while continually assessing safety considerations and risks to the client ~~and~~, informing her of same.

SIX: The licensed midwife refers the client to a physician, as required by law, if at any point during a pregnancy, childbirth, or postpartum care the client's condition deviates from normal.

~~**STANDARD SIX**~~ **SEVEN:** The licensed midwife ~~shall~~ confers and collaborates with other healthcare professionals, including other midwives, as is necessary to professionally meet the client's needs. When the client's condition or needs exceed the midwife's scope of practice or personal practice guidelines, the licensed midwife ~~shall~~ consults with and refers or transfers the client to a physician or other appropriate healthcare provider.

~~**STANDARD SEVEN**~~ **EIGHT:** Should the pregnancy ~~become high-risk~~ deviate from normal and primary care be transferred to a physician, the licensed midwife may continue to counsel, support and advise the client at her request.

~~**STANDARD EIGHT**~~ **NINE:** The licensed midwife ~~shall~~ maintains complete and accurate health care records.

~~**STANDARD NINE**~~ **TEN:** The licensed midwife ~~shall~~ ensures confidentiality of information except with the client's consent, or as required to be disclosed by law, or in extraordinary circumstances where the failure to disclose will result in immediate and grave harm to the client, baby or other immediate family members or professional care providers.

~~**STANDARD TEN**~~ **ELEVEN:** Where geographically feasible, the licensed midwife ~~shall~~ makes a good faith effort to ensure that a second midwife, or a qualified birth attendant

certified in neonatal resuscitation and cardiopulmonary resuscitation, is available during the delivery.

~~**STANDARD ELEVEN**~~ **TWELVE:** The licensed midwife ~~shall~~ orders, uses or administers only those ~~prescription~~ drugs, supplies, devices and procedures that are consistent with the licensed midwife's professional training as described in 16 CCR 1379.30, community standards and the provisions of LMPA and ~~shall~~ does so only in accordance with the client's informed consent.

~~**STANDARD TWELVE**~~ **THIRTEEN:** The licensed midwife ~~shall~~ orders, performs, collects samples for, or interprets those screening and diagnostic tests for a woman or newborn which are consistent with the licensed midwife's professional training, community standards, and provisions of the LMPA, and ~~shall~~ does so only in accordance with the client's informed consent.

~~**STANDARD THIRTEEN**~~ **FOURTEEN:** The licensed midwife ~~shall~~ participates in the continuing education and evaluation of self, colleagues and the maternity care system.

~~**STANDARD FOURTEEN**~~ **FIFTEEN:** The licensed midwife ~~shall~~ critically assesses evidence-based research findings for use in practice and ~~shall~~ supports research activities.

IV. CRITERIA FOR CLIENT SELECTION

Criteria for initial selection of clients for community-based midwifery care assumes:

- Healthy mother without serious pre-existing medical or mental conditions
- History, physical assessment and laboratory results within limits commonly accepted as normal and consistent with Business and Professions Code Section 2507(b)(1) with no clinically significant evidence of the following~~:~~, including but not limited to:

  a. cardiac disease
  b. pulmonary disease
  c. renal disease
  d. hepatic disease
  e. endocrine disease
  f. neurological disease
  g. malignant disease in an active phase
  h. significant hematological disorders or coagulopathies
  i. essential hypertension (~~BP~~ blood pressure ~~>>~~ greater than 140/90 on two or more occasions, six hours apart)
  j. insulin-dependent diabetes mellitus
  k. serious congenital abnormalities affecting childbirth
  l. family history of serious genetic disorders or hereditary diseases that may impact on the current pregnancy
  m. adverse obstetrical history that may impact on the current pregnancy
  n. significant pelvic or uterine abnormalities, including tumors, malformations, or invasive uterine surgery that may impact on the current pregnancy~~.~~
  o. isoimmunization
  p. alcoholism or abuse
  q. drug addiction or abuse
  r. positive HIV status or AIDS
  s. current serious psychiatric illness
  t. social or familiar conditions unsatisfactory for domiciliary birth services
  u. other significant physical abnormality, social or mental functioning that affects pregnancy, parturition and/or the ability to safely care for a newborn
  v. other as defined by the licensed midwife

