State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board and Committee Meetings
October 23-24, 2014

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Sheraton San Diego Hotel and Marina
1380 Harbor Island Drive
San Diego, CA 92101

October 23 – 24, 2014

Thursday, October 23

- **9:30 a.m. – 11:00 a.m.** **Panel A (Room: Fairbanks C&D)**
  (*Members: Yaroslavsky (Chair), Bishop, Lewis, Serrano Sewell, Wright, Yip)*

- **9:30 a.m. – 11:00 a.m.** **Panel B (Room: Fairbanks A&B)**
  (Members: GnanaDev (Chair), Krauss, Levine, Lui, Pines, Schipske)

- **11:00 a.m. – 12:30 p.m.** **Enforcement Committee Meeting (Room: Fairbanks A&B)**
  (Members: Lewis (Chair), Krauss, Lui, Schipske, Serrano Sewell, Yaroslavsky, Yip)

- **12:30 p.m. – 1:30 p.m.** **Lunch Break**

- **1:30 p.m. – 3:30 p.m.** **Executive Committee Meeting (Room: Fairbanks A&B)**
  (Members: Serrano Sewell (Chair), Bishop, Levine, Lewis, Pines, GnanaDev, Yaroslavsky)

- **3:45 p.m. – 5:45 p.m.** **Full Board Meeting (Room: Fairbanks A&B)**
  (All Members)

Friday, October 24

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

Sign Up for CURES at the Medical Board of California October Board Meeting in San Diego

Effective January 1, 2016, all California licensed physicians must be registered to access PDMP/CURES (as required by Section 209 of the California Business and Professions Code). Registering for CURES access allows the physician to access patient activity reports before prescribing controlled substances. The current registration process requires the physician to complete the online application and have the application notarized.

The Medical Board of California has volunteered to assist physicians in registering for access to CURES by reviewing the completed documents and verifying the physician's identity in place of the requirement to have the documents notarized. MBC is authorized to accept the applications and forward them directly to the Department of Justice for expedited processing.

MEETING LOCATION: **Sheraton San Diego Hotel and Marina**
1380 Harbor Island Drive
San Diego, CA 92101

BEFORE COMING TO THE MEETING:

You must start the process by going to oag.ca.gov/cures-pdmp. Select "prescriber," then:

1. **Complete** the online application form
2. **Print** the completed form, then sign and date it
3. **Attach** a copy of:
    - Your CA medical license
    - DEA controlled substances registration
    - Driver's license or other photo government identification

AT THE BOARD MEETING – APPLICANT MUST BE PRESENT TO PROCESS

YOU must bring the **completed** packet in person to Medical Board staff table at the Sheraton San Diego Hotel and Marina on Thursday, October 23 from 10:30 a.m. to 5:30 p.m., or on Friday, October 24 from 9:00 a.m. to 1:00 p.m.

A confirmation will be emailed to you from the Department of Justice once your registration is processed.

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.

Sheraton San Diego Hotel and Marina
Fairbanks C&D Room
1380 Harbor Island Drive
San Diego, CA 92101
619.291.2900 (directions only)

Thursday, October 23, 2014
9:30 a.m. – 11:00 a.m.
(or until completion of business)

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:30 a.m. OPEN SESSION

1. Call to Order/Roll Call

2. Election of Panel Chair and Vice Chair (Business and Professions Code 2008)

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.

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

For additional information call (916) 263-2389.

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

MEDICAL BOARD OF CALIFORNIA

PANEL B MEETING AGENDA

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

Sheraton San Diego Hotel and Marina
Fairbanks A&B Room
1380 Harbor Island Drive
San Diego, CA 92101
619.291.2900 (directions only)

Thursday, October 23, 2014
9:30 a.m. – 11:00 a.m.
(or until completion of business)

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

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MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE
MEETING AGENDA

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

AMENDED – Additional Location Information
Sheraton San Diego Hotel and Marina
Fairbanks A&B Room – **Bay Tower**
1380 Harbor Island Drive
San Diego, CA 92101

Thursday, October 23, 2014
11:00 a.m. – 12:30 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.

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

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

1. Call to Order / Roll Call

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

3. Approval of Minutes from May 1, 2014 Meeting

4. Discussion and Consideration of Pain Management Expert Reviewer Policy – Ms. Zack Simon and Ms. Kirchmeyer

5. Discussion and Consideration of Proposed Amendments to the Statement on Marijuana – Ms. Kirchmeyer

6. Presentation on Physician Assessment and Clinical Education (PACE) – Peter Boal, University of California, San Diego

7. Presentation and Discussion on Utilization Review – Ms. Carrasco

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

9. Disciplinary Action Demographics – Ms. Kirchmeyer

10. Future Agenda Items

11. 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) 230-1096.

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 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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MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE

Sheraton Gateway LAX
6101 Century Boulevard
Los Angeles, CA 92501

Thursday, May 1, 2014

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Enforcement Committee (Committee) of the Medical Board of California (Board) was called to order by Dr. GnanaDev, Chair. With due notice having been mailed to all interested parties, the meeting was called to order at 2:30 p.m.

Members Present:
Dev GnanaDev, M.D., Chair
Howard Krauss, M.D.
Elwood Lui
Gerrie Schipske, R.N.P., J.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Staff Present:
William Boyd, Investigator
Susan Cady, Staff Services Manager II
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Errol Fuller, Investigator
Kimberly Kirchmeyer, Executive Director
Erin Nelson, Business Services Office
Regina Rao, AGPA
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
Tracy Tu, Investigator
See Vang, Business Services Analyst
Kerrie Webb, Staff Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Teresa Anderson, California Academy Physician Assistant
Gloria Castro, Senior Assistant Attorney General, Department of Justice
Yvonne Choong, California Medical Association

Alicia Cole, Consumers Union Safe Patient Project
Julie D'Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Jack French, Consumers Union Safe Patient Project
Michael Gomez, Deputy Director, Department of Consumer Affairs
Marian Hollingworth, Consumers Union Safe Patient Project
Tara Kittle, Consumer
Lisa McGiffert, Consumers Union Safe Patient Project
Tina Minasian, Consumers Union Safe Patient Project
Carol Moss, Consumers Union Safe Patient Project
Ty Moss, Consumers Union Safe Patient Project
Dan Orosco, MWU
Pishi Patel, AZCOM
Sarah Rashid, AZCOM
Suzan Shinazy, Consumers Union Safe Patient Project
Chris Vo, MWU
Michael Wong, AZCOM

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were provided.

Agenda Item 3 Approval of Minutes from October 23, 2013 meeting

A motion was made to approve the minutes from the October 23, 2013 meeting; s/Dr. Krauss. Motion carried.

Agenda Item 4 Discussion on the Memorandum of Understanding Between Medical Board of California and Department of Consumer Affairs Resulting from SB 304

Ms. Kirchmeyer explained the Memorandum of Understanding (MOU) between the Department of Consumer Affairs (DCA) and the Board, stating that it is important to have the MOU in place to identify what is necessary from both DCA and the Board with this transition. Ms. Kirchmeyer wanted to bring the completed draft to the Committee for review prior to signing it. She explained that the MOU is a document that outlines the agreement between DCA and the Board.

Ms. Kirchmeyer reviewed the requirements for DCA related to the types of budget reports that will be provided and how the Board will be charged for the services of the Health Quality Investigative Unit (HQIU).

Dr. GnanaDev stated that the Board is transferring its employees to DCA but it is financially neutral.

Ms. Kirchmeyer also explained DCA is creating a new asset forfeiture account; however the current funds in the Board's account will only be used for HQIU until the funds are

exhausted. The new asset forfeiture account will be exclusively under DCA and they will be able to spend that money for DCA.

Ms. Yaroslavsky questioned the effectiveness or appropriateness of collecting and dispersing the money collected.

Ms. Kirchmeyer stated that DCA was essentially collecting the funds and could be used for its employees.

Mr. Gomez spoke about how the evidence and investigative files can be shared and still maintain privacy in an information technology cloud, but that it is still in the formative stages.

Ms. Kirchmeyer stated that she would be signing the MOU with Mr. Gomez, so it would be in place July 1, 2014.

Agenda Item 5 Update on Transition of Staff to Department of Consumer Affairs Pursuant to SB 304

Mr. Gomez updated the Committee on the SB 304 implementation plan stating that all the contractual programs are moving forward and that only the Office of Standards and Training, the Chief, and Deputy Chief of Enforcement are moving from the Board to DCA.

Mr. Gomez reminded the Board that this month there will be a town hall meeting videocast in nine different venues for all current DCA Division of Investigation employees and the Board employees that are impacted by the transition.

Mr. Gomez also commented that DCA has been successful in getting support to buy new vehicles for all the Supervising Investigators of the HQIU.

Ms. Yaroslavsky questioned the Vertical Enforcement model manual that is being rewritten and wanted to know if she would be able to have a copy because the Board would like to know how it is going to affect the job performance of the investigators.

No public comments

Agenda Item 6 Presentation and Discussion on Enforcement Statistical Reports

Ms. Cady stated that the Enforcement Program routinely provides a lot of statistical reports to the Board Members as background information so that the Members can make informed policy decisions. Ms. Cady explained the current reports being used. She also stated that staff will continue to produce the Board's Annual Report and report the progress being made towards achieving the strategic goal of reducing complaint processing time.

Ms. Cady stated that she had developed a recommendation for a statistical report that consolidates the information currently produced into a single report. This report provides the average number of days to complete the complaint investigation and prosecution process,

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along with the total number of complaints received or completed in that fiscal year. The report will also provide data covering a six-year period of time so that assessments regarding workload trends can be considered. Ms. Cady asked that the Committee provide direction as to what statistical information the Board will need from staff on a regular basis.

Dr. GnanaDev commented that the report was extremely confusing and that he would prefer highlights in the form of bar graphs to the in depth written report.

Ms. Yaroslavsky suggested that the Committee take a look at the enforcement numbers noting that the ability to track across several years gives a much better picture than using just one year. Ms. Yaroslavsky also stated that what the Board really needs to know is how many cases there are.

Ms. Kirchmeyer commented that there actually is a bar graph report for the complaint unit that shows all the information requested.

Tina Minasian, Consumers' Union Safe Patient Project questioned why cases closed because of the statute of limitations (SOL) running out were not listed on the chart.

Ms. Cady replied that in any of the statistical charts that are published it is not necessarily broken down by each and every cause for closure; that level of detail is not produced.

Dr. GnanaDev requested that Board staff provide the Board with the percentage of cases closed due to the statute of limitations expiring.

Ms. Yaroslavsky commented on Ms. Cady's statement that the Committee provide direction as to what statistical information the Board will need from staff on a regular basis. She suggested that the Board needs to have information such as how many cases are closed, and how many cases are referred to the Attorney General's Office. She also suggested that the Board should have the ability to compare and contrast future happenings against past happenings under the system.

Ms. Kirchmeyer replied that graphs will give them a pictorial of the statistics but, what the Board really needs to know is how long the investigation actually takes and how many cases are actually closed.

Ms. Kirchmeyer said that the staff is trying to streamline all the information to where only one set of data is given. She also noted that the information that the Board is asking for could be delivered in quarterly reports which would cut down on the repetition or duplication of information when preparing the annual report.

Agenda Item 7 Presentation on Interim Suspension Order Statistics

Ms. Kirchmeyer noted that the Members had recently asked for information on the number of interim suspension orders (ISOs) that the Board actually pursues and of those, how many are granted or denied.

A Member asked for the timeframe from when a petition is filed to when a petition is granted.

Ms. Kirchmeyer stated that from petition filed to petition granted is not an issue, but there are statistics that tell how long it takes to get to that final suspension.

Yvonne Choong, California Medical Association (CMA), thanked the Board for providing this data, stating that it clarified the questions CMA had about this process. Ms. Choong had some other suggestions for additional information that would help to further expand CMA's understanding of the ISO process; this would include knowing the types of violations that the ISOs are based upon, how many ISOs lead to accusations and actual discipline, which Offices of Administrative Hearing are issuing the ISOs and how many ISOs are being issued without prior hearing or formal written notice.

Agenda Item 8 Clarification of Expert Reviewer and Medical Consultant Responsibilities

Ms. Sweet stated that she was going to attempt to respond to several issues regarding medical consultants and expert reviewers that have been asked. Ms. Sweet explained the difference between the roles of the medical consultant and the medical expert, stating that most important is that the medical consultant is an employee of the Board and also part of the investigative team, while the expert reviewer is an independent contractor. The expert reviews a case that is within their specialty and about which they have articulated specific expertise. Ms. Sweet continued to explain in detail their duties and responsibilities.

Karen Erlich, Licensed Midwife, commented that she had previously been an expert reviewer and wanted to thank Ms. Sweet for this extremely clear rendering of what the difference is. Ms. Erlich stated that she thought it would be a good idea for Ms. Sweet's report to be part of the expert reviewer training, as well as public information available to anyone.

Agenda Item 9 Future Agenda Items

No items were provided.

Agenda Item 10 Adjournment

There being no further business, the meeting was adjourned at 3:45 p.m.

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

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 6, 2014
ATTENTION:	Members, Enforcement Committee
SUBJECT:	Pain Management Expert Reviewer Policy
STAFF CONTACT:	Kimberly Kirchmeyer, Executive Director and Jane Zack Simon, Supervising Deputy Attorney General (SDAG)

REQUESTED ACTION:

After review and consideration of the information, make a motion to change the Medical Board of California's (Board) pain management expert reviewer policy to use one expert reviewer board certified in pain management rather than two expert reviewers.

BACKGROUND:

In 2002, the Board established a policy on the review of cases involving pain management issues. That policy stated for these types of cases the Board would require at least two experts reviewers, one board certified in pain management, and one physician board certified in the same specialty as the physician under investigation. Since the requirement for physicians to obtain continuing medical education has been in effect since January 1, 2002, the Board and the Attorney General's Office do not believe this policy should still be required. The background and further information on this policy is found in the attached document by SDAG Jane Zack Simon (Attachment A).

Attachment A

KAMALA D. HARRIS
Attorney General

State of California
DEPARTMENT OF JUSTICE

455 GOLDEN GATE AVENUE, SUITE 11000
SAN FRANCISCO, CA 94102-7004

Public: (415) 703-5500
Telephone: (415) 703-5544
Facsimile: (415) 703-5480
E-Mail: Janezack.simon@doj.ca.gov

October 6, 2014

Kimberly Kirchmeyer
Executive Director
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Re: Expert Witnesses for Pain Prescribing Cases

Dear Ms. Kirchmeyer:

As you know, the Medical Board currently has an investigative policy unique to cases involving prescribing for treatment of pain. We would like to initiate a discussion regarding the advisability of continuing with that policy.

For more than two decades, the medical profession has grappled with the issue of prescribing for the treatment of pain. This area of medicine has undergone a number of changes, and continues to evolve. As understanding of the role of narcotics in the treatment of pain continues to develop, the Medical Board of California has sought to provide guidance to physicians involved in the treatment of pain.

The Medical Board established its first Guidelines for pain prescribing in 1994. Over the years, the Board has revised and adapted its Guidelines to reflect current medical thinking in this area of medicine. A constant byproduct of the emergence of prescribing to treat pain has been the struggle to balance the acknowledged and laudable interest in adequately treating pain with the danger of inappropriate and unsafe prescription of dangerous and potent drugs. On the one hand, physicians are encouraged to adequately treat pain, and on the other hand, they must be mindful not to over-treat, over-prescribe or prescribe to patients who are not bona fide pain patients. The Medical Board's consistent message has been that physicians should treat and prescribe for pain, but must do so in accordance with the accepted standard of practice.

In the early 2000s, prescribing to treat pain became a hot-button issue. The Medical Board was involved in protracted discussions and deliberations about how to deal with the conundrum posed by this area of medicine. In 2002, the Legislature statutorily required all physicians to complete educational courses in the area of pain management and the treatment of terminally ill and dying patients. The Board's Prescribing Guidelines were updated in 2003. This issue was not

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unique to California; in 2004, the Federation of State Medical Boards adopted its first Model Policy On the Use of Controlled Substances in the Treatment of Pain, Guidelines which were essentially the same as those adopted by the Medical Board of California.

The message to physicians was that they should adequately prescribe to treat pain, while at the same time making sure that the prescribing was medically appropriate and safe to patients. Not surprisingly, given the evolving and sometimes controversial nature of this area of medicine, many physicians feared that they would be subject to discipline for good faith efforts to effectively treat pain.

It was in this context that the Medical Board established its Policy entitled " Investigation Prescribing of Controlled Substances for Pain" ("Policy"). The Policy, which continues to exist today, established a procedure under which investigations involving pain management require review by at least two expert witnesses. One of the experts must be a pain management specialist, while the other must be in the same specialty as the physician under investigation. The thinking was that during the transition period, when all physicians were learning about pain management, those who were not pain management specialists should not be judged exclusively by specialists.

We believe that it would be appropriate for the Board to reassess and revise the Policy. The Policy requiring the use of two experts in different specialty areas has created a number of problems in investigations and trial of pain management cases. First, the additional time and expense incurred in obtaining two expert reviews results in significant investigative delay. Moreover, this is the only type of case in which the investigation uses experts from two different disciplines. In most cases, it is difficult or impossible to reconcile the two reports and perspectives, and to determine precisely whether the prescribing in question is appropriate and within acceptable standards.

At this point, the two-expert Policy has been in effect for more than 10 years. We believe that the Policy has satisfied its purpose, and has outlived its usefulness. All physicians have completed their required education in the area of pain management. Pain management has become a well-established medical specialty, training is widely available to physicians, and the Medical Board's Guidelines have been widely disseminated. There is no longer a need to treat the investigation of pain cases differently from other cases. For example, an investigation of an obstetrician/gynecologist who performs cosmetic surgery is reviewed by an expert in cosmetic surgery; a dermatologist who provides psychiatric treatment to a patient is reviewed by an expert in psychiatry. Physicians who elect to prescribe to pain patients should be held to the standard of practice governing pain medicine.

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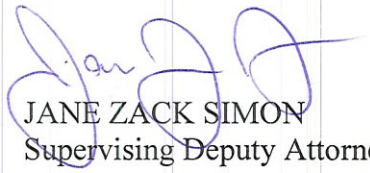
For these reasons, this Office recommends that the Policy be revised to eliminate the two expert requirement and, like all other cases, require only that pain management cases be reviewed by experts in that specialty.

Sincerely,



JANE ZACK SIMON
Supervising Deputy Attorney General

For KAMALA D. HARRIS
Attorney General

JZS:

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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 6, 2014
ATTENTION: Members, Enforcement Committee
SUBJECT: Statement on Marijuana
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:
After review and consideration of the information, make a motion to direct staff to update the Statement on Marijuana as amended and post the new version to the Board's website.

BACKGROUND:
On May 7, 2004, the Medical Board of California (Board) adopted a statement clarifying that the recommendation for marijuana by physicians in their medical practice will not have any effect against their physician's license if they follow good medical practice. This statement is posted on the Board's website.

Board staff have reviewed the statement and believe that some edits need to be made to the statement, as some information is misleading and does not comport with current law. The first series of edits pertain to the term "medical marijuana," which is used throughout the entire document. Although marijuana can be recommended for medical purposes, the term medical marijuana is misleading, as there is no difference between regular marijuana and marijuana used for medical purposes. Therefore, this clarification needs to be made throughout the document.

The other issue with the statement was brought to the Board's attention during an administrative hearing. The statement asserts that the initial examination for the condition for which marijuana is being recommended must be in-person. This statement contradicts the Board's telehealth law. The initial examination must follow the standard of care and must provide for an appropriate prior examination, however, the law does not require that this examination must be in-person.

The edits to the statement are identified below in strikeout and underline.

~~Medical~~ Marijuana for Medical Purposes

This statement was adopted by the full Medical Board on May 7, 2004 and amended in October 2014. ~~For more information, please see our news release dated May 13, 2004.~~

On November 5, 1996, the people of California passed Proposition 215. Through this Initiative Measure, Section 11362.5 was added to the Health and Safety Code, and is also known as the Compassionate Use Act of 1996. The purposes of the Act include, in part:

> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the 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; and

(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

Furthermore, Health and Safety Code section 11362.5(c) provides strong protection for physicians who choose to participate in the implementation of the Act. "Notwithstanding any other provision of law, no physician in this state shall be punished, or denied any right or privilege, for having recommended marijuana to a patient for medical purposes."

The Medical Board of California developed this statement since ~~medical~~ marijuana is an emerging treatment modality. The Medical Board wants to assure physicians who choose to recommend ~~medical~~ marijuana for medical purposes to their patients, as part of their regular practice of medicine, that they WILL NOT be subject to investigation or disciplinary action by the ~~MBC~~ Medical Board if they arrive at the decision to make this recommendation in accordance with accepted standards of medical responsibility. The mere receipt of a complaint that the physician is recommending ~~medical~~ marijuana for medical purposes will not generate an investigation absent additional information indicating that the physician is not adhering to accepted medical standards.

These accepted standards are the same as any reasonable and prudent physician would follow when recommending or approving any other medication, and include the following:

1. History and an appropriate prior examination of the patient.
2. Development of a treatment plan with objectives.
3. Provision of informed consent including discussion of side effects.
4. Periodic review of the treatment's efficacy.
5. Consultation, as necessary.
6. Proper record keeping that supports the decision to recommend the use of ~~medical~~ marijuana for medical purposes.

In other words, if physicians use the same care in recommending ~~medical~~ marijuana to patients as they would recommending or approving any other medication, they have nothing to fear from the Medical Board.

Here are some important points to consider when recommending ~~medical~~ marijuana for medical purposes:

1. Although it could trigger federal action, **making a recommendation in writing** to the patient will not trigger action by the Medical Board of California.
2. A patient need not have failed on all standard medications, in order for a physician to recommend or approve the use of ~~medical~~ marijuana for medical purposes.
3. The physician should determine that ~~medical~~ marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.
4. The Act names certain medical conditions for which ~~medical~~ marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In

all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of ~~medical~~ marijuana is as good, or better, than other medications that could be used for that individual patient.

5. A physician who is not the primary treating physician may still recommend ~~medical~~ marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
6. The initial examination for the condition for which medical marijuana is being recommended must ~~be in-person~~ be an appropriate prior examination and meet the standard of care.
7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.
8. If a physician recommends or approves the use of ~~medical~~ marijuana for a medical purpose for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to the following CMA documents:

- ON-CALL Document #1315 titled "The Compassionate Use Act of 1996", updated annually for additional information and guidance
- "Physician Recommendation of Medical Cannabis", Guidelines of the Council on Scientific Affairs Subcommittee on Medical Marijuana Practice Advisory

Although the Compassionate Use Act allows the use of ~~medical~~ marijuana for medical purposes by a patient upon the recommendation or approval of a physician, California physicians should bear in mind that marijuana is listed in Schedule I of the federal Controlled Substances Act, which means that it has no accepted medical use under federal law. However, in Conant v. Walters (9th Cir.2002) F.3d 629 the United States Court of Appeals recognized that physicians have a constitutionally-protected right to discuss ~~medical~~ marijuana as a treatment option with their patients and make oral or written recommendation for ~~medical~~ marijuana. However, the court cautioned that physicians could exceed the scope of this constitutional protection if they conspire with, or aid and abet, their patients in obtaining ~~medical~~ marijuana.

