State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board and Committee Meetings
Sacramento, CA

July 24-25, 2014

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

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

July 24 – 25, 2014

Thursday, July 24

- **9:00 a.m. – 12:00 p.m.** **Panel A (Golden State C&D Room)**
  (*Members: Yaroslavsky (Chair), Bishop, Lewis, Serrano Sewell, Wright, Yip)*

- **8:30 a.m. – 12:00 p.m.** **Panel B (Golden State A&B Room)**
  (Members: GnanaDev (Chair), Krauss, Levine, Lui, Pines, Schipske)

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

- **1:00 p.m. – 2:00 p.m.** **Licensing Committee (Golden State A&B Room)**
  (Members: Bishop (Chair), Lewis, Pines, Schipske, Wright)

- **2:15 p.m. – 3:45 p.m.** **Education and Wellness Committee (Golden State A&B Room)**
  (Members: Yaroslavsky (Chair), Krauss, Pines, Schipske)

- **4:00 p.m. – 6:00 p.m.** **Full Board Meeting (Golden State A&B Room)**
  (All Members)

Friday, July 25

- **9:00 a.m. – 3:00 p.m.** **Full Board Meeting (Golden State A&B Room)**
  (All Members)

MEDICAL BOARD OF CALIFORNIA

PANEL A MEETING AGENDA

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

Courtyard by Marriott – Cal Expo
Golden State C&D Room
1782 Tribute Road
Sacramento, CA 95815
916.929.7900 (directions only)

Thursday, July 24, 2014
9:00 a.m. – 12:00 p.m.
(or until completion of business)

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

While the Panel intends to webcast this meeting, it may not be possible to webcast due to limitations on resources

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

1. Call to order/Roll Call

2. **Oral Argument on Nonadopted Proposed Decision**

   ALI, Mohamed Sadat, M.D.

9:45 a.m. *CLOSED SESSION – Nonadopted Proposed Decision

   ALI, Mohamed Sadat, M.D.

3. ***CLOSED SESSION**

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

4. **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 Lisa Toof 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.

Courtyard by Marriott – Cal Expo
Golden State A&B Room
1782 Tribute Road
Sacramento, CA 95815
916.929.7900 (directions only)

Thursday, July 24, 2014
8:30 a.m. – 12:00 p.m.
(or until completion of business)

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

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ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

8:30 a.m. OPEN SESSION

1. Call to Order / Roll Call

2. **Oral Argument on Nonadopted Proposed Decision**

   MORGAN, Loren, M.D.

9:15 a.m. *CLOSED SESSION – Nonadopted Proposed Decision

   MORGAN, Loren, M.D.

3. ***CLOSED SESSION**

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

4. **OPEN SESSION**

   Adjournment

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MEDICAL BOARD OF CALIFORNIA

LICENSING COMMITTEE
MEETING AGENDA

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

Thursday July 24, 2014
1:00 p.m. – 2:00 p.m.
(or until the conclusion of business)

Teleconference – see attached
Meeting Information

MEMBERS OF THE LICENSING COMMITTEE
Michael Bishop, M.D., Chair
Ronald Lewis, M.D.
Denise Pines
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.

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

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

4. Presentation on American Board of Medical Specialties, Maintenance of Certification – Ms. Clothier, Vice President, State Health and Public Affairs

5. Review, Discussion and Consideration of the Minimum Number of Years of Approved Postgraduate Training Required for Licensure, and Licensure Exemption While Participating in an Approved Postgraduate Training Program – Mr. Worden/Ms. Webb

6. Future Agenda Items

7. 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) 230-1093.

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 three minutes per agenda item. However, during Agenda Item **2** – Public Comments on Items Not on the Agenda, the Board 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.

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Agenda Item 3

MEDICAL BOARD OF CALIFORNIA

LICENSING COMMITTEE MEETING

Embassy Suites – Burlingame
Santa Cruz Room
150 Anza Blvd.
Burlingame, CA 94010

Thursday, January 31, 2013

MINUTES

Agenda Item 1 Call to Order / Roll Call

Dr. Salomonson called the Licensing Committee meeting to order on January 31, 2013, at 1:48 p.m. Ms. Lowe called the roll. A quorum was present and notice had been sent to interested parties.

Members Present:
Janet Salomonson, M.D., Chair
Michael Bishop, M.D.
Silvia Diego, M.D.
Denise Pines

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

Staff Present:
Douglas Becker, Investigator
Dianne Dobbs, Department of Consumer Affairs, Legal Counsel
Tim Einer, Administrative Assistant
Kurt Heppler, Staff Counsel
Kimberly Kirchmeyer, Deputy Director
Natalie Lowe, Licensing Manager
Armando Melendez, Business Services Analyst
Regina Rao, Business Services Analyst
Lisa Toof, Administrative Assistant
Victor Sandoval, Supervising Investigator I
Kevin Schunke, Outreach Manager
Jennifer Simoes, Chief of Legislation
Melinda Sundt, Investigator
See Vang, Business Services Analyst
Linda Whitney, Executive Director
Curtis J. Worden, Chief of Licensing

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Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants (CAPA)
Angela Blanchard, California Association of Nurse Anesthetists (CANA)
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente

Agenda Item 2 Public Comments on Items Not on the Agenda
No public comment was offered.

Agenda Item 3 Approval of Minutes from the February 2, 2012 Meeting
Ms. Pines made a motion to approve the minutes from the October 25, 2012 meeting; s/Diego. Motion carried.

Agenda Item 4 Update on Licensing Staffing
Mr. Worden thanked staff for continuing to do an excellent job for this quarter, especially considering the impact of the holidays and the considerable amount of time staff is spending on the BreEZe project. Mr. Worden announced that Licensing currently has 2.8 vacant Office Technician (OT) positions. One is a .8 position for the front-end, one for fictitious name permits, and one for the call center. In addition, the Licensing Program has authorization to hire up to four Seasonal Clerk positions, which will be used to replace the Student Assistant positions. Licensing Managers are in the process of conducting interviews and are following up on candidates. In addition, Licensing has tentative permission to hire six Staff Services Analyst Permanent Intermittent positions that will be replacing the Retired Annuitants. Two of the Retired Annuitants were released on January 15, 2013, and four remain. Two of the four Retired Annuitant positions will be released in April 2013, and the last two will be released at the end of June 2013. Licensing staff has been doing an excellent job in maintaining the workload. Managers will continue to monitor and manage the workload, and will try to maintain the workload goals.

Dr. Salomonson asked for clarification about the .8 position and the reason for releasing the Student Assistant and Retired Annuitant positions.

Mr. Worden stated one of the OT positions is a .8 position that is not full-time and is allotted 32 hours a week. Mr. Worden explained that last year the Governor instructed state agencies to release all Student Assistant positions and consider replacement with Seasonal Clerk positions. The Governor also instructed release of Retired Annuitant positions and consider replacement with Permanent Intermittent positions. However, the Medical Board of California (MBC) received an exemption to temporarily keep some Retired Annuitant positions until June 2013 that were deemed mission critical. Student Assistant positions were not deemed mission critical.

Dr. Salomonson asked if the Seasonal Clerk staff took classes, similar to the Student Assistant staff.

Mr. Worden replied that the students must meet certain requirements, such as being enrolled in college. If the students dropped out of school or their grades dropped below a certain grade point average, they were no longer eligible to be employed. The Licensing Program had four Student Assistant positions that were released due to the Governor's agreement with the union and to replace Student Assistant positions with Seasonal Clerk positions.

Dr. Salomonson asked Mr. Worden if a Student Assistant can apply as a Seasonal Clerk.

Mr. Worden explained that there are specific rules within the state hiring system, but they may be eligible.

Dr. Salomonson stated that it seems unfortunate that initially MBC was supporting students by hiring them for work, and now they can no longer remain employed because they are a student.

Mr. Worden stated the students can work much more during their break times than during their scheduled school times. However, for the Seasonal Clerk and Permanent Intermittent positions, the Licensing Program can have much more control over their schedules because they can be adjusted. Although there are limited hours, they can be adjusted from part-time to full-time as workload increases.

Agenda Item 5 Updates on the Business Process Reengineering (BPR) Primary Recommendations

Mr. Worden provided an update on the BPR primary recommendations.

A. Revision of Physician and Surgeon (P&S) Application and Streamlining Process

Mr. Worden stated that the revised P&S application and instructions were posted to the Board's website in October 2012. The revised application clarified previous areas that were confusing to applicants and the print is a little larger in certain areas. As with any new application revision, other areas were discovered that need modifying as well. Staff will be making some minor revisions to the application and instructions in the next few months. One of the revisions will be to add some additional information for the applicants who qualify under Business and Professions Code (B&P) Section 2135.7.

Dr. Salomonson asked Mr. Worden to remind the audience about the candidate pool that will be affected by B&P Section 2135.7.

Mr. Worden replied that B&P Section 2135.7 is the new pathway that became effective January 1, 2013, for applicants who either attended and/or graduated from an unrecognized or disapproved medical school. Even though someone may have graduated from a recognized medical school and received part of their medical school education from an unrecognized or disapproved medical school, they were previously not eligible to apply for a California P&S license.

Dr. Salomonson asked if the final legislation reflected that the applicant needed to be board certified so that their educational bar is higher than other applicants.

Mr. Worden replied the education bar is higher as far as the board certification requirement.

Dr. Salomonson asked about the number of years required to practice in another state.

Mr. Worden replied that for someone who attended an unrecognized school, it is a minimum of 10 years. For a person who attended a disapproved school, it is a minimum of 20 years.

Dr. Bishop asked Mr. Worden if MBC received any applications for those interested in that process.

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Mr. Worden replied that the Licensing Program has an applicant who has met the requirements. The application is going to be presented to the Application Review Committee. Another applicant submitted an application and will be advised of the new minimum years of practice. This applicant will probably be able to meet the requirements once the minimum required number of practicing years is met.

B. Medical Board of California Website Related to Applications
Mr. Worden stated that staff has been reviewing the website and making updates. This project is moving slowly because several staff members are working on the BreEZe project, which takes priority.

Dr. Salomonson asked which department handles the maintenance of the MBC website.

Mr. Worden replied that most of the maintenance is controlled by MBC staff, but some are housed at the Department of Consumer Affairs (DCA). Depending where the particular function of the website is hosted, depends on who is responsible for maintaining it.

Dr. Salomonson asked whom should complaints be directed to regarding Physician Lookup.

Mr. Worden replied that going through the MBC website and asking the Webmaster for assistance is the easiest way to receive help because the Webmaster will route the questions to the appropriate manager.

Dr. Salomonson stated that a spelling error in a physician's name may prompt a Google search if they had not found their doctor on the MBC website because they thought their doctor was unlicensed. There could be one letter off in the name and there is no flexibility in the current look up system to allow for a more sophisticated search.

Mr. Worden stated that this issue is controlled at the DCA level. It is something that DCA and MBC are aware of and hopefully it will be changed in the future.

C. Revision of the Policy and Procedure Manual
Mr. Worden stated that the policy and procedure manual has not been worked on because the staff member responsible for it has been spending approximately 80 percent of his time on the BreEZe project. The other 20 percent of the time is spent processing applications. Once BreEZe is implemented, time can be redirected back to revising/updating the manual.

Agenda Item 6 Update on Strategic Plan Components
Mr. Worden stated that several of the 13 components of the 2012 Strategic Plan designated to the Licensing Program are not slated until 2013 or 2014 so the Licensing Program has not started them at this time. However, staff has made progress in the remaining Strategic Plan goals. One of the goals is regarding international medical schools. Two staff members are assigned to review the medical schools list that is on the MBC's website. The staff have been contacting medical schools to find out if they still meet the requirements to be on the approved international medical school list, and have sent out several letters. Some schools respond quickly and others do not. Some of the schools respond in English and some do not. The other schools that staff is reviewing are the schools that have applied with a self-assessment report. Staff have contacted the medical schools to get further information for the applicants who have attended a

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medical school that may not be recognizable. In addition, staff have been working on how to contact the medical schools and staff have had to conduct a lot of research to obtain current addresses. There are approximately 1,600 medical schools on the list so it is a slow process.

Furthermore, the MBC believes that some of the functions that the Licensing Program currently handles regarding specialty board certification may not be a good a fit for MBC and it is being reviewed in the Sunset Review process.

Dr. Salomonson asked for clarification regarding the specialty boards.

Mr. Worden stated that MBC has the authority to review specialty boards that are not American Board of Medical Specialties (ABMS) certified. To date, MBC has approved only four specialty boards. It was determined that MBC may not be the best fit to conduct the reviews so this recommendation was added to the Sunset Review Report.

Mr. Worden stated that Objective 5.1 is the Licensing Program's goal to review applications within 45 days of receipt. This goal has been met for both quarters of the fiscal year, and the staff has been reviewing applications under 35 days for both United States (U.S.) and international medical school graduates.

Agenda Item 7 Update on Physician Supervision Requirements for Allied Health Care Professions: Perfusionists and Anesthesia Technologist/Technician

Mr. Worden provided an update on physician supervision requirements for perfusionists and anesthesia technologists and technicians.

Dr. Salomonson asked if perfusionists are registered.

Mr. Worden replied that they are not registered or licensed by anyone in California.

Dr. Salomonson asked what MBC's interface is with perfusionists.

Mr. Worden replied that MBC does not interface with perfusionists; however, if someone filed a complaint against a perfusionist, MBC would look into the complaint, but they are not a licensee. It is the physician who is responsible for the perfusionist that the MBC would review.

Dr. Bishop stated that his hospital has a lot of anesthesia technologists and technicians as they are very important to their practice. The anesthetist assistant is the category that he believed Ms. Schipske wanted to discuss.

Mr. Worden stated anesthesiologist assistants are very similar to a nurse anesthetist. They have a little different education pathway. They do more pre-medical and also an anesthesia Master's Program. The program is only recognized in approximately five states and those states do have certification or licensing, although it is limited. They have a limited school set and they have a limited practice area, but California is not one of the states.

Dr. Salomonson stated for the lay public the categories of assistant, technician, and technologist can be

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confusing. Even if they are identifying themselves correctly, it can still be confusing as to what the scope of practice is for these individuals. Dr. Salomonson asked if there were any thoughts on how they can be clarified further. She also stated she did not believe technicians have patient contact.

Dr. Bishop replied that technicians do have patient contact. In many hospitals the technicians are there to assist and they are integrally involved in what physicians do in many cases. The assistant does the anesthesia under the supervision of an anesthesiologist, just like a certified registered nurse anesthetist. Dr. Bishop agrees that information on the MBC website would help clarify for the public about the different allied healthcare profession's roles and responsibilities.

Dr. Salomonson asked if nurse anesthetists are receiving doctorates now.

Dr. Bishop replied that it used to be a Master's Program, but the trend is now more towards a doctorate.

Agenda Item 8 Discussion and Consideration of the Accreditation Council for Graduate Medical Education – International (ACGME-I) and Royal College Canada International (RCCI) Accredited Postgraduate Training Programs

Mr. Worden stated for licensure in California, MBC recognizes postgraduate training from two accreditation agencies. The Accreditation Council for Graduate Medical Education (ACGME) and The Royal College of Physicians and Surgeons of Canada. Both of those entities have developed international accreditation-type programs. They are called the ACGME-I and the RCCI Program. The differences are that ACGME-I has approximately 33 accredited programs in Singapore, and they use a similar accreditation process as used in the U.S. The Canadians have not accredited any programs yet, but they have set up other programs in other countries. Since they are an accreditation business, after they do some monitoring of the programs, they will more than likely start accrediting them as they have done this in Katar, China, and in some other countries. Mr. Worden would like the Licensing Program to monitor these schools because there are currently no other states that accept these accreditation programs, but these accrediting bodies currently have ACGME programs, which is what MBC and Canada accepts.

In addition, it is Mr. Worden's belief that at some point of time, MBC will be asked for the acceptance of this postgraduate training. This will become a bigger issue as more U.S. medical schools partner with international medical schools. Mr. Worden believes that ACGME-I started in Singapore because Duke University has a medical school in association with Singapore University, which is an American-based medical school. It is taught in American-medicine style and is a four-year medical school versus Singapore's six-year medical school. In addition, some of the Canadian programs have some of their curriculum in Australia, Haiti, Chile, India, Saudi Arabia, and China. Mr. Worden stated the Licensing Committee will hopefully direct the Licensing Program to continue to monitor these medical schools and provide to the Licensing Committee new information as it is received so that they can be more on the forefront of this issue, instead of being retroactive and trying to catch up.

Dr. Bishop asked if there has been any input from the Federation of State Medical Boards (FSMB) as it seems that they would have to be a stakeholder as well.

Mr. Worden agreed that FSMB is a stakeholder and added that the Licensing Program discovered that if an applicant is in a postgraduate training program, that a U.S. medical school has to sponsor them to take

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USMLE Step 3. International medical schools do not necessarily have that sponsorship; however, some of the U.S. based schools open these types of schools and may sponsor it in the future.

Mr. Worden stated that FSMB is very interested in this issue. MBC just recognized the Singapore Duke University Medical School, which some programs send some of their students there to train and bring them back. Mr. Worden stated that MBC currently does not recognize international postgraduate training programs, but does recognize U.S. and Canadian-based programs. Approval of postgraduate training for the entities that MBC uses is in regulation and this is something to monitor in case MBC needs to modify the regulations in the future.

Dr. Salomonson reminded people that USMLE Step 3 no longer has English proficiency as a separate test. The only test of English proficiency is USMLE Step 2, Clinical Skills, where physical exams and history of physicals are done on standardized patients who report whether or not they understood the person, and they already know the questions ahead of time. There may be people who have done none of their clinical training in an English speaking country and the only test of their language abilities will be this limited sampling at USMLE Step 2, Clinical Skills. Dr. Salomonson stated there are two types of international students. Those for whom English was their first language, either because they were born in the U.S. and they were training internationally or they come from an English speaking country. Dr. Salomonson stated that it is important to be aware of what this may mean in terms of communication. Staff may want to modify the regulations with the English assessment in mind if there is no clinical training done in the U.S. and all training is done internationally.

Mr. Heppler stated that he does not believe a motion is necessary as the Licensing Committee can direct staff through its action to continue to monitor the situation and report back to the Licensing Committee for guidance.

Dr. Salomonson asked if staff should report on it once a year.

Mr. Worden replied that he suggests staff can report back to the Licensing Committee as new information is developed, and Dr. Salomonson agreed.

Agenda Item 9 Discussion and Consideration to Update Existing Statutes and/or Regulations for Board Recognition of Postgraduate Training due to ACGME/American Osteopathic Association AOA/AACOM Merger: Recommendation Full Board

The Doctor of Osteopathic (D.O.) schools have their own accreditation program for postgraduate training by the American Osteopathic Association (AOA). Most of those training programs are done in hospitals that are accredited by the AOA accrediting body for hospitals, not the Joint Commission. There are some hospitals that are accredited by the Joint Commission, but it is usually a secondary step in order to get ACGME accreditation. As ACGME and AOA have agreed to have ACGME accredit all postgraduate training programs for both M.D. and D.O. graduates, the Joint Commission will no longer be required. The law specifically states that MBC only recognizes ACGME postgraduate training acquired in a hospital that is accredited by the Joint Commission. As they merge, MBC will have applicants with postgraduate training programs in hospitals that are not Joint Commission-accredited. The Licensing Committee will need to advise the full Board of the need to modify B&P Section 2089.5 to include the accrediting body of

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the AOA so that MBC is not excluding people from licensure because they went to postgraduate training at a hospital that was not accredited.

Dr. Diego asked if the D.O. doctors are going to apply to MBC for licensure.

Mr. Worden explained that there is no longer going to be separate training for a D.O. It is all going to be ACGME accredited training. In California and in most states that license D.O.s, they can participate in either program. However, MBC only licenses M.D.s and only accepts ACGME and does not accept the AOA postgraduate training. MBC needs the law to be updated because it states that MBC only accepts ACGME programs and it states it has to be at a Joint Commission hospital. Most of the hospitals that have a D.O. program are accredited by the AOA accrediting body. The Licensing Program does not want M.D. students to participate in a postgraduate training program and not be eligible for licensure in California.

Dr. Salomonson asked if the Joint Commission and the accrediting body are the same.

Mr. Worden replied that they are very similar and some very large hospitals are accredited by them. Some of the hospitals have two accreditations so they can have both programs, but they will not need that anymore.

Mr. Worden stated that he foresees these changes happening very quickly. Fortunately, it is a good time for this to occur because MBC is currently under Sunset Review.

Dr. Salomonson asked if staff foresees any concern.

Mr. Worden replied that he does not see any concern with the postgraduate training since they are going towards the ACGME models. According to ACGME, there are approximately 1,000 D.O.s in ACGME slots. Mr. Worden added that the main focus is the M.D. students who should not be punished for attending a postgraduate training program that they believe is accredited by MBC, but cannot be licensed in California due to a technicality.

Dr. Bishop stated it sounds to him that the different shades between a M.D. and D.O. are progressively blurring and asked Mr. Heppler if there is any speculation that the two boards will merge.

Mr. Heppler replied that it is plausible and he believes there is a code that states the two boards should be treated somewhat synonymously in some areas, so the natural progression would be in that direction.

Dr. Diego asked if it is the schools that are merging or the hospitals.

Mr. Worden replied that it is the accreditation of postgraduate training for both M.D.s and D.O.s that will be one accreditation verses two different accreditations. It was announced that ACGME is going to be the accrediting body.

Mr. Heppler stated the Joint Commission's full name is no longer Joint Commission on Accreditation of Hospitals; it is Joint Commission so the change will need to be made for clarity. Also, since it was only a single accreditation, staff need to add the AOA accreditation. It is either the Joint Commission or the AOA

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component.

Mr. Worden agreed that it is clarifying the Joint Commission name and adding the Osteopathic Health Facilities Accreditation Program.

Dr. Salomonson asked what is needed for the statute and/or regulation changes to be made.

Mr. Heppler stated that it is a statutory change so the Licensing Committee would recommend to the full Board to amend this section of law to clarify the issue identified in Mr. Worden's outline.

Dr. Salomonson asked if there was a motion to proceed with making the statutory changes.

Dr. Bishop made a motion for the Licensing Committee to recommend to the full Board the statutory changes to clarify the Joint Commission name and add the Osteopathic Health Facilities Accreditation Program; s/Diego. Motion carried.

Agenda Item 10 Agenda Items for the April 25-26, 2013 Meeting in the Los Angeles Area

- Dr. Salomonson requested a discussion about the surgery center's accreditation process, including what privileges are given to the physicians and surgeons who practice at the facility that they are potentially going to accredit.

Agenda Item 11 Adjournment

Meeting adjourned at 2:39 p.m.

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

DRAFT

Agenda Item 4

State Health Policy and Public Affairs

Carol Clothier joined the American Board of Medical Specialties (ABMS) in March 2011 as Vice President for State Health Policy and Public Affairs. She is responsible for providing strategic leadership and operational oversight to a program of state policy development and advocacy to state medical boards, state legislatures and other policy organizations.

Clothier has over 20 years of communications, strategic planning and health policy experience, including a 15-year tenure with the Federation of State Medical Boards (FSMB), where she served as vice president for strategic planning and physician competence initiatives, vice president of examination and post-licensure assessment services and assistant vice president for communications and education. During her time at FSMB, Clothier assisted in the strategic management and oversight for initiatives aimed at improving health care quality through physician licensing, including the addition of a test of clinical and communication skills to the national medical licensing examination for physicians and the development of policy recommendations for use by state medical boards in assuring physician licensees maintain their competence throughout their professional careers.

Clothier most recently worked as a consultant to ABMS, where she helped guide the Board of Directors to a decision to create a State Medical Board Outreach Program.
Her professional experience also includes roles with the American Hospital Association in Irving, Texas, Cornerstone Health Management in Dallas, Texas, and Horizon Health Management Company in Oak Brook, Illinois.

ABMS Board Certification: For the Public and the Profession

Carol Clothier
Vice President, State Health Policy and Public Affairs

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Presentation Outline

- Introduction to ABMS
- Requirements for Programs of Continuing Certification
- Updated Standards for MOC
- Processes for managing disciplinary actions
- Aligning MOC and State Licensure Requirements

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ABMS Mission

The mission of the American Board of Medical Specialties (ABMS) is to serve the public and the medical profession by improving the quality of health care through setting professional standards for lifelong certification in partnership with Member Boards.

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ABMS: A Community of Boards

- Umbrella organization of 24 Member Boards
  - 35 member Board of Directors, six of whom are public members
  - Education, advocacy, support services
- Member Boards are independent organizations
  - Over 750,000 practicing physicians in the US are certified by one (or more) of ABMS' 24 Member Boards
  - 65% have time-limited certificates (93% projected by 2020)
  - Over 450,000 Diplomates currently meeting Maintenance of Certification (MOC) requirements

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ABMS Member Boards

37 specialties and 123 Sub-specialties

- Allergy and Immunology
- Anesthesiology
- Colon and Rectal Surgery
- Dermatology
- Emergency Medicine
- Family Medicine
- Internal Medicine
- Medical Genetics
- Neurological Surgery
- Nuclear Medicine
- Obstetrics and Gynecology
- Ophthalmology
- Orthopaedic Surgery
- Otolaryngology
- Pathology
- Pediatrics
- Physical Medicine and Rehabilitation
- Plastic Surgery
- Preventive Medicine
- Psychiatry and Neurology
- Radiology
- Surgery
- Thoracic Surgery
- Urology

ABMS Associate Members

- Accreditation Council for Continuing Medical Education (ACCME)
- Accreditation Council for Graduate Medical Education (ACGME)
- American Hospital Association (AHA)
- American Medical Association (AMA)
- Association of American Medical Colleges (AAMC)
- Council of Medical Specialty Societies (CMSS)
- Educational Commission for Foreign Medical Graduates (ECFMG)
- The Federation of State Medical Boards of the United States (FSMB)
- National Board of Medical Examiners (NBME)

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ABMS Certification

- Voluntary process
- Requirements for Initial Certification
  - MD or DO degree from recognized medical school
  - Complete extended high-quality period of training and assessment in knowledge, skills, and professionalism (usually ACGME-approved residency/fellowship)
  - Complete additional assessments of knowledge, clinical skills, and professionalism specific to the discipline
  - Meet all requirements for licensure
- Internal discussions about alternative pathways to eligibility for initial certification

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Participating in Continuing Certification

- Must have achieved Initial ABMS Board Certification
- Career-long process
- Based in the six ABMS/ACGME Competencies
  - Professionalism; Patient Care and Procedural Skills; Medical Knowledge; Practice-based Learning and Improvement; Interpersonal and Communication Skills; Systems-based Practice
- Continuous learning and assessment
  - Medical/surgical knowledge and judgment
  - Skills
  - Professionalism

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Maintenance of Certification

Four Parts of MOC:

Part I
Professionalism and Professional Standing - Holds a valid, unrestricted medical license

Part II
Lifelong Learning and Self-assessment - Provides evidence of participation, conforms to general and specialty-specific standards

MOC

Part III
Assessment of Knowledge, Judgment, and Skills - Covers the scope and range of the discipline is clinically relevant

Part IV
Improvement in Medical Practice - Incorporates proven scientific, educational and assessment methodology, reflects patient care and quality improvement

MOC Part I Requirements

- An average of 25 hours of CME a year
- CME relevant to Diplomate's scope of certification, free of commercial bias and control of a commercial interest
- At least eight of the annually required credits should involve self-assessment (multiple choice exam, or simulation with checklist)
- For many ABMS Member Boards, a patient safety self-assessment program each MOC cycle

MOC Part IV Requirements

- Practice improvement activity every 2-4 years (initial assessment, improvement activity and re-assessment)
  - AMA PRA Category 1 Practice Improvement credits meet this requirement, provided all stages are completed
  - Registry with a learning collaborative, completion of self administered module offered by Board or Society, participation in a group quality measurement and improvement activity
- Institution-based quality improvement projects that meet specific criteria also accepted

Updated Standards for MOC

American Board of Allergy and Immunology • American Board of Anesthesiology • American Board of Colon and Rectal Surgery • American Board of Dermatology • American Board of Emergency Medicine • American Board of Family Medicine • American Board of Internal Medicine • American Board of Medical Genetics • American Board of Neurological Surgery • American Board of Nuclear Medicine • American Board of Obstetrics and Gynecology • American Board of Ophthalmology • American Board of Orthopaedic Surgery • American Board of Otolaryngology • American Board of Pathology • American Board of Pediatrics • American Board of Physical Medicine and Rehabilitation • American Board of Plastic Surgery • American Board of Preventive Medicine • American Board of Psychiatry and Neurology • American Board of Radiology • American Board of Surgery • American Board of Thoracic Surgery • American Board of Urology

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ABMS PUBLIC COMMENTS ON PROGRAMS FOR MOC

Page 1

Welcome to the *ABMS Public Comment Web Page on the Proposed Standards for the ABMS Program for MOC*.

These proposed standards for the American Board of Medical Specialties Program for Maintenance of Certification (MOC) have been developed over a two-year process, beginning with the 2012 MOC Framework document and continuing, during this past year, with an extensive process for the development of the standards. These standards will provide an overarching framework for the 24 ABMS Member Boards in the development of their Programs for MOC while allowing flexibility for each Board to appropriately tailor its program to the specific discipline as well as to continuously innovate and improve.

The Programs for MOC offer Board Certified specialists a way to enhance professional development and remain current in an increasingly complex practice environment. All health care stakeholders have a shared commitment for continuing professional development for Board Certified specialists while helping support the social pact between the public and the profession.

To date, hundreds of individuals from the ABMS Member Boards Community, including the ABMS Board of Directors, Associate Member organizations, diplomates and the public, have provided input into the development of these proposed standards.

Please be part of the review process by providing your comments.

Following review of the feedback provided during the comment period, the proposed standards will be considered for approval by the ABMS Board of Directors at its January 2014 meeting. No standards will take effect until 2015, and we anticipate working with our Member Boards to assist in their implementation plans during 2014.

Click here to read the preface to the document as it provides history and context to the proposed standards. Click here to read the proposed standards. Please follow the instructions on the next page to review the proposed standards by section. The comment period will close **November 20, 2013.**

Thank you for participating in this process and providing your comments.

Sincerely,

Lois Margaret Nora, MD, JD, MBA
President and Chief Executive Officer

Next

0%

- Board of Directors approved the Standards for the ABMS Program for Maintenance of Certification at its January 15, 2014 meeting.
- The standards adopt a patient-centric perspective with a greater emphasis on professionalism, patient safety, and performance improvement.

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Updated Standards for MOC

Patient Centric

- All the competencies are reflected in MOC programs
- Broadened emphasis on professionalism
- ABMS Member Boards will have a mechanism to evaluate licensure restrictions to assess their relevance to certification and to take action where appropriate regarding professional behavior irrespective of licensure status

Updated Standards for MOC

Patient Centric (Continuation)

- All MOC programs will incorporate safety into their MOC programs, including acquisition of safety knowledge and implementation of practices to reduce harm and complications from care
- Examinations will incorporate "Judgment" – not just what the physician knows but what the physician does with that knowledge
- Part IV is all about on-going improvement of patient care and patient care systems
- Public involvement in review of Programs for MOC

Updated Standards for MOC

Physician Sensitive

- Feedback from the examination to help self-assessment and individual developmental programs
- Flexibility in the construct and delivery of the high-stakes exam
- Explicit attention to on-going increase in value for Diplomates, including sensitivity to cost, time and administrative burdens
- Diplomates incorporated into review processes for MOC Programs

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Updated Standards for MOC

Physician Sensitive (Continuation)

- Encourage MOC credit for system and team-based quality improvement activities
- Evaluate licensure restrictions to assess their relevance to certification and to take certification-related action where appropriate
- Implement process for re-entry to certification

Certifying Boards and Disciplinary Actions

» ABMS Member Boards receive disciplinary notifications from the following sources:

- Disciplinary Alert Notification Service (DANS)
- FSMB Reports
- State Medical Board Reports
- AMA Disciplinary Action Reports
- Diplomate Reported

Managing Disciplinary Actions

» Member Boards verify and investigate each DANS alert

- If an alert is deemed "actionable", supporting evidence is gathered from the originator (Full FSMB Report)
- Internal Member Board Staff and/or Established Committee Review
- Letter of inquiry is sent to the diplomate
- Appeals Process

Member Board Actions

» Member Boards take action based on the disciplinary notification investigations:

- State Medical Board revokes, suspends, restricts, or places a physician's license on probation
- Other Actions may include: Center for Medicare and Medicaid Services (CMS), Drug Enforcement Agency (DEA), etc.

Re-entry from Disciplinary Actions

» Member Boards have a re-entry processes related to certificate revocation, suspension, restriction and/or probation. The requirements include but are not limited to:

- Reinstatement of a full, unrestricted license
- Successful completion of a re-entry or MOC examination (based on time and severity)
- Completion of appropriate CME
- Completion of additional training
- Submission of a petition letter for reinstatement to the Member Board
- Board approved re-entry plan (case-by-case)

Alignment: An ABMS Strategic Priority

- Integrate MOC with current practice environment and the requirements of healthcare organizations
  - Minimize administrative burden for physicians
  - Create value for Diplomates participating in MOC programs
  - Provide organizations a way to engage physicians in quality improvement and continuous professional development
- Examples:
  - CMS recognition of MOC as a quality indicator
  - Alignment of MOC with The Joint Committee standards for OPPE/FPPE

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Aligning MOC and License Renewal Requirements

- What is MOC for CME?
  - A policy that recognizes physician participation in MOC as meeting the state's continuing medical education requirement for license renewal
- What's the benefit?
  - Minimizes the administrative burden for practicing physicians
  - Assures State Medical Board licensee is engaged in a robust program of continuous professional development
  - Potential to simplify audit process for State Medical Board

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MOC for CME

RED

Accepting MOC-4-CME

Oregon, North Carolina, Idaho, West Virginia, Massachusetts, Kansas, Minnesota, and New Mexico*

*New Mexico accepts MOC for CME but is still developing a rule

ORANGE

ABMS in active conversation with SMB

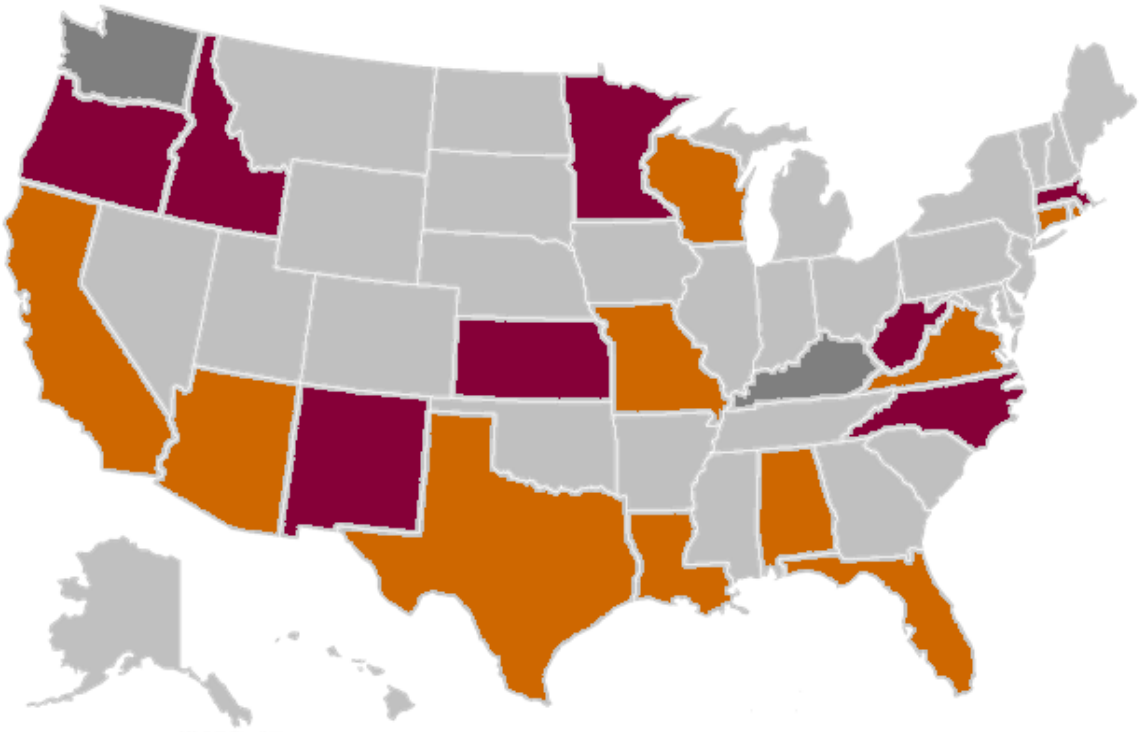
Louisiana, Wisconsin, Connecticut, California, Florida, Arizona, Rohde Island, Virginia, Texas, Missouri, and Alabama

DARK GRAY

SMB has decided not to consider the policy at this time

LIGHT GRAY

Not actively engaged in discussion (requires legislative change, board not ready to discuss, not a priority for the board)



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Opportunity

- Provide CA physicians another option for demonstrating commitment to and compliance with state's expectations for lifelong learning and professional development
- Update existing regulations
  - Reflect current certification processes
  - Accept documentation from certifying boards regarding physician compliance with MOC program requirements

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Additional Information

For More Information:

Carol Clothier
Vice President
State Health Policy and Public Affairs
cclothier@abms.org

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ABMS Resources

- Standards for the ABMS Program for Maintenance of Certification (MOC) - For Implementation in January 2015 (Look for the press release and link to the standards under Hot Topics at abms.org) http://www.abms.org/pdf/Standards%20for%20the%20ABMS%20Program%20for%20MOC%20FINAL.pdf
- MOC Part II Requirements by Board http://www.abms.org/Maintenance_of_Certification/competencies_pdf/ABMS_MemberBoardsRequirementsProject_MOC_PartII_Final.pdf
- MOC Part IV Requirements by Board http://www.abms.org/Maintenance_of_Certification/competencies_pdf/ABMS_MemberBoardsRequirementsProject_MOC_PartIV_FINAL.pdf
- ABMS Evidence Library http://www.abms.org/EvidenceLibrary
- Board Eligibility Requirements http://www.abms.org/News_and_Events/downloads/ABMS_Board_Eligibility_Policy_by_Board_021313.pdf
- ABMS Website http://www.abms.org

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GRADUATE MEDICAL EDUCATION (RESIDENCY TRAINING) LICENSURE REQUIREMENTS

CALIFORNIA APPROVED GRADUATE MEDICAL EDUCATION PROGRAMS

- ACCREDITATION COUNCIL FOR GRADUATE MEDICAL EDUCATION (ACGME) – Programs Completed In The United States Only
- ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF CANADA (RCPSC) – Programs Completed In Canada Only

CALIFORNIA'S CURRENT MINIMUM ACCREDITED GRADUATE MEDICAL EDUCATION (GME) REQUIREMENTS

US and Canada Medical School Graduates:

- Successful completion of one year of ACGME or RCPSC accredited GME

International Medical School Graduates:

- Successful completion of two years of ACGME or RCPSC accredited GME

CALIFORNIA'S CURRENT LICENSE EXEMPTIONS FOR RESIDENTS

US and Canada medical school graduates:

- Must be licensed after completing two years of ACGME and/or RCPSC accredited training anywhere in the US and/or Canada

(BPC Section 2065)

International medical school graduates:

- Must be licensed after completing three years of ACGME and/or RCPSC accredited training anywhere in the US and/or Canada

(BPC Section 2066)

NUMBER OF YEARS TO COMPLETE AN ACGME OR RCPSC ACCREDITED RESIDENCY

Examples of minimum number of years:

- Internal Medicine (General) and Family Medicine Programs - Three Years
- Neurosurgery - Seven Years

Note: Transitional year programs are for residents who need one year of clinical experience to qualify to enter some specialty programs.

IS ONE OR TWO YEARS OF ACGME OR RCPSC TRAINING ENOUGH FOR A PHYSICIAN TO OBTAIN LICENSURE AND PRACTICE SAFELY WITHOUT ANY SUPERVISION?

- Possibly not
- The practice of medicine and medical education is very different today, than in 1980 when BPC Sections 2065 and 2066 became law

WHAT IS THE MINIMUM NUMBER OF YEARS OF RESIDENCY TRAINING REQUIRED BY OTHER STATES FOR LICENSURE?

The minimum requirements vary from state to state between one year to three years, or the successful completion of a complete ACGME or RCPSC accredited program:

US/CAN:	1 Year	2 Years	3 Years	Full Program
Number of States:	31	16	2	1

IMG:	1 Year	2 Years	3 Years	Full Program
Number of States:	2	19	27	1

1 State is 30 Months

Note: Some states will accept Non-ACGME accredited GME

WHAT IS THE FEDERATION OF STATE MEDICAL BOARDS' RECOMMENDATION FOR THE MINIMUM NUMBER OF YEARS OF RESIDENCY TRAINING?

The FSMB recommends three years of ACGME or AOA accredited graduate medical education prior to full licensure.

The FSMB's proposed "Interstate License Compact" states: "Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education..."

HOW MANY YEARS OF ACGME OR RCPSC TRAINING SHOULD THE BOARD CONSIDER REQUIRING TO BE ELIGIBLE FOR LICENSURE IN CALIFORNIA?

The Board should consider increasing the minimum number of years from one (US/CAN) and two (IMG) years to one of the following:

- Two years for both US/CAN and IMG

or

- Three years for both US/CAN and IMG

TWO YEARS OR THREE YEARS OF ACGME AND/OR RCPSC?

US/CAN and IMG Two Years:

- Adds one year to US/CAN
- US/CAN and IMG would have the same minimum requirement
- Does not meet the minimum number of years for an ACGME and/or RCPSC accredited training program
- Does not meet the FSMB minimum recommendation
- Does not seem reasonable to add only one year to US/CAN

TWO YEARS OR THREE YEARS OF ACGME AND/OR RCPSC?

US/CAN and IMG Three Years:

- Adds two years to US/CAN and one year to IMG
- US/CAN and IMG would have the same minimum requirement
- Meets the minimum number of years to complete an ACGME and/or RCPSC accredited training program
- Meets the FSMB minimum recommendation
- Meets the FSMB Interstate Medical Licensure Compact
- Increases consumer protection

IDENTIFIED ISSUES TO CONSIDER

- Will the Board still need to have a medical school recognition process?
- What type of licensure exemption is needed?
- Is a training license for all residents necessary?
- How and when will residents apply for a training license?
- How and when will residents apply for a full license?

IDENTIFIED ISSUES TO CONSIDER

- How will the change affect the California ACGME accreditation programs?
- How will the change affect the residents?
- The need for residents to have DEA registrations. How and when will the residents qualify for DEA registration?
- The need to write prescriptions without a co-signer.

WHAT IS NEEDED TO MAKE A DECISION?

- Input from California ACGME programs
- Input from residents
- Input from physician associations/organizations
- Interested parties' meeting(s)
- Identify all statutes and regulations that would or could be affected by the proposed changes
- Draft proposed language (statutes and/or regulations)
- Identify Legislative author for proposed draft statute(s)

POSTGRADUATE TRAINING REQUIREMENTS BY STATE

State	Requirements for US/Canada Medical School Graduates	Requirements for International Medical School Graduates
Alabama	1 year ACGME training	3 years ACGME training
Alaska	2 years	3 years
Arizona	1 year	3 years
Arkansas	1 year	3 years IMG unless currently enrolled in training program through University of Arkansas for Medical Sciences.
California	1 year ACGME training	3 years ACGME training
Colorado	1 year	3 years
Connecticut	2 years	2 years
Delaware	1 year	3 years
Florida	1 year	2 years
Georgia	1 year	1 year if IMG is on list; 3 years IMG if not on list
Hawaii	1 year	2 years
Idaho	1 year	3 years
Illinois	2 years	2 years
Indiana	2 years	2 years
Iowa	1 year	2 years
Kansas	1 year	3 years IMG (minimum 2 years in a ACGME approved program)
Kentucky	2 years	2 years
Louisiana	1 year	3 years
Maine	Prior to 07/01/04 - 2 years ACGME, after 3 Years ACGME	3 years ACGME training
Maryland	1 year	2 years
Massachusetts	Prior to 01/14 - 1 year, after 01/14 - 2 years	Prior to 01/14 - 2 years, after 01/14 - 3 years
Michigan	2 years	2 years
Minnesota	1 year	2 years
Mississippi	1 year	3 years
Missouri	1 year	3 years

POSTGRADUATE TRAINING REQUIREMENTS BY STATE

State	Requirements for US/Canada Medical School Graduates	Requirements for International Medical School Graduates
Montana	2 years	3 years
Nebraska	1 year	3 years
Nevada	3 years	3 years
New Hampshire	2 years	2 years
New Jersey	Prior to 7/1/03 - 1 year, after 7/1/03 - 2 years	Prior to 7/1/03 - 2 years, after 7/1/03 - 3 years
New Mexico	2 years	2 years
New York	1 year	3 years
North Carolina	1 year	3 years
North Dakota	1 year	30 months ACGME training
Ohio	1 year	2 years
Oklahoma	1 year	2 years
Oregon	1 year	3 years
Pennsylvania	2 years	3 years
Rhode Island	2 years	3 years
South Carolina	1 year	3 years
South Dakota	Successful completion of residency program	Successful completion of residency program
Tennessee	1 year	3 years
Texas	1 year	2 years
Utah	2 years	2 years
Vermont	1 year	3 years
Virginia	1 year	2 years
Washington	2 years	2 years
West Virginia	1 year	1 year
Wisconsin	1 year	1 year
Wyoming	2 years (1 year if applicant has current certification by an ABMS or AOABOS/BOC specialty board, or continuous licensure in good standing in one or more states and/or D.C. for the preceding 5 years.)	

MEDICAL BOARD OF CALIFORNIA

EDUCATION AND WELLNESS COMMITTEE AGENDA

MEMBERS OF THE COMMITTEE

Barbara Yaroslavsky, Chair
Denise Pines
Howard Krauss, M.D.
Gerrie Schipske, R.N.P., J.D.

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

Thursday, July 24, 2014
2:15 p.m. - 3:45 p.m.
(or until the conclusion 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.

ORDER OF ITEMS IS 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 Comments on 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 the Minutes from the February 6, 2014 Meeting

4. Presentation on Healthy Living Programs
   A. Loma Linda University Wellness Campaign – Barbara Couden Hernandez, Ph.D., Director for Physician Vitality
   B. University California Los Angeles Healthy Campus Initiative – Michael Goldstein, Ph.D., Professor of Public Health and Sociology

5. Let's Get Healthy California Task Force Report and the California Wellness Plan - Ronald Chapman, M.D., Director, California Department of Public Health

6. Education and Wellness Committee Strategic Plan Update - Ms. Hockenson

7. Future Agenda Items

8. 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) 230-1093

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 three minutes per agenda item. However, during Agenda Item 2 – Public Comments on Items not on the Agenda, the Board/Committee has a limited public comment period for individuals on the teleconference of 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.

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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) 263-2318 or email lisa.toof@mbc.ca.gov or send a written request to Lisa Toof at the Medical Board of California, 2005 Evergreen Street, Ste. 1200, Sacramento, CA 95815. Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Education and Wellness Committee Meeting

Embassy Suites
150 Anza Boulevard
Burlingame, CA 94010
650-342-6000 (directions only)

Agenda Item 3

Friday, February 6, 2014
1:00 p.m. – 2:30 p.m.

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Education and Wellness Committee of the Medical Board of California (Board) was called to order by Chair Barbara Yaroslavsky at 1:00 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:
Barbara Yaroslavsky, Chair
Silvia Diego, M.D.
Denise Pines

Members of the Committee Not Present:
Howard Krauss, M.D.
Gerrie Schipske, R.N.P., J.D.

Staff Present:
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Interim Executive Director
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant
See Vang, Business Services Analyst
Kerrie Webb, Staff Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Theresa Anderson, California Academy of Physicians Assistants
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Julie D'Angelo Fellmeth, Center for Public Interest Law
Wayne Dysinger, M.D., Chair of Preventative Medicine at Loma Linda University
William Ferguson, Center for Public Health
Jack French, Consumers Union

Faith Gibson, CA College of Midwives
Donna Gray-Bowersox, DHCS
Holly Harris, Consumers Union
Ron Hattis, M.D., Beyond Aids
Gale Jara, California Public Protection and Physician Health
Mona Maggio, Board of Optometry
John McDougall, M.D., Physician, Author
Tina Minasian, Consumers Union
Carole Moss, Consumers Union
Ty Moss, Consumers Union
Jessica Nunez de Ybarra, M.D., California Department of Public Health
Katrina Peters, M.D., Golden State Medical Association
Jessica Sieferman, Board of Optometry
Rick Waltman, Center for Public Interest Law

Agenda Item 2 Approval of Minutes from the July 17, 2013, Education and Wellness Committee Meeting

A motion was made to approve the minutes from the July 17, 2013 meeting; seconded. Motion carried.

Agenda Item 3 Public Comment on Items Not on the Agenda

Ty Moss, co-founder of Niles Law, on behalf of Consumers Union Safe Patient Project, said he has some concerns that the instructions regarding public participation in the Board's teleconferencing program could reduce the public's participation because of the time constraints. Mr. Moss suggested these restrictions run counter to the intention of the Bagley-Keene Act to provide public participation in public meetings and urges the Board to reconsider the instructions relating to teleconferencing.

Ronald Hattis, M.D., president of Beyond Aids, commented on AB 466 and how the bill requires primary care providers to offer HIV testing to adolescents and adults for the purposes of discovering undiagnosed HIV infections. Dr. Hattis added, the bill also creates a new post-test counseling requirement for physicians and eliminates the need for written consent for adolescents.

Holly Harris, Consumers Union Safe Patient Project Network, wanted to encourage the use and availability of the teleconferencing. She noted the importance of teleconferencing because of the time and complications of travel for someone with a profound disability and stated that she would be monitoring the teleconferencing, note how it is working and write a short report.

Agenda Item 4 Presentation and Approval of the Action Plan for SB 380

Ms. Simoes presented SB 380, which requires the Board to start a working group to discuss nutrition and lifestyle behavior for the prevention and treatment of chronic disease. The working group meeting was held at the July 2013 Education and Wellness Committee meeting.

Ms. Simoes reported on Ms. Schipske's approved motion for staff to identify information and resources that would be helpful for physicians. She continued by saying that staff was asked to draft an action plan that would identify the best way to get this information to physicians, provide an evaluation tool and find available resources. Staff is recommending that a webpage be created on the Board's website

to be used as a clearinghouse of information about chronic disease prevention for physicians and consumers.

It was also suggested the Board work with other state agencies to promote its webpage on their websites and send an email blast with this link to all physicians and include at least two articles on this subject per year in the Board's Newsletter. Once the webpage is up and running, the Board can utilize Survey Monkey as an evaluation tool for physicians and include contact information for Board staff. It is important to note links that endorse for profit websites **cannot** be on the Board's webpages.

Board staff is currently working with the University of California to gather more information on what is being taught regarding nutritional lifestyle and behavior changes to prevent chronic diseases. Lastly, Board staff recommends the Board begin discussing the standards for educational activity concerning chronic disease organizations that accredit CME programs, to identify if information on the impact, prevention and cure of the chronic disease by changes in nutrition and lifestyle behavior is included in these courses.

Dr. McDougall spoke about how much money the State of California has spent on dietary diseases since SB 308 was signed into law, stating that doctors are not taught diet therapy nor are they taught about the cause and treatment of dietary disease. Dr. McDougall proposed a requirement for CME to get the eleven medical schools and all the doctors licensed in California involved in treating dietary diseases because the current proposal to provide some education in a Newsletter is not adequate.

Dr. Dysinger, Loma Linda University, spoke about a presentation on lifestyle medicine that was held at Stanford University. It was stated that 80% of health care costs are due to chronic diseases and 80% of those costs could be eliminated if lifestyle medicine was practiced more. He stated there was an opportunity to do something more to encourage every physician to look at lifestyle medicine first, both as a cost effective approach to health and as a way of improving disease outcomes.

Dr. Hattis commented that two articles a year in the Board's Newsletter is an excellent idea and suggested these articles be in the winter issue of the Newsletter because physicians without email addresses receive hard copies of the winter issue and they should contain a link to the website. The working groups proposal was to implement the requirements for CME on subjects of diabetes, obesity and cardiovascular diseases such as hypertension, coronary artery disease and peripheral artery disease where lifestyle and nutrition are the most important factors.

Dr. Nunez de Ybarra, California Department of Public Health (CDPH), asked if the Board could state how experts would be able to share in terms of adding links to the website so that the product would be more robust. Dr. Nunez de Ybarra stated that the California Wellness Plan will be published early next week, and that she would like that link to be promoted through this website, because the Wellness Plan directly looks at evidence based strategies for addressing chronic disease. She added that CDPH wanted the group to be aware of a meeting being held next week to look at a policy agenda for chronic disease.

Ms. Pines made a motion to approve the action plan as reported by Ms. Simoes; seconded. Motion carried.

Agenda Item 5 Consideration and Approval of the Education and Wellness Committee Proposed Goals

Ms. Hockenson presented the new proposed goals that reflect the approved mission statement.

"The mission of the Education and Wellness Committee is to actively pursue opportunities to educate the public on the functions and responsibilities of the Board; to protect the public by continuing to provide current updated information regarding the Board's laws, regulations, as well as relevant healthcare information to both physicians and the public; and to promote strategies and opportunities for physicians to maintain a sound balance in their personal and professional lives so they can offer quality care to their patients."

Proposed goals

1) Educate the public on the Board's mission so they can play an active role in their own healthcare.
2) Educate physicians on 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 healthcare.
5) Review and monitor the public affairs office strategic plan to ensure goals and objectives are being met.

Ms. Pines made a motion to approve the proposed goals as stated; s/ Dr. Diego. Motion carried.

Agenda Item 6 Public Affairs Manager Report

Ms. Hockenson stated since the last Education and Wellness Committee Meeting on July 17, 2013 in Sacramento, Board staff participated in eight community outreach events and meetings. There were 92 media inquiries that resulted in stories between July 17, 2013 and the beginning of January 2014, and the Board issued seven press releases. The Board's new website launched on Thursday, January 16, 2014. In addition to revamping the look of the website, Board staff brought all pages up to date with the changes due to BreEZe, new laws, etc. Board staff welcomes any comments or suggestions with regards to improving the website.

Ms. Hockenson noted that the Board's Winter Newsletter is posted on the website, and additional hard copies will be printed and sent out to all physicians and interested parties without an email address. On February 11, 2014, Ms. Hockenson will be addressing a group of military retirees at the North Highlands Community Center in Sacramento. She will also be working to finalize development of an MBC brochure regarding the statute of limitations on filing a complaint titled, "Don't wait, file a complaint!", which was suggested by the Consumers Union Safe Patient Project. The Board staff liked the idea and is proceeding with completing the brochure. March is Prescription Drug Abuse Awareness Month and there will be a campaign entitled "Spread the word, one pill can kill" based around Senate Concurrent Resolution 8, which was adopted May 8th of 2013. This is an outreach campaign involving PSAs, and other outreach ideas. Ms. Hockenson stated that there is one restriction that affects the statewide outreach process and that is travel.

On April 2, 2014, Ms. Hockenson will again be speaking to Professor John Tamlin's class on consumer health education at Sacramento State University on behalf of the Board. This will be a second appearance, and will likely become a regular presentation every semester. She added that there will be an educational forum sponsored by the California Association of Medical Staff Services on May 8, 2014. It is expected that 300 people will be in attendance and the Board has already received a list of the questions and topics that will be addressed. Finally, Franchise Tax Board will be holding their 19th Annual Health and Wellness Fair on May 14th and the Board will be participating.

Ms. Yaroslavsky suggested that Public Affairs staff look into using Board staff and Board Members that live in other cities to participate in fairs in their absence.

Agenda Item 7 Consideration and Approval of the Social Media Plan

Ms. Hockenson stated that social media is a popular way to disseminate information and get the attention of stakeholders. According to the PEW Research Center, nearly 1 in 10 adults get news through Twitter and Twitter users standout as more mobile and more educated. Ms. Hockenson presented the reasons for using Twitter as follows: 1) It gets the news out faster and it is a way to ensure media attention since the majority of reporters follow Twitter; 2) It is a way to correct and/or ensure accurate information is being presented in real time; 3) It is an easy way to engage the stakeholders through conversation, which means issues can be addressed immediately; 4) The algorithms for Twitter make it easier to track the data, followers and messages; and 5) It is less time consuming than many other social media sites, and it requires less maintenance. Ms. Hockenson addressed the one concern regarding negative comments being posted on Twitter and stated although this can happen, the benefits far outweigh the risks and that the Federation of State Medical Boards and the Department of Consumer Affairs (DCA) both say this is a rare occurrence, even in retweets.

Ms. Hockenson commented on the concerns that staff resources will be used and it will take too much time, stating that sending out a tweet is 140 characters max and takes very little time. Determining what to tweet takes more time. However, a protocol can be set up regarding who manages the tweets and who is authorized to do them. Buffer is a fabulous tool that is free and can assist in managing Twitter accounts. Numerous posts can be written at one time and the Board can choose which social profile will receive them. Buffer will spread the tweets throughout the day or week so that one individual does not need to physically be at the computer in order for the Board to have a social media presence. Since Buffer shortens links, it is able to provide more analytics than if the Board where to post tweets directly. For example, Buffer can tell the Board exactly how many individuals clicked on each link and looked at each tweet.

Ms. Hockenson stated the Board should follow other professional organizations, the Legislature, all media outlets and other stakeholders. The Board should follow others because that is the purpose of reaching out. The Board can delete tweets and block individuals from its account since it has administrative control.

Ms. Hockenson stated the Executive Director will approve all tweets before they are released. The Office of Public Affairs will manage the Twitter account. The Public Affairs manager and one staff member will be the only two authorized to tweet. DCA has guidelines but no concrete policy yet. However, the Board can follow the DCA guidelines that are in attachment B. The Board can set up an

editorial calendar three months in advance listing meetings, Board events, Newsletter tips, etc. to manage its social media platform.

Ms. Hockenson stated Twitter can be used to correct inaccurate media reports or information and announce upcoming Board events, meetings, news releases, Food and Drug Administration recalls, or anything involving the Board that would be of interest to its stakeholders. Pictures of special outreach events and speaking engagements could also be posted to encourage others to contact the Board to request Board attendance at their meetings. The Board can also post any other Board announcements as deemed appropriate.

Ms. Hockenson said there is no cost regarding Twitter, with the exception of minimal staff time each day. She added the Board has an account set up and authorized as the official Medical Board of California Twitter account. Once the Board gives its approval it can be activated. A proposed start date is Monday, April 7, 2014. Information will be reviewed at the end of each week with the Executive Director to determine if the purpose and intent of starting the account is being met and determine if the amount of staff time is manageable.

Ms. Yaroslavsky stated she would like some stats such as how wide spread using Twitter is, how many people are reading it and if they are responding to the feedback.

Jack French, Consumer's Union Safe Patient Project (CUCPP), said they were pleased to see the Committee is considering the use of social media. They believe this is an important tool for reaching California patients, most of whom are unaware of the Board and its responsibilities. He stated that if tweeting is done effectively it could play an important role in helping California patients understand the Board's role, how to engage it, understand how to participate in the Board's public process, and be informed regarding particular physicians who may pose a danger to patient safety. They are strongly in favor of the Board tweeting Board disciplinary actions regarding physicians and outpatient surgery centers and strongly urge that these tweets identify names and position and/or outpatient surgery centers to assist patients in being aware of possible safety issues. Further, they recommend that the Board explore live twitting during Board meetings. They urge the Board to be aggressive and proactive in its outreach. And to expand the number of followers particularly among stakeholder groups representing California patients and consumers.

Ms. Pines made a motion to use Twitter; s/Dr. Diego. Motion carried.

Agenda Item 8 Discussion of Future Agenda Items

- Dr. Levine suggested it would be helpful for the Committee to add a summary of the recommendations from the Let's Get Healthy task force report to a future agenda.
- Ms. Yaroslavsky suggested putting a call to stakeholders to find out what types of programs related to healthy living are going on in the state and to highlight some of them.

Ms. Minasian suggested that the Board use Public Service Announcements (PSAs) on TV along with other social media outlets. She stated that many households do not have access to the social media outlets such as Twitter, Facebook or even the Internet and these announcements could supply them with

lots of information such as upcoming MBC meetings, how to file a complaint, how to look up a doctor and many other things.

Agenda Item 9 Adjournment
The meeting was adjourned at 2:30 p.m.

The complete webcast can be viewed at: http://www.mbc.ca.gov/board/meetings/Index.html

Barbara Couden Hernandez, Ph.D.

Agenda Item 4A

Dr. Barbara Couden (pronounced "cow-den") Hernandez is the Director of Physician Vitality and Professor in the Loma Linda University School of Medicine. She formerly served as Director of Doctoral Clinical Training in the School of Behavioral Health and coordinator of the Medical Family Therapy program at Loma Linda University. Dr. Hernandez holds a Master of Science degree in Marriage and Family Therapy from Loma Linda University and a PhD in Family Social Science from the University of Minnesota. She is a Clinical Diplomate in the American Association of Marital and Family Therapy. She has worked as an intensive care nurse for over 20 years, taught marriage and family therapists, psychologists, public health, and social work graduate students for 15 years, and has provided individual and family therapy services in community mental health, hospital, and university settings, as well as private and group practices. Her publications address issues of spirituality, ambiguous loss, and partner violence.

Promoting Physician Vitality Across the Career

BARBARA HERNANDEZ, PHD

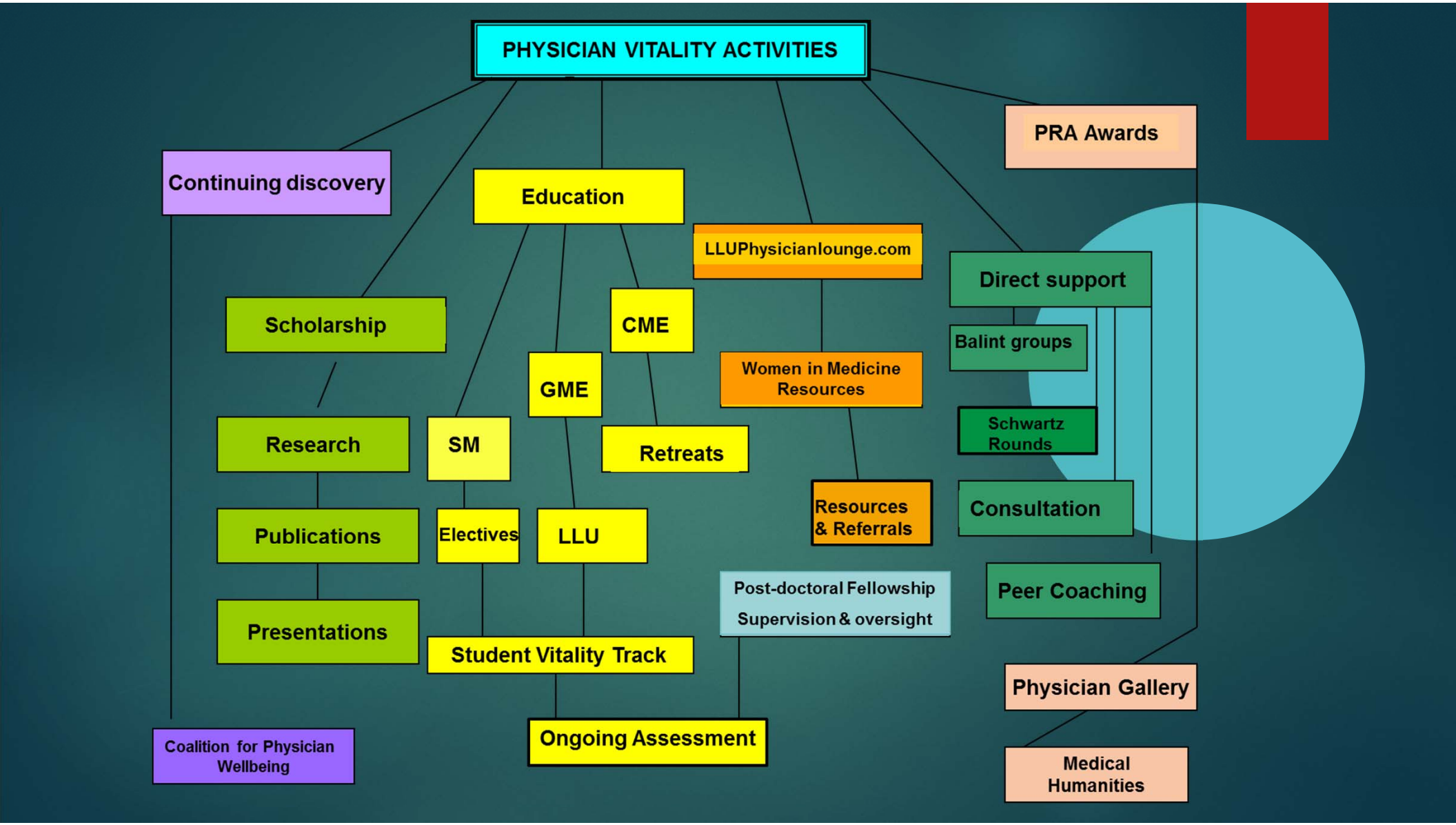
LOMA LINDA UNIVERSITY

So what makes a good doctor?

What can I offer to enhance good doctoring given my skill set?