V. RISK FACTORS IDENTIFIED DURING THE INITIAL INTERVIEW OR ARISING DURING THE COURSE OF CARE

~~A. Responsibility of the Licensed Midwife~~

With respect to the care of a client ~~with a significant risk factor~~ who deviates from a normal pregnancy as identified by the client selection criteria in section IV or other science-based parameters, the licensed midwife ~~shall inform the client about the known material risks and benefits of continuing with midwifery care relative to the identified risk factor and shall recommend to the client that her situation be evaluated by a medical practitioner and if appropriate, to transfer her primary care to a licensed physician who has current training and practice in obstetrics.~~ informs the client that her situation must be evaluated by a licensed physician who has current training and practice in obstetrics and gynecology. If the physician 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, the licensed midwife can continue to provide primary care. The client should further be informed that unresolved significant risk factors will limit the scope of the midwife's care to concurrent care with a physician, regardless of whether the woman has consented to care or refused care by a physician.

It is recognized that the client has the right to refuse the recommended referral; however, pursuant to the law, the licensed midwife cannot continue care. The licensed midwife will document refusal of the referral in the client's record.

B. ~~Client's Rights to Self-Determination~~

~~In recognition of the client's right to refuse that recommendation as well as other risk-reduction measures and medical procedures, the client may, after having been fully informed about the nature of the risk and specific risk-reduction measures available, make a written informed refusal. If the licensed midwife appropriately documents the informed refusal in the client's midwifery records, the licensed midwife may continue to provide midwifery care to the client consistent with evidence-based care as identified in this document and the scientific literature.~~

VI. ANTEPARTUM REFERRAL

- **To define and clarify minimum practice ~~requirements~~ guidelines for the safe care of women and infants in regard to ANTEPARTUM PHYSICIAN CONSULTATION, REFERRAL & TRANSFER OF CARE**

The licensed midwife ~~shall~~ consults with a physician and/or other health care professional whenever there are ~~significant~~ deviations from normal (including abnormal laboratory results) during a client's pregnancy. If a referral to a physician is needed, pursuant to Business and Professions Code Section 2507, the licensed midwife will, if possible, remain in consultation with the physician until resolution of the concern. ~~It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes, during the pregnancy and, if possible, being present during the labor and birth and resuming postpartum care if appropriate.~~

The following conditions, occurring after acceptance ~~for domiciliary~~ of care with a licensed midwife, require ~~physician consultation by the midwife or~~ client referral to a physician and may require transfer of care of the client to a medical health care provider. A referral for immediate medical care does not preclude the possibility of ~~a domiciliary labor and birth if, following the referral, the client does not have or no longer has, any of the conditions set out in this section.~~ care with a licensed midwife if a physician who has current training in obstetrics and gynecology determines, after an examination, 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.

Antepartal Conditions that deviate from normal pregnancy conditions include, but are not limited to:

Maternal:

a. positive HIV antibody test
b. threatened or spontaneous abortion after 14 weeks
c. significant vaginal bleeding
d. persistent vomiting with dehydration
e. symptoms of malnutrition or anorexia
f. protracted weight loss or failure to gain weight
g. gestational diabetes, uncontrolled by diet
h. severe anemia, not responsive to treatment
i. severe or persistent headache
j. evidence of pregnancy induced hypertension (PIH) or pre-eclampsia (2 blood pressure readings ~~>than~~ greater than 140/90, 6 hours apart)
k. deep vein thrombosis (DVT)
l. urinary tract infection (UTI)
m. significant signs or symptoms of infection
n. isoimmunization, positive Rh antibody titer for Rh-negative mother, or any other positive antibody titer which may have a detrimental effect on mother or fetus
o. documented placental anomaly or previa
p. documented low lying placenta in woman with history of previous cesarean

q. preterm labor (before the completion of the ~~37th week of gestation~~ 37 0/7 completed weeks of pregnancy)
r. premature rupture of membranes (before 37 0/7 completed weeks of pregnancy)
s. pregnancy with non-reactive stress test and/or abnormal biophysical profile or amniotic fluid assessment
t. Post-term pregnancy defined as gestation greater than 42 0/7 weeks
u. other as defined by the Midwife