Associate Director of the PACE Program

Peter grew up in a small town in idyllic Sonoma County. In 1997 he moved to San Diego to attend college at the University of California, San Diego. Peter began his career with the UC San Diego PACE Program as a student worker in early 1998. After graduating with a Bachelor of Science degree in Animal Physiology and Neuroscience in 2001, he worked primarily as a case manager until 2006, when he became the Administrative Director of the 2-Phase Assessment Program. In June of 2008, Peter became the Associate Director of the PACE Program. When he's not at work, Peter enjoys traveling, playing golf and tennis, bowling, camping, and spending time with his friends and family.

Director, UC San Diego PACE Program

William A. Norcross, M.D. - Dr. William Norcross was born in 1948 and raised in Toms River, New Jersey. He attended college at tiny Ursinus College in Pennsylvania, and graduated from the Duke University School of Medicine in 1974. He did his residency in Family Medicine at the UCSD Medical Center and never looked back, having now been at UCSD for over 30 years. Dr. Norcross holds the rank of Clinical Professor of Family Medicine, and was Residency Director from 1986 through 1999. He founded the UCSD PACE Program in 1996 and has been the Director ever since. His purpose in creating the PACE Program was to help doctors be the best they could be. He has found that working with the physicians who attend the various PACE offerings to be a very uplifting and enjoyable experience.

Administrative Director of the Assessment Program

Kate Seippel, M.P.H. – Kate grew up in Minneapolis, Minnesota and graduated with a B.A. in Psychology and Spanish from the University of Minnesota in 1999. She relocated to San Diego, California in September, 2004 and began working with PACE in February 2006. She received a Masters of Public Health (MPH) degree from San Diego State University (SDSU) in December of 2010. Kate currently works as a case manager and as the Administrative Director of the PACE 2-Phase Assessment Program.

Physician Assessment and Clinical Education Program (PACE)

Existing Language for Condition #18 Clinical Training Program

- The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

UC San Diego
PACE PROGRAM

Physician Assessment and Clinical Education Program

Home | Assessment Programs | PEP - Physician Monitoring | CPD/CME (Education) | Application/Documents | Links | About Us

Physician Assessment - Phase I

Phase I of the program is a two-day assessment that uses a variety of evaluation methods to provide an overall picture of the physician's skills, knowledge, and physical health. Components of the assessment program include (Click each to expand for further description.):

- Practice Profile
- Chart Review
- 360° Evaluation
- Oral (or Written) Clinical Examination
- Written Exams
- Computer Based Case Simulation
- History and Physical Skills Exam
- Comprehensive Physical and Mental Health Screening
- Exit Interview

After the completion of the assessment, we hold a multidisciplinary staff meeting to discuss the participant's results and generate recommendations for further evaluation, education and remediation as necessary. Some physicians may return for Phase II of the assessment program. For more information on Phase II click here.

UC San Diego
PACE PROGRAM

Physician Assessment and Clinical Education Program

Home | Assessment Programs | PEP - Physician Monitoring | CPD/CME (Education) | Application/Documents | Links | About Us

Physician Assessment - Phase II

Phase II of the assessment program is a minimum one-week clinical education program provided at the UCSD Medical Center or one of its satellite clinics. It is a formative assessment of the participant's clinical skills, knowledge and judgment.

The results of the Phase I Assessment are used to help inform the scope and design of Phase II. Each program will be individually tailored to the participant's specialty and Phase I findings to the extent possible. As a result, Phase II programs will vary widely by specialty and from participant to participant.

The following list represents elements that are common to many Phase II programs (please note that this list is neither all-inclusive, nor are the items on the list necessarily common to all Phase II programs):

- Clinical Observation
- Departmental Conferences & Lectures
- Evidence-Based Medicine Project
- Further Evaluation

At the conclusion of Phase II, a multidisciplinary staff meeting is held to determine if the physician has completed the program satisfactorily or if more evaluation, education, or remediation is necessary.

The University of California, San Diego School of Medicine is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

The University of California, San Diego School of Medicine designates this educational activity for a maximum of 40 *AMA PRA Category 1 Credits*™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

Revised Language for Condition #18 Clinical Training Program

- The Program shall consist of a Comprehensive Assessment program comprised of an assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's current or intended area of practice which takes 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

Medical Board of California PACE Redesigned Assessment October 23, 2014

William Norcross, M.D.

Peter Boal

Kate Seippel, M.P.H.

UC San Diego
SCHOOL OF MEDICINE

Why Are We Changing?

- Because more experienced faculty and staff and better tools allow us to more efficiently and effectively assess competence than in years past
- We have found the strongest assessment is one that is tailored to the physician's practice environment, while also taking into consideration the factors and reasons for his/her discipline

UC San Diego
SCHOOL OF MEDICINE

How Is It Still The Same?

Core values remain unchanged

- **Mission Statement:** *The UCSD Physician Assessment and Clinical Education Program is dedicated to the education of physicians and other health care professionals; the detection, evaluation, and remediation of deficiencies in medical practice; and assisting the medical profession in its quest to deliver the highest quality of health care to the citizens of the United States.*

UC San Diego
SCHOOL OF MEDICINE

How Is It Still The Same?

- Evaluation
  - Screening of mental, physical, **cognitive** health and wellbeing
  - Clinical competence and performance in all 6 of the core domains of physician competence (as defined by the ACGME/ABMS)
- Final Outcomes
  - Category 1 (Clear Pass)
  - Categories 2-3 (Pass with Recommendations)
  - Category 4 (Fail)
- Remedial Education

UC San Diego
SCHOOL OF MEDICINE

How Will It Be Different?

- One phase instead of two
  - Previously 7 days total
  - Now minimum of 3 days (most will complete within 5)
- More tailored to the physician's current or intended area of practice and reason for referral
- Greater use of simulation

UC San Diego
SCHOOL OF MEDICINE

How Is It Better?

- Better for the MBC
  - Easier to track Respondent's participation
  - Confirm competence of safe physicians and identify unsafe physicians faster and with greater confidence
  - Less time needed to complete entire process
- Better for the participants
  - Assessment more specific to his/her practice
  - Less time away from practice
  - Less travel (one trip to PACE)

UC San Diego
SCHOOL OF MEDICINE

Questions?

UC San Diego Center For The Future Of Surgery

UC San Diego
SCHOOL OF MEDICINE

UTILIZATION REVIEW

Presentation by
Ramona Carrasco

UTILIZATION REVIEW COMPLAINTS

Complaint Allegations	Number Received	Percentage
Unlicensed (Alleged the physician performing Utilization Review was not licensed to practice medicine in California)	8	20%
Unprofessional Conduct (e.g., Alleged "false" information in the report, the review was biased, delay in submitting paperwork, etc.)	9	22%
Quality of Care (e.g., Alleged the physician's opinion resulted in delay or denial of benefits/treatment, altered care, etc.)	23	58%
TOTAL	40	

WORKERS' COMPENSATION

Complaint Allegations	Number Received	Percentage
Unlicensed (Alleged the physician performing Utilization Review was not licensed to practice medicine in California)	6	23%
Unprofessional Conduct (e.g., Alleged "false" information in the report, the review was biased, delay in submitting paperwork, etc.)	4	15%
Quality of Care (e.g., Alleged the physician's opinion resulted in delay or denial of benefits/treatment, altered care, etc.)	16	61%
TOTAL	26	

Department of Industrial Relations, Division of Workers' Compensation, Utilization Review process:

- Treatment standards are defined in regulation.
- There is no requirement that Utilization Review physicians be licensed in California, California Code of Regulations, Chapter 4.5, Section 9792.6(v).

INSURANCE COMPANIES

Complaint Allegation	Number Received	Percentage
Unlicensed (Alleged the physician performing Utilization Review was not licensed to practice medicine in California)	2	15%
Unprofessional Conduct (e.g., Alleged "false" information in the report, the review was biased, delay in submitting paperwork, etc.)	5	35%
Quality of Care (e.g., Alleged the physician's opinion resulted in delay or denial of benefits/treatment, altered care, etc.)	7	50%
TOTAL	14	

INDEPENDENT MEDICAL REVIEWS

QUESTIONS?

Ethnic Background Data - Complaints/Investigations/Discipline
FY 10/11, FY 11/12, and FY 12/13

Ethnic Background	FY 10/11			FY 11/12			FY 12/13		
	Complaint	Investigation	Discipline	Complaint	Investigation	Discipline	Complaint	Investigation	Discipline
African-American/Black/African	4.4%	5.3%	4.9%	4.7%	6.0%	3.1%	4.4%	5.7%	4.9%
American Indian/ Native American/Alaskan Native	0.2%	0.1%	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%	0.3%
Asian – Cambodian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Asian - Chinese	4.9%	3.9%	5.2%	5.0%	4.2%	3.3%	5.1%	5.3%	3.3%
Asian - Indian	5.7%	4.1%	3.9%	5.2%	5.4%	4.6%	5.6%	4.6%	3.1%
Asian - Indonesian	0.1%	0.1%	0.3%	0.0%	0.2%	0.3%	0.0%	0.0%	0.3%
Asian - Japanese	0.7%	0.9%	0.0%	0.6%	0.4%	0.5%	0.5%	0.4%	1.0%
Asian - Korean	1.9%	1.9%	0.6%	2.0%	2.0%	1.3%	2.0%	1.7%	2.1%
Asian – Laotian/Hmong	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Asian - Pakistani	0.6%	0.3%	0.0%	0.7%	0.6%	1.0%	0.8%	0.8%	0.5%
Asian - Thai	0.2%	0.2%	0.0%	0.1%	0.1%	0.0%	0.2%	0.2%	0.0%
Asian - Vietnamese	1.7%	1.9%	1.0%	1.5%	1.1%	1.8%	1.4%	1.3%	1.3%
Asian - Other Asian	1.2%	1.3%	0.6%	1.0%	0.7%	1.5%	0.9%	0.6%	0.8%
Caucasian/White/European/Middle Eastern	50.2%	50.7%	46.9%	50.6%	51.1%	47.4%	50.2%	52.0%	52.2%
Latino/Hispanic - Central American	0.2%	0.3%	0.3%	0.3%	0.7%	0.8%	0.2%	0.0%	0.0%
Latino/Hispanic - Cuban	0.2%	0.2%	0.3%	0.1%	0.2%	0.0%	0.1%	0.2%	0.3%
Latino/Hispanic - Mexican	1.8%	2.1%	2.6%	1.7%	1.7%	2.3%	1.7%	1.7%	2.3%
Latino/Hispanic - Puerto Rican	0.1%	0.2%	0.3%	0.5%	0.8%	0.8%	0.8%	0.5%	0.3%
Latino/Hispanic - South American	0.9%	0.7%	1.0%	0.7%	0.7%	0.0%	0.7%	0.5%	1.3%
Latino/Hispanic - Other Hispanic	0.2%	0.2%	1.0%	0.2%	0.2%	0.3%	0.3%	0.5%	0.0%
Native Hawaiian - Fijian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian - Filipino	1.9%	1.1%	3.9%	2.2%	1.4%	2.3%	2.2%	1.9%	1.3%
Native Hawaiian - Guamanian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian - Hawaiian	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian - Samoan	0.0%	0.0%	0.0%	0.0%	0.1%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian - Tongan	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Native Hawaiian - Other Pacific Islander	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	4.3%	4.1%	2.3%	4.5%	3.9%	4.6%	4.5%	4.5%	3.9%
Decline To State/No Response/No Survey Found	14.9%	16.1%	19.1%	14.4%	14.1%	18.2%	15.1%	15.0%	18.8%
Multiple entries - Ethnic Background	3.5%	4.3%	5.5%	3.6%	3.9%	5.6%	2.9%	2.7%	2.3%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

MEDICAL BOARD OF CALIFORNIA

EXECUTIVE COMMITTEE MEETING AGENDA

AMENDED – Additional Location Information

Sheraton San Diego Hotel and Marina
Fairbanks A&B Room – **Bay Tower**
1380 Harbor Island Drive
San Diego, CA 92101

Thursday October 23, 2014
1:30 pm – 3:30 pm
(or until the completion of business)

Teleconference – See Attached
Meeting Information

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

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

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

MEMBERS OF THE EXECUTIVE COMMITTEE
David Serrano Sewell, J.D., President, Chair
Michael Bishop, M.D.
Dev GnanaDev, M.D., Vice President
Sharon Levine, M.D.
Ronald Lewis, M.D.
Denise Pines, Secretary
Barbara Yaroslavsky

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

1. Call to Order / Roll Call

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

3. Approval of Minutes from May 1, 2014 Meeting

4. Discussion on a Compendium of Medical Board of California Policies – Ms. Kirchmeyer and Ms. Simoes

5. Discussion and Consideration of Committees, Task Forces, and Sub Committees – Mr. Serrano Sewell and Ms. Kirchmeyer

6. Update on Strategic Plan – Ms. Kirchmeyer

7. Future Agenda Items

Closed Session

8. Pursuant to Government Code Section 11126(a)(1), the Executive Committee will meet to Conduct the Annual Evaluation of the Executive Director

Return to Open Session

9. 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) 230-1096.

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

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

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.

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 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.

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.

MEDICAL BOARD OF CALIFORNIA

EXECUTIVE COMMITTEE MEETING

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

Thursday, May 1, 2014

MEETING MINUTES

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

Members Present:

David Serrano Sewell, J.D., Vice President
Silvia Diego, M.D., Secretary
Dev GnanaDev, M.D.
Barbara Yaroslavsky

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

Staff Present:

William Boyd, Investigator
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Errol Fuller, Investigator
Kimberly Kirchmeyer, Executive Director
Erin Nelson, Business Service Officer
Regina Rao, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement
Lisa Toof, Administrative Assistant II
Tracy Tu, Investigator
See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:

Gloria Castro, Senior Assistant Deputy Attorney General, Attorney General's Office
Alicia Cole, Consumers Union
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Law
Michael Gomez, Department of Consumer Affairs

Howard Krauss, M.D.
Ronald Lewis, M.D.
Lisa McGiffert, Consumers Union
Tina Minasian, Consumers Union
Carol Moss, Consumers Union
Ty Moss, Consumers Union

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Executive Committee of the Medical Board of California (Board) Meeting to order on May 1, 2014, at 1:04 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

No public comment was heard on this agenda item.

Agenda Item 3 Approval of Minutes from the October 23, 2013 Meeting

Ms. Yaroslavsky made a motion to approve the October, 2013 meeting minutes as submitted; s/Dr. GnanaDev. Motion carried.

Agenda Item 4 Discussion on and Approval of Revisions to the Strategic Plan

Ms. Kirchmeyer gave a brief background on the Strategic Plan. She referred the Members to pages EXEC 4-19 through EXEC 4-26 which is the revised document from the input of the last Executive Committee meeting. Ms. Kirchmeyer stated, staff took the outcome from that meeting and worked with staff from the Department of Consumer Affairs (DCA) to put together the final changes to the Goals and Objectives as approved by the Executive Committee. From those Goals and Objectives, tasks were assigned. She noted that in the packet, Members would see what staff has identified, with hopes to have the plan approved at this meeting to present to the Full Board for final approval.

She began with Goal 1 - Professional Qualifications. Ms. Kirchmeyer asked if the Members had any questions concerning this goal.

There were no questions from the Members or the public on this goal.

Ms. Yaroslavsky made a motion to approve Goal 1 as written; s/Dr. Diego. Motion carried.

Ms. Kirchmeyer moved forward to Goal 2 – Regulations and Enforcement. Ms. Kirchmeyer asked if the Members had any questions on this goal.

There were no questions from the Members or the public on this goal.

Ms. Yaroslavsky made a motion to approve Goal 2 as written; s/Dr. GnanaDev. Motion carried.

Ms. Kirchmeyer continued with Goal 3 - Consumer and Licensee Education. This goal includes the Board's outreach plan, including working and collaborating with the media, and producing informational videos for both consumer and physician outreach. Staff will also create some educational webinars and reach out to interested stakeholders to try to find opportunities for the Board to provide education on the roles and objectives of the Board, whether it is to a consumer group or a group of physicians.

Ms. Yaroslavsky recommended in Goal 3.2a, and 3.2d, striking the words "at least," and adding the words "two or more" in substitution.

Ms. Kirchmeyer stated that in Goal 3.4, Ms. Yaroslavsky had also recommended changing the priority from the current medium priority to a high priority. Ms. Kirchmeyer agreed that would be a reasonable change.

Dr. Diego stated she is concerned about 3.1a, to rescind the 10-year time limit for posting disciplinary information/documents. She asked what would happen in its place if rescinded.

Ms. Kirchmeyer noted that this objective was in the Board's Sunset Review bill and the Board approved the legislation. The current bill, Assembly Bill 1886, has been amended to remove the 10-year requirement for all decisions, with the exception of public letters of reprimand.

Lisa McGiffert, Consumers Union, encouraged the Board to be more specific about the pro-active approach in communicating with the public by adding an objective that promotes the phone number or website letting consumers know how to file a complaint.

Mr. Serrano Sewell asked Ms. Kirchmeyer to give a brief update on some website changes that are being worked on, in regard to providing clearer links to filing a complaint.

Ms. Kirchmeyer stated the Board has revised their website, and has discussed with Ms. Yaroslavsky about sitting down with groups to review the newest site and be sure it is more consumer friendly about how to file a complaint.

Ms. Kirchmeyer noted another item the Board is working on is a project to produce a video on how to file a complaint. The Board is looking at creating a short video clip tutorial as to what type of complaints the Board will investigate, what happens with those complaints, the complaint process, as well as how to file the complaint.

Mr. Serrano Sewell asked Ms. Yaroslavsky if she would accept a friendly amendment to her motion, to add a 3.4d, "promote the Board's website and provide consumer friendly information on how to file a complaint." Ms. Yaroslavsky accepted that amendment to her motion.

Ms. Yaroslavsky made a motion to approve Goal 3 as amended; s/Dr. GnanaDev. Motion carried.

Ms. Kirchmeyer continued with Goal 4 - Organizational Relationships. She stated that this goal is about building relationships with elected officials, which staff has already begun to do, but wants to continue and improve on that. The Board has not yet done a lot with hospitals, health systems and those types of organizations, but will do so in the future. Objective 4.3 includes a list of groups,

organizations, and associations that staff will continue to work with and build stronger relationships with them.

Ms. Yaroslavsky made a motion to approve Goal 4 as written; s/Dr. GnanaDev. Motion carried.

Ms. Kirchmeyer moved to Goal 5 - Organizational Effectiveness. The first Objective is to improve licensing and complaint time frames. The additional Objective in Goal 5 is looking at where the Board can obtain feedback, educating staff about Board activities, educating the Board about staff activities, as well as a review of committees every two years to be sure the committees the Board has are fulfilling the purpose for which they were established.

Ms. Yaroslavsky made a motion to approve Goal 5 as written; s/Dr. GnanaDev. Motion carried.

Ms. Kirchmeyer continued with Goal 6 - Access to Care, Workforce, and Public Health. This Objective will educate the Board on the Affordable Care Act (ACA) and how it will affect physician practice, workforce, and utilization of allied healthcare professionals.

Ms. Yaroslavsky stated she feels the Board has more than enough information on the ACA. She feels that it is now more important to assist physicians when faced with certain situations to educate their patients on how to get access to care.

It was recommended that 6.1 be 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.”

Ms. Kirchmeyer suggested adding an objective “c” under 6.1 to read, “Educate physicians on opportunities to assist patients not within the ACA in obtaining access to care.”

Ms. Yaroslavsky made a motion to approve Goal 6 with amendments; s/Dr. GnanaDev. Motion carried.

With no further questions or comments from the Members or the public, the meeting was adjourned at 1:40 pm.

MEDICAL BOARD ISSUE PAPER

DATE REPORT ISSUED: October 9, 2014
ATTENTION: Members, Executive Committee
SUBJECT: Medical Board Policy Compendium
STAFF CONTACT: Jennifer Simoes, Chief of Legislation

ISSUE:

The Medical Board of California (Board) has requested staff to look at issue areas that routinely are addressed in legislation for the Board to adopt general policy guidance. There are times when bills are significantly amended and the Board's previous position on the bill no longer applies. Currently, the Chief of Legislation has to wait to bring each amended bill to the Board at the next Quarterly Board Meeting for a new position to be taken. During this time, the Chief of Legislation cannot testify at Committee Hearings on the Board's position or write position letters until a new position is taken. In order for the Board to take action on amended bills in a more rapid manner, the Board has asked staff to look at areas where policy can be adopted by the Board, so the Chief of Legislation can use the relevant policy in these circumstances. This will allow for prompt testimony and amended positions, even if the amended bill has not been formally brought to the Board at a Quarterly Board Meeting of the Medical Board of California.

BACKGROUND:

The Chief of Legislation reviews all new bills that are introduced. If a bill impacts the Board, the Chief of Legislation contacts the author's office to obtain background information on the bill. If the bill appears to be problematic or contain language that the Board may potentially oppose, the Chief of Legislation does contact the author's office to let the staff know which provisions may be problematic, based on positions that the Board has historically taken. The Chief of Legislation also has other Medical Board staff review the bill, and many times offers input and technical assistance to the author's office, in order to address potential issues before the bill gets to the Board. Oftentimes, legislative staff is more than willing to take amendments to address any potential concerns. This communication with the author's office is routine and is done with almost every bill that comes before the Board for a position. In addition, if a bill is amended that significantly impacts the Board, the Executive Director and Chief of Legislation discuss the amendments with the Board President, who determines if an immediate Executive Committee Meeting should be held in order for a new position to be taken on the bill, prior to a regularly scheduled Board Meeting.

POLICY AREAS:

Scope of Practice

Background

The Board many times takes positions on bills that impact the scope of practice for health care practitioners. These bills can be difficult to weigh the scope expansion versus the need to ensure consumer protection. However, the Board has both supported and opposed bills that expand the scope of practice. For example, Senator Hernandez authored three bills in 2013 that would have expanded the scope of practice:

- SB 493, which was supported by the Board and signed into law, allows pharmacists to furnish medication, order and interpret tests, furnish self-administered hormonal contraceptives, furnish prescription medications not requiring a diagnosis recommended by the Centers for Disease Control and Prevention for individuals traveling outside the United States, independently initiate and administer vaccines, and furnish prescription nicotine replacement products and smoking cessation services. This bill requires the Board of Pharmacy (BOP) and the Medical Board to develop standardized procedures or protocols for the furnishing of self-administered hormonal contraceptives and nicotine replacement products and also establishes an Advanced Practice Pharmacist (APP) recognition. The Board supported this bill because allowing pharmacists to furnish self-administered hormonal contraceptives in accordance with standardized procedures developed by BOP, the Board, and stakeholders, and allowing pharmacists to furnish nicotine replacement products and provide smoking cessation services, is in line with their scope of practice. Allowing pharmacists to initiate and administer routine vaccines seems appropriate and furthers the Board's mission of promoting access to care.