Needs Assessment, 2011

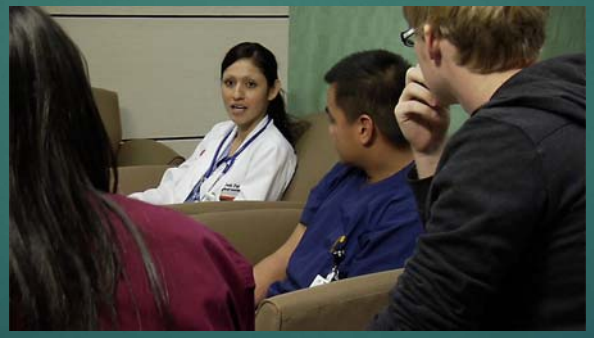
- Students
  - Overwhelmed, specialty area, relationships, acculturation
- Interns and Residents
  - No control, hungry, affirmation and tools, reprieve
- Fellows
  - Professional development, refinement of self and skills
- Junior Faculty
  - Tired, research agenda, practice management, family life
- Senior Faculty
  - Futility of care, administration, reimbursement, training, career fulfillment, meaning and legacy


PHYSICIAN VITALITY ACTIVITIES
Continuing discovery
Education
LLUPhysicianlounge.com
PRA Awards
Direct support
Scholarship
CME
GME
Balint groups
Women in Medicine Resources
Research
SM
Retreats
Schwartz Rounds
Resources & Referrals
Consultation
Publications
Electives
LLU
Post-doctoral Fellowship Supervision & oversight
Peer Coaching
Presentations
Student Vitality Track
Physician Gallery
Coalition for Physician Wellbeing
Ongoing Assessment
Medical Humanities

Education

- Schwartz Center Rounds
- Medical Humanities concentration
- Chief Resident Peer Coaching certificate
- Grand Rounds and Seminars
  - *When the Nurse Drives You Crazy*
  - *It's Not Your Mother's Birds & Bees Talk*
  - *Suicide: A Goodbye Gone*
  - *Staying Warm Without Burning Out*
  - *How to Hold Effective Family Conferences*

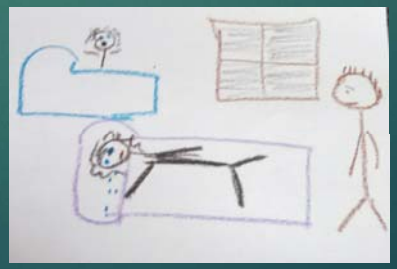
Collaborative Reflective Training



Support For Residents and Faculty

- Peer Support Training
- Family Medicine Support Group
- Lunch Meetings (Group and Individual)
- Evaluation and Referral Service
- Palliative Care Rounds
- Crisis Management
- Consultation
- Coaching

Retreats and Conferences: Power of the Pause



Pediatrics
NICU
Med Students
Psychiatry
Family Medicine
Internal Medicine
Prev Medicine
Chief Residents
Faculty Leadership
Department Chairs

Physician Gallery and Exhibits

School of Medicine

- Recruit by fit to our mission
- Ongoing program evaluation
- Altruistic and mission opportunities
- Advising, mentoring, coaching
- Incorporation of reflection
  - ORM course
  - Senior project
  - Portfolios

Medical Student Coaching

- Time management
- Study skills
- Self-defeating attitudes
- Relationship stressors
- Acculturation into medicine
- Family and relationship concerns

The Small Print About Being a Doctor

- Burnout prevention strategies
- Substance abuse and diversion programs
- Mental health and help-seeking
- Suicide
- Intimate partner violence
- Litigation
- Work-life balance strategies

School of Medicine Electives

- Electives
  - Critical Life Narratives in Clinical Practice
    - Self of physician
    - Power, privilege
    - Narrative emphasis
  - Sexual Health and Wellness
    - Self of physician
    - Skill set
    - Diversity

Student Vitality Track--2015

- Option to standard medical education
- Change culture re: hidden curriculum
- Adds 72 hours of curriculum aimed to
  - Promote reflection
  - Develop self-management skills
  - Teach psychosocial-relational clinical skills
  - Increase ability to tolerate ambiguity
  - Create resilience plan for the career span
  - Identify markers for resilience

Agenda Item 4B

UCLA Associate Vice Provost, Healthy Campus Initiative
Professor, Community Health Sciences and Sociology
Faculty Associate, UCLA Center for Health Policy Research

Michael S. Goldstein, has served the campus as interim Vice Provost for Graduate Education and the Dean of the Graduate Division. Goldstein was co-principal investigator and program director of CHIS-CAM, an NCI-funded follow-up study to the 2001 California Health Interview Survey that examines use of complementary and alternative medicine (CAM) among California adults, particularly those with cancer, and other chronic illnesses. At UCLA, he teaches graduate courses on complementary and alternative medicine, self-help, and self-care.

Goldstein's published research on health promotion spans 30 years. During the late 1980s, his research examined factors that led conventionally trained physicians to become involved with CAM. In the early 1990s, Goldstein spent two years conducting research at The Wellness Community, a support center for people with cancer. In the mid-1990s, he was among the first researchers supported by the Office of Alternative Medicine for his study of patient satisfaction with CAM. More recently, he collaborated on a study to compare the impact of treatment confidence on pain and disability among patients with low- back pain treated by either physicians or chiropractors. His current work deals with the potential for CAM providers to assume a greater role in the provision of primary care in the nation's health care system.

Goldstein is the author of two books: *The Health Movement: Promoting Fitness in America* (Macmillan 1992), and *Alternative Health Care: Medicine, Miracle, or Mirage* (Temple Univ. 1999). Both strive to understand changes in the way people seek to prevent and respond to serious illnesses as part of broader social and cultural changes in American society.

Contact information:
Email: msgoldst@ucla.edu

Building a Social Movement Around Health & Wellness: The UCLA Healthy Campus Initiative*

Michael S. Goldstein, Ph.D.
Associate Vice Provost, UCLA
Professor, Fielding School of Public Health, UCLA

Medical Board of California
Sacramento, CA
July 24, 2014

- Envisioned and supported by a generous grant from Jane and Terry Semel.

The UCLA Healthy Campus Initiative

- **Chancellor Gene Block's commitment to make UCLA the healthiest campus in America;**
- **Jane & Terry Semel share the vision and provide the means to make the vision a reality.**
- **What does "health" or being the "healthiest" campus mean?**
  - Is health the absence of symptoms and disease?
  - World Health Organization: health is "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"
  - Does a group of healthy individuals = a healthy community/campus ?

MSGoldstein

What is the best way to build a healthy campus?

- **Include existing programs and targeted interventions.**
- **However, a review of best practices made it clear that while HCI would include all sorts of targeted interventions, building a healthy campus would require a different focus:**
  - Marginal success of targeted interventions
  - "Success" is either non-existent or very small, not long lasting nor clinically significant, especially for vulnerable populations

- Davies et.al. 2012 Meta Analysis of Internet Delivered Interventions to Increase Physical Activity Levels. INTL J BEHAVIORAL NUTRITION AND PHYSICAL ACTIVITY 2012, 9:52.
- Kelly et.al. 2013 Systematic Review of Dietary Interventions with College Students: Directions for Future Research and Practice. J NUTRITION EDUCATION AND BEHAVIOR 2013 45:304-313.
- Geaney et. al. The effectiveness of work place dietary modification interventions: A systematic review. PREVENTIVE MEDICINE 2013 57:438-447.
- Rongen, et. al. Workplace health promotion: A meta-analysis of effectiveness. AMER J PREVENTIVE MED 2013 44:406-415.
- Caloyeras et. al. Managing manifest diseases, but not health risks, saved PepsiCo money over seven years. HEALTH AFFAIRS 2014 33:124-131.
- Glasgow et. al. The future of health behavior change research: What is needed to improve translation of research into health promotion practice? ANNALS OF BEHAVIORAL MEDICINE 2004 27:3-12.

MSGoldstein

Although targeted programs showed only limited success, history demonstrated that major changes on campus were possible…

- **Over the past 50 years we have seen significant changes:**
  - Civil rights/racial and ethnic diversity
  - Feminism
  - Disability rights
  - LGBT rights
  - Environmentalism/sustainability
- **What each of these changes had in common is that they grew out of social movements.**
- **Given these vivid successes, the decision was made to attempt to build a social movement around health and wellness on campus.**

MSGoldstein

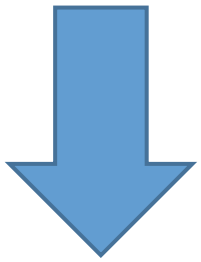
A health-driven social movement begins with:

- Understanding that the unhealthy choice is usually the norm;
- Acknowledging that society has not made healthy choices easy choices;
- Accepting that these norms reflect the dominance of certain groups and interests who benefit from the way things are.

The health-driven social movement evolves as the focus shifts from:

CHANGING the **INDIVIDUAL**

to



CHANGING the **STRUCTURE/CONTEXT**
in which the individual exists

MSGoldstein

Is it realistic for health and wellness to be core values on campuses today?

- **On one hand, institutions of higher education can be particularly inhospitable to making health a core value:**
  - Higher education places value on skepticism and questioning authority, versus conforming to rules about how to live one's life.
  - College life presents students with newfound opportunities to make myriad of choices about life on a daily basis: what you eat, what substances you imbibe, who you have sex with, how late you stay up…

MSGoldstein

- **On the other hand, colleges increasingly recognize that health and wellness can be:**
  - A means of "branding" themselves;
  - A way (hypothesized) of saving money;
  - A major issue for a growing number of campus groups:
    - Gender/sexuality
    - Ethnic (especially health disparities)
    - Sustainability/green/environmental
    - Health oriented groups: nutrition, mental health (meditation etc.), physical exercise, bicycle coalitions
- **Thus, for many campuses, including UCLA, the time is ripe for making health and wellness core values on campus!**

MSGoldstein

Key Organizing Principle: BOTTOM UP

- **We start where people are:**
  - Defining health according to their own ideas, needs and values
  - Placing value on shared personal experiences
  - In terms of cost/benefits for risk, what do people really want?
    - Jobs, happiness, fulfillment, creativity, security, achievement

      versus
    - Cutting risk of illness or injury

MSGoldstein

A Healthy Campus movement is…

- Unafraid of conflict:
  - Law students want to protest quality of dining commons;
  - Faculty want to measure and improve air quality in the workplace;
  - Cyclists challenging University relationship with politicians over off campus bike lanes.
- Supports groups with opposing goals:
  - Campus bike group fosters the use of bike helmets;
  - Another bike group wants to increase bicycle commuting and opposes helmet use, which is seen as a deterrent to cycling.
  - Student groups favoring caloric labels on all foods;
  - Body image support groups opposed to caloric labeling.
- Supports gender and ethnic-specific programs
  - LGBT groups with a focus on identity specific goals;
  - Groups (e.g. Sex Squad) that focus on common concerns (STDs, ability to say "no").

WE SUPPORT THEM ALL!

MSGoldstein

"TOP DOWN" approaches are also important:

- Successful organizations (e.g. Kaiser Permanente, IBM, LAUSD) which have made health and wellness core values all say that strong leadership from the top is key to success.
- But for the most part, the top is responding to the bottom, not telling the bottom what to do.

LEADING BY EXAMPLE
Executive Directives & Actions

MEDIA

Statements from the Chancellor…
BruinPost, launch, press releases…

DECISION-MAKING

An independent Steering Committee with representatives from every part of campus including students and staff…

POLICY

Preamble to planning and development document…

100% Tobacco Free campus…

Negotiations with beverage companies for pouring rights…

Cutting Recreation membership fees for low salary level workers…

INFRASTRUCTURE

Building healthier dining halls…

Bike lanes…

MSGoldstein

LIVE WELL
UCLA IS A HEALTHY CAMPUS

WE BUILD

- Alliances
- Awareness
- Our brand
- The movement

Our logo goes most everywhere…

LIVE WELL
EAT WELL
BREATHE WELL
MIND WELL
MOVE WELL
BE WELL

UCLA IS A HEALTHY CAMPUS

MSGoldstein

Ronald Chapman, M.D., MPH

Agenda Item 5

On June 13, 2011, Ron Chapman, MD, MPH, was sworn in as director and state health officer of the California Department of Public Health.

Dr. Chapman is a board-certified family physician who has dedicated his career to public health and medicine caring for the uninsured and underinsured in California.

Dr. Chapman was the chief medical officer of Partnership HealthPlan of California (PHC), a managed care Medi-Cal plan serving Yolo, Solano, Napa, and Sonoma counties. For six years prior to that, he was the public health officer and deputy director of public health in Solano County, California. From 1998 to 2004, he worked at the California Department of Health Services as the founding chief of the Medicine and Public Health section.

Dr. Chapman has a medical degree from the University of Southern California, and a Masters in public health from the University of Michigan. He has completed fellowships in academic medicine at the University of California, San Francisco and graduated in the inaugural class of the California Health Care Foundation's Health Care Leadership Program. Before entering public health practice Dr. Chapman was on the faculty at the University of California, Davis School of Medicine. He is the American Medical Association 2008 Dr. Nathan Davis Award Winner for local government service.

Dr. Chapman's primary interests are in the areas of care for the uninsured, the interface between public health and medicine, and chronic disease management.

Caroline Peck, MD, MPH, FACOG has served as California's Chronic Disease Director and the Chronic Disease Control Branch Chief in the California Department of Public Health since 2008.

Dr. Peck is a board-certified obstetrician/gynecologist and preventive medicine/public health physician who has devoted her career in medicine and public health to caring for the uninsured and underinsured.

Immediately after completing her Obstetrics and Gynecology residency at the University of California, San Francisco, Dr. Peck served as Staff and then Chair of the Obstetrics and Gynecology Department at the Northern Navajo Medical Center in New Mexico. This experience sparked her interest in population health, and she returned to complete a General Preventive Medicine/Public Health residency at the California Department of Public Health. Dr. Peck then worked in local and state government overseeing maternal-child health, breast, and cervical cancer early detection programs. Seeing the need to maintain a pipeline of public health physicians and scientists, she became Section Chief and Director of the California Department of Public Health General Preventive Medicine/Public Health Residency and California Epidemiologic Investigative Service Fellowship.

Dr. Peck has a medical degree from the George Washington University School of Medicine, and a Masters in public health from the University of California, Berkeley. Dr. Peck is a Volunteer Clinical Faculty at the University of California, Davis.

Dr. Peck's primary interests are in a broad approach to chronic disease prevention, health economics, and women's health.

Jessica M. Núñez de Ybarra is a physician and public health medical officer at the California Department of Public Health (CDPH) working as Chief of the Coordinated Chronic Disease Prevention Section since October 2012.

She is Board Certified in Public Health and General Preventive Medicine and a Fellow of the American College of Preventive Medicine.

Starting July 1, 2014, she will serve as the Director of Coordination in implementing the California Wellness Plan (CWP), the state chronic disease prevention and health promotion plan that she and a multi-disciplinary team developed in collaboration with internal and external partners. In this position, she will work with Partners to convene a statewide workgroup to increase integration of public health and the health care sector. She will also monitor and track specific program activities relevant to CWP implementation for collective impact in the prevention and control of chronic diseases and associated risk factors. Jessica previously worked for CDPH Center for Infectious Diseases facilitating internal public health communications, training, and preparedness activities to address emerging public health threats including creation and oversight of CDPH LabAspire, a public health laboratory director's training program from 2006 through 2012.

Jessica received a Medical Doctorate from UCD in 1997 and a Master in Public Health in Health Services Administration from the University of California, Los Angeles in 2000. She successfully completed CDPH PMRP in 2001 and a CDPH Policy Fellowship in 2002. She currently serves as faculty for CDPH Preventive Medicine Residency Program (PMRP) and as volunteer Assistant Clinical Professor at the University of California Davis (UCD) School of Medicine Department of Public Health Sciences.

She is actively engaged as a physician leader serving as President of the Sacramento Latino Medical Association (SaLMA). In this capacity, she joined forces with UCD Women's Cardiovascular Medicine Program to conduct the Cardiovascular Disease Community-Based Preventive Intervention for High-Risk Latina Women in Sacramento County in 2013 partially funded by the Sierra Health Foundation.

Let's Get Healthy California Task Force Report and California Wellness Plan, 2014

Moving Forward with Implementation

Ron Chapman, MD, MPH
California Department of Public Health

July 24, 2014

Presentation Objectives

State of California Wellness Initiatives:

- Provide LGHCTF Report 2012 overview
- Introduce California Wellness Plan 2014
- Describe CWP Implementation Initiatives
- Provide CalSIM overview
- Propose Collaboration Opportunities

Opportunities and Challenges in CA

- Chronic conditions and an aging population
- Patient Protection and Affordable Care Act: Transformation in health care delivery
- Significant health disparities
- Increasing health care costs
- State fiscal challenges

Governor's Executive Order B-19-12

Develop 10 year plan

- To improve the health of CA, control costs and improve quality of health care, promote personal responsibility for health, and advance health equity
- Let's Get Healthy California Taskforce Charge by Secretary: What will it take for CA to be the healthiest state in the nation?

LGHCTF
Strategic Directions & Goals

Health Across the Lifespan

1. Healthy Beginnings: Foundation for a Healthy Life
2. Living Well: Prevention and Managing Chronic Disease
3. End-of-Life: Maintaining Health, Dignity and Independence

Pathways to Health

4. Redesigning the Health System: Efficient, Safe and Patient-centered Care
5. Creating Healthy Communities: Enabling Healthy Living
6. Lowering the Costs of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes

CDPH California Department of PublicHealth

California Wellness Plan

- California's Chronic Disease Prevention and Health Promotion Plan
- Let's Get Healthy California Task Force Priorities
- 9 year timeframe; numerous Programs
- Population health focus
- Performance Measures with baseline, benchmark and target outcomes
- Healthy Community Indicators

California Wellness Plan Goals

Equity in Health and Wellness

1. Healthy Communities
2. Optimal Health Systems Linked with Community Prevention
3. Accessible and Usable Health Information
4. Prevention Sustainability and Capacity

Plan posted online February 28, 2014

http://www.cdph.ca.gov/programs/cdcb/Pages/CAWellnessPlan.aspx

California Wellness Plan Desired Outcomes

- Understanding of the multiple factors that contribute to chronic disease
- Increased transparency of CDPH prevention activities
- Roadmap for collaboration between CDPH and partner organizations
- Ability to measure improvements in chronic disease outcomes, inequities and costs

CWP Goal 2 Optimal Health Systems Linked with Community Prevention

Improve patient and community health by building on these strategic opportunities:

- Current investments and innovations in the Patient Protection and Affordable Care Act,
- Coverage of preventive services and,
- Expanded managed care

CDPH Commitment: Goal 2

- Statewide Workgroup to increase integration of public health and the health care sector
- Health economist to perform return on investment (ROI) analyses of prevention activities
- Health Reform Coordinator
- Coordination with Partner Organizations

CDPH Office of Health Equity

California Statewide Plan to Promote Health and Mental Health Equity

- To be released August, 2014

CDPH Office of Quality Performance and Accreditation

- CDPH Accreditation Application
  - State Health Improvement Plan is LGHCTF Report
  - Quality Improvement Plan/System
- Public Health Accreditation Board

  Site Visit August 2014

Key Performance Accreditation Requirements

State Health Improvement Plan

Standard 5.2

California's commitment to being the healthiest state in the nation.

Strategic Plan

Standard 5.3

Identifies the department's goals in alignment with Let's Get Healthy California and the Quality Performance Plan.

Quality Improvement Process / Plan

Standard 9.2

Process followed as needed to improve the quality of services provided.

Quality Performance Plan

Standard 9.1

A plan that empowers CDPH to be a quality performing, innovative organization.

PHAB
Version 1.5

http://www.phaboard.org/wp-content/uploads/PHAB-Standards-and-Measures-Version-1.0.pdf

California Department of PublicHealth

CDPH California Department of PublicHealth

Center for Medicare and Medicaid Innovation
State Innovation Model Design Grant

- In 2013, California received grant and used LGHCTF report as a foundation for an implementation plan for health system and payment reforms
  - California State Health Care Innovation Plan
- In 2014, California will submit application for funding to implement plan

California State Health Care Innovation Plan

Maternity Care: Reduce elected early deliveries, reduce C-Sections, increase vaginal birth after C-Section delivery

Health Homes for Complex Patients: Expand HHCP model to provide high-risk patients with better coordinated care

Palliative Care: Better align care with patient preferences with new benefit and payment approaches

Accountable Communities for Health: Improve health of the entire community by linking community prevention activities with health care

Medical Board of California Opportunities

- Promote CWP as resource for measureable population health performance metrics
- Encourage Physicians to contact local health departments about community prevention
- CDPH HIE gateway for electronic reporting (Meaningful Use) http://hie.cdph.ca.gov/ to increase breadth & quantity of public health data
- Join CWP Goal 2 Work Group

CME Activity for MBC Newsletter

Colorectal Cancer Prevention and Early Detection: What Role Does the Primary Care Provider Play?

- Free to first 600 users. Discount Code "C4PSpecial"
- 1.5 AMA PRA Category 1 Credits™. ($35 value)
- UCSF faculty advisors: Dr. Michael Potter & Dr. Lukejohn Day. http://www.cdph.ca.gov/programs/Pages/C4P.aspx

Coming Soon!

CDPH Open Data Portal

- Promoting the liberation of public health data
- Partner: California Health Care Foundation

  Free the Data Initiative
  http://www.chcf.org/projects/2012/free-the-data

Questions?

Jessica Núñez de Ybarra, MD, MPH, FACPM

Director of Coordination

Chronic Disease Control Branch

California Department of Public Health

916.552.9877 Jnunez2@cdph.ca.gov

Let's Get Healthy California Task Force Final Report

December 19, 2012

Letter from Task Force Co-Chairs

It is with great pride and enthusiasm that we present the "Let's Get Healthy California" Task Force report.

Over the past six months, California's leaders in health and health care have come together to share their expertise, passion, and creativity to develop this vision to improve the health of all Californians. The Task Force's charge was ambitious—envision what California will look like in ten years if we commit to becoming the healthiest state in the nation.

We know that time is of the essence. Californians are experiencing an unprecedented increase in chronic disease. In addition, racial and ethnic disparities across many health outcomes are widening and health care costs continue to surpass the rate of inflation.

Yet faced with these challenges, this report recognizes that opportunities abound. California has a strong track record of utilizing our world-class talent and diversity to spur innovation and improve health, including being an early implementer of the federal Affordable Care Act. Building on these successes, this report looks forward at ways we can work together to achieve dramatic and critically necessary changes that will result in better health, better care, and lower health care costs for all Californians.

The report provides a framework for assessing Californians' health across the lifespan, with a focus on healthy beginnings, living well, and end-of-life. The Task Force also identified three areas that most profoundly affect the health and health care landscape: redesigning the health care delivery system, creating healthy communities and neighborhoods, and lowering the cost of care. Importantly, the report makes clear that eliminating health disparities is an over-arching goal. We will not see improvements in health without viewing changes through a health equity lens.

Within each of six goals, the Task Force identified a set of priorities. To track progress within these goals 39 health indicators were selected that, taken together, paint a picture of the state's overall level of health; nine additional indicators were identified that don't yet have a data source. We have created a Dashboard that contains the 39 indicators, the data behind them, and ten-year targets. We will use the Dashboard to follow whether Californians are becoming healthier, or not, over time. The Dashboard reflects priorities and indicators at this point in time and will likely change as our needs and our ability to measure them evolve. It is our hope that by tracking these indicators, we will stimulate actions to collectively make a measurable difference.

Some such actions are highlighted in the first two appendices of the report (see Appendix I., II.). In myriad ways, Californians are already working together to build a healthier state through innovative, evidence-based projects and practices. It is these catalysts for change that will enable us to move forward on improvements in health.

We are indebted to the members of the Task Force, the Expert Advisors, staff, and the wide-range of organizations and individuals who have given so generously of their time and talent to develop this report. We are grateful for their commitment and leadership as we work toward our call-to-action---Let's Get Healthy California!

Diana S. Dooley, JD
Secretary, California Health and Human Services Agency
Task Force Co-Chair

Donald Berwick, MD, MPP, FRCP
Former Administrator, Centers for Medicare and Medicaid Services
Task Force Co-Chair

Acknowledgements

We would like to express deep appreciation to The California Endowment (TCE) for supporting the "Let's Get Healthy California" Task Force. We also would like to acknowledge and thank the leadership of the Service Employees International Union – United Healthcare Workers West (SEIU-UHW) for their role in the initial planning and development of the "Let's Get Healthy California" Task Force.

Special thanks to TCE, Kaiser Permanente, the Sutter Center for Health Professions, and their talented staff for hosting our three in-person meetings.

We extend our gratitude to the California Department of Health Care Services information technology team which made our many webinars possible.

We are grateful to the many organizations that lent expertise and provided information on various priority areas and indicators. Where appropriate, such contributors are noted in footnotes and listed in an Appendix.

Finally, we are indebted to the members of the public who attended and contributed to Task Force webinars and meetings, and submitted written comments. Your feedback greatly helped to improve this report.

Executive Summary

On May 3, 2012, Governor Jerry Brown issued Executive Order B-19-12 establishing the Let's Get Healthy California Task Force to "develop a 10-year plan for improving the health of Californians, controlling health care costs, promoting personal responsibility for individual health, and advancing health equity." The Executive Order directed the Task Force to issue a report by mid-December, 2012, with recommendations for how the state can make progress toward becoming the healthiest state in the nation over the next decade.

Co-chaired by California Health and Human Services Secretary Diana S. Dooley and Dr. Don Berwick, Founder and former President and CEO of the Institute for Healthcare Improvement and former Administrator of the Centers for Medicare and Medicaid Services (CMS), the Task Force brought together 23 California leaders in health and health care, supported by an equally distinguished group of 19 Expert Advisors. The Task Force's charge was to lay out a course to address two questions:

What will it look like if California is the healthiest state in the nation?
&
What will it take for California to be the healthiest state in the nation?

With the Triple Aim as a foundation, and informed by extensive and wide-ranging feedback—collected through a series of webinars, online surveys, and meetings—the Task Force developed an overarching Framework. The Framework identified six goals, organized under two strategic directions.

The first strategic direction, Health Across the Lifespan, sets out key milestones and markers of health and well-being in three critical life stages:

Health Across the Lifespan
Goal 1. Healthy Beginnings: Laying the Foundation for a Healthy Life
Goal 2. Living Well: Preventing and Managing Chronic Disease
Goal 3. End of Life: Maintaining Dignity and Independence

The second strategic direction, Pathways to Health, covers the practice and policy changes needed to improve the quality and efficiency of the health care system and to make community environments more conducive to being healthy.

Pathways to Health
Goal 4. Redesigning the Health System: Efficient, Safe, and Patient-Centered Care
Goal 5. Creating Healthy Communities: Enabling Healthy Living
Goal 6. Lowering the Cost of Care: Making Coverage Affordable and Aligning Financing to Health Outcomes.

The Task Force identified a total of 30 priorities within these six goals; a Dashboard was developed, with 39 measurable indicators that, taken together, convey the state of California's health—at both the population and system levels; nine additional indicators were identified that don't yet have a data source behind them.

Furthermore, the Framework makes clear that health equity should be fully integrated across the entire effort. Health outcomes vary dramatically by demographics, geography and a host of socio-economic conditions. For California to be the healthiest state in the nation, health disparities must be reduced and, ultimately, eliminated. The underlying principle guiding the establishment of ten-year targets is that these gaps can be closed.

With the Framework and Dashboard finalized, the challenge going forward is to identify evidence-based interventions and quicken the pace of uptake across the state. The report identifies a range of private sector efforts and public sector programs that seek to improve one or more of the priorities. This list is just a start, however. Although the Let's Get Healthy California Task Force officially ends, a website will be created and housed at the California Health and Human Services (CHHS) Agency. It will serve as a repository of the report, the Dashboard and the inventory of change strategies, and as a way to promote information sharing, facilitate collaboration, and enable progress to be collectively tracked.

The high level of participation and enthusiasm expressed throughout this process by more than three-dozen Task Force members and Expert Advisers, along with countless others, is a testament to the strong desire and commitment to make California the healthiest state in the nation. The Task Force encourages stakeholders, policymakers, and the public to join together to advance the goals and priorities identified in this report and create a statewide culture of health. The CHHS Agency will play a convening role to advance this agenda going forward.

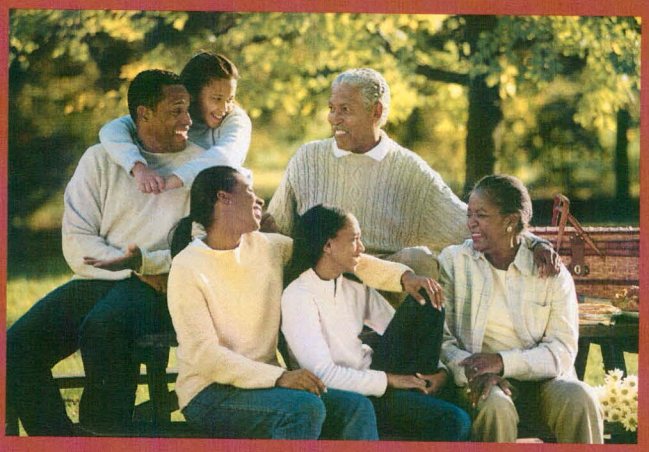
To View Full Report, Click Below Link

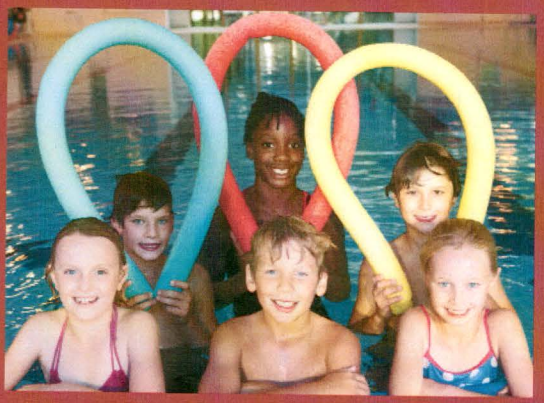
http://www.chhs.ca.gov/pages/LGHCTF.aspx

California Department of Public Health

California Wellness Plan

2014





California Wellness Plan 2014

Inquiries regarding this Plan may be directed to:

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Message from the Director

February 12, 2014

The California Department of Public Health (CDPH) is committed to the coordination of chronic disease prevention efforts to achieve equity in health and wellness.

CDPH's chronic disease and risk factor programs aim to promote health and eliminate preventable chronic disease. These include programs addressing cardiovascular disease, cancer, stroke, diabetes, obesity, asthma, dental caries, Alzheimer's disease, arthritis, tobacco use, physical inactivity, poor nutrition, injury and violence prevention, and environmental/occupational health. These programs coordinate with other CDPH programs that promote Health in All Policies, school health, maternal child adolescent health, workforce development and public health accreditation, health statistics, and health informatics. Most importantly, these programs collaborate with local and state partners engaged in chronic disease prevention.

The California Wellness Plan (Plan) is the result of a statewide process led by CDPH to develop a roadmap with partners to create communities in which people can be healthy, improve the quality of clinical and community care, increase access to usable health information, assure continued public health capacity to achieve health equity, and empower communities to create healthier environments.

I am thankful to the many program staff and statewide partners involved in the development of this Plan. Through this coordinated effort, CDPH provides a venue to align public health chronic disease prevention and health promotion efforts to ensure the best possible population health outcomes for all Californians. I invite you to review the Plan and join in our ambitious effort to find common approaches to reduce the burden and impact of chronic disease in California.

Sincerely,

Ron Chapman, MD, MPH
Director and State Health Officer
California Department of Public Health

1 – Executive Summary

Chronic Disease Problem

Cardiovascular disease, cancer, stroke, diabetes, asthma, chronic obstructive pulmonary disease, obesity, mental health conditions, substance-use disorders, dental caries, arthritis, Alzheimer's disease, and unintentional injury are the leading causes of death, disability, and diminished quality of life in California. These chronic conditions impact some populations more than others, resulting in significant inequities in health outcomes and quality of life within California's population of approximately 38 million people.[1]

Fourteen million people in California are estimated to be living with at least one chronic condition; more than half of this group has multiple chronic conditions. Chronic disease and injury not only cause the majority of deaths, but also contribute to poor quality of life, disability, and premature death. The prevalence of chronic disease raises public health concerns and has significant economic impacts. And, the costs of chronic disease continue to rise. In 2002, the most recent year for which data is available, approximately $70 billion, or 80 percent of California's health care expenditures, was spent on people with chronic conditions.[2]

Chronic disease is defined broadly in this Plan, and includes chronic conditions, injuries, violence, and environmental, occupational, and infectious causes of chronic disease. Chronic disease prevention is inclusive of primary, secondary, and tertiary prevention, and involves addressing a broad array of risk factors using a Health in All Policies approach and a Life Course Perspective.

Prevention is Possible

Chronic diseases are largely preventable.[2] Up to 80 percent of cardiovascular disease, stroke, type 2 diabetes, and over 30 percent of cancers could be prevented by eliminating tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol. It is estimated that $10 per person per year invested in prevention would yield $1.7 billion annually in health care savings in California within 5 years, a return of $4.80 for every $1 spent.[3]

California's communities and health care systems have a significant impact on health. However, current laws and policies have led to community conditions that contribute to poor health, and health care systems geared to treat acute events (such as heart attacks) rather than prevent disease. Prevention includes interventions that keep disease at bay, diagnose disease early, prevent progression of disease through delivery of quality care, and provide care in the context of the community.

To improve the health of Californians, it is critical to increase the social desire and ability of communities to make changes to their environment, so that the healthy choice is the default choice. Only 5 of the 30 year life expectancy gain since the 1900s is attributable to better health care.[4] Health care provider recommendations for behavior change or prescriptions for medication and access to health care are not the only solutions needed. A focus only on disease ignores the common risk factors that are at the root of poor health. Prevention of chronic disease and improved health depends on an environment that supports healthful choices, in addition to access to quality, coordinated health systems.

Roadmap to Prevention

The Overarching Goal of the California Wellness Plan (Plan) is ***Equity in Health and Wellbeing***, with an emphasis on the elimination of preventable chronic disease. To attain this, the following four Goals were determined by partners through a collaborative statewide process. Statewide partners have proposed Focus Areas (under Goals) around which to align efforts for the next 2 years, as a means to achieve synergy and greater impact.

1. ***Healthy Communities***

    I. *Create healthy, safe, built environments that promote active transport, regular daily physical activity, healthy eating, and other healthy behaviors, such as by adoption of health considerations into General Plans*

2. ***Optimal Health Systems Linked with Community Prevention***

    I. *Build on strategic opportunities, current investments and innovations in the Patient Protection and Affordable Care Act, prevention, and expanded managed care, to create a systems approach to improving patient and community health*

3. ***Accessible and Usable Health Information***

    I. *Expand access to comprehensive statewide data with flexible reporting capacity to meet state and local needs*

4. ***Prevention Sustainability and Capacity***

    I. *Collaborate with health care systems, providers and payers to show the value of greater investment in community–based prevention approaches that address underlying determinants of poor health and chronic disease*
    II. *Explore dedicated funding streams for community-based prevention*
    III. *Align newly secured and existing public health and cross-sectoral funding sources to support broad community-based prevention*

The Plan includes 26 Priorities and Performance Measures determined by the Let's Get Healthy California Taskforce (LGHCTF) in 2012. It fits within the LGHCTF overarching framework under the first Strategic Direction: "Health Across the Lifespan," and Goal 2, "Living Well: Preventing and Managing Chronic Disease." The Plan includes evidence-based strategies, and identifies California Department of Public Health (CDPH) and partner chronic disease prevention Objectives, including performance measure baselines and targets. The Plan provides California with a roadmap to prevent chronic disease and promote equity for the largest number of Californians possible. As social determinants of health cannot be changed by individuals alone, collaborative, organized policy efforts at community, regional, and state levels are required to achieve equity in health status. This will be achieved through continuing communication, collaboration, and coordination with partners.

The Plan is intended to be dynamic as CDPH coordinates with partners, monitors population health outcomes, and adapts to changes in funding and policy. The "Advancing Prevention in the 21st Century" conference is scheduled to be held in February 2014 to further refine the Plan. The conference will bring together key partners from across the state to identify and commit to Focus Areas for aligned efforts over the next two years.

This public–private sector collaboration will strengthen California's infrastructure to improve health in both community and clinical settings. It illuminates the important role public health has in joint efforts to improve population outcomes, bend the medical care cost curve, and achieve health equity.

To View Full Report, Click Below Link

http://www.cdph.ca.gov/programs/cdcb/Pages/CAWellnessPlan.aspx

Education and Wellness Committee
Strategic Plan Update

Please Note: Only activities assigned to the Public Information Officer are listed in the update. In addition, only those items that are due or have actions completed will have updates included.

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.3	**Identify methods to help ensure the Board is receiving all the mandated reports.**		**High - 3**
Activities		**Date**	**Responsible Parties**
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
• **The Summer Newsletter will have an article from the Los Angeles Coroner on the need for physicians to sign death certificates.** • **Board staff are completing an article for the coroners to include in their newsletter on the need for a coroner to report to the Medical Board pursuant to Business and Professions Code section 802.5.** • **The Summer Newsletter will have an article on the importance of physicians reporting pesticide poisoning to the local health department and the protocol to file the report.**			
d.	Conduct outreach on reporting requirements to all mandated reporters, as resources allow.	July-2014 and ongoing	Public Information Officer
• **On May 8, 2014, a presentation was provided to the California Association of Medical Staff Services in Sacramento addressing mandatory reporting requirements, specifically focusing on the Business and Professions Code Sections 805 and 805.01 reporting process and requirements. Approximately 100 individuals were in attendance.** • **On August 1, 2014, a presentation will be provided to the California Association of Medical Staff Services in Riverside addressing the Business and Professions Code Sections 805 and 805.01 reporting process.**			

Education and Wellness Committee
Strategic Plan Update

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
3.2	**Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.**		**High - 2**
Activities		**Date**	**Responsible Parties**
a.	Engage in two or more consumer outreach events with area organizations, as travel permits.	Quarterly	Public Information Officer

- **On February 11, 2014, a presentation was provided to military retirees at McClellan Air Force Base on the role of the Medical Board.**
- **On March 20, 2014, a presentation on the Outpatient Surgery Setting Program and Task Force was provided to the California Ambulatory Surgery Association. The presentation was on the evolution of the surgery centers, what the Board is currently doing, legislative proposals for improving the outpatient setting requirements, and what is going to be done in the future.**
- **On March 24, 2014, the Medical Board participated in the ENOUGH! Rally at the State Capitol sponsored by the National Coalition Against Prescription Drug Abuse (NCAPDA). Board staff set up a table with information on the Medical Board, including how to file a complaint, and a presentation regarding how the Medical Board is battling this issue was provided.**
- **On April 2, 2014, a presentation on the Medical Board and its roles and duties was provided to a Consumer Health class at Sacramento State University.**
- **On May 14, 2014, Board staff attended the Annual Franchise Tax Board Health Fair. Board materials were passed out and questions were answered about the Medical Board's roles.**
- **In April, 2014, a PSA was released to educate physicians on the prescription drug abuse epidemic.**
- **In June, 2014, a PSA was released featuring Olympic Swimmer Natalie Coughlin designed to inform and educate consumers on the prescription drug abuse epidemic.**
- **On June 4, 2014, Board staff met with the Alzheimer's Association of California to discuss future articles in the Newsletter on issues impacting Alzheimer's and Dementia patients, as well as public speaking engagements and outreach by the Board to educate the Association on the Medical Board's roles and functions.**

Education and Wellness Committee
Strategic Plan Update

• **On July 29, 2014, Board staff will be joining the State Bar of California and other state consumer agencies in its first Town Hall Meeting. This meeting is for the Hispanic community in Santa Ana California, and is hosted by Assemblyman Tom Daly's District Office. Board staff will be passing out materials in Spanish and will be providing a presentation on the Medical Board's roles and functions, concentrating on the complaint process.** • **On August 23, 2014, Board staff will attend a Town Hall Meeting with the California State Bar hosted by Assemblyman Steve Fox's District Office in Palmdale. The Town Hall will be focusing on seniors and Board staff will present information on the Medical Board's roles and functions, concentrating on the complaint process.** **In August 2014, the Board staff will be participating in a Health Forum in Oakland.**			
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
• **The Summer Newsletter will have an article regarding the inadvertent unlicensed practice of medicine by postgraduate training individuals.** • **The Summer Newsletter will have an article explaining the priority review status for applicants who will be working in underserved areas.**			
c.	Launch a Twitter account to provide stakeholders with updates on best practices, changes in laws and regulations, and recent Board activities.	Aug-2014	Public Information Officer
• **This is on hold due to a staff shortage. Once the vacant position is filled, the Board will begin the launch of a Twitter account.**			
d.	Provide two or more articles to appropriate media outlets regarding laws and regulations and what they mean to stakeholders.	Quarterly	Public Information Officer
• **As mentioned in 2.3c above, Board staff are preparing an article to address the need for a coroner to report to the Medical Board pursuant to Business and Professions Code section 802.5.** • **Board staff will be looking at other opportunities to provide articles to media outlets.**			

Education and Wellness Committee
Strategic Plan Update

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
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**
Activities		**Date**	**Responsible Parties**
a.	Work with DCA to establish webinar protocol and the tools needed to hold successful webinars.	Jun-2014	Public Information Officer
• **The Board just hired an individual that will begin working on July 14, 2014. This individual will be focused on identifying needed webinars/training and moving forward with this objective.**			
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

Education and Wellness Committee
Strategic Plan Update

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
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.**		**High - 4**
Activities		**Date**	**Responsible Parties**
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. Provides updates to the Board.	Quarterly	Public Information Officer
• **The Town Hall meetings discussed in 3.2a will be a key to developing this goal.** • **In April, 2014, Board staff (including a Spanish-speaking investigator) assisted Telemundo with a multiple-part series on consumer protection for the Hispanic community. The Board has established a good working relationship with Telemundo and will continue to identify ways to work with it in the future.**			
b.	Engage in television and radio interviews promoting transparency and providing needed information as requested.	Ongoing	Public Information Officer
• **This is done on a daily basis with both California and National media.**			
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
• **In April, 2014, a PSA was released to educate physicians on the prescription drug abuse epidemic.** • **In June, 2014, a PSA was released featuring Olympic Swimmer Natalie Coughlin designed to inform and educate consumers on the prescription drug abuse epidemic.** • **A third PSA for the consumer is also going to be released in July or August.**			

Education and Wellness Committee
Strategic Plan Update

d.	Promote the Board's website and provide consumer friendly information on how to file a complaint.	Ongoing	Public Information Officer
• **Board staff is working on a video to be placed on the Board's website explaining how to file a complaint.** • **Board staff is working on a video to be placed on the Board's website explaining "how to look up your physician." The Board will promote this video once it is completed.**			

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
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**
Activities		**Date**	**Responsible Parties**
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
• **The Board staff has a list, and will continue to expand it in the future.**			
b.	Cultivate relationships with groups not previously engaged, in order to provide seminars.	Sep-2014	Public Information Officer
• **The Summer Newsletter will have an article reaching out to readers and stakeholders offering speakers to provide presentations at meetings regarding the Board.**			
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

Education and Wellness Committee
Strategic Plan Update

Goal 4: Organizational Relationships: Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.			
4.2	**Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.**		**High - 2**
Activities		**Date**	**Responsible Parties**
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 Appropriate Subject Matter Expert
• **See 2.3d and 3.2a above.** • **On June 18, 2014, Board staff met with the UC Schools and the UC Regents representative to discuss graduate medical education issues and overall application/licensing issues.**			
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**
Activities		**Date**	**Responsible Parties**
a.	Develop a contact list of representatives for stakeholder organizations.	Mar-2014 and update annually	Public Information Officer
• **The Public Information Officer is maintaining a contact list for the stakeholder organizations who have contacted the Board and will continue to add to this list.**			

Education and Wellness Committee
Strategic Plan Update

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
• **See 2.3d and 3.2a above.** • **The Summer Newsletter will have an article reaching out to readers and stakeholders offering speakers to provide presentations at meetings regarding the Board.**			
c.	Maintain regular communication with stakeholders, including attending stakeholder meetings as appropriate, as travel permits.	Ongoing	Public Information Officer
• **Board staff met, and will meet on a quarterly basis, with the California Medical Association on issues of interest.** • **Board staff met, and will continue to meet, with Consumer's Union on issues of interest.** • **Board staff met with a specialty board regarding the impact of disciplinary action on a physician's board certification.** • **Board staff have attended webinars provided by the Federation of State Medical Boards (FSMB) and have provided input on issues raised by the FSMB.** • **Board staff meet with Department of Consumer Affairs Executive Staff on an ongoing basis.**			
d.	Invite stakeholders to participate in the Board's Newsletter with articles and information, approved by the Editorial Committee, pertinent to licensees.	Mar-2014 and ongoing	Public Information Officer
• **The Summer Newsletter will have an article provided by the Los Angeles County Coroner.** • **The Summer Newsletter will have an article provided by the Office of Environmental Health Hazard Assessment.**			
e.	Provide activity reports to the Education and Wellness Committee.	At each committee meeting	Public Information Officer
• **Provided July 24, 2014**			

Education and Wellness Committee
Strategic Plan Update

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	**Inform the Board and stakeholders on the Affordable Care Act (ACA) and how it will impact the physician practice, workforce, and utilization of allied healthcare professionals, and access to care for patients.**		**High**
Activities		**Date**	**Responsible Parties**
b.	Identify and obtain ACA articles to print in the Board's Newsletter.	Bi-annually	Public Information Officer
• **The President's Message in the Summer Newsletter will focus on the ACA roll out.**			
c.	Educate physicians on opportunities to assist patients not within the ACA in obtaining access to care.	Bi-annually	Public Information Officer

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

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

Thursday July 24, 2014
4:00 p.m. – 6:00 p.m.
(or until the conclusion of business)

Friday, July 25, 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
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, July 24, 2014

1. 4:00 p.m. Call to Order/Roll Call

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

3. Approval of Minutes from the May 1-2, 2014 Meeting

4. Presentation on Improvements and Changes to the Controlled Substance Utilization Review and Evaluation System (CURES) – Mike Small, Department of Justice

5. Presentation on Physician Impairment – Ms. Cady

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

7. President's Report – Dr. Levine

8. 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
F. Discussion and Consideration of State Licensure for Telemedicine
G. 2015 Proposed Board Meeting Dates

9. Election of Officers

Friday, July 25, 2014

10. 9:00 a.m. Call to Order/Roll Call

11. 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)].

12. Update from the Department of Consumer Affairs – Mr. Kidane/Ms. Lally
    A. BreEZe Update

13. Update on the Health Professions Education Foundation – Ms. Yaroslavsky

14. Update on Education and Wellness Committee Meeting – Ms. Yaroslavsky

15. Update on Licensing Committee Meeting – Dr. Bishop

16. Discussion and Consideration of Disclosure of Approved Postgraduate Training – Ms. Kirchmeyer

17. Discussion and Consideration of Proposed Regulations for Amendments to Title 16 CCR, Sections 1364.10, 1364.12 1364.13, and 1364.14 – Citations and Fines – Ms. Kirchmeyer

18. Discussion and Consideration of Proposed Regulations Updating the Disciplinary Guidelines, Title 16 CCR, Section 1361 – Ms. Cady

19. Update on Transition of Staff to the Department of Consumer Affairs – Mr. Gomez

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

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

22. Update on Physician Assistant Board – Dr. Bishop

23. Discussion and Consideration of Legislation/Regulations – Ms. Simoes
    A. 2014 Legislation
    B. Status of Regulatory Actions

24. Agenda Items for October 23-24, 2014 Meeting in San Diego

25. 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) 230-1093.

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 three minutes per agenda item. However, during Agenda Item **2 and 11** – Public Comments on Items Not on the Agenda, the Board 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.

Agenda Item 3

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

Sheraton Gateway – LAX
6101 West Century Boulevard
Los Angeles, CA 90045

May 1-2, 2014

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:
David Serrano Sewell, J.D., Vice President
Michael Bishop, M.D.
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Howard Krauss, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Denise Pines
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:
Sharon Levine, M.D., President

Staff Present:
William Boyd, Investigator, Valencia District Office
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Errol Fuller, Investigator, Glendale District Office
Kimberly Kirchmeyer, Executive Director
Erin Nelson, Business Service Analyst
James Nuovo, M.D., Medical Consultant
Regina Rao, Associate Governmental Program Analyst
Mark Servis, M.D., Medical Consultant
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
Tracy Tu, Investigator, Glendale District Office
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
Alicia Cole, Consumer's Union
Patrick Domelian, Medical University of the Americas
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jack French, Consumer's Union
Jodi Hicks, California Academy of Family Physicians
Tara Kittle
Lisa McGiffert, Consumer's Union
Tina Minasian, Consumer's Union
Carole Moss, Niles Project and California Safe Patient Project
Ty Moss, Niles Project and California Safe Patient Project
Danielle Nunez, Consumer's Union
William Pinsky, M.D., Ochsner Health System
Harrison Robbins, M.D., California Academy of Cosmetic Surgeons
Steven Rodger, Medical University of the Americas
Cesar Victoria, Department of Consumer Affairs

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell began by recognizing a former Board Member and past President of the Board, which recently passed away, Dr. Mitch Karlan, and asked for a moment of silence. Dr. Karlan was a respected member of the Los Angeles physicians' community, and a respected instructor at the UC School of Medicine. The American Cancer Society also honored him as "man of the year."

Ms. Kirchmeyer recognized and introduced a few staff members from the local district offices, Tracy Tu, William Boyd, and Errol Fuller.

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on May 1, 2014, at 4:17 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

Tara Kittle requested an agenda item for the next Board meeting. She asked that the Board establish a committee to identify physician obstacles that occur in their daily practice of medicine and propose various solutions.

Alicia Cole, Consumer's Union Safe Patient Project, requested that the Board amend the guidelines to make it a standard condition of probation that a physician who continues to see patients while under a disciplinary order, be required to inform their patients that he/she is on probation.

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

Ms. Yaroslavsky made a motion to approve the February 2014 Meeting Minutes as submitted; s/Dr. Yip. Motion carried.

Agenda Item 4 Discussion and Consideration of Queensland/Ochsner Medical School Application for Recognition

Mr. Worden introduced Dr. Nuovo from the University of California Davis School of Medicine. Dr. Nuovo gave a brief presentation on the site visit to Queensland/Ochsner Medical School that took place March 18-21, 2014. The attendees of this site visit included, Dr. GnanaDev, Mr. Worden, Ms. Webb, and Dr. Nuovo. The presentation gave an overview of what the site visit involved, as well as the areas of concern that were identified. The goal of this site visit was to address the areas of concern from the comprehensive review to determine whether the program was in compliance with Business and Professions (B&P) Code Sections 2089 and 2089.5, and California Code of Regulations (CCR) Title 16, section 1314.1. One area of concern was the application selection process, and the fact that the school was not interviewing students as part of the selection process for attendance. The Board also looked at the communication process between the University of Queensland, in Brisbane, Australia, and the Ochsner Clinical School campus in New Orleans to identify the challenges of distance and time zone. Another focus of the site visit was the process of addressing academic concerns. Prior to the site visit, staff received a report from Dr. Crawford, Head of the University of Queensland School of Medicine, stating that he reviewed and approved the interview process plan and that faculty and students from Ochsner will be involved in the interview process by the Board. With this change, Dr. Nuovo determined the process is consistent with the methods that United States (U.S.) and Canadian schools use to admit students to their respective schools and consistent with CCR Title 16, section 1314.1.

Dr. Nuovo stated he is confident that the school complies with all statutes and regulations and recommends recognition by the Board.

Dr. GnanaDev thanked the Board staff and Dr. Nuovo for their hard work and dedication to this visit. He then complimented the Ochsner Clinic and University of Queensland (UQ) for taking all of the staff's recommendations and implementing them graciously.

Dr. GnanaDev stated that the school has one of two new models of medical education. The two new models are problem-based learning, as well as the case presentation model. Both start with patient care and clinical-related activity beginning day one of medical school. Only seven schools in the U.S. use these models. He feels that the students will have a lot more training their first two years when compared to the traditional medical school.

Dr. Krauss stated that when Ochsner announced this program in 2009, the motivation was to deal with physician shortages in South Louisiana. He asked why there is a concern for California licensure.

Mr. Worden stated that this is an international school, so there will be applicants from California who will want to attend, but need to ensure the school is recognized by California prior to licensure. Additionally, other states use California's recognition process. Therefore, it is important for any international school to be recognized by the Board.

Dr. Pinsky stated that one of the goals when starting the program was knowing that there was a physician shortage in the country. Another was to increase the number of medical school graduates in the U.S. When looking at population densities and where students are coming from, California is clearly important.

Ms. Kirchmeyer added that if the Board did not go through this process and recognize these schools, those students could not apply for licensure in California.

Dr. Lewis asked if after reviewing the vitaes and backgrounds of the training faculty, were they sufficient for medical school teaching. He also asked after interviewing the students, what was learned from them concerning their relationships and education from the faculty.

Dr. Nuovo stated after reviewing all of the qualifications of the faculty that were in the packet from the University of Queensland, it was determined they were equivalent to the faculty at a U.S. school. In regards to the student interviews, Dr. Nuovo stated that he interviewed several students in several different settings in different facilities. The conversations were typical of any student in any school in that there are strengths and weaknesses in the programs, and that in general, the students were very positive about their educational experiences, and felt the faculty was very "approachable."

Ms. Yaroslavsky stated her concerns about the school's resources for the class sizes that are expected.

Dr. Pinsky stated the site team visited the schools new academic building, which includes both education and research. It also includes the classrooms and testing center. The school is a ten-hospital system and has over 200 academic titleholders. They have over 900 physicians and 42 clinics. There are no space problems for the growth of the class sizes.

Dr. GnanaDev made a motion to approve the recommendation to recognize the University of Queensland School of Medicine/Ochsner Clinical School Program (UQO)and to extend that recognition to those who matriculate at UQO on or after January 1, 2009; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 5 Discussion and Consideration of Medical University of the Americas Medical School Application for Recognition

Mr. Worden stated the Medical University of the Americas (MUA) Medical School is another school that is being evaluated by the Board for recognition. Mr. Worden noted that this is the first time the Board has had a chance to evaluate this school. Mr. Worden introduced Dr. Servis as the medical expert for this school review.

Dr. Servis stated the Medical University of the Americas Medical School is a for-profit school and is based on the Island of Nevis in the Caribbean. Dr. Servis reviewed the various documents that were provided and found some areas of concern. The nine areas of concern are listed in his report. In the areas where he felt more information was needed, he requested follow-up documentation from the school. The follow-up documents that were received had addressed several of the original areas of concern. However, after careful review, five areas of concern remain. In summary, MUA may not be currently meeting certain 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 experiences between students and alignment with stated clinical competencies; (3) Unacceptable 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 assessment from graduates.

Dr. Servis noted that 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.

Dr. Servis stated further evaluation is warranted to confirm the information provided in the MUA Self-Assessment Report and the additional documentation provided by MUA. It was recommended that a site visit to MUA and some of its affiliated hospitals where students receive clinical clerkship courses be scheduled to provide the Board a full evaluation of MUA.

Steven Rodger, Chairman and CEO of R3 Education, stated that R3 Education is the enterprise that owns Medical University of Americas. He thanked Dr. Servis for his extensive and thorough work. Mr. Rodger noted that he does agree with the five areas of concern that Dr. Servis discussed, but wanted the Board to understand that these same areas were agenda items for them before Mr. Servis had written his report. In 2011, the decision was made to transfer to a competency-based program.

Ms. Yaroslavsky asked if MUA would be ready for the Board to review the school now or is it going to take time to resolve the areas of concern.

Mr. Serrano Sewell agreed with Ms. Yaroslavsky's concerns and based upon Dr. Servis' report, he feels there is a need for a site visit.

Mr. Worden recommended a site visit be conducted when the school has implemented the identified changes and the changes can be verified.

Dr. Lewis made a motion to conduct a future site visit, at a time determined by the Executive Director, and provide a report to the Board that is comprehensive and takes into account all of the relevant issues; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 6 Update on the Executive Committee and Consideration of Recommendation

Mr. Serrano Sewell gave a brief update on the decisions of the Executive Committee in regard to the Board's Strategic Plan. He stated the Committee discussed each individual goal and objective in the plan. Mr. Serrano Sewell noted three amendments were made as follows: item 3.2a and 3.2d, striking the words "at least" and adding the words "two or more;" Goal 3.4, the priority was changed from Medium priority to a High priority; Goal 6.1 is changed to read, "Inform the Board and Stakeholders on the Affordable Care Act, and how it will impact the physician practice, workforce, utilization of allied healthcare professionals, and access to care for patients." The Committee also added an objective "c" under 6.1 to read, "Educate physicians on opportunities to assist patients, not within the ACA, in obtaining access to care."

Dr. Lewis made a motion to adopt the strategic plan with the above-approved changes; s/Ms. Wright. Motion carried.

Agenda Item 7 Update on the Health Professions Education Foundation

Ms. Yaroslavsky stated that the Health Professions Education Foundation (HPEF) has had a good year. With the generosity of the California Endowment, they have received quite a bit of money. The HPEF report that was handed out has a lot of information about the Steven M. Thompson loan repayment program and the goal to come up with 103 awardees with 47 alternates. The HPEF is working on the criteria. It is changing all the time, and because they had an additional amount of money this year, the regulations allowed them to go outside the normal standards of criteria. The regulations need to be changed to be more in line to meet the needs of the people of California.

Ms. Yaroslavsky urged the Board to look at the report and noted that every Federal Qualified Health Center (FQHC) received applications. The HPEF needs to do a better job on outreach, and identifying the opportunities because it is up to $105,000 dollars toward the loan repayment for a three-year commitment in underserved communities. Ms. Yaroslavsky noted that she is proud of the work of the HPEF.

Dr. Diego added there was two recipients at the meeting to receive their awards and it was nice to hear their stories. She would like to have it publicized more so that people can really understand what great work this is and the dedication these physicians have to the underserved areas.

Tara Kittle reinforced that this program is a great program to help physicians pay back their loans. She stated that this is an issue of the Board as the burden of student loans directly affects the kind of medical care and the type of medical care that physicians can actually give.

Agenda Item 8 Update from the Department of Consumer Affairs

Mr. Serrano Sewell announced that Ms. Lally from the Department of Consumer Affairs (DCA) was unable to attend this month's meeting, so there will be no update given today.

Ms. Kirchmeyer briefly noted that she is continuing to meet with the DCA Director on a bi-weekly basis, and as of her last meeting, there was nothing discussed that needed to be brought to the Board's attention at this time.

Agenda Item 9 Board Member Communications with Interested Parties

Dr. GnanaDev stated he continues to participate with the AMA, CMA, the LCME, and the AAMC. He keeps the Board issues out of discussions with these entities.

Dr. Krauss continues to serve on the Board of the California Ambulatory Surgery Association (CASA.). He and Ms. Kirchmeyer participated in CASA's last board meeting by giving a presentation. Dr. Krauss is still a trustee of the California Medical Association (CMA).

Agenda Item 10 President's Report

Mr. Serrano Sewell noted that he and Dr. Levine continue to meet with the Board's Executive staff twice a month to discuss projects at the Board and to assure that everything is moving forward as needed. Dr. Levine will be speaking at the Prescription Drug Abuse summit in San Francisco on May 7, 2014. She will be speaking on what the Board has been doing to help fight the prescription drug abuse issues.

Mr. Serrano Sewell referred the members to agenda item 10 in their packets, which refers to Committee appointments. The only change since the last meeting is Mr. Lui has been added to the Enforcement Committee and Dr. Levine has been removed from that committee.

Agenda Item 11 Executive Management Reports – Ms. Kirchmeyer

Ms. Kirchmeyer asked for a motion for approval of orders following completion of probation and orders for license surrender during probation.

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

Ms. Kirchmeyer noted that the reports under the Executive Management reports which previously included just the Executive Director's Report, now includes the Enforcement report and the Licensing report. These reports are all under agenda item 11. There will be no verbal report unless a Member has any questions concerning one of these reports.

Ms. Kirchmeyer pointed out a few items to the Members. One item is regarding the Board's outreach and video for Prescription Drug Awareness Month, which was in March. Board staff along with assistance from DCA staff produced a video. This video was narrated by Dr. Bishop. This video can be found on the Board's website and several entities have linked the video to their websites. In the upcoming weeks, staff will be filming another public service announcement (PSA) with a Gold Medalist that will have more emphasis from a consumer aspect of the overprescribing issues. Staff will continue to make PSAs to use for both consumer and physician education purposes.

Ms. Kirchmeyer stated that there have been several phone calls received regarding the Board's licensing timeframes. The Board is currently reviewing applications within 40 – 45 days from receipt of application. If all of the necessary forms and paper work are received with the application, physicians can be licensed within five days of initial review. However, only 12% of the applications are complete when first reviewed. On the day the application is reviewed, the analyst sends a deficiency letter to the applicant stating what items are outstanding. From that point, the length of time it takes for licensure depends on the applicant and the entities that need to submit documentation to the Board. It was noted that when applicants say that it took them a long time to be licensed, in most cases it is due to the applicant not getting the necessary documents back to the Board in a timely manner. The only time the Board has delays is when there is an issue with the application that needs to be reviewed at a senior staff level, such as a conviction or residency issue, etc.

Ms. Kirchmeyer stated one problem that is occurring that is not in the Board materials is the time that it is taking to provide license verification. Due to the new BreEZe system, staff has been unable to provide information to the VeriDoc system that is responsible for the 24-hour license verifications. All verifications are being conducted at the Board, which is slowing the process down. A plan is being developed to eliminate the backlog on processing these documents.

Ms. Yaroslavsky noted her frustrations with the new BreEZe system. She asked if there was any way to go back to having access to the old system to look up licensees while the new system is being modified.

Ms. Kirchmeyer stated that DCA is working with the vendor to get changes made as soon as possible. In the meantime, DCA is looking at going outside of the BreEZe system to a different look-up system that is directly housed with DCA. Staff would have more control over this system and would not be hindered by the current vendor. Ms. Kirchmeyer stated she would take the Board's concerns regarding the look-up issues back to the leadership at DCA.

Dr. Bishop asked Ms. Kirchmeyer if she believed this system would ever work the way it was intended. Ms. Kirchmeyer stated she believes the system will work once all of the defects are worked out.

Ms. Kirchmeyer then stated the Board had recently received a letter regarding physicians on probation. This letter called upon the Board to immediately drug test every physician on probation, to create a random drug testing procedure for those on probation, and to require that every physician on probation be checked in the CURES system.

Ms. Kirchmeyer reminded the Board that every physician on probation who has biological fluid testing as a condition of probation is already randomly tested. The Board does not have the authority to test if this condition is not in the order unless it has probable cause to do so. Should that cause become apparent, the Board would request the physician to voluntarily be tested or compel the physician to be tested. The Board does run a CURES report on physicians on probation if the physician has certain restrictions, such as abstaining from alcohol or drugs or has a prescribing restriction.

Ms. Kirchmeyer reported the Federation of State Medical Boards held their annual meeting from April 24 – 26, 2014. There is an outline in the packet of the presentations that were held at that meeting. One notable item not shown in the packet is the House of Delegates adopted the policy guidelines for safe practice of telemedicine. The Board submitted written comments on this policy and Board Members provided great suggestions that were included in the written comments.

Ms. Kirchmeyer asked Ms. Threadgill and her attending staff to stand. Ms. Kirchmeyer announced that due to the transition this would be the last time they attend the Board meetings as Board staff. Ms. Kirchmeyer thanked Ms. Threadgill and staff for all of the hard work they have done for the Board, all the work they will continue to do after the transition, asked them to be sure and pass this same thank you on to all of their co-workers.

Alicia Cole stated that the PSA by Dr. Bishop was well edited and very informative. She thanked the Board for their openness and honesty concerning the challenges of the BreEZe system. She stated that as a consumer group, the Consumer Union participants had a round table and went over the BreEZe system in detail and created a list of items where consumers are experiencing issues. She offered their services to the Board and DCA to work together to help work out some of the functionality issues for both the consumers and the physicians.

Julie D'Angelo Fellmeth encouraged the Board and Ms. Kirchmeyer to follow up with the DCA to shift the license look-up system outside of BreEZe. She noted that several things that are required by law to be posted and are not available on BreEZe at this point.

Tara Kittle encouraged the Board to consider putting a section on the website that is encrypted, safe and protects the public where a physician is required to look up a patient to see if they have received the same or similar type of prescription from another physician.

Jack French, Consumers Union Safe Patient Project, stated they are pleased the Board has begun offering teleconferencing to allow expanded public participation in the meetings. It is stated in Ms. Kirchmeyer's report that after this meeting, the teleconferencing services will be evaluated for efficiency and cost. Consumer's Union encourages the Board to continue the teleconferencing options to those who are unable to travel to these meetings, yet still wish to share their comments.

Meeting recessed at 6:05 p.m. until 9:00 a.m. Friday, May 2, 2014

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Friday May 2, 2014

Members Present:
David Serrano Sewell, J.D., Vice President
Michael Bishop, M.D.
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Ronald H. Lewis, M.D.
Howard Krauss, M.D.
Elwood Lui

Denise Pines
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:
Sharon Levine, M.D., President

Staff Present:
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Julie Escat, Supervising Investigator I, Valencia District Office
Kimberly Kirchmeyer, Executive Director
Caroline Montgomery, Investigator, Cerritos District Office
Erin Nelson, Business Services Analyst
Regina Rao, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Jack Sun, Investigator, San Dimas District Office
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
See Vang, Business Services Analyst
Caesar Victoria, Department of Consumer Affairs
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
Genevieve Clavreul
Alicia Cole, Consumer's Union, Safe Patient Project
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Jack French, Consumer's Union, Safe Patient Project
D. Anthony Jackson, M.D., Black American Political Association of California
Tara Kittle
Kim Kreifeldt, California Academy Physician Assistants
Lisa McGiffert, Consumer's Union
Greg Mennie, California Academy Physician Assistants
Tina Minasian, Consumer's Union, Safe Patient Project
Michele Monserratt-Ramos, Consumer's Union, Safe Patient Project
Ty Moss, Consumer's Union, Safe Patient Project
Teresa Pena, Assembly Member Bloom's Office
Harrison Robbins, M.D., California Academy of Cosmetic Surgeons
Cesar Victoria, Department of Consumer Affairs

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

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on May 2, 2014, at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 13 Public Comments on Items not on the Agenda

Tara Kittle commented on a public comment from the prior day's meeting, regarding a physician on probation and requiring them to notify their patients. She does not feel that if the disciplinary action was taken and the Board determined that the physician was safe to practice on probation that the physician should have to announce this to each patient.