Fetal:

a. lie other than vertex at term
b. multiple gestation
c. fetal anomalies compatible with life which are affected by site of birth
d. marked decrease in fetal movement, abnormal fetal heart tones (FHTs) non-reassuring non-stress test (NST)
e. marked or severe poly- or oligo-hydramnios (too much or too little amniotic fluid)
f. evidence of intrauterine growth restriction (IUGR)
g. significant abnormal ultrasound findings
h. other as defined by the licensed midwife

VII. INTRAPARTUM REFERRAL

- **To define and clarify minimum practice ~~requirements~~ guidelines for the safe care of women and infants in regard to INTRAPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife ~~shall~~ consults with a physician and/or other health care professional whenever there are ~~significant~~ deviations from normal during a client's labor and birth, and/or with her newborn. If a referral to a physician is needed pursuant to Business and Professions Code Section 2507, the licensed midwife will, if possible, remain in consultation with the physician ~~until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible,~~ in accordance with the client's wishes, remain~~ing~~ present throughout the birth and ~~resuming~~ resume postpartum care if appropriate.

A. The following conditions require referral to a physician ~~consultation~~ and may require transfer of care. ~~Consultation~~ Referral does not preclude the possibility of return to ~~domiciliary labor and birth~~ care with a licensed midwife if~~, following the consultation, the client does not have any of the conditions set out in this section.~~ a physician who has current training in obstetrics and gynecology 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.

Intrapartum Conditions - Serious medical/obstetrical or perinatal conditions, including but not limited to:

Maternal:

a. prolonged lack of progress in labor
b. abnormal bleeding, with or without abdominal pain; evidence of placental abruption
c. rise in blood pressure above woman's baseline (more than 30/15 points or greater than 140/90) with proteinuria
d. signs or symptoms of maternal infection
e. signs or symptoms of maternal shock
f. client's request for transfer to obstetrical care
g. active genital herpes lesion in labor
h. gestation greater than 42 0/7 weeks

Fetus:

a. abnormal fetal heart tones (FHT)
b. signs or symptoms of fetal distress
c. thick meconium or frank bleeding with birth not imminent
d. lie not compatible with spontaneous vaginal delivery or unstable fetal lie

B. Emergency Transport: If on initial or subsequent assessment during the 1st, 2nd or 3rd stage of labor, one of the following conditions exists, the licensed midwife ~~shall~~ initiates immediate ~~consult with a physician and/or~~ emergency transfer to medical care. Transport via private vehicle is an acceptable method of transport if, in the clinical judgment of the licensed midwife, that is the safest and most expedient method to access medical services.

a. prolapsed umbilical cord
b. uncontrolled hemorrhage
c. preeclampsia or eclampsia
d. severe abdominal pain inconsistent with normal labor
e. chorioamnionitis
f. ominous fetal heart rate pattern or other manifestation of fetal distress
g. seizures or unconsciousness in the mother
i. evidence of maternal shock
j. presentation not compatible with spontaneous vaginal delivery
k. laceration requiring repair outside the scope of practice or practice policies of the individual licensed midwife
l. retained placenta or placental fragments
m. neonate with unstable vital signs
n. any other condition or symptom which could threaten the life of the mother, fetus, or neonate as assessed by the licensed midwife exercising ordinary skill and knowledge.

C. **Emergency Exemptions Clause - Business and Professions Code Section 2058 – Medical Practice Act**

The California licensed midwife may deliver a woman with any of the above complications or conditions, or other bona fide emergencies, if the situation is a verifiable emergency and no physician or other equivalent medical services are available. **EMERGENCY** is defined as a situation that presents an immediate hazard to the health and safety of the client or entails extraordinary and unnecessary human suffering.