- SB 492, which died in the Legislature, was opposed by the Board. This bill would have expanded the scope of an optometrist 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. The Board opposed this bill because it believes that the bill did now allow for sufficient education to prepare optometrists for a significant scope expansion; as such, this could put patients at serious risk of harm and significantly impact consumer protection.

- SB 491, which also died in the Legislature, was opposed by the Board. This bill would have established independent practice for nurse practitioners (NPs) by removing provisions in existing law that require physician supervision through standardized procedures, collaboration or consultation with a physician. This bill would also have allowed a NP to order, furnish or prescribe drugs. The Board opposed this bill because NPs are well qualified to provide medical care when practicing under standardized procedures and physician supervision; however, the standardized procedures and physician supervision, collaboration, and consultation are in existing law to ensure that the patient care provided by a NP includes physician involvement and oversight, as physicians should be participating in the patient's care in order to ensure consumer protection. Expanding the scope of practice for a NP would have compromised patient care and consumer protection.

Policy and Principles

Although it would depend on the particular language in each bill, Board staff believes that the following policy statement could be adopted by the Board, due to the broadness of the policy, for bills that propose scope of practice expansions:

1) The Department of Consumer Affairs, (DCA), the Board and other healthcare boards of the DCA are duty-bound, first and foremost to protect and serve California Consumers

2) Protecting and serving healthcare consumers requires that DCA and its member healthcare boards assure, as best as practicable, that healthcare consumers are:

a. Evaluated and managed by California licensees practicing within their scope of practice, as defined by law or regulation;

b. Evaluated and managed by licensees who are in compliance with all applicable federal, state and local laws and regulations;

c. Evaluated and managed by competent licensees, practicing within community standards of care.

d. Entitled to be evaluated and managed in accordance with the highest standard of care applicable to any of the licensed or certificated practitioners.

3) The Board holds that all California Consumers should know the background, training, education, certification and history of disciplinary actions of any healthcare provider they may consider seeing.

4) The Board recommends that any legislatively proposed expansion of scope of practice include criteria to be met regarding education, training, certification and continuing oversight of any practitioner who obtains expanded scope. First and foremost consumers must be protected and any proposed scope expansion must assure adequate mechanisms and oversight to reduce patient risk of harm. Care provided to patients in California should be of the same quality, regardless of who is providing the care.

Continuing Medical Education (CME)

Background
There are many bills that initially propose requiring mandatory CME. Due to the Board's history in opposing these bills, the Chief of Legislation always advises the legislative office that the Board will likely oppose mandatory CME. Many times the author's office decides to include language instead that would encourage physicians take a certain type of CME or encourage the Board to set specific standards.

Policy Statement Recommendation
The Board opposes the concept of mandated CME topics. The Board believes that each licensed physician should decide which type of continuing education is most appropriate for their particular practice.

Funding for Physician Education

Background
The Board has routinely supported bills that provide additional funding for the practice of medicine. This includes bills that improve or provide more funding for loan programs, provide more funding for medical schools, and provide funding for additional residency positions. When these types of bills are introduced, the Chief of Legislation does advise the author's office that the Board will likely be in support of additional funding.

Policy Statement Recommendation

The Board supports additional funding for physician education, including funding for additional residency positions, funding for medical schools in California, and funding for loan programs, including the Steven M. Thompson Loan Repayment Program.

If Members have other policy recommendations these can be brought back to the Board at future meetings to be discussed and added to the compendium.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 6, 2014
ATTENTION:	Members, Executive Committee
SUBJECT:	Review of Current Committees, Task Forces, and Sub Committees
STAFF CONTACT:	David Serrano Sewell, Board President and Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:
After review, discussion, and consideration of the information, vote to approve the committee changes as indicated below.

BACKGROUND:
The Medical Board of California's (Board) Strategic Plan states that at every other October Board Meeting the Executive Committee and the Board will review the Board's Committee Roster and identify committees that may no longer be needed or may need reconfigured (Goal 5, Objective 5.4). The Board last reviewed the committees in October 2012. At that time, the Board elected to consolidate committees.

Upon Mr. Serrano Sewell's appointment as President, he met with Ms. Kirchmeyer to review and discuss the committees and task forces, and their roles and responsibilities..

In consultation with Ms. Kirchmeyer, Mr. Serrano Sewell recommends the following changes be made in order to increase the output, efficiency, and time commitments by Members. Essentially, the recommendations widen the scope of authority of the committees and task forces while ensuring the work of the Board can be completed in an effective manner.

The following is a list of the Board's current committees, a description of each of these committees, and a recommendation (for complete details on each committee, please see **Attachment A**).

COMMITTEES REQUIRED BY STATUTE

Application Review Committee (Business and Profession Code section 2135.5)
Membership: Determined by the President (normally limited to three members with minimum of one physician)
Responsibility: Evaluate the credentials of licensure applicants, where statute provides the Board to exercise discretion; and make recommendations to the Licensing Program regarding eligibility for licensure; (for example, postgraduate training hardship petitions per California Code of Regulations Title 16 section 1321(d) and written licensing exam waiver requests per Business and Professions Code section 2113).
Recommendation: Combine this Committee with the Special Programs Committee (listed below). These two Committees do similar work and, therefore, could be combined with the responsibility just being expanded. The new Committee would be called the Application Review and Special Programs Committee.

Special Programs Committee (Business and Professions Code sections 2072, 2073, 2111, 2112, 2113, and 2115)
Membership: Determined by President (normally limited to three members with minimum of one physician)
Responsibility: Provide guidance and expertise to Board staff regarding special program laws and regulations, specific applications, medical school site visits, and issues of concern; and make recommendations to the Licensing Program.
Recommendation: Combine this Committee with the Application Review Committee (listed above). These two Committees do similar work and, therefore, could be combined with the responsibility just being expanded. The new Committee would be called the Application Review and Special Programs Committee.

Special Faculty Permit Review Committee (Business and Professions Code section 2168.1(c)(1))
Membership: A physician member and public member of the Board determined by the President. One representative from each California medical school nominated by the school dean.
Responsibility: Evaluate the credentials of applicants proposed by a California medical school to meet the requirements of Section 2168.1(a); determine whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need; and submit a recommendation to the Board for each proposed candidate for final approval or denial.
Recommendation: Keep this Committee as is due to statutory requirement.

Midwifery Advisory Council (Business and Professions Code section 2509)
Membership: Determined by the Board as specified in law
Responsibility: Develop solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including physician supervision, challenge mechanisms, and examinations, as specified by the Board.
Recommendation: Keep this Committee as is due to statutory requirement.

STANDING COMMITTEES CREATED BY THE BOARD

Executive Committee
Membership: President, Vice President, Secretary, and Immediate Past President. The Past President exercised her discretion to include the Chairs of the Board's Standing Committees to serve on the Executive Committee.
Responsibility: Oversee various administrative functions of the board, such as budgets and personnel, and to review legislation; provide recommendations to the full Board; annually evaluate the performance of the Executive Director; and act for the Board in emergency circumstances (as determined by the Chair) when the full board cannot be convened.
Recommendation: Retain the current membership of this Committee, to include the President, Vice President, Secretary, and the Chairs of the Board's Standing Committees, which is recommended as Enforcement, Licensing, and Education and Wellness, for a total of seven members.

Enforcement Committee
Membership: Determined by the President
Responsibility: Serve as an expert resource and advisory body to members of the Board and its Enforcement Program by educating board members and the public on enforcement processes; identify program improvements in order to enhance protection of health care consumers; and review via a task force the Board's Vertical Enforcement/Prosecution Program.
Recommendation: Keep this Committee as a Standing Committee of the Board since enforcement is one of the Board's main regulatory functions.

Licensing Committee
Membership: Determined by the President
Responsibility: Serve as an expert resource and advisory body to members of the Board and its Licensing Program by educating board members and the public on the licensing process; identify program improvements; and review licensing regulations, policies, and procedures.
Recommendation: Keep this Committee as a Standing Committee of the Board since licensing is one of the Board's main regulatory functions.

Education and Wellness Committee and Sub Committee
Membership: Determined by the President
Responsibility: Develop various informational materials for publication and Internet posting; monitor the Board's strategic communication plan; develop physician wellness information by identifying available activities and resources which renew and balance a physician's life, both personal and professional.
Recommendation: Keep this Committee as a Standing Committee of the Board since educating physicians and the public is one of the Board's main functions. However, it is recommended the Sub Committee be eliminated, however, the Board should continue to use these individuals to act as subject matter experts as issues arise and to also assist with *Newsletter* articles.

Access-to-Care/Cultural and Linguistic Competency Committee and Sub Committee
Membership: Determined by the President
Responsibility: Identify opportunities for the Board to promote and assist physician involvement in access to care issues by providing policy development, program direction, and recommendations to the Board; and encourage activities designed to promote the cultural and linguistic competency of physicians.
Recommendation: Eliminate this Committee. The last time the committees were discussed this Committee was established by combining the Access to Care Committee and the Cultural and Linguistic Competency Committee. The Cultural and Linguistic Competency Committee was established in response to legislation regarding cultural and linguistic competency and is no longer needed. Activities of this Committee could be placed in the Education and Wellness Committee or the Licensing Committee. There has not been any issues brought to this Committee for several years.

Committee on Physician Supervisory Responsibilities
Membership: Determined by the President. Currently includes both Members and non-Members.
Responsibility: Develop regulatory language related to physician availability in cosmetic surgery settings that use laser impulse light.
Recommendation: The issues identified for this Committee have been resolved. However, new items brought forward by this Committee (e.g. regulations on medi-spas, etc.) would be more appropriate for discussion before the Licensing or Enforcement Committee, depending on the subject matter. Also, the Board can make use of interested parties meetings to facilitate discussion and obtain valuable information on issues that can then be used to inform actions by the Licensing or Enforcement Committee. As information is gathered on any issue, the Board could place information in its Newsletter or on its website, or could seek and legislative/regulatory change through the full Board. Therefore, this Committee could be eliminated.

SUB COMMITTEES/TASK FORCES OF TWO MEMBERS OR LESS

Legislation Subcommittee
Membership: Determined by the President
Responsibility: Review legislative amendments and pending legislation as necessary.
Recommendation: Eliminate this Sub Committee. The Executive Director and Chief of Legislation will discuss legislation as it arises and reach out to Members for assistance depending upon the area of expertise needed. In addition, the Executive Committee can also discuss legislation in between the Board Meetings, if necessary.

Organization Effectiveness Committee
Membership: Determined by the President
Responsibility: Oversee the policy implementation of the Board, provide budgetary assistance/decisions on behalf of the Board, provide guidance and assistance to the Executive Director on Board related matters, and review/assist with the strategic plan.
Recommendation: Eliminate this Committee. The Board President and Vice President have calls with Executive Staff on a bi-weekly basis to discuss the issues identified for this Committee and therefore this Committee is no longer needed.

Outpatient Surgery Setting Task Force
Membership: Determined by the President
Responsibility: To review the Outpatient Surgery Setting Program and provide input on the laws, rules, policies, etc.
Recommendation: Eliminate this Task Force. The issues requiring the establishment of this Task Force have been resolved for the most part, and those items that need continuing discussion can be moved to the Enforcement Committee or the Licensing Committee as necessary based upon the issue.

Prescribing Task Force
Membership: Determined by the President
Responsibility: To identify ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication, and outreach by engaging all stakeholders in this endeavor.
Recommendation: Keep this Task Force as is in order to complete the tasks that have been identified for this Task Force. All the work of this Task Force will be provided to the full Board for review, discussion, and decision.

COMMITTEES OF THE BOARD

Sept 2014

REQUIRED COMMITTEES

Executive Committee

Membership:	President of the Board, Chair Vice President of the Board Secretary of the Board Immediate Past President of the Board (The president may select additional members at his/her discretion.)
Responsibility:	Oversee various administrative functions of the board, such as budgets and personnel, and to review legislation; provide recommendations to the full Board; annually evaluate the performance of the Executive Director; and act for the Board in emergency circumstances (as determined by the Chair) when the full board cannot be convened.
Staff:	Kim Kirchmeyer, Executive Director
Current Members:	David Serrano Sewell, J.D., (Chair), Dev GnanaDev, M.D. (Vice President), Denise Pines, (Secretary), Michael Bishop, M.D., Sharon Levine, M.D., Ronald Lewis, M.D., Barbara Yaroslavsky
List of Issues:	- Legislation discussions and positions - Executive Officer evaluation - Strategic planning - Administrative issues - Assessment regarding effectiveness and efficiency of Board Meetings/Committees and suggestions for improvement
Meeting Schedule:	Meets on an as needed basis, usually during Quarterly Board Meetings, but may also meet off-cycle of Quarterly Board Meetings

Application Review Committee

(Business and Profession Code section 2135.5)

Membership: Determined by the President (normally limited to three members with minimum of one physician)

Responsibility: Evaluate the credentials of licensure applicants, where statute provides the Board to exercise discretion; and make recommendations to the Licensing Program regarding eligibility for licensure; (for example, postgraduate training hardship petitions per California Code of Regulations Title 16 section 1321(d) and written licensing exam waiver requests per Business and Professions Code section 2113).

Staff: Curt Worden, Chief of Licensing

Current Members: Gerrie Schipske, R.N.P., J.D. (Chair), Ron Lewis, M.D.,

Meeting Schedule: Meets on an as needed basis during Quarterly Board Meetings.

Midwifery Advisory Council

(Business and Professions Code section 2509)

Membership:	Determined by the Board as specified in law
Responsibility:	Develop solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including physician supervision, challenge mechanisms, and examinations, as specified by the Board.
Staff:	Curt Worden, Chief of Licensing
	Current Members: Carrie Sparrevohn, L.M. (Chair), Karen Ehrlich, L.M., Barbara Yaroslavsky, James Byrne, M.D., Monique Webster, Tosi Marceline, L.M. List of Issues: - Physician supervision - Barriers to care - Mandatory annual reporting - Midwife assistants - Midwife apprenticeships - Definition of “enrolled” for midwife students - Enforcement of midwives – licensed or unlicensed - Outreach to physician groups regarding midwifery
Meeting Schedule:	Meets three times per year, usually off-cycle of Quarterly Board Meetings

Special Faculty Permit Review Committee

(Business and Professions Code section 2168.1(c)(1))

Membership: A physician member and public member of the Board determined by the President. One representative from each California medical school nominated by the school dean.

Responsibility: Evaluate the credentials of applicants proposed by a California medical school to meet the requirements of Section 2168.1(a); determine whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need; and submit a recommendation to the Board for each proposed candidate for final approval or denial.

Staff: Curt Worden, Chief of Licensing

Current Members: Felix Yip, M.D., Chair, Barbara Yaroslavsky, Vice Chair, Neal Cohen, M.D. – UCSF, Daniel Giang, M.D. – Loma Linda, John A. Heydt, M.D – UCR, Jonathan Hiatt, M.D. – UCLA, Laurence Katznelson, M.D. – Stanford, James Nuovo, M.D. – UCD, Andrew Ries, M.D. – UCSD, Frank R. Sinatra, M.D. – USC, Julianne Toohey, M.D. - UCI

List of Issues: Periodic examination of the performance and status of all 2168 Special Faculty Permit holders based upon information from their institutions and elsewhere.

Meeting Schedule: Meets off-cycle of Quarterly Board Meetings on an as needed basis

Special Programs Committee

(Business and Professions Code sections 2072, 2073, 2111, 2112, 2113, and 2115)

Membership:	Determined by President (normally limited to three members with minimum of one physician)
Responsibility:	Provide guidance and expertise to Board staff regarding special program laws and regulations, specific applications, medical school site visits, and issues of concern; and make recommendations to the Licensing Program.
Staff:	Curt Worden, Chief of Licensing
Current Members:	(Chair-VACANT)
Meeting Schedule:	Meets on an as needed basis during Quarterly Board Meetings

COMMITTEES CREATED BY THE BOARD

Enforcement Committee

Membership:	Determined by the President
Responsibility:	Serve as an expert resource and advisory body to members of the Board and its Enforcement Program by educating board members and the public on enforcement processes; identify program improvements in order to enhance protection of health care consumers; and review via a task force the Board's Vertical Enforcement/Prosecution Program.
Staff:	Renee Threadgill, Chief of Enforcement
Current Members:	Ronald Lewis, M.D. (Chair), Gerrie Schipske, R.N.P., J.D., David Serrano Sewell, J.D., Barbara Yaroslavsky, Felix Yip, M.D., Howard Krauss, M.D., Elwood Lui
List of Issues:	- Review the time lines for processing complaints, investigations, and disciplinary actions in an effort to determine efficiencies and identify where changes can be made - Training and recruitment of expert reviewers - VE/P evaluation report recommendations - Probation Program enhancements
Meeting Schedule:	Full Committee meets on an as needed basis during Quarterly Board Meetings; task force meets off-cycle of Quarterly Board Meetings

Licensing Committee

Membership:	Determined by the President
Responsibility:	Serve as an expert resource and advisory body to members of the Board and its Licensing Program by educating board members and the public on the licensing process; identify program improvements; and review licensing regulations, policies, and procedures.
Staff:	Curt Worden, Chief of Licensing
Current Members:	Michael Bishop, M.D. (Chair), Dev GnanaDev, M.D., Gerrie Schipske, R.N.P., J.D., Denise Pines, Ron Lewis, M.D., Jamie Wright, Esq.
List of Issues:	- Implementation of the 2010 Reengineering Report's recommendations regarding: o Policy and procedures o Revised application and Web site - Maintenance of licensure (MOL) - Other programs of the Board related to licensing: o Fictitious name permits o Registered Dispensing Optician/Research Psychoanalyst programs o Continuing medical education and audit o Polysomnography program o Outpatient Setting Accreditation Agencies and process
Meeting Schedule:	Meets on an as needed basis during Quarterly Board Meetings, but may also need to meet off-cycle of Quarterly Board Meetings

Access-to-Care/Cultural and Linguistic Competency Committee

Membership:	Determined by the President
	Responsibility: Identify opportunities for the Board to promote and assist physician involvement in access to care issues by providing policy development, program direction, and recommendations to the Board; and encourage activities designed to promote the cultural and linguistic competency of physicians.
Staff:	Kevin Schunke, Manager
	Current Members: Barbara Yaroslavsky, (Chair), Elwood Lui
Subcommittee Members:	Sergio Aguilar-Gaxiola, M.D., Ph.D., David Hayes-Bautista, Ph.D.
List of Issues:	- Continue to gather information on collaborative care models – inform physicians via newsletter, link to articles, etc. - Receive updates on loan programs/placements - Examine methods to enhance the use of physician volunteers in the workforce: gather information on volunteers in the workforce, inform the Board, and determine if the Board wants to pursue any action other than information - Encourage activities designed to promote the cultural and linguistic competency of physicians.
Meeting Schedule:	Meets off-cycle of Quarterly Board Meetings on an as needed basis

Committee on Physician Supervisory Responsibilities

Membership:	Determined by the President
	Responsibility: Develop regulatory language related to physician availability in cosmetic surgery settings that use laser impulse light.
Staff:	Jennifer Simoes, Chief of Legislation
	Current Members: Gerrie Schipske, R.N.P., J.D. (Chair), Christopher Barnard, M.D., Michael Bishop, M.D., Jack Bruner, M.D., Beth Grivett, P.A,, Suzanne Kilmer, M.D., James Newman, M.D., Paul Phinney, M.D., Harrison Robbins, M.D.
List of Issues:	- Implement Senate Bill 100 related to physician availability - Other issues identified by Chair and Members
Meeting Schedule:	Meets off-cycle of Quarterly Board Meetings on an as needed basis

Education and Wellness Committee

Membership:	Determined by the President
Responsibility:	Develop various informational materials for publication and Internet posting; monitor the Board's strategic communication plan; develop physician wellness information by identifying available activities and resources which renew and balance a physician's life, both personal and professional.
Staff:	Public Information Officer
Current Members:	Barbara Yaroslavsky (Chair), Gerrie Schipske, R.N.P., J.D., Denise Pines, Howard Krauss, M.D.
Subcommittee Members:	Daniel Giang, M.D., Laurie Gregg, M.D., William Norcross, M.D., Gary Nye, M.D.
List of Issues:	- Discuss the requirements of Senate Bill 380 related to educational material regarding the prevention and treatment of chronic disease, including holding an interested parties workshop by January 2015 - Educate physicians regarding physician wellness - Review education materials by the Board
Meeting Schedule:	Meets on an as needed basis, usually off-cycle of Quarterly Board Meetings

SUBCOMMITTEES OF TWO MEMBERS OR LESS

Legislation Subcommittee

Membership: Determined by the President

Responsibility: Review legislative amendments and pending legislation as necessary.

Staff: Jennifer Simoes, Chief of Legislation

Current Members: Sharon Levine, M.D.

Organization Effectiveness Committee

Membership: Determined by the President

Responsibility: Oversee the policy implementation of the Board, provide budgetary assistance/decisions on behalf of the Board, provide guidance and assistance to the Executive Director on Board related matters, and review/assist with the strategic plan.

Staff: Kimberly Kirchmeyer, Executive Director

Current Members: Sharon Levine, M.D.

Prescribing Task Force

Membership: Determined by the President

Responsibility: To identify ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication and outreach by engaging all stakeholders in the endeavor.

Staff: Kimberly Kirchmeyer, Executive Director

Current Members: Michael Bishop, M.D.
Barbara Yaroslavsky

Outpatient Surgery Settings Task Force

Membership: Determined by the President

Responsibility: To review the Outpatient Surgery Setting Program and provide input on the laws, rules, policies, etc.

Staff: Curt Worden, Chief of Licensing

Current Members: Dev GnanaDev, M.D.
David Serrano Sewell

Medical Board of California

STRATEGIC PLAN 2014

October 2014 Update

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

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

1.2	**Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure (MOL) and the American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) initiatives to determine if changes are needed to existing requirements in California (continuing medical education) in order to ensure maintenance of competency of California physicians.**	**HIGH - 2**

Activities		**Date**	**Responsible Parties**
a.	Review the FSMB MOL and the ABMS MOC documents and identify the various components.	Jan-2015	Licensing Outreach Manager
b.	Compare the elements with California's laws and regulations regarding continuing medical education and determine if there are differences.	Apr-2015	Licensing Outreach Manager
c.	Staff will draft changes to laws and regulations as necessary.	May-2015	Licensing Outreach Manager
d.	Hold an interested parties meeting to discuss the proposed changes.	Jun-2015	Chief of Legislation
e.	Present the final changes to the laws and regulations to the Board for consideration.	Jul-2015	Chief of Legislation
f.	Based on the discussion by the Board, if legislative changes are needed, find an author and initiate the legislative process.	Oct-2015	Chief of Legislation
g.	Based on the discussion by the Board, if regulatory changes are needed, have staff initiate the rule-making process.	Oct-2015	Licensing Outreach Manager

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

2.1	Effectively transition the investigators from the Board to Department of Consumer Affairs in order to improve investigative time frames.		High - 1	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Identify existing investigative timeframes.	Dec-2013	Executive Director and Chief of Enforcement	Completed – however, due to BreEZe only have statistics as of October 3, 2013.
b.	Hold regular meetings with DCA to discuss the transition of the investigators.	Oct-2013 and ongoing	Executive Director and Chief of Enforcement	Completed
c.	Review and approve the Memorandum of Understanding to identify how the transition will be implemented and DCA/Board responsibilities.	Mar-2014	Executive Director, Chief of Enforcement and Senior Staff Counsel	Completed
d.	Update the Board on the transition of staff.	Quarterly	Executive Director and Chief of Enforcement	Completed – July 2014
e.	Meet with labor relations to discuss transition issues.	Apr-2014	Executive Director and Chief of Enforcement	Completed
f.	Meet with staff to discuss the transition.	Ongoing	Executive Director and Chief of Enforcement	Completed
g.	Finalize the transition and movement of staff.	Jul-2014	Executive Director and Chief of Enforcement	Completed
h.	Gather and review investigative timeframes.	Monthly	Executive Director and Enforcement Manager	Due to the transition to the BreEZe system, unable to obtain reports indicating these timeframes.
i.	Report investigative timeframes to the Board.	Quarterly	Executive Director and Enforcement Manager	Due to the transition to the BreEZe system, unable to obtain reports indicating these timeframes.