Anthony Jackson, M.D., First AME Churches, the NAACP of California and BAPAC, discussed an American Medical Association global letter of apology that was issued in July 10, 2008. He stated this letter helped explain the racial disparities in healthcare, which still exist. He added that BAPAC and the California NAACP jointly adopted HR 4 to address these disparities. He questioned why mortality and morbidity for blacks are still disproportionately high even when social economic status and co-morbidity such as smoking, diet, drugs, are statistically accounted for. He stated that a study showed that the professional well-being of black physicians has a direct impact on the health and welfare of their patients. He requested that the matter of racial disparity in healthcare and in disciplinary actions taken be placed on the next agenda of the Board.

Rae Greulich, Consumer's Union, via teleconference, stated she feels that all California outpatient surgery centers should be required by law to report their infections to the state. She requested that the Board sponsor legislation for this to become a requirement to help protect California consumers.

Agenda Item 14 Update on Enforcement Committee

Dr. GnanaDev gave an update on the Enforcement Committee Meeting. The Committee received a presentation from Ms. Kirchmeyer on the MOU between the Board and DCA related to the transition. This MOU is an agreement between the Board and the DCA, and defines the relationship between the two parties, including the responsibilities of DCA and the Board, and the specific roles of each party during the transition.

The Committee also received an update on the progress of the transition pursuant to SB 304 from Mr. Gomez, DCA Division of Investigation (DOI). Mr. Gomez reported that town hall meetings were scheduled for the week of May 5, 2014. These meetings will include participation from all employees, the Board and DOI. Mr. Gomez reported that meet and confer sessions have occurred between DCA and affected bargaining units. Mr. Gomez stated he had completed his meet and greets with the Board's investigative staff. Mr. Gomez noted he has formed a team that includes representatives from the Board and the DCA to work on a rewrite of the Vertical Enforcement (VE) manual. This rewrite will be completed before the transition effective date of July 1, 2014.

Mr. Gomez announced the scheduled swearing in ceremonies for sworn staff. One will be held in Riverside on June 30, 2014, and one in Sacramento on July 1, 2014. Board Members are welcome to attend either ceremony.

Ms. Kirchmeyer and Ms. Cady provided a presentation on statistical reports, which included data currently received by the Board and a recommendation to simplify the data received by the by the Board after July 1, 2014. The Committee requested data on the investigation timelines and compliance of open cases in a closed bar graph format.

The Committee also received a report on data for interim suspension orders (ISOs). The data included the number of ISOs requested and granted. The Committee requested additional information regarding how long it takes to request an ISO after a complaint is received.

The Committee received clarification on the role of the medical consultants that are Board employees versus expert reviewers, which are independent, unbiased reviewers of the Board.

Agenda Item 15 Vertical Enforcement Program Report

Ms. Castro began with an update on the case of Chiarottino vs. Linda Whitney. Dr. Chiarottino came to the Board's attention in 2011. In February 2012, an investigator had identified five patients from a CURES report and attempted to procure medical records. Since that time, those records are still being requested and the Court of Appeals just recently agreed that the Board has the ability, along with other law enforcement agencies, to search CURES. Dr. Chiarottino appealed the trial court order granting the Board's petition to compel compliance with investigative subpoenas. Subsequent to that, Dr. Chiarottino submitted an argument, which was supported by the CMA. In a published decision, the Court of Appeal upheld the Board's use of CURES and found the Board was authorized to review CURES data under Health and Safety Code Section 11165.

Ms. Castro announced some staffing changes in the Health Quality Enforcement Section (HQES). She stated two of her Deputies Attorney General (DAG) would be retiring, one from the San Francisco Office, and one from the Sacramento Office. She stated there would be two new people joining HQES staff, one will be located in the San Diego office, and the other in the Los Angeles office as of June 2, 2014.

Ms. Castro noted that ProLaw was mentioned at the previous day's meeting and that the AG's office is looking for a way to provide a portal so that relevant information needed for the Board can be accessible. She stated that law firms do not traditionally allow access to the attorney-client privilege work files, but feels it is important enough to provide markers in a way that that information can be managed. It cannot be linked with BreEZe at this point, and may not ever be able to, but a work around is being developed to assist in getting the Board the information they need.

Ms. Castro stated that she and Ms. Kirchmeyer continue to meet on a regular basis. She has worked for the past year to be sure that all of her staff at HQES manages the program in a similar manner and will continue that same management style after the transition takes place.

She recommended that the Board, DOJ, and DCA staff meet prior to July 1, 2014, to be sure everyone is on the same page and to memorialize the agreements that are already in place with Ms. Kirchmeyer and Ms. Threadgill.

In regard to the VE Manual, the version that was approved by the AG's office was sent to DCA on February 14, 2014. On March 5, 2014, Ms. Castro was told that DCA is working on restructuring it. She stated the manual they have now is very detailed and structured by a continuing partnership so the case can be completed as soon as possible. Ms. Castro would like to have a joint manual that both the AG's office and DCA can use together, rather than have two different ones.

Ms. Yaroslavsky thanked Ms. Castro for her efforts and engagement in trying to make things work. She stated that she is distressed that there is no joint manual currently and encouraged Ms. Castro to strive for a joint manual to keep things running smoothly for both her staff as well as Board staff.

Dr. GnanaDev asked Ms. Castro when the CURES system might become user friendly.

Ms. Castro stated she does not have a time line, but there is a team working on it that meets every two weeks and the meetings are very robust. They are working to get it completed as soon as possible, especially since it is becoming a multi-user platform.

Ms. Kirchmeyer thanked DAG Esther La and the AG's office for its hard work on the Chiarottino case.

Agenda Item 16 Update on the Prescribing Task Force

Dr. Bishop stated on February 9, 2014, the Prescribing Task Force held its second meeting. This meeting focused on potential revisions on the Board's Pain Management Guidelines. Invitations were sent to representatives from prescribing and dispensing communities, law enforcement, consumer groups, other regulatory boards, associations, other state agencies, pharmacies, pharmaceutical companies, and legislative staff. The meeting began with a brief overview of the Board's current guidelines. Dr. Fishman, representing the Federation of State Medical Boards (FSMB), provided a presentation on the FSMB's recently issued model policy on the use of opioid analgesics in the treatment of chronic pain. Dr. Reimer followed with a presentation on the Canadian Guidelines for the Safe and Effective Use of Opioids for Chronic Non-Cancer Pain. After the presentations, the Task Force went through the policies to see what items should be considered for inclusion in the Board's revised guidelines. Members were able to receive electronic feedback from the audience. The items where consensus was not obtained were discussed with the group. The Task Force was able to review approximately half of the FSMB's policy at the meeting. The next meeting will be in June and the Board will provide draft guidelines for the Task Force and interested parties to review. Additionally, the Board received a document on prescribing opioids from the CMA that provided some valuable information that will also be reviewed. The Task Force hopes to bring the revised guidelines to the Board for discussion at the October 2014 Board Meeting.

Dr. Bishop stated after the Task Force revises the guidelines, the Task Force will review best practices for prescribing opioid medication. They want to gather as much information as possible from all interested parties and subject matter experts. The information obtained on best practices will be used to establish Newsletter articles, a website specific to best practices, outreach presentations and other educational tools for the physicians and the public.

Yvonne Choong, CMA, reiterated Dr. Bishop's comments regarding the report that CMA had put out regarding clinical guidelines. The report was developed by their internal council on scientific affairs. The intended audience was to provide clinical guidelines for physicians who are not in this specialty field. CMA would appreciate being included in the process.

Dr. GnanaDev noted that on the enforcement cases, it has been recognized that it is the primary care physicians who get into trouble with the prescription drug issue, not the pain management doctors. The goal is to educate those who are not experts at pain management to follow the guidelines.

Dr. Bishop added he feels that whatever guidelines are decided on, they have to be easy to follow by the non-pain specialists. If they are not easy to follow, many physicians may decide to stop practicing in that area, which leaves patients at a loss for where to get pain medication when it is legitimately needed.

Ms. Yaroslavsky reminded the Board that the most important issue is to protect the consumer, so the sooner a proper methodology can be agreed upon, the better. It will not only protect the consumer, but physicians, as well.

Dr. Khadijan Lang, via teleconference, expressed her concerns regarding the treatment of physicians in minority neighborhoods.

Dr. James Tucker, via teleconference, voiced his support for the comments made by Dr. Jackson and Dr. Lang.

Agenda Item 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 referred the Members to tab 17 in the packets. The proposed regulations were sent out for a 15-day comment period, following the last Board Meeting. The word "or" was struck from the last sentence as approved by the Board. The comments received during the 15-day comment period were not specifically related to this change. Following consideration on the comments and discussions with counsel from the DCA and HQES, staff recommended further clarifying the definition of "immediately available." The proposed change would read as follows, "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 to address any situation requiring the supervising physician's services.

Ms. Webb asked for a motion allowing staff to refer this modified language back to the Physician Assistant Board (PAB) for review and approval. If the PAB approves the modified language, it would need to be noticed for another 15-day comment period.

Dr. Lewis made a motion to approve the modified language and refer the matter back to the PAB for review and approval. Upon approval, authorize the modified language to be noticed for another 15-day comment period and if no negative comments are received, authorize the Executive Director to make any non-substantive changes to the regulations and submit the package to the Office of Administrative Law. The motion was seconded by Dr. Bishop.

Kimberly Kreifeldt, physician assistant in San Diego, stated she attended the February Board Meeting when the Board was being urged to clarify Title 16 of the CCR, section 1399.541. She stated although she was disappointed that the counsel from the DCA and HQES felt it necessary to bring it back to the Board after the comment period, after reviewing their comments, she feels that it further defines "immediately available," and believes it is a reasonable request. The current recommendation does not change the intent of what was being sought to clarify. It will further protect consumers as well as bring physician assistants in line with the current community standards. Ms. Kreifeldt stated she supports these changes and urged the Board to do so as well.

Greg Mennie stated the modified language further protects the physician assistants, the surgeons, and the patient. He thanked the Board for considering these newest changes and urged the Board's support.

Motion carried.

Agenda Item 18 Update on Physician Assistant Board

Dr. Bishop announced that in early April 2014, the PAB implemented the ability for applicants to apply on-line in the BreEZe system. The PAB is scheduled to allow licensees to submit on-line renewals in August 2014. The PAB's strategic plan was last updated in 2009. The PAB recently reviewed and updated the plan. A draft of the plan was presented to the PAB at the February 2014 meeting and Members voted to adopt the draft as its strategic plan for 2014 to 2018.

Dr. Bishop noted that the current CURES system does not have the capability to meet the current and future demands and needs to be updated. SB 809 signed by the Governor in 2013 will address funding issues and allow enhancements to the system that will better meet the needs of the users of this information. SB 809 has also created a twelve-dollar fee for physician assistant (PA) renewals. This fee started with 2014 renewals as is done with licensees of the Medical Board. Work continues on the feasibility study report (FSR) between the DCA and the DOJ, which manages the CURES system. The FSR will address multiple business objectives, including automation and improvements to the CURES system and changes that apply with the legislative mandates of SB 809. Dr. Bishop stated future

meetings would be scheduled between DCA, including the PAB and DOJ to finalize the FSR for submission to the California Department of Technology for their review and approval.

Dr. Bishop announced that a diversion fee schedule has been developed to inform Administrative Law Judges, DAGs, licensees and applicants of typical costs of participation in the PAB's diversion program. This document will also inform applicants and licensees of initial practice restrictions required by SB 1441 when entering the program. This document has also been posted to the PAB website.

Dr. Bishop noted that DCA is in the process of redesigning various boards' websites to ensure a more updated and uniform look. In late February, PAB staff met with the DCA internet team to begin implementing this new design. The new site should be on-line either late May or early June 2014. The PAB was recently informed by Medical Board staff that all of the mandatory reporting forms used to report B&P Code Section 800 series have been updated to include physician assistants. These forms are available on the Medical Board and PAB's websites.

Dr. Bishop announced that the next PAB meeting is scheduled for May 19, 2014, in Sacramento.

Agenda Item 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 stated there were two letters received concerning SB 1441 Uniform Standards after the 15-day comment period. One letter was received from Consumer's Union. The second was from the California Medical Association (CMA). Consumer's Union requested that language be added from Uniform Standard 4 that states the Board may re-establish 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.

Ms. Webb recommended leaving the current language as it is, since the current proposed language under section 1361.5(c)(3)(D) states, "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." Further, under section 1361.5(c)(3)(C), the proposed language indicates, "The Board may order a licensee to undergo a biological fluid test on any day, at any time, including weekends and holidays."

Ms. Webb stated if the Board feels the need to order a licensee to undergo a biological fluid test and it returns negative, the Board will continue to monitor the physician. If the test returns positive, additional action will be ordered, as a positive test is a major violation.

Ms. Webb noted Consumer's Union comment is an important one, but feels the current language will cover the situation if the Board has a suspicion of a violation. She recommended no change be made to that particular section.

Ms. Webb continued with the next comment from the CMA. CMA requested the Board harmonize the use of "negative biological fluid tests" and "prohibited substance," under the proposed regulations and asked for the following amendment/addition to the proposed language under 1361.5(c)(1)(D), "or biological fluid tests indicating that licensee has not used, consumed, ingested or administered to himself or herself a prohibited substance, as defined in section 1361.51(e)."

Ms. Webb recommended 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 asked for an amendment/addition to section 1361.53(c), stating, "or negative biological fluid testing reports for a prohibited substance, indicating that a licensee has not used, consumer, ingested or administered to himself or herself a prohibited substance, as designated in section 1361.51(e),"

Ms. Webb recommended the Board adopt the proposed language in concept, but recommended a slight modification, so that the language is consistent with the proposed change to 1361.5(c)(1)(D). Thus, it was recommended that the following change be made to 1361.53(c) to read as follows:

> "(c) Negative biological fluid tests or biological fluid test 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."

Ms. Webb asked for a motion to approve the recommended changes to the proposed language to implement the Uniform Standards for Substance-Abusing Licensees and to further direct staff to notice the modified language for a second 15-day comment period. If no negative comments are received within the 15-day comment period, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rule-making process and adopting Title 16, California Code of Regulations (CCR), section 1361, and adding sections 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 with the modified text.

Dr. GnanaDev made a motion to approve the recommended changes as shown above in the requested motion; s/Dr. Lewis.

Tina Minasian, Consumer's Union, thanked Ms. Webb for working with Consumer's Union on the language for Uniform Standard 4. They are pleased the regulation incorporates the full Uniform Standards that they believe are essential tools for the Board and staff. Ms.

Minasian thanked the Board and staff for their hard work in making California consumers safer.

Ms. Choong, CMA, expressed her appreciation for the Board's consideration of CMA's comments on this important issue.

Ms. Clareval stated she had some concerns in the proposed language changes and that she would submit them to the Board during the next 15-day comment period.

Motion carried.

Agenda Item 20 Consideration of Legislation/Regulations

Ms. Simoes directed the Members to their Legislative Board packets. Ms. Simoes stated she had contacted all legislative district offices in the Los Angeles area inviting them to attend the Board meeting. On the updated tracker list, the bills in blue are either two-year bills or bills the Board has already taken a position on, therefore these bills were not discussed at the meeting. The bills in pink are the Board-sponsored bills and were discussed first. The bills in green and orange required discussion and a position at the meeting.

Ms. Simoes stated AB 1838 (Bonilla) and AB 1886 (Eggman) are both sponsored bills that have already been discussed and are continuing to move through the legislative process.

SB 1466 (Committee on Business, Professions, and Economic Development) is the Omnibus bill was to carry technical changes for all of the boards. The language would allow the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP), as an approved accreditation agency for hospitals offering accredited postgraduate training programs. This bill will also strike "scheduled" from existing language that requires physicians who perform a "scheduled" medical procedure outside of a hospital, which results in a death, to report the occurrence to the Board within fifteen days. This bill will have an additional provision when it goes to the Assembly that will allow the Board to adopt regulations regarding physician availability in all clinical settings. The proposals were previously approved by the Board to be included in the omnibus bill, so the Board supports these revisions and a vote was not needed on the bill.

Dr. Lewis asked what is happening with AB 1838 (Bonilla) and AB 1886 (Eggman).

Ms. Simoes stated both bills have passed through their policy committees. AB 1838 had no changes, and was recently assigned to the Senate B&P Committee. AB 1886 had small amendments taken because of some concerns from the chair of the Senate B&P Committee. This bill passed out of Assembly B&P Committee and is now going to Appropriations Committee.

AB 1535 (Bloom) would allow pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures developed and approved by the Board of Pharmacy (BOP) and the Board. This bill was amended since the last Board meeting to address concerns raised by the CMA. It now requires the BOP and the Board to include specific procedures in the standardized protocols to ensure education of the person to whom the drug is being furnished. It also requires procedures to

be included for the notification of the patient's primary care provider with patient consent. The amendment would require the patient receive consultation from the pharmacist and would not allow it to be waived. This bill would increase at-risk patients' access to naloxone, while at the same time, insuring standardized procedures and protocols are in place. The recent amendments further consumer protection and address many of the concerns previously raised by the Board.

Theresa Pena, Assembly Member Bloom's Office, spoke on behalf of Member Bloom thanking the Board for their support on this bill. Ms. Pena stated reducing overdose fatalities in California is a high priority of the Member and believes this bill can do just that. This bill has received lots of support with no opposition, has passed through both policy committees with unanimous bi-partisan support, and is now pending on the Assembly Floor. The Assembly Member would appreciate the Board's full support.

Mr. Serrano Sewell thanked Ms. Pena for attending the meeting, and requested she extend the Board's gratitude to the Assembly Member for his hard work on this bill.

Ms. Yaroslavsky made a motion to support this bill; s/Dr. Yip.

Dr. Bishop asked if this allows for dispensation only to the individual who is intended to receive it or family members, loved ones, etc., that would administer it.

Ms. Simoes stated this particular bill is to allow a pharmacist to dispense it to a particular person. That person would be required to receive proper education, training, etc., and follow procedures and protocols before it can be dispensed to them.

Dr. GnanaDev noted that these new amendments include several additional protections that were concerns at the last Board meeting and makes the bill much easier to support.

Motion carried.

Dr. Harrison Robbins commented on AB 916 stating this bill says that the word "board" cannot be used in advertising and patients cannot be informed of additional training if the word "board" is in a sentence the doctor is using. This seems completely objectionable and wondered if that statement has been noted, and if that is the intent of the Board.

Ms. Simoes stated AB 916, which is a two-year bill and still in the legislative process, is not being discussed at this meeting.

Lisa McGiffert, Consumer's Union stated they strongly support AB 1886 and believe that all information that is public by law should be readily available on the Board's website. They are actively supporting this bill by engaging consumers in California to support the bill. After reviewing the amendments, they feel the information should still be readily available to consumers. It is important the public know they can still get the information indefinitely.

AB 1841 (Mullin) would allow Medical Assistants (MA) to hand patients properly labeled and pre-packaged prescription drugs that have been ordered by a licensed physician, podiatrist, PA, nurse

practitioner (NP), or a certified nurse-midwife (CNM). The 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 the medication to a patient. This bill would exclude controlled substances. Allowing MAs to hand over these medications is a minor increase in the MAs duties and one that does not compromise consumer protection, as the physician is the one to label the medication for the patient and package the medication.

Ms. Yaroslavsky made a motion to take a neutral position on AB 1841; s/Dr. Krauss.

Dr. Lewis expressed his concern about when a prescription is dispensed to a patient; there is often a dialogue between the physician and the patient stating what the medication is for, when to take it, etc.

Ms. Simoes stated the patient would have already been consulted by the physician before the MA was given the prescription to hand to the patient.

Dr. Diego asked why staff recommended a neutral position rather than a support position.

Ms. Simoes stated the neutral position simply shows that the Board has no concerns with the language in the bill. The Board could change the neutral position to a support position if desired.

Ms. Yaroslavsky withdrew the original motion to take a neutral position on this bill.

Ms. Yaroslavsky made a new motion to take a support position on AB 1841; s/Dr. GnanaDev. Motion carried.

AB 1894 (Ammiano) would enact the Medical Cannabis Regulation and Control Act and would designate the Department of Alcoholic Beverage Control as the medical cannabis regulatory agency. However, this analysis only covers the portion of the bill related to the requirements on physicians recommending medical marijuana and the Board.

This bill would include in the Board's priorities, cases that allege a physician has recommended marijuana to patients for medical purposes without a prior good faith medical examination and medical reason. It would require physicians to perform an appropriate prior examination before recommending medical marijuana, which must include an in-person examination. This bill would not allow a medical marijuana clinic or dispensary to directly employ physicians to provide medical marijuana recommendations.

This bill would give the Board much needed enforcement tools to more efficiently regulate physicians who recommend medical marijuana. The bill expressly requires a physician to perform an appropriate prior examination before recommending medical marijuana, which must include an in-person examination. This bill would also make medical marijuana cases a priority of the Board, which will help to ensure consumer protection. It will not allow physicians to be employed by medical marijuana clinics or dispensaries, which will help to ensure that physicians are not making medical marijuana recommendations for financial, or employment purposes.

Ms. Yaroslavsky made a motion to take a support position on the provisions of this bill that impact the Board; s/Ms. Wright.

Dr. GnanaDev asked how this is different from current law.

Ms. Simoes stated that at this point, the Board has certain priorities and these types of cases are handled first. This bill would specifically add medical marijuana without a good faith in-person examination as one of those priorities. It will also make it clear that the exam has to be an in-person exam and that dispensaries cannot directly hire a physician just to prescribe medical marijuana.

Ms. Yaroslavsky noted the proliferation of the different establishments in the different communities and the idea that they can hire a physician just for prescribing medical marijuana. She feels this is a big step toward helping the communities, as well as consumers.

Dr. Krauss asked why this bill is supported by the California Cannabis Association, but opposed by several law enforcement agencies.

Ms. Simoes stated the law enforcement organizations are the sponsors of another medical marijuana bill SB 1262 (Correa), which is a little bit different from this bill. The requirements for the physicians and the Board vary between AB 1894 and SB 1262 and the law enforcement agencies chose to sponsor SB 1262 over AB 1894.

Mr. Serrano Sewell noted the author of AB 1894 is a highly respected and recognized leader in this subject matter. He has had to make some difficult decisions, some of which upset his own constituents and has taken the Board's needs very seriously on this issue. Mr. Serrano Sewell stated that pursuant to the motion, a support position would be best at this point.

Ms. Simoes stated that this bill directly ties this to unprofessional conduct, so the investigators do not have to prove that what they find during their investigation is a specific code violation.

Dr. Bishop stated his concern at the disciplinary end is the "good faith" exam and questioned if that "good faith" exam should be further clarified. Another concern was if a vote should be taken on this particular bill at this point, knowing that there is another bill coming up for discussion and vote on the same subject during this meeting.

Ms. Schipske expressed concern with the language in this bill that refers to medications that are prescribed as opposed to recommended. She would like to have further clarification shown in the bill to decipher prescribed from recommended.

Ms. Kirchmeyer noted some clarification on several concerns the Members had on this bill. She noted that when the author was going over this bill, they were looking at the biggest issues with current law that were being brought forward, and one of those was the "in-person" exam. Current law states a physician has to follow the same steps they would when prescribing any other type of medication. The author purposely put the words "in-person" in the language of the bill, knowing it was a consumer protection concern.

Dr. Yip stated he had briefly read the other bill on this subject and believes that taking a "support" position on this bill will not effect, in any way, the discussion, or outcome of the upcoming bill. Dr. Yip also asked if any physician could recommend medical marijuana or if they have to be specifically trained in that area.

Ms. Simoes confirmed any physician could recommend medical marijuana under current law. No specific certification is required at this time.

Ms. Kirchmeyer stated taking a position on this bill would not hinder any position on the other bill.

Tara Kittle feels it is atrocious that physicians can recommend any type of medication without a good faith exam and there is an underlying problem, which is the notion of marijuana in general. There is no way to prescribe an actual dosage like there would be in other medications.

Motion carried.

AB 2139 (Eggman) would require a health care provider who makes a diagnosis that a patient has a terminal illness, to notify the patient, or the patient's agent, of the patient's right to comprehensive information and counseling regarding 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. It would define terminal illness as a medical condition resulting in a prognosis of life expectancy of one year or less, if the disease follows its normal course.

Existing law requires health care providers to provide comprehensive information and counseling regarding end-of-life options only 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.

Dr. Lewis made a motion to take a neutral position on this bill; s/Ms. Yaroslavsky. Motion carried.

AB 2214 (Fox) would require the Board, when determining continuing medical education (CME) 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. Currently, the Board does not track employment information for physicians, so the Board would not know which physicians are emergency room physicians. If the Board decides that it is important to get out information to physicians, it could include an article in its Newsletter or put information on the Board's website.

Ms. Yaroslavsky made a motion to take a neutral position on this bill; s/Dr. GnanaDev. Motion carried.

AB 2458 (Bonilla) would establish the Graduate Medical Education Fund (GMEF) to finance additional positions at residency programs in California hospitals and teaching health centers. It would appropriate $2.84 million per year for three years from the California Health Data and Planning Fund into the GMEF. It would also appropriate $24 million from the General Fund in 2014/2015 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.

Dr. Lewis made a motion to take a support position on this bill; s/Ms. Wright.

Dr. GnanaDev stated the Board strongly supports this bill as not enough residency programs is a problem in many states.

Ms. Yaroslavsky asked if the money pays for the training positions and where the money is being obtained.

Ms. Simoes stated $2.84 million would come from the California Health Data and Planning Fund and $25 million would come from the General Fund.

Dr. Bishop asked if this money could be used for other types of residency programs besides primary care positions.

Ms. Simoes noted criteria would be developed for distribution of the funding.

Dr. Krauss stated his understanding is that the Office of Statewide Health, Planning, and Development's (OSHPD) specific motivation is primary care in underserved areas.

Yvonne Choong, CMA, noted they are a co-sponsor of this bill with the California Academy of Family Physicians. She let the Board know that primary care will certainly be addressed when creating the details of this bill and would appreciate the Board's support vote.

Motioned carried.

Ms. Simoes stated the next bill on the tracking list SB 966 (Lieu), was amended recently to include some of the Board's outpatient-setting proposals. However, per recent contact from the author's office, this bill will not be moving forward this year. With that, this bill was not discussed at the meeting.

SB 1083 (Pavley) would authorize 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. PAs are

already allowed to certify temporary disability and issue disable person placards. It is reasonable to allow PAs to certify claims for DI with EDD in alignment with the PA scope of practice. The PA is still under a delegated services agreement with a physician, and as such, this bill would not compromise consumer protection.

Dr. Bishop made a motion to take a support position on this bill; s/Ms. Yaroslavsky. Motion carried.

SB 1116 (Torres) allows physicians to donate an additional $75 to the Board for the purposes of funding the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP). Currently, a physician could donate more than the mandatory $25.00 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, but does not mean a physician could not donate more than that amount to the STLRP. If this bill becomes law, the Board would include specific information on the ability for a physician to donate to the STLRP in any amount and would 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 would further the Board's mission of promoting access to care.

Ms. Yaroslavky made a motion to take a support position on this bill; s/Wright.

Dr. GnanaDev stated the STLRP is a great program, but feels this fee is being pushed on the licensees and believes these funds should be more diversified rather than put on the licensees alone and the STLRP should find other sources of revenue.

Yvonne Choong, CMA, stated they are in opposition to this bill and proposed an amendment. CMA feels there should be some flexibility to check off another amount. They believe this bill could discourage some from donating if they do not have an option to donate less than the $75.

Motion carried.

AB 2346 (Gonzalez) would authorize the establishment of a Physician and Surgeon Assistance Program (PSAP) within the Board. The PSAP would be modeled after the State Bar's Lawyer Assistance Program and would be a voluntary and confidential program to support a physician in his or her rehabilitation and competent practice of medicine. The PSAP, if established, would aid a physician and surgeon struggling with substance abuse, mental health concerns, stress, burnout, and other issues affecting his or her productivity.

This bill would allow the Board to refer a physician into the PSAP, but neither acceptance into or participation in the program shall relieve the physician of any lawful duties and obligations under any disciplinary action. Participation in the PSAP would be disclosed if required as a condition of probation. The bill would require participants to be responsible

for all expenses related to treatment and recovery and would allow the Board to charge a reasonable administrative fee to participants for offsetting the costs of maintaining the program.

If the Board were to establish a PSAP, it would require the Board to actively engage in outreach activities to make physicians, the medical community, and the public aware of the existence and availability of the program. This bill would require the outreach to include, but not be limited to, the development and certification of minimum continuing education courses relating to the prevention, detection, and treatment of substance abuse, including no-cost and low-cost programs and materials.

Ms. Simoes stated the Board's previous Diversion Program had many issues, including the fact that the Board could not effectively and efficiently monitor substance-abusing physicians and ensure that the public was adequately protected. The Program was made inoperable because the public and the Legislature did not believe it was appropriate for the Board to be diverting physicians from enforcement and allowing them to participate in a confidential substance abuse monitoring program. Since 2008, when the Board's Diversion Program was made inoperable, the Board has taken the stance that it is the physician's responsibility to maintain sobriety and well-being. The Board's role is to monitor the physician's compliance with her or her recovery efforts, thus meeting the Board's mandate of public protection. It is not the Board's role, as a regulatory agency, to provide a confidential rehabilitation program, as these services are already widely available to physicians in California.

There would be a substantial fiscal impact to the Board to create this program in addition to the fiscal impact associated with the outreach requirements in this bill. The Board estimates startup costs alone to be at least $250,000.

Ms. Yaroslavsky noted she was present at the Assembly B&P presentation of this bill and was disappointed after having been through the previous Diversion Program situation. It was very difficult to get the program removed from the Board's oversight. This bill wants this program to be put back in the Board's oversight. She stated she cannot urge the Board enough to take an oppose position on this bill.

Dr. Krauss stated the Board cannot get away from the fact that the role of the Board is consumer protection. After reviewing the records of physicians who have not served the public in the best way, he sees that most physicians are placed on probation and find some means of rehabilitation so they can continue to safely serve the public. He believes physicians who may be impaired, for whatever reason, are fearful of entering any type of recovery program because they fear it will be reported to the Board, resulting in disciplinary action being taken against them. He feels there needs to be a physician health program. The FSMB has a document recommending physician health programs and most states have this type of program. He added that this problem cannot be ignored. He suggested rather than opposing the bill, the Board should sit down with interested parties and work to establish some type of physician health program.

Dr. Lewis stated the Board does need some type of program brought back into place and should not necessarily take an oppose position, but perhaps a neutral position. He added this would allow staff

to work on something that would take a proactive approach in the future. In the interest of protecting the public, rehabilitating physicians and being proactive to the stakeholders, the Board should look at a more neutral position on this bill.

Dr. Bishop stated there needs to be a mechanism for a doctor who wants to seek help to be allowed to do so in a protected fashion, but to also protect the public.

Dr. GnanaDev stated he supports the concept of the program, without a diversion component. He added prevention is the key. By treating the physicians early, it is preventing them from possibly harming a patient, rather than disciplining them after harm is done to a patient.

Mr. Serrano Sewell stated the Board could learn from the errors with the previous diversion program and use what did and did not work to create some sort of program that will not jeopardize patient safety and see how everyone involved can benefit from such a program.

Dr. Lewis made a motion to take a support in concept on this bill; s/Ms. Schipske.

Ms. Schipske requested a presentation by the State Bar be brought back to the Board for review, as their program has been very effective.

Tina Minasian, Consumer's Union, stated she was a victim of a physician that was in the Board's previous Diversion Program. AB 2346 will create another diversion program, only this time, not only will the physician's participation be a secret from the consumer, but a secret from the Board, with no mandatory reporting requirements. She strongly urged the Board to oppose this bill.

Julie D'Angelo Fellmeth, Center for Public Interest Law, stated they oppose this bill and strongly urges the Board to oppose it as well, or at least demand some significant safeguards to protect patients. This bill should not be associated with the Board. She added that if it should happen that this bill does fall under the Board, the Board should insist on the following: 1) the program adheres to the current Uniform Standards, as this bill does not require the use of the Uniform Standards; 2) if it is located within the Board, the program must be required to notify the Board's Enforcement Program when a participant relapses or fails to comply with the rules, as there is nothing in this bill in regard to notifying the Board; 3) if it is located within the Board, the Board should insist on a complete fiscal analysis, as there has not been one performed. The Board should also insist on a sunset date, a mandatory audit, and a provision requiring competitive bidding when contracting out to the private sector. The Board should also demand a provision that anyone who played a role in overseeing the prior Diversion Program cannot oversee this one.

Tara Kittle highly recommended the Board reinstate the Wellness Committee that used to be a part of the Board. There are many issues taking place now regarding physician wellness and its impact on the healthcare consumer. She stated much of the mess of the prior diversion program was in the eyes of the public. She added it was a failed public relations situation, as the public had misconceived notions regarding what it is like to be a physician. She feels every rehabilitated physician is good for the people of California.

Michelle Monseratt-Ramos strongly urged the Board to oppose this bill, as this bill does not mention the existence of the SB 1441 Uniform Standards. She added it keeps the program confidential from the patients as well as from the Board.

Yvonne Choong, CMA, stated she appreciates the discussion on this important bill and the Board's willingness to move to a support in concept position that will allow some time to work with the author, the Board, and other stakeholders to work together on this bill. She noted it is CMA's intent to include a financial analysis, and intends to specify the nature of the contracting arrangement. She noted for those members who are new to the Board, CMA is not asking for anything that is new to the State. Other agencies that have a diversion program in place also have a voluntary program.

Genieve Claurveul asked to Board to oppose this bill and noted monitoring and rehabilitation should be done by an outside entity and not the Board.

Lisa McGiffert, Consumer's Union Safe Patient Project, strongly urged the Board to oppose this bill. She stated this bill did not exist a week ago and has not had the proper amount of time for the public and elected officials to thoroughly review it and its implications. She noted it is not the Board's responsibility that physicians get the treatment they need. There is nothing stopping physicians from getting confidential treatment today.

Dr. Jim Hay, Chair of California Public Protection and Physician Health and past President of CMA, via teleconference, noted why the creation of a physician health program is so important in California. Most physicians believe in preventive and evidence-based medicine. The current method of dealing with physicians who have potentially apparent substance abuse, psychological, or medical problems is neither of those. This program is helpful because it identifies the problem before the physician gets the attention of their licensing board. The physician does so entirely because of confidential and supportive systems that encourages participation as opposed to enforcement only methods that discourage self-referral.

Mr. Lui noted that supporting the concept of diversion is important, but the concern is who should undertake this program. He feels a diversion program is a good thing, but the Board should not be the one to undertake this program, it should be an outside entity from the Board.

Dr. Krauss is uncomfortable with taking any position today on a bill that he believes still needs work. He is concerned about the public comment that was heard today and feels it is critical to protect the public. Some of the safeguards that were mentioned are important and should be included in more discussion. He feels there are still too many things that need to be discussed before making a decision and does not believe there is enough time in this legislative cycle to include all that needs to be included.

Dr. Lewis withdrew his original motion to support in concept.

Ms. Yaroslavsky made a motion to table this bill and have Members work with staff, and the author, to encompass all of the comments heard today and to report back to the Board at the next meeting; s/Dr. Yip. Motion carried.

SB 1258 (DeSaulnier) would require all prescriptions for Schedules II, III, IV and V controlled substances beginning January 1, 2016, to be submitted electronically and to comply with the DEA regulations. For medical practices with two or fewer physicians, and for providers in underserved rural areas, these requirements would become effective January 1, 2017. This bill would provide an exception to the electronic prescribing requirement if technological failure prevents electronic transmission of the prescription. This bill adds Schedule V controlled substances to those that have to be reported to CURES. It would allow an individual designated by a board, bureau, or program within DCA to access CURES data for investigative purposes if an application is submitted to DOJ to obtain approval to access this information. This bill would require the application to contain facts demonstrating the probable cause to believe the licensee has violated a law governing controlled substances. According to the author's office, the provision would allow designated DCA investigators to access CURES information. However, with the Board's investigators moving to DCA, this portion of the bill could be problematic.

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 either 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 or any other condition or circumstance for which the physician determines is a medical necessity. The reason for the medical necessity must be noted in the prescription and in the patient's medical record. This bill would not allow a prescription for a controlled substance to be prescribed, filled, compounded or dispensed if another prescription for that 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. It now states that this section would not prohibit a patient from being issued multiple prescriptions, each for a different controlled substance, at a given time.

Ms. Yaroslavsky made a motion to support in concept; s/Wright.

Dr. GnanaDev stated this bill needs a lot of work. He feels this is micromanagement of the medical practice, which does not make sense. He added the concept is fine, but it goes beyond what should be put into legislation.

Genieve Clarevuel noted she sent a letter to the sponsors of this bill stating it is a horrible bill and the only thing good about it is the electronic prescribing part. She feels the bill is overreaching, is poorly written and will create many conflicts the way it is worded.

Yvonne Choong, CMA, said she appreciated Dr. GnanaDev's comments as CMA is taking an oppose position on this bill. The e-prescribing requirements related to controlled substances are infeasible at this time. She feels the bill is overly descriptive in determining how much a physician can prescribe. It also imposes a lot of new requirement on the CURES system at a time when it is in the process of trying to upgrade the system. They believe the intent of the bill is to curb prescription drug abuse, but that really needs to be balanced with what physicians need to do for their patients.

Motion carried.

SB 1262 (Correa) would put various licensing and enforcement requirements on medical marijuana dispensaries and cultivation facilities. It would also put requirements on physicians recommending medical marijuana and on the Board. Ms. Simoes stated the analysis only covered the portion of the bill relating to the requirements on physicians recommending medical marijuana and on the Board.

The bill 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 marijuana use is appropriate, consult with the patient as necessary, and periodically review the treatments efficacy.

A physician that recommends medical marijuana would also 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, and low CBD levels; and explain the reason for recommending that particular strain. Under no circumstances would a physician be able to recommend butane hash oil. The physician must maintain a system of recordkeeping that supports the decision to recommend the use of medical marijuana for individual patients and, 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.

The bill would make it unprofessional conduct if a physician recommends medical marijuana without an appropriate prior exam and a medical indication, or recommends marijuana for non-medical purposes. The bill would also subject physicians recommending medical marijuana to the laws in B&P Code Section 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/her immediate family has a financial interest. The bill would not allow a physician to advertise for medical marijuana physician recommendations unless the advertisement meets the requirements in the advertising section of B&P Code Section 651.

The bill would also 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. The bill would expressly spell out what a physician must do before medical marijuana is recommended, what a physician must do if a medical marijuana recommendation is issued, and places appropriate anti-kick back and advertising restrictions on physicians who recommend medical marijuana. It also directly ties non-compliance with some of these requirements to unprofessional conduct.

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.

Dr. Lewis made a motion to take an oppose unless amended position; s/Dr. GnanaDev.

Dr. Krauss agreed with the motion and stated that medical marijuana is an oxy-moron, in his opinion, and then to have the prescription micro-managed is an even great absurdity. He is in full support of the oppose unless amended position.

Motion carried.

Ms. Simoes reminded the Members the regulations' matrix is in the packet on page BRD 20B-1 and asked if anyone had any questions concerning the matrix. No questions were asked.

Agenda Item 21 Special Faculty Permit Committee Recommendation; Approval of Applicant

Dr. Yip stated that the Special Faculty Permit Review Committee (SFPRC) had a telephone conference meeting on March 27, 2014. The SFPRC reviewed one application from the Stanford School of Medicine for Dr. Maria-Grazia Roncarolo. In addition to the Special Faculty Permit appointment, Stanford is also requesting the Board's approval for Dr. Roncarolo to be the Division Chief of Pediatric Translational and Regenerative Medicine. Dr. Roncarolo has been granted an extremely rare waiver due to Dr. Roncarolo's highly regarded international reputation in the field of stem cell research, gene therapy, and autoimmune diseases. It would be difficult to find another clinician-scientist of her caliber. If approved and appointed, Dr. Roncarolo would be the principal investigator of Stanford's application to the California Institute of Legion Medicine of Alpha Clinic. She would also be Co-Director at the Institute of Stem Cell Biology and Regenerative Medicine. In addition, if approved, Dr. Roncarolo would 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 would also be a mentor to pediatric residents, and pediatric hematology oncology fellows.

Dr. Yip stated the SFPRC recommends the Board approve Dr. Roncarolo for Special Faculty Review Appointment and recommends approval of the request to be the Division Chief.

Dr. Yip made a motion to approve the recommendation to appoint Dr. Roncarolo for a Special Faculty Permit Appointment at Stanford pursuant to Business and Professions Code Section 2168.1(a)(1)(A); s/Ms. Yaroslavsky. Motion carried.
Dr. Yip made a motion to approve Dr. Roncarolo to be the Division Chief of the Pediatric Translational and Regenerative Medicine pursuant to Business and Professions Code Section 2168(c); s/Ms. Yaroslavsky. Motion carried.

Agenda Item 22 Update on and Consideration of Recommendations from the Midwifery Advisory Council (MAC)

Ms. Karen Ehrlich presented this agenda item on behalf of Ms. Sparrevohn.

Ms. Ehrlich referred Members to tab 22, page BRD 22A-1and BRD 22A-2 for review of the requested MAC meeting future agenda items. The items being requested to be added to a future agenda included:

- Updates on the task forces established for midwife assistants, a Board informational packet on licensed midwives, and the licensed midwife annual report data collection tool, and
- Update on regulatory changes required by AB 1308.

Ms. Yaroslavsky made a motion to approve the requested upcoming agenda items; s/Mr. Lui. Motion carried.

Ms. Webb referred the Members to tab 22, pages BRD 22B-1 and BRD 22B-2. Ms. Webb stated that with AB 1308 (Bonilla, Chapter 665, Statutes of 2013) going into effect January 1, 2014, there were some changes made to the law affecting licensed midwives. Under B&P Code Section 2507, physician supervision was removed as a requirement for licensed midwives to practice. However, new limitations were placed on client selection. AB 1308 also removed the authority for Title 16CCR, section 1379.19, which incorporated the Standards of Care for California Licensed Midwives by reference into the Board's regulations. The document included in the packet has incorporated the necessary modifications pursuant to AB 1308. Ms. Webb stated the document will no longer be in regulation but will be guidelines for licensed midwives.

After review and consideration of the proposed changes, Ms. Webb asked for a motion to approve the Practice Guidelines for California Licensed Midwives including posting them on the Board's website, and to authorize staff to make any non-substantive changes to the document in preparation for posting.

Ms. Yaroslavsky made a motion to approve the Practice Guidelines; s/Dr. Krauss. Motion carried.

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

Mr. Serrano Sewell reminded Members that the election of officers and the discussion of 2015 meeting dates would be agenda items at the next meeting.

Dr. Bishop requested a future agenda item on the number of years of postgraduate training required for licensure of California physicians.

Ms. Wright requested statistics on the rate of physician impairment, whether it is mental health or substance abuse, as well as options from staff on what can be done, since diversion is not an option to assist in this area.

Lisa McGiffert, Consumer's Union, Safe Patient Project, requested that the Board agendize the issue of disclosure by physicians of probation status to patients and options of ways to disclose that information. She would also like to have the statute of limitations issue put on the agenda of the Enforcement Committee or the Board.

Agenda Item 24 Adjournment

Mr. Serrano Sewell adjourned the meeting at 12:33 pm.

_____ _____
David Serrano Sewell, Vice President Date

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

_____ _____
Kimberly Kirchmeyer, Executive Director Date

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

Agenda Item 4

California Department of Justice

Bureau of Criminal Identification and Investigative Services

Department of Justice Administrator II Mike Small has 30 years of criminal justice program and administrative experience with the California Department of Justice (DOJ). Mr. Small began his career as an intelligence analyst in narcotics enforcement and organized crime, managed firearms regulatory activities, served as Assistant Director of the Western State Information Network (WSIN), and served as manager of DOJ's Intelligence Operations Program. Mr. Small assumed program manager duties for DOJ's CURES/PDMP program during December 2011. Mr. Small has a B.A. from the University of Southern California.

PDMP

A Powerful Tool

May, 2014

pdmp

No reportable financial interest.

pdmp

"During the spring and summer of 2001, U.S. intelligence agencies received a stream of warnings that al Qaeda planned, as one report put it, "something very, very, very big."

The Director of Central Intelligence said, "The system was blinking red."

Executive Summary, The 9/11 Commission Report, Page 6

pdmp

The FBI's approach to counterterrorism investigations was, "case-specific, decentralized, and geared toward prosecution."

Executive Summary, The 9/11 Commission Report, Page 13

"Each agency's incentive structure opposes sharing, with risks (criminal, civil, and internal administrative sanctions) but few rewards for sharing information."

The 9/11 Commission Report, Page 417

pdmp

The 9/11 Commission's bottom-line recommendation called for a…

Unity of Effort

pdmp

One fight, one team

pdmp

2,390 Pearl Harbor Deaths

2,973 9/11 Deaths

http://www.cbsnews.com/2100-224_162-2035427.html

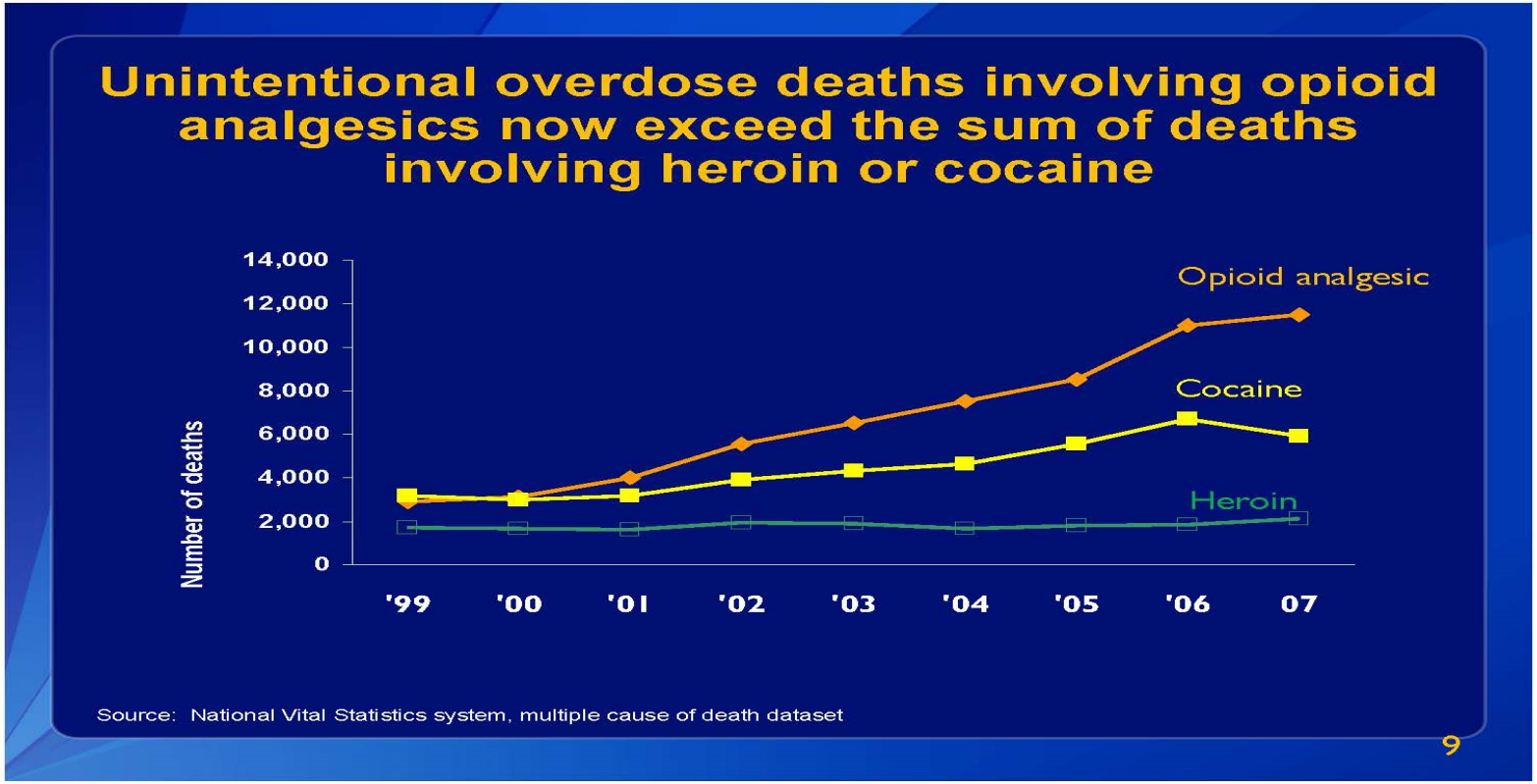
pdmp

> 15,500

Prescription Painkiller Overdose Deaths CY 2009

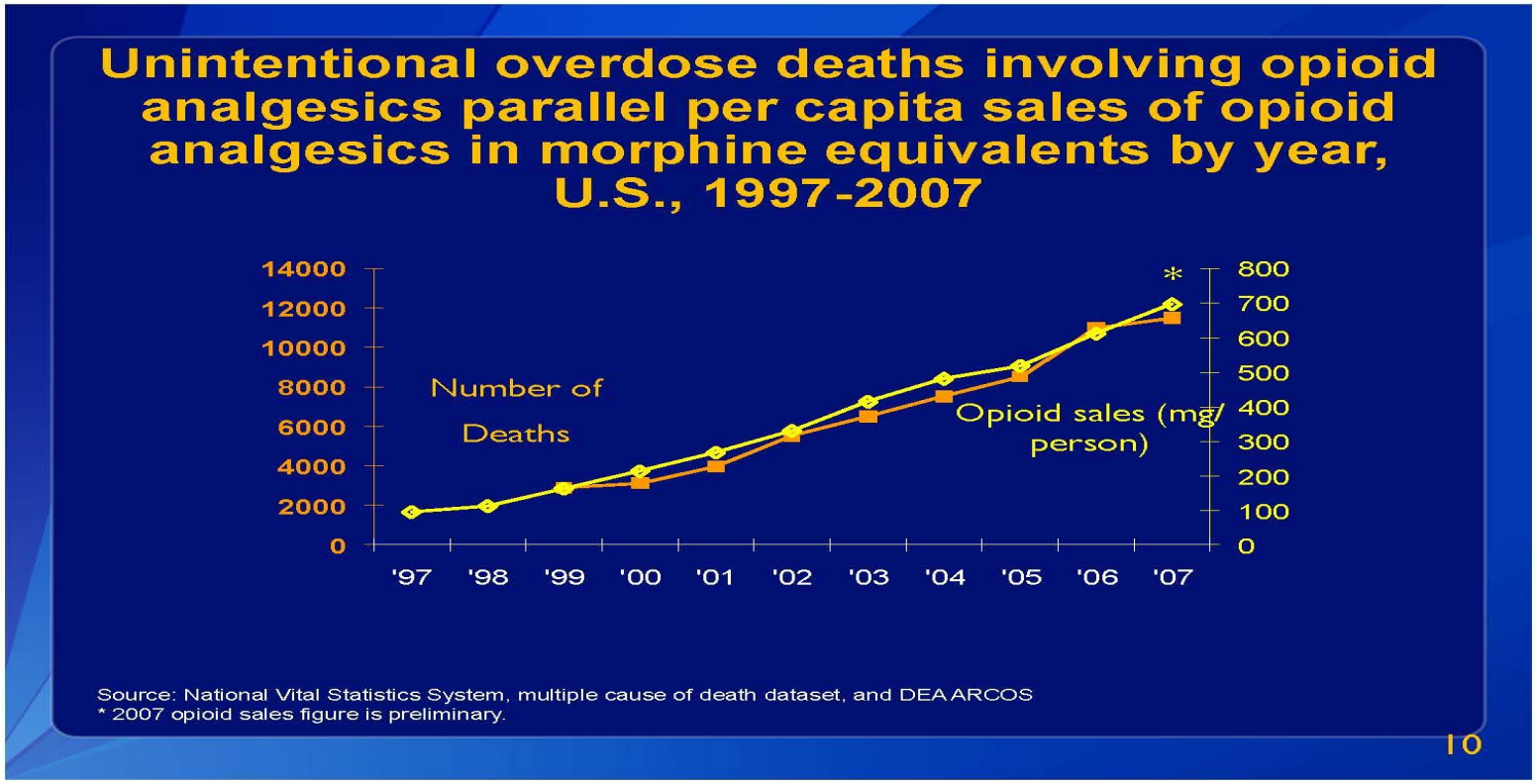
http://www.cdc.gov/vitalsigns/MethadoneOverdoses

pdmp



The Prescription Drug Overdose Epidemic and the Role of PDMPs in Stopping It, Len Paulozzi, MD, MPH, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

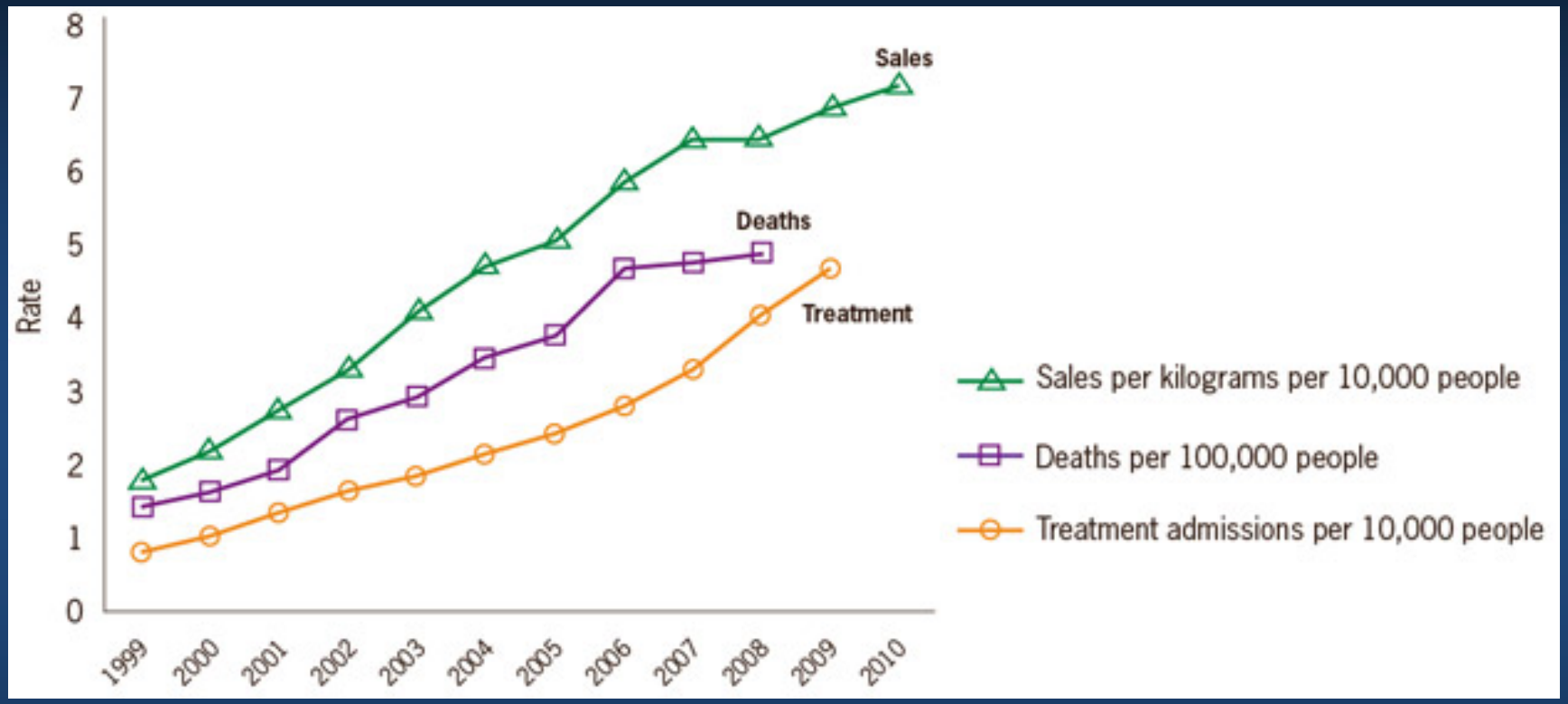
pdmp



The Prescription Drug Overdose Epidemic and the Role of PDMPs in Stopping It, Len Paulozzi, MD, MPH, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention

pdmp

Rates of Prescription Painkiller Sales, Deaths and Substance Abuse treatment admissions (1999-2010)



SOURCES: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009

http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html

pdmp

Two keys to prescription acquisition…

The Prescriber
The Dispenser

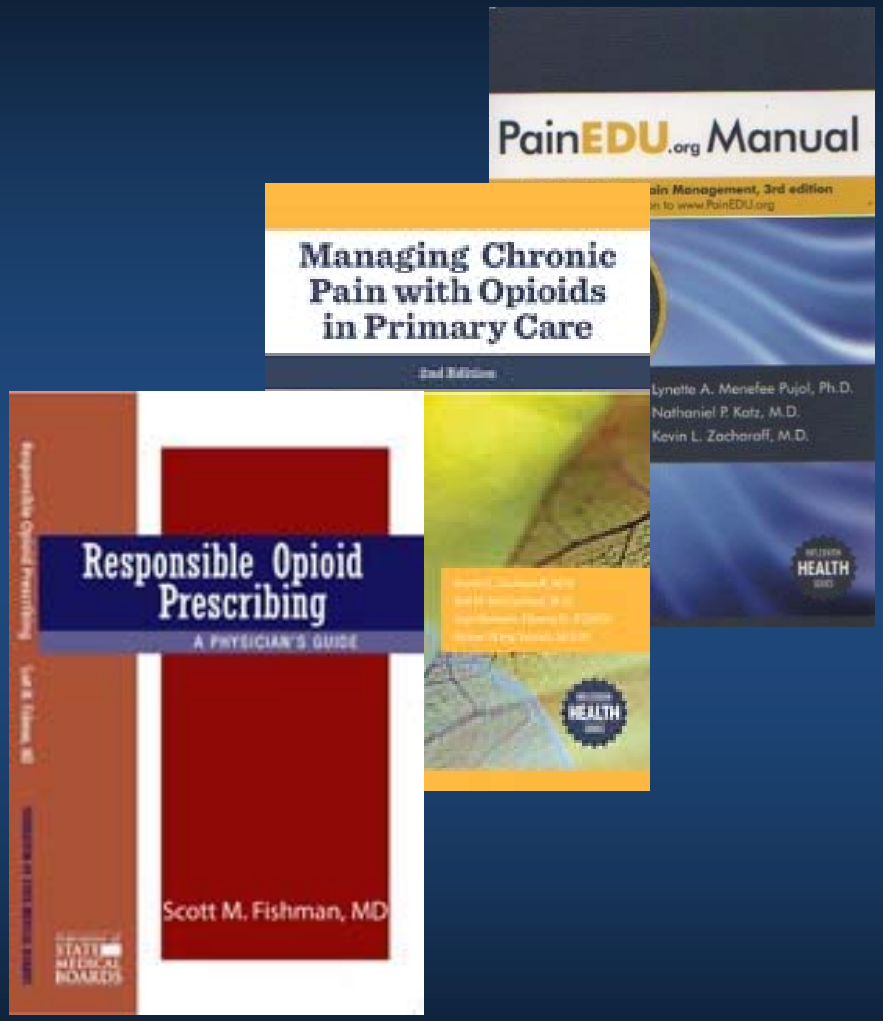
pdmp

Most prescription painkillers are prescribed by primary care and internal medicine doctors and dentists, not specialists.

Roughly 20% of prescribers prescribe 80% of all prescription painkillers.

Policy Impact: Prescription Painkiller Overdoses, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, Page 7, November 2011

pdmp


PainEDU.org Manual
Lynette A. Menefee Pujol, Ph.D.
Nathaniel P. Katz, M.D.
Kevin L. Zacharoff, M.D.
HEALTH
Managing Chronic Pain with Opioids in Primary Care
2nd Edition
HEALTH
Responsible Opioid Prescribing
A PHYSICIAN'S GUIDE
Scott M. Fishman, MD
STATE MEDICAL BOARDS

Rx

pdmp Office of National Drug Control Policy

Education: critical for the public and for healthcare providers to increase awareness about the dangers of prescription drug abuse, and about ways to appropriately dispense, store, and dispose of controlled substance medications.

Tracking and Monitoring: the enhancement and increased utilization of prescription drug monitoring programs will help to identify "doctor shoppers" and detect therapeutic duplication and drug-drug interactions.

Proper Medication Disposal: the development of consumer-friendly and environmentally-responsible prescription drug disposal programs may help to limit the diversion of drugs.

Enforcement: provide law enforcement agencies with support and the tools they need to expand their efforts to shut down "pill mills" and to stop "doctor shoppers" who contribute to prescription drug trafficking.

Epidemic: Responding to America's Prescription Drug Abuse Problem. Office of National Drug Control Policy, 2011, Pages 2-8

pdmp

CDC Prevention Strategies

Prescription Monitoring…
to stop users of multiple providers for the same drug.
Insurers can contribute substantively.