D. The California licensed midwife provides records, including prenatal records, and consults with the receiving physician about labor up to the point of transfer to a hospital.

VIII. POSTPARTUM REFERRAL

- **To define and clarify minimum practice ~~requirements~~ guidelines for the safe care of women and infants in regard to POSTPARTUM PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT**

The licensed midwife ~~shall~~ consults with a physician and/or other health care professional whenever there are ~~significant~~ deviations from normal (including abnormal laboratory results) during the postpartum period. If a referral to a physician who has current training and practice in obstetrics and gynecology is needed, the licensed midwife may resume postpartum care if the physician 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 affect the client's postpartum care. ~~will remain in consultation with the physician until resolution of the concern. It is appropriate for the licensed midwife to maintain care of her client to the greatest degree possible, in accordance with the client's wishes.~~

A. Immediate Postpartum Conditions.

The licensed midwife ~~shall~~ arranges for immediate referral and transport according to the emergency plan identified in the informed consent document if the following abnormal conditions are present:

a. uterine prolapse or inversion
b. uncontrolled maternal hemorrhage
c. seizure or unconsciousness
d. sustained on-going instability or abnormal vital signs
e. adherent or retained placenta~~;~~
f. repair of laceration(s)/episiotomy beyond licensed midwife's level of expertise
g. anaphylaxis
h. other serious medical or mental conditions

B. Extended Postpartum Condition.

The licensed midwife ~~shall~~ arranges for physician consultation, client referral and/or transport when/if:

a. signs or symptoms of maternal infection
b. signs of clinically significant depression
c. social, emotional or other physical conditions as defined by the licensed midwife and outside her scope of practice.

IX. ~~NEONATAL~~ NEONATE REFERRAL

- **To define and clarify minimum practice ~~requirements~~ guidelines for the safe care of women and infants in regard to PHYSICIAN CONSULTATION, REFERRAL & ELECTIVE TRANSFER OF CARE & EMERGENCY TRANSPORT OF THE NEONATE**

The licensed midwife ~~shall~~ consults with a physician or other health care practitioner whenever there are ~~significant~~ deviations or complications relative to the newborn. If a referral to a physician is needed, the licensed midwife will, if possible, remain in consultation with the physician ~~until resolution of the concern. It is appropriate for the licensed midwife to continue caring for her client to the greatest degree possible, in accordance with the client's wishes, during the postpartum/postnatal period~~.

The following conditions ~~require~~ will prompt referral to a physician ~~physician consultation or client referral~~ and may require transfer of care.

A. Neonatal Conditions: The licensed midwife ~~shall~~ arranges for immediate ~~consultation~~ referral and transport according to the emergency plan identified in the informed consent document if the following conditions exist~~.~~:

a. Apgar score of 6 or less at five minutes of age, without significant improvement by 10 minutes
b. persistent respiratory distress
c. persistent cardiac irregularities
d. persistent central cyanosis or pallor
e. persistent lethargy or poor muscle tone
f. prolonged temperature instability
g. significant signs or symptoms of infection
h. significant clinical evidence of glycemic instability
i. seizures
j. abnormal bulging or depressed fontanel
k. birth weight <2300 grams
l. significant clinical evidence of prematurity
m. clinically significant jaundice apparent at birth
n. major or medically significant congenital anomalies
o. significant or suspected birth injury
p. other serious medical conditions
q. parental request

B. Postnatal Care: The licensed midwife ~~will~~ arranges for ~~consultation,~~ referral or transport for an infant who exhibits the following:

a. abnormal cry
b. diminished consciousness
c. inability to suck

d. passes no urine in 30 hours or meconium in 48 hours after delivery or inadequate production of urine or stool during the neonatal period
e. clinically significant abnormalities in vital signs, muscle tone or behavior
f. clinically significant color abnormality- cyanotic, pale, grey
g. abdominal distension, projectile vomiting
h. jaundice within 30 hours of birth
i. significant signs or symptoms of infection
j. abnormal lab results
k. signs of clinically significant dehydration or failure to thrive
l. other concerns of family or licensed midwife