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

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

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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**	**Status**
a.	Send individual notifications to all mandated reporters regarding the reporting requirements.	Annually	Enforcement Manager	Pending the hiring of the Chief of Enforcement and will be done in January 2015.
b.	Obtain a list of reports from the National Practitioner Databank to cross check with the Board's information.	May annually	Research Program Specialist	Completed May 2014
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 Public Information Officer is working with the L.A. County Coroner's Office to include an article about their mandated reporting for the coroners. The Public Information Officer will be contacting various hospitals to place an article in their newsletters on the reporting requirements of 805.
d.	Conduct outreach on reporting requirements to all mandated reporters, as resources allow.	July-2014 and ongoing	Public Information Officer	On August 28, 2014, a presentation on reporting requirements pursuant to Business and Professions Code section 805 was provided to Rancho Los Amigos Rehabilitation Hospital. On September 26, 2014, a presentation was given to the California Association Medical Staff Services on Business and Professions Code section 805 reporting.

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.4	**Determine whether the Registered Dispensing Optician (RDO) Program should remain within the authority of the Board.**	**High - 4**	
Activities	**Date**	**Responsible Parties**	**Status**
a. Initiate discussions with the DCA, Board of Optometry, stakeholders, professional groups, and consumer representatives to discuss the potential transfer of the RDO program.	Aug-2014	Chief of Legislation; Executive Director	Board staff have begun discussions with the Executive Officer of the Board of Optometry regarding this issue. Meetings are being scheduled in October for the stakeholders on this issue.
b. Write a summary report of the discussions for the Board's review and approval.	Oct-2014	Chief of Legislation; Executive Director	Pending discussions with stakeholders.
c. Make recommendations to the Business and Professions Committees and seek legislation if necessary.	Nov-2014	Chief of Legislation; Executive Director	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

2.5	Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.	High - 5		
Activities		**Date**	**Responsible Parties**	**Status**
a.	Continue to evaluate, revise, and update the training program and materials for experts.	Ongoing	Enforcement Manager	Pending the hiring of the Chief of Enforcement. However, staff will be working with a retired annuitant to update the training materials and schedule future training.
b.	Require the Deputies Attorney General who use the experts to provide evaluations on each expert report and each expert that testifies.	Within 30 days of completion of each expert task	Enforcement Manager	This is being completed as cases proceed through the enforcement process.
c.	Examine the evaluations to determine if there is a need for remediation or elimination of the experts.	Within 30 days of the evaluation	Enforcement Manager	The Expert Reviewer Program Analyst watches the evaluations to determine appropriate action, and when necessary forwards the information to appropriate parties. Full assessment is pending the hiring of the Chief of Enforcement.
d.	Continue to provide statewide trainings for the expert reviewers.	Provide two trainings	Enforcement Manager	Pending the hiring of the Chief of Enforcement and assistance from a retired annuitant.
e.	Provide a status report to the Board on the Expert Reviewer Program.	Quarterly	Enforcement Manager	Completed – July 2014

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

2.6	**Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.**		**Med - 6**	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Examine recent disciplinary decisions to identify any training needed for the Administrative Law Judges.	Monthly	Enforcement Manager	Currently the Executive Director is performing this function.
b.	Identify subject matter experts and arrange OAH training at least every other month.	Six times annually	Enforcement Manager	Training was provided to OAH in June on medical terminology. Another training was scheduled for October 31, 2014, however, at this time it is unknown whether that will take place.
c.	Provide OAH with updates on the Board issues and changes to disciplinary guidelines.	Annually	Executive Director and Enforcement Manager	Upon passage of the SB 1441 regulations a meeting will be scheduled with OAH.
2.7	**Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks.**		**Med - 7**	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Identify the metrics to be used to examine disciplinary cases within last five years.	Aug-2014	Research Program Specialist	Pending initiation due to other important projects and lack of staff.
b.	Identify the red flags that could be used to predict patterns before serious harm occurs.	Nov-2014	Research Program Specialist	
c.	Draft a report based upon the findings to present to the Board for possible action.	Jan-2015	Research Program Specialist	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.				
3.1	**Review the Board's public disclosure laws regarding posting postgraduate information and move forward with rescinding the 10-year time limit for posting disciplinary information/documents.**		**High - 1**	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Seek legislation to rescind the 10-year time limit for posting disciplinary information/documents.	Feb-2014	Chief of Legislation	AB 1886 – passed and will become effective January 1, 2015.
b.	Discuss the proposal to remove the posting of postgraduate training information with interested parties, specifically consumer interest groups.	Aug-2014	Chief of Legislation and Chief of Licensing	Due to the ability in BreEZe to gather this information, at the July 2014 Board Meeting staff presented, and the Board approved, the recommendation to not seek legislation to remove the posting of postgraduate information.
c.	Provide the recommendation on postgraduate training information to the Board for approval.	Oct-2014	Chief of Legislation and Chief of Licensing	Due to the ability in BreEZe to gather this information, at the July 2014 Board Meeting staff presented, and the Board approved, the recommendation to not seek legislation to remove the posting of postgraduate information.
d.	Make recommendations to the Business and Professions Committees and seek legislation.	Nov-2014	Chief of Legislation	Due to the ability in BreEZe to gather this information, at the July 2014 Board Meeting staff presented, and the Board approved, the recommendation to not seek legislation to remove the posting of postgraduate information.

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**	**Status**
a.	Engage in two or more consumer outreach events with area organizations, as travel permits.	Quarterly	Public Information Officer	On July 29, 2014, staff attended a Fraud Prevention Workshop sponsored by Assemblyman Tom Daly's office in Santa Ana and the California State Bar. The workshop reached out to the Hispanic community, and involved a presentation by the Board staff in both English and Spanish as well as a Q & A session. On August 12, 2014, staff provided a presentation was provided at a Senior Scam Stoppers event sponsored by Assemblywoman Beth Gaines office in Sun City Lincoln Hills. The presentation concentrated on what the Medical Board does and what seniors need to know. On August 25, 2014, staff provided a presentation was provided at Assemblywoman Beth Gaines' Senior Scam Stoppers town hall in Roseville. Again, the presentation concentrated on the role of the Medical Board and what seniors need to know. On September 18, 2014, staff provided a presentation was provided at a town hall in Citrus Heights sponsored by Assemblyman Ken Cooley and the California State Bar. The event reached out to the Ukraine, Russian, Iraq, and Afghan communities. What the Medical Board does an how we protect consumers was the basis of the presentation. On September 26, 2014, staff provided a presentation was provided at a Scam Busters event sponsored by Assemblyman Roger Dickenson in Sacramento. What the Medical Board does and how it protects consumers was the basis of the presentation. On October 15, 2014, staff participated in a Town Hall at Neil Orchard Senior Activities Center in Sacramento. The topic was consumer protection for seniors. On October 15, 2014, staff participated in a Fraud Awareness Fair with the Yolo/Sacramento County District Attorney Offices. The messaging was how consumers can protect themselves and what they can do if they feel victimized.

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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. (cont.)**		**High - 2**	
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 contained an article titled "Pesticide Illness Reporting Requirements" to remind physicians of the requirements and expectations when pesticide illness is suspected. The Summer Newsletter contained an article titled "What To Know About Providing A Recommendation For Marijuana." The Summer Newsletter contained an article titled "ACGME Program Directors Warning! Are You Aiding and Abetting The Unlicensed Practice Of Medicine?" The Summer Newsletter contained an article titled "Requirement For Physicians to Sign Death Certificates."
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	Pending initiation due to other important projects and lack of staff.
d.	Provide two or more articles to appropriate media outlets regarding laws and regulations and what they mean to stakeholders.	Quarterly	Public Information Officer	

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**	**Status**
a.	Work with DCA to establish webinar protocol and the tools needed to hold successful webinars.	Jun-2014	Public Information Officer	
b.	Work with healthcare agencies and organizations regarding topics of interest for training purposes.	Sep-2014	Public Information Officer	Staff have received requests for topics to provide education to licensees and are working to develop training tools.
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	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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**	**Status**
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.	Quarterly	Public Information Officer	At a September Town Hall staff developed a working relationship with Asian Resources and will be working with them to reach out and provide a presentation.
b.	Engage in television and radio interviews promoting transparency and providing needed information as requested.	Ongoing	Public Information Officer	Board staff engages regularly with both California media and out of state media. Provided an Opinion Editorial for the Knoxville News on a story they published on September 27, 2014 titled "Let Doctors Cross Borders For Free Medical Clinics".
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	Completed a PSA with Natalie Coughlin addressing consumers on the prescription drug epidemic. Working to get this PSA aired in Los Angeles, Bay Area, and Sacramento viewing markets. Completed an instructional video/tutorial in September instructing individual licensees how to complete the U.S./Canadian Medical School Graduate Application.
d.	Promote the Board's website and provide consumer friendly information on how to file a complaint.	Ongoing	Public Information Officer	Board staff are working on a video for consumers on the complaint process, including everything a consumer needs to know to file a complaint.

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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**	**Status**
a.	Develop a list of groups who have shown interest for Board speakers in the past, in order to identify similar groups that the Board can reach out to for potential seminars.	Sep-2014	Public Information Officer	
b.	Cultivate relationships with groups not previously engaged, in order to provide seminars.	Sep-2014	Public Information Officer	
c.	Revise and update presentations already developed for the purpose of providing seminars.	Jan-2015	Public Information Officer, Senior Staff Counsel, and Enforcement Manager	
d.	Conduct and record the seminar and post it on the Board's website.	Mar-2015 and ongoing	Public Information Officer, Senior Staff Counsel, and Enforcement Manager	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

4.1	**Build collaborative relationships with elected officials and their staffs to work toward shared interests in consumer protection and advancing the profession.**	**High - 1**	
Activities	**Date**	**Responsible Parties**	**Status**
a. Develop a plan to visit Senate and Assembly Business and Professions Committee members and staff with Board members.	Oct-2014	Chief of Legislation	Staff are planning on a Legislative Day where the Members, in teams of two, visit Legislative Offices to provide information to Legislative Members and their staff. Day to be held hopefully in February.
b. Invite legislative members and staff to Board meetings.	Quarterly	Chief of Legislation	Completed – July 2014
c. Continue to reach out to new legislative members to inform them of the Board's roles and responsibilities.	Ongoing	Chief of Legislation	Completed as new Members join the Senate and Assembly Business and Professions Committee.

4.2	**Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.**	**High - 2**	
Activities	**Date**	**Responsible Parties**	**Status**
a. Arrange licensing fairs and orientations at teaching facilities to educate applicants on the Board and its application and licensing processes.	Monthly	Licensing Outreach Manager	Completed – 13 events held in the last quarter.
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	On August 28, 2014, a presentation on reporting requirements pursuant to Business and Professions Code section 805 was provided to Rancho Los Amigos Rehabilitation Hospital. On September 10, 2014, a presentation was given to the Joint Review Committee of the Beverly hospital in Montebello California on what a decision by the Medical Board on a physician means to a hospital. On September 16, 2014 , a presentation was provided to the medical staff at White Memorial Medical Center in Los Angeles on impaired or disruptive physicians. On September 26, 2014, a presentation was given to the California Association Medical Staff Services on Business and Professions Code section 805 reporting.

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

Goal 4: Organizational Relationships: Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.				
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**	**Status**
a.	Develop a contact list of representatives for stakeholder organizations.	Mar-2014 and update annually	Public Information Officer	Developing for completion in March 2015.
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	On September 12, a presentation was provided to the California Ambulatory Surgery Association regarding the Board and its role with Outpatient Surgery Settings. See Objective 4.2b above.
c.	Maintain regular communication with stakeholders, including attending stakeholder meetings as appropriate, as travel permits.	Ongoing	Public Information Officer	On a quarterly basis, staff meets with the California Medical Association. On a bi-weekly basis, the Executive Director meets with Executive Staff at the Department of Consumer Affairs. Board staff attend webinars from the Federation of State Medical Boards and the Executive Director is in contact with the Federation frequently. The Executive Director attended a Health Care Executive Officer Council meeting to discuss issues of mutual concern. Board staff are involved with a working group consisting of a number of State agencies to address the prescription drug epidemic.
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 contained articles from the Food and Drug Administration, Los Angeles Coroner's Office, and the Office of Environmental Health Hazard Assessment.
e.	Provide activity reports to the Education and Wellness Committee.	At each committee meeting	Public Information Officer	Completed – July 2014

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.			
5.1	**Review licensing applications within 45 days. Reduce complaint processing, investigations, and discipline timelines by 10% from prior fiscal year; reduce complaint processing median to less than 70 days, with 50-60% less than 50 days.**	**High - 1**	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Gather and evaluate statistics regarding the Board's application review timeframes.	Quarterly	Chief of Licensing	Completed
b.	Determine if the Board is reviewing applications within 45 days, and if not, identify possible problems and solutions.	Quarterly	Chief of Licensing	Completed
c.	Implement the possible solutions for licensing process enhancement.	As Necessary	Chief of Licensing	
d.	Gather and evaluate statistics regarding the Board's enforcement timeframes.	Quarterly	Enforcement Manager	Due to BreEZe, the Board has been unable to obtain enforcement statistics.
e.	Determine if the Board is meeting enforcement timeframes goals, and if not, identify possible problems and solutions.	Quarterly	Enforcement Manager	Due to BreEZe, the Board has been unable to obtain enforcement statistics.
f.	Implement the possible solutions for enforcement process enhancements.	As Necessary	Enforcement Manager	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.				
5.2	**Obtain and monitor feedback from those who access Board services and provide a report to the Board.**		**High - 2**	
Activities		**Date**	**Responsible Parties**	**Status**
a.	Evaluate consumer satisfaction statistics.	Quarterly	Research Program Specialist	The Board is working with DCA to identify a better consumer satisfaction survey and will be providing that to complainants.
b.	Evaluate applicant satisfaction statistics.	Quarterly	Research Program Specialist	Completed
c.	Evaluate web user satisfaction statistics.	Quarterly	Research Program Specialist	Completed (this survey has recently been revised).
d.	Evaluate Newsletter reader satisfaction statistics.	Quarterly	Research Program Specialist	Completed
e.	Create a summary report of satisfaction statistics and present them to the Board.	Quarterly	Research Program Specialist and Executive Director	Board staff will complete this for the January 2015 Board Meeting.
f.	Implement changes as needed based upon the feedback received.	As Necessary	Research Program Specialist and Executive Director	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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

5.3	Establish a consistent approach to educating staff about the Board's activities and priorities set by Board Members, including but not limited to facilitating staff attendance at meetings and Board Member attendance at staff meetings.	Med - 3	
Activities	**Date**	**Responsible Parties**	**Status**
a. Send an email to all staff after each Board meeting indicating the action taken by the Board and any projects that will need to be completed.	Quarterly	Executive Director	Completed after the July Board Meeting
b. Send emails to all staff updating them on projects of the Board.	Monthly	Executive Director	This has been done more on a quarterly basis, but will be moved to a monthly basis upon the hiring of additional staff.
c. Hold regular staff meetings and provide a Q and A time for staff.	Quarterly	Executive Director	Completed in prior quarter, however, in the last quarter we held a staff appreciation event instead.
d. Send an email to staff notifying them of upcoming meetings where they may attend.	Quarterly	Executive Director	Completed for the July Board Meeting
e. Invite Board Members to all staff meetings.	Quarterly	Executive Director	Completed for staff appreciation event (in Board Member update).

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

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

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

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**	**Status**
a.	Continue to invite appropriate speakers to inform the Board about the ACA.	Bi-annually	Chief of Legislation and Executive Director	
b.	Identify and obtain ACA articles to print in the Board's Newsletter.	Bi-annually	Public Information Officer	The President's Message in the Summer Newsletter was regarding the ACA and its rollout.
c.	Educate physicians on opportunities to assist patients not within the ACA in obtaining access to care.	Bi-annually	Public Information Officer	

Green activity is complete. Yellow activity is in process. Red activity has not been completed in the timeframe requested.

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

AMENDED – Additional Location Information
Sheraton San Diego Hotel & Marina
Fairbanks A&B – **Bay Tower**
1380 Harbor Island Drive
San Diego, CA 92101

Thursday October 23, 2014
3:45 p.m. – 5:45 p.m.
(or until the conclusion of business)

Friday, October 24, 2014
9:00 a.m. – 3:00 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.

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

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

ORDER OF ITEMS IS SUBJECT TO CHANGE

Thursday, October 23, 2014

1. 3:45 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 July 24 – 25, 2014 Meeting

4. Update and Consideration of Recommendations from the Midwifery Advisory Council Meeting – Ms. Sparrevohn

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

6. President's Report – Mr. Serrano Sewell

7. Update and Consideration of Recommendations from the Executive Committee Meeting – Mr. Serrano Sewell

8. Executive Management Reports – Ms. Kirchmeyer
   A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
   B. Administrative Summary
      1. CURES Update
      2. Update on Safe Prescribing CME Course in Los Angeles on September 19, 2014
   C. Enforcement Program Summary

D. Licensing Program Summary
E. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children

9. Federation of State Medical Boards Summary – Ms. Kirchmeyer
   A. Update on Federation of State Medical Board Activities
   B. Approval of Recommendation for FSMB Committees
   C. Update on Interstate Compact

10. Update and Consideration of Recommendations from the Enforcement Committee Meeting – Dr. Lewis

11. Vertical Enforcement Program Report
   A. Program Update from the Department of Consumer Affairs – Mr. Gomez
   B. Program Update from the Health Quality Enforcement Section – Ms. Castro

12. Update from the Attorney General's Office – Ms. Castro

Friday, October 24, 2014

13. 9:00 a.m. Call to Order/Roll Call

14. 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)]

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

16. Update and Consideration of Recommendations from the Prescribing Task Force – Dr. Bishop and Ms. Yaroslavsky
   A. Review and Consideration of *Guidelines for Prescribing Controlled Substances for Pain*

17. Update on the Regulatory Hearing to Amend Title 16 CCR, Sections 1364.10, 1364.12 1364.13, and 1364.14 – Citations and Fines – Ms. Kirchmeyer

18. Presentation on Fictitious Name Permits – Mr. Worden

19. Discussion and Consideration of the Proposed Regulations to Amend the Continuing Medical Education Requirements – Mr. Worden

20. Special Faculty Permit Review Committee Recommendations; Approval of Applicants – Dr. Yip

21. Discussion and Consideration of Legislation/Regulations – Ms. Simoes
   A. 2014 Legislation
   B. 2015 Legislation Proposals
   C. Status of Regulatory Actions

22. Update on the Physician Assistant Board – Dr. Bishop

23. Update on the Health Professions Education Foundation – Ms. Yaroslavsky and Dr. Yip

24. Agenda Items for the January 29 – 30, 2015 Meeting in Sacramento

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.

Thursday 10/23 - The call-in number for teleconference comments is: 1-800-230-1096.

Friday 10/24 - The call-in number for teleconference comments is: 1-800-762-4758.

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 14** – 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.

Sign Up for CURES at the Medical Board of California October Board Meeting in San Diego

Effective January 1, 2016, all California licensed physicians must be registered to access PDMP/CURES (as required by Section 209 of the California Business and Professions Code). Registering for CURES access allows the physician to access patient activity reports before prescribing controlled substances. The current registration process requires the physician to complete the online application and have the application notarized.

The Medical Board of California has volunteered to assist physicians in registering for access to CURES by reviewing the completed documents and verifying the physician's identity in place of the requirement to have the documents notarized. MBC is authorized to accept the applications and forward them directly to the Department of Justice for expedited processing.

MEETING LOCATION: **Sheraton San Diego Hotel and Marina**
1380 Harbor Island Drive
San Diego, CA 92101

BEFORE COMING TO THE MEETING:

You must start the process by going to oag.ca.gov/cures-pdmp. Select "prescriber," then:

1. **Complete** the online application form
2. **Print** the completed form, then sign and date it
3. **Attach** a copy of:
    - Your CA medical license
    - DEA controlled substances registration
    - Driver's license or other photo government identification

AT THE BOARD MEETING – APPLICANT MUST BE PRESENT TO PROCESS

YOU must bring the **completed** packet in person to Medical Board staff table at the Sheraton San Diego Hotel and Marina on Thursday, October 23 from 10:30 a.m. to 5:30 p.m., or on Friday, October 24 from 9:00 a.m. to 1:00 p.m.

A confirmation will be emailed to you from the Department of Justice once your registration is processed.

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

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

July 24-25, 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:
Sharon Levine, M.D., President
Michael Bishop, M.D.
Dev GnanaDev, M.D.
Howard Krauss, M.D.
Ronald H. Lewis, M.D.
Denise Pines
David Serrano Sewell, J.D., Vice President
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

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

Staff Present:
Adam Brearly, Investigator, HQIU
Susan Cady, Staff Services Manager II
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Virginia Gerard, Associate Government Program Analyst
Catherine Hayes, Staff Services Manager
Cassandra Hockenson, Public Affairs Manager
Anne Hutchison, Staff Services Analyst
Kimberly Kirchmeyer, Executive Director
Armando Melendez, Business Services Officer
Roberto Moyer, Investigator, HQIU
Destiny Pavlacka, Office Assistant
Regina Rao, Associate Governmental Program Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Renee Threadgill, Chief of Enforcement, HQIU
Lisa Toof, Administrative Assistant II
See Vang, Business Services Officer

Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing
Christine Zimmer, Staff Services Manager I

Members of the Audience:
Theresa Anderson, California Academy of Physician Assistants
GV Ayers, Senate Business and Professions Committee
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Scott Clark, California Medical Association
Genevieve Clavreul, (via Teleconference)
Zennie Coughlin, Kaiser Permanente
Frank Cuny, California Citizens for Health Freedom
Julie D'Angelo Fellmeth, Center for Public Interest Law
Jodi Hicks, California Academy of Family Physicians
Marian Hollingsworth, Consumer's Union
Christine Lally, Deputy Director, Boards and Bureau's, Department of Consumer Affairs
Tina Minasian, Consumer's Union
Anita Scuri
Suzan Shinary, Consumer's Union
Mike Small, Department of Justice
Cesar Victoria, Department of Consumer Affairs

Agenda Item 1 Call to Order/Roll Call

Dr. Levine called the meeting of the Medical Board of California (Board) to order on Thursday, July 24, 2014 at 4:06 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

Frank Cuny, Director for California Citizens for Health Freedom, stated next year, they will be introducing a bill that will deal with making integrative treatment of cancer legal in California. The bill will define what integrative treatment is, what the factors are, and what kind of rights the patient has including knowing what background the provider has for providing it. In addition, the patient will know what the conventional approaches are for treatments and the differences between the two. Currently under the cancer law, cancer treatments have to be approved by the Federal Drug Administration (FDA), which is strictly the drug approach and physicians who are not following could be disciplined by the Board. They feel there are other treatments out there that are very successful.