Improve legislation and enforcement of existing laws…
i.e., anti-doctor shopping and pill mill

Improve medical practice in prescribing opioids…
to update prescribers on under-appreciated risks of high-dosage therapy and provide evidence-based guidelines

Centers for Disease Control and Prevention, CDC Grand Rounds: Prescription Drug Overdoses – a U.S. Epidemic, January 13, 2012

pdmp

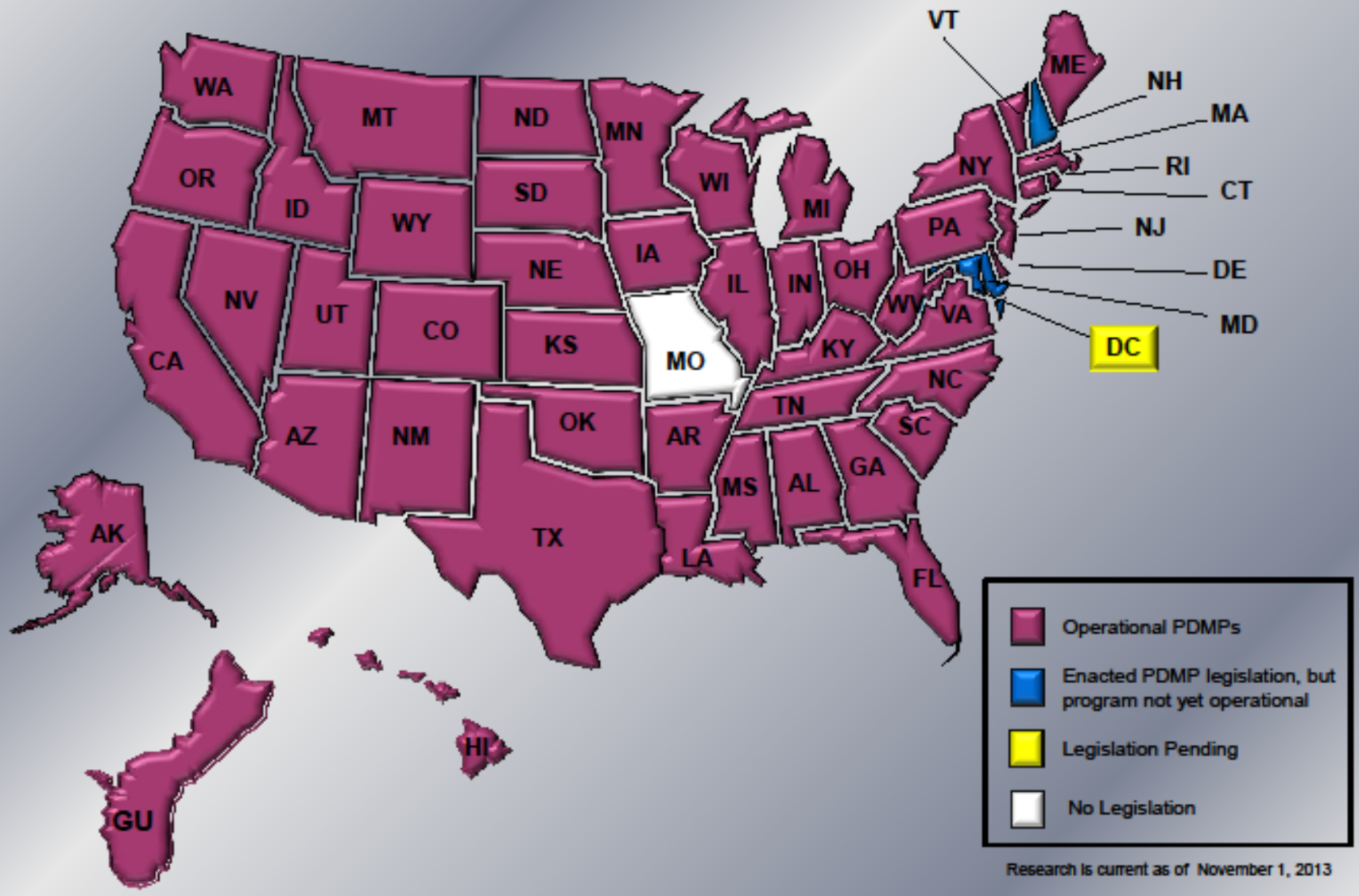
"America's Biggest Drug Problem Isn't Heroin, It's Doctors"

Governing Magazine, June 2014

PDMP Training & Technical Assistance Center

Status of Prescription Drug Monitoring Programs (PDMPs)

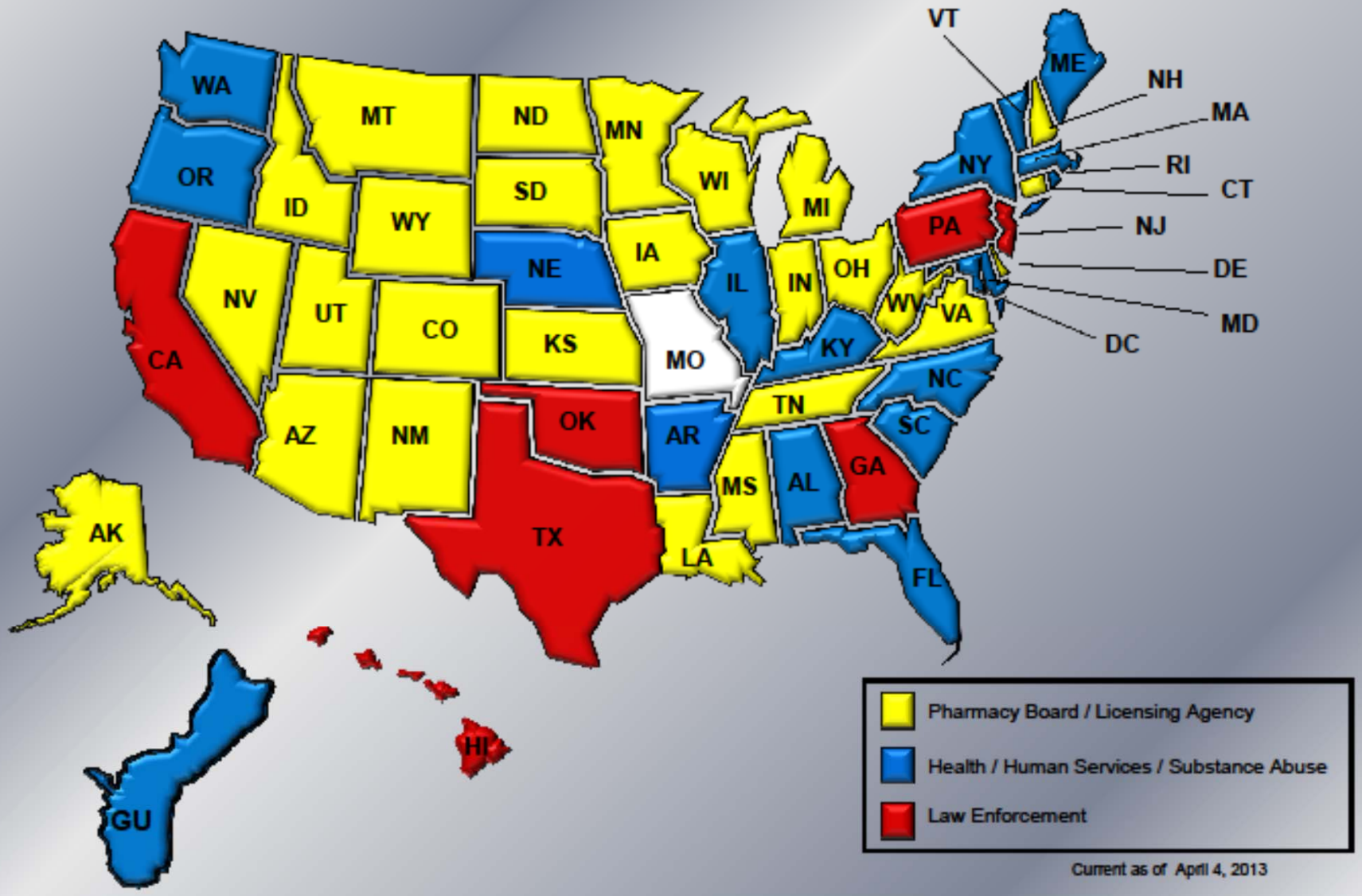
** To view PDMP Contact information, hover the mouse pointer over the state abbreviation*



Research is current as of November 1, 2013

PDMP Training & Technical Assistance Center

Prescription Drug Monitoring Program (PDMP) Agency Types



pdmp

Current CURES/PDMP Program

- CURES stores and reports Schedule II, III and IV prescription dispensation data reported by dispensers to DOJ.
- Pharmacists are required to report dispensations of Schedules II through IV controlled substances at least weekly.
- In order to reflect exactly what dispensers report to DOJ, the department does not touch or modify dispenser-reported data.
- Presently, the database contains over 100 million entries of controlled substance drugs that have been dispensed in California.

pdmp

Current CURES/PDMP Program

- In FY 11/12, the program responded to 1,063,952 requests.
- Provides registered prescribers and dispensers with 6- or 12-month Patient Activity Reports (PAR).
- CURES/PDMP serves the public health and the public safety. CURES data can assist health practitioners identify, intervene, and deter abuse of scheduled drugs. CURES data can assist investigators, regulators, and prosecutors.
- Use of the PDMP by prescribers and dispensers for prescription abuse prevention/intervention is *voluntarily*.

pdmp California PDMP Participation

Dentists	37,494
Medical Physicians	128,697
Optometrists	4,939
Osteopathic Physicians	6,376
Physician Assistants	8,520
Podiatrists	1,918
Registered Nurse Midwives (Furnishing)	778
Registered Nurse Practitioners (Furnishing)	12,125
Veterinarians	10,985
Prescribers	**174,338**
Pharmacists	**38,293**
TOTAL	**212,631**

PDMP Registrants **27,211**

(as of 06/27/2014)

pdmp

12.80%

June 3, 2014
25,706 Registrants

216%

December, 2011
8,600 Registrants

pdmp

CURES 2.0
Integration / Interoperation

PDMPs need to integrate and interoperate with the major health care systems in their regions.

PDMP data can be rendered by the health care system to be presented with the EHR when the practitioner walks into the exam room to see the patient.

pdmp

CURES 2.0
Integration / Interoperation

Integration/Interoperation will leverage a trust arrangement that the various interoperation partners vet their respective members.

Integration/Interoperation can facilitate peer-to-peer collaboration.

Integration/Interoperation can facilitate “watch” flags across member systems.

pdmp

CURES Program Contacts

California Department of Justice
PDMP/CURES
P.O. Box 160447
Sacramento, California 95816

Phone: (916) 227-3843
FAX: (916) 227-4589
Email: PMP@doj.ca.gov

http://oag.ca.gov/cures-pdmp

pdmp

¿¿¿ One fight, one team ???

PHYSICIAN IMPAIRMENT

External Resources for Physicians

- Wellness Committees
- Physician Health Programs
- Substance Abuse Treatment Centers
- Individual Therapy

Voluntary License Status Modifications

- ## Disabled License

Any licensee who demonstrates to the satisfaction of the Board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The Board requires that an application be filed which contains a certification from the attending physician attesting to the fact that the individual is unable to practice medicine along with an estimate as to whether the disability is permanent or temporary. While the physician's license is in "disabled" status, he or she cannot practice medicine. The license status can be returned to "active" status by submitting another application with a certification from the attending physician that the physician is able to return to practice with no restrictions.

- ## Voluntary Limitations on Practice

A licensee may also apply to restore his or her license from a disabled "no practice allowed" status to an active status with limitations on practice. To apply for this status, the licensee must sign an agreement on a form prescribed by the Board in which the licensee agrees to limit his or her practice in the manner as prescribed by the reviewing physician and pays the current (active license) renewal fee.

Complaint Statistics – Complaints received in FY 2012/2013

Complaint Allegations	Substance Abuse	Mental Illness
Total Number Received	45 (7 from out-of-state cases)	57
Closed in CCU	8	14
Referred to Investigation	30	43

Administrative actions of cases involving substance abuse or mental illness

Fiscal Year	Self Use/Substance Abuse	Mental Illness
2012-2013	46	25
2011-2012	41	26
2010-2011	19	10
2009-2010	30	18
*2008-2009	32	11
2007-2008	34	20
2006-2007	37	20
2005-2006	25	7
2004-2005	33	24
2003-2004	29	26
2002-2003	27	25

*Diversion Program eliminated in July 2008

Current Disciplinary Guidelines recommend the following conditions for substance abuse violations:

- Suspension of 60 days or more
- Controlled Substances-Abstain From Use
- Alcohol-Abstain from Use
- Biological Fluid Testing
- Ethics Course
- Psychiatric Evaluation
- Psychotherapy
- Medical Evaluation and Treatment
- Monitoring-Practice/Billing

Additional Conditions for Substance Abusing Licensees

- Clinical Diagnostic Evaluation
- Notice of Employer/Supervisor Information
- Biological Fluid Testing
- Group Support Meetings (if recommended by evaluator)
- Worksite Monitors

Current Disciplinary Guidelines recommend the following conditions for mental/physical illness violations:

- Psychiatric Evaluation
- Psychotherapy
- Medical Evaluation and Treatment
- Monitoring-Practice/Billing
- Solo Practice Prohibition
- Prohibited Practice (i.e., practice restrictions)

Conditions focused on ensuring the physician is "safe to practice"

- Controlled Substances-Abstain From Use
- Alcohol-Abstain from Use
- Biological Fluid Testing
- Psychiatric Evaluation
- Psychotherapy
- Medical Evaluation and Treatment

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 7, 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, Mr. 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 at the Board as well as a pending projects list.
- Regular meetings were held with Denise Brown, Director of the Department of Consumer Affairs (DCA) and other DCA Executive staff. Meetings will continue with the new Director Awet Kidane.
- Regular meetings continue to be held with Gloria Castro, Senior Assistant Attorney General. The Board staff and DCA staff have also been meeting with Ms. Castro and other DOJ staff regarding a way to share documents using a Cloud Sharing System.
- Board staff have been meeting with the DCA and the Department of Justice to discuss requirements for the new CURES database. The Medical Board has been placed on the Joint Executive Steering Committee for this project. Board staff has begun to attend Joint Application Design (JAD) sessions with DOJ, DCA, other prescribing/dispensing licensing boards.
- Board staff have met with, and will meet on a quarterly basis, with the California Medical Association on issues of interest to both parties.
- Board staff have met with Consumer's Union on issues of interest to both parties.
- Board staff and DCA staff have met numerous times to finalize the transition of the Board's investigators to the DCA.
- Board staff have been meeting with Legislative Members and Staff regarding bills impacting the Board.
- Board staff continue to meet with representatives from the California Department of Public Health, the Board of Pharmacy, Dental Board, the Department of Health Care Services, the Department of Justice, the Emergency Medical Services Authority, and the DCA regarding prescription opioid misuse and overdose. The group is identifying ways all the entities can work together to educate prescribers, dispensers, and patients regarding this issue of serious concern.
- An all headquarters' staff meeting was held to provide staff with a copy of the Board's new Strategic Plan and to provide an update on Board activities.

Staffing Update:
On July 1, 2014 the transition of the Board's investigators was finalized with the staff moving to the DCA. Prior to the transition, the Board had 271.1 permanent full-time employees. This transition moved 116 of those permanent full-time positions to the DCA. In addition, on July 1, 2014 the Board was authorized, through two approved Budget Change Proposals (BCP) to receive five positions for enforcement enhancement positions and a new Chief of Enforcement (to be called an Enforcement Program Manager). With all of the changes, the Board now has 160.1 permanent full-time positions (in addition to temporary staff). Based upon this new staff total, the Board is at a 10% vacancy rate which equates to 16 vacant positions. This is up from the report provided in the last Administrative Summary in part because of the loss of the investigator positions, but also because five of these positions were just added through the BCP process (and some are still pending approval by DCA). However, of those 16 vacant positions, the Board has 2 individuals pending a start date, or pending

verification of eligibility. Therefore, the Board only has 14 positions that do not have an individual identified for the position. This equates to a **9 % vacancy rate** for the Board.

The Board Complaint Investigative Office is completely staffed and is working on investigating cases for the Board (one Supervising Special Investigator and six Special Investigators). As previously stated, these positions were a result of the Consumer Protection Enforcement Initiative (CPEI). These positions are unfunded in the Board's budget, but the Board is using savings from vacant positions to be able to fill these positions. This unit is investigating some of the less complex cases, whereby reducing the caseload for the sworn investigators in the district offices. Also as previously stated, 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.

The Board is in the process of hiring a new Deputy Director for the Medical Board. Initial interviews have been completed and the second round of interviews have been scheduled with Dr. Levine. The Board hopes to have an individual in this position by at least August 1, 2014, if not prior.

Budget Update:
The Board had four Budget Change Proposals approved for fiscal year (FY) 14-15. The BCPs include: 1) five additional employees to enhance the Board's Enforcement Program (one of the positions was for an investigator so the position was transferred to the DCA), 2) funding for the BreEZe system for FY 2014/2015, 3) reimbursement authority for the License 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 an Enforcement Program Manager.

The Board's budget documents are attached, beginning on page BRD 8B-4 and continue to page BRD 8B-14. The Board's fund condition on page BRD 8B-4 projects the Board's fund reserve, at the end of FY 2013/2014, to be at 4.3 months. However, based upon projections the Board will revert monies due to vacancies as well as the BreEZe project not being implemented when projected. A final budget document will be provided at the next Board meeting.

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 8B-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 May 31, 2014, can be found on page BRD 8B-6, and pages BRD 8B-7 to 8B-11 show the budget report specifically for enforcement, the AG expenditures, and licensing. Page BRD 8B-14 provides the Board Members' expenditure report as of June 27, 2014.

BreEZe Update:
Staff continue to identify and submit requests for changes/fixes to DCA for the BreEZe system. Several of the Board's issues have been resolved, however, 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. Several releases that include fixes to the system have been completed since April 2014. In addition, a release is planned for August 2014 that will hopefully contain a significant number of improvements to the system. As new issues arise, the Board has to prioritize whether the new issue needs to be fixed prior to some of the old pending requests. The Board's Information System Branch staff has be instrumental in making sure the Board's issues are being identified and provided to the DCA for resolution. As previously stated, DCA is working to amend the contract to obtain a better maintenance process for the Boards who are currently working in the BreEZe system.

The Board is beginning to be able to work on reports specific to the needs of the Board. The Board hopes to have reports available for both licensing and enforcement by the October Board meeting.

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 8B-15 and 16). The two boards (Medical and 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	$ 1,531		
	CURES		$ 819	$ 819		
	Enforcement Enhancements			$ 471	$ 415	$ 415
	SB 304			$ 118	$ 118	$ 118
	Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
	Anticipated Future Costs					
	BreEZe Costs				$ 1,531	$ 1,531
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.

7/2/2014

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	$ 1,531		
	CURES		$ 819	$ 819		
	Enforcement Enhancements			$ 471	$ 415	$ 415
	SB 304			$ 118	$ 118	$ 118
	Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
	Anticipated Future Costs					
	BreEZe Costs				$ 1,531	$ 1,531
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.

7/2/2014

Medical Board of California
FY 13/14
Budget Expenditure Report
(As of May 31, 2014)
(90% 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	14,256,519	86.2	2,284,331
Board Members	31,500	69,225	219.8	(37,725)
Phy Fitness Incentive Pay	29,623	6,535	22.1	23,088
Temp Help	1,800,000	1,131,127	62.8	668,873
Overtime	50,000	115,398	230.8	(65,398)
Staff Benefits	8,328,522	7,151,821	85.9	1,176,701
BL 12-03 Blanket	0	91,067		0
TOTALS, PERS SERVICES	26,780,495	22,821,692	85.2	4,049,870
OPERATING EXP & EQUIP				
General Expense	300,535	581,408	193.5	(280,873)
Fingerprint Reports	333,448	268,031	80.4	65,417
Minor Equipment	24,300	95,724	393.9	(71,424)
Printing	435,755	209,931	48.2	225,824
Communications	257,190	212,318	82.6	44,872
Postage	182,511	143,855	78.8	38,656
Insurance	41,053	16,106	39.2	24,947
Travel In-State	361,298	318,546	88.2	42,752
Travel Out-of-State	7,000	13,318	190.3	(6,318)
Training	78,895	64,991	82.4	13,904
Facilities Operation (Rent)	2,490,025	2,457,038	98.7	32,987
Consult/Prof Services	2,198,594	1,559,710	70.9	638,884
Departmental Prorata	5,034,442	5,035,167	100.0	(725)
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	416,159	64.0	234,071
Data Processing	129,492	293,949	227.0	(164,457)
Central Admin Svcs (Statewide Prorata)	2,417,774	2,417,774	100.0	0
Attorney General Services	13,347,280	11,865,043	88.9	1,482,237
Office of Administrative Hearings	1,525,080	927,509	60.8	597,571
Evidence/Witness	1,893,439	1,597,299	84.4	296,140
Court Reporter Services	225,000	282,976	125.8	(57,976)
Major Equipment	392,120	143,263	36.5	248,857
Other Items of Expense	81	32,213	39,769.1	(32,132)
Vehicle Operations	247,925	277,976	112.1	(30,051)
Court-ordered Payments	0	1,816		(1,816)
Board of Control Claim	0	992		(992)
TOTALS, OE&E	32,578,609	29,233,112	89.7	3,345,497
TOTALS, EXPENDITURES	59,359,104	52,054,804	87.7	7,304,300
Scheduled Reimbursements	(384,000)	(444,538)	115.8	60,538
Distributed Costs	(780,000)	(515,745)	66.1	(264,255)
NET TOTAL, EXPENDITURES	58,195,105	51,094,521	87.8	7,100,583
Unscheduled Reimbursements		(1,318,830)		
		49,775,691		

Budget Expenditure Report.xls
Date:6/24/14

MEDICAL BOARD OF CALIFORNIA
LICENSING PROGRAM
BUDGET REPORT
JULY 1, 2013 - MAY 31, 2014

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,776,800	2,374,433	current
Staff Benefits	1,303,330	1,133,415	current
TOTAL PERSONAL SERVICES	4,080,130	3,507,848	
OPERATING EXPENSES & EQUIPMENT			
General Expense	47,000	17,087	1-2
Fingerprint Reports*	333,448	266,878	1-2
Printing	99,876	53,472	1-2
Communications	32,246	21,452	1-2
Postage	100,000	78,787	1-2
Travel In-State	9,758	10,470	1-2
Travel Out-State	0	5,341	
Training	8,500	897	1-2
Facilities Operation	226,000	267,742	current
Consult/Professional Services	1,810,873	1,270,571	1-2
Departmental Services	697,774	575,940	current
Interagency Services	587	0	current
Data Processing	4,000	4,063	1-2
Statewide Pro Rata	335,103	335,103	current
Attorney General	190,000	47,899	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	20,636	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,902,915	2,976,338	
SCHEDULED REIMBURSEMENTS	(384,000)	(444,538)	
DISTRIBUTED COSTS	(31,131)	(18,738)	
TOTAL BUDGET/EXPENDITURES	**7,567,914**	**6,020,910** **	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports
** Includes Polysom
6/24/2014

MEDICAL BOARD OF CALIFORNIA
ENFORCEMENT PROGRAM
BUDGET REPORT
JULY 1, 2013- MAY 31, 2014

	FY 13/14 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	10,926,314	9,391,851	current
Staff Benefits	4,869,104	4,217,224	current
TOTAL PERSONAL SERVICES	15,795,418	13,609,075	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	144,768	409,656	1-2
Printing	157,926	114,416	1-2
Communications	127,358	136,649	1-2
Postage	69,500	62,846	1-2
Insurance	38,235	13,870	current
Travel In-State	229,018	231,547	1-2
Travel Out-State	7,000	7,768	1-2
Training	31,000	49,896	1-2
Facililties Operations	1,922,825	1,733,984	current
Consultant/Professional Services	300,000	266,771	1-2
Departmental Services	3,440,033	3,551,802	current
Interagency Services	3,629	0	1-2
Data Processing	18,000	46,511	1-2
Statewide Pro Rata	1,652,065	1,652,065	current
Attorney General 1/	13,157,280	11,817,144	current
OAH	1,525,080	927,509	1
Evidence/Witness Fees	1,820,939	1,503,910	1-2
Court Reporter Services	224,750	282,976	1-2
Major Equipment	0	128,827	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	81	31,785	1-2
Vehicle Operations	206,925	235,508	1-2
Minor Equipment	0	49,480	1-2
Court-Ordered Payments	0	1,816	current
TOTAL OPERATING EXPENSES & EQUIPMENT	25,076,412	23,256,736	
DISTRIBUTED COSTS	(744,054)	(488,580)	
TOTAL BUDGET/EXPENDITURES	**40,127,776**	**36,377,231**	
Unscheduled Reimbursements		(232,934)	
		36,144,297	

1/See next page for monthly billing detail

6/24/2014

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	6,227.00	170.00	1,058,590.00
	Paralegal Services	4.25	120.00	510.00
	Auditor/Analyst	210.75	99.00	20,864.25
	Cost of Suit			51.50
				1,080,015.75
February				
	Attorney Services	5,671.75	170.00	964,197.50
	Paralegal Services	163.00	120.00	19,560.00
	Auditor/Analyst	153.75	99.00	15,221.25
	Cost of Suit			2,333.47
				1,001,312.22
March				
	Attorney Services	5,931.50	170.00	1,008,355.00
	Paralegal Services	250.25	120.00	30,030.00
	Auditor/Analyst Services	199.75	99.00	19,775.25
	Cost of Suit			15,738.00
				1,073,898.25
April				
	Attorney Services	6,290.00	170.00	1,069,300.00
	Paralegal Services	308.75	120.00	37,050.00
	Auditor/Analyst Services	164.00	99.00	16,236.00
	Cost of Suit			1,074.16
				1,123,660.16
May				
	Attorney Services	6,049.25	170.00	1,028,372.50
	Paralegal Services	297.25	120.00	35,670.00
	Auditor/Analyst Services	152.50	99.00	15,097.50
	Cost of Suit			511.65
				1,079,651.65
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 06/24/2014

FYTD Total =	**11,817,144.12**
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	0	100	50		3,050
Criminal Cost Recovery	499	698	1,050	3,127	8,857	204	2,824	9,707	100	7,352	1,235		35,653
Probation Monitoring	69,560	54,598	28,303	0	100,901	115,137	439,694	161,273	109,197	136,412	63,742		1,278,817
Exam	7,232	6,164	4,537	0	5,568	1,500	7,328	3,075	4,929	5,784	3,953		50,070
Cite/Fine	2,850	5,450	2,000	4,925	2,975	2,850	1,100	1,100	0	750	1,850		25,850
MONTHLY TOTAL	80,791	67,460	36,440	8,052	118,301	119,741	451,996	175,205	114,226	150,398	70,830	0	1,393,439
FYTD TOTAL	80,791	148,251	184,691	192,743	311,044	430,784	882,780	1,057,985	1,172,211	1,322,609	1,393,439	1,393,439	

excel:enfreceiptsmonthlyprofile.xls.revised 6/13/2014

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.

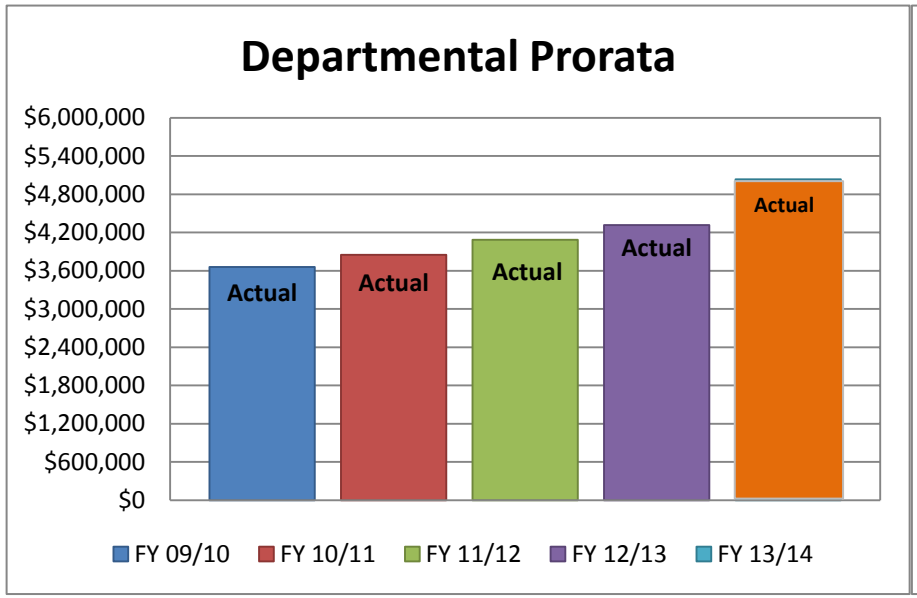
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

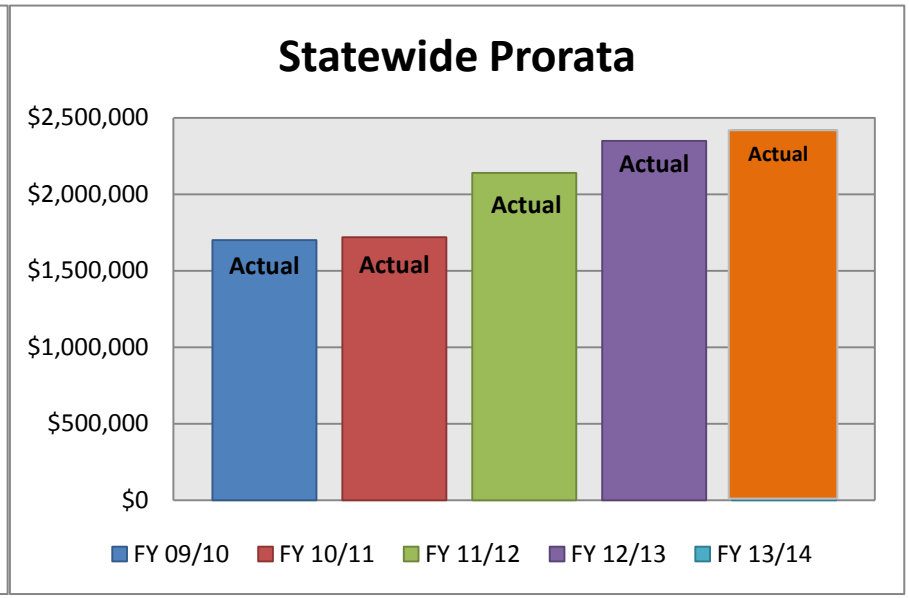
	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 10/11								
$ Budgeted	1,944,000	37,720,000	577,000	5,045,000	1,688,000	3,118,000	1,735,000	51,827,000
$ Spent *	1,771,000	34,420,000	651,000	5,061,000	1,564,000	2,948,000	487,000	46,902,000 *
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 05/31*	1,321,398	36,144,297	822,190	6,020,910	1,532,229	2,959,005	975,662	49,775,691 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1

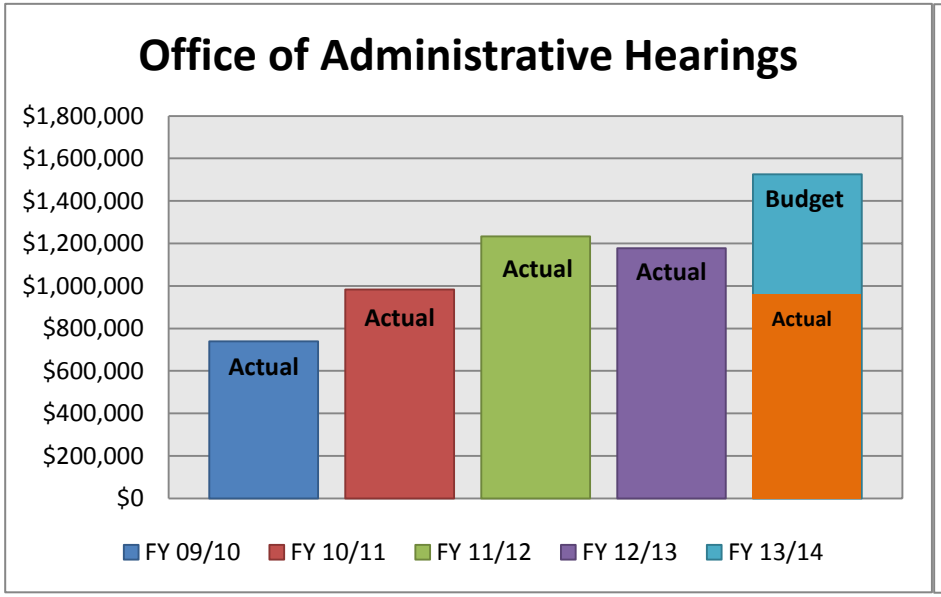
* net expenditures (includes unscheduled reimbursements)

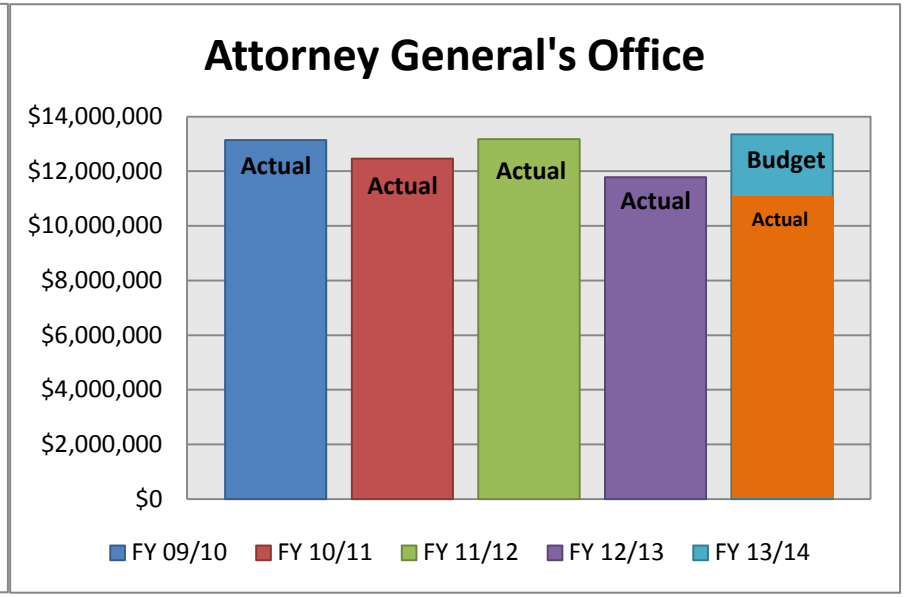
6/24/2014
Budget Overview by Program.xls

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	$ 200.00	$ 700.00	$ 800.00	$ -	$ 6,200.00
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	$ 200.00	$ 700.00	$ 800.00	$ -	**$ 9,999.30**
DR. DIEGO - Per diem	$ 500.00	$1,700.00	$ -	$ 1,700.00	$1,400.00	$1,300.00	$ 400.00	$ 900.00	$ 400.00	$ 600.00	$ 400.00	$ -	$ 9,300.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 503.35	$ -	$ -	$ 744.09	$ -	$ 1,247.44
	$ 500.00	$1,700.00	$ -	$ 1,700.00	$1,400.00	$1,300.00	$ 400.00	$1,403.35	$ 400.00	$ 600.00	$1,144.09	$ -	**$ 10,547.44**
DR GNANADEV - Per diem	$ 900.00	$1,300.00	$1,100.00	$ 900.00	$ 800.00	$1,200.00	$ 900.00	$ 700.00	$ 800.00	$ 700.00			$ 9,300.00
Travel	$ 521.96			$ 46.86	$ 475.38	$ -	$ 946.64	$ 324.82	$1,229.09				$ 3,544.75
	$1,421.96	$1,300.00	$1,100.00	$ 946.86	$1,275.38	$1,200.00	$1,846.64	$1,024.82	$2,029.09	$ 700.00	$ -	$ -	**$ 12,844.75**
DR. KRAUSS - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$1,400.00	$ -	$ -	$ -	$ 1,400.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$1,400.00	$ -	$ -	$ -	**$ 1,400.00**
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	$1,000.00	$1,200.00	$1,000.00	$ -	$ 9,200.00
Travel	$ -	$ -	$ 416.26	$ 389.08	$ -	$ -	$1,007.49	$ -	$ 405.03	$ -	$ -	$ -	$ 2,217.86
	$ -	$ -	$ 416.26	$ 1,389.08	$ 700.00	$1,300.00	$2,607.49	$1,400.00	$1,405.03	$1,200.00	$1,000.00	$ -	**$ 11,417.86**
MR. LUI - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 200.00	$ -	$ -	$ 200.00	$ -	$ 400.00
Travel	$ -	$ -	$ -	$ -	$ 564.87	$ -	$ 502.50	$ -	$ -	$ -	$ 210.42	$ -	$ 1,277.79
	$ -	$ -	$ -	$ -	$ 564.87	$ -	$ 502.50	$ 200.00	$ -	$ -	$ 410.42	$ -	**$ 1,677.79**
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	$1,000.00	$1,400.00	$1,100.00	$ -	$ 13,900.00
Travel	$ 771.58	$ -	$ -	$ 254.32		$ -	$ 661.14	$ -	$ -	$ -	$ 72.93	$ -	$ 1,759.97
	$2,271.58	$1,400.00	$1,200.00	$ 1,754.32	$1,200.00	$1,000.00	$1,961.14	$1,300.00	$1,000.00	$1,400.00	$1,172.93	$ -	**$ 15,659.97**
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	$ 200.00	$ 400.00	$ 900.00	$ -		$ 7,800.00
Travel	$ 742.37	$ -	$ -	$ 277.41	$ -	$ -	$ -	$ -	$ -	$ -	$ 103.32	$ -	$ 1,123.10
	$1,842.37	$1,000.00	$1,200.00	$ 1,477.41	$ -	$ 900.00	$ 900.00	$ 200.00	$ 400.00	$ 900.00	$ 103.32	$ -	**$ 8,923.10**
MR. SERRANO SWELL- Per diem	$ 800.00	$ 500.00	$ 700.00	$ 800.00	$ 500.00	$ 600.00	$ 600.00	$ 800.00	$ 700.00	$ 700.00	$ 700.00	$ -	$ 7,400.00
	$ -	$ -	$ -	$ 783.34	$ -	$ -	$ -	$ -	$ -	$ 754.06	$ -	$ -	$ 1,537.40
	$ 800.00	$ 500.00	$ 700.00	$ 1,583.34	$ 500.00	$ 600.00	$ 600.00	$ 800.00	$ 700.00	$1,454.06	$ 700.00	$ -	**$ 8,937.40**
MS.WRIGHT - Per diem	$ -	$ -	$ 300.00	$ 1,200.00	$ 900.00	$1,000.00	$1,400.00	$1,300.00	$1,100.00	$1,800.00	$ 800.00	$ -	$ 9,800.00
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 954.28	$ -	$ -	$ 60.76	$ -	$ 1,015.04
	$ -	$ -	$ 300.00	$ 1,200.00	$ 900.00	$1,000.00	$1,400.00	$2,254.28	$1,100.00	$1,800.00	$ 860.76	$ -	**$ 10,815.04**
MS. YAROSLAVSKY - Per diem	$1,300.00	$ 600.00	$ 800.00	$ -	$ -	$1,000.00	$ 800.00	$ -	$ -	$ 800.00	$1,100.00	$ -	$ 6,400.00
Travel	$ 764.12	$ -	$ -	$ 352.58	$ -	$ -	$ -	$2,016.52	$ 463.54	$2,142.12	$ -	$ -	$ 5,738.88
	$2,064.12	$ 600.00	$ 800.00	$ 352.58	$ -	$1,000.00	$ 800.00	$2,016.52	$ 463.54	$2,942.12	$1,100.00	$ -	**$ 12,138.88**
DR. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of:6/27/2014

TOTAL PER DIEM	$ 81,300.00
TOTAL PER DIEM BUDGETED	$ 31,500.00
TOTAL TRAVEL	$ 24,418.05
TOTAL	**$ 105,718.05**

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.

July 8, 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 May. During this meeting, the subcommittee heard reports on augmentations suggested by UCSD School of Pharmacy professors to broaden the board's website links relating to prescription drug abuse.

The board has developed a brochure for pharmacists on corresponding responsibility and "red flags" that could alert pharmacists about patients seeking controlled drugs and not medical therapy. Additionally on the subject of corresponding responsibility, I recently filmed a brief introduction to a video produced by the National Association of Boards of Pharmacy and Cardinal Healthcare regarding red flags when dispensing controlled substances. This video should be available from the board's website shortly.

Two board staff participated in the contract evaluation for a new CURES computer system. The board also is now assisting the DOJ in registering pharmacists into CURES by collecting registration packets from pharmacists in the board's office, and during board and committee meetings.

The board is also partnering with the DEA to do two six-hour continuing education seminars on prescription drug abuse, drug thefts and diversion, corresponding responsibility and the CURES program. One presentation will be in Santa Barbara in September and one sometime this summer in the San Fernando Valley.

The next meeting of this subcommittee is August 26, likely in Sacramento.

General data on prescription volume in CA:

650 million prescriptions filled in CA each year
9.05 million C II prescriptions reported in CURES 4/1/2013-3/31/2014
19.04 million C III prescriptions reported in CURES 4/1/2013-3/31/2014

19.81 million C IV prescriptions reported in CURES 4/1/2013-3/31/2014

78,500 pounds of unwanted medication was collected by the California DEA offices during the April 2014 Drug Take Back event.

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, recently adopted amendments to require 12 point font as the minimum font size. The 45-day initial comment period for the regulation is now underway.

On July 31 as the second day of the quarterly Board of Pharmacy Meeting, the board will convene a forum on prescription label design for patient information. Experts in the field will provide information on current thinking of the optimal design of prescription container labels for maximum patient ease and comprehension.

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 this summer. Medical board staff will be part of the process as well.

Sterile Compounding Pharmacies

On July 1, 2014, the board implemented 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 has inspected all California hospitals to identify and license sterile compounding areas. Meanwhile, the board is continuing to work on a major revision to California's regulations for compounded medication.

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

CALIFORNIA

THE RX OPIOID OVERDOSE EPIDEMIC

7.1 - 11.8 | 11.9 - 15.2 | 15.3 - 36.3

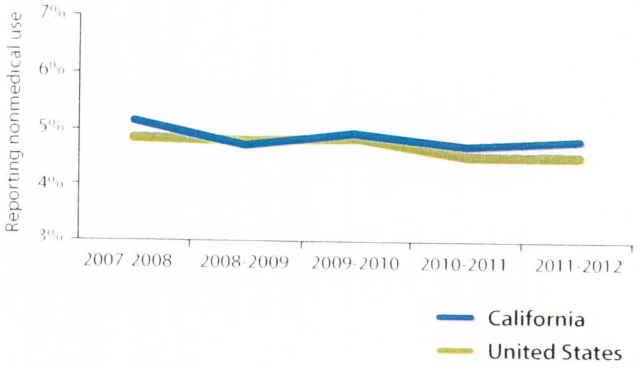
California has the **40th highest drug overdose death rate** in the U.S.

Drug Overdose Deaths (All Drugs) per 100,000 People, 2011[1]

California: 10.7	**United States: 13.2**
Alaska: 14.2	Nevada: 22.8
Arizona: 16.8	Oregon: 13.5
Hawaii: 12.4	Washington: 14.1
Idaho: 12.9	

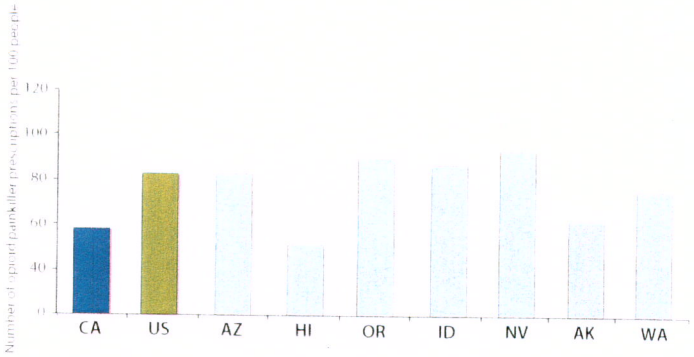
California has the **20th highest rate of past year nonmedical prescription opioid pain reliever use** in the U.S.

Past Year Nonmedical Use of Prescription Opioid Pain Relievers Among Persons Aged 12 or Older[3]



California has the **2nd lowest opioid pain reliever prescribing rate** in the U.S.

Opioid Pain Reliever Prescribing, 2012[2]



Sources: (1) CDC, National Vital Statistics System, 2011. (2) IMS Health, 2012. (3) Substance Abuse and Mental Health Services Administration, National Survey on Drug Use and Health 2006-2012.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS245481

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 7, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Enforcement Program Summary
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

Requested Action:
This report is intended to provide the Members with an update on the Enforcement Program at the Medical Board of California (Board). No action is needed at this time.

Expert Reviewer Program Update:
There are currently 951 experts in the Medical Board of California's expert database. 238 experts were utilized to review 322 cases in the first and second quarter of calendar year 2014. Attachment A provides the Expert Reviewer Program statistics. Additional experts are needed in the following specialties:

- Pain Medicine
- Dermatology
- Urology
- Neurosurgery

Vacancy Rate/Staffing Update:
Although the Board's investigators have transitioned to the Department of Consumer Affairs (DCA), the following provides the final vacancy information for the Board's Investigation Unit. Future reports will be provided by DCA. As of July 1, 2014, there were 7 sworn investigator vacancies (9% vacancy rate). However, 2 of these positions have individuals who are in background for the vacancy, which reduces the vacancy rate to 6%. There are 2 Supervisor vacancies (10% vacancy rate). The overall vacancy rate for all sworn staff is 9%, or 7% taking into consideration the candidates in background.

Laura Sweet, Deputy Chief of the Board's Investigative Unit, notified Board Management that she will be retiring October 8, 2014. However, she will be using her leave credits and therefore her last day with the Board was June 30, 2014, although she will continue to assist with the completion of the Board's revision of the prescribing guidelines and other special projects until October. Ms. Sweet has been a huge asset to the Board and will be greatly missed. During her time with the Board, Ms. Sweet has been instrumental in multiple projects, but most notable is the work she did on the Board's Expert Reviewer Program. She overhauled the Expert Reviewer training program in order to ensure our experts understood their role and the part they play in the Board's disciplinary process. The Board thanks Ms. Sweet for her service to the Board.

Consumer Protection Enforcement Initiative (CPEI) Positions:
On June 2, 2014, the Board started its Complaint Investigation Office (CIO). The CIO is a unit made up of six (6) Special Investigators (non-sworn) and a Supervising Special Investigator I who will be investigating certain cases that do not require investigation by the DCA Health Quality Investigative Unit (HQIU). The cases that this unit will investigate include: physicians who have been charged with or convicted of a criminal offense, physicians who violate a term or condition of probation following a disciplinary action, reports of disciplinary action taken by another state or jurisdiction, physicians petitioning for reinstatement of a license following revocation or surrender, physicians petitioning for modification or early termination of probation, and certain quality of care investigations following a malpractice settlement or judgment.

Not all enforcement activities or investigative duties require the use of sworn peace officer investigators. Many tasks associated with investigations can be performed by non-sworn investigators such as detecting and verifying violations, interviewing witnesses, gathering information, analyzing testimony, serving legal papers, or serving as an expert witness amongst other non-sworn duties. The ultimate goal in utilizing these positions is to assist in decreasing the number of cases currently assigned to the HQIU's investigators, thus decreasing the time it takes to complete the investigation process, which is consistent with the Board's strategic goals, objectives, and mission.

Transition:
On July 1, 2014, the Board's Investigative Unit and its support staff moved to the DCA pursuant to SB 304. The Board staff and DCA staff held a town hall with all affected employees on May 6, 2014. The meeting was held statewide via videoconferencing. At this meeting a list of questions and answers was provided to staff and staff also had the ability to ask questions. In addition, on June 30 and July 1, 2014 the DCA held swearing in ceremonies for all the Investigators of the new HQIU. At this time the transition is now complete. However, Board staff and DCA staff will continue to work closely together on the investigations of Board complaints.

Medical Board of California
Expert Reviewer Program Report

Agenda Item 8C

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
7/1/2014

SPECIALTY	**Number of cases sent to Experts / reviewed (January-June)**	**Number of Experts Utilized (January-June)**	**Active List Experts 7.1.14 951↑**
ADDICTION	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	13 ↓
ALLERGY & IMMUNOLOGY (A&I)			4
ANESTHESIOLOGY (Anes)	10	**7 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	72 ↑
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	3
COMPLEMENTARY/ALTERNATIVE MEDICINE	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	19 ↓
CORRECTIONAL MEDICINE			26 ↓
DERMATOLOGY (D)	12	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 COMPANION CASES	9 ↓
EMERGENCY (EM)	10	**7 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	49 ↑
FAMILY (FM) ** INVOLVED CASE REVIEWS AND PREP/TESTIMONY*	33	**20 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES*	76 ↑

Medical Board of California
Expert Reviewer Program Report

Agenda Item 8C

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
7/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-June)	Number of Experts Utilized (January-June)	Active List Experts 7.1.14 951↑
INTERNAL (General Internal Med) *involved companion cases	33	**25 EXPERTS** 20 LIST EXPERTS REIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	178 ↓
Cardiovascular Disease (Cv)	9	**8 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 5 CASES	33
Endocrinology, Diabetes and Metabolism (EDM)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 2 CASES	7
Gastroenterology (Ge)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	19
Infectious Disease (Inf)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	11 ↑
Medical Oncology (Onc)			12
Nephrology (Nep)			9
Rheumatology (Rhu)			7
MIDWIFE REVIEWER	1	**1 EXPERT** 1 LIST EXPERT	6
NEUROLOGICAL SURGERY (NS) *[*SHORT LIST OF REVIEWERS]*	11	**4 EXPERTS** 1 OFF LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	9
NEUROLOGY (N)	10	**6 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	24 ↑
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2

Medical Board of California
Expert Reviewer Program Report

Agenda Item 8C

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ACTIVE LIST EXPERTS BY SPECIALTY
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SPECIALTY	**Number of cases sent to Experts / reviewed (January-June)**	**Number of Experts Utilized (January-June)**	**Active List Experts 7.1.14 951↑**
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG)	33	**27 EXPERTS** 18 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	73 ↑
OCCUPATIONAL MEDICINE			8
OPHTHALMOLOGY (Oph)	7	**6 EXPERTS** 1 OFF LIST EXPERT REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	29 ↓
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY (OrS)	5	**5 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	30 ↑
OTOLARYNGOLOGY (Oto)	2	**1 EXPERT** 1 LIST EXPERT REVIEWED 2 CASES	18 ↓
PAIN MEDICINE (PM)	31	**15 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES	27
PATHOLOGY (Path)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	9
PEDIATRICS (Ped)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	48 ↑

Medical Board of California
Expert Reviewer Program Report

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ACTIVE LIST EXPERTS BY SPECIALTY
7/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-June)	Number of Experts Utilized (January-June)	Active List Experts 7.1.14 951↑
PHYSICAL MEDICINE & REHABILITATION (PMR)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	9
PLASTIC SURGERY (PIS)	13	**8 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 3 LIST EXPERTS REVIEWED 3 CASES	51 ↓
PSYCHIATRY (Psyc)	50	**38 EXPERTS** 23 LIST EXPERTS REVIEWED 1 CASE 11 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES	76 ↓
RADIOLOGY (Rad)	8	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	35
RADIATION ONCOLOGY			4
SLEEP MEDICINE (S)			7 ↓
SURGERY (S)	18	**13 EXPERTS** 7 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	35 ↓
Vascular Surgery (VascS)	3	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 2 CASES	7 ↓
THORACIC SURGERY (TS)	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	16
(MEDICAL) TOXICOLOGY	1	**1 EXPERT** 1 OFF LIST EXPERT	5

Medical Board of California
Expert Reviewer Program Report

Agenda Item 8C

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
7/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-June)	Number of Experts Utilized (January-June)	Active List Experts 7.1.14 951↑
UROLOGY (U)	7	**6 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16 ↓

TOTAL CASES SENT: JANUARY-JUNE, 2014	**322**
TOTAL LIST EXPERTS UTILIZED: JANUARY-JUNE, 2014	**238**
TOTAL ACTIVE LIST EXPERTS: JULY 1, 2014	**951**

Expert Program/sg (6.2014)

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: July 7, 2014
ATTENTION: Board Members
SUBJECT: Licensing Program Summary
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
The Licensing Program staff, continued to work hard in the fourth quarter of FY 13/14 to meet the needs of licensing the residents who needed Physician's and Surgeon's (P&S) Licenses or Postgraduate Training Authorization Letters (PTAL) by July 1, 2014. Although, Licensing has filled some vacancies, several staff have been out for various reasons. The BreEZe system requires more information to be entered and therefore it takes longer to process application files.

Licensing currently has the following vacancies:

- 1 OT - Call Center
- 1 MST - US/CAN P&S Application Reviewer
- 1 SSA - IMG P&S Application Reviewer

Interviews will be schedule in the next few weeks.

STATISTICS:
The statistics are on pages BRD 8D - 5 through BRD 8D - 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 – 23,758 (BRD 8D - 5)
- Consumer Information Unit, telephone calls abandoned - 6,392 (BRD 8D - 5)
    - 3,193 fewer abandon calls than the previous quarter
- Consumer Information Unit, telephone calls requesting a call back – 7,776 (BRD 8D - 5)
    - 2,849 fewer call back requests than the previous quarter
- P&S applications initial review completed – 1,026. This was gathered by other means than BreEZe and has a margin of error.
- P&S applications not reviewed – 666 (includes PTAL, IMG & US). This was gathered by other means than BreEZe and has a margin of error.
- P&S licenses issued – 1,969
    - This number is an increase of 712 licenses issued from the previous quarter. The Board issued 82 more licenses in FY 13/14 than 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 one (1) of the 13 weeks in the fourth quarter of FY 13/14. This was due to staff prioritizing applications from applicants who needed to be licensed or have a PTAL by July 1, 2014. In addition, it will take staff a few weeks to meet this goal in the first quarter of FY 14/15 as a result of prioritizing the applicants who needed a PTAL or license by July 1, 2014. The Licensing management will continue to monitor the review dates closely and working with staff to reach the Board's goals.

INTERNATIONAL MEDICAL SCHOOLS:
The statistics for the International Medical School Reviews are on page BRD 8D - 6.
The review of International Medical Schools continues to be a demanding workload for the Board. There are currently six Self-Assessment Reports that are in the review process. Three Self-Assessment Reports were closed due to lack of response from the medical schools.

OUTPATIENT SURGERY SETTINGS:
Staff is planning a meeting with all of the Outpatient Surgery Setting Accreditation Agencies before the October 2014 Board meeting.

SPONSORED FREE HEALTHCARE EVENTS:
The Board approved two 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, Bridges to Health, at "The Armory Community Center" in San Francisco, April 23-24, 2014, and at the "Oracle Arena East-Side Club" in Oakland, April 25, 2014.

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. Staff is working on the language that will be used in the BreEZe system for the applicants to view the status of their application. Staff plan on completing this project within the next 60 days. However, the information will be from updates received point forward, and the information will not be as informative as in the previous WAAS applicant status system. This is a result of the differences in application designs. The lack of having a system to view the application status has resulted in a large number of telephone calls regarding application status and whether the Board has received specific documents.

The Consumer Information Unit (CIU) is answering as many calls as possible. However, many of the telephone calls are still taking up to 20 minutes each due to questions regarding BreEZe and the need to assist physicians who are trying to renew their licenses. CIU is experiencing more calls than the Board is staffed to handle at the end of the month when physicians need their license renewed to continue to practice.

The Board's Information Systems Branch (ISB) staff 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. 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. Licensing 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 or grand round lectures, 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
- May 1: UCLA
- May 2: St Mary's Long Beach

The Licensing Outreach Manager was invited to participate in new resident orientation at the following teaching hospitals:

- 6/18: St Mary's SF (about 40 residents)
- 6/19: UCLA-Day 1 (about 175 residents) and USC (about 10 residents and the program director)
- 6/20: UCI-Day 1 (about 150 residents) and St Mary's Long Beach (about 40 residents)
- 6/23: UC-Riverside (about 45 residents and a few program staff – first time visit), Loma Linda-Day 1 (about 200 residents), White Memorial (about 35 residents and a few program staff – first time visit).
- 6/30: UCSF (about 195 residents)
- 7/1: UCI-Day 2 (about 75 residents), Loma Linda-Day 2 (about 75 residents) and UCLA-Day 2 (about 75 residents)

The following licensing workshops have been planned (additional licensing workshops may be added if there is a need for more and, when appropriate, residents from affiliated hospitals are invited to attend):

- 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)

All trips are planned in consideration of the Governor's Executive Order to limit and condense travel to reduce costs.

WORKLOAD REPORT
as of June 30, 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	23,758
Calls Requesting Call Back	**12,403**	3,861	8,542	10,625	7,776
Calls Abandoned	**11,205**	3,147	8,058	9,585	6,392
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	4
PG/Medical Knowledge	**28**	19	9	18	21
Convictions	**16**	11	5	4	9
Other	**45**	29	16	24	26

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	108
Pending Self-Assessment Reports (included above)	**N/A**	9	10	9	6*
New Self-Assessment Reports Received	**1**	1	0	1	0
New Unrecognized Schools Received	**46**	21	25	10	17
School Recognized Pursuant to CCR 1314(a)(1)	**41**	18	23	7	20
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0	0*	1
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	102	104	108	101

*Three CCR 1314.1(a)(2) school files were closed due to lack of response to the 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: July 8, 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 Update:
For the last several years, former Board Member Hedy Chang has been the Board's liaison with the FSMB. However, Ms. Chang's term on the FSMB has expired. The Board was recently informed by the FSMB Board Chair, Donald H. Polk, D.O., that Jacqueline A. Watson, D.O., MBA, would be replacing Ms. Chang as the Board's liaison. Ms. Watson is the Executive Director of the District of Columbia Board of Medicine. The FSMB will be planning a visit at a future Board meeting.

One of the most significant projects at the FSMB is the development of an Interstate Compact. In 2013, the FSMB House of Delegates passed a resolution directing the FSMB to explore the formation of an Interstate Compact to enhance license portability. The FSMB developed a framework for an Interstate Medical Licensure Compact, which would provide a new licensing option under which qualified physicians seeking to practice in multiple states would be eligible for expedited licensure in all states participating in the Compact. The FSMB, in consultation with State Medical Board representatives, identified eight consensus principles. Those principles are:

- Participation in an interstate compact for medical licensure will be strictly voluntary for both physicians and state boards of medicine.
- Participation in an interstate compact creates another pathway for licensure, but does not otherwise change a state's existing Medical Practice Act.
- The practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.
- An interstate compact for medical licensure will establish a mechanism whereby any physician practicing in the state will be known by, and under the jurisdiction of, the state medical board where the practice occurs.
- Regulatory authority will remain with the participating state medical boards, and will not be delegated to any entity that would administer a compact.
- A physician practicing under an interstate compact is bound to comply with the statutes, rules and regulations of each compact state wherein he/she chooses to practice.
- State boards participating in an interstate compact are required to share complaint/investigative information with each other.
- The license to practice can be revoked by any or all of the compact states.

Based upon these principles, the FSMB developed a draft compact, which was sent to the Board in December 2013. The Board provided feedback on the proposed compact. At the April 2014 FSMB Annual Meeting the Interstate Compact was an item of discussion. Based upon feedback

received, the FSMB edited the draft to incorporate some of the issues identified. In May 2014, the FSMB submitted a second draft (**see Attachment A**) for review and comment.

The FSMB has stated that final model legislation for the interstate medical licensure compact will be ready for state legislative consideration beginning in 2015. Under the new proposed system, participating state medical boards would retain their licensing and disciplinary authority, but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders. Again, participation in the compact would be voluntary, for both states and physicians.

Based upon Board staff review the most significant concern in the Interstate Compact is the fact that it does not require individuals to be fingerprinted. The Board requires all applicants to be fingerprinted. This requirement assists the Board in two areas. First, it verifies that the information the physician is providing to the Board is accurate. The Board asks all applicants if they have been convicted of a crime. The only way to ensure the response received is accurate is by having an individual fingerprinted. The second reason that fingerprints are necessary, is because if the individual is arrested, the Board is notified via a subsequent arrest report. Therefore, the Board staff believes that in California the applicant would still need to be fingerprinted. Board staff has provided this information to the FSMB.

FSMB's Foundation Grants:

As stated at the May 2014 Board Meeting, the FSMB Foundation awarded the Board a $10,000 grant to provide educational programming on extended-release and long-acting opioid analgesic prescribing to healthcare professionals. The grant is to be used to conduct free live seminars on extended-release and long-acting opioid analgesic prescribing for licensees. By December 31, 2014, the Board must secure a minimum of 250 prescribers to participate in the three-hour program.

Board staff has been working on the specifics of this training, including locating a physician trainer, locating a location and facility, identifying outreach opportunities to advertise for the training, etc. The training will be held in the Los Angeles area on a Friday in September 2014. Once the details have been finalized, the Board will be sending an email out to all physicians encouraging participation, as well as reaching out to physician associations and organizations. Board staff has already been in contact with several organizations who are willing to help promote this event.

If the Board is unable to obtain the necessary prescribers during the training in the Los Angeles are, the Board plans to hold another training session in Northern California either late October or the first week of November. The Board believes this training will very helpful for physicians.

D R A F T

FOR DISCUSSION ONLY

INTERSTATE MEDICAL LICENSURE COMPACT

(May 5, 2014)

The ideas and conclusions set forth in this draft, including the proposed statutory language and any comments or notes, have not been formally endorsed by the Federation of State Medical Boards or its Board of Directors. This draft has been prepared to study the feasibility of an interstate compact, and does not necessarily reflect the views of the Federation of State Medical Boards, the Board of Directors of the Federation of State Medical Boards, or any state medical board or its members.

INTERSTATE MEDICAL LICENSURE COMPACT

SECTION 1. PURPOSE

In order to strengthen access to health care and in recognition of the advances in the delivery of health care, the member states of the Interstate Medical Licensure Compact have allied in common purpose to develop a comprehensive process that complements the existing licensing and regulatory authority of state medical boards, ensures the safety of patients, and enhances the portability of a medical license, providing a streamlined process that allows physicians to become licensed in multiple states. The Compact also adopts the prevailing standard for licensure, that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. State medical boards that participate in the Compact retain the jurisdiction to impose an adverse action against a license to practice medicine in that state issued to a physician through the procedures in the Compact.

SECTION 2. DEFINITIONS

In this compact:

(a) “Bylaws” means those bylaws established by the Interstate Commission pursuant to Section 11 for its governance, or for directing and controlling its actions and conduct.

(b) “Commissioner” means the voting representative appointed by each member board pursuant to Section 11.

(c) "Conviction" means a finding by a court that an individual is guilty of a criminal offense through adjudication, or entry of a plea of guilt or no contest to the charge by the

offender. Evidence of an entry of a conviction of a criminal offense by the trial court shall be considered final for purposes of disciplinary action by a member board.

(d) "Expedited License" means a full and unrestricted medical license granted by a member state to an eligible physician through the process set forth in the Compact.

(e) “Interstate Commission" means the interstate commission created pursuant to Section 11.

(f) "License" means authorization by a state for a physician to engage in the practice of medicine, which would be unlawful without the authorization.

(g) "Medical Practice Act" means laws and regulations governing the practice of allopathic and osteopathic medicine within a member state.

(h) “Member Board" means a state agency in a member state that acts in the sovereign interests of the state by protecting the public through licensure, regulation, and education of physicians as directed by the state government.

(i) "Member State" means a state that has enacted the Compact.

(j) "Practice of medicine" means the clinical prevention, diagnosis, or treatment of human disease, injury, or condition requiring a physician to obtain and maintain a license in compliance with the Medical Practice Act of a member state.

(k) "Physician" means any person who:

(1) Is a graduate of

(a) a medical school accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation; or

(b) a medical school listed in the International Medical Education Directory or equivalent, and has

(i) Passed each part of the United States Medical Licensing Examination (USMLE) within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes, and

(ii) Held a full and unrestricted license to practice medicine in any state for at least the past 5 years;

(2) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(3) Holds specialty certification recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(4) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(5) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(6) Has never held a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license;

(7) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration;

(8) Is not under active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction.

(l) "Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

(m) “Rule” means a written statement by the Interstate Commission promulgated pursuant to Section 12 of the Compact that is of general applicability, implements, interprets, or prescribes a policy or provision of the Compact, or an organizational, procedural, or practice requirement of the Interstate Commission, and has the force and effect of statutory law in a member state, and includes the amendment, repeal, or suspension of an existing rule.

(n) “State” means any state, commonwealth, district, or territory of the United States.

(o) "State of Principal License" means a member state where a physician holds a license to practice medicine and which has been designated as such by the physician for purposes of registration and participation in the Compact.

SECTION 3. ELIGIBILITY

(a) A physician must meet the eligibility requirements as defined in Section 2(k) to receive an expedited license under the terms and provisions of the Compact.

(b) A physician who does not meet the requirements of Section 2(k) may obtain a license to practice medicine in a member state if the individual complies with all laws and requirements, other than the Compact, relating to the issuance of a license to practice medicine in that state.

SECTION 4. DESIGNATION OF STATE OF PRINCIPAL LICENSE

(a) A physician shall designate a member state as the state of principal license for purposes of registration for expedited licensure through the Compact if the physician possesses a full and unrestricted license to practice medicine in that state, and the state is:

(1) the state of primary residence for the physician, or

(2) the state where at least 25% of the practice of medicine occurs, or

(3) the location of the physician's employer, or

(4) if no state qualifies under subsection (1), subsection (2), or subsection (3), the state designated as state of residence for purpose of federal income tax.

(b) A physician may redesignate a member state as state of principal license at any time, as long as the state meets the requirements in subsection (a).

(c) The Interstate Commission is authorized to develop rules to facilitate redesignation of another member state as the state of principal license.

SECTION 5. APPLICATION AND ISSUANCE OF EXPEDITED LICENSURE

(a) A physician seeking licensure through the Compact shall file an application for an expedited license with the member board of the state selected by the physician as the state of principal license.

(b) Upon receipt of an application for an expedited license, the member board in the state selected as the state of principal license shall evaluate whether the physician is eligible for expedited licensure and issue a letter of qualification, verifying or denying the physician's eligibility, to the Interstate Commission. Static qualifications, which include verification of medical education, graduate medical education, results of any medical or licensing examination, and other qualifications as determined by the Interstate Commission through rule, shall not be subject to additional primary source verification where already primary source verified by the state of principal licensure. Appeal on the determination of eligibility shall be made to the member state where the application was filed and shall be subject to the law of that state.

(c) Physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state, including the

payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under Section 6, a member board shall issue an expedited license to the physician. This license shall authorize the physician to practice medicine in the issuing state consistent with the Medical Practice Act and all applicable laws and regulations of the issuing member board and member state.

(e) An expedited license shall be valid for a period consistent with the licensure periods in the member state and in the same manner as required for other physicians holding a license within the member state.

(f) An expedited license obtained though the Compact shall be terminated if a physician fails to maintain a license in the state of principal licensure for a non-disciplinary reason, without redesignation of a new state of principal licensure.

(g) The Interstate Commission is authorized to develop rules regarding the application process and the issuance of an expedited license.

SECTION 6. FEES FOR EXPEDITED LICENSURE

(a) A member state issuing an expedited license authorizing the practice of medicine in that state may impose a fee for a license issued or renewed through the Compact.

(b) The Interstate Commission is authorized to develop rules regarding fees for expedited licenses.

SECTION 7. RENEWAL AND CONTINUED PARTICIPATION

(a) A physician seeking to renew an expedited license granted in a member state shall

complete a renewal process with the Interstate Commission if the physician:

(1) Maintains a full and unrestricted license in a state of principal license,

(2) Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction,

(3) Has not had a license authorizing the practice of medicine subject to discipline by a licensing agency in any state, federal, or foreign jurisdiction, excluding any action related to non-payment of fees related to a license,

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration, and

(5) Is not under investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction at the time renewal is sought.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements in member states where renewal is sought.

(c) The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

(c) Upon receipt of any renewal fees collected in subsection (b), a member board shall renew the physician's license.

(d) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(e) The Interstate Commission is authorized to develop rules to address renewal of licenses obtained through the Compact.

SECTION 8. COORDINATED INFORMATION SYSTEM

(a) The Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure, under Section 5.

(b) Notwithstanding any other provision of law, member boards shall report to the Interstate Commission any public action or complaints against a physician licensed who has applied or received an expedited license through the Compact.

(c) Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission.

(d) Member boards may report any non-public complaint, disciplinary, or investigatory information not required by subsection (c) to the Interstate Commission.

(e) Member boards shall share complaint or disciplinary information about a physician upon request of another member board.

(f) All information provided to the Interstate Commission or distributed by member boards shall be confidential, filed under seal, and used only for investigatory or disciplinary matters.

(g) The Interstate Commission is authorized to develop rules for mandated or discretionary sharing of information by member boards.

SECTION 9. JOINT INVESTIGATIONS

(a) Licensure and disciplinary records of physicians are deemed investigative.

(b) In addition to the authority granted to a member board by its respective Medical Practice Act or other applicable state law, a member board may participate with other member boards in joint investigations of physicians licensed by the member boards.