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

Ms. Yaroslavsky made a motion to approve the May 1-2, 2014 Meeting Minutes as submitted; s/Dr. Lewis. Motion carried.

Agenda Item 4 Presentation on Improvements and Changes to the Controlled Substance Abuse Utilization Review and Evaluation System (CURES)

Dr. Levine introduced Mr. Small from the Department of Justice (DOJ). Mr. Small has been program manager for DOJ's CURES/Prescription Drug Monitoring Program (PDMP) since December 2011. He has been the leader and advocate of the redesign of an updated CURES system.

Mr. Small provided a presentation including an update on current statistics of the CURES system as well as issues presently being worked on to meet the future needs of physicians and pharmacists. One particular issue that Mr. Small discussed is the registration process. Historically, this process has not been optimal. The web-based database system for practitioners today was originated in 2009. Like many PDMPs, it was built from small federal grants over the course of a couple of years and has proved to not be sufficient enough to carry on the mission that is needed with the ever-increasing frequency of opioid drug abuse and misuse. In addition, in 2011, the Governor and the Legislature defunded CURES. Since then the system has been running on unofficial status, recognizing that it is an important public health and public safety program. DOJ has been trying to sustain it, but consequently, has been unable to respond satisfactorily to the constituent needs, particularly the practitioners. Staff has been unable to answer phone calls timely and taking it is far too long to process applications for new registrants and new users of the system. Fortunately, DOJ has recently been able to bring on six student interns, which has allowed DOJ to accept phone calls and emails. It is taking staff two to three days to respond to calls and emails, but they are now able to return them.

In terms of registration, it is recognized that it is a burdensome process. Staff has put together a process for facilities with groups of 20 or more qualified participants who have their application packets complete, less the notarization requirement, DOJ will come out to the facility and verify those participants in person and collect those applications. DOJ has made offers to public entities such as the Board of Pharmacy that has staff who accept the applications and sign off on the confirmed identity of the applicant and then forward the applications to DOJ where they are processed, waiving the notary requirement. Ms. Small is proud to announce that with no authorized staff, registrations have increased by 216% since December 2011.

SB 809 reinstates CURES funding effective July 1, 2015, at which point DOJ can begin hiring staff again. However, in the same bill, all DEA holding prescribers and all pharmacists have to be registered with the CURES system, which is going to be a tough process with the current registration system as it stands now. Mr.Small's goal for the July 2015 effective date is to work with the boards that license prescribers and pharmacists to ingest elements of the boards data files necessary for them to register users in order to create an automated registration program. This process will produce an official source of files documenting licensure rather than having to start from scratch. Licensees would be able to identify themselves electronically, complete the on-line application form, provide a DEA

number, etc. At that point, the registration would be complete, a password would be issued, and the licensees would then be considered registered and able to use the system.

Aside from registration itself, DOJ is envisioning the system doing a number of things it currently cannot do. DOJ is planning to interoperate with all of the major health care systems and pharmaceutical Information Technology (IT) systems in the State, so that CURES queries can be sent electronically, based on anticipated appointments, or in case of an emergency room visit.

Mr. Small noted they hope to add a few new features to the new system that are not available in the current system. They hope that by achieving interoperability, they will be able to create a bridge between email systems, so that if a physician in one setting sees a CURES report that is alarming to him or her, there would be a peer-to-peer communication to let them know there may be an issue with a particular patient. He would also like to give physicians the option and ability to enter the patient's name into the system and if that patient goes to another physician, and if a CURES report was run, it would tell the new physician, the previous physician wishes to be contacted before any additional narcotic drugs are prescribed. Mr. Small would also like the physician to have the ability to have a list of patients on their landing page of the system who in total have been prescribed more than 100 milligrams of opioids from all various sources of prescribers. Another option he would like to see offered is a statistical page that provides rates of prescribing throughout the state and by zip code.

Dr. Lewis stated real-time information is what is truly needed most. Dashboards are good for private type practices, but not for urgent care or emergency room care.

Mr. Small agreed and reminded the Board that his hands are tied by the Legislature and current law. Current law gives a seven-day period to submit the data by the pharmacists. The system will be able to accept data on a real-time basis, but that does not mean it will be updated due to the law.

Dr. GnanaDev asked Mr. Small, if a colleague wanted to sign up for CURES right now, how long it would take them.

Mr. Small stated there is an approximately five to six week backlog on processing applications at the current time.

Dr. GnanaDev noted this backlog is frustrating to the physician and gives the public a false sense of security. If Proposition 46 passes, Dr. GnanaDev believes there is no way the system will be ready and it worries him. He asked what could be done to make registering faster and easier.

Mr. Small noted the new statue is going to enable them to make IT integration connections with the board's data to facilitate making registering much simpler and quicker. It is not a difficult task, but takes funding to do it.

Dr. GnanaDev asked for clarification on getting the information to a physician before a patient's appointment.

Mr. Small stated once the new system is fully developed, there will be interoperability to other systems and physicians could choose to go to the expense to transmit query data to CURES in bulk, the day before the appointment. They would then be able to get the data back, so it is in the system when the physician meets with the patient for their scheduled appointment.

Dr. Krauss thanked Mr. Small for the presentation, as he believes CURES is a very valuable resource and without his single-handed efforts, it would be non-existent by now. Dr. Krauss asked if funding and staff were provided today, how soon the CURES system could register 100,000 practitioners.

Mr. Small stated the first step would be to create the registration section of the system that could accommodate that many practitioners, which is a priority for him. However, since he works for DOJ and it is responsible for title and summary for all the public initiatives, he cannot comment too much on any specific situation that may force a contracted enrollment period.

Dr. Krauss asked if the new CURES system is running or if it is still being designed.

Mr. Small stated it is being designed. The requirements have been approved by the California Technology Agency and the contractor was just recently hired. There are a lot of meetings and planning that have to take place to refine the project to a level where a viable system will be produced.

Dr. Krauss asked what the time line would be with the vendor to have a functional system.

Mr. Small stated at this point it would be July 1, 2015.

Ms. Yaroslavsky asked if the program, as it exists today, is convenient for the benefit of the people using it, or is that being put aside in order to build a new more effective program.

Mr. Small stated when he started on this program in 2011, changes to the existing system were frozen due to lack of staff funding. The current system is not the best or most user-friendly system; however, those who do use the current system state that it is indispensable to them. It can certainly be made better in the future, which is the goal.

Dr. Krauss asked if the new system would provide real-time information.

Mr. Small replied no. If the Legislature only requires pharmacists to provide information every seven days, there is no possibility of having a real-time system even if it was planned. The system is being built to accept data in real-time, but a legislative change would need to be made to tell the pharmacies they must submit that data when the patient walks away after picking it up.

Dr. Lewis stated when the Members look at some disciplinary cases the accusation often states the physician did not consult CURES. He asked if there are consumer protection groups involved in any of the discussions for the new system so they can understand the difficulties of the database and that it is not perfect yet.

Mr. Small stated he is not at the level of being an advocate, but can guarantee that he confers with them, so they all know what his thoughts and ideas are.

Dr. Levine asked, for those registered in the system, what the response time is for getting information back when queried.

Mr. Small stated it could take from just seconds to hours, depending on the size of the inquiry response. He noted if the response is too large; it could actually crash the system as it stands now.

Dr. Levine asked if they have an end users group informing the Joint Application Design (JAD) process.

Mr. Small stated they do have a stakeholder group of practitioners that was established by their Office of Legislative Affairs, during the course of the Legislative life cycle. DOJ held a stakeholders session and the information that came from that meeting is being designed in the new system.

Dr. Levine recommended holding additional sessions, such as that one, to continue to gain knowledge from the group.

Dr. Krauss asked if the utilization limit has been identified for the current CURES system.

Mr. Small stated he is not able to answer that as he is not an IT person, but stated, the system limit, as it stands right now, is quite fragile.

Genevieve Clavreul (via teleconference) noted she is very disappointed with the current system and feels it needs to be much closer to real-time responses. She stated it needs more research and time put into it. DOJ should be looking at other States' systems that are real-time and learn from them. She also stated she does not understand why the CURES system is housed under the DOJ, as in several other states, it is not.

Agenda Item 5 Presentation on Physician Impairment

Ms. Cady stated that at a previous meeting a Board member asked what is done in cases where a physician has a mental illness diagnosis. This question followed a discussion of legislation sponsored by CMA to establish a physician assistance program within the Board to provide services to physicians suffering from substance abuse or mental illness. Although this legislation was unsuccessful, Members raised the question about what resources are available to the physician community to provide services and support for physician wellness.

Ms. Cady provided a presentation showing complaint statistics and current disciplinary guideline recommendations, as well as external resources for mental illness and substance abusing licensees.

Ms. Yaroslavsky asked how the information that a physician can apply for a disabled license or voluntary limitation license is distributed.

Ms. Cady noted it is posted on the Board's website as one of the license status options.

Ms. Yaroslavsky suggested an article in the next Newsletter.

Dr. GnanaDev noted he did not know that these status options were available. He asked what the physician has to do and disclose on the status change application.

Ms. Cady stated the physician initiates the request to change their license status; the attending physician will provide some basic information about the physician's condition and the length of time the physician should stay in that status. The return to active status is the reverse of the first process. The attending physician releases the physician to continue practicing. Should that physician have a complaint filed against them while in a different status, the enforcement process would be the same no matter what status the license is in at the time of the complaint.

Agenda Item 7 President's Report

Dr. Levine stated she is pleased to have had Mr. Serrano Sewell join her on the bi-weekly meetings with the Executive Staff of the Board. Staff has been very helpful in keeping them up to date with things that are going on, as well as preparing them for upcoming Board meetings.

Dr. Levine went on to discuss a couple of important issues that were a part of the Federation of State Medical Board's (Federation) most recent meeting: the first being telehealth, the second being state licensure versus federal licensure. The connection between the two of them is that the telecommunications industry sees an enormous opportunity in leveraging physicians to provide telehealth services across state lines. The current model of state licensure in the United States (U.S.) means that if a physician is taking care of a patient in California, that physician has to be licensed in California. There has been intense lobbying at the federal level to reverse the requirement for State licensure and to approve federal licensure. The Federation has alternative approaches. The first being a model policy introduced in April 2014 for the appropriate use of telemedicine technologies in the practice of medicine.

Dr. Levine stated that core to this policy is the practice of medicine occurs where the patient resides, not where the physician is physically located. The critical part of this is, as a medical board, to do anything other than that would literally separate the licensing and enforcement functions. If a patient in California were being treated by a physician that has a national license, it would be uncertain as to whom that consumer would bring concerns. The Board would be able to license a physician in California but would have no recourse if a California licensed physician were creating a problem in another state. It is critical to maintain the connection

between licensure and enforcement. The Federation and each of the individual medical boards support that position and the Board has made it clear to the sponsors of the federal legislation that this practice is not safe for consumers and that the state medical boards feel strongly about their obligation to protect consumers by being able to both license and enforce action against physicians.

The Federation has come up with an alternative approach that would facilitate licensure across state lines, but it would still require licensure in each venue in which the physician intended to practice.

Dr. Levine announced this would be her last Board Meeting as President and stated it has been a pleasure to serve as Board President and she has learned from all the Board Members and appreciated the confidence that was placed in her. She stated the Board has accomplished a lot over that past two years. The Board has been through the Sunset Review process, has looked critically at the process and procedures of the Board, and has taken action in areas where it was realized that the Board needed to improve. The Outpatient Surgery Center Task Force was developed with a clear commitment to raise the standards of Accrediting Agencies. Great work has begun on addressing the overprescribing issues, with Dr. Bishop and Ms. Yaroslavsky doing a great job on the Prescribing Task Force.

Dr. Levine thanked everyone again for the confidence and support as President and then turned the discussion over to Ms. Kirchmeyer to continue with the Federation update.

Agenda Item 8F Discussion and Consideration of State Licensure of Telemedicine

Ms. Kirchmeyer referred the Members to page 8F-1 in their packets. She stated this report requested a board policy statement on State licensure for telehealth. 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 in located. 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.

Ms. Kirchmeyer noted current California law 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. When these types of federal legislative bills come up, the Board does not take a position on them; however, to make things easier for staff, Ms. Kirchmeyer and Ms. Simoes would like to have the Board adopt a Board policy. The policy would read as follows, "The Medical Board of California believes that the practice of medicine occurs where the patient resides at the time of the physician/patient telehealth encounter and therefore requires the physician to be under the jurisdiction of the State Medical Board where the patient resides."

Ms. Yaroslavsky made a motion to accept the policy as read; s/Dr. Lewis.

Dr. Krauss stated concern about the potential misunderstanding of the word "resides." As phrased in Agenda Item 8F, it uses the words "where the patient is located"and he feels that would be better wording, so there is no confusion at a later date.

Dr. Levine noted she had a concern about the word "located." She used the example of a patient on vacation in New York who calls up their physician, who is licensed in California, and says her daughter's asthma is acting up and does not have her inhaler. Currently, the physician would call a pharmacy, provide all of their credentials needed, and the pharmacy would allow a courtesy fill of the prescription. If the word "located" were used, the physician would be unable to handle the situation that way.

Dr. Krauss then suggested using the words "resides, or is currently located."

Ms. Webb stated that law will vary from state to state and California has law pursuant to Business and Profession Code Section 2060 on the subject of status on non-resident practioners. A physician from another state may not provide care to a patient in California whether there is an on-going relationship between the physician and patient, with very select exceptions.

Dr. Levine retracted her concern about the word "located," and after discussion believes, the word "located" is the proper term to be used.

Ms. Kirchmeyer stated the language should stay as it is shown in the packet.

Dr. Levine read the language as "The Medical Board of California believes that the practice of medicine occurs where the patient is located at the time of the physician/patient telehealth encounter and therefore requires the physician to be under the jurisdiction of the State Medical Board where the patient is located."

The previous motion was withdrawn. Dr. Lewis made a motion to keep the language as it reads in the Board packet and as read by Dr. Levine after further discussion; s/Ms. Yaroslavsky.

Dr. Bishop still had some concerns about the proper language that should be used. He feels that it needs further discussion, since there may be some ramifications the Board may not understand. New technology allows for many loopholes and believes that not all concerns have been addressed.

Mr. Serrano Sewell stated he agrees with Dr. Bishop that further discussions should take place. However, to aid staff and the Board in replying to inquiries, it is important to get a policy statement, which can always be changed.

Ms. Yaroslavsky agreed with Mr. Serrano Sewell's statement given there is federal legislation going on at a national level, something needs to be available for staff.

Ms. Webb stated the current statute is supportive of the Legislature's directive, but a policy statement from the Board addressed to the federal level would be helpful for staff to be

authorized to respond on behalf of the Board.

Motion carried (9-1) with further discussion to be continued at a future meeting.

Dr. Levine stated Dr. Krauss suggested there are other areas where the Board sees frequent legislation on a regular basis that in some areas may be useful for the Board to have policy statements that would useful to staff in terms of working with legislative staff with how the Board is likely to respond to a given piece of legislation. Dr. Levine stated this subject would be placed on a future board meeting agenda for further discussion.

Agenda Item 8E Federation of State Medical Boards Summary

Ms. Kirchmeyer continued with her report referring the Members to tab 8E in their Board packets. Ms. Kirchmeyer stated one of the most significant projects at the Federation is the development of an Interstate Compact. The Federation developed a framework for this Interstate 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. For example, an individual applies for a license in Arizona and states they would like to be licensed in California and Nevada also. Arizona would verify the individual's eligibility and submit that information to a newly established Commission. The licensee would then submit the licensure fees to the Commission who would send the fees and application to both California and Nevada. California would then issue this individual a license. The requirements for an applicant to enter into the Interstate Compact are quite rigid and are as follows: the applicant would hold one full and unrestricted license within a compact state; have successfully completed medical school and a postgraduate program; are board certified; have passed the USMLE within three attempts; do not have discipline in any state license; have not been convicted; and are not under investigation by any agency or law enforcement.

When this compact was reviewed by staff, one significant concern was that it did not require these individuals to be fingerprinted. The Board requires all applicants to be fingerprinted for two reasons. The first is it verifies that the information the physician is providing to the Board is accurate. The second is because if the individual is arrested, the Board is notified via a subsequent arrest report.

Ms. Kirchmeyer stated the Federation is taking this concern into consideration and the next draft Compact should include language that would include fingerprinting be done by the FBI as opposed to the DOJ. If the Board were to decide to join the Compact, the Board would have to go through the legislative process, as this would be a legislative change. Ms. Kirchmeyer feels that nothing needs to be done at this point, stating the Board should wait until the next draft is released, but wanted the Board to be aware of what the Federation is considering. She also noted the Legislature would not put through any type of Compact without fingerprinting being a requirement. After talking with the Federation staff, they stated the fingerprinting requirement could be put into a rule under the Commission. Staff is following this closely as it progresses. The reason this issue has come forward is that the telehealth community is really pushing for a licensure that would allow anyone with a license in another state to practice across any state line. The Board requires the physician to be licensed in California.

Dr. GnanaDev stated the Federation has developed a decent compromise with this Compact. There is a lot of push in Congress to make it a national issue rather than a state issue.

Dr. Levine noted another benefit is that the Compact stipulates that the physician will have to be board certified, which is a higher standard than any state currently requires.

Agenda Item 8G 2015 Proposed Board Meeting Dates

Ms. Kirchmeyer moved on to Agenda Item 8G, the proposed 2015 Board Meeting dates. She noted there are two proposed dates in January/February and two proposed dates in October/November. She also noted that there are two proposed locations for the January/February meeting as well as the July meeting. In the past, the January/February meetings have always been held in the San Francisco Bay Area and the July meetings in the Sacramento area. It was suggested that those two locations be reversed.

Dr. Krauss commented on the proposed February 5/6 and the November 5/6 dates, as he has a standing monthly meeting already scheduled for the 2015 year that happens to fall on those dates.

Ms. Yaroslavsky suggested choosing January 29/30 and October 29/30 with that in mind.

Dr. Levine read the following dates that are up for approval: January 29-30, 2015 in Sacramento, April 30-May 1, 2015 in Los Angeles, July 30-31, 2015 in San Francisco, and October 29-30, 2015 in San Diego.

Dr. Lewis made a motion to approve the dates and locations as stated; s/Ms. Yaroslavsky.

Julie D'Angelo Fellmeth, Center for Public Interest Law, commented on the Interstate Compact and the issue of practicing across state lines, where the patient is located at time of treatment. She stated this issue should not be overlooked. The medical profession is not the only profession that this issue is effecting. If the Board is going to agree to let an out-of-state physician practice in California, they should have to agree to be subject to this Board and California law.

Genevieve Clavreul via teleconference stated she is glad that the Board is discussing this very important issue.

Motion carried.

Agenda Item 6 Board Member Communications with Interested Parties

Dr. Krauss reminded the Board that he sits on the Board of the California Ambulatory Surgery Association (CASA) and is still a Trustee of the California Medical Association (CMA). There have been no conversations regarding issues before the Board.

Agenda Item 8A Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation

Ms. Yaroslavsky made a motion to approve the orders following completion of probation and orders for license surrender during probation; s/Dr. Lewis. Motion carried.

Agenda Item 9 Elections of Officers

Dr. Levine asked for nominees for Secretary of the Board.

Dr. Lewis nominated Denise Pines for Secretary of the Board; s/Mr. Serrano Sewell.
Motion carried.

Dr. Levine then asked for nominees for Vice President.

Dr. Levine nominated Dr. GnanaDev for Vice President of the Board; s/Mr. Serrano Sewell.
Motion carried.

Dr. Levine then asked for nominees for President of the Board.

Ms. Yaroslavsky nominated David Serrano Sewell as President; s/Dr. Lewis.
Motion carried.

Mr. Serrano Sewell thanked Members for the opportunity and stated he looks forward to working with the Executive Director, and staff this next year. He then expressed his great appreciation to Dr. Levine for her great leadership, often in a challenging environment. He stated the Board benefited from her intellect, her ethics, and her commitment to public service, as well as her patience. He noted Dr. Levine leads by example and as the new term begins, that will be the standard.

He presented her, on behalf of the Board and staff, a personally engraved gavel as a thank you gift for her hard work as President of the Board.

Dr. Levine presented Dr. Reginald Low, a prior Board Member, with a plaque to thank him for his service on the Board from 2006 to 2013. Dr. Low served on the Board in many capacities. He took a leadership role, served as Chair of the Enforcement Committee, and was a shining light in identifying where there were problems and what needed to be done to correct them. He was instrumental in working with staff in the enforcement process in identifying ways to reduce complaint-processing times. He also did remarkable work in his leadership role in the importance of training expert reviewers. Dr. Levine thanked Dr. Low for his outstanding service to the Board.

Dr. Low thanked Dr. Levine for the kind words and then congratulated Ms. Kirchmeyer on her appointment as Executive Director. Her appointment is a great addition and offers such expertise and knowledge to the position. He then thanked Dr. Levine for her work as President when the Board was in somewhat of disarray in terms of the perception from the Legislature, helped the Board through the Sunset Review process, and stated it was an honor and privilege to serve on the Board. He noted there is a lot of challenging work ahead, encouraged the Members to continue

their outstanding work, and thanked everyone for the incredible relationships he has developed by being on the Board.

Meeting was recessed at 6:15 p.m. until 9:00 a.m. on Friday, July 25, 2014.

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Friday July 25, 2014

Members Present:
David Serrano Sewell, J.D., President
Michael Bishop, M.D.
Dev GnanaDev, M.D., Vice President
Ronald H. Lewis, M.D.
Howard Krauss, M.D.
Denise Pines, Secretary
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:
Sharon Levine, M.D.,
Elwood Lui
Gerrie Schipske, R.N.P., J.D.

Staff Present:
Nicola Biasi, Investigator, HQIU
Susan Cady, Staff Services Manager II
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Armando Melendez, Business Services Officer
Regina Rao, Associate Governmental Program Analyst
Kevin Schunke, Licensing Outreach Manager
Jennifer Simoes, Chief of Legislation
Laura Sweet, Deputy Chief of Enforcement, HQIU
Renee Threadgill, Chief of Enforcement, HQIU
Lisa Toof, Administrative Assistant II
See Vang, Business Services Officer
Anna Vanderveen, Investigator, HQIU
Caesar Victoria, Department of Consumer Affairs
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing
Christine Zimmer, Staff Services Manager I

Members of the Audience:
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GV Ayers, Senate Business and Professions Committee
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul (via Teleconference)
Zennie Coughlin, Kaiser Permanente
Julie D' Angelo Fellmeth, Center for Public Interest Law
Karen Ehrlich, L.M., Midwifery Advisory Council
Karen Fischer, Executive Officer, Dental Board
Mike Gomez, Deputy Director, Department of Consumer Affairs
Marian Hollingsworth, Consumer's Union
Sarah Huchel, Assembly Business and Professions Committee
Doreathea Johnson, Deputy Director of Legal Affairs, Department of Consumer Affairs
E.A. Jones, Supervising Deputy Attorney General, Attorney General's Office
Christine Lally, Deputy Director, Department of Consumer Affairs
Marcus McCarther, Department of Consumer Affairs
Jason Piccone, Department of Consumer Affairs
Anita Scuri
Suzan Shinary, Consumer's Union

Agenda Item 10 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Board to order on Friday, July 25, 2014 at 9:08 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 11 Public Comments on Items not on the Agenda

Genevieve Clavreul asked a question about a physician charging an upfront fee for a patient who had insurance. Ms. Kirchmeyer referred Ms. Clavreul to a staff person to assist her off-line.

Agenda Item 7 President's Report

Mr. Serrano Sewell returned to the President's Report to announce a change in Committee assignments. He stated Dr. Lewis has agreed to serve as the Chair of the Enforcement Committee, since Dr. GnanaDev is now Vice President of the Board. Dr. GnanaDev is moving from the Enforcement Committee to the Licensing Committee and Dr. Yip has agreed to serve on the Health Professions Education Foundation.

Agenda Item 8 Executive Management Reports

Ms. Kirchmeyer referred the Members to their packets to review the Administrative, Enforcement, and Licensing Program summaries.

Ms. Kirchmeyer stated she had received a specific question from one of the Board Members and wanted to respond accordingly. On page 8B-8, the amount of the Attorney General (AG) line item

will remain the same even with the investigators moving over to the Department of Consumer Affairs (DCA). The AG's Office has its own line item in the Board's budget, which also includes the Vertical Enforcement portion and will continue to be paid directly by the Board. For fiscal year 14/15, staff will provide two budget reports for Enforcement. One report will be for the Board, the other will be for the Health Quality Investigative Unit (HQIU). An update on both reports will be provided at the October Board Meeting.

Ms. Kirchmeyer announced that the State has entered into a contract with a travel agency to do the travel for all state employees. This contract requires users to use the new travel agent beginning November 2014. Staff will be providing all Members with the information needed as they will need to sign up with log in information, create a profile, etc. Ms. Rao will be assisting the Members with that process.

Ms. Kirchmeyer thanked the staff for their hard work in getting all of the applicants licensed by the deadline of July 1, 2014. Staff from other units assisted as well and Ms. Kirchmeyer thanked everyone for a job well done.

Ms. Kirchmeyer announced that last week she traveled to Washington, D.C. to represent California at a meeting hosted by the California Department of Health and Human Services (DHHS). The meeting was entitled "*Advancing Policy and Practice; a 50 State Working Meeting to Avoid Opioid Related Overdoses.*" It was held July 17 and 18 and was very well attended and almost every state was represented. Joining Ms. Kirchmeyer from California was Virginia Herold from the Board of Pharmacy and Jackie Dauer from the California Department of Public Health (CDPH). The meeting began with an overview of the epidemiology and the evidence base for interventions. Both the Secretary and Deputy Secretary for the Department of Health and Human Services stressed three components addressing each of the following issues: the first issue was provider oversight; the second was a prescription drug-monitoring program; and the third, prescribing guidelines and providing education. In some areas, California was ahead of other states, in other areas, other states were ahead of California. During the breakout sessions, the region states got together and discussed what they had done in each area and what still needed to be done. The Department of Health and Human Services will be gathering all input received and will provide an overview of the work gathered at the meeting and will be providing it to all attendees. Ms. Kirchmeyer stated she would forward that information to the Members once it has been received. The meeting ended with the Chief of Staff from the White House of the National Drug Control Policy talking about its goals. There were many handouts brought back, one of them being provided to the Members for review. This document shows where California fits within the rest of the nation as far as the information gathered by the Centers for Disease Control (CDC.) This particular document shows that as of the year 2011, California ranks very well with the states, with it being the 40th highest drug overdose death rate. For every 100,000 people, California only had 10.7 overdose deaths. California was also identified as the second lowest opioid pain reliever-prescribing rate in the U.S. per 100,000 people.

Ms. Kirchmeyer announced the Board still intends to have another joint forum in the future after the prescribing guidelines are revised.

Ms. Kirchmeyer then provided an update on the CDPH's Opioid Public Workgroup where she and Ms. Simoes are both members. This group is made up of state agencies including all the dispensing and prescribing boards under DCA, as well as several units within the Department of Healthcare Services, The Department of Education, local county health officers, Emergency Medical Services Agency, and the Department of Justice. Others will be included in the future. At the last meeting, it was recommended that the Board's prescribing guidelines be the actual kickoff for this group. CDPH will do a large press conference as soon as the Board's guidelines are approved. The release of the guidelines will be the catalyst for all of the agencies to put their outreach plans into play. As stated in the update in the Board packet, the Board is going to be providing free CME on extended release and long acting opioid prescribing on September 19, 2014 in Los Angeles.

Ms. Kirchmeyer announced that the Board would be working with Mr. Small to allow physicians to register for the CURES system at future Board Meetings. Staff is also looking to allow physicians to come into the Board's Sacramento office and register as well. Those are a couple of steps to assist in getting individuals registered before that January 2016 deadline.

Ms. Yaroslavsky recommended discussing perhaps having the district offices also offer the option to register for CURES in each of those offices and making it part of the outreach campaign when staff is in other areas doing outreach.

Dr. GnanaDev strongly suggested the Board continue to work with DOJ in getting the CURES system to be a real-time system. With the way the system is set up now, he feels it gives a false sense of security.

Ms. Kirchmeyer reminded the Members until the law changes to require a real-time system, and immediate input of prescriptions at issuance, the current system will never be a real-time system. Obtaining the information from the system will be real-time though.

Dr. Krauss stated the technology to upgrade the CURES system has existed for a long time. The problem is the lack of dedication of dollars and resources to build it.

Dr. Bishop asked what needed to be done to get the law changed concerning the current CURES system. He feels seven days is much too long to allow prescriptions to be the system and is not what the physicians expected from the system when it was put into place.

Mr. Serrano Sewell stated it had been discussed at several prior meetings for the Board to do a legislative day in Sacramento, where the Members spend a day at the Capitol. This would give the Board Members the opportunity to reintroduce themselves to the elected officials and their staff and talk with them about what it would mean for consumer protection to have the current CURES law changed to allow a real-time system put in place.

Ms. Kirchmeyer stated she believes the Board will receive push back on changing that law until there is a system in place that is capable of real-time interoperable service. She noted that in the next two years, once this new CURES system is up-to-date, the Board would need to work with the Board of Pharmacy to assist in working on getting the law changed.

Ms. Clavreul thanked the Board for setting up a legislative day and requested the Board look into the prescribing statistics and the Oklahoma PDMP.

Agenda Item 12 Update from the Department of Consumer Affairs

Ms. Lally began by congratulating the newly elected President, Vice President, and Secretary of the Board. She, on behalf of the Director and the Department, thanked Dr Levine for her extraordinary service. She reminded the Board of the newest leadership at the DCA, as Mr. Awet Kidane was appointed as the new Director and Ms. Tracy Rhine as the new Chief Deputy Director.

Ms. Lally then introduced Jason Piccione, DCA's Chief Technology Officer to give an update on the BreEZe system.

Mr. Piccione stated he understands that a big concern of the Board is the schedule to get requested fixes and changes completed. He gave the update of the current schedule for the next three production releases. They are as follows: production release 1.14 is scheduled for August 14, 2014; production release 1.15 is scheduled for September 19, 2014 and production release 1.2 is scheduled for early November 2014. This modified schedule represents an acceleration of production releases. DCA has identified a need for a more robust and agile production maintenance structure. DCA is in talks with the contracted vendor to establish a higher capacity dedicated production maintenance team. A DCA team of dedicated expert vendor staff would increase the throughput of their production maintenance. The intent of this effort is to run higher capacity releases on a five to six week cycle.

Another key discussion taking place is to accelerate knowledge transfer. DCA believes the sooner they can perform critical development tasks in the area of configuration, and build and deploy, the more responsive the maintenance structure will be. Another area of interest for the Board is the usability of the BreEZe on-line experience. There have been many opportunities identified to increase the usability of the BreEZe on-line system. These efforts include deleting the existing BreEZe home page and having the current BreEZe login page act as the initial landing page for the BreEZe system, eliminating the initial, potentially confusing, upfront page for users.

Another improvement is to redesign the home page with better instructions and increased usability, and to provide a scrolling announcement section on the home page that can be updated by staff and provide announcements to the public. The additional two edits are more technical; including providing links to pre-populate drop downs in the searches as well as providing links to specific resources. DCA expects details from the vendor for redoing the home page at the July 28, 2014, Change Control Board meeting and expects an analysis for the remaining items at the August 11, 2014, Change Control Board meeting. Mr. Piccone believes this is a start to a better user experience.

Ms. Yaroslavsky thanked Ms. Piccione for being so responsive to the issues and concerns of the Board and recommended using stakeholders when updating the BreEZe system rather than just

IT staff in order to get an outside perspective of what changes would be helpful to make the system more user friendly.

Dr. GnanaDev asked if DCA is working closely with CURES to make the two work together at some point.

Mr. Piccione stated currently there is no interface between the two systems planned, however, the need has been identified, and the DCA has provided the CURES project with the BreEZe data dictionary so that all data elements are known to that project, since clearly an interface in the future will be required.

Yvonne Choong, CMA, made a request for BreEZe to have the ability to show the status of the licensing application and where that application is in the process. She also stated that CMA agrees with the fact that CURES and BreEZE will need to be able to interact in the future and noted CMA would be happy to participate in any type of usability stakeholder meetings in regard to this interface completion.

Dr. Lewis asked if there is a difference in the timeline between a new applicant to California and a renewal within the BreEZe system.

Ms. Kirchmeyer stated they are handled differently as they are completely different transactions. New applications have to be reviewed individually to be sure all needed documents are included and current. Renewals can be done on-line in BreEZe and can usually be done in about 20 minutes or so, assuming there are no complications. If a renewal is mailed in, it could take four to six weeks to be processed and completed.

Ms. Kirchmeyer announced the Board just hired a student assistant who is working on creating a video to walk an applicant through the application process from beginning to end along with some questions and answers that will be posted on-line once completed.

Agenda Item 13 Update of the Health Professions Education Foundation (HPEF)

Ms. Yaroslavsky reported the HPEF has had a great year with the Steven Thompson Loan Repayment monies. They awarded thirty one million, eight hundred and thirty five dollars' worth of loan repayments to a total of two thousand, and eighty-three participants. She announced that 75% were women and 24% were men. These participants were from all different areas of California. She stated she is pleased that Dr. Yip will be joining the HPEF team.

Agenda Item 14 Update of Education and Wellness Committee Meeting

Ms. Yaroslavsky thanked staff for putting together such a great array of guests. The first presentation was Dr. Barbara Hernandez, Director for Physician Vitality from Loma Linda University who outlined the University's Wellness Campaign, which is designed to promote physician vitality across their career. The second presentation was from Dr. Michael Goldstein, professor of Public Health and Sociology at the University of Los Angeles who presented his report

on UCLA's initiative to become a healthy campus, entirely smoke free with healthy eating programs. The program could be a model for the State of California. Dr. Jessica de Ybarra, a physician and public health medical officer from the CDPH, gave a presentation and report on the Let's Get Healthy Task Force and California Wellness Plan. One main goal of this Task Force is to prevent chronic diseases for a healthier California.

Ms. Yaroslavsky reported the Education and Wellness Strategic Plan was distributed to Committee Members for review and Members were pleased with the plan.

Agenda Item 15 Update on Licensing Committee Meeting

Dr. Bishop stated the Licensing Committee had two presentations. The first one was given by Ms. Carol Clothier, Vice President of State Health and Public Affairs. She discussed the ABMS Maintenance of Certification (MOC) requirements and identified how the ABMS MOC has several elements to meet Continuing Medical Education (CME) requirements for license renewal. Ms. Clothier advised the Licensing Committee that she had met with staff, and staff had advised her that the Board might be able to accept ABMS MOC as meeting the Board's CME requirements with an amendment to current regulations.

Dr. Bishop asked for a motion to have staff review the current CME regulations regarding the feasibility of adding ABMS MOC as meeting the Board's CME requirements and to have staff present the feasibility of amending the CME regulations, including draft language, if appropriate, to the Board for review and consideration.

Ms. Wright made a motion to approve staff begin the regulatory process to allow ABMS MOC meet the CME requirements./s: Dr. Lewis. Motion carried.

Dr. Bishop stated the second presentation and discussion was given by Mr. Worden on the minimum number of years of approved postgraduate training required for licensure and licensure exemption while participating in an approved postgraduate training program in California. Board staff was asked to evaluate the pros and cons of increasing the minimum number of years for U.S. and Canadian medical school graduates from one year to either two or three years and for international medical school graduates from two to three years. The FSMB is recommending three years of postgraduate training for licensure. The minimum number of years for an Accreditation Council for Graduate Medical Education (ACGME) on Royal College of Physicians and Surgeons of Canada (RCPSC) accredited residency program is three years. In addition, the newly proposed FSMB Interstate Compact would require a minimum for three years and ABMS certification. The Licensing Committee made and adopted a motion to have staff proceed with interested parties meetings to obtain input regarding the impact of extending the minimum requirements of postgraduate training for licensure in California.

Agenda Item 16 Discussion and Consideration of Disclosure of Approved Postgraduate Training

Ms. Kirchmeyer referred the Members to tab 16 in the Board packets. She stated in the Board's Sunset Review Report, the Board had identified several issues for consideration by the Senate Business, Professions, and Economic Development Committee (B & P Committee). An issue the Board had requested the Committee consider was elimination of the requirement for the Board to post approved postgraduate training on the physician's profile. At the time of the Sunset Review, the information could not be posted on the Board's website using its current IT system. However, when the Board staff identified fields for the new BreEZe system, they ensured this information would be able to be captured in the new system. Since the Board went live with BreEZe, this information has been entered into the system for those individuals who have applied since the system was put into place. Therefore, this information is now being captured, including the complete name of the postgraduate training program. With this new information being entered in the system, staff no longer believes the requirement needs to be removed from the Board's current statute. It is recommended that the Board direct staff to 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.

Ms. Yaroslavsky made a motion to direct staff not to pursue the elimination of the requirement for the Board to disclose postgraduate training on a physician's website profile/s: Dr. Krauss. Motion carried.

Agenda Item 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 referred the Members to tab 17 in their Board packets. She stated the Board's current regulation authorizes a "Board official" to issue a citation, a fine, and an order of abatement. These regulations also require the Board official who issued the citation to perform certain functions, including holding the informal conference, authorizing an extension, etc. The regulation defines "Board official" as the Chief, Deputy Chief, or Supervising Investigator II of the Enforcement Program of the Board. Within the transition of the investigators, these positions are no longer part of the Board. The regulations now need to be amended to allow the Executive Director or his or her designee to issue citations and perform the function 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. Due to the need to expedite these regulations, the hearing should be held immediately following the 45-day comment period, rather than waiting until the next Board meeting. If no negative comments are received, staff will finalize the rulemaking package and submit it to the Office of Administrative Law. If negative comments are received, the matter will then be brought back to the Board at its October meeting or possibly a teleconference meeting scheduled before the October Board 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.

Dr. GnanaDev made a motion to direct staff to notice the amended regulatory language and to hold a hearing immediately after the 45-day comment period, and if no negative comments were received, the Board would then delegate the Executive Director to proceed with the rulemaking process/s: Dr. Krauss. Motion carried.

Agenda Item 18 Discussion and Consideration of Proposed Regulations Update the Disciplinary Guidelines, Title 16 CCR, Section 1361

Ms. Cady stated in December 2011, section 1361 containing the Board's Disciplinary Guidelines was amended. Since that time, a number of statutory and program changes have occurred which has prompted the need to amend the Disciplinary Guidelines to be consistent with current practices. Staff has identified a number of non-substantive changes that should be addressed in this regulatory proposal as well.

The first change is in Conditions 9, 10 and 11, which relate to the abstention from the use of alcohol and controlled substances and biological fluid testing. These conditions 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 Code11529 extending the timeframe in which an accusation must be filed following the issuance of a suspension order from 15 days to 30 days.

The second proposed change is under Condition 18, which is the clinical training program. The PACE program has revised their clinical assessment component and staff would like to modify the Board's Disciplinary Guidelines to be consistent.

The next proposed change is under Condition 19, which requires an oral clinical examination be administered pursuant to the requirements outlined in Business and Professions Code Section 2293. With the transfer of staff to DCA, the district medical consultants are no longer available to the Probation Unit to provide the coordination of the oral clinical examinations should they 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.

The next proposed change is under Condition 25, which requires a third party chaperone be identified by the physician within 30 days, however if the chaperone leaves, the physician is given 60 days to identify 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 consumer protection.

The next proposed change is under Condition 28, which prohibits the licensee from supervising physician assistants during the period of probation. It has been identified that advance practice nurses perform a similar function and have to be supervised by a physician. An amendment to Condition 28 is needed to prohibit physicians on probation from supervising physician assistants and advance practice nurses.

The final proposed change is under Condition 31, which outlines general probation requirements, and was found to contain language that conflicted with language in Condition 33, non-practice while on probation. An amendment to this condition is required eliminating this conflict.

Ms. Cady asked for a motion to direct staff to notice the amended regulatory language and hold a hearing at the October Board meeting after the 45-day public comment period.

Ms. Webb had some additional changes she asked to be included in the original motion. She asked for the capitalizations and term usage consistent through the guidelines. Also on item 28, she would like to have approval to change the heading to read, Supervision of Physician Assistant and Advanced Practice Nurses.

Dr. Krauss made a motion to direct staff to notice the amended regulatory language, with comments made by Ms. Webb for consistency, title change, and drafting issues and also to hold a hearing at the October 2014 Board meeting after the 45-day public comment period/s: Dr. Lewis.

Ms. Kirchmeyer explained that should the regulations for the SB 1441 Uniform Standards not be completed, the regulatory hearing would be at the January or April 2015 meeting.

Ms. Castro recommended that the word “use” in the first line of Condition 10 be expanded as the biological fluid tests can be very sensitive.

Motion carried.

Agenda Item 19 Update of Transition of Staff to the Department of Consumer Affairs

Mr. Gomez, Deputy Director of Enforcement at DCA, stated the transition of staff to the DCA has been successful. He announced there was a swearing in ceremony on June 30 and July 1, 2014. Mr. Gomez stated the transition has gone very well and it is with much thanks to the work of the Board staff, the DCA staff, and support staff. Mr. Gomez stated with the assistance of Ms. Kirchmeyer, Ms. Threadgill, and Ms. Sweet, he has become immersed in what the Board and the investigators actually do. He noted none of the district offices have been impacted by the transition, and no staff has been relocated, except the Office of Standards and Training, which affected approximately seven people.

Mr. Gomez announced they had finalized the meet and confers with all of the unions last month. The meetings were very successful with only some minor things to be worked out with regard to some concerns the unions had.

Mr. Gomez stated he is looking closely at the efficiencies and inconsistencies that can be improved. He is learning to understand the work and commitment the investigators have to their work and protecting consumers of California. They are highly trained and very dedicated people.

Ms. Threadgill, the DCA Deputy Chiefs and Mr. Gomez had a leadership meeting to start discussions on the differences, what resources they have available, what processes will be with the field offices, and other issues of concern. Another meeting will be held with all of the supervisors of HQIU to look at what works and what improvements can be made to better the investigator practices and to better protect consumers in the joint mission with the Board.

Mr. Gomez stated there are still some outstanding matters that need to be addressed, but he is optimistic that there will be better investigative timelines in the future and in the meantime that no further delays are created.

Ms. Yaroslavsky asked Mr. Gomez what future benchmarks the Board can expect and how success is going to be measured.

Mr. Gomez replied there are a couple of things to review. One being working with Ms. Threadgill and staff, making sure case management cycle times hit the benchmark of June 30 or July 1. That is the basis from which they are trying to either decrease certain timelines or make some efficiencies in the quality of investigations with the AG's Office as well.

Agenda Item 20 Vertical Enforcement Program Report
A. Program Update

Ms. Castro began by congratulating Mr. Serrano Sewell in his new role as President of the Board, stating she is looking forward to working under his leadership. Ms. Castro noted she and Ms. Kirchmeyer continue to meet regularly and she often speaks with Ms. Webb with respect to ideas, and efficiencies on things that could affect the outcome of cases.

She stated the Vertical Enforcement (VE) Manual that was in effect from 2006 to July 1, 2014, established the course for those investigations. The Health Quality Enforcement Section enjoyed a direct line of communication with the Executive Director and with the Board, as a client, as well, through the Board's enforcement chain of command. When the AG's Office directed these investigations, pursuant to Senate Bill (SB) 231, they were directly involved with the investigative employees in the Board's chain of command. The AG's Office has been exercising this authority to direct investigations established by SB 231 for the past eight and a half years. In enacting SB 231 and creating the VE model, the Legislature amended portions of the Government Code that directly governed the statutory duties of the AG. SB 231 also reorganized the operation of the Health Quality Enforcement Section itself. The AG, working closely with the Board, has been executing these duties for the past eight and one half years and their view of how these responsibilities are imposed on them by the Government Code has been reflected by various versions of the VE Manual since January 1, 2006. They have been working under the most recent version of the VE Manual dated January 2011. The AG's Office has revised the manual as of July 2014. Ms. Castro stated Ms. Kirchmeyer had provided the Members with the most current version of the manual for their review. The same version has also been provided to the Health Quality Enforcement (HQE) Unit as well as DCA.

Ms. Castro stated the joint manual continues to take forth-prior relationships with the AG's office with the exception of the names being changed to accommodate the changes that SB 304 put into

place. Notwithstanding this change, these investigations are still subject to VE and continue to be directed by the AG's Office. However, the Executive Director will still determine what is sent to the HQIU and as such, will continue to be responsive to what will be investigated by HQIU. In addition, Ms. Kirchmeyer has the obligation and oversight to review final investigation reports on closed investigations. The AG's Office is going to continue to be very involved in that process and hopes that Ms. Kirchmeyer will continue to look to them for any background on legal justifications, evidentiary issues, and medical expert opinions. At the same time, the AG's office has provided the most current VE Manual that has been in effect since July 1, 2014. It reflects that the investigations will continue to be directed by the AG's Office to fulfill her statutory responsibilities to provide legal advice to the Board.