(c) A subpoena issued by a member state shall be enforceable in other member states.

(d) Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact.

(e) Any member state may investigate actual or alleged violations of the statutes authorizing the practice of medicine in any other member state in which a physician holds a license to practice medicine.

SECTION 10. DISCIPLINARY ACTIONS

(a) Any disciplinary action taken by any member board against a physician licensed through the Compact shall be deemed unprofessional conduct which may be subject to discipline by other member boards, in addition to any violation of the Medical Practice Act or regulations in that state.

(b) If a license granted to a physician by the member board in the state of principal license is revoked, surrendered or relinquished in lieu of discipline, or suspended for an indefinite period of time, all licenses issued to the physician by member boards shall automatically be placed, without further action necessary by any member board, on the same status. If the member board in the state of principal license subsequently reinstates the physician's license, a licensed issued to the physician by any other member board shall remain encumbered until that respective member board takes action to reinstate the license.

(c) If disciplinary action is taken against a physician by a member board not in the state of principal license, any other member board may deem the action conclusive as to matter of law and fact decided, and:

(i) impose the same or lesser sanction(s) against the physician;

(ii) or pursue separate disciplinary action against the physician under its

respective medical practice act, regardless of the action taken in other member states.

(d) If a license granted to a physician by a member board is revoked, surrendered or relinquished in lieu of discipline, or suspended for an indefinite period of time, any license(s) issued to the physician by any other member board(s) shall be suspended, automatically and immediately without further action necessary by the other member board(s), for ninety (90) days upon entry of the order by the disciplining board, to permit the member board(s) to investigate the basis for the action. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period.

SECTION 11. INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION

(a) The member states hereby create the "Interstate Medical Licensure Compact Commission".

(b) The purpose of the Interstate Commission is the administration of the Interstate Medical Licensure Compact, which is a discretionary state function.

(c) The Interstate Commission shall be a body corporate and joint agency of the member states and shall have all the responsibilities, powers, and duties set forth in the Compact, and such additional powers as may be conferred upon it by a subsequent concurrent action of the respective legislatures of the member states in accordance with the terms of the Compact.

(d) The Interstate Commission shall consist of two voting representatives appointed by each member state who shall serve as Commissioners. In states where allopathic and osteopathic physicians are regulated by separate member boards, or if the licensing and disciplinary authority is split between multiple member boards within a member state, the member state shall appoint

one representative from each member board. A Commissioner shall be a(n):

(1) Allopathic or osteopathic physician appointed to a member board,

(2) Executive director, executive secretary, or similar executive of a member board, or

(3) Member of the public appointed to a member board.

(e) The Interstate Commission shall meet at least once each calendar year. A portion of this meeting shall be a business meeting to address such matters as may properly come before the Commission, including the election of officers. The chairperson may call additional meetings and shall call for a meeting upon the request of a majority of the member states.

(f) The bylaws may provide for meetings of the Interstate Commission to be conducted by telecommunication or electronic communication.

(g) Each Commissioner participating at a meeting of the Interstate Commission is entitled to one vote. A majority of Commissioners shall constitute a quorum for the transaction of business, unless a larger quorum is required by the bylaws of the Interstate Commission. A Commissioner shall not delegate a vote to another Commissioner. In the absence of its Commissioner, a member state may delegate voting authority for a specified meeting to another person from that state who shall meet the requirements of subsection (d).

(h) The Interstate Commission shall provide public notice of all meetings and all meetings shall be open to the public. The Interstate Commission may close a meeting, in full or in portion, where it determines by a two-thirds vote of the Commissioners present that an open meeting would be likely to:

(1) Relate solely to the internal personnel practices and procedures of the Interstate Commission;

(2) Discuss matters specifically exempted from disclosure by federal statute;

(3) Discuss trade secrets, commercial, or financial information that is privileged or confidential;

(4) Involve accusing a person of a crime, or formally censuring a person;

(5) Discuss information of a personal nature where disclosure would constitute a clearly unwarranted invasion of personal privacy;

(6) Discuss investigative records compiled for law enforcement purposes; or

(7) Specifically relate to the participation in a civil action or other legal proceeding.

(i) The Interstate Commission shall keep minutes which shall fully describe all matters discussed in a meeting and shall provide a full and accurate summary of actions taken, including record of any roll call votes.

(j) The Interstate Commission shall make its information and official records, to the extent not otherwise designated in the Compact or by its rules, available to the public for inspection.

(k) The Interstate Commission shall establish an executive committee, which shall include officers, members, and others as determined by the bylaws. The executive committee shall have the power to act on behalf of the Interstate Commission, with the exception of rulemaking, during periods when the Interstate Commission is not in session. The executive committee shall oversee the administration of the Compact including enforcement and compliance with the provisions of the Compact, its bylaws and rules, and other such duties as necessary.

(l) The Interstate Commission may establish other committees for governance and

administration of the Compact.

SECTION 12. POWERS AND DUTIES OF THE INTERSTATE COMMISSION

The Interstate Commission shall have the duty and power to

(a) Oversee and maintain the administration of the Compact;

(b) Promulgate rules which shall be binding to the extent and in the manner provided for in the Compact;

(c) Issue, upon the request of a member state or member board, advisory opinions concerning the meaning or interpretation of the Compact, its bylaws, rules, and actions;

(d) Enforce compliance with Compact provisions, the rules promulgated by the Interstate Commission, and the bylaws, using all necessary and proper means, including but not limited to the use of judicial process;

(e) Establish and appoint committees including, but not limited to, an executive committee as required by Section 11, which shall have the power to act on behalf of the Interstate Commission in carrying out its powers and duties;

(f) Pay, or provide for the payment of the expenses related to the establishment, organization, and ongoing activities of the Interstate Commission;

(g) Establish and maintain one or more offices;

(h) Borrow, accept, hire, or contract for services of personnel;

(i) Purchase and maintain insurance and bonds;

(j) Employ an executive director who shall have such powers to employ, select or appoint employees, agents, or consultants, and to determine their qualifications, define their duties, and fix their compensation;

(k) Establish personnel policies and programs relating to conflicts of interest, rates of

compensation, and qualifications of personnel;

(l) Accept donations and grants of money, equipment, supplies, materials and services, and to receive, utilize, and dispose of it in a manner consistent with the conflict of interest policies established by the Interstate Commission;

(m) Lease, purchase, accept contributions or donations of, or otherwise to own, hold, improve or use, any property, real, personal, or mixed;

(n) Sell, convey, mortgage, pledge, lease, exchange, abandon, or otherwise dispose of any property, real, personal, or mixed;

(o) Establish a budget and make expenditures;

(p) Adopt a seal and bylaws governing the management and operation of the Interstate Commission;

(q) Report annually to the legislatures and governors of the member states concerning the activities of the Interstate Commission during the preceding year. Such reports shall also include reports of financial audits and any recommendations that may have been adopted by the Interstate Commission;

(r) Coordinate education, training, and public awareness regarding the Compact, its implementation, and its operation;

(s) Maintain records in accordance with the bylaws;

(t) Seek and obtain trademarks, copyrights, and patents; and

(u) Perform such functions as may be necessary or appropriate to achieve the purposes of the Compact.

SECTION 13. FINANCE POWERS

(a) The Interstate Commission may levy on and collect an annual assessment from each member state to cover the cost of the operations and activities of the Interstate Commission and its staff. The total assessment must be sufficient to cover the annual budget approved each year for which revenue is not provided by other sources. The aggregate annual assessment amount shall be allocated upon a formula to be determined by the Interstate Commission, which shall promulgate a rule binding upon all member states.

(b) The Interstate Commission shall not incur obligations of any kind prior to securing the funds adequate to meet the same.

(c) The Interstate Commission shall not pledge the credit of any of the member states, except by and with the authority of the member state.

(d) The Interstate Commission shall be subject to a yearly financial audit conducted by a certified or licensed public accountant and the report of the audit be included in the annual report of the Interstate Commission.

SECTION 14. ORGANIZATION AND OPERATION OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall, by a majority of members present and voting, adopt bylaws to govern its conduct as may be necessary or appropriate to carry out the purposes of the Compact within twelve (12) months of the first Interstate Commission meeting.

(b) The Interstate Commission shall elect or appoint annually from among its members a chairperson, a vice-chairperson, and a treasurer, each of whom shall have such authority and duties as may be specified in the bylaws. The chairperson, or in the chairperson's absence or disability, the vice-chairperson, shall preside at all meetings of the Interstate Commission.

(c) Officers selected in subsection (b) shall serve without compensation or remuneration from the Interstate Commission.

(d) The officers and employees of the Interstate Commission shall be immune from suit and liability, either personally or in their official capacity, for a claim for damage to or loss of property or personal injury or other civil liability caused or arising out of or relating to an actual or alleged act, error, or omission that occurred, or that such person had a reasonable basis for believing occurred, within the scope of Interstate Commission employment, duties, or responsibilities; provided that such person shall not be protected from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(1) The liability of the executive director and employees of the Interstate Commission or representatives of the Interstate Commission, acting within the scope of such person's employment or duties for acts, errors, or omissions occurring within such person’s state, may not exceed the limits of liability set forth under the constitution and laws of that state for state officials, employees, and agents. The Interstate Commission is considered to be an instrumentality of the states for the purposes of any such action. Nothing in this subsection shall be construed to protect such person from suit or liability for damage, loss, injury, or liability caused by the intentional or willful and wanton misconduct of such person.

(2) The Interstate Commission shall defend the executive director, its employees, and subject to the approval of the attorney general or other appropriate legal counsel of the member state represented by an Interstate Commission representative, shall defend such Interstate Commission representative in any civil action seeking to impose liability arising out of an actual or alleged act, error or omission that occurred within the scope of Interstate

Commission employment, duties or responsibilities, or that the defendant had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such person.

(3) To the extent not covered by the state involved, member state, or the Interstate Commission, the representatives or employees of the Interstate Commission shall be held harmless in the amount of a settlement or judgment, including attorney's fees and costs, obtained against such persons arising out of an actual or alleged act, error, or omission that occurred within the scope of Interstate Commission employment, duties, or responsibilities, or that such persons had a reasonable basis for believing occurred within the scope of Interstate Commission employment, duties, or responsibilities, provided that the actual or alleged act, error, or omission did not result from intentional or willful and wanton misconduct on the part of such persons.

SECTION 15. RULEMAKING FUNCTIONS OF THE INTERSTATE COMMISSION

(a) The Interstate Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact. Notwithstanding the foregoing, in the event the Interstate Commission exercises its rulemaking authority in a manner that is beyond the scope of the purposes of the Compact, or the powers granted hereunder, then such an action by the Interstate Commission shall be invalid and have no force or effect.

(b) Rules shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and as subsequently amended, as may be appropriate to the operations of the Interstate Commission.

(c) Not later than thirty (30) days after a rule is promulgated, any person may file a petition for judicial review of the rule in the United States District Court for the District of Columbia or the federal district where the Interstate Commission has its principal offices; provided, that the filing of such a petition shall not stay or otherwise prevent the rule from becoming effective unless the court finds that the petitioner has a substantial likelihood of success. The court shall give deference to the actions of the Interstate Commission consistent with applicable law and shall not find the rule to be unlawful if the rule represents a reasonable exercise of the authority granted to the Interstate Commission.

SECTION 16. OVERSIGHT OF INTERSTATE COMPACT

(a) The executive, legislative, and judicial branches of state government in each member state shall enforce the Compact and shall take all actions necessary and appropriate to effectuate the Compact's purposes and intent. The provisions of the Compact and the rules promulgated hereunder shall have standing as statutory law but shall not override existing state authority to regulate the practice of medicine.

(b) All courts shall take judicial notice of the Compact and the rules in any judicial or administrative proceeding in a member state pertaining to the subject matter of the Compact which may affect the powers, responsibilities or actions of the Interstate Commission.

(c) The Interstate Commission shall be entitled to receive all service of process in any such proceeding, and shall have standing to intervene in the proceeding for all purposes. Failure to provide service of process to the Interstate Commission shall render a judgment or order void as to the Interstate Commission, the Compact, or promulgated rules.

SECTION 17. ENFORCEMENT OF INTERSTATE COMPACT

(a) The Interstate Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

(b) The Interstate Commission may, by majority vote of the Commissioners, initiate legal action in the United States District Court for the District of Columbia or, at the discretion of the Interstate Commission, in the federal district where the Interstate Commission has its principal offices, to enforce compliance with the provisions of the Compact, and its promulgated rules and bylaws, against a member state in default. The relief sought may include both injunctive relief and damages. In the event judicial enforcement is necessary, the prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

(c) The remedies herein shall not be the exclusive remedies of the Interstate Commission. The Interstate Commission may avail itself of any other remedies available under state law or the regulation of a profession.

SECTION 18. DEFAULT PROCEDURES

(a) The grounds for default include, but are not limited to, failure of a member state to perform such obligations or responsibilities imposed upon it by the Compact, or the rules and bylaws of the Interstate Commission promulgated under the Compact.

(b) If the Interstate Commission determines that a member state has defaulted in the performance of its obligations or responsibilities under the Compact, or the bylaws or promulgated rules, the Interstate Commission shall:

(1) Provide written notice to the defaulting state and other member states, of the nature of the default, the means of curing the default, and any action taken by the Interstate Commission. The Interstate Commission shall specify the conditions by which the defaulting

state must cure its default, and

(2) Provide remedial training and specific technical assistance regarding the default.

(c) If the defaulting state fails to cure the default, the defaulting state shall be terminated from the Compact upon an affirmative vote of a majority of the Commissioners and all rights, privileges, and benefits conferred by the Compact shall terminate on the effective date of termination. A cure of the default does not relieve the offending state of obligations or liabilities incurred during the period of the default.

(d) Termination of membership in the Compact shall be imposed only after all other means of securing compliance have been exhausted. Notice of intent to terminate shall be given by the Interstate Commission to the governor, the majority and minority leaders of the defaulting state's legislature, and each of the member states.

(e) The Interstate Commission shall establish rules and procedures to address licenses and physicians that are materially impacted by the termination of a member state, or the withdrawal of a member state.

(f) The member state which has been terminated is responsible for all dues, obligations, and liabilities incurred through the effective date of termination including obligations, the performance of which extends beyond the effective date of termination.

(g) The Interstate Commission shall not bear any costs relating to any state that has been found to be in default or which has been terminated from the Compact, unless otherwise mutually agreed upon in writing between the Interstate Commission and the defaulting state.

(h) The defaulting state may appeal the action of the Interstate Commission by petitioning the United States District Court for the District of Columbia or the federal district

where the Interstate Commission has its principal offices. The prevailing party shall be awarded all costs of such litigation including reasonable attorney's fees.

SECTION 19. DISPUTE RESOLUTION

(a) The Interstate Commission shall attempt, upon the request of a member state, to resolve disputes which are subject to the Compact and which may arise among member states or member boards.

(b) The Interstate Commission shall promulgate rules providing for both mediation and binding dispute resolution as appropriate.

SECTION 20. MEMBER STATES, EFFECTIVE DATE AND AMENDMENT

(a) Any state is eligible to become a member state of the Compact.

(b) The Compact shall become effective and binding upon legislative enactment of the Compact into law by no less than seven (7) states. Thereafter, it shall become effective and binding on a state upon enactment of the Compact into law by that state.

(c) The governors of non-member states, or their designees, shall be invited to participate in the activities of the Interstate Commission on a non-voting basis prior to adoption of the Compact by all states.

(d) The Interstate Commission may propose amendments to the Compact for enactment by the member states. No amendment shall become effective and binding upon the Interstate Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

SECTION 21. WITHDRAWAL

(a) Once effective, the Compact shall continue in force and remain binding upon each and every member state; provided that a member state may withdraw from the Compact by specifically repealing the statute which enacted the Compact into law.

(b) Withdrawal from the Compact shall be by the enactment of a statute repealing the same, but shall not take effect until one (1) year after the effective date of such statute and until written notice of the withdrawal has been given by the withdrawing state to the governor of each other member state.

(c) The withdrawing state shall immediately notify the chairperson of the Interstate Commission in writing upon the introduction of legislation repealing the Compact in the withdrawing state.

(d) The Interstate Commission shall notify the other member states of the withdrawing state's intent to withdraw within sixty (60) days of its receipt of notice provided under subsection (c).

(e) The withdrawing state is responsible for all dues, obligations and liabilities incurred through the effective date of withdrawal, including obligations, the performance of which extend beyond the effective date of withdrawal.

(f) Reinstatement following withdrawal of a member state shall occur upon the withdrawing state reenacting the compact or upon such later date as determined by the Interstate Commission.

(g) The Interstate Commission is authorized to develop rules to address the impact of the withdrawal of a member state on licenses granted in other member states to physicians who designated the withdrawing member state as the state of principal license.

SECTION 22. DISSOLUTION

(a) The Compact shall dissolve effective upon the date of the withdrawal or default of the member state which reduces the membership in the Compact to one (1) member state.

(b) Upon the dissolution of the Compact, the Compact becomes null and void and shall be of no further force or effect, and the business and affairs of the Interstate Commission shall be concluded and surplus funds shall be distributed in accordance with the bylaws.

SECTION 23. SEVERABILITY AND CONSTRUCTION

(a) The provisions of the Compact shall be severable, and if any phrase, clause, sentence, or provision is deemed unenforceable, the remaining provisions of the Compact shall be enforceable.

(b) The provisions of the Compact shall be liberally construed to effectuate its purposes.

(c) Nothing in the Compact shall be construed to prohibit the applicability of other interstate compacts to which the states are members.

SECTION 24. BINDING EFFECT OF COMPACT AND OTHER LAWS

(a) Nothing herein prevents the enforcement of any other law of a member state that is inconsistent with the Compact.

(b) All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.

(c) All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

(d) All agreements between the Interstate Commission and the member states are binding in accordance with their terms.

(e) In the event any provision of the Compact exceeds the constitutional limits imposed on the legislature of any member state, such provision shall be ineffective to the extent of the conflict with the constitutional provision in question in that member state.

Federation of STATE MEDICAL BOARDS

Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine

April 2014

Federation of STATE MEDICAL BOARDS

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Report of the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup

INTRODUCTION

The Federation of State Medical Boards (FSMB) Chair, Jon V. Thomas, MD, MBA, appointed the State Medical Boards' Appropriate Regulation of Telemedicine (SMART) Workgroup to review the "Model Guidelines for the Appropriate Use of the Internet in Medical Practice" (HOD 2002)[1] and other existing FSMB policies on telemedicine and to offer recommendations to state medical and osteopathic boards (hereinafter referred to as "medical boards" and/or "boards") based on a thorough review of recent advances in technology and the appropriate balance between enabling access to care while ensuring patient safety. The Workgroup was charged with guiding the development of model guidelines for use by state medical boards in evaluating the appropriateness of care as related to the use of telemedicine, or the practice of medicine using electronic communication, information technology or other means, between a physician in one location and a patient in another location with or without an intervening health care provider.

This new policy document provides guidance to state medical boards for regulating the use of telemedicine technologies in the practice of medicine and educates licensees as to the appropriate standards of care in the delivery of medical services directly to patients[2] via telemedicine technologies. It is the intent of the SMART Workgroup to offer a model policy for use by state medical boards in order to remove regulatory barriers to widespread appropriate adoption of telemedicine technologies for delivering care while ensuring the public health and safety.

In developing the guidelines that follow, the Workgroup conducted a comprehensive review of telemedicine technologies currently in use and proposed/recommended standards of care, as well as identified and considered existing standards of care applicable to telemedicine developed and implemented by several state medical boards.

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[1] *The policy on the Appropriate Use of Telemedicine Technologies in the Practice of Medicine supersedes the Model Guidelines for the Appropriate Use of the Internet in Medical Practice (HOD 2002).*

[2] *The policy does not apply to the use of telemedicine when solely providing consulting services to another physician who maintains the physician-patient relationship with the patient, the subject of the consultation.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Model Guidelines for State Medical Boards' Appropriate Regulation of Telemedicine

Section One. Preamble

The advancements and continued development of medical and communications technology have had a profound impact on the practice of medicine and offer opportunities for improving the delivery and accessibility of health care, particularly in the area of telemedicine, which is the practice of medicine using electronic communication, information technology or other means of interaction between a licensee in one location and a patient in another location with or without an intervening healthcare provider.[3] However, state medical boards, in fulfilling their duty to protect the public, face complex regulatory challenges and patient safety concerns in adapting regulations and standards historically intended for the in-person provision of medical care to new delivery models involving telemedicine technologies, including but not limited to: 1) determining when a physician-patient relationship is established; 2) assuring privacy of patient data; 3) guaranteeing proper evaluation and treatment of the patient; and 4) limiting the prescribing and dispensing of certain medications.

The [Name of Board] recognizes that using telemedicine technologies in the delivery of medical services offers potential benefits in the provision of medical care. The appropriate application of these technologies can enhance medical care by facilitating communication with physicians and their patients or other health care providers, including prescribing medication, obtaining laboratory results, scheduling appointments, monitoring chronic conditions, providing health care information, and clarifying medical advice.[4]

These guidelines should not be construed to alter the scope of practice of any health care provider or authorize the delivery of health care services in a setting, or in a manner, not otherwise authorized by law. In fact, these guidelines support a consistent standard of care and scope of practice notwithstanding the delivery tool or business method in enabling Physician-to-Patient communications. For clarity, a physician using telemedicine technologies in the provision of medical services to a patient (whether existing or new) must take appropriate steps to establish the physician-patient relationship and conduct all appropriate evaluations and history of the patient consistent with traditional standards of care for the particular patient presentation. As such, some situations and patient presentations are appropriate for the utilization of telemedicine technologies as a component of, or in lieu of, in-person provision of medical care, while others are not.[5]

The Board has developed these guidelines to educate licensees as to the appropriate use of telemedicine technologies in the practice of medicine. The [Name of Board] is committed to assuring patient access to the convenience and benefits afforded by telemedicine technologies, while promoting the responsible practice of medicine by physicians.

It is the expectation of the Board that physicians who provide medical care, electronically or otherwise, maintain the highest degree of professionalism and should:

- Place the welfare of patients first;
- Maintain acceptable and appropriate standards of practice;

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[3] *See Center for Telehealth and eHealth Law (Ctel), http://ctel.org/ (last visited Dec. 17, 2013).*

[4] *Id.*

[5] *See Cal. Bus. & Prof. Code § 2290.5(d).*

- Adhere to recognized ethical codes governing the medical profession;
- Properly supervise non-physician clinicians; and
- Protect patient confidentiality.

Section Two. Establishing the Physician-Patient Relationship

The health and well-being of patients depends upon a collaborative effort between the physician and patient.[6] The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient.

The physician-patient relationship is fundamental to the provision of acceptable medical care. It is the expectation of the Board that physicians recognize the obligations, responsibilities, and patient rights associated with establishing and maintaining a physician-patient relationship. A physician is discouraged from rendering medical advice and/or care using telemedicine technologies without (1) fully verifying and authenticating the location and, to the extent possible, identifying the requesting patient; (2) disclosing and validating the provider's identity and applicable credential(s); and (3) obtaining appropriate consents from requesting patients after disclosures regarding the delivery models and treatment methods or limitations, including any special informed consents regarding the use of telemedicine technologies. An appropriate physician-patient relationship has not been established when the identity of the physician may be unknown to the patient. Where appropriate, a patient must be able to select an identified physician for telemedicine services and not be assigned to a physician at random.

Section Three. Definitions

For the purpose of these guidelines, the following definitions apply:

"Telemedicine" means the practice of medicine using electronic communications, information technology or other means between a licensee in one location, and a patient in another location with or without an intervening healthcare provider. Generally, telemedicine is not an audio-only, telephone conversation, e-mail/instant messaging conversation, or fax. It typically involves the application of secure videoconferencing or store and forward technology to provide or support healthcare delivery by replicating the interaction of a traditional, encounter in person between a provider and a patient.[7]

"Telemedicine Technologies" means technologies and devices enabling secure electronic communications and information exchange between a licensee in one location and a patient in another location with or without an intervening healthcare provider.

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[6] *American Medical Association, Council on Ethical and Judicial Affairs, Fundamental Elements of the Patient-Physician Relationship (1990), available at http://www.ama-assn.org/resources/doc/code-medical-ethics/1001a.pdf.*

[7] *See Ctel.*

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

Section Four. Guidelines for the Appropriate Use of Telemedicine Technologies in Medical Practice

The [Name of Board] has adopted the following guidelines for physicians utilizing telemedicine technologies in the delivery of patient care, regardless of an existing physician-patient relationship prior to an encounter:

Licensure:
A physician must be licensed, or under the jurisdiction, of the medical board of the state where the patient is located. The practice of medicine occurs where the patient is located at the time telemedicine technologies are used. Physicians who treat or prescribe through online services sites are practicing medicine and must possess appropriate licensure in all jurisdictions where patients receive care.[8]

Establishment of a Physician-Patient Relationship:
Where an existing physician-patient relationship is not present, a physician must take appropriate steps to establish a physician-patient relationship consistent with the guidelines identified in Section Two, and, while each circumstance is unique, such physician-patient relationships may be established using telemedicine technologies provided the standard of care is met.

Evaluation and Treatment of the Patient:
A documented medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient to establish diagnoses and identify underlying conditions and/or contra-indications to the treatment recommended/provided must be obtained prior to providing treatment, including issuing prescriptions, electronically or otherwise. Treatment and consultation recommendations made in an online setting, including issuing a prescription via electronic means, will be held to the same standards of appropriate practice as those in traditional (encounter in person) settings. Treatment, including issuing a prescription based solely on an online questionnaire, does not constitute an acceptable standard of care.

Informed Consent:
Evidence documenting appropriate patient informed consent for the use of telemedicine technologies must be obtained and maintained. Appropriate informed consent should, as a baseline, include the following terms:

- Identification of the patient, the physician and the physician's credentials;
- Types of transmissions permitted using telemedicine technologies (e.g. prescription refills, appointment scheduling, patient education, etc.);
- The patient agrees that the physician determines whether or not the condition being diagnosed and/or treated is appropriate for a telemedicine encounter;
- Details on security measures taken with the use of telemedicine technologies, such as encrypting data, password protected screen savers and data files, or utilizing other reliable authentication techniques, as well as potential risks to privacy notwithstanding such measures;
- Hold harmless clause for information lost due to technical failures; and
- Requirement for express patient consent to forward patient-identifiable information to a third party.

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[8] *Federation of State Medical Boards, A Model Act to Regulate the Practice of Medicine Across State Lines (April 1996), available at http://www.fsmb.org/pdf/1996_grpol_telemedicine.pdf.*

Continuity of Care:

Patients should be able to seek, with relative ease, follow-up care or information from the physician [or physician's designee] who conducts an encounter using telemedicine technologies. Physicians solely providing services using telemedicine technologies with no existing physician-patient relationship prior to the encounter must make documentation of the encounter using telemedicine technologies easily available to the patient, and subject to the patient's consent, any identified care provider of the patient immediately after the encounter.

Referrals for Emergency Services:

An emergency plan is required and must be provided by the physician to the patient when the care provided using telemedicine technologies indicates that a referral to an acute care facility or ER for treatment is necessary for the safety of the patient. The emergency plan should include a formal, written protocol appropriate to the services being rendered via telemedicine technologies.

Medical Records:

The medical record should include, if applicable, copies of all patient-related electronic communications, including patient-physician communication, prescriptions, laboratory and test results, evaluations and consultations, records of past care, and instructions obtained or produced in connection with the utilization of telemedicine technologies. Informed consents obtained in connection with an encounter involving telemedicine technologies should also be filed in the medical record. The patient record established during the use of telemedicine technologies must be accessible and documented for both the physician and the patient, consistent with all established laws and regulations governing patient healthcare records.

Privacy and Security of Patient Records & Exchange of Information:

Physicians should meet or exceed applicable federal and state legal requirements of medical/health information privacy, including compliance with the Health Insurance Portability and Accountability Act (HIPAA) and state privacy, confidentiality, security, and medical retention rules. Physicians are referred to "Standards for Privacy of Individually Identifiable Health Information," issued by the Department of Health and Human Services (HHS).[9] Guidance documents are available on the HHS Office for Civil Rights Web site at: www.hhs.gov/ocr/hipaa.

Written policies and procedures should be maintained at the same standard as traditional face-to-face encounters for documentation, maintenance, and transmission of the records of the encounter using telemedicine technologies. Such policies and procedures should address (1) privacy, (2) health-care personnel (in addition to the physician addressee) who will process messages, (3) hours of operation, (4) types of transactions that will be permitted electronically, (5) required patient information to be included in the communication, such as patient name, identification number and type of transaction, (6) archival and retrieval, and (7) quality oversight mechanisms. Policies and procedures should be periodically evaluated for currency and be maintained in an accessible and readily available manner for review.

Sufficient privacy and security measures must be in place and documented to assure confidentiality and integrity of patient-identifiable information. Transmissions, including patient e-mail, prescriptions, and laboratory

[9] *45 C.F.R. § 160, 164 (2000).*

results must be secure within existing technology (i.e. password protected, encrypted electronic prescriptions, or other reliable authentication techniques). All patient-physician e-mail, as well as other patient-related electronic communications, should be stored and filed in the patient's medical record, consistent with traditional record-keeping policies and procedures.

Disclosures and Functionality on Online Services Making Available Telemedicine Technologies:
Online services used by physicians providing medical services using telemedicine technologies should clearly disclose:

- Specific services provided;
- Contact information for physician;
- Licensure and qualifications of physician(s) and associated physicians;
- Fees for services and how payment is to be made;
- Financial interests, other than fees charged, in any information, products, or services provided by a physician;
- Appropriate uses and limitations of the site, including emergency health situations;
- Uses and response times for e-mails, electronic messages and other communications transmitted via telemedicine technologies;
- To whom patient health information may be disclosed and for what purpose;
- Rights of patients with respect to patient health information; and
- Information collected and any passive tracking mechanisms utilized.

Online services used by physicians providing medical services using telemedicine technologies should provide patients a clear mechanism to:

- Access, supplement and amend patient-provided personal health information;
- Provide feedback regarding the site and the quality of information and services; and
- Register complaints, including information regarding filing a complaint with the applicable state medical and osteopathic board(s).

Online services must have accurate and transparent information about the website owner/operator, location, and contact information, including a domain name that accurately reflects the identity.

Advertising or promotion of goods or products from which the physician receives direct remuneration, benefits, or incentives (other than the fees for the medical care services) is prohibited. Notwithstanding, online services may provide links to general health information sites to enhance patient education; however, the physician should not benefit financially from providing such links or from the services or products marketed by such links. When providing links to other sites, physicians should be aware of the implied endorsement of the information, services or products offered from such sites. The maintenance of preferred relationships with any pharmacy is prohibited. Physicians shall not transmit prescriptions to a specific pharmacy, or recommend a pharmacy, in exchange for any type of consideration or benefit form that pharmacy.

Prescribing:

Telemedicine technologies, where prescribing may be contemplated, must implement measures to uphold patient safety in the absence of traditional physical examination. Such measures should guarantee that the identity of the patient and provider is clearly established and that detailed documentation for the clinical evaluation and resulting prescription is both enforced and independently kept. Measures to assure informed, accurate, and error prevention prescribing practices (e.g. integration with e-Prescription systems) are encouraged. To further assure patient safety in the absence of physical examination, telemedicine technologies should limit medication formularies to ones that are deemed safe by [Name of Board].

Prescribing medications, in-person or via telemedicine, is at the professional discretion of the physician. The indication, appropriateness, and safety considerations for each telemedicine visit prescription must be evaluated by the physician in accordance with current standards of practice and consequently carry the same professional accountability as prescriptions delivered during an encounter in person. However, where such measures are upheld, and the appropriate clinical consideration is carried out and documented, physicians may exercise their judgment and prescribe medications as part of telemedicine encounters.

Section Five. Parity of Professional and Ethical Standards

Physicians are encouraged to comply with nationally recognized health online service standards and codes of ethics, such as those promulgated by the American Medical Association, American Osteopathic Association, Health Ethics Initiative 2000, Health on the Net and the American Accreditation HealthCare Commission (URAC). There should be parity of ethical and professional standards applied to all aspects of a physician's practice.

A physician's professional discretion as to the diagnoses, scope of care, or treatment should not be limited or influenced by non-clinical considerations of telemedicine technologies, and physician remuneration or treatment recommendations should not be materially based on the delivery of patient-desired outcomes (i.e. a prescription or referral) or the utilization of telemedicine technologies.

MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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MODEL POLICY FOR THE APPROPRIATE USE OF TELEMEDICINE TECHNOLOGIES IN THE PRACTICE OF MEDICINE

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 8, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: State Licensure Requirement for Telehealth
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:
After review and consideration of the information, make a motion to endorse a Medical Board of California (Board) policy position that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located.

BACKGROUND:
In the past year, federal legislation has been introduced that, if enacted, would allow physicians in another state to practice via telehealth without requiring additional state licensure where the patient is located. For example, H.R. 3077, *The TELE-MED Act of 2013*, if enacted, would allow a Medicare provider licensed in any state to treat any Medicare beneficiary in another state via telemedicine, without being licensed in the state where the patient is located. The Board has been notified that other similar bills are in the drafting stages, as well.

California law currently requires physicians who treat patients in California, whether through face-to-face office visits or via the provision of telehealth services, to be licensed in California, enabling the Board to verify, according to California standards, the credentials of the licensees, and, should there be a problem, to investigate and enforce discipline on the physician's license. Any federal legislation that changes this requirement would undermine the Board's ability to protect health care consumers, as the Board would have no authority over, or ability to discipline, providers who are treating patients in California via telehealth and are licensed in another state. The Board would not be able to investigate and take action on any allegations of inappropriate care or conduct for these physicians.

In addition, allowing individuals who are licensed in another state to treat California patients would be confusing to patients receiving care via telehealth in California. The patient would have no way of knowing what state the physician is licensed in and would not know where to check the physician's license and disciplinary history. Additionally, the patient would not know what entity to file a complaint with regarding the physician's care.

In order to assist Board staff with replying to these federal bills as they arise, the Board should have a policy position stating that the practice of medicine occurs where the patient is located at the time of the physician-patient encounter, and, therefore, requires the physician to be under the jurisdiction of the state medical board where the patient is located. This would allow staff to reply to any federal legislation that is introduced and to provide the Board's position on this very serious issue.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Agenda Item 8G

2015 BOARD MEETING DATES FOR CONSIDERATION

January 29 – 30 or **February 5 – 6**	**San Francisco Bay Area** **Sacramento Area**
April 30 – May 1 **(FSMB Meeting April 22-26)**	**Los Angeles Area**
July 30 – 31	**Sacramento Area** **San Francisco Bay Area**
October 29 – 30 or **November 5 – 6**	**San Diego Area**

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

Chapter 4. Selection of Officers & Committees

Officers of the Board
(B&P Code Section 2012)

The Board shall select a President, Vice President, and Secretary from its Members.

Election of Officers
(Board Policy)

The Board shall elect the officers at the first meeting of the fiscal year. Officers shall serve a term of one year beginning the next meeting day. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board Member is running per office. An officer may be re-elected and serve for more than one term.

Panel Members
(B&P Code section 2008)

A Panel of the Board shall at no time be composed of less than four Members and the number of public Members assigned shall not exceed the number of licensed physician and surgeon Members assigned to the Panel. The Board President shall not be a member of any Panel if a full complement of the Board has been appointed (15 Members). The Board usually is comprised of two panels, however, if there is an insufficient number of Members, there may only be one Panel.

Election of Panel Members
(B&P Code section 2008)

Each Panel shall annually, at the last meeting of the calendar year, elect a Chair and a Vice Chair.

Officer Vacancies
(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers then shall serve the remainder of the term.

Committee Appointments
(Board Policy)

The Board President shall establish Committees, whether standing or special, as he or she deems necessary. The composition of the Committees and the appointment of the Members shall be determined by the Board President in consultation with the Vice President, Secretary, and the Executive Director. Committees may include the appointment of non-Board Members.

Attendance at Committee Meetings
(Government Code section 11120 et seq.)

Board Members are encouraged to attend a meeting of a Committee of which he or she is not a member. Board Members who are not Members of the Committee that is meeting cannot vote during the Committee meeting and may participate only as observers if a majority of the Board is present at a Committee meeting.

Duties of the Officers

The following matrix delineates the duties of the Board officers, Committee Chairs, and Panel officers.

Roles of Board Officers/Committee Chairs/Panel Officers

President

- Spokesperson for the Medical Board (including but not limited to) – may attend legislative hearings and testify on behalf of the Board, may attend meetings with stakeholders and Legislators on behalf of Board, may talk to the media on behalf of the Board, and signs letters on behalf of the Board
- Meets and communicates with the Executive Director on a regular basis
- Communicates with other Board Members for Board business
- Authors a president's message in every quarterly newsletter
- Approves Board Meeting agendas
- Chairs and facilitates Board Meetings
- Chairs the Executive Committee
- Signs specified full board enforcement approval orders
- Signs the minutes for each of the Board's quarterly Board Meetings
- Represents the Board at Federation of State Medical Boards meetings and other such meetings

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee

Secretary

- Signs the minutes for each of the Board's quarterly Board Meetings
- Is a member of Executive Committee

Past President

- Is responsible for mentoring and imparting knowledge to the new Board President
- May attend meetings and legislative hearings to provide historical background information, as needed
- Is a member of Executive Committee

Committee Chair

- Approves the Committee Agendas
- Chairs and facilitates Committee Meetings

Panel Officers

- Chair – Chairs and facilitates Panel Meetings
- Chair – Signs orders for Panel decisions
- Vice Chair – Acts as Chair when Chair is absent

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 1, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Disclosure of Postgraduate Training
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

After review and consideration of the information, direct staff to not pursue elimination of the requirement for the Medical Board of California (Board) to disclose postgraduate training on a physician's website profile.

BACKGROUND:

In the Board's Sunset Review Report released November 1, 2012, the Board identified several issues for consideration by the Senate Business, Professions and Economic Development Committee (Committee) during their sunset review of the Board. One of the issues the Board requested the Committee to consider was elimination of the requirement in Business and Professions Code Sections 803.1 and 2027 for the Board to post approved postgraduate training on the physician's profile. The report stated the Board could not post the information on the Board's website using its current information technology system. The report added that the Board did report the number of years of postgraduate training, but that information was self-reported by the physician. In addition, the report pointed out that the information the Board had was the postgraduate training originally received from the physician at the time of application, which did not include all of the postgraduate information.

The Committee responded to the Board's request for elimination of this information in its recommendations to the Board after their review of the Sunset Review Report. The Committee stated the Board should discuss this proposal with stakeholders, specifically those representing consumer interests, and then report back to the Committee those findings. It added that if those findings were that the Board should eliminate this requirement, that the Board provide language to the Committee for the elimination of this requirement.

When the Sunset Review Report was being completed, the Board was not using the BreEZe system and did not have the postgraduate training information in a system that could be used to display the information on the Board's website. However, when Board staff identified fields for the new BreEZe system, they ensured this information would be able to be captured in the BreEZe system.

Since the Board went live with the new BreEZe system, this information has been entered into the computer system for those individuals who have applied after October 2013 and for those who had pending applications at the time the Board went to BreEZe. Therefore, this information is now being captured, including the complete name of the postgraduate training program. In addition, the Board staff could work with the BreEZe administrators to be able to post this information on a physician's profile in the future. Something to note, though, is that the postgraduate training information being entered at the time of application is only the

postgraduate training that was verified during the application process and does not include any additional training the licensee completes after licensure.

With this new information being entered into the system, staff no longer believes that this requirement needs to be removed from the Board's current statute. It is recommended that the Board no longer pursue this legislative change and instead move forward with working on a change to the BreEZe system so this information could be posted to a physician's profile.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 1, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Citation Regulations
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

After review and consideration of the attached proposed amendments to the citation regulatory language, make a motion to direct staff to notice the amended regulatory language and hold a hearing as soon as possible after the 45-day comment period. If no negative comments are received during the 45-day comment period or at the hearing, 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 1364.10, 1364.12, 1364.13, and 1364.14 with the modified text. Lastly, the motion should include a request to the Office of Administrative Law to make the regulations effective immediately upon approval.

BACKGROUND:

On July 1, 2014, pursuant to Senate Bill 304 (Lieu, Chapter 515, Statutes of 2013), the Medical Board of California's (Board) sworn staff and their support staff were transferred to the Department of Consumer Affairs (DCA). Among the positions included in the transfer were the Chief of Enforcement, the Deputy Chief of Enforcement, and the Supervising Investigator IIs.

The Board's regulations pertaining to the issuance of citations authorizes a "board official" to issue a citation, a fine, and an order of abatement. The regulations also require the board official *who issued the citation* to perform certain functions, including holding the informal conference, authorizing an extension, etc. The regulations define "board official" as the Chief, Deputy Chief or Supervising Investigator II of the enforcement program of the Board or the Chief of Licensing.

As of July 1, 2014, the only remaining staff person at the Board authorized to issue a citation is the Chief of Licensing. However, the regulations state that the Chief of Licensing can only issue citations to physicians who practiced on a delinquent, inactive or restricted license or to an individual who practices beyond the exemptions authorized in Sections 2065 and 2066 of the Business and Professions Code.

Therefore, based upon the transfer of staff to DCA, there is no staff person authorized to issue citations for minor violations of the Medical Practice Act. The regulations need to be amended to allow the Executive Director or his or her designee to issue citations and perform the functions once a citation is issued. This amendment needs to be done in a more expeditious manner than the normal rulemaking process usually used by the Board. The Board usually holds regulatory hearings at its regularly scheduled quarterly Board Meetings. However, this is not a requirement and several other boards under DCA do not hold hearings at quarterly meetings. Due to the need to expedite these regulations, the hearing should be held immediately following the 45-day comment period. This will allow staff, if no negative comments are received, to finalize the rulemaking package and submit it to the Office of Administrative Law once the package is

completed. If negative comments are received, the matter will be brought back to the Board at its October meeting.

This regulatory change is consistent with other boards under DCA that state the Executive Director or his or her designee are authorized to issue citations and perform other functions associated with the citation, such as holding informal conferences and authorizing extensions for compliance.

California Code of Regulations
Title 16, Division 13, Chapter 2, Article 6.

Section 1364.10. Citations and Fines.
(a) For purposes of this article, "board official" shall mean the ~~chief, deputy chief or supervising investigator II of the enforcement program of the board or the chief of licensing~~ executive director of the board or his or her designee.
(b) A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in Section 1364.11.
(c) A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

Section 1364.12. Compliance with Orders of Abatement.
(a) If a cited person who has been issued an order of abatement is unable to complete the correction within the time set forth in the citation because of conditions beyond his or her control after the exercise of reasonable diligence, the person cited may request an extension of time in which to complete the correction from the board official ~~who issued the citation~~. Such a request shall be in writing and shall be made within the time set forth for abatement.
(b) When an order of abatement is not contested or if the order is appealed and the person cited does not prevail, failure to abate the violation charged within the time allowed shall constitute a violation and a failure to comply with the order of abatement. An order of abatement shall either be personally served or mailed by certified mail, return receipt requested. The time allowed for the abatement of a violation shall begin when the order of abatement is final and has been served or received. Such failure may result in disciplinary action being taken by the ~~Division of Medical Quality~~ board or other appropriate judicial relief being taken against the person cited.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

Section 1364.13. Citations for Unlicensed Practice.
A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon is required under the Medical Practice Act. ~~The chief of licensing is authorized to issue citations and orders of abatement and levy fines only in the case of (a) physicians who have practiced medicine with a delinquent, inactive or restricted license or (b) applicants for licensure as a physician and surgeon who practice medicine beyond the exemptions authorized in Sections 2065 and 2066 of the Business and Professions Code.~~ Each citation issued shall contain an order of abatement. Where appropriate, a board official shall levy a fine for such unlicensed activity in accordance with subdivision (b)(3) of Section 125.9 of the code. The provisions of Sections 1364.10 and 1364.12 shall apply to the issuance of citations for unlicensed activity under this subsection. The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

Section 1364.14. Contest of Citations.
(a) In addition to requesting a hearing as provided for in subdivision (b)(4) of Section 125.9 of the code, the person cited may, within ten (10) days after service or receipt of the citation, notify the board official ~~who issued the citation~~ in writing of his or her request for an informal conference with the board official regarding the acts charged in the citation. The time allowed for the request shall begin the first day after the citation has been served or received.
(b) The board official ~~who issued the citation~~ shall, within 30 days from the receipt of the request, hold an informal conference with the person cited or his or her legal counsel or authorized representative. At the conclusion of the informal conference the board official may affirm, modify or dismiss the citation, including any fine levied or order of abatement issued. The board official shall state in writing the reasons for his or her action and serve or mail a copy of his or her findings and decision to the person cited within ten days from the date of the informal conference, as provided in subsection (b) of Section 1364.12. This decision shall be deemed to be a final order with regard to the citation issued, including the fine levied and the order of abatement.
(c) The person cited does not waive his or her request for a hearing to contest a citation by requesting an informal conference after which the citation is affirmed by a board official. If the citation is dismissed after the informal conference, the request for a hearing on the matter of the citation shall be deemed to be withdrawn. If the citation, including any fine levied or order of abatement, is modified, the citation originally issued shall be considered withdrawn and new citation issued. If a hearing is requested for the subsequent citation, it shall be requested within 30 days in accordance with subdivision (b)(4) of Section 125.9 of the code.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

Agenda Item 18

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	July 1, 2014
ATTENTION:	Members, Medical Board of California
SUBJECT:	Proposed Changes to the Manual of Model Disciplinary Orders and Disciplinary Guidelines
FROM:	Susan Cady, Staff Services Manager II

REQUESTED ACTION:

After review and consideration of the attached proposed amendments to the Manual of Model Disciplinary Orders and Disciplinary Guidelines, make a motion to direct staff to notice the amended regulatory language and hold a hearing at the October 2014 Board meeting after the 45-day public comment period.

BACKGROUND:

In December 2011, section 1361 containing the Medical Board of California (Board's) Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) was amended. Since that time, a number of non-substantive changes were identified and are being addressed in this regulatory proposal. In addition, a number of statutory and program changes have prompted the need to amend the Disciplinary Guidelines to be consistent with current practices.

In January 2014, Senate Bill 304 (Lieu, Chapter 515, Statutes of 2013) amended Government Code Section 11529 extending the timeframe in which an accusation must be filed following the issuance of a suspension order from 15 days to 30 days. The Disciplinary Guidelines related to the abstention from the use of alcohol and controlled substances and biological fluid testing (Conditions 9, 10 and 11) authorize the issuance of a cease practice order, but require that an accusation be filed within 15 days or the cease practice order will be dissolved. An amendment is required in order to be consistent with the timelines for filing an accusation following a suspension currently defined in the Government Code.

The Board has implemented the Uniform Standards for Substance-Abusing Licensees by incorporating terms and conditions under CCR, Title 16, section 1361.5 that must be ordered without deviation when the physician is deemed to be a substance-abusing licensee. However, there are some circumstances when the Board places individuals on probation and requires biological fluid testing or the abstention from drugs or alcohol even when the physician does not meet the definition of a substance-abusing licensee. Some examples would include physicians who are being placed on probation following the reinstatement of their license who may be ordered to submit to biological fluid testing despite the fact that their initial cause for discipline was not related to the use of drugs or alcohol. Physicians may also be placed on probation due to mental health issues and are required as a condition of probation to be monitored through

biological fluid testing to ensure they are compliant with their ordered medication(s). For those situations, the Board believes it is appropriate to retain Conditions 9, 10 and 11 in addition to those conditions that could be ordered for substance-abusing licensees.

For the past year, the University of California - San Diego School of Medicine has been working on redesigning the clinical training program which is required under Condition 18. The redesigned assessment program is ready for implementation but amendments to the language in this condition are required to more accurately describe the components of the comprehensive assessment program.

Condition 19 provides an alternative method of evaluating a physician's medical knowledge when a clinical training program is not considered to be an appropriate condition to order for physicians charged with gross negligence or repeated negligent acts. This condition requires that an oral clinical examination be administered pursuant to the requirements outlined in Business and Professions Code Section 2293. The Board's district medical consultants were instrumental in facilitating and coordinating the administration of an ordered oral clinical examination. On July 1, 2014, pursuant to Senate Bill 304, the Board's sworn staff and their support staff, including the district medical consultants, were transferred to the Department of Consumer Affairs (DCA). The district medical consultants are no longer available to the Probation Unit to provide the coordination of the oral clinical examination should it be ordered as a condition of probation. An amendment to this condition is required to eliminate the oral clinical examination as a condition that could be ordered.

Condition 25 requires a third party chaperone be identified and nominated by the physician within 30 days, however, if the chaperone leaves the licensee's employ, the physician is given 60 days to nominate a new chaperone. An amendment to this condition is necessary to reduce the time allowed to replace a chaperone to 30 days in order to enhance patient protection.

Condition 28 prohibits the licensee from supervising physician assistants during the period of probation. It was identified that advance practice nurses perform a similar function and have a very similar scope of practice to that of a physician assistant. An amendment to Condition 28 is needed to prohibit physicians on probation from supervising advance practice nurses.

Condition 31, which outlines general probation requirements, was found to contain language that conflicted with language in Condition 33, Non-Practice While on Probation. An amendment to this condition is required to eliminate this conflict.

When the disciplinary guidelines were revised in 2011, two conditions that described what was expected from a physician who was not practicing medicine during probation, either in California or out-of-state, were consolidated into one condition, Non-Practice While on Probation. After implementation it was discovered that the new language did not adequately address what terms and conditions a non-practicing physician was expected to comply with during this time. An amendment to this condition is needed to clarify the requirement that a physician residing in California is expected to comply with all conditions of probation. Staff is

also proposing that, in lieu of requiring the physician to enroll in a comprehensive assessment program after 18 months of non-practice, the physician be allowed to complete the Special Purpose Examination (SPEX) instead. An amendment to Condition 33 is needed to allow this substitution.

If the Board Members support these modifications, the motion identified under Requested Action above should be made.

California Code of Regulations
Title 16, Division 13, Chapter 2, Article 4.
Section 1361. Disciplinary Guidelines

The following edits would be made to the Manual of Model Disciplinary Orders and Disciplinary Guidelines and then incorporated by reference into section 1361.

9. Controlled Substances - Abstain From Use

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

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

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

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

10. Alcohol - Abstain From Use

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

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

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

11. Biological Fluid Testing

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

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

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

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

18. Clinical Competence Assessment ~~Training~~ Program

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

The Program shall consist of a Comprehensive Assessment ~~program comprised of an two-day assessment~~ of respondent's physical and mental health; ~~basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment~~ and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice ~~in which respondent was alleged to be deficient, and at minimum, a 40 hour a program of clinical education in the respondent's~~

~~area of practice in which respondent was alleged to be deficient and~~ . The Program shall ~~which~~ take~~s~~ into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 to 5 days as determined by the Program for the assessment and clinical education evaluation.

At the end of the evaluation, the Program will submit a report to ~~Based on respondent's performance and test results in the assessment and clinical education, the Program will advise~~ the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the Clinical Competence Assessment, the Program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition~~, treatment for any~~ or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the Program's recommendations.

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

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

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

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

19. ~~Oral and/or~~ Written Examination

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

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

~~If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.~~
~~If respondent is required to take and pass a written exam, that examination shall be either~~ the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

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

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

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

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

25. Third Party Chaperone

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

If respondent fails to obtain approval of a third party chaperone within 60 calendar days of the effective date of this Decision, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a chaperone is approved to provide monitoring responsibility.
Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

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

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

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within 30 ~~60~~ calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

(Option)

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

28. Supervision of Physician Assistants

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

31. General Probation Requirements

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

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

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

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

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

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

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine ~~in California~~ as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination ~~a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines"~~ prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice, outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; ~~and~~ General Probation Requirements, Quarterly Declarations, Abstain from the Use of alcohol and/or controlled substances and Biological Fluid Testing.

State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board Meeting

July 25, 2014

* *

2014 Legislation

Agenda Item 23

Consideration of Legislation/Regulations

MEDICAL BOARD OF CALIFORNIA - 2014 TRACKER LIST
July 14, 2014

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Sen. 3rd Reading	Support	6/25/14
AB 496	Gordon	CME: Sexual Orientation, Gender Identity, and Gender Expression	Sen. 3rd Reading	Reco: Support	6/25/14
AB 809	Logue	Healing Arts: Telehealth	Sen. Health	Reco: Support	5/19/14
AB 1535	Bloom	Pharmacists: Naloxone Hydrochloride	Sen. 3rd Reading	Support	6/24/14
AB 1838	Bonilla	Accelerated Medical School Programs	Enrolled	Sponsor/Support	5/14/14
AB 1841	Mullin	Medical Assistants	Sen. 3rd Reading	Support	6/2/14
AB 1886	Eggman	Medical Board Internet Posting: 10-year Restriction	Sen. Approps	Sponsor/Support	6/26/14
AB 2139	Eggman	End-of-Life Care: Patient Notification	Sen. 3rd Reading	Neutral	5/13/14
AB 2214	Fox	Emergency Room Physicians: CME	Sen. Approps	Neutral	6/26/14
SB 491	Hernandez	Nurse Practitioners	Asm. Approps.	Oppose – 2-year Bill	8/14/13
SB 492	Hernandez	Optometrist Practice: Licensure	Asm. Approps	Reco: Oppose	7/1/14
SB 500	Lieu	Medical Practice: Pain Management	Asm. Inactive	Support	5/29/14
SB 1083	Pavley	Physician Assistants: Disability Certifications	Assembly	Support	
SB 1116	Torres	Physicians and Surgeons: STLRP	Assembly	Reco: Support	6/19/14
SB 1243	Lieu	Professions and Vocations	Asm. Approps	Reco: Support if Amended	6/30/14
SB 1262	Correa	Medical Marijuana	Asm. Approps	Reco: Neutral	7/2/14
SB 1466	Sen. B&P	Omnibus	Asm. Approps	Sponsor/Support MBC Provisions	7/1/14

Pink – Sponsored Bill, Green & Orange – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1838
Author: Bonilla
Bill Date: May 14, 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), the Committee on Accreditation of Canadian Medical Schools (CACMS), or the Commission on Osteopathic College Accreditation (COCA).

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, CACMS, or for doctors of osteopathic medicine, COCA. 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: Medical Board of California (Co-Sponsor), University of California (Co-Sponsor), Association of California Healthcare Districts, and Kaiser Permanente

OPPOSITION: None on file

CHAPTER _____

An act to add Section 2084.5 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1838, Bonilla. Healing arts: 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, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation is deemed to meet the requirements described above.

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

SECTION 1. Section 2084.5 is added to the Business and Professions Code, to read:

2084.5. Notwithstanding any other law, a medical school or medical school program accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation shall be deemed to meet the requirements of Sections 2089 and 2089.5.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1886
Author: Eggman
Bill Date: June 26, 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 currently and formerly licensed physicians can only be posted on the Board's website for 10 years. AB 1886 would allow the Board to post the most serious disciplinary information, which is already public information, on the Board's website for as long as it remains public.

BACKGROUND

The Board raised the 10-year posting restriction as a new issue in its 2012 Sunset Report. Business and Professions Code (BPC) Section 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 Section 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 BPC Section 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 the most serious disciplinary information, which is already public information, on the Board's website for as long as it remains public. This bill was amended to address concerns raised by the California Medical Association (CMA) and other provider groups. CMA raised concerns that posting all public information indefinitely would be punitive, especially for information that is a lesser form of discipline or is not considered discipline. CMA also raised concerns that the existing statute was confusing and convoluted. The author, sponsor, and CMA worked on amendments, and with these amendments, CMA is now neutral on this bill. The amendments do the following: restructure the statute to reflect the current and historical information that can be posted to the Board's website related to physicians; require malpractice settlement information to be posted over a 5-year period, instead of a 10-year period (the posting would be in the same manner as specified in BPC Section 803.1); require public letters of reprimand to be posted for 10 years, instead of indefinite posting; and require citations to be posted that have not been resolved or appealed within 30 days, and once the citation has been resolved, to only be posted for 3 years, instead of 5 years (citations are not considered discipline).

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 the serious disciplinary public information available for consumers on the Board's website. This bill will further the Board's mission of consumer protection.

FISCAL: Minimal and absorbable

SUPPORT: Medical Board of California (Sponsor)
Center for Public Interest Law

OPPOSITION: None on file

AMENDED IN SENATE JUNE 26, 2014

AMENDED IN SENATE JUNE 16, 2014

AMENDED IN ASSEMBLY MAY 28, 2014

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 Section 2233 of, and to repeal and add Section 2027 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 revise and recast these provisions, and would, among other things, require specified information regarding all current and former licensed physicians and surgeons, including enforcement actions, disciplinary actions, civil judgments, arbitration awards, and certain

misdemeanor convictions, to be posted indefinitely on the board's Internet Web site. This bill would also reduce the period that settlement information is required to be posted on the Internet Web site from 10 years to 5 years. This bill would require that public letters of reprimand issued within the past 10 years by the board or the board of another jurisdiction be posted 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 repealed.
3 SEC. 2. Section 2027 is added to the Business and Professions
4 Code, to read:
5 2027. (a) The board shall post on its Internet Web site the
6 following information on the current status of the license for all
7 current and former licensees:
8 (1) Whether or not the licensee is presently in good standing.
9 (2) Current American Board of Medical Specialties certification
10 or board equivalent as certified by the board.
11 (3) Any of the following enforcement actions or proceedings
12 to which the licensee is actively subjected:
13 (A) Temporary restraining orders.
14 (B) Interim suspension orders.
15 (C) Revocations, suspensions, probations, or limitations on
16 practice ordered by the board or the board of another state or

jurisdiction, including those made part of a probationary order or stipulated agreement.

(D) Current accusations filed by the Attorney General, including those accusations that are on appeal. For purposes of this paragraph, "current accusation" means an accusation that has not been dismissed, withdrawn, or settled, and has not been finally decided upon by an administrative law judge and the board unless an appeal of that decision is pending.

(E) Citations issued that have not been resolved or appealed within 30 days.

(b) The board shall post on its Internet Web site all of the following historical information in its possession, custody, or control regarding all current and former licensees:

(1) Approved postgraduate training.

(2) Any final revocations and suspensions, or other equivalent actions, taken against the licensee by the board or the board of another state or jurisdiction or the surrender of a license by the licensee in relation to a disciplinary action or investigation, including the operative accusation resulting in the license surrender or discipline by the board.

(3) Probation or other equivalent action ordered by the board, or the board of another state or jurisdiction, completed or terminated, including the operative accusation resulting in the discipline by the board.

(4) Any felony convictions. 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.

(5) Misdemeanor convictions resulting in a disciplinary action or accusation that is not subsequently withdrawn or dismissed. 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.

(6) Civil judgments issued in any amount, whether or not vacated by a settlement after entry of the judgment, that were not reversed on appeal, and arbitration awards issued in any amount, for a claim or action for damages for death or personal injury

caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(7) Except as provided in subparagraphs (A) and (B), a summary of any final hospital disciplinary actions that resulted in the termination or revocation of a licensee's hospital staff privileges for a medical disciplinary cause or reason. The posting shall provide any additional explanatory or exculpatory information submitted by the licensee pursuant to subdivision (f) of Section 805. The board shall also post on its Internet Web site a factsheet that explains and provides information on the reporting requirements under Section 805.

(A) 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 shall remain posted on the Internet Web site for a period of 10 years from the restoration date of the privileges, and at the end of that period shall be removed.

(B) 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 on the Internet Web site shall be immediately removed. For purposes of this subparagraph, "peer review" has the same meaning as defined in Section 805.

(8) Public letters of reprimand issued within the past 10 years by the board or the board of another state or jurisdiction, including the operative accusation, if any, resulting in discipline by the board.

(9) Citations issued within the last three years that have been resolved by payment of the administrative fine or compliance with the order of abatement.

(10) All settlements within the last five years in the possession, custody, or control of the board shall be disclosed for a licensee in the low-risk category if there are three or more settlements for that licensee within the last five years, and for a licensee in the high-risk category if there are four or more settlements for that licensee within the last five years. Classification of a licensee in either a "high-risk category" or a "low-risk" category depends upon the specialty or subspecialty practiced by the licensee and

the designation assigned to that specialty or subspecialty by the board pursuant to subdivision (f) of Section 803.1.

(A) For the purposes of this paragraph, "settlement" means a settlement in an amount of thirty thousand dollars ($30,000) or more of any claim or action for damages for death or personal injury caused by the physician and surgeon's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services.

(B) For the purposes of this paragraph, "settlement" does not include a settlement by a licensee, regardless of the amount paid, when (i) the settlement is made as a part of the settlement of a class claim, (ii) the amount paid in settlement of the class claim is the same amount paid by the other licensees in the same class or similarly situated licensees in the same class, and (iii) the settlement was paid in the context of a case for which the complaint that alleged class liability on behalf of the licensee also alleged a products liability class action cause of action.

(C) The board shall not disclose the actual dollar amount of a settlement, but shall disclose settlement information in the same manner and with the same disclosures required under subparagraph (B) of paragraph (2) of subdivision (b) of Section 803.1.

(11) Appropriate disclaimers and explanatory statements to accompany the information described in paragraphs (1) to (10), inclusive, 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.

(c) The board shall provide links to other Internet Web sites that provide information on board certifications that meet the requirements of subdivision ~~(b) of Section 851.~~ *(h) of Section 651.* The board may also provide links to any other Internet Web sites that provide information on the affiliations of licensed physicians and surgeons. The board may provide links to other Internet Web sites on the Internet that provide information on health care service plans, health insurers, hospitals, or other facilities.

SEC. 3. 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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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1466
Author: Committee on Business, Professions, and Economic Development
Bill Date: July 1, 2014, Amended
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 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:

This bill was amended on June 2, 2014 to include the Board's sponsored language that would allow the Board to adopt regulations regarding physician availability for all clinical settings, as the Board's current physician availability regulations only apply to clinics or other settings using laser or intense pulse light devices for elective cosmetic surgery. However, this language was later amended out of the bill on July 1, 2014, at the request of the Assembly Business, Professions, and Consumer Protection Committee. The Committee asked the author to take this language out of the bill because the Committee believes this issue needs further discussion.

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.

The 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: Board of Psychology
Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JULY 1, 2014

AMENDED IN ASSEMBLY JUNE 2, 2014

SENATE BILL No. 1466

Introduced by Committee on Business, Professions and Economic Development (Senators Lieu (Chair), Berryhill, Block, Corbett, Galgiani, Hernandez, Hill, Padilla, and Wyland)

March 25, 2014

An act to amend Sections 27, 655.2, 2023.5, 2089.5, 2240, 2530.5, 2532.2, 2532.7, 2936,4021.5, 4053, 4980, ~~4980.36,~~ 4980.37, 4980.399, 4980.41, 4980.43, 4980.55, 4980.72, 4980.78, 4987.5, 4989.16, 4989.22, 4992.09, 4996.17, 4996.23, 4998, 4999.55, 4999.58, 4999.59, 4999.60, and 4999.123 of, to amend the heading of Chapter 13 (commencing with Section 4980) of Division 2 of, ~~to add Section 2023 to,~~ and to repeal Sections 2930.5 and 2987.3 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 amended, Committee on Business, Professions and Economic Development. Health care professionals.

(1) Existing law prohibits a physician and surgeon, licensed medical corporation, or any audiologist who is not a licensed hearing aid dispenser from employing a licensed hearing aid dispenser for the purpose of fitting or selling hearing aids.

This bill would prohibit a licensed hearing aid dispenser from employing a physician and surgeon or any audiologist who is not a licensed dispensing audiologist or hearing aid dispenser, or contracting with a licensed medical corporation, for the purpose of fitting or selling hearing aids.

(2) 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 Medical Board of California to review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures, in conjunction with the Board of Registered Nursing and in consultation with other specified groups. Existing law requires the board and the Board of Registered Nursing to adopt regulations, by January 1, 2009, with regard to the use of laser or intense pulse light devices for elective cosmetic procedures, as specified. Existing law requires the board to adopt regulations, by January 1, 2013, regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures.

This bill would delete the provisions that require the board to adopt regulations by January 1, 2009, and January 1, 2013. ~~The bill would instead require the board to adopt regulations, by January 1, 2016, regarding the appropriate level of physician availability needed within all clinics or other settings.~~

(3) 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.

(4) 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.

(5) Existing law, the Psychology Licensing Law, provides for the licensure and regulation of psychologists by the Board of Psychology. Under certain circumstances, existing law authorizes the board to issue a fictitious-name permit to a psychologist, as specified.

This bill would repeal the provision that authorizes the issuance of a fictitious-name permit, and would make conforming changes with regard to that repeal. The bill would make other changes to update a provision related to consumer notices, as specified.

(6) 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 a 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.

~~(7) Existing law, the Licensed Marriage and Family Therapist Act, provides for the licensure and regulation of marriage and family therapists by the Board of Behavioral Sciences. Existing law sets forth the educational and training requirements for licensure as a marriage and family therapist. Existing law, among other requirements, requires an applicant for licensure to complete 75 hours of client centered advocacy or face-to-face counseling, as specified.~~

~~This bill would authorize an applicant for licensure to meet this requirement by completing 75 hours of client centered advocacy or face-to-face counseling, or any combination thereof.~~

~~(8)~~

(7) Existing law, the Educational Psychologist Practice Act, provides for the licensure and regulation of educational psychologists by the Board of Behavioral Sciences. Existing law authorizes an applicant for examination who has passed the standard written examination to take a clinical vignette written examination for licensure if that applicant is the subject of a complaint or under investigation by the board, as specified.

This bill would eliminate the clinical vignette written examination for those purposes, and would make conforming changes to other provisions.

~~(9)~~

(8) Existing law requires an applicant for a license as a marriage and family therapist, clinical 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, with an expiration date no later than June 30, 2016, 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 licensure or issuance of a subsequent registration number. The bill would also permit an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, 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 during the next renewal period or prior to licensure, whichever occurs first.

This bill would make other changes relating to licensure as a marriage and family therapist, clinical social worker, or a professional clinical counselor.

The bill would also make other technical, conforming, and clarifying changes.

~~(10)~~

(9) 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:

SECTION 1. Section 27 of the Business and Professions Code is amended to read:

27. (a) Each entity specified in subdivisions (c), (d), and (e) shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as his or her address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the Internet.

(b) In providing information on the Internet, each entity specified in subdivisions (c) and (d) shall comply with the Department of Consumer Affairs' guidelines for access to public records.

(c) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board for Professional Engineers, Land Surveyors, and Geologists shall disclose information on its registrants and licensees.

(2) The Bureau of Automotive Repair shall disclose information on its licensees, including auto repair dealers, smog stations, lamp and brake stations, smog check technicians, and smog inspection certification stations.

(3) The Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation shall disclose information on its licensees and registrants, including major appliance repair dealers, combination dealers (electronic and appliance), electronic repair dealers, service contract sellers, and service contract administrators.

(4) The Cemetery and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

(5) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(6) The Contractors' State License Board shall disclose information on its licensees and registrants in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(7) The Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

(8) The California Board of Accountancy shall disclose information on its licensees and registrants.

(9) The California Architects Board shall disclose information on its licensees, including architects and landscape architects.

(10) The State Athletic Commission shall disclose information on its licensees and registrants.

(11) The State Board of Barbering and Cosmetology shall disclose information on its licensees.

(12) The State Board of Guide Dogs for the Blind shall disclose information on its licensees and registrants.

(13) The Acupuncture Board shall disclose information on its licensees.

(14) The Board of Behavioral Sciences shall disclose information on its licensees, including licensed marriage and family therapists, licensed clinical social workers, licensed educational psychologists, and licensed professional clinical counselors.

(15) The Dental Board of California shall disclose information on its licensees.

(16) The State Board of Optometry shall disclose information regarding certificates of registration to practice optometry, statements of licensure, optometric corporation registrations, branch office licenses, and fictitious name permits of its licensees.

(17) The Board of Psychology shall disclose information on its licensees, including psychologists, psychological assistants, and registered psychologists.

(d) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(e) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(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 655.2 of the Business and Professions Code is amended to read:

655.2. (a) (1) No physician and surgeon or medical corporation licensed under Chapter 5 (commencing with Section 2000), nor any audiologist who is not a licensed dispensing audiologist or hearing aid dispenser shall employ any individual licensed pursuant to Article 8 (commencing with Section 2538.10) of Chapter 5.3 for the purpose of fitting or selling hearing aids.

(2) No individual licensed pursuant to Article 8 (commencing with Section 2538.10) of Chapter 5.3 shall employ any physician and surgeon or any audiologist who is not a licensed dispensing audiologist or hearing aid dispenser, or contract with a medical corporation licensed under Chapter 5 (commencing with Section 2000), for the purpose of fitting or selling hearing aids.

(b) This section shall not apply to any physician and surgeon or medical corporation that contracts with or is affiliated with a comprehensive group practice health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act, as set forth in Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

~~SEC. 3. Section 2023 is added to the Business and Professions Code, to read:~~

~~2023. On or before January 1, 2016, the board shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings.~~

~~SEC. 4.~~

SEC. 3. Section 2023.5 of the Business and Professions Code is amended to read:

2023.5. (a) The board, in conjunction with the Board of Registered Nursing, and in consultation with the Physician Assistant Committee and professionals in the field, shall review issues and problems surrounding the use of laser or intense light pulse devices for elective cosmetic procedures by physicians and surgeons, nurses, and physician assistants. The review shall include, but need not be limited to, all of the following:

(1) The appropriate level of physician supervision needed.

(2) The appropriate level of training to ensure competency.

(3) Guidelines for standardized procedures and protocols that address, at a minimum, all of the following:

(A) Patient selection.

(B) Patient education, instruction, and informed consent.

(C) Use of topical agents.

(D) Procedures to be followed in the event of complications or side effects from the treatment.

(E) Procedures governing emergency and urgent care situations.

(b) Nothing in this section shall be construed to modify the prohibition against the unlicensed practice of medicine.

~~SEC. 5.~~

SEC. 4. 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. 6.~~

SEC. 5. Section 2240 of the Business and Professions Code is amended to read:

2240. (a) A physician and surgeon who performs a 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) 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. 7.~~

SEC. 6. 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 Commission on Teacher Credentialing as long as the practice is

conducted within the confines of or under the jurisdiction of a public preschool, elementary, or secondary school by which they are employed and those persons do not either offer to render or render speech-language pathology or audiology services to the public for compensation over and above the salary they receive from the public preschool, elementary, or secondary school by which they are employed for the performance of their official duties.

(d) Nothing in this chapter shall be construed as restricting the activities and services of a student or speech-language pathology intern in speech-language pathology pursuing a course of study leading to a degree in speech-language pathology at an accredited or approved college or university or an approved clinical training facility, provided that these activities and services constitute a part of his or her supervised course of study and that those persons are designated by the title as "speech-language pathology intern," "speech-language pathology trainee," or other title clearly indicating the training status appropriate to his or her level of training.

(e) Nothing in this chapter shall be construed as restricting the activities and services of a student or audiology intern in audiology pursuing a course of study leading to a degree in audiology at an accredited or approved college or university or an approved clinical training facility, provided that these activities and services constitute a part of his or her supervised course of study and that those persons are designated by the title as "audiology intern," "audiology trainee," or other title clearly indicating the training status appropriate to his or her level of training.

(f) Nothing in this chapter shall be construed as restricting the practice of an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 and who has been issued a temporary license pursuant to Section 2532.7. The number of applicants who may be supervised by a licensed speech-language pathologist or a speech-language pathologist having qualifications deemed equivalent by the board shall be determined by the board. The supervising speech-language pathologist shall register with the board the name of each applicant working under his or her supervision, and shall submit to the board a description of the proposed professional responsibilities of the applicant working under his or her supervision. The number of

applicants who may be supervised by a licensed audiologist or an audiologist having qualifications deemed equivalent by the board shall be determined by the board. The supervising audiologist shall register with the board the name of each applicant working under his or her supervision, and shall submit to the board a description of the proposed professional responsibilities of the applicant working under his or her supervision.

(g) Nothing in this chapter shall be construed as restricting hearing screening services in public or private elementary or secondary schools so long as these screening services are provided by persons registered as qualified school audiometrists pursuant to Sections 1685 and 1686 of the Health and Safety Code or hearing screening services supported by the State Department of Health Care Services so long as these screening services are provided by appropriately trained or qualified personnel.

(h) Persons employed as speech-language pathologists or audiologists by a federal agency shall be exempt from this chapter.

(i) Nothing in this chapter shall be construed as restricting consultation or the instructional or supervisory activities of a faculty member of an approved or accredited college or university for the first 60 days following appointment after the effective date of this subdivision.

~~SEC. 8.~~

SEC. 7. Section 2532.2 of the Business and Professions Code is amended to read:

2532.2. Except as required by Section 2532.25, to be eligible for licensure by the board as a speech-language pathologist or audiologist, the applicant shall possess all of the following qualifications:

(a) Possess at least a master's degree in speech-language pathology or audiology from an educational institution approved by the board or qualifications deemed equivalent by the board.

(b) (1) Submit evidence of the satisfactory completion of supervised clinical practice with individuals representative of a wide spectrum of ages and communication disorders. The board shall establish by regulation the required number of clock hours, not to exceed 375 clock hours, of supervised clinical practice necessary for the applicant.

(2) The clinical practice shall be under the direction of an educational institution approved by the board.

(c) Submit evidence of no less than 36 weeks of satisfactorily completed supervised professional full-time experience or 72 weeks of professional part-time experience obtained under the supervision of a licensed speech-language pathologist or audiologist or a speech-language pathologist or audiologist having qualifications deemed equivalent by the board. This experience shall be evaluated and approved by the board. The required professional experience shall follow completion of the requirements listed in subdivisions (a) and (b). Full time is defined as at least 36 weeks in a calendar year and a minimum of 30 hours per week. Part time is defined as a minimum of 72 weeks and a minimum of 15 hours per week.

(d) (1) Pass an examination or examinations approved by the board. The board shall determine the subject matter and scope of the examinations and may waive the examination upon evidence that the applicant has successfully completed an examination approved by the board. Written examinations may be supplemented by oral examinations as the board shall determine. An applicant who fails his or her examination may be reexamined at a subsequent examination upon payment of the reexamination fee required by this chapter.

(2) A speech-language pathologist or audiologist who holds a license from another state or territory of the United States or who holds equivalent qualifications as determined by the board and who has completed no less than one year of full-time continuous employment as a speech-language pathologist or audiologist within the past three years is exempt from the supervised professional experience in subdivision (c).

(e) As applied to licensure as an audiologist, this section shall apply to applicants who graduated from an approved educational institution on or before December 31, 2007.

~~SEC. 9.~~

SEC. 8. Section 2532.7 of the Business and Professions Code is amended to read:

2532.7. (a) Upon approval of an application filed pursuant to Section 2532.1, and upon payment of the fee prescribed by Section 2534.2, the board may issue a required professional experience (RPE) temporary license for a period to be determined by the board to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

(b) Effective July 1, 2003, no person shall obtain the required professional experience for licensure in either an exempt or nonexempt setting, as defined in Section 2530.5, unless he or she is licensed in accordance with this section or is completing the final clinical externship of a board-approved audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25 in another state.

(c) A person who obtains an RPE temporary license outside the State of California shall not be required to hold a temporary license issued pursuant to subdivision (a) if the person is completing the final clinical externship of an audiology doctoral training program in accordance with paragraph (2) of subdivision (b) of Section 2532.25.

(d) Any experience obtained in violation of this act shall not be approved by the board.

(e) An RPE temporary license shall terminate upon notice thereof by certified mail, return receipt requested, if it is issued by mistake or if the application for permanent licensure is denied.

(f) Upon written application, the board may reissue an RPE temporary license for a period to be determined by the board to an applicant who is obtaining the required professional experience specified in subdivision (c) of Section 2532.2 or paragraph (2) of subdivision (b) of Section 2532.25.

~~SEC. 10.~~

SEC. 9. Section 2930.5 of the Business and Professions Code is repealed.

~~SEC. 11.~~

SEC. 10. Section 2936 of the Business and Professions Code is amended to read:

2936. The board shall adopt a program of consumer and professional education in matters relevant to the ethical practice of psychology. The board shall establish as its standards of ethical conduct relating to the practice of psychology, the "Ethical Principles *of Psychologists* and Code of Conduct" published by the American Psychological Association (APA). Those standards shall be applied by the board as the accepted standard of care in all licensing examination development and in all board enforcement policies and disciplinary case evaluations.

To facilitate consumers in receiving appropriate psychological services, all licensees and registrants shall be required to post, in

a conspicuous location in their principal psychological business office, a notice which reads as follows:

"NOTICE TO CONSUMERS: The Department of Consumer Affair's Board of Psychology receives and responds to questions and complaints regarding the practice of psychology. If you have questions or complaints, you may contact the board by email at bopmail@dca.ca.gov, on the Internet at www.psychology.ca.gov, by calling 1-866-503-3221, or by writing to the following address:

Board of Psychology
1625 North Market Boulevard, Suite –215
Sacramento, California 95834"

~~SEC. 12.~~

SEC. 11. Section 2987.3 of the Business and Professions Code is repealed.

~~SEC. 13.~~

SEC. 12. Section 4021.5 of the Business and Professions Code is amended to read:

4021.5. "Correctional pharmacy" means a pharmacy, licensed by the board, located within a correctional facility for the purpose of providing pharmaceutical care to inmates of the correctional facility.

~~SEC. 14.~~

SEC. 13. Section 4053 of the Business and Professions Code is amended to read:

4053. (a) Notwithstanding Section 4051, the board may issue a license as a designated representative to provide sufficient and qualified supervision in a wholesaler or veterinary food-animal drug retailer. The designated representative shall 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.

(b) An individual who is at least 18 years of age may apply for a designated representative license. In order to obtain and maintain that license, the individual shall meet all of the following requirements:

(1) He or she shall be a high school graduate or possess a general education development certificate equivalent.

(2) He or she shall have a minimum of one year of paid work experience in a licensed pharmacy, or with a drug wholesaler, drug distributor, or drug manufacturer, in the past three years, related to the distribution or dispensing of dangerous drugs or dangerous devices or meet all of the prerequisites to take the examination required for licensure as a pharmacist by the board.

(3) He or she shall complete a training program approved by the board that, at a minimum, addresses each of the following subjects:

(A) Knowledge and understanding of California law and federal law relating to the distribution of dangerous drugs and dangerous devices.

(B) Knowledge and understanding of California law and federal law relating to the distribution of controlled substances.

(C) Knowledge and understanding of quality control systems.

(D) Knowledge and understanding of the United States Pharmacopoeia standards relating to the safe storage and handling of drugs.

(E) Knowledge and understanding of prescription terminology, abbreviations, dosages, and format.

(4) The board may, by regulation, require training programs to include additional material.

(5) The board may not issue a license as a designated representative until the applicant provides proof of completion of the required training to the board.

(c) The veterinary food-animal drug retailer or wholesaler shall not operate without a pharmacist or a designated representative on its premises.

(d) Only a pharmacist or a designated representative shall prepare and affix the label to veterinary food-animal drugs.

(e) Section 4051 shall not apply to any laboratory licensed under Section 351 of Title III of the Public Health Service Act (Public Law 78-410).

~~SEC. 15.~~

SEC. 14. The heading of Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code is amended to read:

CHAPTER 13. LICENSED MARRIAGE AND FAMILY THERAPISTS

~~SEC. 16.~~

SEC. 15. Section 4980 of the Business and Professions Code is amended to read:

4980. (a) (1) Many California families and many individual Californians are experiencing difficulty and distress, and are in need of wise, competent, caring, compassionate, and effective counseling in order to enable them to improve and maintain healthy family relationships.

(2) Healthy individuals and healthy families and healthy relationships are inherently beneficial and crucial to a healthy society, and are our most precious and valuable natural resource. Licensed marriage and family therapists provide a crucial support for the well-being of the people and the State of California.

(b) No person may engage in the practice of marriage and family therapy as defined by Section 4980.02, unless he or she holds a valid license as a marriage and family therapist, or unless he or she is specifically exempted from that requirement, nor may any person advertise himself or herself as performing the services of a marriage, family, child, domestic, or marital consultant, or in any way use these or any similar titles, including the letters "L.M.F.T." "M.F.T.," or "M.F.C.C.," or other name, word initial, or symbol in connection with or following his or her name to imply that he or she performs these services without a license as provided by this chapter. Persons licensed under Article 4 (commencing with Section 4996) of Chapter 14 of Division 2, or under Chapter 6.6 (commencing with Section 2900) may engage in such practice or advertise that they practice marriage and family therapy but may not advertise that they hold the marriage and family therapist's license.

~~SEC. 17. Section 4980.36 of the Business and Professions Code is amended to read:~~

~~4980.36. (a) This section shall apply to the following:~~

~~(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.~~

~~(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.~~

~~(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.~~

~~(b) To qualify for a license or registration, applicants shall possess a doctoral or master's degree meeting the requirements of this section in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education, or accredited by either the Commission on Accreditation for Marriage and Family Therapy Education, or a regional accrediting agency that is recognized by the United States Department of Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.~~

~~(c) A doctoral or master's degree program that qualifies for licensure or registration shall do the following:~~

~~(1) Integrate all of the following throughout its curriculum:~~

~~(A) Marriage and family therapy principles.~~

~~(B) The principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others.~~

~~(C) An understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery.~~

~~(2) Allow for innovation and individuality in the education of marriage and family therapists.~~

~~(3) Encourage students to develop the personal qualities that are intimately related to effective practice, including, but not limited to, integrity, sensitivity, flexibility, insight, compassion, and personal presence.~~

~~(4) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.~~

~~(5) Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.~~

~~(d) The degree described in subdivision (b) shall contain no less than 60 semester or 90 quarter units of instruction that includes, but is not limited to, the following requirements:~~

~~(1) Both of the following:~~

~~(A) No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.~~

~~(B) Practicum that involves direct client contact, as follows:~~

~~(i) A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.~~

~~(ii) A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.~~

~~(iii) A student must be enrolled in a practicum course while counseling clients, except as specified in subdivision (c) of Section 4980.42.~~

~~(iv) The practicum shall provide training in all of the following areas:~~

~~(I) Applied use of theory and psychotherapeutic techniques.~~

~~(II) Assessment, diagnosis, and prognosis.~~

~~(III) Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.~~

~~(IV) Professional writing, including documentation of services, treatment plans, and progress notes.~~

~~(V) How to connect people with resources that deliver the quality of services and support needed in the community.~~

~~(v) Educational institutions are encouraged to design the practicum required by this subparagraph to include marriage and family therapy experience in low income and multicultural mental health settings.~~

~~(vi) In addition to the 150 hours required in clause (ii), 75 hours of either of the following, or a combination thereof:~~

~~(I) Client centered advocacy, as defined in Section 4980.03.~~

~~(II) Face-to-face experience counseling individuals, couples, families, or groups.~~

~~(2) Instruction in all of the following:~~

~~(A) Diagnosis, assessment, prognosis, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer reviewed literature.~~

~~(B) Developmental issues from infancy to old age, including instruction in all of the following areas:~~

~~(i) The effects of developmental issues on individuals, couples, and family relationships.~~

~~(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.~~

~~(iii) Aging and its biological, social, cognitive, and psychological aspects. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.~~

~~(iv) A variety of cultural understandings of human development.~~

~~(v) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.~~

~~(vi) The understanding of human behavior within the social context of a representative variety of the cultures found within California.~~

~~(vii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.~~

~~(C) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:~~

~~(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.~~

~~(ii) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.~~

~~(iii) Cultural factors relevant to abuse of partners and family members.~~

~~(iv) Childbirth, child rearing, parenting, and stepparenting.~~

~~(v) Marriage, divorce, and blended families.~~

~~(vi) Long-term care.~~

~~(vii) End of life and grief.~~

~~(viii) Poverty and deprivation.~~

~~(ix) Financial and social stress.~~

~~(x) Effects of trauma.~~

~~(xi) The psychological, psychotherapeutic, community, and health implications of the matters and life events described in clauses (i) to (x), inclusive.~~

~~(D) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.~~

~~(E) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process.~~

~~(F) The effects of socioeconomic status on treatment and available resources.~~

~~(G) Resilience, including the personal and community qualities that enable persons to cope with adversity, trauma, tragedy, threats, or other stresses.~~

~~(H) Human sexuality, including the study of physiological, psychological, and social cultural variables associated with sexual behavior and gender identity, and the assessment and treatment of psychosexual dysfunction.~~

~~(I) Substance use disorders, cooccurring disorders, and addiction, including, but not limited to, instruction in all of the following:~~

~~(i) The definition of substance use disorders, cooccurring disorders, and addiction. For purposes of this subparagraph, "cooccurring disorders" means a mental illness and substance abuse diagnosis occurring simultaneously in an individual.~~

~~(ii) Medical aspects of substance use disorders and cooccurring disorders.~~

~~(iii) The effects of psychoactive drug use.~~

~~(iv) Current theories of the etiology of substance abuse and addiction.~~

~~(v) The role of persons and systems that support or compound substance abuse and addiction.~~

~~(vi) Major approaches to identification, evaluation, and treatment of substance use disorders, cooccurring disorders, and addiction, including, but not limited to, best practices.~~

~~(vii) Legal aspects of substance abuse.~~

~~(viii) Populations at risk with regard to substance use disorders and cooccurring disorders.~~

~~(ix) Community resources offering screening, assessment, treatment, and followup for the affected person and family.~~

~~(x) Recognition of substance use disorders, cooccurring disorders, and addiction, and appropriate referral.~~

~~(xi) The prevention of substance use disorders and addiction.~~

~~(J) California law and professional ethics for marriage and family therapists, including instruction in all of the following areas of study:~~

~~(i) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the scope of practice of marriage and family therapy.~~

~~(ii) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including, but not limited to, family law.~~

~~(iii) The current legal patterns and trends in the mental health professions.~~

~~(iv) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.~~

~~(v) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.~~

~~(vi) Differences in legal and ethical standards for different types of work settings.~~

~~(vii) Licensing law and licensing process.~~

~~(e) The degree described in subdivision (b) shall, in addition to meeting the requirements of subdivision (d), include instruction in case management, systems of care for the severely mentally ill, public and private services and supports available for the severely mentally ill, community resources for persons with mental illness and for victims of abuse, disaster and trauma response, advocacy for the severely mentally ill, and collaborative treatment. This instruction may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.~~

~~(f) The changes made to law by this section are intended to improve the educational qualifications for licensure in order to~~

~~better prepare future licentiates for practice, and are not intended to expand or restrict the scope of practice for marriage and family therapists.~~

~~SEC. 18.~~

SEC. 16. Section 4980.37 of the Business and Professions Code is amended to read:

4980.37. (a) This section shall apply to applicants for licensure or registration who begin graduate study before August 1, 2012, and complete that study on or before December 31, 2018. Those applicants may alternatively qualify under paragraph (2) of subdivision (a) of Section 4980.36.

(b) To qualify for a license or registration, applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by a regional accrediting agency that is recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this section, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. This instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment. The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect on individuals, couples, and family

relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, abuse and neglect of older and dependent adults, and geropsychology.

(4) A variety of approaches to the treatment of children.

The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(c) (1) In addition to the 12 semester or 18 quarter units of coursework specified in subdivision (b), the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic technique, assessments, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(d) As an alternative to meeting the qualifications specified in subdivision (b), the board shall accept as equivalent degrees those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(e) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program that meets the educational qualifications for licensure or registration under this section shall do all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(f) Educational institutions are encouraged to design the practicum required by this section to include marriage and family therapy experience in low income and multicultural mental health settings.

(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

~~SEC. 19.~~

SEC. 17. Section 4980.399 of the Business and Professions Code is amended to read:

4980.399. (a) Except as provided in subdivision (a) of Section 4980.398, each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be

allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a board-approved continuing education provider, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

~~SEC. 20.~~

SEC. 18. Section 4980.41 of the Business and Professions Code is amended to read:

4980.41. (a) An applicant for licensure whose education qualifies him or her under Section 4980.37 shall complete the following coursework or training in order to be eligible to sit for

the licensing examinations as specified in subdivision (d) of Section 4980.40:

(1) A two semester or three quarter unit course in California law and professional ethics for marriage and family therapists, which shall include, but not be limited to, the following areas of study:

(A) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the profession's scope of practice.

(B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including family law.

(C) The current legal patterns and trends in the mental health profession.

(D) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(E) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

This course may be considered as part of the 48 semester or 72 quarter unit requirements contained in Section 4980.37.

(2) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28 and any regulations promulgated thereunder.

(3) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.37.

(4) For persons who began graduate study on or after January 1, 1986, a master's or doctor's degree qualifying for licensure shall include specific instruction in alcoholism and other chemical substance dependency as specified by regulation. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it shall be considered as part of the 48 semester or 72 quarter unit requirement contained in Section 4980.37. Coursework required under this paragraph may be satisfactory if taken either in fulfillment of other educational requirements for

licensure or in a separate course. The applicant may satisfy this requirement by successfully completing this coursework from a master's or doctoral degree program at an accredited or approved institution, as described in subdivision (b) of Section 4980.37, or from a board-accepted provider of continuing education, as described in Section 4980.54.

(5) For persons who began graduate study during the period commencing on January 1, 1995, and ending on December 31, 2003, a master's or doctor's degree qualifying for licensure shall include coursework in spousal or partner abuse assessment, detection, and intervention. For persons who began graduate study on or after January 1, 2004, a master's or doctor's degree qualifying for licensure shall include a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this paragraph may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course. The applicant may satisfy this requirement by successfully completing this coursework from a master's or doctoral degree program at an accredited or approved institution, as described in subdivision (b) of Section 4980.37, or from a board-accepted provider of continuing education, as described in Section 4980.54.

(6) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychological testing. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.37.

(7) For persons who began graduate study on or after January 1, 2001, an applicant shall complete a minimum of a two semester or three quarter unit survey course in psychopharmacology. When coursework in a master's or doctor's degree program is acquired to satisfy this requirement, it may be considered as part of the 48 semester or 72 quarter unit requirement of Section 4980.37.

(8) The requirements added by paragraphs (6) and (7) are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice and are not

intended in any way to expand or restrict the scope of practice for licensed marriage and family therapists.

(b) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

~~SEC. 21.~~

SEC. 19. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) Prior to applying for licensure examinations, each applicant shall complete experience that shall comply with the following:

(1) A minimum of 3,000 hours completed during a period of at least 104 weeks.

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,700 hours of supervised experience completed subsequent to the granting of the qualifying master's or doctoral degree.

(4) (A) Not more than 1,300 hours of supervised experience obtained prior to completing a master's or doctoral degree.

(B) The applicant shall not be credited with more than 750 hours of counseling and direct supervisor contact prior to completing the master's or doctoral degree.

(5) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction and becoming a trainee except for personal psychotherapy.

(6) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(7) Not more than a combined total of 1,000 hours of experience in the following:

(A) Direct supervisor contact.

(B) Professional enrichment activities. For purposes of this chapter, "professional enrichment activities" include the following:

(i) Workshops, seminars, training sessions, or conferences directly related to marriage and family therapy attended by the applicant that are approved by the applicant's supervisor. An

applicant shall have no more than 250 hours of verified attendance at these workshops, seminars, training sessions, or conferences.

(ii) Participation by the applicant in personal psychotherapy, which includes group, marital or conjoint, family, or individual psychotherapy by an appropriately licensed professional. An applicant shall have no more than 100 hours of participation in personal psychotherapy. The applicant shall be credited with three hours of experience for each hour of personal psychotherapy.

(8) Not more than 500 hours of experience providing group therapy or group counseling.

(9) For all hours gained on or after January 1, 2012, not more than 500 hours of experience in the following:

(A) Experience administering and evaluating psychological tests, writing clinical reports, writing progress notes, or writing process notes.

(B) Client centered advocacy.

(10) Not less than 500 total hours of experience in diagnosing and treating couples, families, and children. For up to 150 hours of treating couples and families in conjoint therapy, the applicant shall be credited with two hours of experience for each hour of therapy provided.

(11) Not more than 375 hours of experience providing personal psychotherapy, crisis counseling, or other counseling services via telehealth in accordance with Section 2290.5.

(12) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by interns and trainees only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to

employees and volunteers. Experience shall not be gained by interns or trainees as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(c) Except for experience gained pursuant to subparagraph (B) of paragraph (7) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(d) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(e) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (d), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied the requirements of subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(f) Except as provided in subdivision (g), all persons shall register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure.

(g) Except when employed in a private practice setting, all postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board.

(h) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(i) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(j) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(k) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational

institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

~~SEC. 22.~~

SEC. 20. Section 4980.55 of the Business and Professions Code is amended to read:

4980.55. As a model for all therapeutic professions, and to acknowledge respect and regard for the consuming public, all licensed marriage and family therapists are encouraged to provide to each client, at an appropriate time and within the context of the psychotherapeutic relationship, an accurate and informative statement of the therapist's experience, education, specialities, professional orientation, and any other information deemed appropriate by the licensee.

~~SEC. 23.~~

SEC. 21. Section 4980.72 of the Business and Professions Code is amended to read:

4980.72. (a) This section applies to persons who are licensed outside of California and apply for licensure on or after January 1, 2016.

(b) The board may issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a valid license in good standing issued by a board of marriage counselor examiners, board of marriage and family therapists, or corresponding authority, of any state or country, if all of the following conditions are satisfied:

(1) The applicant's education is substantially equivalent, as defined in Section 4980.78. The applicant's degree title need not be identical to that required by Section 4980.36 or 4980.37.

(2) The applicant complies with Section 4980.76, if applicable.

(3) The applicant's supervised experience is substantially equivalent to that required for a license under this chapter. The board shall consider hours of experience obtained outside of California during the six-year period immediately preceding the date the applicant initially obtained the license described above.

(4) The applicant passes the California law and ethics examination.

(5) The applicant passes a clinical examination designated by the board. An applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with

the board without taking the clinical examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

~~SEC. 24.~~

SEC. 22. Section 4980.78 of the Business and Professions Code is amended to read:

4980.78. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016.

(b) For purposes of Sections 4980.72 and 4980.74, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from a school, college, or university accredited by an accrediting agency that is recognized by the United States Department of Education and consists of, at a minimum, 48 semester or 72 quarter units, including, but not limited to, both of the following:

(A) Six semester or nine quarter units of practicum, including, but not limited to, a minimum of 150 hours of face-to-face counseling.

(B) Twelve semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment, as specified in subparagraph (A) of paragraph (1) of subdivision (d) of Section 4980.36.

(2) The applicant completes any units and course content requirements under subdivision (d) of Section 4980.36 not already completed in his or her education.

(3) The applicant completes credit level coursework from a degree-granting institution that provides all of the following:

(A) Instruction regarding the principles of mental health recovery-oriented care and methods of service delivery in recovery model practice environments.

(B) An understanding of various California cultures and the social and psychological implications of socioeconomic position.

(C) Structured meeting with various consumers and family members of consumers of mental health services to enhance

understanding of their experience of mental illness, treatment, and recovery.

(D) Instruction in addiction and cooccurring substance abuse and mental health disorders, as specified in subparagraph (I) of paragraph (2) of subdivision (d) of Section 4980.36.

(4) The applicant completes an 18-hour course in California law and professional ethics. The content of the course shall include, but not be limited to, advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and licensing process.

(5) The applicant's degree title need not be identical to that required by subdivision (b) of Section 4980.36.

~~SEC. 25.~~

SEC. 23. Section 4987.5 of the Business and Professions Code is amended to read:

4987.5. A marriage and family therapy corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees rendering professional services who are licensed marriage and family therapists, physicians and surgeons, psychologists, licensed professional clinical counselors, licensed clinical social workers, registered nurses, chiropractors, or acupuncturists are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and any other statute or regulation pertaining to that corporation and the conduct of its affairs. With respect to a marriage and family therapy corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Board of Behavioral Sciences.

~~SEC. 26.~~

SEC. 24. Section 4989.16 of the Business and Professions Code is amended to read:

4989.16. (a) A person appropriately credentialed by the Commission on Teacher Credentialing may perform the functions authorized by that credential in a public school without a license issued under this chapter by the board.

(b) Nothing in this chapter shall be construed to constrict, limit, or withdraw the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), the Psychology Licensing Law (Chapter 6.6 (commencing with Section 2900)), the Licensed Marriage and Family Therapist Practice Act (Chapter 13 (commencing with Section 4980)), the Clinical Social Worker Practice Act (Chapter 14 (commencing with Section 4991)), or the Licensed Professional Clinical Counselor Act (Chapter 16 (commencing with Section 4999.10)).

~~SEC. 27.~~

SEC. 25. Section 4989.22 of the Business and Professions Code is amended to read:

4989.22. (a) Only persons who satisfy the requirements of Section 4989.20 are eligible to take the licensure examination.

(b) An applicant who fails the written examination may, within one year from the notification date of failure, retake the examination as regularly scheduled without further application. Thereafter, the applicant shall not be eligible for further examination until he or she files a new application, meets all current requirements, and pays all fees required.

(c) Notwithstanding any other provision of law, the board may destroy all examination materials two years after the date of an examination.

(d) The board shall not deny any applicant, whose application for licensure is complete, admission to the written examination, nor shall the board postpone or delay any applicant's written examination or delay informing the candidate of the results of the written examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(e) Notwithstanding Section 135, the board may deny any applicant who has previously failed the written examination

permission to retake the examination pending completion of the investigation of any complaint against the applicant. Nothing in this section shall prohibit the board from denying an applicant admission to any examination, withholding the results, or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Section 11503 or 11504 of the Government Code, or the applicant has been denied in accordance with subdivision (b) of Section 485.

~~SEC. 28.~~

SEC. 26. Section 4992.09 of the Business and Professions Code is amended to read:

4992.09. (a) Except as provided in subdivision (a) of Section 4992.07, an applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except for as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by

this section shall be taken through a board-approved continuing education provider, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

~~SEC. 29.~~

SEC. 27. Section 4996.17 of the Business and Professions Code is amended to read:

4996.17. (a) (1) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially the equivalent of the requirements of this chapter.

(2) Commencing January 1, 2014, an applicant with education gained outside of California shall complete an 18-hour course in California law and professional ethics. The content of the course shall include, but not be limited to, the following: advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws related to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and process.

(b) The board may issue a license to any person who, at the time of application, holds a valid active clinical social work license issued by a board of clinical social work examiners or

corresponding authority of any state, if the person passes, or has passed, the licensing examinations as specified in Section 4996.1 and pays the required fees. Issuance of the license is conditioned upon all of the following:

(1) The applicant has supervised experience that is substantially the equivalent of that required by this chapter. If the applicant has less than 3,200 hours of qualifying supervised experience, time actively licensed as a clinical social worker shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours.

(2) Completion of the following coursework or training in or out of this state:

(A) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(3) Commencing January 1, 2014, completion of an 18-hour course in California law and professional ethics. The content of the course shall include, but not be limited to, the following: advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws related to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and process.

(4) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(5) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(6) The applicant shall provide a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(7) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.

(c) The board may issue a license to any person who, at the time of application, holds a valid, active clinical social work license issued by a board of clinical social work examiners or a corresponding authority of any state, if the person has held that license for at least four years immediately preceding the date of application, the person passes, or has passed, the licensing examinations as specified in Section 4996.1, and the person pays the required fees. Issuance of the license is conditioned upon all of the following:

(1) Completion of the following coursework or training in or out of state:

(A) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(B) A minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 25, and any regulations promulgated thereunder.

(C) A minimum of 15 contact hours of training or coursework in alcoholism and other chemical substance dependency, as specified by regulation.

(D) A minimum of 15 contact hours of coursework or training in spousal or partner abuse assessment, detection, and intervention strategies.

(2) Commencing January 1, 2014, completion of an 18-hour course in California law and professional ethics. The content of

the course shall include, but not be limited to, the following: advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws related to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and process.

(3) The applicant has been licensed as a clinical social worker continuously for a minimum of four years prior to the date of application.

(4) The applicant's license is not suspended, revoked, restricted, sanctioned, or voluntarily surrendered in any state.

(5) The applicant is not currently under investigation in any other state, and has not been charged with an offense for any act substantially related to the practice of social work by any public agency, entered into any consent agreement or been subject to an administrative decision that contains conditions placed by an agency upon an applicant's professional conduct or practice, including any voluntary surrender of license, or been the subject of an adverse judgment resulting from the practice of social work that the board determines constitutes evidence of a pattern of incompetence or negligence.

(6) The applicant provides a certification from each state where he or she holds a license pertaining to licensure, disciplinary action, and complaints pending.

(7) The applicant is not subject to denial of licensure under Section 480, 4992.3, 4992.35, or 4992.36.

(d) Commencing January 1, 2016, an applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with the board without taking the clinical examination specified in Section 4996.1 if the applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

~~SEC. 30.~~

SEC. 28. Section 4996.23 of the Business and Professions Code is amended to read:

4996.23. The experience required by subdivision (c) of Section 4996.2 shall meet the following criteria:

(a) All persons registered with the board on and after January 1, 2002, shall have at least 3,200 hours of post-master's degree supervised experience providing clinical social work services as permitted by Section 4996.9. At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a licensed mental health professional acceptable to the board as defined by a regulation adopted by the board. This experience shall consist of the following:

(1) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling.

(2) A maximum of 1,200 hours in client-centered advocacy, consultation, evaluation, and research.

(3) Of the 2,000 clinical hours required in paragraph (1), no less than 750 hours shall be face-to-face individual or group psychotherapy provided to clients in the context of clinical social work services.

(4) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

(5) Experience shall not be credited for more than 40 hours in any week.

(b) "Supervision" means responsibility for, and control of, the quality of clinical social work services being provided. Consultation or peer discussion shall not be considered to be supervision.

(c) (1) Prior to the commencement of supervision, a supervisor shall comply with all requirements enumerated in Section 1870 of Title 16 of the California Code of Regulations and shall sign under penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" form.

(2) Supervised experience shall include at least one hour of direct supervisor contact for a minimum of 104 weeks. For

purposes of this subdivision, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours of face-to-face contact in a group conducted within the same week as the hours claimed.

(3) An associate shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained. No more than five hours of supervision, whether individual or group, shall be credited during any single week.

(4) Group supervision shall be provided in a group of not more than eight supervisees and shall be provided in segments lasting no less than one continuous hour.

(5) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, and of the 52 weeks of required individual supervision, not less than 13 weeks shall be supervised by a licensed clinical social worker.

(6) Notwithstanding paragraph (2), an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved.

(d) The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(e) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(f) Experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(g) Employment in a private practice as defined in subdivision (h) shall not commence until the applicant has been registered as an associate clinical social worker.

(h) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(i) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

(j) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

(k) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

(*l*) An associate shall not do the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

(m) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

(n) Notwithstanding any other provision of law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

~~SEC. 31.~~

SEC. 29. Section 4998 of the Business and Professions Code is amended to read:

4998. A licensed clinical social worker corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees

rendering professional services who are licensed clinical social workers, physicians and surgeons, psychologists, licensed professional clinical counselors, licensed marriage and family therapists, registered nurses, chiropractors, or acupuncturists are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and all other statutes and regulations now or hereafter enacted or adopted pertaining to that corporation and the conduct of its affairs. With respect to a licensed clinical social worker corporation, the governmental agency referred to in the Moscone-Knox Professional Corporation Act is the Board of Behavioral Sciences.

~~SEC. 32.~~

SEC. 30. Section 4999.55 of the Business and Professions Code is amended to read:

4999.55. (a) Each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application, except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at minimum, a 12-hour course in California law and ethics in order to be eligible to participate in

the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a board-approved continuing education provider, a county, state, or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative January 1, 2016.

~~SEC. 33.~~

SEC. 31. Section 4999.58 of the Business and Professions Code is amended to read:

4999.58. (a) This section applies to a person who applies for examination eligibility between January 1, 2011, and December 31, 2015, inclusive, and who meets both of the following requirements:

(1) At the time of application, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States.

(2) Has held the license described in paragraph (1) for at least two years immediately preceding the date of application.

(b) The board may issue a license to a person described in subdivision (a) if all of the following requirements are satisfied:

(1) The education and supervised experience requirements of the other jurisdiction are substantially the equivalent of this chapter, as described in subdivision (e) and in Section 4999.46.

(2) The person complies with subdivision (b) of Section 4999.40, if applicable.

(3) The person successfully completes the examinations required by the board pursuant to paragraph (3) of subdivision (a) of Section 4999.50. An applicant who obtained his or her license or registration under another jurisdiction by taking a national examination that is required by the board may apply for licensure with the board without retaking that examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the national licensing examination that is required by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

(4) The person pays the required fees.

(c) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter. The board shall consider hours of experience obtained in another state during the six-year period immediately preceding the applicant's initial licensure by that state as a licensed professional clinical counselor.

(d) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, and if the applicant has completed the training or coursework required under subdivision (e) of Section 4999.32, which includes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics for professional clinical counselors.

(e) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:

(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.

(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.

(3) The applicant's degree otherwise complies with this section.

(f) This section shall become inoperative on January 1, 2016, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2016, deletes or extends that date.

~~SEC. 34.~~

SEC. 32. Section 4999.59 of the Business and Professions Code is amended to read:

4999.59. (a) This section applies to a person who applies for examination eligibility or registration between January 1, 2011, and December 31, 2015, inclusive, who meets both of the following requirements:

(1) At the time of application, holds a valid license described in paragraph (1) of subdivision (a) of Section 4999.58.

(2) Has held the license described in paragraph (1) for less than two years immediately preceding the date of application.

(b) Experience gained outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to that required by this chapter, if the applicant complies with Section 4999.40, if applicable, and if the applicant has gained a minimum of 250 hours of supervised experience in direct counseling within California while registered as an intern with the board. The board shall consider hours of experience obtained in another state during the six-year period immediately preceding the applicant's initial licensure in that state as a professional clinical counselor.

(c) Education gained while residing outside of California shall be accepted toward the licensure requirements if it is substantially equivalent to the education requirements of this chapter, and if the applicant has completed the training or coursework required under subdivision (e) of Section 4999.32, which includes, in addition to the course described in subparagraph (I) of paragraph (1) of subdivision (c) of Section 4999.32, an 18-hour course in California law and professional ethics for professional clinical counselors.

(d) For purposes of this section, the board may, in its discretion, accept education as substantially equivalent if the applicant's education meets the requirements of Section 4999.32. If the applicant's degree does not contain the content or the overall units

required by Section 4999.32, the board may, in its discretion, accept the applicant's education as substantially equivalent if the following criteria are satisfied:

(1) The applicant's degree contains the required number of practicum units under paragraph (3) of subdivision (c) of Section 4999.32.

(2) The applicant remediates his or her specific deficiency by completing the course content and units required by Section 4999.32.

(3) The applicant's degree otherwise complies with this section.

(e) An applicant who obtained his or her license or registration under another jurisdiction by taking a national examination that is required by the board may apply for licensure with the board without retaking that examination if both of the following conditions are met:

(1) The applicant obtained a passing score on the national licensing examination that is required by the board.

(2) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

(f) This section shall become inoperative on January 1, 2016, and as of that date is repealed, unless a later enacted statute, which is enacted before January 1, 2016, deletes or extends that date.

~~SEC. 35.~~

SEC. 33. Section 4999.60 of the Business and Professions Code is amended to read:

4999.60. (a) This section applies to persons who are licensed outside of California and apply for examination eligibility on or after January 1, 2016.

(b) The board may issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States, if all of the following conditions are satisfied:

(1) The applicant's education is substantially equivalent, as defined in Section 4999.62.

(2) The applicant complies with subdivision (b) of Section 4999.40, if applicable.

(3) The applicant's supervised experience is substantially equivalent to that required for a license under this chapter. The board shall consider hours of experience obtained outside of California during the six-year period immediately preceding the date the applicant initially obtained the license described above.

(4) The applicant passes the examinations required to obtain a license under this chapter. An applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with the board without taking the clinical examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

~~SEC. 36.~~

SEC. 34. Section 4999.123 of the Business and Professions Code is amended to read:

4999.123. A professional clinical counselor corporation is a corporation that is authorized to render professional services, as defined in Section 13401 of the Corporations Code, so long as that corporation and its shareholders, officers, directors, and employees who are rendering professional services and who are licensed professional clinical counselors, licensed marriage and family therapists, physicians and surgeons, psychologists, licensed clinical social workers, registered nurses, chiropractors, or acupuncturists, are in compliance with the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code), this article, and any other statute or regulation pertaining to that corporation and the conduct of its affairs. With respect to a professional clinical counselor corporation, the term "governmental agency" in the Moscone-Knox Professional Corporation Act (Part 4 (commencing with Section 13400) of Division 3 of Title 1 of the Corporations Code) shall be construed to mean the Board of Behavioral Sciences.

~~SEC. 37.~~

SEC. 35. Section 14132.55 of the Welfare and Institutions Code is amended to read:

14132.55. For the purposes of reimbursement under the Medi-Cal program, a speech pathologist or audiologist shall be licensed by the Speech-Language Pathology and Audiology Examining Committee of the Medical Board of California or similarly licensed by a comparable agency in the state in which he or she practices. Licensed speech-language pathologists or licensed audiologists are authorized to utilize and shall be reimbursed for the services of those personnel in the process of completing requirements under the provisions of subdivision (c) of Section 2532.2 of the Business and Professions Code.

~~SEC. 38.~~

SEC. 36. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 186
Author: Maienschein
Bill Date: June 25, 2014, Amended
Subject: Military Spouses: Temporary Licenses
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow spouses of military personnel that have moved to California based upon active duty orders of the military spouse, and who have a physician and surgeon license in another state, to receive a 12-month temporary license, if they meet the licensing requirements, complete an application and provide specified information.

Recent amendments would not affect the Medical Board of California (Board), they are related to other boards under the Department of Consumer Affairs (DCA).

ANALYSIS:

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

This bill would require most boards under DCA, including the Board, to issue a 12-month temporary license to applicants who hold a current, active, and unrestricted license to practice in another state, and who qualify for an expedited license if the applicant has not committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license and if the applicant has not been disciplined by a licensing entity in another jurisdiction and is not the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. This bill would require the applicant to submit an application that includes an affidavit that the information submitted in the application is accurate and that verification documentation from the other jurisdiction has been requested. The temporary license would expire 12 months after issuance, upon issuance of an expedited license (pursuant to Business and Professions Code Section 115.5), or upon denial of the application for expedited licensure, whichever occurs first. This bill would allow the Board to conduct an investigation of applicants and would allow the Board to require the applicant to submit fingerprints and conduct a criminal background check. This bill would allow the Board to adopt necessary regulations. This bill would specify that the bill does not apply to boards that already have a temporary licensing process.

In addition, this bill would allow a temporary license to be immediately terminated upon a finding that the temporary license holder failed to meet the requirements of the bill or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. Once the temporary license is terminated, this bill would require the Board to issue a notice of termination that would require the temporary license holder to immediately cease the practice of medicine.

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

This bill would require the applicant to meet all licensing requirements in existing law and would require fingerprints to be cleared, would require license verification through the American Medical Association and/or the National Practitioner's Data bank, and verification from the state the applicant is licensed in before the provisional license could be issued. The Board originally took a support if amended position on this bill and asked that language be added to specify if the information on the applicant's application is found to be inaccurate or contrary to the affidavit, that the Board could require the individual that has been issued a temporary license to immediately cease practice, in order to ensure consumer protection. This language was amended into the bill, as such, the Board now has a support position on this bill.

FISCAL: Minor and absorbable

SUPPORT: Easter Seals Disability Services
California Board of Accountancy
California Architects Board
Medical Board of California
78 individuals

OPPOSITION: Board of Behavioral Sciences

AMENDED IN SENATE JUNE 25, 2014

AMENDED IN SENATE MAY 29, 2014

AMENDED IN SENATE JUNE 24, 2013

AMENDED IN ASSEMBLY MAY 24, 2013

AMENDED IN ASSEMBLY APRIL 22, 2013

AMENDED IN ASSEMBLY APRIL 1, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 186

Introduced by Assembly Member Maienschein
(Principal coauthor: Assembly Member Hagman)
(Coauthors: Assembly Members Chávez, Dahle, Donnelly, Beth Gaines, Garcia, *Gorell*, Grove, Harkey, Olsen, Patterson, and V. Manuel Pérez)
(Coauthors: Senators Fuller and Huff)

January 28, 2013

An act to add Section 115.6 to the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

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

Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs. Existing law provides for the issuance of reciprocal licenses in certain fields where the applicant, among other requirements, has a

license to practice within that field in another jurisdiction, as specified. Existing law requires that the licensing fees imposed by certain boards within the department be deposited in funds that are continuously appropriated. Existing law requires a board within the department to expedite the licensure process for an applicant who holds a current license in another jurisdiction in the same profession or vocation and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders.

This bill would, in addition to the expedited licensure provisions described above, establish a temporary licensure process for an applicant who holds a ~~current~~ *current, active, and unrestricted* license in another jurisdiction, as specified, and who supplies satisfactory evidence of being married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in California under official active duty military orders. The bill would require a temporary license to expire 12 months after issuance, upon issuance of an expedited license, or upon denial of the application for expedited licensure by the board, whichever occurs first.

This bill would require an applicant seeking a temporary license as a civil engineer, geotechnical engineer, structural engineer, land surveyor, professional geologist, professional geophysicist, certified engineering geologist, or certified hydrogeologist to successfully pass the appropriate California specific examination or examinations required for licensure in those respective professions by the Board for Professional Engineers, Land Surveyors, and Geologists. The bill would also authorize a board to require an applicant to successfully pass an examination in jurisprudence or California law and ethics for the issuance of a temporary license if successfully passing the examination is a requirement for all applicants for full licensure.

This bill would exclude the California Architects Board, *the Landscape Architects Technical Committee, the Contractors' State License Board*, the State Board of Chiropractic Examiners, ~~or~~ *and* a board that established a temporary licensing process before January 1, 2014, from these provisions.

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, 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:

SECTION 1. Section 115.6 is added to the Business and Professions Code, to read:

115.6. (a) A board within the department shall, after appropriate investigation, issue a temporary license to an applicant if he or she meets the requirements set forth in subdivision (c). The temporary license shall expire 12 months after issuance, upon issuance of an expedited license pursuant to Section 115.5, or upon denial of the application for expedited licensure by the board, whichever occurs first.

(b) The board may conduct an investigation of an applicant for purposes of denying or revoking a temporary license issued pursuant to this section. This investigation may include a criminal background check.

(c) An applicant seeking a temporary license pursuant to this section shall meet the following requirements:

(1) The applicant shall supply evidence satisfactory to the board that the applicant is married to, or in a domestic partnership or other legal union with, an active duty member of the Armed Forces of the United States who is assigned to a duty station in this state under official active duty military orders.

(2) The applicant shall hold a ~~current license~~ *current, active, and unrestricted license that confers upon him or her the authority to practice,* in another state, district, or territory of the United ~~States in~~ *States,* the profession or vocation for which he or she seeks a temporary license from the board.

(3) The applicant shall submit an application to the board that shall include a signed affidavit attesting to the fact that he or she meets all of the requirements for the temporary license and that the information submitted in the application is accurate, to the best of his or her knowledge. The application shall also include written verification from the applicant's original licensing jurisdiction stating that the applicant's license is in good standing in that jurisdiction.

(4) The applicant shall not have committed an act in any jurisdiction that would have constituted grounds for denial,

suspension, or revocation of the license under this code at the time the act was committed. A violation of this paragraph may be grounds for the denial or revocation of a temporary license issued by the board.

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

(6) The applicant shall, upon request by a board, furnish a full set of fingerprints for purposes of conducting a criminal background check.

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

(e) A temporary license issued pursuant to this section for the practice of medicine may be immediately terminated upon a finding that the temporary licenseholder failed to meet any of the requirements described in subdivision (c) or provided substantively inaccurate information that would affect his or her eligibility for temporary licensure. Upon termination of the temporary license, the board shall issue a notice of termination that shall require the temporary licenseholder to immediately cease the practice of medicine upon receipt.

(f) An applicant seeking a temporary license as a civil engineer, geotechnical engineer, structural engineer, land surveyor, professional geologist, professional geophysicist, certified engineering geologist, or certified hydrogeologist pursuant to this section shall successfully pass the appropriate California-specific examination or examinations required for licensure in those respective professions by the Board for Professional Engineers, Land Surveyors, and Geologists.

(g) A board within the department may require an applicant to successfully pass an examination in jurisprudence or California law and ethics for the issuance of a temporary license pursuant to this section if successfully passing the examination is a requirement for all applicants for full licensure.

(h) This section shall not apply to the California Architects ~~Board~~ *Board, the Landscape Architects Technical Committee, the Contractors' State License Board,* or the State Board of Chiropractic Examiners.

(i) This section shall not apply to a board that established a temporary licensing process before January 1, 2014.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 496
Author: Gordon
Bill Date: June 25, 2014, Amended
Subject: CME: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor: Equality California

DESCRIPTION OF CURRENT LEGISLATION:

This bill would amend the existing cultural competency continuing medical education (CME) course requirement to also include information pertinent to the provision of appropriate treatment and care to the lesbian, gay, bisexual, transgender, and intersex (LGBTI) communities.

ANALYSIS:

This bill previously reauthorized the Task Force on Culturally and Linguistically Competent Physicians and Dentists in order to expand the Task Force's membership and charge to include the lesbian, gay, bisexual, transgender, and intersex (LGBTI) community. This bill would have required the reconstituted Task Force to report its findings to the Legislature by January 1, 2016. This bill would have expanded the definition of cultural competency. This bill also would have required local medical societies to develop and distribute a survey for language minority patients and LGBTI patients to measure the degree of satisfaction with physicians who have taken the educational classes on cultural and linguistic competency provided pursuant to this bill. This bill would have required local medical societies to develop an evaluation survey for physicians to assess the quality of education or training programs on cultural and linguistic competency. This bill would have required the survey information to be shared with the Board's Cultural and Linguistic Competency (CLC) Workgroup. The Board previously had a support position on this bill.

Existing law requires physicians to take CME courses in order to renew their medical licenses. All CME courses are required to contain curriculum that includes cultural and linguistic competency in the practice of medicine. The course must address at least one or a combination of the following:

- Applying linguistic skills to communicate effectively with the target population.
- Utilizing cultural information to establish therapeutic relationships.
- Eliciting and incorporating pertinent cultural data in diagnosis and treatment.
- Understanding and applying cultural and ethnic data to the process of clinical care.

This bill was substantially amended and would now only add to the existing cultural competency CME course requirement of understanding and applying cultural and ethnic data to the process of clinical care, to also include information pertinent to the provision of appropriate treatment and care to LGBTI communities, as appropriate.

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

The Board could work with organizations that accredit CME courses to ensure compliance with the new requirement. This bill does not expand the Board's Cultural and Linguistic Physician Competency Program Workgroup, but would require organizations that accredit CME courses to update their standards, if necessary, to meet the new requirements in this bill. Since this bill does not expand the working group convened by the Board, the Board would only need to include agenda items at future meetings to hear from the organizations who have addressed the amended cultural and linguistic competency curriculum requirement.

The Board supported the previous version of this bill because the Board believes it is important that LGBTI cultural issues be addressed by providers, so physicians can provide appropriate care for all patients and believes cultural competency is an important factor in the physician-patient relationship. The Board also believes that LGBTI cultural competency is important for all providers, in order to ensure that LGBTI cultural issues are addressed and that LGBTI patients are delivered appropriate care. For these reasons, staff is suggesting that the Board continue to support this bill.

FISCAL: Minimal and absorbable

SUPPORT: Equality California (sponsor); AIDS Legal Referral Panel; Asian & Pacific Islander Wellness Center; California Pan Ethnic Health Network; GMLA: Health Professionals Advancing LGBT Equality; L.A. Gay & Lesbian Center; Mental Health America of Northern California; National Center for Lesbian Rights; Our Family Coalition; Planned Parenthood Affiliates of California; Queer Humboldt; Rainbow Community Center of Contra Costa County; and Transgender Law Center

OPPOSITION: None on File

POSITION: Recommendation: Support

AMENDED IN SENATE JUNE 25, 2014

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 10, 2013

AMENDED IN ASSEMBLY APRIL 2, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 496

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

February 20, 2013

An act to amend ~~Sections 852, 2198, and 2198.1~~ *Section 2190.1* of the Business and Professions Code, relating to medicine.

LEGISLATIVE COUNSEL'S DIGEST

AB 496, as amended, Gordon. Medicine: *continuing medical education:* sexual orientation, gender identity, and gender expression.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under the act, a physician and surgeon is required to demonstrate satisfaction of continuing education requirements. Existing law requires all continuing medical education courses on or after July 1, 2006, to contain curriculum that includes cultural and linguistic competency, as defined, in the practice of medicine. Existing law requires accrediting associations to develop standards for compliance with the cultural competency requirement before July 1, 2006, and authorizes the development of these standards in conjunction with an

advisory group that has expertise in cultural and linguistic competency issues, as specified.

This bill would authorize the accrediting associations to update these compliance standards, as needed, in conjunction with the advisory group described above.

Existing law, for purposes of these provisions, defines cultural competency as a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. Existing law recommends that this definition, at a minimum, include, among other things, understanding and applying cultural and ethnic data to the process of clinical care.

This bill would expand this recommendation to include, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities.

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

~~This bill would replace the Director of Health Care Services with the Deputy Director of the Office of Health Equity, or his or her designee, as cochair of the task force. The bill would also instead require the appointment of members to be made in consultation with the Office of Health Equity. The bill would authorize a designee of the Director of Consumer Affairs to serve as cochair of the task force and would authorize designees of the Executive Director of the Medical Board of California and the Executive Director of the Dental Board of California to serve as task force members. The bill would require the licensed task~~

~~force members and advocate task force members to be providers of health services to, or advocates on behalf of, members of language and ethnic minority groups as well as lesbian, gay, bisexual, transgender, and intersex groups. The bill would require the task force to report its findings to the Legislature and appropriate licensing boards by January 1, 2016.~~

~~Existing law, the Cultural and Linguistic Competency of Physicians Act of 2003, establishes the cultural and linguistic physician competency program which is operated by local medical societies of the California Medical Association and is monitored by the Medical Board of California. That voluntary program consists of educational classes for all interested physicians and is designed to teach foreign language and cultural beliefs and practices that may impact patient health care practices and allow physicians to incorporate this knowledge in the diagnosis and treatment of patients who are not from the predominate culture in California.~~

~~This bill would additionally require the program to address lesbian, gay, bisexual, transgender, and intersex groups of interest to local medical societies. The bill would require the training programs to be formulated in collaboration with California-based lesbian, gay, bisexual, transgender, and intersex medical societies.~~

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

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

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

~~This bill would redefine the term "cultural and linguistic competency" to also include understanding and applying the roles that sexual orientation, gender identity, and gender expression play in diagnosis, treatment, and clinical care, and developing behaviors that increase a~~

~~patient's satisfaction with, and trust in, his or her physicians and health care institutions. The bill would also make related technical, nonsubstantive changes.~~

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

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

SECTION 1. Section 2190.1 of the Business and Professions Code is amended to read:

2190.1. (a) The continuing medical education standards of Section 2190 may be met by educational activities that meet the standards of the Division of Licensing and *that* serve to maintain, develop, or increase the knowledge, skills, and professional performance that a physician and surgeon uses to provide care, or *to* improve the quality of care provided ~~for patients, including,~~ *to patients. These may include,* but *are* not limited to, educational activities that meet any of the following criteria:

(1) Have a scientific or clinical content with a direct bearing on the quality or cost-effective provision of patient care, community or public health, or preventive medicine.

(2) Concern quality assurance or improvement, risk management, health facility standards, or the legal aspects of clinical medicine.

(3) Concern bioethics or professional ethics.

(4) Are designed to improve the physician-patient relationship.

(b) (1) On and after July 1, 2006, all continuing medical education courses shall contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(2) Notwithstanding the provisions of paragraph (1), a continuing medical education course dedicated solely to research or other issues that does not include a direct patient care component ~~and~~ *or* a course offered by a continuing medical education provider that is not located in this state ~~are~~ *is* not required to contain curriculum that includes cultural and linguistic competency in the practice of medicine.

(3) Associations that accredit continuing medical education courses shall develop standards before July 1, 2006, for compliance with the requirements of paragraph (1). The associations may ~~develop~~ *update* these ~~standards~~ *standards, as needed,* in

conjunction with an advisory group that has expertise in cultural and linguistic competency issues.

(4) A physician and surgeon who completes a continuing education course meeting the standards developed pursuant to paragraph (3) satisfies the continuing education requirement for cultural and linguistic competency.

(c) In order to satisfy the requirements of subdivision (b), continuing medical education courses shall address at least one or a combination of the following:

(1) Cultural competency. For the purposes of this section, "cultural competency" means a set of integrated attitudes, knowledge, and skills that enables a health care professional or organization to care effectively for patients from diverse cultures, groups, and communities. At a minimum, cultural competency is recommended to include the following:

(A) Applying linguistic skills to communicate effectively with the target population.

(B) Utilizing cultural information to establish therapeutic relationships.

(C) Eliciting and incorporating pertinent cultural data in diagnosis and treatment.

(D) Understanding and applying cultural and ethnic data to the process of clinical ~~care~~ *care, including, as appropriate, information pertinent to the appropriate treatment of, and provision of care to, the lesbian, gay, bisexual, transgender, and intersex communities*.

(2) Linguistic competency. For the purposes of this section, "linguistic competency" means the ability of a physician and surgeon to provide patients who do not speak English or who have limited ability to speak English, direct communication in the patient's primary language.

(3) A review and explanation of relevant federal and state laws and regulations regarding linguistic access, including, but not limited to, the federal Civil Rights Act (42 U.S.C. Sec. 1981, et seq.), Executive Order 13166 of August 11, 2000, of the President of the United States, and the Dymally-Alatorre Bilingual Services Act (Chapter 17.5 (commencing with Section 7290) of Division 7 of Title 1 of the Government Code).

(d) Notwithstanding subdivision (a), educational activities that are not directed toward the practice of medicine, or are directed

primarily toward the business aspects of medical practice, including, but not limited to, medical office management, billing and coding, and marketing shall not be deemed to meet the continuing medical education standards for licensed physicians and surgeons.

(e) Educational activities that meet the content standards set forth in this section and are accredited by the California Medical Association or the Accreditation Council for Continuing Medical Education may be deemed by the Division of Licensing to meet its continuing medical education standards.

~~SECTION 1. Section 852 of the Business and Professions Code is amended to read:~~

~~852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:~~

~~(1) The Deputy Director of the Office of Health Equity, or his or her designee, and the Director of Consumer Affairs, or his or her designee, who shall serve as cochairs of the task force.~~

~~(2) The Executive Director of the Medical Board of California, or his or her designee.~~

~~(3) The Executive Director of the Dental Board of California, or his or her designee.~~

~~(4) One member appointed by the Senate Committee on Rules.~~

~~(5) One member appointed by the Speaker of the Assembly.~~

~~(b) Additional task force members shall be appointed by the Director of Consumer Affairs, in consultation with the Office of Health Equity, as follows:~~

~~(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.~~

~~(2) California licensed physicians and dentists who provide health services to members of language and ethnic minority groups, as well as lesbian, gay, bisexual, transgender, and intersex groups.~~

~~(3) Representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups, as well as lesbian, gay, bisexual, transgender, and intersex groups.~~

~~(4) Representatives of entities that offer continuing education for physicians and dentists.~~

~~(5) Representatives of California's medical and dental schools.~~

~~(6) Individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(A) Language minority patients.~~

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

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

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

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

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

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

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

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

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

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 809
Author: Logue
Bill Date: May 19, 2014, Amended
Subject: Healing Arts: Telehealth
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would revise the existing requirement on health care providers that they must verbally inform and document consent of the patient prior to delivery of health care services via telehealth. This bill would now require health care providers prior to initiating the use of telehealth to inform (it does not have to be verbally) the patient at the originating site about the use of telehealth. This bill would also allow the health care provider to obtain consent in writing (in addition to verbal consent), for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of care and treatment. This bill would specify that it shall not preclude a patient from receiving in-person health care delivery services during a specified course of care and treatment after agreeing to receive services via telehealth.

ANALYSIS:

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

This bill would now require health care providers prior to initiating the use of telehealth to inform (it does not have to be verbally) the patient at the originating site about the use of telehealth. This bill would now allow the health care provider to obtain consent in writing (in addition to verbal consent), for the use of telehealth as an acceptable mode of delivering health care services and public health during a specified course of care and treatment. This bill would also specify that it shall not preclude a patient from receiving in-person health care delivery services during a specified course of care and treatment after agreeing to receive services via telehealth.

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

believes that the requirement included in his bill in 2011 eliminates efficiencies achieved in rendering telehealth services and was an unintended consequence that is inconsistent with the intent and principles of his bill. The latest amendments were taken in response to concerns raised by the Chair of the Senate Health Committee and Kaiser Permanente.

This bill would allow the Telemedicine Advancement Act of 2011 to be implemented as intended, which will help to improve access to care via telehealth. The latest amendments do not adversely affect the Board or the reason why the Board supports this bill, as such, board staff is suggesting the Board continue to support AB 809.

FISCAL: None

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

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

POSITION: Recommendation: Support

AMENDED IN SENATE MAY 19, 2014

AMENDED IN SENATE JUNE 25, 2013

AMENDED IN ASSEMBLY APRIL 29, 2013

AMENDED IN ASSEMBLY APRIL 3, 2013

CALIFORNIA LEGISLATURE—2013–14 REGULAR SESSION

ASSEMBLY BILL No. 809

Introduced by Assembly Member Logue
(Coauthor: Senator Galgiani)

February 21, 2013

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

LEGISLATIVE COUNSEL'S DIGEST

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

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

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

~~care provider to either obtain confirmation of the patient's consent from the originating site provider or separately obtain and document consent from the patient about the use of telehealth, as specified.~~ *record.*

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

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

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

SECTION 1. Section 2290.5 of the Business and Professions Code is amended to read:

2290.5. (a) For purposes of this division, the following definitions shall apply:

(1) "Asynchronous store and forward" means the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.

(2) "Distant site" means a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

(3) "Health care provider" means a person who is licensed under this division.

(4) "Originating site" means a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.

(5) "Synchronous interaction" means a real-time interaction between a patient and a health care provider located at a distant site.

(6) "Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.

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

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

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

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

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

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

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

entity, as described in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

(2) By enacting this subdivision, it is the intent of the Legislature to authorize a hospital to grant privileges to, and verify and approve credentials for, providers of telehealth services as described in paragraph (1).

(3) For the purposes of this subdivision, "telehealth" shall include "telemedicine" as the term is referenced in Sections 482.12, 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to protect the health and safety of the public due to a lack of access to health care providers in rural and urban medically underserved areas of California, the increasing strain on existing providers ~~expected to occur~~ *that occurred* with the implementation of the federal Patient Protection and Affordable Care Act, and the assistance that further implementation of telehealth can provide to help relieve these burdens, it is necessary for this act to take effect immediately.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number:	AB 1535
Author:	Bloom
Bill Date:	June 24, 2014, Amended
Subject:	Pharmacists: Naloxone Hydrochloride
Sponsor:	Drug Policy Alliance California Pharmacists Association
Position:	Support

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.