In addition, Ms.. Castro stated the HQIU has been informed how cases should be presented to HQE to allow for official handling and receipt of cases at the AG's Office. She has provided transmittal case guidelines, which were provided to all DCA boards. These guidelines coupled with the new procedures set forth in the manual aim to ensure the cases can be efficiently processed between offices. Matters such as scheduling physician's interviews, expert selection, expert report review and the AG's Office consideration for prosecution proceeds effectively and efficiently for the benefit of the investigations and their resolution. Ms. Castro stated the authority of the AG's Office to decide what cases will be prosecuted continues as before, as does the Executive Director's ability to decide thereafter what will be filed as a disciplinary action on behalf of the Board. This procedure remains unchanged and the Board's policy and filing postures will continue as before. She added that SB 304 did not dilute the Board's ability to function as needed in fulfilling its statutory charges to enforce the Medical Practices Act.

Ms. Castro noted SB 304 did not affect the team concept or the management of the Board's cases. The HQIU staff will be engaged in a team effort to be responsible for obtaining the evidence needed for the AG's Office to make proper legal determinations and provide legal advice to the Executive Director on investigation outcomes and filing decisions. The AG and HQIU are both committed to complete these investigations as efficiently as possible and the goal to find improved avenues to complete investigations as efficiently as possible is a shared goal. Ms. Castro stated she has shared her ideas with HQIU and looks forward to continuing that conversation. She has met with Mr. Gomez a number of times since November/December of last year and has been working on dispute resolutions on cases. She stated efficient operation of the HQIU is a crucial component of everything that the AG's Office does and evidence collection is key. The AG's ability to make its legal recommendations rest on the AG having the required evidence collected in the investigations and proper steps being taken in procuring this information, such as service of subpoenas of medical records, properly questioning subject physicians during investigation, and obtaining reviews from qualified medical experts. All of these components are needed to work efficiently so the AG can advise the Board on legal issues developed during investigations.

In conclusion, Ms. Castro stated as the attorneys for the Board and Executive Director, the AG's Office holds all of the obligations to the highest regard and will continue to uphold all of their ethical obligations. She stated they need to ensure the continuation of the VE model after July 1, 2014. The AG's Office will meet with the DCA to discuss the possibility of a joint manual and the AG will work with DCA to identify and create efficiencies in the workflow, especially with regard

to evidence sharing between the two agencies. She will report to the Board at the October 2014 meeting with the status of those conversations.

B. HQE Organization and Staffing

Ms. Castro announced two new DAGs that have joined the section: Karolyn Westfall in San Diego and Christine Sein has joined the Los Angeles office.
Ms. Castro then reported on (*Alwin Carl Lewis, M.D. v. Medical Board of California*). A decision was reached by the Court of Appeal on May 29, 2014. Dr. Lewis had filed a Petition for Writ of Mandate, which sought relief from an order. One item that was an issue in this case involved CURES and whether the Board could obtain data from CURES during a disciplinary investigation of the physician without obtaining a prior warrant or administrative subpoena demonstrating good cause. The Court of Appeal ruled that the Board can access CURES during the course of a disciplinary investigation and it did not constitute a serious invasion of the patients' right to informational privacy. Further, there were two very important state interests weighing in favor of the Board. One, controlling the diversion and abuse of controlled substances and two, exercising its regulatory power to protect the public against incompetent, impaired, or negligent physicians. The Court of Appeals also held that to impose a good cause requirement before accessing CURES data would not necessarily involve litigating the privacy issue in advance. This delay would defeat the legislative purpose of CURES, which is to allow physicians to instantly look up a new patient's controlled substance history and to determine whether a patient legitimately needs pain medication or is doctor shopping. The court also found that the Board's access to CURES should not be limited by the nature of the complaint against the licensee.

Dr. Lewis asked Ms. Castro to name some inefficiencies that the AG's Office has at this time that could affect what the Board does and also asked if the AGs Office meets with the Office of Administrative Hearing's (OAH) and has discussions for feedback between both parties.

Ms. Castro stated she is looking forward to continuing the conversation about is the development of a cloud. She has met with Mr. Kidane and Ms. Rhine from DCA along with her own staff involving the case management section. She stated that evidence is the most important thing in an investigation and DCA and Ms. Kirchmeyer are both open minded on how to efficiently transfer evidence between staffs that are not co-located. The VE model does not require staff to be co-located as long as there is an efficient way to transfer information between offices. She wants there to be a way for things to be sent instantly to the attorney safely, with proper encryption, and a way that forwards the attorney real-time evidence that is needed to prepare a subject interview.

Ms. Castro stated she does meet on a regular basis with Mr. Chang and Ms. Johnson from DCA to share some of the issues with the OAH and some efficiencies that could be found together. She does meet on a frequent basis with OAH with the assistance of the DCA legal counsel.

Dr. GnanaDev thanked Ms. Castro for the update and stated she is going to be the integral part of the triangle between DCA, the Medical Board, and the AG's Office to streamline the process.

Ms. Castro stated as the Board's attorney, she is always cognizant of how the Board is being portrayed to the public. She wishes the Board's efforts were highlighted more; however, there are cases that come to the attention of the public. She reminded the Board that when that happens, the AG's Office works with Ms. Kirchmeyer, Mr. Gomez and the investigators, too.

Ms. Yaroslavsky also thanked Ms. Castro for the update. She referred Ms. Castro back to her description about the investigative staff, and noted this relationship is going to be key. After reading the manual, Ms. Yaroslavsky noticed that there is a lot of opportunity for collegiality in the manual, however she also noticed there were many direct processes. Ms. Yaroslavsky recommended, Ms. Castro be cognizant of the fact that the two need to work together and that hopefully it will weigh more towards the collegiality side as opposed to direction being given by the AG's Office.

Ms. Castro stated that it reads that way to her staff as well. She wants her staff to be engaged in these cases and take them in high regard.

Mr. Gomez, noted the 2014 VE manual has not been put into effect for DCA HQIU. He has staff looking at DCA's current practices to determine efficiencies and collaboration. He needs to understand how the AG's Office directs, understands professionalism, and team work, and look at best practices for the State of California, other local governments, and the District Attorney's Offices. Mr. Gomez reiterated they have not imposed that manual on the DCA staff yet. In reference to Ms. Yaroslavsky's comment regarding the investigation staff, Mr. Gomez stated that Chief Deputy Director Rhine is coordinating a meeting with Ms. Castro and her staff to re-look at how things can be done better, the roles of the investigators and prosecutors, and whether training is needed. When they say team, it has to mean team.

Ms. Kirchmeyer asked Ms. Laura Sweet and Ms. Susan Cady to stand and stated that, at the Board's great loss, they have announced their retirement. These individuals have been with the Board a very long time and to lose them is going to be a great loss of knowledge. She wanted to recognize them and thank them for their hard work and dedication to the Board.

Agenda Item 21 Update on the Prescribing Task Force

Dr. Bishop reported that on June 19, 2014, the Prescribing Task Force held an interested parties meeting. Prior to this meeting, Board staff had drafted revised prescribing guidelines for all individuals to review and provide comment. While drafting these guidelines, staff reviewed several existing guidelines and incorporated them into the Board's revisions. In addition, staff incorporated information received from the prior task force meetings. Several items needed expert input, such as the appropriate morphine equivalency that would raise a red flag. Several physician organizations in the group were able to provide guidance and input on the guidelines. The meeting had representatives from the prescribing and dispensing communities, law enforcement, and other regulatory boards, including the Dental Board, Board of Pharmacy, Physician Assistant Board, and the Nursing Board.

There was a great discussion on the guidelines; their intent, their purpose, and what needed to be included in them. Overall, the group thought the guidelines needed to cover all scenarios that may

occur. One member of the audience made a great observation; that the best practice is one patient, with one physician, at one time. Indicating that every possible scenario cannot be in a guideline, but they do need to provide basic guidance to assist in making decisions in all situations.

The other issue that needs to be clarified is treating acute pain versus non-acute or chronic pain. At the end of the meeting, everyone was offered an opportunity to continue to review the guidelines and provide comments to staff. To date, staff has received comments from several different organizations. Dr. Bishop stated Board staff was scheduled to meet the following week to review the comments received at the meeting and to put them together for the next Task Force meeting. Board staff will also be meeting with some physician field experts prior to the next meeting to provide input for the final document. The task force wants to complete the revision to the guidelines prior to the October Board meeting. This would allow the Board to approve the guidelines at that meeting so they can be sent to all physicians and placed on the Board's website.

During the course of this process, staff gathered some best practices for opioid medication, which is still a future issue for the Task Force that will be looked into after the revision of the guidelines. It is believed the process of revising the guidelines has provided the opportunity to have all stakeholders weigh in on this process in order to get the best product. The goal is to have a document that can educate providers and assist in appropriate prescribing.

Agenda Item 22 Update on The Physician Assistant Board

Dr. Bishop provided an update on the activities at the Physician Assistant Board (PAB). He stated for the personal presence regulations; the Medical Board is the agency that adopts any scope of practice regulations on behalf of the PAB. The Board held a regulatory hearing at its February 2014 Board meeting. After discussion, it was proposed to delete "or" from one section of the language. The Board adopted this change and there was a 15-day public comment period. At the Medical Board meeting in May 2014, the Members reviewed public comments received and following consideration of comments received from the AG's Office, Board staff recommended further clarification of the definition of "immediately available." Board Members voted to approve the language, but referred it back to the PAB for consideration. The modified language was approved by the PAB at its May 2014 Board meeting. It was then referred back to the Medical Board and noticed for an additional 15-day comment period. Since no public comment was received, the rulemaking file is currently being finalized and will be submitted to the DCA for review and approval prior to submission to the Office of Administrative Law. On behalf of the PAB, Dr. Bishop thanked the Medical Board Members and staff for this regulatory change.

Dr. Bishop announced that the PAB website is being updated by PAB staff and the DCA internet team. DCA is requesting that boards, bureaus, and commissions within the Department have similar looking websites.

Dr. Bishop added that with respect to SB 352, supervision of medical assistants, the PAB has updated the website to reflect the implementation of SB 352, which allows physicians to delegate medical assistant supervision to physician assistants, certified nurse practitioners, and certified nurse midwives. The PAB site continues to include a link to the Medical Board's website section regarding medical assistant laws and regulations.

Dr. Bishop noted PAB staff had recently updated the paper application for licensure to reflect compliance with AB 258, which requires the application to include the following statement: "Have you ever served in the United States Military?" PAB requested the BreEZe team make similar updates to the on-line application. The next PAB meeting is scheduled for August 18, 2014 in Sacramento.

Agenda Item 23 Discussion and Consideration of Legislation/Regulations

A. 2014 Legislation

Ms. Simoes stated she had invited several Legislative offices to attend the Board meeting. She introduced G.V. Ayers from the Senate Business and Professions Committee and Sarah Huchel from Assembly Business and Professions Committee.

Ms. Simoes referred the Members to the tracker list in the Board packet. She stated the bills in blue are two-year bills that the Board has already taken positions on and will not be discussed. The bills in pink are Board-sponsored bills and will provide an update and the bills in green and orange, will need to be discussed and have a position taken on them.

AB 1838 (Bonilla) 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). Ms. Simoes stated the Governor just recently signed this bill into law and it will become effective January 1, 2015.

AB 1886 (Eggman) would allow the Board to post the most serious disciplinary information, which is already public information, on the Boards website for as long as it remains public. This bill was recently amended to address concerns raised by the CMA and other provider groups. Concerns were raised 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, which Board staff agreed. The author, sponsor and CMA worked on amendments, and with these amendments, there is no opposition on the bill. The amendments would 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 be posted over a five-year period, instead of a ten-year period; require public letters of reprimand to be posted for ten-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 three-years, instead of five-years (citations are not considered discipline).

SB 1466 (Committee on Business, Professions, and Economic Development) is the health omnibus bill which contains technical amendments for all of the health boards. The portions related to the Board include the American Osteopathic Association (AOA) Health Care Facilities Accreditation Program to be an approved accreditation agency and striking "scheduled" from the existing law that requires physicians who perform a scheduled medical procedure outside a general acute care

hospital that results in a death, to report the occurrence to the Board within 15 days. This bill is moving through the process.

Dr. GnanaDev stated there is one new issue with the residency programs. That issue is AOA and ACGME have agreed that the osteopathic accredited programs can take all osteopathic physicians into their program starting in 2015. The Board needs to make sure that until all programs become part of ACGME (by 2020) the gap in time is still considered part of the postgraduate training.

AB 496 (Gordon) is a two-year bill and was introduced in 2013. 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 was recently substantially amended and would now only add to the existing cultural competency CME course requirement to also include information pertinent to the provision of appropriate treatment and care to LGBTI communities, as appropriate. The Board could work with organizations that accredit CME courses to ensure compliance with the new requirement if this bill was signed into law. 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 requirement 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 did support the previous version of this bill because the Board believes it is important that LGBTI cultural issues are 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. Board staff recommends the Board still support this bill with amendments.

Ms. Yaroslavsky made a motion to support this bill with the amendments as presented/s: Dr. Lewis.

Dr. GnanaDev wanted to be sure that this bill does not mandate any CME.

Ms. Simoes noted this bill changes the requirements the CME must meet and just integrates LGBTI issues into the existing requirements.

Motion carried.

AB 809 (Logue) would delete the requirement included in the Telehealth Advancement Act of 2011 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 should 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. 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 and Board staff is suggesting the Board continue to support AB 809.

Dr. Krauss made a motion to support this bill with the amendments as presented/s: Dr. GnanaDev.

Yvonne Choong, CMA stated they are currently neutral on this bill. She noted there would be a couple of additional amendments that will be forthcoming on this bill. They feel the language as proposed to be amended is broad enough to allow them as an organization to continue recommending to physicians that they obtain consent for each course of care provided via telehealth, as they believe that is the best practice. The proposed amendments broaden that language and their concern is the amendments could be interpreted to require consent for each use of telehealth once "during a specified course of care and treatment." They feel that a physician should not have to be required to obtain consent for each visit if it is a course of treatment.

Motion carried.

SB 1116 (Torres) previously would have allowed physicians to donate an additional $75.00 to the Board to help fund the Steven M. Thompson Loan Repayment Program (STLRP). Amendments were taken to address concerns and this bill 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. Currently, a physician could donate more than the mandatory $25.00; however, this information is not included on the initial licensing or renewal application. This bill would ensure that physicians are aware of their ability to donate additional funding to the STLRP. The Board is already planning to make these revisions. Staff recommends the Board continue to support this bill and any other measures that help fund the STLRP.

Ms. Yaroslavsky made a motion to support this bill with amendments as presented/s: Dr. Lewis. Motion carried.

SB 1243 (Lieu) is a sunset review bill for several boards under the DCA. New language was recently added that would impact all boards under DCA. The purpose of the language is to increase transparency of information distributed by DCA and would require DCA, the AG's Office and the OAH to submit specified reports to the Legislature on an annual basis. The information required to be reported by DCA is modeled after the Board's existing law (Business and Professions Code (BPC) Section 2313) that requires the Board 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 affect the Board.

This bill would require boards under and within DCA to provide written notice of a board meeting by regular mail, email, or both. The board 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 boards under and within DCA (not just those listed in existing law).

This bill would require DCA to provide an opportunity for an employee of 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.

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.

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 information relative to the performance of each board (including the Board.)

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 1 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.

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. 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 refer 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.

Ms. Yaroslavsky made a motion to support this bill if amended as presented/s: Dr. GnanaDev.

Ms. Yaroslavsky stated she does not feel that being mentored by someone on another Board should be mandated by law. She liked the idea of enforcement staff going on retreats; however, training every year is a concern to her due to the time away from duties.

Dr. GnanaDev feels this bill has something good and something worrisome. The good thing is cooperation and transparency are important, but micromanagement is a bad idea. Staff needs to work with the author to eliminate as much of this micromanagement as possible, while leaving the cooperation and transparency.

Motion carried.

SB 1262 (Correa) would put various licensing and enforcement requirements on marijuana dispensaries and cultivation facilities and would create a Bureau of Medical Marijuana Regulation (Bureau) in the DCA that would be the regulatory agency performing the licensing functions. It also gives local agencies the primary responsibility for enforcement of the Bureau standards, in accordance with Bureau regulations.

This bill would impose specified requirements on physicians recommending marijuana and on the Board. Ms. Simoes stated her analysis would only cover the portion of the bill related to the requirements on physicians recommending marijuana and requirements of the Board.

This bill 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 marijuana to a patient unless that person is the patients' attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code (HSC). This bill would also subject physicians recommending marijuana to the laws in 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 marijuana recommendations unless the advertisement contains a specified notice to consumers and meets the requirements of BPC Section 651.

Lastly, this bill requires the Board to consult with University of California's (UC) Center for Medicinal Cannabis Research (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 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 marijuana, and includes in the Board's priorities cases involving repeated acts of excessively recommending marijuana to a patient for medical purposes without a prior appropriate 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 marijuana.

Dr. Lewis asked the difference between an oppose unless amended position, versus a neutral position.

Ms. Simoes stated the oppose unless amended position is a much stronger position, more of a negative position. The author's office has been very diligent about keeping the Board's recommendations in mind and speaking with Ms. Simoes often about the bill and she feels like taking an oppose unless amended position would not be correct at this time.

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

Ms. Genevieve Clavreul stated that marijuana is a Schedule I drug and this bill needs much more clarification.

Motion carried.

SB 492 (Hernandez) would have expanded the scope of an optometrist. This bill was amended and would instead generally revise the Optometry Practice Act to clarify and expand the optometrist's scope of practice and create an advanced practice optometry certificate.

Per the Assembly Business, Professions, and Consumer Protection Committee analysis, the Committee convened six separate meetings during 2013 to hear expert testimony and discuss key components of advanced practice including 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. The primary 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 therapeutic pharmaceutical agents (TPA) 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 affect consumer protection. Since the Board is nearing the end of the legislative session and further negotiation is unlikely at this point, Board staff suggests that the Board oppose this bill.

Dr. Lewis made a motion to take an oppose position on this bill/s: Dr. Krauss.

Ms. Clavreul stated she is glad to see the Board is opposing the bill. She feels optometrists do not have enough background or education to extend their performance on this issue.

Dr. Krauss stated the interested parties put in many hours and a lot of hard work to come up with a reasonable program of supervised education and acquisition of skill sets so that everyone would be comfortable with these procedures being carried out safely. When this program was brought to the Committee, the author of the bill rejected it. The author of this bill has submitted bills in the past that, in essence, expanded the scope to include everything an ophthalmologist does if someone presents with visual symptoms. If there is inadequate assurance of public protection, he does not see anything that can be amended, or revised, in this session that could possibly allow the Board to support this bill. He is firmly in support of the oppose position.

Motion carried.

Dr. Krauss thanked Ms. Simoes for her dedication and hard work and stated that he has recently been made aware of the fact that bills can move from the committee to the floor of the Legislature rather quickly. With the structure of the Board as it is, these bills are only discussed among the Members on a quarterly basis, which can sometimes put Ms. Simoes in a position where she may not be comfortable in testifying at a hearing if the bill has significantly changed since discussion at

the prior quarterly Board Meeting. He suggested that the Executive Committee, develop a compendium of Board policy that Ms. Simoes can always refer back to at hearings, rather than be absent from them.

Mr. Serrano Sewell agreed with Dr. Krauss' suggestion and stated that this issue will be put on the next Executive Committee meeting agenda.

Dr. Lewis also complimented Ms. Simoes on her hard work and stated she can count on Member participation when it is needed.

B. Status of Regulatory Actions

Ms. Simoes referred members to the matrix in the Board Packet under agenda item 23B and stated this document provided an update on the Board's regulatory packages.

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

Mr. Serrano Sewell noted that the following agenda items would be included on the October 2014 Board meeting agenda including legislative proposals and a regulatory hearing on disciplinary guidelines.

Dr. Lewis requested another CURES update be included in the Executive Management Report.

Ms. Yaroslavsky requested a discussion on the fictitious name permits to see if it is meeting the need of the stakeholders and if not, to convene an interested parties meeting.

Mr. Serrano Sewell stated if anyone else has anything to be added to the October agenda, to contact Ms. Kirchmeyer.

Agenda Item 25 Adjournment

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

_____ _____
David Serrano Sewell, Vice President Date

_____ _____
Denise Pines, Secretary Date

_____ _____
Kimberly Kirchmeyer, Executive Director Date

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

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 6, 2014
ATTENTION: Board Members
SUBJECT: Midwifery Advisory Council (MAC) Chair Report
CONTACT: Carrie Sparrevohn, L.M., Chair

REQUESTED ACTION:

Approval of the following agenda items are requested for the December 4, 2014 MAC meeting:

- Task Force Updates:
  - Midwife Assistant
  - Board Information Packet
  - Licensed Midwife Annual Report (LMAR) Data Collection Tool
- Update on regulatory changes required by Assembly Bill (AB) 1308
- Update on interested parties meeting scheduled for October 15, 2014
- Update on Certified Nurse Midwife (CNM) to Licensed Midwife (LM) entry

BACKGROUND:

The last MAC meeting was held on August 14, 2014. At this meeting, the MAC continued its discussion surrounding the changes for LMs mandated by AB 1308 (Bonilla, Chapter 665, Statutes of 2013).

The MAC engaged in a lengthy discussion regarding the inclusion of patient and provider names on the current version of the hospital reporting form. Discussion included staff pointing out that there will be an interested parties meeting in the near future to finalize the content of the form and further discussion would be had at that meeting. Members of the audience reported that there continues to be issues surrounding LMs ability to obtain necessary testing and lifesaving drugs. A longtime provider of medications to LMs changed hands and is no longer able to provide this service. Staff is working to find a solution. LMs continue to be challenged in obtaining some testing that is usually only done in a hospital setting, but is not considered outside of normal care or requiring a physician referral from the LM.

As had been discussed at prior MAC meetings, as well as before the Board, there is a need for LMs to have an assistant at births. Because it is not always possible for that assistant to be either another LM or a student, statutory changes are necessary to define the roles of an LM assistant. The task force formed at the March MAC meeting submitted language that is very similar to the medical assistant language, as well as the language allowing naturopathic physicians to train their own assistants. The language was adapted from those two California Business and Professions Code (B&P) Sections 2069 and 3613(g) to meet the specific needs of LMs. The MAC voted to send this language to the full Board for a legislative proposal for the new legislative session in 2015. Jennifer Simoes, Chief of Legislation will present the LM assistant language as part of her presentation to the Board.

The task force for the creation of an information packet for new Board Members provided a finished document that was constructed by the American College of Nurse-Midwives (ACNM) and California Association of Midwives (CAM). It was agreed at the last MAC meeting that it would be best if this document could be synthesized to one page. Upon completion of the document, and approval by the MAC, it will be provided to Board staff to disseminate to new Board Members as part of the orientation packet.