Recent amendments allow the BOP to adopt emergency regulations to establish the standardized procedures or protocols that would remain in effect until the final standardized procedures or protocols are developed.

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 effects 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.

Recent amendments allow the BOP to adopt emergency regulations to establish the standardized procedures or protocols that would remain in effect until the final standardized procedures or protocols are developed.

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 patients access to naloxone, while at the same time ensuring standardized procedures and protocols are in place. The Board currently has a Support position on this bill and recent amendments do not change the purpose of the bill or the reasons the Board supports 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; Bay Area Addiction Recovery Treatment; 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; County Alcohol and Drug Program Administrators Association of California; 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; Los Angeles HIV Drug and Alcohol Task Force; Mary Magdalene Project; Medical Board of California; National Federation of Independent Business; Not One More; Paving the Way Foundation; Phoenix House of Los Angeles; Primary Purpose Sober Living Homes; San Fernando Recovery Center; Safer Alternatives Through Networking and Education; SHIELDS For Families; Soberspace; and Solace

OPPOSITION: None on file

AMENDED IN SENATE JUNE 24, 2014

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 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 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.

This bill would authorize the California State Board of Pharmacy to adopt emergency regulations to establish the standardized procedures or protocols that would remain in effect until the earlier of 180 days following their effective date or the effective date of regulations adopted as described above.

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

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

1 SECTION 1. Section 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 standardized procedures or protocols developed and approved
6 by both the board and the Medical Board of California, in
7 consultation with the California Society of Addiction Medicine,
8 the California Pharmacists Association, and other appropriate
9 entities. In developing those standardized procedures or protocols,
10 the board and the Medical Board of California shall include the
11 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.

(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.

(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 does not expand the authority of a pharmacist to prescribe any prescription medication.

(e) The board may adopt emergency regulations to establish the standardized procedures or protocols. The adoption of regulations pursuant to this subdivision shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The emergency regulations authorized by this subdivision are exempt from review by the Office of Administrative Law. The emergency regulations authorized by this subdivision shall be submitted to the Office of Administrative Law for filing with the Secretary of State and shall remain in effect until the earlier of 180 days following their effective date or the effective date of regulations adopted pursuant to subdivision (a).

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1841
Author: Mullin
Bill Date: June 2, 2014, Amended
Subject: Medical Assistants
Sponsor: Planned Parenthood
Position: Support

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, podiatrist, PA, NP, or CNM to verify that it is the correct medication and dosage for that specific patient and provide the appropriate patient consultation regarding use of the drug, 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 would 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 and provide the appropriate patient consultation regarding use of the drug, before the MA can hand over the medication to the patient.

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, package the medication, and provide the appropriate patient consultation. The Board has a support position on this bill and recent amendments do not affect the Board's position or the reasons for taking that position.

FISCAL: None

SUPPORT: Planned Parenthood (Sponsor)
Association of California Healthcare Districts
California Association for Nurse Practitioners
Medical Board of California

OPPOSITION: California Right to Life Committee, Inc.
California Society of Health-System Pharmacists (unless amended)

AMENDED IN SENATE JUNE 2, 2014

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. *Existing law authorizes specified facilities licensed by the California State Board of Pharmacy to purchase drugs at wholesale for administration or dispensing, under the direction of a physician and surgeon, to patients registered for care at those facilities.*

This bill would specify that the "technical supportive services" a medical assistant may perform *in those California State Board of Pharmacy licensed facilities* 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:

SECTION 1. Section 2069 of the Business and Professions Code is amended to read:

2069. (a) (1) Notwithstanding any other law, a medical assistant may administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical supportive services upon the specific authorization and supervision of a licensed physician and surgeon or a licensed podiatrist. A medical assistant may also perform all these tasks and services upon the specific authorization of a physician assistant, a nurse practitioner, or a certified nurse-midwife.

(2) The supervising physician and surgeon may, at his or her discretion, in consultation with the nurse practitioner, certified nurse-midwife, or physician assistant, provide written instructions to be followed by a medical assistant in the performance of tasks or supportive services. These written instructions may provide that the supervisory function for the medical assistant for these tasks or supportive services may be delegated to the nurse practitioner, certified nurse-midwife, or physician assistant within the standardized procedures or protocol, and that tasks may be

performed when the supervising physician and surgeon is not onsite, if either of the following apply:

(A) The nurse practitioner or certified nurse-midwife is functioning pursuant to standardized procedures, as defined by Section 2725, or protocol. The standardized procedures or protocol, including instructions for specific authorizations, shall be developed and approved by the supervising physician and surgeon and the nurse practitioner or certified nurse-midwife.

(B) The physician assistant is functioning pursuant to regulated services defined in Section 3502, including instructions for specific authorizations, and is approved to do so by the supervising physician and surgeon.

(b) As used in this section and Sections 2070 and 2071, the following definitions apply:

(1) "Medical assistant" means a person who may be unlicensed, who performs basic administrative, clerical, and technical supportive services in compliance with this section and Section 2070 for a licensed physician and surgeon or a licensed podiatrist, or group thereof, for a medical or podiatry corporation, for a physician assistant, a nurse practitioner, or a certified nurse-midwife as provided in subdivision (a), or for a health care service plan, who is at least 18 years of age, and who has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board. The medical assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. A copy of the certificate shall be retained as a record by each employer of the medical assistant.

(2) "Specific authorization" means a specific written order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising physician and surgeon or the supervising podiatrist, or the physician assistant, the nurse practitioner, or the certified nurse-midwife as provided in subdivision (a), authorizing the procedures to be performed, the duration of which shall be consistent with accepted medical

practice. A notation of the standing order shall be placed on the patient's medical record.

(3) "Supervision" means the supervision of procedures authorized by this section by the following practitioners, within the scope of their respective practices, who shall be physically present in the treatment facility during the performance of those procedures:

(A) A licensed physician and surgeon.

(B) A licensed podiatrist.

(C) A physician assistant, nurse practitioner, or certified nurse-midwife as provided in subdivision (a).

(4) (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, *in a facility licensed by the California State Board of Pharmacy under Section 4180 or 4190, other than a facility operated by the state*, "technical supportive services" *also* includes handing to a patient a ~~properly labeled and~~ prepackaged prescription drug, excluding a controlled substance, *that is labeled in compliance with Section 4170 and all other applicable state and federal laws and* ordered by a licensed physician and surgeon, a licensed podiatrist, a physician assistant, a nurse practitioner, or a certified nurse-midwife in accordance with subdivision (a). In every instance, prior to handing the medication to a patient *pursuant to this subparagraph*, 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 *and shall provide the appropriate patient consultation regarding use of the drug*.

(c) Nothing in this section shall be construed as authorizing any of the following:

(1) The licensure of medical assistants.

(2) The administration of local anesthetic agents by a medical assistant.

(3) The board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(4) A medical assistant to perform any clinical laboratory test or examination for which he or she is not authorized by Chapter 3 (commencing with Section 1200).

(5) A nurse practitioner, certified nurse-midwife, or physician assistant to be a laboratory director of a clinical laboratory, as those terms are defined in paragraph (8) of subdivision (a) of Section 1206 and subdivision (a) of Section 1209.

(d) A nurse practitioner, certified nurse-midwife, or physician assistant shall not authorize a medical assistant to perform any clinical laboratory test or examination for which the medical assistant is not authorized by Chapter 3 (commencing with Section 1200). A violation of this subdivision constitutes unprofessional conduct.

(e) Notwithstanding any other law, a medical assistant shall not be employed for inpatient care in a licensed general acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2139
Author: Eggman
Bill Date: May 13, 2014, Amended
Subject: End-of-Life Care: Patient Notification
Sponsor: Author
Position: Neutral

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, another person authorized to make health care decisions for the patient, of the patient's right to comprehensive information and counseling regarding legal end-of-life options pursuant to existing law.

This bill would specify that this notification may be provided at the time of diagnosis or at a subsequent visit in which the provider discusses treatment options with the patient or the other authorized person.

ANALYSIS

Existing law, Health and Safety 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 their authorized person of

the patient's right to request this information seems reasonable, as the patient should know that these resources are available. The Board has a neutral position on this bill and recent amendments do not affect the Board's position or the reasons for taking that position.

FISCAL: None

SUPPORT: Alzheimer's Foundation of America; American Cancer Society Cancer Action Network; California Advocates for Nursing Home Reform; California Commission on Aging; California Hospice and Palliative Care Association; Compassion and Choices California; and National Association of Social Workers, California Chapter

OPPOSITION: Association of Northern California Oncologists; California Medical Association; California Right to Life Committee; and Medical Oncology Association of Southern California

AMENDED IN ASSEMBLY MAY 13, 2014

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 amend Sections ~~442, 442.5,~~ *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 bill would apply these provisions to ~~an agent under a power of attorney for health care~~ *another person authorized to make health care*

decisions, as defined, for a patient with a terminal illness diagnosis. The bill would additionally require the health care provider to notify, *except as specified,* the patient or, when applicable, the ~~agent,~~ *other person authorized to make health care decisions,* when the health care provider makes a diagnosis that a patient has a terminal illness, of the patient's *and the other authorized person'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:

~~SECTION 1. Section 442 of the Health and Safety Code is amended to read:~~

~~442. For the purposes of this part, the following definitions shall apply:~~

~~(a) "Actively dying" means the phase of terminal illness when death is imminent.~~

~~(b) "Agent" means an individual designated in a power of attorney for health care, as provided in Article 1 (commencing with Section 4670) and Article 2 (commencing with Section 4680) of Chapter 1 of Part 2 of Division 4.7 of the Probate Code, to make a health care decision for the patient who has been diagnosed with a terminal illness, regardless of whether the person is known as an agent or attorney in fact, or by some other term.~~

~~(c) "Disease-targeted treatment" means treatment directed at the underlying disease or condition that is intended to alter its natural history or progression, irrespective of whether or not a cure is a possibility.~~

~~(d) "Health care provider" means an attending physician and surgeon. It also means a nurse practitioner or physician assistant practicing in accordance with standardized procedures or protocols developed and approved by the supervising physician and surgeon and the nurse practitioner or physician assistant.~~

~~(e) "Hospice" means a specialized form of interdisciplinary health care that is designed to provide palliative care, alleviate the physical, emotional, social, and spiritual discomforts of an individual who is experiencing the last phases of life due to the existence of a terminal disease, and provide supportive care to the~~

~~primary caregiver and the family of the hospice patient, and that meets all of the criteria specified in subdivision (b) of Section 1746.~~

~~(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.~~

~~(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 1. Section 442.5 of the Health and Safety Code is amended to read:

442.5. *(a)* When a health care provider makes a diagnosis that a patient has a terminal illness, the health care provider shall ~~notify~~ *do both of the following:*

(1) 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 or agent's request, provide the patient or agent~~ *right of another person authorized to make health care decisions for the patient to, comprehensive information and counseling regarding legal end-of-life options. This notification maybe provided at the time of diagnosis or at a subsequent visit in which the provider discusses treatment options with the patient or the other authorized person.*

(2) Upon the request of the patient or another person authorized to make health care decisions for the patient, provide the patient or other authorized person 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~~ *other authorized person* 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)~~

(b) If ~~the patient or agent indicates a desire to receive the information and counseling,~~ *a patient or another person authorized to make health care decisions for the patient, requests information and counseling pursuant to paragraph (2) of subdivision (a),* 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) ~~If the patient has not appointed an agent under a power of attorney for health care, the~~ *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)~~

(c) The information described in subdivision ~~(a)~~ *(b)* 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).~~ *(b).*

~~(c)~~

(d) 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),~~ *(b)*, 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)~~

(e) The information and counseling sessions may include a discussion of treatment options in a *culturally sensitive* manner that the patient and his or her family, or, when applicable, ~~the agent,~~ *another person authorized to make health care decisions for the patient,* can easily understand. If the patient or ~~agent~~ *other authorized person* requests information on the costs of treatment options, including the availability of insurance and eligibility of the patient for coverage, the patient or ~~agent~~ *other authorized person* shall be referred to the appropriate entity for that information.

(f) The notification in paragraph (1) of subdivision (a) shall not be required if the patient or other person authorized to make health care decisions, as defined in Section 4617 of the Probate Code, for the patient has already received the notification.

(g) For purposes of this section, "health care decisions" has the meaning set fourth in Section 4617 of the Probate Code.

~~SEC. 3.~~

SEC. 2. 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 *of another person authorized to make health care decisions, as defined in Section 4617 of the Probate Code, for the patient* 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~~ *other person authorized to make health care decisions for the patient* with information on

procedures to transfer to another health care provider that shall provide the requested information.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2214
Author: Fox
Bill Date: June 26, 2014, Amended
Subject: Continuing Medical Education: Geriatric Care
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Board, when determining continuing medical education (CME) 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 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. The Board has a neutral position on this bill and recent amendments were purely technical in nature (changing "division" to "board").

FISCAL: None

SUPPORT: California Commission on Aging
California Long-Term Care Association

OPPOSITION: None on file

AMENDED IN SENATE JUNE 26, 2014

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 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. *Existing law abolishes the division, provides for the board to handle the responsibilities of the division, and deems a reference to the division to refer to the board.*

This bill would require the ~~division,~~ *board* in determining continuing education requirements, to consider including a course in geriatric care for emergency room physicians and surgeons. *The bill would make nonsubstantive, technical, and conforming changes.*

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

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

SECTION 1. This act shall be known and may be cited as the Dolores H. Fox Act.

SEC. 2. Section 2191 of the Business and Professions Code is amended to read:

2191. (a) In determining its continuing education requirements, the ~~Division of Licensing~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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~~ *board* 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 continuing education requirements, the ~~division~~ *board* shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the ~~division~~ *board* shall consider including a course in geriatric care for emergency room physicians and surgeons.

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AMENDED IN ASSEMBLY AUGUST 14, 2013

AMENDED IN ASSEMBLY AUGUST 8, 2013

AMENDED IN ASSEMBLY AUGUST 5, 2013

AMENDED IN SENATE MAY 21, 2013

AMENDED IN SENATE MAY 1, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 491

Introduced by Senator Hernandez

February 21, 2013

An act to add Section 2835.3 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 491, as amended, Hernandez. Nurse practitioners.

Existing law, the Nursing Practice Act, provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. Existing law authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including, among others, ordering durable medical equipment, and, in consultation with a physician and surgeon, approving, signing, modifying, or adding to a plan of treatment or plan for an individual receiving home health services or personal care services. A violation of those provisions is a crime.

This bill would authorize a nurse practitioner to perform those acts and certain additional acts without physician supervision if the nurse

practitioner meets specified experience and certification requirements *and is practicing in a clinic, health facility, county medical facility, accountable care organization, or group practice*. The bill would require a nurse practitioner to refer a patient to a physician and surgeon or other licensed health care provider under certain circumstances~~, and would require specified nurse practitioners to maintain a current list of licensed health care providers most often used for the purposes of obtaining information or advice~~. The bill would also require a nurse practitioner practicing under these provisions to maintain professional liability insurance, as specified. The bill would also specify that a nurse practitioner practicing under the provisions of the bill shall not supplant a physician and surgeon employed by specified health care facilities. Because a violation of those provisions would be a crime, this bill would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 2835.3 is added to the Business and
2 Professions Code, to read:
3 2835.3. (a) Notwithstanding any other provision of this chapter,
4 a nurse practitioner who holds a certification as a nurse practitioner
5 from a national certifying body may practice under this section
6 without physician supervision if the nurse practitioner~~ meets the~~
7 ~~requirements of this article and one of the following is met:~~
8 ~~(1) He or she~~ has practiced under the supervision of a physician
9 for at least 4160 hours and is practicing in one of the following:
10 ~~(A)~~
11 *(1)* A clinic, health facility, or county medical facility.
12 ~~(B)~~
13 *(2)* An accountable care organization, as defined in Section
14 3022 of the federal Patient Protection and Affordable Care Act
15 (Public Law 111-148).
16 ~~(C)~~

(3) A group practice, including a professional medical corporation, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

~~(2) He or she has practiced under the supervision of a physician for at least 6240 hours.~~

(b) Notwithstanding any other law, in addition to any other practices authorized in statute or regulation, a nurse practitioner practicing under this section may do any of the following:

(1) Order durable medical equipment. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care.

(5) Manage the physical and psychosocial health status of patients.

(6) Analyze multiple sources of data, including patient history, general behavior, and signs and symptoms of illness, identify alternative possibilities as to the nature of a health care problem, and select, implement, and evaluate appropriate treatment.

(7) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section.

(8) Order, furnish, or prescribe drugs or devices.

(9) Refer patients to physicians or other licensed health care providers as provided in subdivision (c).

(10) Delegate tasks to a medical assistant that are within the medical assistant's scope of practice.

(11) Perform additional acts that require education and training and that are recognized by the board as proper to be performed by a nurse practitioner.

(12) Order hospice care as appropriate.

(13) Perform procedures that are necessary and consistent with the nurse practitioner's education and training.

(c) A nurse practitioner shall refer a patient to a physician and surgeon or another licensed health care provider if a situation or condition of the patient is beyond the nurse practitioner's education or training.

~~(d) A nurse practitioner described in paragraph (2) of subdivision (a) shall maintain a current list of licensed health care providers most often used for the purposes of obtaining information or advice.~~

~~(e)~~

(d) A nurse practitioner practicing under this section shall maintain professional liability insurance that is appropriate for his or her practice setting.

~~(f)~~

(e) Nothing in this section shall do either of the following:

(1) Limit a nurse practitioner's authority to practice nursing.

(2) Limit the scope of practice of a registered nurse authorized pursuant to this chapter.

~~(g)~~

(f) The board shall adopt regulations by July 1, 2015, establishing the means of documenting completion of the requirements of this section.

~~(h)~~

(g) A nurse practitioner practicing pursuant to this section shall not supplant a physician and surgeon employed by a health care facility specified in ~~subparagraph (A) of~~ paragraph (1) of subdivision (a).

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 492
Author: Hernandez
Bill Date: July 1, 2014, Amended
Subject: Optometrist Practice: Licensure
Sponsor: California Optometric Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill originally would have deleted the definition of the practice of optometry in existing law and would have expanded the scope of an optometrist by allowing an optometrist: to examine, prevent, diagnose, and treat any disease, condition, or disorder of the visual system, the human eye, and adjacent and related structures; to perform surgical and nonsurgical primary care procedures; and to prescribe drugs, including narcotics, among other allowances.

This bill was amended and would instead generally revise the Optometry Practice Act to clarify and expand the optometrists scope of practice and create an advanced practice optometry certificate. The advanced practice certificate would enable optometrists to perform a range of therapeutic laser procedures for the eye, surgical procedures for the eyelid, and certain injections and immunizations.

ANALYSIS:

This bill is part of a package of bills intended to expand the scope of NPs, pharmacists, and optometrists (the pharmacist bill was signed into law in 2013). Currently, optometrists measure and correct vision, prescribe and fit lenses, as well as provide some basic primary care services.

This bill would revise the definition of the practice of optometry in existing law and would expand the scope of an optometrist. The bill would do the following:

- Allow an optometrist to provide habilitative optometric services.
- Allow an optometrist who is certified to use therapeutic pharmaceutical agents (TPA) to diagnose and treat the human eye or any of its appendages for all of the following conditions:
    - The lacrimal gland, lacrimal drainage system, and the sclera in patients under the age of 12.
    - Ocular inflammation of the anterior segment and adnexa nonsurgical in cause, except when co-managed with the treating physician and surgeon. This bill would remove existing limitations relating to the treatment of ocular inflammation, referral to an ophthalmologist, and the requirement that the

optometrist consult with an ophthalmologist or appropriate physician in recurring cases.
    - Corneal surface disease and dry eyes, including treatment with the use of mechanical lipid extraction of meibomian glands using nonsurgical techniques.
    - Eyelid disorders, including hypotrichosis and blepharitis.
- Delete the requirement that optometrists can only use a specified list of TPAs, and would instead authorize an optometrist to use all TPAs approved by the Food and Drug Administration (FDA) for use in treating eye conditions, consistent with the scope of practice, limited to a maximum of five days.
- Delete the requirement that optometrists who are certified to use TPAs refer patients with certain conditions to opthalmologists only, as specified.
- Revise consultation provisions related to the maintenance of written records to apply to all physicians, instead of opthalmologists only.
- Require, in cases when an optometrist consults with a physician, for both the optometrist and physician to maintain a written record in the patients file of the information provided to the physician, the physician's response, and other relevant information. Upon the request of the optometrist or the physician, and with the patient's consent, a copy of the record must be furnished to the requesting party.
- Allow TPA-certified optometrists to remove sutures, upon notification of the treating physician, instead of upon prior consultation, and adds an optometrist as an individual to provide notification.
- Delete the specific authorization for TPA-certified optometrists to administer oral fluorescein to patients suspected as having diabetic retinopathy.
- Delete the list of specific tests that TPA-certified optometrists are allowed to order, and instead permits optometrist to order any appropriate laboratory and diagnostic imaging tests necessary to diagnose conditions of the eye or adnexa.
- Clarify that a TPA-certified optometrist may perform a clinical laboratory test or examination necessary to diagnose conditions of the eye or adnexa classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988 (CLIA), provided the tests are performed in compliance with both state and federal law, as specified, and that any ancillary personnel utilized shall also be in compliance.
- Delete the restriction on the use of needles in the removal of foreign bodies from the eye.
- Require the Board of Optometry to certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform lacrimal irrigation and dilation after submitting proof of satisfactory completion of 10 procedures under the supervision of a lacrimal irrigation and dilation certified optometrist.
- Delete obsolete language pertaining to glaucoma certification.
- Require the Board of Optometry to grant a glaucoma-certified optometrist a certificate for the use of specified advanced procedures after the optometrist meets the following applicable requirements:
    - For licensees who graduated from an accredited school of optometry, on or after May 1, 2016, submit proof of completion at that school of a satisfactory curriculum on advanced procedures, as determined by Board of Optometry,

including passage of a test for competency and performance of specified procedures required (see below requirements).
    - For Licensees who graduated from an accredited school before May 1, 2016, submit proof of completion of a board-approved course that meets specified requirements, including competency testing and specific laser and surgical procedure didactic instruction (page 7 of the bill).
    - A glaucoma-certified optometrist must also pass a written test utilizing the National Board of Medical Examiners in Optometry format to obtain an advanced practice certificate.
    - The clinical or laboratory experience must include video demonstration. It must also include between 20 and 35 clinical eyelid or adnexa surgical training procedures, between 18 and 25 laser training procedures and between six and 12 injection training procedures. This bill would require Board of Optometry to convene an advisory committee to establish the exact number of training procedures required and the advisory committee must be composed of the following: two practicing optometrists, two practicing opthalmologists, one faculty member of a school of optometry, one ophthalmologist that teaches at a school of optometry, and chaired by the Director of the Department of Consumer Affairs (DCA) or his or her appointee. Recommendations from the advisory committee must be reported to the Board of Optometry within 6 months of being convened.
    - The clinical or laboratory experience must also include a formal clinical or laboratory practical exam.
- Define the term "advanced procedures" as meaning any of the following:
    - Therapeutic lasers used for posterior capsulotomy secondary to cataract surgery.
    - Therapeutic lasers appropriate for treatment of glaucoma and peripheral iridotomy for the prophylactic treatment angle closure glaucoma.
    - Removal, destruction, or drainage of lesions of the eyelid and adnexa clinically evaluated by the optometrist to be noncancerous and closure of any related wound.
    - Injections for the treatment of conditions of the eye and adnexa that a TPA-certified optometrist may treat, excluding intraorbital injections and injections administered for cosmetic effect.
- Require the Board of Optometry to grant to a glaucoma-certified optometrist a certificate to administer immunizations after the optometrist meets the following requirements:
    - For licensees who graduated from an accredited school of optometry on or after May 1, 2016, that includes satisfactory curriculum on immunizations, as determined by the Board of Optometry, submission of proof of graduation from that institution.
    - Licensees that graduated from an accredited school before May 1, 2016, must do the following: submit proof of completion of a Board-approved immunization training program, as specified; be certified in basic life support for health care professionals; and comply with all state and federal

recordkeeping reporting requirements, as specified.

- Authorize the administration of immunizations for influenza, Herpes Zoster Virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency for individuals over the age of 18.
- Authorize the Board of Optometry to authorize optometrists to use any noninvasive technology to treat any condition specified as treatable by a TPA-certified optometrist, as specified.
- State that it is the intent of the Legislature that the Office of Statewide Health Planning and Development (OSHPD), under the Health Workforce Pilot Projects Program (HWPP), designate a pilot project intended to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia.
- Specify that an optometrist diagnosing other diseases shall be held to the same standard of care to which physicians and osteopathic physicians are held.
- Require an optometrist to consult with, and if necessary, refer a patient to a physician or other appropriate health care provider if a situation or condition occurs that is beyond the optometrists scope of practice.

Per the Assembly Business, Professions, and Consumer Protection Committee analysis: "In response to the author's request, the Committee convened six separate meetings during 2013 to hear expert testimony and discuss key components of advanced practice: laser procedures, surgical procedures, immunizations, and injections. The Committee also conducted a tour of the UC Berkeley School of Optometry. Formal discussions concluded in January without consensus, although the working group had significantly reduced the range of open issues. Additional discussions between optometry and medicine continued from January 2014 through June 2014, often, but not always, with the Committee's involvement. By June, the parties had largely narrowed down the range of procedures under discussion, and were primarily concerned with the minimum number of supervised procedures required to perform the procedures safely and achieve certification. Unfortunately, the parties were unable to find a mutually-agreeable objective standard to bridge the remaining distance. Having failed to reach consensus, this bill was amended on June 16, 2014 to reflect the preferred position of the author and the sponsor, the California Optometric Association."

Although this bill was significantly amended, it still expands the scope of practice of an optometrist by authorizing advanced practice certification and by allowing optometrists to treat ocular inflammation and pain, non-surgically and surgically; treat eyelid disorders; treat the lacrimal gland, lacrimal drainage system, and the sclera in patients under 12 years of age; use all TPAs approved by the FDA for use in treating eye conditions, including codeine with compounds and hydrocodone with compounds; administer immunizations; expand ability to order laboratory tests; and allow for certified advanced practice optometrists to perform surgical procedures. This is a significant expansion of the scope of practice of an optometrist. Although some provisions in this bill may be reasonable, this bill would allow optometrists to diagnose, treat, and manage ocular conditions, perform surgical procedures, and be granted full drug prescribing authority, including controlled substances, which is a significant scope

expansion. Even with the amendments that require additional education and clinical and didactic experience, it is likely not enough to provide the appropriate education to prepare optometrists for this significant scope expansion; as such, this bill could put patients at serious risk of harm and significantly impact consumer protection. Since we are nearing the end of the legislative session and further negotiation is unlikely at this point, Board staff suggests that the Board oppose this bill.

FISCAL: None

SUPPORT: California Optometric Association (Sponsor); Bay Area Council; Blue Shield of California; California Association of Nurse Practitioners; California Association of Public Hospitals and Health Systems; California Pharmacists Association/California Society of Health-System Pharmacists; Californians for Patient Care; Dignity Health; St. Mary's Medical Center; and United Nurses Associations of California/Union of Health Care Professionals

OPPOSITION: American College of Emergency Physicians- California Chapter; American Academy of Pediatrics, California; Blind Children's Center; California Academy of Eye Physicians & Surgeons; California Academy of Family Physicians; California Association for Medical Laboratory Technology; California Diabetes Program; California Medical Association; California Right to Life Committee; California Society of Anesthesiologists; California Society of Dermatology and Dermatologic Surgery; California Society of Plastic Surgeons; Diabetes Coalition of California; Engineers and Scientists of California; Here 4 Them, Inc.; Let's Face it Together; Lighthouse for Christ Mission Eye Center; Sansum Diabetes Research Institute; and The Dream Machine Foundation

POSITION: Recommendation: Oppose

AMENDED IN ASSEMBLY JULY 1, 2014

AMENDED IN ASSEMBLY JUNE 16, 2014

AMENDED IN ASSEMBLY AUGUST 5, 2013

AMENDED IN SENATE MAY 8, 2013

AMENDED IN SENATE APRIL 24, 2013

AMENDED IN SENATE APRIL 16, 2013

AMENDED IN SENATE APRIL 1, 2013

SENATE BILL No. 492

Introduced by Senator Hernandez

February 21, 2013

An act to amend Sections 3041, 3041.1, and 3110 of the Business and Professions Code, relating to optometry.

LEGISLATIVE COUNSEL'S DIGEST

SB 492, as amended, Hernandez. Optometrist: practice: licensure.

The Optometry Practice Act creates the State Board of Optometry, which licenses optometrists and regulates their practice. Existing law defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified

conditions, use specified pharmaceutical agents, and order specified diagnostic tests. Any violation of the act is a crime.

This bill would include the provision of habilitative optometric services within the scope of practice of optometry. The bill would expand the scope of practice of optometrists who are certified to use therapeutic pharmaceutical agents by, among other things, authorizing those optometrists to use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration and indicated for use in diagnosing and treating the eye conditions covered by these provisions. The bill would also modify the ability of an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat certain diseases. The bill would require the board to grant a certificate to an optometrist for the use of advanced procedures, as defined, if the optometrist meets certain educational and certification requirements. The board would also be required to grant a certificate to an optometrist for immunizations if the optometrist meets certain educational and certification requirements. The bill would authorize the board to allow optometrists to use any noninvasive technology to treat specified conditions.

Existing law requires optometrists in diagnosing or treating eye disease to be held to the same standard of care as physicians and surgeons and osteopathic physicians and surgeons.

This bill would expand this requirement to include diagnosing other diseases, and would require an optometrist to consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition was beyond the optometrist's scope of practice.

This bill would delete obsolete provisions and make conforming changes.

Because this bill would change the definition of a crime, it would create a state-mandated local program.

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

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

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

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

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

(b) (1) An optometrist who is certified to use therapeutic pharmaceutical agents, pursuant to Section 3041.3, may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa.

(B) Ocular allergies of the anterior segment and adnexa.

(C) Ocular inflammation of the anterior segment and adnexa nonsurgical in cause, except when comanaged with the treating physician and surgeon.

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal surface disease and dry eyes. Treatment for purposes of this subparagraph includes, but is not limited to, the use of mechanical lipid extraction of meibomian glands using nonsurgical techniques.

(F) Ocular pain nonsurgical in cause, except when comanaged with the treating physician and surgeon.

(G) Pursuant to subdivision (f), glaucoma in patients over 18 years of age, as described in subdivision (m).

(H) Eyelid disorders, including hypotrichosis and blepharitis.

(2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (c), and the procedures described in subdivision (e).

(c) In diagnosing and treating the conditions listed in subdivision (b), an optometrist certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may use all therapeutic pharmaceutical agents approved by the United States Food and Drug Administration and indicated for use in diagnosing and treating eye conditions set forth in this chapter, including codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the federal Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of controlled substances shall be limited to five days.

(d) In any case that an optometrist consults with a physician and surgeon, the optometrist and the physician and surgeon shall both maintain a written record in the patient's file of the information provided to the physician and surgeon, the physician and surgeon's response, and any other relevant information. Upon the request of the optometrist or physician and surgeon and with the patient's consent, a copy of the record shall be furnished to the requesting party.

(e) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to Section 3041.3 may also perform all of the following:

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, upon notification of the treating physician and surgeon or optometrist.

(6) Treatment or removal of sebaceous cysts by expression.

(7) Use of an auto-injector to counter anaphylaxis.

(8) Ordering of appropriate laboratory and diagnostic imaging tests necessary to diagnose conditions of the eye or adnexa.

(9) A clinical laboratory test or examination necessary to diagnose conditions of the eye or adnexa and classified as waived under the federal Clinical Laboratory Improvement Amendments of 1988 (42 U.S.C. Sec. 263a) (CLIA). These laboratory tests are required to be performed in compliance with both CLIA and all clinical laboratory licensing requirements in Chapter 3 (commencing with Section 1200), and any ancillary personnel utilized shall be in compliance with those same requirements.

(10) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

(11) The prescription of therapeutic contact lenses, including lenses or devices that incorporate a medication or therapy the optometrist is certified to prescribe or provide.

(12) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a scalpel. Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

(13) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion of 10 procedures under the supervision of an ophthalmologist or lacrimal irrigation and dilation certified optometrist as confirmed by the ophthalmologist or lacrimal irrigation and dilation certified optometrist. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, is exempt from the certification requirement contained in this paragraph.

(f) The board shall grant a certificate to an optometrist certified pursuant to Section 3041.3 for the treatment of glaucoma, as described in subdivision (m), in patients over 18 years of age after the optometrist meets the following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section prior to January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board pursuant to Section 3041.10.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board pursuant to Section 3041.10.

(g) The board shall grant to an optometrist, certified pursuant to subdivision (f), a certificate for the use of advanced procedures, as described in subdivision (h), after the optometrist meets the following applicable requirement:

~~(1) For licensees who graduated from an accredited school of optometry that includes satisfactory curriculum on advanced procedures, as determined by the board, on or after May 1, 2016, submission of proof of graduation from that institution.~~

(1) Licensees who graduated from an accredited school of optometry, on or after May 1, 2016, shall submit proof of completion at that school of a satisfactory curriculum on advanced procedures, as determined by the board, including passage of a test for competency and performance of the procedures contained in subparagraph (F) of paragraph (2).

(2) Licensees who graduated from an accredited school before May 1, 2016, are required to submit proof of completion of a board-approved course that meets all of the ~~following requirements:~~ *requirements in subparagraphs (A) to (G), inclusive. An optometrist certified pursuant to Section 3041.3 may perform the training procedures in their own practices under the supervision of a physician and surgeon or an optometrist with an advanced procedure certification.*

(A) Provided by an accredited school of ~~optometry.~~ *optometry and developed in consultation with an ophthalmologist who has experience teaching optometric students.*

(B) Taught by full-time or adjunct faculty members of an accredited school of optometry.

(C) Sponsored by an organization that meets the standards of Section 1536 of Title 16 of the California Code of Regulations.

(D) Included passage of a test for competency.

~~(D)~~

(E) Included all of the following didactic instruction:

(i) Laser physics, hazards, and safety.

(ii) Biophysics of laser.

(iii) Laser application in clinical optometry.

(iv) Laser tissue interactions.

(v) Laser indications, contraindications, and potential complications.

(vi) Gonioscopy.

(vii) Laser therapy for open angle glaucoma.

(viii) Laser therapy for angle closure glaucoma.

(ix) Posterior capsulotomy.

(x) Common complications: lids, lashes, and lacrimal.

(xi) Medicolegal aspects of anterior segment procedures.

(xii) Peripheral iridotomy.

(xiii) Laser Trabeculoplasty.

(xiv) Minor surgical procedures.

(xv) Overview of surgical instruments, asepsis, and the federal Occupational Safety and Health Administration.

(xvi) Surgical anatomy of the eyelids.

(xvii) Emergency surgical procedures.

(xviii) Chalazion management.

(xix) Epilumeninesence microscopy.

(xx) Suture techniques.

(xxi) Local anesthesia: techniques and complications.

(xxii) Anaphylaxsis and other office emergencies.

(xxiii) Radiofrequency surgery.

(xxiv) Postoperative wound care.

~~(E)~~

(F) Included all of the following clinical or laboratory experience:

(i) Video demonstration.

~~(ii) A minimum of six procedures involving the removal, destruction, or drainage of eye lesions and 14 laser eye procedures, as described in paragraph (3) of subdivision (h).~~

(ii) Between 20 and 35 clinical eyelid or adnexa surgical training procedures, between 18 and 25 laser training procedures, and between six and 12 injection training procedures. The board shall convene an advisory committee to establish the exact number of training procedures required, including a minimum number of training procedures for each procedure listed in subdivision (h). The advisory committee shall be composed of the Director of Consumer Affairs or his or her appointee, who shall also serve as the chair, two practicing optometrists, two practicing ophthalmologists, one faculty member of a school of optometry, and one ophthalmologist that teaches at a school of optometry. The members of the advisory committee shall be appointed by the respective licensing boards. Recommendations from the advisory committee shall be reported to the board within six months of being convened.

(iii) A formal clinical or laboratory practical examination.

~~(F)~~

(G) Required passage of a written test utilizing the National Board of Examiners in Optometry format.

(h) For the purposes of this chapter, "advanced procedures" means any of the following:

(1) Therapeutic lasers used for posterior capsulotomy secondary to cataract surgery.

(2) Therapeutic lasers appropriate for treatment of glaucoma and peripheral iridotomy for the prophylactic treatment of angle closure glaucoma.

(3) Removal, destruction, or drainage of lesions of the eyelid and adnexa clinically evaluated *by the optometrist* to be noncancerous.

(4) Closure of a wound resulting from a procedure described in paragraph (3).

(5) Injections for the treatment of conditions of the eye and adnexa described in paragraph (1) of subdivision (b), excluding intraorbital injections and injections administered for cosmetic effect.

(i) The board shall grant to an optometrist, certified pursuant to subdivision (f), a certificate for immunizations, as described in

subdivision (o), after the optometrist meets all of the following applicable requirements:

(1) For licensees who graduated, *on or after May 1, 2016,* from an accredited school of optometry that includes satisfactory curriculum on immunizations, as determined by the board, ~~on or after May 1, 2016,~~ submission of proof of graduation from that institution.

(2) Licensees who graduated from an accredited school before May 1, 2016, shall do all of the following:

(A) Submit proof of completion of a board-approved immunization training program that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.

(B) Be certified in basic life ~~support.~~ *support for health care professionals.*

(C) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(j) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(k) Except as authorized by this section, the practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. Nothing in this section shall limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

(*l*) An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

(m) For purposes of this chapter, "glaucoma" means either of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

(n) For purposes of this chapter, "adnexa" means ocular adnexa.

(o) For the purposes of this chapter, "immunization" means administration of immunizations for influenza, *Pertussis,* herpes

zoster virus, and additional immunizations that may be necessary to protect public health during a declared disaster or public health emergency in compliance with individual Advisory Committee on Immunization Practices (ACIP) vaccine recommendations published by the federal Centers for Disease Control and Prevention (CDC) for persons ~~eight~~ *18* years of age or older.

(p) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

(q) The board may authorize optometrists to use any noninvasive technology to treat a condition listed in paragraph (1) of subdivision (b).

SEC. 2. Section 3041.1 of the Business and Professions Code is amended to read:

3041.1. With respect to the practices set forth in Section 3041, optometrists diagnosing or treating eye disease or diagnosing other diseases shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider if a situation or condition occurs that is beyond the optometrist's scope of practice.

SEC. 3. Section 3110 of the Business and Professions Code is amended to read:

3110. The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly assisting in or abetting the violation of, or conspiring to violate any provision of this chapter or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions.

(d) Incompetence.

(e) The commission of fraud, misrepresentation, or any act involving dishonesty or corruption, that is substantially related to the qualifications, functions, or duties of an optometrist.

(f) Any action or conduct that would have warranted the denial of a license.

(g) The use of advertising relating to optometry that violates Section 651 or 17500.

(h) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license by another state or territory of the United States, by any other governmental agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

(i) Procuring his or her license by fraud, misrepresentation, or mistake.

(j) Making or giving any false statement or information in connection with the application for issuance of a license.

(k) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of an optometrist, in which event the record of the conviction shall be conclusive evidence thereof.

(*l*) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or using alcoholic beverages to the extent, or in a manner, as to be dangerous or injurious to the person applying for a license or holding a license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a license to conduct with safety to the public the practice authorized by the license, or the conviction of a misdemeanor or felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof.

(m) *(1)* Committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist.

(2) Committing any act of sexual abuse, misconduct, or relations with a patient. The commission of and conviction for any act of sexual abuse, sexual misconduct, or attempted sexual misconduct, whether or not with a patient, shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee. This paragraph shall not apply to sexual contact between any person licensed under this chapter and his or her spouse or person in an equivalent domestic relationship when that

licensee provides optometry treatment to his or her spouse or person in an equivalent domestic relationship.

(3) Conviction of a crime that requires the person to register as a sex offender pursuant to Section 290 of the Penal Code. A conviction within the meaning of this paragraph means a plea or verdict of guilty or a conviction following a plea of nolo contendere. A conviction described in this paragraph shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee.

(n) Repeated acts of excessive prescribing, furnishing or administering of controlled substances or dangerous drugs specified in Section 4022, or repeated acts of excessive treatment.

(o) Repeated acts of excessive use of diagnostic or therapeutic procedures, or repeated acts of excessive use of diagnostic or treatment facilities.

(p) The prescribing, furnishing, or administering of controlled substances or drugs specified in Section 4022, or treatment without a good faith prior examination of the patient and optometric reason.

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

(r) Performing, or holding oneself out as being able to perform, or offering to perform, any professional services beyond the scope of the license authorized by this chapter.

(s) The practice of optometry without a valid, unrevoked, unexpired license.

(t) The employing, directly or indirectly, of any suspended or unlicensed optometrist to perform any work for which an optometry license is required.

(u) Permitting another person to use the licensee's optometry license for any purpose.

(v) Altering with fraudulent intent a license issued by the board, or using a fraudulently altered license, permit certification, or any registration issued by the board.

(w) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood borne infectious diseases from optometrist to patient, from patient to patient, or from patient to optometrist. In administering this subdivision, the board shall consider the standards, regulations, and guidelines of the State Department of Health Care Services developed pursuant

to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, hepatitis B, and other blood borne pathogens in health care settings. As necessary, the board may consult with the Medical Board of California, the Board of Podiatric Medicine, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision.

(x) Failure or refusal to comply with a request for the clinical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, unless the licensee is unable to provide the documents within this time period for good cause.

(y) Failure to refer a patient to an appropriate physician if an examination of the eyes indicates a substantial likelihood of any pathology that requires the attention of that physician.

SEC. 4. It is the intent of the Legislature that the Office of Statewide Health Planning and Development, under the Health Workforce Pilot Projects Program, designate a pilot project intended to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 500
Author: Lieu
Bill Date: May 29, 2014, Amended
Subject: Medical Practice: Pain Management
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) to update the pain management guidelines every five years, beginning July 1, 2015. This bill would require the Board to convene a task force to develop and recommend the revised guidelines to the Board. This bill would allow the Task Force to consult with specified entities when developing the revisions to the pain management guidelines.

ANALYSIS

At the April 25, 2013 Enforcement Committee Meeting, the Committee established a Prescribing Task Force. This Task Force was convened to further 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 Prescribing Task Force met on February 19, 2014, and June 19, 2014 and discussed revisions to the pain management guidelines, including reviewing revised guidelines drafted by Board staff. The revised guidelines will be taken to the Board for approval after staff finalizes revising the guidelines, in accordance with input received at the last Prescribing Task Force Meeting.

This bill would require the Board to update the pain management guidelines every five years, beginning July 1, 2015. This bill would require the Board to convene a task force to develop and recommend the revised guidelines to the Board. Lastly, this bill would allow the Task Force to consult with the American Pain Society, the American Academy of Pain Medicine, the California Society of Anesthesiologists, the California Chapter of the American College of Emergency Physicians, the Osteopathic Medical Board of California, the American Cancer Society, a physician who treats or evaluates patients as part of the workers compensation system, other medical entities specializing in pain control therapies, an osteopathic physician, a physician assistant, and specialists in pharmacology and addiction medicine, when developing the revisions to the pain management guidelines.

This bill would codify work that the Board has already begun to address related to the important consumer protection issue of inappropriate prescribing. The Board has identified revising these guidelines as an important tool to help combat inappropriate prescribing. This bill will ensure that the pain management guidelines are revised, and then reviewed in a consistent, ongoing manner to provide appropriate guidance to physicians who are prescribing pain medication. The Board currently supports this bill because it furthers the Board's mission of consumer protection and recent amendments do not affect the Board's position or the reasons for taking that position.

FISCAL: Minimal and absorbable fiscal, as a task force has already been convened and meetings are already planned to address this issue.

SUPPORT: Medical Board of California

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN ASSEMBLY MAY 29, 2014

AMENDED IN SENATE JANUARY 9, 2014

AMENDED IN SENATE JANUARY 6, 2014

SENATE BILL No. 500

Introduced by Senator Lieu

February 21, 2013

An act to amend Section 2241.6 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 500, as amended, Lieu. Medical practice: pain management.

Existing law establishes the Medical Board of California within the Department of Consumer Affairs. Existing law, among other things, required the board to develop standards before June 1, 2002, to ensure the competent review in cases concerning the management, including, but not limited to, the undertreatment, undermedication, and overmedication of a patient's pain.

This bill would require the board, on or before July 1, 2015, to update those standards. The bill would require the board to convene a task force to develop and recommend the updated standards to the board. The bill would also require the board to update those standards on or before July 1 each 5th year thereafter.

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

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

SECTION 1. Section 2241.6 of the Business and Professions Code is amended to read:

2241.6. (a) (1) The board shall develop standards before June 1, 2002, to ensure the competent review in cases concerning the management, including, but not limited to, the undertreatment, undermedication, and overmedication of a patient's pain.

(2) The board may consult with entities such as the American Pain Society, the American Academy of Pain Medicine, the California Society of Anesthesiologists, the California Chapter of the American College of Emergency Physicians, *the Osteopathic Medical Board of California,* and any other medical entity specializing in pain control therapies to develop the standards utilizing, to the extent they are applicable, current authoritative clinical practice guidelines.

(b) The board shall update the standards adopted pursuant to subdivision (a) on or before July 1, 2015, and on or before July 1 each fifth year thereafter.

(c) The board shall convene a task force to develop and recommend the updated standards to the board. The task force, in developing the updated standards, may consult with the entities specified in paragraph (2) of subdivision (a), the American Cancer Society, a physician who treats or evaluates patients as part of the workers' compensation system, *an osteopathic physician, a physician assistant,* and specialists in pharmacology and addiction medicine.

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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)
Position: Support

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. The Board believes it is appropriate to also allow PAs to certify claims for DI with EDD 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. The Board supports this bill because it believes this bill will help to increase efficiencies and further the Board's mission of increasing access to care.

FISCAL: None

SUPPORT: CAPA (sponsor); Kaiser Permanente; Medical Board of California; and Physician Assistant Board

OPPOSITION: None on file

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:

SECTION 1. Section 3502.3 of the Business and Professions Code is amended to read:

3502.3. (a) Notwithstanding any other provision of law, in addition to any other practices that meet the general criteria set forth in this chapter or the Medical Board of California's regulations for inclusion in a delegation of services agreement, a delegation of services agreement may authorize a physician assistant to do any of the following:

(1) Order durable medical equipment, subject to any limitations set forth in Section 3502 or the delegation of services agreement. Notwithstanding that authority, nothing in this paragraph shall operate to limit the ability of a third-party payer to require prior approval.

(2) For individuals receiving home health services or personal care services, after consultation with the supervising physician, approve, sign, modify, or add to a plan of treatment or plan of care.

(3) After performance of a physical examination by the physician assistant under the supervision of a physician and surgeon consistent with this chapter, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(b) Nothing in this section shall be construed to affect the validity of any delegation of services agreement in effect prior to the enactment of this section or those adopted subsequent to enactment.

SEC. 2. Section 2708 of the Unemployment Insurance Code, as added by Section 2 of Chapter 350 of the Statutes of 2013, is amended to read:

2708. (a) (1) In accordance with the director's authorized regulations, and except as provided in subdivision (c) and Sections 2708.1 and 2709, a claimant shall 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. 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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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1116
Author: Torres
Bill Date: June 19, 2014, Amended
Subject: Steven M. Thompson Loan Repayment Program (STLRP)
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require the Medical Board of California (Board) by July 1, 2015, to develop a mechanism for physicians to pay a voluntary contribution, at the time of application for initial license or renewal, to the 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 mandatory 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 previously would have allowed physicians to donate an additional $75 to the Board to help fund the STLRP. This bill was amended to address concerns raised by the California Medical Association and would now require the Board by July 1, 2015, to develop a mechanism for physicians to pay a voluntary contribution, at the time of application for initial license or renewal, to the STLRP.

This bill will ensure that physicians are aware of their ability to donate additional funding to the STLRP. This information should already be included on the initial license and renewal applications as physicians can already donate any amount to the STLRP, and the Board is already planning on making these revisions. This bill will allow for a mechanism for additional funding for the STLRP, which will help fund 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. The Board supported the previous version of this bill and staff recommends that the Board continue to support this bill and any other measures that help fund or make improvements to the STLRP.

FISCAL: Minimal and absorbable

SUPPORT: California Arthritis Foundation Council; California Chapter of the American College of Emergency Physicians; Primary Care Association; California Rheumatology Alliance; and the Medical Board of California

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY JUNE 19, 2014

SENATE BILL No. 1116

Introduced by Senator Torres
(Coauthor: Senator Lara)

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.~~ *surgeons.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1116, as amended, 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~~ *that* 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~~ *require each of those boards, on or before July 1, 2015, to develop a mechanism for* a physician and surgeon ~~and~~ *or* an osteopathic physician and surgeon, *respectively,* to pay ~~an additional $75 to the board~~ *a voluntary contribution, at the time of application for initial licensure or biennial renewal,* for those purposes. ~~By increasing the amount of revenue in a continuously appropriated fund, the bill would make an appropriation.~~

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

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

SECTION 1. Section 2436.5 of the Business and Professions Code is amended to read:

2436.5. (a) (1) In addition to the fees charged for the initial issuance or biennial renewal of a physician and surgeon's certificate pursuant to Section 2435, and at the time those fees are charged, the board shall charge each applicant or renewing licensee an additional twenty-five-dollar ($25) fee for the purposes of this section.

(2) The twenty-five-dollar ($25) fee shall be paid at the time of application for initial licensure or biennial renewal and shall be due and payable along with the fee for the initial certificate or biennial renewal.

(3) ~~A~~ *On or before July 1, 2015, the board shall develop a mechanism for a* physician and surgeon ~~may pay an additional seventy-five dollars ($75) to the board~~ *to pay a voluntary contribution, at the time of application for initial licensure or biennial renewal,* for the purposes of this section.

(b) 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 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.

(c) Up to 15 percent of the funds collected pursuant to this section shall be dedicated to loan assistance for physicians and

surgeons who agree to practice in geriatric care settings or settings that primarily serve adults over ~~the age of~~ 65 years *of age* or adults with disabilities. Priority consideration shall be given to those physicians and surgeons who are trained in, and practice, geriatrics and who can meet the cultural and linguistic needs and demands of diverse populations of older Californians.

SEC. 2. Section 2455.1 of the Business and Professions Code 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~~ *On or before July 1, 2015, the board shall develop a mechanism for an* osteopathic physician and surgeon ~~may~~ *to* pay ~~an additional seventy-five dollars ($75) to the board~~ *a voluntary contribution, at the time of initial application for licensure or biennial renewal,* for the purposes of this section.

(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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1243
Author: Lieu
Bill Date: June 30, 2014, amended
Subject: Professions and Vocations
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill is a sunset review bill for several boards under the Department of Consumer Affairs (DCA). However, language was recently added that will affect all boards under DCA. The purpose of the language is to increase transparency of information distributed by DCA and this bill would require DCA, the Attorney General's Office (AG) and the Office of Administrative Hearings (OAH) to submit specified reports to the Legislature on an annual basis. The information required to be reported by DCA is modeled after existing law (Business and Professions Code (BPC) Section 2313) that requires the Medical Board of California to report specific data in the Board's annual report. This bill would also enhance unlicensed advertising enforcement, require DCA to develop enforcement academy curriculum, amend public meeting notice requirements, and establish a board member mentor program. This analysis will only cover the portions of the bill that impact the Board.

ANALYSIS:

This bill contains various provisions that aim to increase transparency and enhance enforcement for boards under DCA.

This bill would require agencies under and within DCA to provide written notice of a board meeting by regular mail, email, or both. The agency shall also provide individuals these options and comply with the individuals' chosen method of notice delivery. This bill would require an agency that plans to webcast a meeting to include in the meeting notice the intent to webcast the meeting; however, this bill would allow the meeting to be webcast even if the information is not included in the meeting notice.

This bill would expand the existing authority of boards to request telephone disconnection for advertising of unlicensed activity to any form of advertisement, not just those in a telephone directory, as currently permitted, and provides this authority to all agencies under and within DCA (not just those listed in existing law).

This bill would require DCA to provide an opportunity for an employee of an agency comprising DCA, who performs enforcement functions, to attend an enforcement academy on an annual basis. This bill would require DCA to develop the enforcement academy curricula in consultation and cooperation with the AG's Office and OAH. The curricula must include, but is not limited to, complaint intake, determining which cases should be referred for investigation, preparing cases suitable

for filing accusations, and the Administrative Procedure Act. This bill would require DCA to develop and implement a measure of training outcomes that includes a pre-test and post-test of an employee's knowledge of the training subject matter, and any other performance measures that DCA deems appropriate.

This bill would require DCA to submit a report of the accounting of the pro rata calculation of administrative expenses to the appropriate policy committees of the Legislature on or before July 1, 2015, and on or before July 1 of each subsequent year. This bill would require DCA to conduct a study of its current system for prorating administrative expenses to determine if the current system is the most productive, efficient, and cost-effective manner for DCA and the agencies comprising DCA. The study must include consideration on whether some of the administrative services offered by DCA should be outsourced or charged on an as-needed basis, and whether the agencies should be allowed to elect not to receive and be charged for certain administrative services. DCA shall include the findings of the study in the report to the Legislature. If DCA hires a third-party consultant to assess operations, DCA shall submit the final third-party report, as soon as it is received, to the Legislature.

This bill revises information contained in DCA's annual report to the Governor and the Legislature that is due January 1 each year to include the total number of restraining orders or interim suspension orders, as specified, and to include the following information relative to the performance of each constituent entity (including the Board); these requirements are modeled after Board reporting requirements in existing law (BPC Section 2313):

- Number of consumer calls received,
- Number of consumer calls or letters designated as discipline-related complaints,
- Number of complaint forms received,
- Number of convictions of licensees reported to the constituent entity,
- Number of criminal filings reported to the constituent entity,
- Number of complaints and referrals closed, referred out, or resolved without discipline, respectively, prior to the accusation,
- Number of accusations filed and final disposition of accusations through the constituent entities and court review, respectively,
- Final discipline by category,
- Number of citations issued with and without fines,
- Number of cases in process more than six months after a constituent entity receives information regarding the acts relevant to a filed accusation,
- The average and median times in processing complaints from when a constituent entity receives a complaint to each stage of discipline and court review,
- Number of public reprimands issued,
- Probation violation reports and probation revocation filings and dispositions,
- Number of petitions for reinstatement and the dispositions of those petitions,
- Caseloads for investigators for both original cases and probation cases,
- Number of reports pursuant to BPC Section 805 or BPC Section 805.01 by type of peer review body reporting, and, where applicable, the type of health care facility involved and the number and type of administrative or disciplinary actions taken by a constituent issue with respect to those reports,

- Number of reports pursuant to BPC Section 801.01 or 803,
- The number of malpractice settlements in excess of thirty thousand dollars reported pursuant to BPC Section 801.01,
- Number of coroner's reports received by a constituent entity, and
- Average length of time for a constituent entity to reach specified milestones in the enforcement process.

This bill would require the AG's Office to submit a report to DCA, the Governor and the Legislature on or before January 1, 2016 and on or before January 1st of each subsequent year. The report must include specified information regarding the number of cases referred, the number that no action is taken, the number of accusations filed and withdrawn and the average number of days it takes for different steps of the enforcement process where the AG is involved.

This bill would also require OAH to submit a report to DCA, the Governor, and the Legislature on or before January 1, 2016 and on or before January 1st of each subsequent year. The report must include specified information on the number of cases referred to OAH and the average amount of time it takes to set a hearing, to conduct a hearing, and to issue a proposed decision.

Lastly, this bill would require DCA to develop a board member mentor program where experienced board members will be trained to act as mentors to newly appointed board members. A mentor member should be assigned to a new board member who serves on a different board and a mentor can be a current or former board member.

This bill would increase transparency; enhance enforcement processes, procedures, and training; and ensure that performance statistics are being reported in a standard manner across all boards. This bill will also take steps to improve DCA's pro-rata methodology that all boards are required to adhere to and ensure that it is productive, efficient, and cost effective.

Board staff does have some technical concerns with some of the reporting requirements that all boards would have to adhere. The required reporting in large part is based on information that the Board is already required to report pursuant to BPC Section 2313. However, the reporting should be changed to July, instead of January, to be consistent with the fiscal year reporting, instead of calendar year reporting. This bill would require the number of complaints to be reported, in addition to the number of consumer calls or letters designated as discipline related complaints, and the number of complaint forms. This is duplicative and is captured in the number of complaints received, which is something already included in the Board's annual report. The reporting requirements make reference to BPC Section 801.01, but this section only applies to the Board, so it should be amended to apply to all boards. Lastly, this bill defines "action" as proceedings brought on or on behalf of DCA's constituent agencies against licensees for unprofessional conduct. Proceedings can be brought against licensees for actions that are not included under unprofessional conduct, so this term should be taken out to ensure that all actions are included.

Board staff is suggesting that the Board support this bill if the technical amendments identified are addressed.

FISCAL: Minimal and absorbable

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support if the Board's suggested technical amendments are made

AMENDED IN ASSEMBLY JUNE 30, 2014

AMENDED IN ASSEMBLY JUNE 18, 2014

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 1243

Introduced by Senator Lieu
(Principal coauthor: Assembly Member Bonilla)

February 20, 2014

An act to amend Sections 149, 201, 312, 453, 4800, 4804.5, 11506, and 22259 of, and to add Sections 101.7, 154.1, 211, and 312.1 to, the Business and Professions Code, relating to professions and vocations.

LEGISLATIVE COUNSEL'S DIGEST

SB 1243, as amended, Lieu. Professions and vocations.

(1) Under existing law, the Department of Consumer Affairs is comprised of various boards, bureaus, commissions, committees, and similarly constituted agencies that license and regulate the practice of various professions and vocations. Existing law requires those agencies to hold public meetings and provide public notice of a meeting.

This bill would require each of those agencies to offer a person requesting to receive notice of a meeting the option to receive that notice by regular mail, email, or both regular mail and email, and would require the agency to comply with that request. The bill would require an agency that intends to Web cast a meeting, to provide notice of intent to Web cast the meeting.

(2) Existing law authorizes certain agencies within the department, upon investigation and with probable cause to believe that a person is advertising in a telephone directory with respect to the offering or performance of services, without being properly licensed by or registered

with the agency, to issue a citation including an order of correction. Existing law authorizes those agencies to notify the Public Utilities Commission if a person does not comply with a final order of correction, and requires the commission to require the telephone corporation providing the telephone services to disconnect the service.

This bill would apply those provisions to all agencies that comprise the department, and would delete the requirement that the advertising appear in a telephone directory.

(3) Existing law imposes specified duties on the department and allows the department to levy a charge for the estimated administrative expenses in advance on a pro rata share basis against funds of an agency comprising the department.

This bill would require the department to conduct a study of its system for prorating administrative expenses and to submit a report to the appropriate policy committees of the Legislature, on or before July 1, 2015, and on or before July 1 of each subsequent year, including the findings of the study and an accounting of the pro rata calculation. The bill would also require the department, if it engages a third-party consultant to assess the department's operations, to promptly, upon receipt of the consultant's final report on that assessment, to submit that report to the appropriate policy committees of the Legislature including the entire study upon its completion.

The bill would require the department to develop an enforcement academy, as specified, and to provide an opportunity for an employee of an agency comprising the department who performs enforcement functions to attend an enforcement academy, at least annually, to provide a solid, standard baseline of knowledge and practices for all employees who perform enforcement functions.

(4) Existing law requires an agency comprising the ~~board~~ *department* to investigate a consumer accusation or compliant against a licensee and, where appropriate, the agency is authorized to impose disciplinary action against a licensee. Under existing law, an agency comprising the ~~board~~ *department* may refer a compliant to the Attorney General or Office of Administrative Hearings for further action. Existing law requires the Director of Consumer Affairs to submit an annual report to the Governor and the Legislature, on or before January 1, that includes information regarding consumer complaints and the action taken on those complaints.

This bill would require the director's report to include specific, detailed information regarding those complaints and actions. The bill

would require the Attorney General to submit a report to the department, the Governor, and the appropriate policy committees of the Legislature, on or before January 1, 2016, and on or before January 1 of each subsequent year, that includes specified information regarding the actions taken by the Office of the Attorney General pertaining to accusations and cases relating to consumer complaints against a person whose profession or vocation is licensed by an agency comprising the department. The bill would require the Office of Administrative Hearings to submit a report to the same parties in the same timeframe as described above that includes actions taken by that office with respect to cases pertaining to those complaints.

(5) Existing law requires a newly appointed member of a board comprising the department to, within one year of assuming office, complete a training and orientation program offered by the department.

This bill would require the department to develop a board member mentor program to assign an experienced board member to mentor a new board member serving on a different board.

(6) Existing law regulates the practice of veterinary medicine. Existing law, until January 1, 2016, provides for a Veterinary Medical Board within the Department of Consumer Affairs. Existing law, until January 1, 2016, authorizes the board to appoint a person exempt from civil service to be designated as an executive officer of the board, as specified.

This bill would extend those provisions until January 1, 2017.

(7) Existing law regulates the practice of common interest development managers, and makes those provisions effective only until January 1, 2015.

This bill would extend the effectiveness of those provisions until January 1, 2019, and subject those provisions to review by the appropriate policy committees of the Legislature. The bill would also delete an obsolete reference.

(8) Existing law establishes the California Tax Education Council, a nonprofit organization, and requires the council to register and regulate tax preparers. Existing law makes those provisions effective only until January 1, 2015.

This bill would extend the effectiveness of those provisions until January 1, 2019.

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

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

SECTION 1. Section 101.7 is added to the Business and Professions Code, to read:

101.7. (a) An agency within the department that is required to provide a written notice pursuant to subdivision (a) of Section 11125 Government Code, may provide that notice by regular mail, email, or by both regular mail and email. An agency shall give a person who requests a notice the option of receiving the notice by regular mail, email, or by both regular mail and electronic mail. The agency shall comply with the requester's chosen form or forms of notice.

(b) An agency that plans to Web cast a meeting shall include in the meeting notice required pursuant to subdivision (a) of Section 11125 of the Government Code a statement of the board's intent to Web cast the meeting. An agency may Web cast a meeting even if the agency fails to include that statement of intent in the notice.

SEC. 2. Section 149 of the Business and Professions Code is amended to read:

149. (a) If, upon investigation, an agency designated in Section 101 has probable cause to believe that a person is advertising with respect to the offering or performance of services, without being properly licensed by or registered with the agency to offer or perform those services, the agency may issue a citation under Section 148 containing an order of correction that requires the violator to do both of the following:

(1) Cease the unlawful advertising.

(2) Notify the telephone company furnishing services to the violator to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

(b) This action is stayed if the person to whom a citation is issued under subdivision (a) notifies the agency in writing that he or she intends to contest the citation. The agency shall afford an opportunity for a hearing, as specified in Section 125.9.

(c) If the person to whom a citation and order of correction is issued under subdivision (a) fails to comply with the order of correction after that order is final, the agency shall inform the Public Utilities Commission of the violation and the Public Utilities Commission shall require the telephone corporation furnishing

services to that person to disconnect the telephone service furnished to any telephone number contained in the unlawful advertising.

(d) The good faith compliance by a telephone corporation with an order of the Public Utilities Commission to terminate service issued pursuant to this section shall constitute a complete defense to any civil or criminal action brought against the telephone corporation arising from the termination of service.

SEC. 3. Section 154.1 is added to the Business and Professions Code, to read:

154.1. (a) The Legislature hereby finds and declares all of the following:

(1) The department is currently providing opportunities for employees of agencies comprising the department who perform enforcement functions to attend an enforcement academy.

(2) It is in the best interest of consumers in the state for the department to continue to provide these opportunities for employees performing enforcement functions for each agency comprising the department.

(b) The department shall provide an opportunity for an employee of an agency comprising the department who performs enforcement functions to attend an enforcement academy, at least annually, to provide a solid, standard baseline of knowledge and practices for all employees who perform enforcement functions. The department shall encourage an agency executive officer, registrar, executive director, bureau chief, enforcement manager, supervisor, or staff member to attend an enforcement academy.

(c) The department shall develop the enforcement academy curricula in consultation and cooperation with the Office of the Attorney General and the Office of Administrative Hearings. The curricula shall include, but not be limited to, complaint intake, determining which cases should be referred for investigation, preparing a case suitable for filing an accusation, and the Administrative Procedure Act.

(d) The department shall develop and implement a measure of training outcomes that includes a pretest and posttest of an employee's knowledge of the training subject matter, and any other performance measures that the department deems appropriate.

SEC. 4. Section 201 of the Business and Professions Code is amended to read:

201. (a) A charge for the estimated administrative expenses of the department, not to exceed the available balance in any appropriation for any one fiscal year, may be levied in advance on a pro rata share basis against any of the boards, bureaus, commissions, divisions, and agencies, at the discretion of the director and with the approval of the Department of Finance. The department shall submit a report of the accounting of the pro rata calculation of administrative expenses to the appropriate policy committees of the Legislature on or before July 1, 2015, and on or before July 1 of each subsequent year.

(b) The department shall conduct a study of its current system for prorating administrative expenses to determine if that system is the most productive, efficient, and cost-effective manner for the department and the agencies comprising the department. The study shall include consideration of whether some of the administrative services offered by the department should be outsourced or charged on an as-needed basis and whether the agencies should be permitted to elect not to receive and be charged for certain administrative services. The department shall include in its report pursuant to subdivision (a) the findings of the study.

SEC. 5. Section 211 is added to the Business and Professions Code, to read:

211. If the department hires a third-party consultant to assess the department's operations, the department shall, promptly upon receipt of the consultant's final report on that assessment, submit that report to the appropriate policy committees of the Legislature.

SEC. 6. Section 312 of the Business and Professions Code is amended to read:

312. (a) The director shall submit to the Governor and the Legislature on or before January 1, 2003, and annually thereafter, a report of programmatic and statistical information regarding the activities of the department and its constituent entities. The report shall include information concerning the director's activities pursuant to Section 326, including the number and general patterns of consumer complaints and the action taken on those complaints.

(1) The report shall include, at a minimum, all of the following information:

(2) The total number of temporary restraining orders or interim suspension orders sought by each constituent entity to enjoin licensees pursuant to Sections 125.7 and 125.8, the circumstances

in each case that prompted the constituent entity to seek that injunctive relief, and whether a restraining order or interim suspension order was issued.

(3) Information relative to the performance of each constituent entity, including all of the following:

(A) Number of consumer calls received.

(B) Number of consumer calls or letters designated as discipline-related complaints.

(C) Number of complaint forms received.

(D) Number of convictions of licensees reported to the ~~board~~ *constituent entity*.

(E) Number of criminal filings reported to the constituent entity.

(F) Number of complaints and referrals closed, referred out, or resolved without discipline, respectively, prior to accusation.

(G) Number of accusations filed and final disposition of accusations through the constituent entities and court review, respectively.

(H) Final discipline by category.

(I) Number of citations issued with and without fines.

(J) Number of cases in process more than six months after a constituent entity receives information regarding the acts relevant to a filed accusation.

(K) The average and median times in processing complaints from when a constituent entity receives a complaint to each stage of discipline and court review.

~~(L) Final discipline by category.~~

~~(M)~~

(L) Number of public reprimands issued.

~~(N)~~

(M) Probation violation reports and probation revocation filings and dispositions.

~~(O)~~

(N) Number of petitions for reinstatement and the dispositions of those petitions.

~~(P)~~

(O) Caseloads of investigators for both original cases and probation cases.

~~(Q)~~

(P) Number of reports pursuant to Section 805 or Section 805.01 by type of peer review body reporting and, where applicable, the

type of health care facility involved and the number and type of administrative or disciplinary actions taken by a constituent entity with respect to those reports.

~~(R)~~

(Q) Number of reports pursuant to Section 801.01 or 803.

~~(S)~~

(R) The number of malpractice settlements in excess of thirty thousand dollars ($30,000) reported pursuant to Section 801.01.

~~(T)~~

(S) Number of coroner's reports received by a ~~board~~ *constituent entity*.

~~(U)~~

(T) Average length of time for a constituent entity to reach each of the following milestones in the enforcement process:

(i) Average number of days from when a constituent entity receives a complaint until the ~~board~~ *constituent entity* assigns an investigator to the complaint.

(ii) Average number of days from a constituent entity opening an investigation conducted by the constituent entity staff or the Division of Investigation to closing the investigation regardless of outcome.

(iii) Average number of days from a constituent entity closing an investigation to imposing formal discipline.

(iv) Average number of days for a constituent entity to conduct a supplemental investigation for a case that was rereferred by the constituent entity to the Attorney General to file an accusation.

(b) "Action," for purposes of this section, means a proceeding brought by, or on behalf of, a constituent entity against a licensee for unprofessional conduct that has not been finally adjudicated, and a disciplinary action taken by a constituent entity against a licensee.

(c) A report submitted pursuant to subdivision (a) shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 7. Section 312.1 is added to the Business and Professions Code, to read:

312.1. (a) The Attorney General shall submit a report to the department, the Governor, and the appropriate policy committees of the Legislature on or before January 1, 2016, and on or before

January 1 of each subsequent year that includes, at a minimum, all of the following:

(1) Number of cases referred to the Attorney General by each constituent entity comprising the department.

(2) Number of cases referred by the Attorney General back to each constituent entity with no further action.

(3) Number of cases rereferred by a constituent entity to the Attorney General after each constituent entity or the Division of Investigation completes a supplemental investigation.

(4) Number of accusations filed by each constituent entity.

(5) Number of accusations a constituent entity withdraws.

(6) Average number of days from the Attorney General receiving a case to filing an accusation on behalf of each constituent entity.

(7) Average number of days to prepare an accusation for a case that is rereferred to the Attorney General after a supplemental investigation is conducted by staff of a constituent entity or the Division of Investigation for each constituent entity.

(8) Average number of days from filing an accusation to transmitting a stipulated settlement for each constituent entity.

(9) Average number of days from filing an accusation to transmitting a default decision for each constituent entity.

(10) Average of days from filing an accusation to scheduling a hearing for each constituent entity.

(11) Average numbers of days from scheduling a hearing to conducting a hearing for each constituent entity.

(b) The Office of Administrative Hearings shall submit a report to the department, the Governor, and the Legislature on or before January 1, 2016, and on or before January 1 of each subsequent year that includes, at a minimum, all of the following:

(1) Number of cases referred by each constituent entity to each office of the Office of Administrative Hearings for a hearing.

(2) Average number of days from receiving a request to setting a hearing date at each office of the Office of Administrative Hearings.

(3) Average number of days from setting a hearing to conducting the hearing.

(4) Average number of days after conducting a hearing to transmitting the proposed decision by each office of the Office of Administrative Hearings.

SEC. 8. Section 453 of the Business and Professions Code is amended to read:

453. (a) Every newly appointed board member shall, within one year of assuming office, complete a training and orientation program offered by the department regarding, among other things, his or her functions, responsibilities, and obligations as a member of a board. The department shall adopt regulations necessary to establish this training and orientation program and its content.

(b) The department shall develop a board member mentor program through which experienced board members will be trained to act as mentors to newly appointed board members. A mentor member should be assigned to a new board member who serves on a different board. A mentor may be a current or former board member.

SEC. 9. Section 4800 of the Business and Professions Code is amended to read:

4800. (a) There is in the Department of Consumer Affairs a Veterinary Medical Board in which the administration of this chapter is vested. The board consists of the following members:

(1) Four licensed veterinarians.

(2) One registered veterinary technician.

(3) Three public members.

(b) This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

(c) Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature. However, the review of the board shall be limited to those issues identified by the appropriate policy committees of the Legislature and shall not involve the preparation or submission of a sunset review document or evaluative questionnaire.

SEC. 10. Section 4804.5 of the Business and Professions Code is amended to read:

4804.5. The board may appoint a person exempt from civil service who shall be designated as an executive officer and who shall exercise the powers and perform the duties delegated by the board and vested in him or her by this chapter.

This section shall remain in effect only until January 1, 2017, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2017, deletes or extends that date.

SEC. 11. Section 11506 of the Business and Professions Code is amended to read:

11506. This part shall be subject to review by the appropriate policy committees of the Legislature. This part shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 12. Section 22259 of the Business and Professions Code is amended to read:

22259. (a) This chapter shall be subject to review by the appropriate policy committees of the Legislature.

(b) This chapter shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1262
Author: Correa
Bill Date: July 2, 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 create a Bureau of Medical Marijuana Regulation (Bureau) in the Department of Consumer Affairs that would be the regulatory agency performing the licensing functions. It also gives local agencies the primary responsibility for enforcement of Bureau standards, in accordance with Bureau regulations.

This bill would impose specified 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 requirements of the Board.

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.

In May 2004, the Board issued a statement on the Compassionate Use Act and a physician's role in recommending medical marijuana, which is still the recognized policy. The statement clarifies that physicians who recommend medical marijuana will not be subject to investigation or disciplinary action by the Board if the decision to recommend medical marijuana is made in accordance with accepted standards of medical responsibility, which is not specifically defined. The statement also indicates that a mere complaint that a physician is recommending medical marijuana will not

generate an investigation absent information that a physician is not adhering to accepted medical standards.

According to the Senate Health Committee analysis, the University of California's (UC) Center for Medicinal Cannabis Research (CMCR) was created pursuant to SB 847 (Vasconcellos, Chapter 750, statutes of 1999). The CMCR is tasked with developing and conducting studies intended to ascertain the general medical safety and efficacy of marijuana and, if found valuable, to develop medical guidelines for the appropriate administration and use of medical marijuana. According to CMCR's web site, CMCR coordinates and supports cannabis research throughout California, which focuses on the potential medical benefits of cannabis, the general medical safety and efficacy of cannabis, and on examining alternative forms of cannabis administration.

ANALYSIS:

SB 1262 would require the Board to include, in its investigative priorities, cases involving repeated acts of excessively recommending marijuana to a patient for medical purposes without a good faith examination of the patient and a medical reason for the recommendation.

This bill would prohibit a physician from recommending medical marijuana to a patient unless that person is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code (HSC). The HSC defines an "attending physician" as an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

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 are licensed and regulated by the Medical Board of California and arrive at the decision to make this recommendation in accordance with the accepted standards of medical responsibility."

Lastly, this bill requires the Board to consult with CMCR on developing and adopting medical guidelines for the appropriate administration and use of marijuana.

This bill has been significantly amended and no longer expressly spells out what a physician must do before medical marijuana is recommended, including the requirement that an in-person patient examination must be conducted. This bill still places anti-kick back and advertising restrictions on physicians who recommend medical marijuana, and includes in the Board's priorities cases involving repeated acts of excessively recommending marijuana to a patient for medical purposes without a good faith examination of the patient and a medical reason for the recommendation.

This bill requires the Board to consult with CMCR when developing guidelines, but does not expressly require the Board to develop and adopt guidelines for the appropriate administration and use of marijuana. If this bill were to pass, the Board would need to update its current statement and at that time would consult and solicit input from the CMCR.

Board staff is suggesting the Board take a neutral position on this bill, as it no longer contains many of the enforcement tools for the Board to utilize regarding requirements physicians must follow when recommending medical marijuana.

FISCAL: Minor and absorbable costs

SUPPORT: California Police Chiefs Association (Co-Sponsor); League of California Cities (Co-Sponsor); Americans for Safe Access; Association of Orange County Deputy Sheriffs; City of Beaumont; City of Camarillo; City of Concord; City of Del Mar; City of El Cajon; City of La Mirada; City of Palmdale; City of Rancho Cucamonga; City of Rosemead; and City of Sacramento

OPPOSITION: Cannabis Action California Education Foundation; Drug Policy Alliance; Emerald Growers Association; Marijuana Policy Project; and Mendocino County Small Farmer's Association

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY JULY 2, 2014

AMENDED IN ASSEMBLY JUNE 15, 2014

AMENDED IN SENATE MAY 27, 2014

AMENDED IN SENATE MAY 7, 2014

AMENDED IN SENATE APRIL 21, 2014

SENATE BILL No. 1262

Introduced by Senator Correa
(Principal coauthor: Assembly Member Ammiano)

February 21, 2014

An act to amend Section 2220.05 of, to add Article 25 (commencing with Section 2525) to Chapter 5 of Division 2 of, and to add Part 5 (commencing with Section 18100) to Division 7 of, the Business and Professions Code, *to add Section 23028 to the Government Code, and* to add Article 8 (commencing with Section 111658) to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code~~, and to add Chapter 3.8 (commencing with Section 7295) to Part 1.7 of Division 2 of the Revenue and Taxation Code,~~ relating to medical marijuana, *and making an appropriation therefor*.

LEGISLATIVE COUNSEL'S DIGEST

SB 1262, as amended, Correa. Medical marijuana: regulation of physicians, dispensaries, cultivation sites, and processing facilities.

(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. Existing law provides for the licensure of various professions by the Department of Consumer Affairs. Existing law, the Sherman Food, Drug, and Cosmetic Law, provides for the regulation of food, drugs, devices, and cosmetics, as specified. A violation of that law is a crime.

This bill would ~~require~~ *establish within* the Department of Consumer Affairs *a Bureau of Medical Marijuana Regulation* to license dispensing facilities, cultivation sites, and processing facilities that provide, process, and grow marijuana for medical use, as specified, ~~including requiring~~ *subject to local ordinances. The bill would require* a background check ~~for license~~ *of* applicants *for licensure to be administered by the Department of Justice*. The bill would make these licenses subject to the restrictions of the local jurisdiction in which the facility operates or proposes to operate. The bill would, among other things, require licensees to implement sufficient security measures to both deter and prevent unauthorized entrance into areas containing marijuana and theft of marijuana at their facilities, including establishing limited access areas accessible only to authorized facility personnel, and would require these licensees to notify appropriate law enforcement authorities within 24 hours after discovering specified breaches in security. The bill would set forth provisions related to the transportation, testing, and distribution of marijuana. *The bill would set forth provisions for the revocation or suspension of a license for a violation of these provisions or of local ordinances, and would require the bureau to make recommendations to the Legislature pertaining to the establishment of a judicial review process.* The 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. Violation of these provisions would be punishable by a civil fine of up to $35,000 for each individual violation, *or as otherwise specified*.

The bill would establish the Medical Marijuana Regulation Fund and would require the deposit of fees collected pursuant to this act into the fund. The bill would continuously appropriate moneys from the fund to the bureau for the purposes of administering this act, thereby making an appropriation. The bill would require the deposit of penalty moneys collected pursuant to this act into the General Fund.

The bill would provide that it shall not supersede provisions of Measure D, as approved by the voters of the City of Los Angeles, as specified.

The bill would require the ~~department~~ *bureau* to administer and enforce these provisions. The bill would require the ~~department~~ *bureau* to establish quality assurance protocols by July 1, 2016, to ensure uniform testing standards of medical marijuana, and would require licensees to comply with these provisions. The bill would further set forth provisions regulating edible marijuana products, as specified. By adding these provisions to the Sherman Food, Drug, and Cosmetic Law, a violation of which is a crime, the bill would impose a state-mandated local program.

(2) 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 prioritize investigations and prosecutions of physicians and surgeons representing the greatest threat of harm, as specified. Existing law identifies the cases that are to be given priority, which include cases of repeated acts of excessively prescribing, furnishing, or administering controlled substances without a good faith prior examination of the patient. Existing law provides that a violation of the Medical Practice Act is a crime.

This bill would require the board to consult with the Center for Medicinal Cannabis Research on developing and adopting medical guidelines for the appropriate administration and use of marijuana.

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~~ *the* bill would impose a state-mandated local program.

The bill would provide that specified acts of recommending marijuana without a good faith examination are among the types of cases that should be given priority for investigation and prosecution by the board, as described above. The bill would further prohibit a ~~person~~ *physician and surgeon* from recommending medical marijuana to a patient unless that person is the patient's attending physician, as defined. Because a violation of that provision would be a crime, the bill would impose a state-mandated local program.

(3) Existing law authorizes the legislative body of a city or county to impose various taxes, including a transactions and use tax at a rate

of 0.25%, or a multiple thereof, if approved by the required vote of the legislative body and the required vote of qualified voters, and limits the combined rate of transactions and use taxes within a city or county to 2%.

This bill would authorize the ~~legislative body~~ *board of supervisors* of a county to ~~levy~~ *impose* a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, *donating, selling,* or distributing marijuana or products containing marijuana. The bill would authorize the tax to be imposed for either general or specific governmental purposes. The bill would require a tax imposed pursuant to this authority to be subject to any applicable voter approval requirement.

(4) This bill would provide that its provisions are severable.

(5) Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

~~The~~

(6) 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~~ *yes*. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. The Legislature finds and declares all of the following:

(a) In 1996, the people of the State of California enacted the Compassionate Use Act of 1996, codified in Section 11362.5 of the Health and Safety Code. The people of the State of California declared that their purpose in enacting the measure was, among other things, “to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that 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 in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."

(b) The Compassionate Use Act of 1996 called on state government to implement a plan for the safe and affordable distribution of marijuana to all patients in medical need of marijuana, *while ensuring that nothing in this act shall be construed to condone the diversion of marijuana for nonmedical purposes*.

(c) In 2003, the Legislature enacted the Medical Marijuana Program Act (MMPA), codified in Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code.

(d) Greater certainty and minimum statewide standards are urgently needed regarding the obligations of medical marijuana facilities, and for the imposition and enforcement of regulations to prevent unlawful cultivation and the diversion of marijuana to nonmedical use.

(e) Despite the passage of the Compassionate Use Act of 1996 and the MMPA, because of the lack of an effective statewide system for regulating and controlling medical marijuana, cities, counties and local law enforcement officials have been confronted with uncertainty about the legality of some medical marijuana cultivation and distribution activities. The current ~~system of collectives and cooperatives~~ *state of affairs* makes law enforcement difficult and endangers patient safety because of an inability to monitor the supply of medical marijuana in the state and the lack of quality control, testing, and labeling requirements.

(f) The California Constitution grants cities and counties the authority to make and enforce, within their borders, "all local 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. *Nothing in this act shall diminish, erode, or modify that authority.*

(g) 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, *regulations, or enforcement actions* regarding the sale and use of medical marijuana, including, but not limited to, security, signage, lighting, and inspections.

(h) 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 *nonmedical* access to medical marijuana by minors.

(i) Nothing in this act shall be construed to promote or facilitate the nonmedical, recreational possession, sale, or use of marijuana.

SEC. 2. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances, or recommending marijuana to patients for medical purposes, without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(5) Practicing medicine while under the influence of drugs or alcohol.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 3. 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) 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 Part 5 (commencing with Section 18100) of Division 7, 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.

2525.1. The board shall consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, authorized pursuant to Section 11362.9 of the Health and Safety Code, on developing and adopting medical guidelines for the appropriate administration and use of marijuana.

2525.2. ~~No person~~ *A physician and surgeon* shall *not* recommend medical marijuana to a patient, unless that person is the patient's attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code.

SEC. 4. Part 5 (commencing with Section 18100) is added to Division 7 of the Business and Professions Code, to read:

PART 5. MEDICAL MARIJUANA

18100. For purposes of this part, the following definitions shall apply:

~~(a) "Certified testing laboratory" means a laboratory that is certified by the department to perform random sample testing of marijuana pursuant to the certification standards for these facilities promulgated by the department.~~

~~(b) "Department" means the Department of Consumer Affairs.~~

~~(c) "Dispensary" means a distribution operation that provides marijuana or marijuana derived products to patients.~~

~~(d) "Licensed cultivation site" means a facility that grows marijuana for medical use and that is licensed pursuant to Section 18101.~~

~~(e) "Licensed dispensing facility" means a dispensary or other facility that provides marijuana for medical use that is licensed pursuant to Section 18101.~~

~~(f) "Licensed processing facility" means a facility where marijuana or marijuana products are inspected, packaged, labeled, or otherwise prepared prior to being provided to another facility licensed pursuant to this section, to a patient with a medical marijuana recommendation, or otherwise distributed, and that is licensed pursuant to Section 18101.~~

~~(g) "Licensed transporter" means an individual or entity licensed by the department to transport marijuana to and from facilities licensed pursuant to this part.~~

~~(h) "Marijuana" means marijuana, as defined by Section 11018 of the Health and Safety Code.~~

(a) "Bureau" means the Bureau of Medical Marijuana Regulation in the Department of Consumer Affairs.

(b) "Certified testing laboratory" means a laboratory that is certified by the bureau to perform random sample testing of marijuana pursuant to the certification standards for these facilities promulgated by the bureau.

(c) "Dispensary" means a distribution operation that provides marijuana or marijuana derived products to patients.

(d) "Fund" means the Medical Marijuana Regulation Fund established pursuant to Section 18101.4.

(e) "Licensed cultivation site" means a facility that grows marijuana for medical use and that is licensed pursuant to this part.

(f) "Licensed dispensing facility" means a dispensary or other facility that provides marijuana for medical use that is licensed pursuant to this part.

(g) "Licensed processing facility" means a facility where marijuana or marijuana products are inspected, packaged, labeled, or otherwise prepared, warehoused, or stored prior to being provided to another facility licensed pursuant to this part, to a patient with a medical marijuana recommendation, or otherwise distributed, and that is licensed pursuant to this part.

(h) "Licensed transporter" means an individual or entity licensed by the bureau to transport marijuana to and from facilities licensed pursuant to this part.

(i) "Marijuana" means all parts of the plant Cannabis sativa, cannabis indica, or cannabis ruderalis, whether growing or not; the seeds thereof; the resin, whether crude or purified, extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or resin. "Marijuana" does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination. "Marijuana" also means marijuana, as defined by Section 11018 of the Health and Safety Code.

~~18101. (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 marijuana other than at a licensed cultivation site.~~

~~(c) 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 process marijuana other than at a licensed processing facility.~~

~~(d) A person shall not transport marijuana from one facility licensed pursuant to this part to another, other than a licensed transporter.~~

~~(e) To meet the requirement of Sections 111658 to 111663, inclusive, of the Health and Safety Code, marijuana and marijuana products shall be tested by a certified testing laboratory.~~

~~(f) The department shall require, prior to issuing a license to a dispensing facility or a cultivation site pursuant to this part, 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 part.~~

~~(7) (A) An applicant's fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state and federal convictions and arrests, and information as to the existence and content of a record of state and federal convictions and arrests for which the Department of Justice establishes that the person is free on bail, or on his or her own recognizance, pending trial or appeal.~~

~~(B) The Department of Justice shall forward the fingerprint images and related information received pursuant to subparagraph (A) to the Federal Bureau of Investigation and request a federal summary of criminal information. The Department of Justice shall review the information returned from the Federal Bureau of Investigation and compile and disseminate a response to the department.~~

~~(C) The Department of Justice shall charge a fee sufficient to cover the reasonable cost of processing the requests described in this paragraph.~~

~~(D) The department may deny a license based on a past criminal conviction if the crime is substantially related to the qualifications, functions, or duties of the business for which the license will be issued.~~

~~(8) In the case of a cultivation site, the GPS coordinates of the site.~~

~~(9) Any other information as required by the department.~~

~~(g) The department shall deny a license if the application fails to state with sufficient specificity the jurisdiction in which the applicant proposes to establish operations.~~

~~(h) Each application for a license approved by the department pursuant to this part is separate and distinct. A licensee shall not hold a license in more than one class of specified medical marijuana activities. A licensee shall not be an officer, director, member, owner, or shareholder in another entity licensed pursuant to this part. The officers, directors, owners, members, or shareholders of a licensee in one class may not hold a license in another class, and may not be an officer, director, member, owner, or shareholder of an entity licensed pursuant to this part.~~

18101. (a) (1) There is hereby created in the Department of Consumer Affairs the Bureau of Medical Marijuana Regulation. The bureau shall be administered by an executive officer who shall be a civil servant appointed pursuant to civil service rules by the Governor, and who shall be known as the Executive Officer of the Bureau of Medical Marijuana Regulation.

(2) Funds for the establishment and support of the bureau shall be advanced as a loan by the Department of Consumer Affairs and shall be repaid by the initial proceeds from fees collected pursuant to subdivision (b) of Section 18101.1, paragraph (9) of subdivision (f) of Section 18101.2, and subdivision (b) of Section 18101.3.

(b) (1) The bureau shall have the power to license persons for the cultivation, manufacture, transportation, storage, distribution, and sale of medical marijuana within the state and to collect licensing fees in connection with these actions.

(2) The bureau shall exercise its authority pursuant to paragraph (1) consistent with subdivision (f) of Section 1 of the act that added this section and consistent with the provisions of this part.

18101.1. The bureau shall have the authority, subject to local ordinances, to license persons for the cultivation, manufacture, transportation, storage, and sale of medical marijuana within the state, and to levy appropriate related licensing fees not to exceed the reasonable costs of enforcement and administration of this part. The bureau shall not issue a license if the applicant has not met all requirements pursuant to this part. A license, once issued, shall be suspended within 10 days of notification to the bureau by a local agency that a licensee is no longer in compliance with any local ordinance or regulation. The bureau shall have the power necessary for the administration of this part, including, but not limited to, the following:

(a) Establishing statewide minimum standards for the cultivation, manufacturing, transportation, storage, distribution, provision, donation, and sale of medical marijuana and medical marijuana products, and procedures for the issuance, renewal, suspension, and revocation of licenses.

(b) Establishing a scale of application, license, and renewal fees, to be imposed by the state, for licenses for the cultivation, manufacturing, transportation, distribution, and sale of medical marijuana and medical marijuana products. The bureau may charge separate fees for each license application for cultivation, manufacturing, transportation, distribution, and sale. The total fees imposed pursuant to this part shall be based on the actual costs of administering and enforcing this part.

(c) Making and proscribing any rule that may be necessary or proper to carry out the purposes and intent of this part and to enable it to exercise the powers and perform the duties conferred upon it by this part and in accordance with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the performance of its duties, the bureau has the powers as set forth in Article 2 (commencing with

Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Approving or denying applications, subject to local ordinances, for cultivation, manufacturing, labeling, transportation, distribution, provision, donation, and sale of medical marijuana pursuant to this part.

(e) The bureau shall, with input from local agencies, deny, suspend, or revoke any license issued pursuant to this part, or fine any licensee, if the bureau determines that the granting or continuance of the license would be contrary to public welfare or morals or that a person holding or seeking a license has violated any law prohibiting conduct involving moral turpitude or an applicable local ordinance.

(f) Imposing any penalty authorized by this part or any rule or regulation adopted pursuant to this part.

(g) Taking any action with respect to a license application in accordance with procedures established pursuant to this part.

(h) The bureau shall make recommendations to the Legislature pertaining to the establishment of an appeals and judicial review process for persons aggrieved by a final decision of the bureau.

(i) Developing any forms, identification certificates, and applications that are necessary or convenient in the discretion of the bureau for the administration of this part or any of the rules or regulations adopted pursuant to this part.

(j) Overseeing the operation of the Medical Marijuana Regulation Fund established pursuant to Section 18101.4.

(k) Establishing reasonable fees for processing all applications, licenses, notices, or reports required to be submitted to the bureau. The amount of the fees shall reflect, but shall not exceed, the direct and indirect costs of the bureau for the administration of this part and the rules or regulations adopted pursuant to this part.

(l) The bureau may consult with other state agencies, departments, or public or private entities for the purposes of establishing statewide standards and regulations.

18101.2. (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 marijuana other than at a licensed cultivation site.

(c) 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 process marijuana other than at a licensed processing facility.

(d) A person shall not transport marijuana from one facility licensed pursuant to this part to another, other than a licensed transporter.

(e) To meet the requirements of Article 8 (commencing with Section 111658) of Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, marijuana and marijuana products shall be tested by a certified testing laboratory.

(f) The bureau shall require, prior to issuing a license pursuant to this part, all of the following:

(1) The name of the owner or owners of a proposed facility, including all persons or entities having an ownership interest other than a security interest, lien, or encumbrance on any property that will be used by the applicant.

(2) The name, address, and date of birth of each principal officer and board member.

(3) The address and telephone number of the proposed facility.

(4) A description of the scope of business of the proposed facility.

(5) A certified copy of the local jurisdiction's approval to operate within its borders.

(6) Operating and inventory control procedures to ensure security and prevent diversion.

(7) Detailed operating procedures for the proposed facility, which shall include, but not be limited to, provisions for facility and operational security, prevention of diversion, employee screening, storage of medical marijuana, personnel policies, and recordkeeping procedures.

(8) A completed application, as required by the bureau.

(9) Payment of a fee, in an amount to be determined by the bureau, not to exceed the amount necessary, but that is sufficient to cover, the actual costs of the administration of this part.

(10) (A) An applicant's fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record

of state and federal convictions and arrests, and information as to the existence and content of a record of state and federal convictions and arrests for which the Department of Justice establishes that the person is free on bail, or on his or her own recognizance, pending trial or appeal.

(B) The Department of Justice shall charge a fee sufficient to cover the reasonable cost of processing the requests described in the paragraph.

(11) In the case of a cultivation site, the GPS coordinates of the site.

(12) Any other information as required by the bureau.

(13) The bureau shall deny a license based on a past felony criminal conviction for drug trafficking, a felony conviction for embezzlement, a felony conviction involving fraud or deceit, or any violent or serious felony conviction pursuant to subdivision (c) of Section 667.5 of, or subdivision (c) of Section 1192.7 of, the Penal Code. The bureau may also deny a license based on a past criminal conviction if the crime was substantially related to the qualifications, functions, or duties of the business for which the license will be issued.

(g) The bureau shall deny a license if the application fails to state with sufficient specificity the jurisdiction in which the applicant proposes to establish operations.

(h) (1) Each application for a license approved by the bureau pursuant to this part is separate and distinct, and the bureau may charge a separate fee for each. A licensee shall not hold a license in more than one class of specified medical marijuana activities, except that a licensee may have a transporter license in addition to a license to cultivate, process, or dispense medical marijuana.

(2) A licensee shall not be an officer, director, member, owner, or shareholder in another entity licensed pursuant to this part. The officers, directors, owners, members, or shareholders of a licensee in one class of license may not hold a license in another class, and may not be an officer, director, member, owner, or shareholder of an entity licensed pursuant to this part.

18101.3. Beginning January 1, 2015, the bureau shall provide for provisional licenses, as follows:

(a) The bureau shall request that every city, county, or city and county provide the bureau with a list of approved entities providing medical marijuana to qualified patients and caregivers within the

city's, county's, or city and county's jurisdiction, if any, the location at which the entity is operating, and the names of the persons who operate the entity.

(1) If the jurisdiction represents that the entity has been operating in compliance with local laws and regulations, or has limited immunity under local laws, including, but not limited to, Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, the bureau shall issue a provisional license to the entity until the time that the entity's application for a license has been approved or denied under this part, but no later than 90 days after the bureau begins accepting applications for licenses.

(2) The bureau shall consult with relevant local agencies in making a determination on whether a provisional license applicant is in compliance with any applicable ordinance. The bureau shall issue a provisional license to an individual or entity once the bureau has obtained confirmation from the relevant local agency that the six months prior to January 1, 2015, the applicant was regularly cultivating or distributing medical marijuana collectively or cooperatively in full compliance with any applicable local ordinance. The bureau shall continue to issue provisional licenses until such time as the licensee's application for a standard license has been approved or denied under this part, but no later than 90 days after the bureau begins accepting applications. To qualify for a provisional license, an applicant shall be required to disclose to the bureau the following information in writing on or before January 20, 2015, in order to obtain provisional licensure:

(A) The names, addresses, and dates of birth of each principal officer, owner, or board member.

(B) The common street address and assessor's parcel number of the property at which the applicant will conduct any activity under the authority of the license.

(C) The common street address and assessor's parcel number of the property at which any cultivation activity was or is to be conducted.

(D) For the six months prior to January 1, 2015, the quantity of medical marijuana cultivated at a location and the quantity expected to be cultivated from January 1, 2015, to June 30, 2015, inclusive. The applicant shall make its records of current activity

and activity for the six months prior to January 1, 2015, available to the bureau upon request.

(b) The bureau shall charge an application fee of eight thousand dollars ($8,000) for each provisional license.

(c) Notwithstanding any other provision of this section, the bureau shall not issue a provisional license to any individual or entity, or for any premises, against whom there are pending state or local administrative or judicial proceedings or actions initiated by a city, county, or city and county under any applicable local ordinance or who has been determined through those proceedings to have violated any applicable local ordinance.

18101.35. Beginning July 1, 2016, the bureau shall provide for standard licenses as follows:

(a) The bureau shall request that every city, county, or city and county provide the bureau with a list of approved entities providing medical marijuana to qualified patients and caregivers within the city's, county's, or city and county's jurisdiction, if any, the location at which the entity is operating, and the names of the persons who operate the entity.

(b) If the jurisdiction represents that the entity has been operating in compliance with local laws and regulations, or has limited immunity under local laws, including, but not limited to, Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, the bureau shall issue a license to the entity if it meets the licensing requirements of this part.

(c) The bureau shall consult with relevant local agencies in making a determination as to whether a standard license applicant is in compliance with local ordinances. The bureau shall issue a standard license only after it has obtained confirmation from the relevant local agency that the applicant has satisfied all local permitting requirements for cultivating or distributing medical marijuana in compliance with local ordinances, and fulfilled all other requirements under this part.

(d) The bureau shall charge an application fee of eight thousand dollars ($8,000) for each standard license.

18101.4. (a) The Medical Marijuana Regulation Fund is hereby established within the State Treasury. Notwithstanding Section 16305.7 of the Government Code, the fund shall include any interest and dividends earned on the money in the fund.

(b) All fees collected pursuant to this part shall be deposited into the Medical Marijuana Regulation Fund. Notwithstanding Section 13340 of the Government Code, all moneys within the fund are hereby continuously appropriated, without regard to fiscal year, to the bureau solely for the purposes of fully funding and administering this part, including, but not limited to, the costs incurred by the bureau for its administrative expenses.

(c) All moneys collected pursuant to this part as a result of penalties imposed under this part shall be deposited directly into the General Fund, to be available upon appropriation.

(d) The bureau may establish and administer a grant program to allocate moneys from the Medical Marijuana Regulation Fund to state and local entities for the purpose of assisting with medical marijuana regulation and the enforcement of this part and other state and local laws applicable to licensees.

18102. (a) A facility licensed pursuant to this part shall not acquire, cultivate, process, possess, store, manufacture, ~~test,~~ distribute, sell, 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 of the Health and Safety Code.

(b) A licensed dispensing facility shall not acquire, cultivate, process, possess, store, manufacture, ~~test,~~ distribute, sell, deliver, transfer, transport, or dispense marijuana plants or marijuana products except through a licensed cultivation site or processing facility.

18103. (a) A licensed transporter shall ship only to facilities licensed pursuant to this part and only in response to a request for a specific quantity and variety from those facilities.

(b) Prior to transporting any medical marijuana product, a licensed transporter shall do the following:

(1) Complete a shipping manifest using a form prescribed by the ~~department.~~ *bureau.*

(2) Securely transmit a copy of the manifest to the licensee that will receive the medical marijuana product, and to the ~~department,~~ *bureau,* prior to transport.

(c) The licensed transporter making the shipment and the licensee receiving the shipment shall maintain each shipping manifest and make it available to local code enforcement officers,

any other locally designated enforcement entity, and the ~~department~~ *bureau* upon request.

18104. (a) Transported medical marijuana products shall:

(1) Be transported only in a locked, safe and secure storage compartment that is securely affixed to the interior of the transporting vehicle.

(2) Not be visible from outside the vehicle.

(b) Any vehicle transporting medical marijuana products shall travel directly from one licensed facility to another licensed facility authorized to receive the shipment.

18105. (a) All transport vehicles shall be staffed with a minimum of two employees. At least one transport team member shall remain with the vehicle at all times that the vehicle contains medical marijuana.

(b) Each transport team member shall have access to a secure form of communication by which each member can communicate with personnel at the licensed facility at all times that the vehicle contains medical marijuana.

(c) Each transport team member shall possess documentation of licensing and a government-issued identification card at all times when transporting or delivering medical marijuana and shall produce it to any representative of the department or law enforcement official upon request.

(d) This part shall not be construed to authorize or permit any licensee to transport, or cause to be transported, marijuana or marijuana products outside the state.

18105.5. A local jurisdiction shall not prevent transportation through or to a licensed entity by a licensed transporter who acts in compliance with this part.

~~18106. (a) The department shall have the authority, subject to local ordinances, to license persons for the cultivation, manufacture, testing, transportation, storage, and sale of medical marijuana within the state, and to levy appropriate related licensing fees not to exceed the reasonable costs of enforcement and administration of this part. The department shall not issue a license if the applicant has not met all requirements pursuant to Section 18101. A license, once issued, shall be suspended within five days of notification to the department by a local agency that a licensee is no longer in compliance with local ordinances or regulation.~~

~~(b)~~

18106. (a) The ~~department~~ *bureau* shall promulgate, by July 1, 2016, regulations for implementation and enforcement of this part, including all of the following:

(1) Procedures for the issuance, renewal, suspension, and revocation of licenses.

(2) Application, licensing, and renewal forms and fees.

(3) A time period in which the ~~department~~ *bureau* shall approve or deny an application for a license to operate a facility or dispensary.

(4) Qualifications for licensees.

(5) Standards for certification of testing laboratories to perform random sample testing of all marijuana products intended for sale, to identify and eliminate chemical residue, microbiological contaminants, and mold.

(6) Requirements to ensure conformance with standards analogous to state statutory environmental, agricultural, consumer protection, and food and product safety requirements. At a minimum, these standards shall do all of the following:

(A) Prescribe sanitation standards analogous to the California Retail Food Code (Part 7 (commencing with Section 113700) of Division 104 of the Health and Safety Code) for food preparation, storage, and handling and sale of edible marijuana products.

(B) Require that edible marijuana products produced, distributed, provided, donated, or sold by licensees shall be limited to nonpotentially hazardous food as established by the State Department of Public Health pursuant to Section 114365.5 of Health and Safety Code.

(C) Provide standards for labeling edible marijuana products to ensure that the products cannot be mistaken as food not containing marijuana.

(D) Require that facilities in which edible marijuana products are prepared shall be constructed in accordance with applicable building standards, health and safety standards, and other state laws.

(E) Provide that any weighing or measuring devices used in connection with the sale or distribution of marijuana are required to meet standards analogous to Division 5 (commencing with Section 12001).

(F) Require that any application of pesticides or other pest control in connection with the indoor or outdoor cultivation of

marijuana shall meet standards analogous to Division 6 (commencing with Section 11401) of the Food and Agricultural Code and its implementing regulations.

~~(c)~~

(b) The ~~department~~ *bureau* shall promulgate, by July 1, 2016, regulations for minimum statewide health and safety standards and quality assurance standards pursuant to Section 111658 of the Health and Safety Code associated with the cultivation, transport, storage, and sale of all medical marijuana produced in this state. Local agencies shall have primary responsibility for enforcement of these standards in accordance with ~~department~~ *bureau* regulations.

~~(d)~~

(c) An application for or renewal of a license shall not be approved if the ~~department~~ *bureau* determines any of the following:

(1) The applicant fails to meet the requirements of this part or any regulation adopted pursuant to this part or any applicable ~~city or~~ *city* county, *or city and county* ordinance or regulation.

(2) The applicant, or any of its officers, directors, owners, members, or shareholders is a minor.

(3) The applicant has knowingly answered a question or request for information falsely on the application form, or failed to provide information requested.

(4) The applicant, or any of its officers, directors, owners, members, or shareholders has been sanctioned by the ~~department,~~ *bureau,* a city, county, or city and county, for marijuana activities conducted in violation of this part or any applicable local ordinance or has had a license revoked in the previous five years.

(5) The proposed cultivation, processing, possession, storage, manufacturing, testing, transporting, distribution, provision, or sale of medical marijuana will violate any applicable local law or ordinance.

(6) (A) The bureau shall deny an application for a license if issuance of that license would tend to create a law enforcement problem, or if issuance would result in or add to an undue concentration of licenses.

(B) For purposes of this paragraph, the following definitions shall apply:

(i) "Population within the census tract or census division" means the population as determined by the most recent United

States decennial or special census. The population determination shall not operate to prevent an applicant from establishing that an increase of resident population has occurred within the census tract or census division.

(ii) "Reported crimes" means the most recent yearly compilation by the local law enforcement agency of reported offenses of criminal homicide, forcible rape, robbery, aggravated assault, burglary, larceny, theft, and motor vehicle theft, combined with all arrests for other crimes, both felonies and misdemeanors, except traffic citations.

(iii) "Reporting districts" means geographical areas within the boundaries of a single governmental entity (city or the unincorporated area of a county) that are identified by the local law enforcement agency in the compilation and maintenance of statistical information on reported crimes and arrests.

(iv) "Undue concentration" means:

(I) The applicant premises are located in a crime reporting district that has a 20 percent greater number of reported crimes than the average number of reported crimes as determined from all crime reporting districts within the jurisdiction of the local law enforcement agency.

(II) The ratio of licenses to population within the census tract or census division in which the applicant premises are located exceeds the ratio of licenses to population in the county in which the applicant premises are located.

~~(e)~~

(d) The ~~department~~ *bureau* may consult with other state agencies, state departments, public entities, or private entities for the purposes of establishing statewide standards and regulations.

~~(f)~~

(e) The ~~department~~ *bureau* may assist state taxation authorities in the development of uniform policies for the state taxation of licensees.

~~(g)~~

(f) The ~~department~~ *bureau* may assist the Division of Occupational Safety and Health in the Department of Industrial Relations in the development of industry-specific regulations related to the activities of licensees.

18107. (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.

(b) Advertising for physician recommendations for medical marijuana shall meet all requirements of Section 651. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discounts, premiums, gifts, or statements of a similar nature.

18108. (a) A facility licensed pursuant to this part 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 qualifying patients, the patient's primary caregiver, 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~~ *secured and locked room, safe, or vault,* and in a manner as to prevent diversion, theft, and loss.

(b) A facility licensed pursuant to this part 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 reweigh, reinventory, and account for on video, all transported marijuana.

18108.5. (a) The ~~department~~ *bureau* shall require an annual audit of all licensees licensed pursuant to this part or otherwise licensed by the ~~department~~ *bureau* to cultivate, manufacture, process, ~~test,~~ transport, store, or sell marijuana to be paid for by each licensed vendor and dispensary.

(b) Completed audit reports shall also be submitted by the licensee to local code enforcement offices, or the appropriate locally designated enforcement entity, within 30 days of the completion of the audit.

(c) It is the responsibility of each licensee licensed pursuant to this part or otherwise licensed by the ~~department~~ *bureau* to cultivate, manufacture, process, ~~test,~~ transport, store, or sell marijuana to develop a robust quality assurance protocol that includes all of the provisions of this part.

18108.6. (a) A laboratory certified by the bureau to perform random sample testing of marijuana products pursuant to paragraph (5) of subdivision (a) of Section 18106 shall not acquire, cultivate, process, possess, store, manufacture, distribute, sell, 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 of the Health and Safety Code.

(b) A laboratory certified by the bureau to perform random sample testing of marijuana products pursuant to paragraph (5) of subdivision (a) of Section 18106 shall not acquire, cultivate, process, possess, store, manufacture, distribute, sell, deliver, transfer, transport, or dispense marijuana plants or marijuana products except through a licensed cultivation site, or processing facility.

18109. In addition to the provisions of this part, a license granted pursuant to this part 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 part, a facility shall not operate in a local jurisdiction that prohibits the establishment of that type of business.

~~18110. Violation of this part shall be punishable by a civil fine of up to thirty-five thousand dollars ($35,000) for each individual violation.~~

18110. (a) A willful violation of Section 18101.2, including any attempt to falsify information on an application as required by Section 18101.2, or to otherwise defraud or mislead a state or local agency in the course of the application process, shall be punishable by a civil fine of up to thirty-five thousand dollars ($35,000) for each individual violation. This subdivision shall apply to both the provisional and permanent licensing application processes under this part.

(b) A technical violation of Section 18101.2 shall, at the bureau's discretion, be punishable by a civil fine of up to ten thousand dollars ($10,000) for each individual violation. This subdivision shall apply to both the provisional and permanent licensing application processes under this part.

18110.1. The executive officer or any district attorney, county counsel, city attorney, or city prosecutor may bring an action to enjoin a violation or the threatened violation of any provision of this part, including, but not limited to, a licensee's failure to correct objectionable conditions following notice or as a result of any rule promulgated pursuant to this part. The action shall be brought in the county in which the violation occurred or is threatened to occur. Any proceeding brought pursuant to this part shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure. Nothing in this section shall diminish the authority of local government to take requisite enforcement actions pertaining to its own ordinances or regulations.

18111. Nothing in this part shall prevent a city or other local governing body from taking action as specified in Section 11362.83 of the Health and Safety Code.

18112. This part shall in no way supersede the provisions of Measure D, approved by the voters of the City of Los Angeles on

the May 21, 2013, ballot for the city, which granted marijuana businesses and dispensaries qualified immunity consistent with the terms of the measure and local ordinances. Notwithstanding the provisions of this part, marijuana businesses and dispensaries subject to the provisions of Measure D and its qualified immunity shall continue to be subject to the ordinances and regulations of the City of Los Angeles.

~~18113. (a) This part shall not apply to, and shall have no diminishing effect on, the rights and protections granted to a patient or a primary caregiver pursuant to the Compassionate Use Act of 1996.~~

~~(b) (1)~~

18113. (a) A patient who cultivates, possesses, stores, manufactures, or transports marijuana exclusively for his or her personal medical use and who does not sell, distribute, donate, or provide marijuana to any other person is not considered a licensee under this part and is exempt from licensure under this part.

~~(2)~~

(b) A primary caregiver who cultivates, possesses, stores, manufactures, transports, or provides marijuana exclusively for the personal medical purposes of ~~a~~ *no more than five* specified qualified ~~patient~~ *patients* for whom he or she is the primary caregiver within the meaning of Section 11362.7 of the Health and Safety Code and who does not receive remuneration for these activities except for compensation in full compliance with subdivision (c) of Section 11362.765 of the Health and Safety Code is not considered a licensee under this part and is exempt from licensure under this part.

18114. (a) Information identifying the names of patients, their medical conditions, or the names of their primary caregivers received and contained in records kept by the bureau for the purposes of administering this part are confidential and exempt from the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and are not subject to disclosure to any individual or private entity, except as necessary for authorized employees of the State of California to perform official duties pursuant to this part:

(b) (1) Nothing in this section shall preclude any of the following:

(A) Bureau employees notifying state or local agencies about information submitted to the bureau that the employee suspects is falsified or fraudulent.

(B) Notifications from the bureau to state or local agencies of apparent violations of this part or any applicable local ordinance.

(C) Verification of requests by state or local agencies to confirm licenses and certificates issued by the bureau or other state agency.

(D) Provision of information requested pursuant to a court order or subpoena issued by a court or an administrative agency or local governing body authorized by law to issue subpoenas.

(2) Information shall not be disclosed beyond what is necessary to achieve the goals of a specific investigation or notification or the parameters of a specific court order or subpoena.

18115. (a) The actions of a licensee or provisional licensee, its employees, and its agents, permitted pursuant to a license or provisional license issued by the bureau or otherwise permitted by this part, that are conducted in accordance to the requirements of this part and regulations adopted pursuant to the authority granted by this part, are not unlawful under state law and shall not be an offense subject to arrest or prosecution.

(b) The actions of a person who, in good faith and upon investigation, allows his or her property to be used by a licensee or provisional licensee, its employees, and its agents, as permitted pursuant to a license or provisional license issued by the bureau or otherwise permitted by this part, are not unlawful under state law and shall not be an offense subject to arrest or prosecution.

(c) This section shall not be deemed to limit the authority or remedies of a city, county, or city and county under any provision of law, including, without limitation, Section 7 of Article XI of the California Constitution.

18116. (a) A licensee shall not cultivate, process, store, manufacture, transport, or sell medical marijuana in the state unless accurate records are kept at the licensed premises of the growing, processing, storing, manufacturing, transporting, or selling by the licensee in the state. These records shall include the name and address of the supplier of any marijuana received or possessed by the licensee, the location at which the marijuana was cultivated, the amount of marijuana received, the form in which it is received, the name of the employee receiving it, and the date of receipt. These records shall also include receipts for all

expenditures incurred by the licensee and banking records, if any, for all funds obtained or expended in the performance of any activity under the authority of the license, provided that a licensee licensed to act at more than one premises may keep all records at one of the licensed premises. Required records shall be kept for a period of seven years from the date of the transaction.

(b) The bureau and any state or local agency may make any examination of the books and records of any licensee and may visit and inspect the premises of any licensee that the bureau may deem necessary to perform its duties under this part.

(c) Any books or records requested by the bureau or any state or local agency shall be provided by the licensee no later than at the end of the next business day after the request is made.

(d) The bureau or any state or local agency may enter and inspect the premises of any facility operated by a licensee between the hours of 8 a.m. and 8 p.m. on any day that the facility is open, or at any reasonable time, to ensure compliance and enforcement of the provisions of this part or any local ordinance.

(e) If a licensee or any employee of a licensee refuses, impedes, obstructs, or interferes with an inspection pursuant to this part or local ordinance, or if the licensee fails to maintain or provide the books and records required by this section, the licensee may be summarily suspended pursuant to this part and the bureau shall directly commence proceedings for the revocation of the license in accordance with this part.

SEC. 5. Section 23028 is added to the Government Code, to read:

23028. (a) (1) In addition to any authority otherwise provided by law, the board of supervisors of any county may impose, by ordinance, a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing marijuana by a licensee operating pursuant to Chapter 18 (commencing with Section 26000) of Division 9 of the Business and Professions Code. The tax may be imposed for general governmental purposes or for purposes specified in the ordinance by the board of supervisors.

(2) The board of supervisors shall specify in the ordinance proposing the tax the activities subject to the tax, the applicable rate or rates, the method of apportionment, and the manner of collection of the tax. A tax imposed pursuant to this section is a

tax and not a fee or special assessment, and the tax is not required to be apportioned on the basis of benefit to any person or property or be applied uniformly to all taxpayers or all real property.

(3) A tax imposed by a county pursuant to this section by a county may include a transactions and use tax imposed solely for marijuana or marijuana products, which shall otherwise conform to Part 1.6 (commencing with Section 7251) of Division 2 of the Revenue and Taxation Code. Notwithstanding Section 7251.1 of the Revenue and Taxation Code, the tax may be imposed at any rate specified by the board of supervisors, and the tax rate authorized by this section shall not be considered for purposes of the combined tax rate limitation established by that section.

(4) The tax authorized by this section may be imposed upon any or all of the activities set forth in paragraph (1), regardless of whether the activity is undertaken individually, collectively, or cooperatively, and regardless of whether the activity is for compensation or gratuitously, as determined by the board of supervisors.

(5) The board of supervisors shall specify whether the tax applies throughout the entire county or within the unincorporated area of the county.

(b) In addition to any other method of collection authorized by law, the board of supervisors may provide for collection of the tax imposed pursuant to this section in the same manner, and subject to the same penalties and priority of lien, as other charges and taxes fixed and collected by the county.

(c) Any tax imposed pursuant to this section shall be subject to applicable voter approval requirements imposed by any other law.

(d) For purposes of this section, "marijuana" shall have the meanings set forth in Section 18100 of the Business and Professions Code.

(e) This section does not limit or prohibit the levy or collection or any other fee, charge, or tax, or any license or service fee or charge upon, or related to, the activities set forth in subdivision (a) as otherwise provided by law. This section shall not be construed as a limitation upon the taxing authority of any county as provided by other law.

~~SEC. 5.~~

SEC. 6. Article 8 (commencing with Section 111658) is added to Chapter 6 of Part 5 of Division 104 of the Health and Safety Code, to read:

Article 8. Medical Marijuana

111658. For purpose of this article, the following definitions shall apply:

(a) "Bureau" means the Bureau of Medical Marijuana Regulations in the Department of Consumer Affairs.

~~(a)~~

(b) "Certified testing laboratories" means a laboratory that is certified by the ~~department~~ *bureau* to perform random sample testing of marijuana pursuant to the certification standards for those facilities promulgated by the ~~department.~~ *bureau.*

~~(b) "Department" means the Department of Consumer Affairs.~~

(c) "Edible marijuana product" means marijuana or a marijuana-derived product that is ingested or meant to be ingested through the mouth and into the digestive system.

~~(d) "Marijuana" means marijuana, as defined by Section 11018.~~

(d) "Marijuana" means all parts of the plant Cannabis sativa L. sativa, cannabis indica, or cannabis ruderalis, whether growing or not; the seeds thereof; the resin, whether crude or purified, extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or resin. "Marijuana" does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination. "Marijuana" also means marijuana, as defined by Section 11018.

(e) "Representative samples" means samples taken from each batch or shipment of marijuana received from a licensed cultivation site or any other source if intended for sale.

111659. The ~~department,~~ *bureau,* by July 1, 2016, shall accomplish the following:

(a) Establish quality assurance protocols to ensure uniform testing standards for all marijuana sold via dispensaries or other

facilities, or cultivated by any facilities, that are licensed pursuant to Part 5 (commencing with Section 18100) of Division 7 of the Business and Professions Code.

(b) In consultation with outside entities at its discretion, develop a list of certified testing laboratories that can perform uniform testing in compliance with this article, and post that list on its Internet Web site.

111660. (a) Licensees licensed pursuant to Part 5 (commencing with Section 18100) of Division 7 of the Business and Professions Code shall bear the responsibility for contracting with certified testing laboratories for regular, systematic testing of representative samples of all marijuana cultivated or intended for sale or distribution, and shall bear the cost of that testing.

(b) Licensees licensed pursuant to Part 5 (commencing with Section 18100) of Division 7 of the Business and Professions Code shall provide results of test reports to local code enforcement officers, any other locally designated enforcement entity, and the ~~department~~ *bureau* both on a quarterly basis and upon request.

111661. Quality assurance protocols shall be required between all licensed cultivation sites or licensed processing facilities and licensed dispensing facilities to guarantee safe and reliable medicinal marijuana delivery to all patients. These quality assurance protocols shall include:

(a) Providing of supplier information to dispensaries in order for recall procedures to be implemented, if and when necessary.

(b) Safety testing of all marijuana prior to packaging for sale and patient exposure to identify and eliminate microbiological contaminants and chemical residue.

(c) Labeling of all marijuana and marijuana products that shall, at a minimum, include the following:

(1) Clear dosage in total milligrams delivered for all products.

(2) Clear indication, in bold font, that the product contains marijuana.

(3) Tetrahydrocannabinol (THC) and cannabidiol (CBD) content.

111662. For purposes of this article, edible marijuana products are deemed to be unadulterated food products. In addition to the quality assurance standards provided in Section 111661, all edible marijuana products shall comply with the following requirements:

(a) Baked edible marijuana products (such as brownies, bars, cookies, and cakes), tinctures, and other edible marijuana products that do not require refrigeration or hot holding may be manufactured, sold, or otherwise distributed at facilities licensed pursuant to Part 5 (commencing with Section 18100) of Division 7 of the Business and Professions Code.

(b) Licensed marijuana facilities shall have an owner or employee who has successfully passed an approved and accredited food safety certification examination as specified in Sections 113947.1, 113947.2, and 113947.3 of the Health and Safety Code prior to selling, manufacturing, or distributing edible marijuana products requiring refrigeration or hot holding.

(c) Individuals' manufacturing or selling edible marijuana products shall thoroughly wash their hands before commencing production and before handling finished edible marijuana products.

(d) All edible marijuana products shall be individually wrapped at the original point of preparation. All edible marijuana products shall be packaged in a fashion that does not exceed a single individual serving size.

(e) Products containing tetrahydrocannabinol (THC) shall be prepared in compliance with maximum potency standards for THC and THC concentrates set forth in the ~~department's~~ *bureau's* regulations.

(f) Prior to sale or distribution at a licensed dispensing facility, edible marijuana products shall be labeled and in an opaque and tamper evident package. Labels and packages of edible marijuana products shall meet the following requirements:

(1) Edible marijuana packages and labels shall not be made to be attractive to children.

(2) All edible marijuana product labels shall include the following information, prominently displayed and in a clear and legible font:

(A) Manufacture date.

(B) The statement "KEEP OUT OF REACH OF CHILDREN."

(C) The statement "FOR MEDICAL USE ONLY."

(D) Net weight of marijuana in package.

(E) A warning, if nuts or other known allergens are used, and shall include the total weight, in ounces or grams, of marijuana in the package.

(F) Tetrahydrocannabinol (THC) and cannabidiol (CBD) content.

(g) Photos or images of food are not allowed on edible marijuana product packages or labels.

(h) Only generic food names may be used to describe edible marijuana products. For example, "snickerdoodle" may not be used to describe a cinnamon cookie.

~~SEC. 6. Chapter 3.8 (commencing with Section 7295) is added to Part 1.7 of Division 2 of the Revenue and Taxation Code, to read:~~

~~CHAPTER 3.8. MEDICAL MARIJUANA~~

~~7295. (a) In addition to any authority otherwise provided by law, the legislative body of any county may levy a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, or distributing marijuana or products containing marijuana.~~

~~(b) The tax may be levied for general governmental purposes or for specific purposes specified by the legislative body.~~

~~(c) The legislative body shall specify the activities subject to the tax, the applicable rate or rates, the method of apportionment, and manner of collection of the tax. A tax imposed pursuant to this section is a tax and not a fee or special assessment, and there is no requirement that the tax be apportioned on the basis of benefit to any property or be applied uniformly to all taxpayers or all real property. The tax imposed pursuant to this section may be based on any reasonable basis as determined by the legislative body.~~

~~(d) In addition to any other method of collection authorized by law, the legislative body may provide for collection of the tax imposed pursuant to this section in the same manner, and subject to the same penalties and priority of lien as, other charges and taxes fixed and collected by the county.~~

~~(e) The tax may be imposed upon any or all of the activities set forth in subdivision (a), regardless of whether the activity is undertaken individually, collectively, or cooperatively, and regardless of whether the activity is undertaken for compensation or without compensation or profit, as determined by the legislative body.~~

~~(f) Any tax levied pursuant to this section shall be subject to any applicable voter approval requirement imposed by any other provision of law.~~

~~(g) The tax, when levied by the legislative body of a county, shall apply throughout the entire county or within the unincorporated area of the county, as specified by the legislative body.~~

~~(h) For purposes of this section, "marijuana" means marijuana, as defined by Section 11018 of the Health and Safety Code.~~

~~(i) This section is declaratory of existing law, and does not limit or prohibit the levy or collection or any other fee, charge, or tax, or any license or service fee or charge upon, or related to, the activities set forth in subdivision (a) as provided by other provisions of law.~~

SEC. 7. The provisions of this act are severable. If any provision of this act 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.

SEC. 8. The Legislature finds and declares that Section 4 of this act imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitation imposed under this act is necessary for purposes of compliance with the federal Health Insurance Portability and Accountability Act (42 U.S.C. Sec. 1320d et seq.), the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and the Insurance Information Privacy Protection Act (Article 6.6 (commencing with Section 79) of Chapter 1 of Part 2 of Division 1 of the Insurance Code).

~~SEC. 7.~~

SEC. 9. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty

for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MBC TRACKER II BILLS
7/17/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 357	Pan	California Healthy Child Advisory Task Force	Sen. Approps	07/01/14
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 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	Sen. Approps	06/30/14
AB 1310	Bonta	Medi-Cal: Telehealth	Sen. Approps	07/01/14
AB 1558	Hernandez	California Health Data Organization	Sen. Approps	06/05/14
AB 1575	Pan	Public Contracts for Services	Sen. Approps	05/20/14
AB 1592	Gaines	California Diabetes Program	Sen. Approps	06/23/14
AB 1612	Donnelly	State Government: Regulations	Sen. Approps	05/23/14
AB 1621	Lowenthal	Emergency Medical Services: Data and Informaiton System	Sen. Approps	06/24/14
AB 1650	Jones-Sawyer	Public Contracts: Bidders	Sen. Approps	05/28/14
AB 1702	Maienschein	Professions and Vocations: Incarceration	Sen. 3rd Reading	04/23/14
AB 1727	Rodriguez	Prescription Drugs: Collection and Distribution Program	Enrolled	06/15/14
AB 1735	Hall	Nitrous Oxide: Dispensing and Distributing	Sen. Approps	07/01/14
AB 1743	Ting	Hypodermic Needles and Syringes	Sen. 3rd Reading	05/27/14
AB 1755	Gomez	Medical Information	Sen. 3rd Reading	07/01/14
AB 1758	Patterson	Healing Arts: Initial License Fees: Proration	Sen. Approps	06/30/14
AB 1812	Pan	Health Facilities: Information: Disclosure	Assembly	06/17/14
AB 1822	Bonta	Tissue Banks	Sen. Approps	05/28/14
AB 1868	Gomez	Medi-Cal: Optional Benefits: Podiatric Medicine	Sen. Approps	06/10/14
AB 1890	Chau	Athletic Trainers	Enrolled	05/13/14
AB 1898	Brown	Public Health Records: Reporting: HIV/AIDS	Sen. 3rd Reading	05/06/14

MBC TRACKER II BILLS
7/17/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1917	Gordon	Outpatient Prescription Drugs: Cost Sharing	Sen. Approps	06/24/14
AB 1921	Holden	Public Contracts for Services: Access to Records	Sen. Approps	04/28/14
AB 2052	Gonzalez	Worker's Compensation	Sen. Approps	04/08/14
AB 2058	Wilk	Open Meetings	Sen. 3rd Reading	06/19/14
AB 2059	Muratsuchi	Medical Records: Electronic Delivery	Sen. 3rd Reading	06/15/14
AB 2062	Hernandez	Health Facilities: Surgical Technologists	Sen. Approps	07/03/14
AB 2069	Maienschein	Immunizations: Influenza	Sen. Approps	04/24/14
AB 2102	Ting	Licensees: Data Collection	Sen. Approps	06/02/14
AB 2143	Williams	Clinical Laboratories: Chiropractors	Sen. Approps	05/27/14
AB 2198	Levine	Mental Health Professionals: Suicide Prevention Training	Sen. Approps	04/21/14
AB 2232	Gray	UC: Medical Education	Sen. Approps	06/12/14
AB 2374	Mansoor	Substance Abuse: Recovery and Treatment Services	Sen. Approps	07/01/14
AB 2387	Pan	Commission on Peace Officer Standards and Training	Sen. 3rd Reading	04/21/14
AB 2396	Bonta	Convictions: Expungement: Licenses	Sen. Approps	05/15/14
AB 2399	Perez	Organ and Tissue Donor Registry: Driver's License	Sen. Approps	04/24/14
AB 2418	Bonilla	Health Care Coverage: Prescription Drug Refills	Sen. Approps	07/03/14
AB 2471	Frazier	Public Contracts: Change Orders	Sen. Approps	06/30/14
AB 2491	Nestande	Substance Abuse: Adult Recovery Maintenance Facilities	Sen. Approps	07/01/14
AB 2605	Bonilla	Pharmacy: Third-Party Logistics Providers	Sen. Approps	06/17/14
AB 2616	Skinner	Workers Compensation: Hospital Employers	Sen. Approps	04/29/14
AB 2675	Lowenthal	State Agency: Public Contracts	Sen. Approps	
AB 2720	Ting	State Agencies: Meetings: Record of Action Taken	Senate	04/02/14
AB 2723	Medina	Administrative Procedure: Small Business	Sen. Approps	05/01/14
AB 2757	Bocanegra	Centralized Hospital Packaging Pharmacies: Medication Labels	Sen. Approps	07/02/14
ACR 93	Buchanan	Prescription Drug Abuse Awareness Month	Chaptered, #23	03/24/14

MBC TRACKER II BILLS
7/17/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
ACR 107	Bloom	Year of the Family Physician	Chaptered, #82	
ACR 110	Fox	Health Care District Month	Chaptered, #55	05/08/14
ACR 111	Levine	Colorectal Cancer Awareness Month	Chaptered, #25	03/20/14
ACR 125	Perez	Donate Life California Day: Driver's License	Chaptered, #27	04/07/14
ACR 152	Pan	Patient Centered Medical Homes	Senate	07/03/14
SB 18	Leno	Medi-Cal Renewal	Asm. Approps	06/30/14
SB 20	Hernandez	Individual Health Care Coverage: Enrollment Periods	Chaptered, #24	05/08/14
SB 204	Corbett	Prescription Drugs: Labeling	Asm. 3rd Reading	06/10/14
SB 266	Lieu	Prevailing Wages	Asm. Approps	06/30/14
SB 570	DeSaulnier	Advanced Alcohol and Drug Licensing Act	Asm. Approps	07/02/14
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	Asm. Approps	06/25/14
SB 600	Lieu	Drugs	Asm. Approps	06/30/14
SB 852	Leno	Budget Act of 2014	Chaptered, #25	05/14/14
SB 906	Correa	Elective Percutaneous Coronary Intervention Offsite Program	Asm. Approps	06/04/14
SB 973	Hernandez	Narcotic Treatment Programs	Assembly	06/02/14
SB 1014	Jackson	Pharmaceutical Waste: Home Generated	Asm. Approps	06/30/14
SB 1039	Hernandez	Pharmacy: Third-Party Logistics Providers	Asm. Approps	06/26/14
SB 1053	Mitchell	Health Care Coverage: Contraceptives	Asm. Approps	07/02/14
SB 1135	Jackson	Inmates: Sterilization	Asm. Approps	06/26/14
SB 1159	Lara	Professions and Vocations: Federal Tax ID Number	Asm. Approps	06/30/14
SB 1176	Steinberg	Health Care Coverage: Cost Sharing: Tracking	Asm. Approps	06/24/14
SB 1193	Evans	Controlled Substances: Marijuana	Asm. Approps	06/19/14
SB 1256	Mitchell	Medical Services: Credit	Assembly	06/25/14
SB 1266	Huff	Pupil Health: Epinephrine Auto-Injectors	Asm. Approps	07/01/14
SB 1315	Monning	Medi-Cal: Providers	Asm. Approps	06/30/14

MBC TRACKER II BILLS
7/17/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1322	Hernandez	California Health Care Cost and Quality Database	Asm. Approps	06/30/14
SB 1337	DeSaulnier	Reports	Assembly	05/27/14
SB 1340	Hernandez	Health Care Coverage: Provider Contracts	Chaptered, #83	03/24/14
SB 1438	Pavley	Controlled Substances: Opioid Antagonists	Asm. Approps	06/11/14
SB 1445	Evans	Developmental Services: Telehealth	Assembly	06/25/14
SB 1457	Evans	Medical Care: Electronic Treatment Authorization Requests	Asm. Approps	06/30/14
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	To DCA for final review and approval	7/19/13	9/06/13	10/25/13	5/02/14	6/19/14 Final package to DCA for review and approval		
PA – Supervision Requirements	The 15-day comment period ended 6/10/14 Preparing final package for submission to DCA	10/25/13	12/13/13	2/07/14	5/02/14			

Prepared by Chris Valine
Updated July 7, 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.