Staff provided a report on the interested parties meeting held August 7, 2014, that discussed the Hospital Reporting Form and a possible pathway for CNMs to become LMs. Regarding the Hospital Reporting Form, interested parties seemed to agree that less information on the form was better, due to the amount of hospital staff time to create the reports. It was understood that when the Board required additional clarity it could request the information, either from the hospital which submitted the form and/or from the LM or patient involved. Regarding the CNM to LM issue, since LMs removed the requirement for physician supervision from statute, CNMs who are practicing in a domiciliary setting have been requesting a route to gain an LM license. Staff held an interested parties meeting to explore CNMs with a current California license being able to directly obtain their LM license.

Staff reported that an interested parties meeting would be set for the near future to gather information related to the implementation of changes brought to B&P Section 2507 (b)(1)(A)(i) and (ii), secondary to the passage of AB 1308 related to medical conditions that would require a LM to refer to a physician for evaluation. This interested parties meeting will also include further discussion on the content of the Hospital Reporting Form. As of this writing this meeting is scheduled for October 15th and additional information will be presented regarding those developments at the Board Meeting.

The task force on updating the LMAR was continued to the December meeting.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 8, 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.

- Mr. Serrano Sewell, Dr. GnanaDev 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 Awet Kidane, Director, Tracy Rhine, Chief Deputy Director, Christine Lally, Deputy Director, of the Department of Consumer Affairs (DCA) and other DCA Executive staff.
- Regular meetings continue to be held with Gloria Castro, Senior Assistant Attorney General. Board staff and DCA staff have also been meeting with Ms. Castro and other Department of Justice (DOJ) staff regarding the vertical enforcement manual.
- Board staff have been meeting with the DCA and the DOJ to discuss requirements for the new CURES database.
- Board staff have met, and will continue to meet on a quarterly basis, with the California Medical Association on issues of interest to both parties.
- Board staff have been meeting with Legislative Staff providing updates on the Board, its actions, and issues of interest.
- 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 (DHCS), 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.
- Board staff have been meeting with staff of the California Department of Social Services and the DHCS to discuss the issue of psychotropic medications for foster children.

Staffing Update:
The Board has 160.1 permanent full-time positions (in addition to temporary staff). The Board is at a 11% vacancy rate which equates to 17 vacant positions. This is up from the report provided in the last Administrative Summary in part because of several retirements that are occurring in several units. However, of those 17 vacant positions, the Board has 4 individuals pending a start date or verification of eligibility. Therefore, the Board only has 13 positions that do not have an individual identified for the position. This equates to an 8% vacancy rate for the Board.

The Board is still in the process of hiring a new Deputy Director for the Medical Board. Although initial interviews were completed and second interviews were conducted, it was determined that a broader candidate pool was needed. The Board re-advertised the position and is now going conducting evaluations of the new applications that were received. It is the Board's intention to have someone in the position by the end of November.

Another important position that is currently vacant is the Board's Chief of Enforcement. This position was obtained through the Budget Change Proposal (BCP) process for fiscal year (FY) 14-15 due to the transition of the investigators to the DCA pursuant to Senate Bill 304 and the loss of the Chief of Enforcement position. Although this request was transmitted to the DCA in April 2014, it is still pending at the California Department of Human Resources (CalHR). Board staff has responded to questions from CalHR and has worked with the DCA to get this position approved. However, to date this position is still pending approval and is therefore vacant.

Budget Update:
Board staff determined that due to the uncertainty of the Board with the transition of the investigative staff and the need to determine the impact of BreEZe on the licensing and enforcement processing, no BCPs would be submitted for FY 15-16. However, the Board is obtaining statistics to see if future positions are needed in order to meet the increasing workload and the increase in time to process documents using BreEZe. Based upon this information, BCPs may be submitted next year for FY 16-17.

The Board's budget documents are attached, beginning on page BRD 8B-5 and continue to page BRD 8B-17. The Board's fund condition on page BRD 8B-5 identifies the Board's fund reserve was at 5.0 months at the end of FY 13-14. This shows a decrease from last year. Due to the transition to BreEZe, the Board is working with DCA to resolve issues with the Board's revenue report. The amount of revenue received for renewal fees for FY 13-14 on the reports on pages 8B-5 and 8B-6 are estimates based upon the Board's prior spending. It appears that money that should have been reported in FY 14-15 is being reported in FY 13-14.

The fund condition report indicates that the Board's fund reserve will be below its mandated level in FY 16-17. 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-6 shows repayment of the outstanding loans in FYs 16-17 and 17-18. 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 13-14, can be found on page BRD 8B-7 and for FY 14-15 as of August 31, 2014, can be found on BRD 8B-8. Pages BRD 8B-9 to 8B-13 show the budget report specifically for licensing, enforcement, the Health Quality Investigation Unit (HQIU), and the AG expenditures. The chart on page BRD 8B-11 is a new chart that provides the budget and expenditures for the HQIU. Page BRD 8B-17 provides the Board Members' expenditure report as of October 6, 2014.

BreEZe Update:
On September 16, 2014, the Board received an update from the DCA regarding the BreEZe project. A large portion of the update pertained to the Board in release 2 and 3. However, the update did state that the DCA is currently amending the contracts with the vendor (Accenture) to add more dedicated staff to production support, which will increase the number of business functions to each release for maintenance, as well as how often these changes can be implemented. This should allow for more changes per release and the changes will

occur more frequently. In addition, the amendments should also address the need to include additional and future business functionality, e.g. legislative changes that occur after requirements have been approved.

Board staff continue to submit requests for changes/fixes to DCA for the BreEZe system. The Board still has a significant number of outstanding requests for changes that were identified prior to implementation but were not fixed prior to the release of BreEZe because they were deemed not detrimental to the Board being able to go live. As previously stated, 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 is still working on reports specific to the needs of the Board. It has been difficult to obtain reports due to the work required to develop them and also due to the need to verify the data.

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-18 and 19). The two boards (Medical and Pharmacy) continue to work together on issues of similar interest.

Licensing Application Tutorial:
In September 2014 the Board released an online tutorial for licensing applicants. This tutorial walks an applicant through completing the paper licensure application for a physician's and surgeon's license. In addition to being able to review the tutorial in its entirety, the Board also put a link on every page of the application (on the Board's website) specific to the how to complete that specific page of the application or a specific document (e.g. Certificate of Medical Education). At a recent licensing fair attended by the Board's Outreach Manager, the facility was continuously playing this tutorial video for the individuals to watch to obtain information on completing the application. The Board hopes this will bring down the percentage of applications that arrive with incomplete information or are deficient due to missing documentation.

Legislative Day:
The Board is planning on doing a "Legislative Day" at the Capitol sometime in the Spring. The objective would be to meet with Legislative Members to provide them with information about the Board and its mission, roles, and responsibilities. Board Members, in teams of two, would meet with the Legislative Member to provide them with materials, including information on how to check a physician online.

Controlled Substance Utilization Review and Evaluation System (CURES) Update
The CURES project is moving forward. The DCA and the DOJ have entered into an Interagency Agreement, which sets forth roles and responsibilities of both agencies and a Joint Executive Steering Committee (JESC) has been established and is meeting on a monthly basis. Three meetings have been held on the project to date. Ms. Kirchmeyer is a member of the JESC, as well as Virginia Herold and Tracy Rhine. Board staff attended a "kickoff" meeting on September 12, 2014, and the vendor provided information on the project, as well as a demonstration of the system.

Board staff have been attending all of the Joint Application Design (JAD) sessions with DOJ, DCA, and other prescribing/dispensing licensing boards. Staff has been providing information on how the system should be designed and what prescribing information is needed for the Board to investigate complaints received by the Board. JAD sessions have discussed user registration, data collection, interoperability, queries/reports, user dashboard, auditing, and user roles. In addition, on October 8, 2014, a JAD session was held for the stakeholders (licensee organizations) to provide input from their perspective on the system design and needed

requirements. This information is being gathered to use to write the requirements for the system. A draft project schedule is slated to be provided to the JESC by October 10, 2014. A project plan is also being worked on and will be provided to the JESC once it is completed. Once the requirements are drafted, the JESC will review the document and provide feedback to DOJ.

Board staff are assisting DOJ with obtaining registration for the CURES system by offering physicians the ability to provide documentation at the Board meetings. Board staff will verify the documentation and then provide the documentation to DOJ so the physician can be registered. This eliminates the need to have the documents notarized. In addition, the Board is offering individuals to visit the Board's headquarters office in Sacramento and its Probation Unit offices in San Dimas and Cerritos to also register for CURES. The intent is to assist in getting physicians registered for CURES by January 2016, as required by Senate Bill 809 (DeSaulnier, Chapter 400, Statutes of 2013).

Update on Safe Prescribing Continuing Medical Education (CME) Course

On September 19, 2014, the Board sponsored a three hour CME course entitled "Extended-Release and Long-Acting (ER/LA) Opioid Analgesics Risk Evaluation and Mitigation Strategy" in Los Angeles. Although the Board received over 500 registrations, the course was attended by 227 physicians.

This course was developed by the U.S. Food and Drug Administration and focused on assessing patients for treatment with ER/LA opioid analgesic therapy. The course discussed initiating therapy, modifying dosing, discontinuing the use of ER/LA opioid analgesics, managing therapy, and counseling patients and caregivers about the safe use of ER/LA opioid analgesics. The course also included general and specific drug information for ER/LA opioid analgesics.

The Board was able to offer this CME course thanks to a grant from the Federation of State Medical Boards Foundation. The three hours of CME credits were granted by the University of Nebraska Medical Center, Center for Continuing Education.

The Board also plans to offer this course in Northern California either in early December or early next year. In addition, the Board is working on posting information on the its website about a one hour CME online course that is also available on this topic.

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

		ACTUAL 2013-14	CURRENT YEAR 2014-15	BY 2015-16	BY+1 2016-17	BY+2 2017-18
BEGINNING BALANCE		$ 26,498	$ 24,653	$ 18,465	$ 14,750	$ 7,418
Prior Year Adjustment		$ 234	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 26,732	$ 24,653	$ 18,465	$ 14,750	$ 7,418
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 157	$ 331	$ 331	$ 331	$ 331
125700	Other regulatory licenses and permits	$ 6,994	$ 5,960	$ 5,961	$ 5,961	$ 5,961
125800	Renewal fees	$ 45,414	$ 45,727	$ 45,727	$ 45,727	$ 45,727
125900	Delinquent fees	$ 238	$ 98	$ 98	$ 98	$ 98
141200	Sales of documents	$ 12	$ 12	$ 12	$ 12	$ 12
142500	Miscellaneous services to the public	$ 1	$ 30	$ 30	$ 30	$ 30
150300	Income from surplus money investments	$ 75	$ 65	$ 70	$ 45	$ 37
160400	Sale of fixed assets	$ -	$ 3	$ 3	$ 3	$ 3
161000	Escheat of unclaimed checks and warrants	$ 11	$ 11	$ 11	$ 11	$ 11
161400	Miscellaneous revenues	$ 2	$ 16	$ 16	$ 16	$ 16
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 52,904	$ 53,153	$ 53,159	$ 53,134	$ 53,126
Transfers:						
TOTALS, REVENUES AND TRANSFERS		$ 52,904	$ 53,153	$ 53,159	$ 53,134	$ 53,126
TOTAL RESOURCES		$ 79,636	$ 77,806	$ 71,624	$ 67,884	$ 60,544
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 3	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 259	$ 48	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 54,721	$ 56,367	$ 56,354	$ 58,415	$ 59,625
2014-15 and ongoing Approved Costs						
BreEZe Costs			$ 1,531			
CURES			$ 819			
Enforcement Enhancements			$ 471	$ 415	$ 415	$ 415
SB 304			$ 118	$ 118	$ 118	$ 118
Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)	$ (13)
Anticipated Future Costs						
BreEZe Costs				$ 1,531	$ 1,531	$ 1,531
Totals, Disbursements		$ 54,983	$ 59,341	$ 56,874	$ 60,466	$ 61,676
FUND BALANCE						
Reserve for economic uncertainties		$ 24,653	$ 18,465	$ 14,750	$ 7,418	$ (1,132)
Months in Reserve		5.0	3.9	2.9	1.4	-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.

10/9/2014

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

		ACTUAL 2013-14	CURRENT YEAR 2014-15	BY 2015-16	BY+1 2016-17	BY+2 2017-18
BEGINNING BALANCE		$ 26,498	$ 24,653	$ 18,465	$ 14,721	$ 13,358
Prior Year Adjustment		$ 234	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 26,732	$ 24,653	$ 18,465	$ 14,721	$ 13,358
REVENUES AND TRANSFERS						
Revenues:						
125600	Other regulatory fees	$ 157	$ 331	$ 331	$ 331	$ 331
125700	Other regulatory licenses and permits	$ 6,994	$ 5,960	$ 5,961	$ 5,961	$ 5,961
125800	Renewal fees	$ 45,414	$ 45,727	$ 45,727	$ 45,727	$ 45,727
125900	Delinquent fees	$ 238	$ 98	$ 98	$ 98	$ 98
141200	Sales of documents	$ 12	$ 12	$ 12	$ 12	$ 12
142500	Miscellaneous services to the public	$ 1	$ 30	$ 1	$ 1	$ 1
150300	Income from surplus money investments	$ 75	$ 65	$ 70	$ 43	$ 37
160400	Sale of fixed assets	$ -	$ 3	$ 3	$ 3	$ 3
161000	Escheat of unclaimed checks and warrants	$ 11	$ 11	$ 11	$ 11	$ 11
161400	Miscellaneous revenues	$ 2	$ 16	$ 16	$ 16	$ 16
164300	Penalty assessments - Probation Monitoring		$ 900	$ 900	$ 900	$ 900
Totals, Revenues		$ 52,904	$ 53,153	$ 53,130	$ 53,103	$ 53,097
Transfers:						
	Proposed General Fund Loan Repayment				$ 6,000	$ 7,000
TOTALS, REVENUES AND TRANSFERS		$ 52,904	$ 53,153	$ 53,130	$ 59,103	$ 60,097
TOTAL RESOURCES		$ 79,636	$ 77,806	$ 71,595	$ 73,824	$ 73,455
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 3	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 259	$ 48	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 54,721	$ 56,367	$ 56,354	$ 58,415	$ 59,625
	2014-15 and ongoing Approved Costs					
	BreEZe Costs		$ 1,531			
	CURES		$ 819			
	Enforcement Enhancements		$ 471	$ 415	$ 415	$ 415
	SB 304		$ 118	$ 118	$ 118	$ 118
	Establish Spending Authority for Midwifery		$ (13)	$ (13)	$ (13)	$ (13)
	Anticipated Future Costs					
	BreEZe Costs			$ 1,531	$ 1,531	$ 1,531
Totals, Disbursements		$ 54,983	$ 59,341	$ 56,874	$ 60,466	$ 61,676
FUND BALANCE						
Reserve for economic uncertainties		$ 24,653	$ 18,465	$ 14,721	$ 13,358	$ 11,779
Months in Reserve		5.0	3.9	2.9	2.6	2.3

NOTES:

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

B. INTEREST ON FUND ESTIMATED AT .361%

$9 million was loaned to the General Fund by the Board in FY 11/12 and $6 million was loaned to the General Fund in FY 08/09. These loans will be repaid when the fund is nearing its minimum mandated level.

10/9/2014

Medical Board of California
FY 13/14
Budget Expenditure Report
(As of June 30, 2014)
(100% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	16,540,850	15,608,041	94.4	932,809
Board Members	31,500	75,125	238.5	(43,625)
Phy Fitness Incentive Pay	29,623	6,600	22.3	23,023
Temp Help	1,800,000	1,351,227	75.1	448,773
Overtime	50,000	152,653	305.3	(102,653)
Staff Benefits	8,328,522	7,859,877	94.4	468,645
BL 12-03 Blanket	0	130,170		0
TOTALS, PERS SERVICES	26,780,495	25,183,693	94.0	1,726,972
OPERATING EXP & EQUIP				
General Expense	300,535	526,470	175.2	(225,935)
Fingerprint Reports	333,448	296,283	88.9	37,165
Minor Equipment	24,300	137,253	564.8	(112,953)
Printing	435,755	281,723	64.7	154,032
Communications	257,190	270,978	105.4	(13,788)
Postage	182,511	117,962	64.6	64,549
Insurance	41,053	16,106	39.2	24,947
Travel In-State	361,298	377,763	104.6	(16,465)
Travel Out-of-State	7,000	11,057	158.0	(4,057)
Training	78,895	64,991	82.4	13,904
Facilities Operation (Rent)	2,490,025	2,460,235	98.8	29,790
Consult/Prof Services	3,017,594	2,103,643	69.7	913,951
Departmental Prorata	5,034,442	4,967,736	98.7	66,706
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	496,182	76.3	154,048
Data Processing	129,492	296,770	229.2	(167,278)
Central Admin Svcs (Statewide Prorata)	2,417,774	2,417,774	100.0	0
Attorney General Services	13,347,280	13,018,087	97.5	329,193
Office of Administrative Hearings	1,525,080	1,154,251	75.7	370,829
Evidence/Witness	1,893,439	2,021,476	106.8	(128,037)
Court Reporter Services	225,000	325,360	144.6	(100,360)
Major Equipment	392,120	403,544	102.9	(11,424)
Other Items of Expense	81	31,013	38,287.7	(30,932)
Vehicle Operations	247,925	350,242	141.3	(102,317)
Court-ordered Payments	0	0		0
Board of Control Claim	0	2,808		(2,808)
TOTALS, OE&E	33,397,609	32,149,707	96.3	1,247,902
TOTALS, EXPENDITURES	60,178,104	57,333,400	95.3	2,844,704
Scheduled Reimbursements	(384,000)	(604,410)	157.4	220,410
Distributed Costs	(780,000)	(616,950)	79.1	(163,050)
NET TOTAL, EXPENDITURES	59,014,105	56,112,040	95.1	2,902,064
Unscheduled Reimbursements		(1,390,459)		
		54,721,581		

Budget Expenditure Report.xls
Date:9/19/14

Medical Board of California
FY 14/15
Budget Expenditure Report
(As of August 31, 2014)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	9,272,626	1,361,198	14.7	7,911,428
Board Members	31,500	8,700	27.6	22,800
Temp Help	755,888	10,294	1.4	745,594
Overtime	44,441	737	1.7	43,704
Staff Benefits	4,564,227	736,753	16.1	3,827,474
BL 12-03 Blanket	0	91,394		0
TOTALS, PERS SERVICES	14,668,682	2,209,076	15.1	12,551,000
OPERATING EXP & EQUIP				
General Expense	72,874	76,583	105.1	(3,709)
Fingerprint Reports	333,448	26,519	8.0	306,929
Minor Equipment	28,950	8,599	29.7	20,351
Printing	194,755	49,695	25.5	145,060
Communications	106,190	14,244	13.4	91,946
Postage	149,511	21,338	14.3	128,173
Insurance	2,053	0	0.0	2,053
Travel In-State	130,298	9,635	7.4	120,663
Travel Out-of-State	0	954	0.0	(954)
Training	54,895	2,294	4.2	52,601
Facilities Operation (Rent)	928,140	2,291,100	246.8	(1,362,960)
Consult/Prof Services	1,482,088	2,005,585	135.3	(523,497)
Departmental Prorata	4,963,707	1,240,930	25.0	3,722,777
HQIU	15,804,000	963,549	6.1	14,840,451
Interagency Services	5,142	0	0.0	5,142
Consolidated Data Center	650,230	14,333	2.2	635,897
Data Processing	117,492	44,600	38.0	72,892
Central Admin Svcs (Statewide Prorata)	2,865,649	716,662	25.0	2,148,987
Attorney General Services	13,347,280	2,084,980	15.6	11,262,300
Office of Administrative Hearings	1,525,080	0	0.0	1,525,080
Evidence/Witness	1,893,439	113,676	6.0	1,779,763
Court Reporter Services	225,000	163,876	72.8	61,124
Major Equipment	57,180	0	0.0	57,180
Other Items of Expense	81	15,198	18,763.0	(15,117)
Vehicle Operations	31,925	9,614	30.1	22,311
Court-ordered Payments	0	0		0
Board of Control Claim	0	0		0
TOTALS, OE&E	44,969,407	9,873,964	22.0	35,095,443
TOTALS, EXPENDITURES	59,638,089	12,083,040	20.3	47,555,049
Scheduled Reimbursements	(384,000)	(56,555)	14.7	(327,445)
Distributed Costs	(780,000)	0	0.0	(780,000)
NET TOTAL, EXPENDITURES	58,474,089	12,026,485	20.6	46,447,604
Unscheduled Reimbursements		(8,000)		
		12,018,485		

Budget Expenditure Report.xls
Date:9/22/14

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

	FY 14/15 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,888,597	427,561	current
Staff Benefits	727,215	231,547	current
TOTAL PERSONAL SERVICES	3,615,812	659,108	
OPERATING EXPENSES & EQUIPMENT			
General Expense	15,349	656	1-2
Fingerprint Reports*	333,448	26,519	1-2
Printing	99,876	23,916	1-2
Communications	25,000	2,378	1-2
Postage	78,111	13,100	1-2
Travel In-State	9,758	3,547	1-2
Training	5,000	0	1-2
Facilities Operation	226,000	320,065	current
Consult/Professional Services	1,227,873	971,271	1-2
Departmental Services	592,170	148,042	current
Interagency Services	587	0	current
Data Processing	3,000	1,549	1-2
Statewide Pro Rata	341,872	85,468	current
Attorney General	190,000	3,502	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	0	1-2
TOTAL OPERATING EXPENSES & EQUIPMENT	3,155,794	1,600,013	
SCHEDULED REIMBURSEMENTS	(384,000)	(56,555)	
DISTRIBUTED COSTS	(31,131)	0	
TOTAL BUDGET/EXPENDITURES	**6,356,475**	**2,202,566** **	

*Department of Justice invoices for fingerprint reports, name checks, and subsequent arrest reports
** Includes Polysom
9/25/2014

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

	FY 14/15 BUDGET	EXPENDITURES/ ENCUMBRANCES YR-TO-DATE	LAG TIME (MONTHS)
PERSONAL SERVICES			
Salaries & Wages	2,705,134	433,602	current
Staff Benefits	2,716,797	213,519	current
TOTAL PERSONAL SERVICES	5,421,931	647,121	
OPERATING EXPENSE & EQUIPMENT			
General Expense/Fingerprint Reports	15,340	56,754	1-2
Printing	35,279	15,602	1-2
Communications	14,510	7,124	1-2
Postage	60,000	8,046	1-2
Insurance	0,000	0	current
Travel In-State	17,531	3,181	1-2
Travel Out-State		0	1-2
Training	31,000	1,065	1-2
Facililties Operations	367,140	1,659,038	current
Consultant/Professional Services	166,494	993,521	1-2
Departmental Services	3,642,865	910,717	current
Interagency Services	3,629	0	1-2
HQIU	15,804,000	963,549	
Data Processing	17,492	31,961	1-2
Statewide Pro Rata	2,103,100	525,775	current
Attorney General 1/	13,157,280	2,081,478	current
OAH	1,525,080	0	1
Evidence/Witness Fees	1,820,939	112,076	1-2
Court Reporter Services	224,750	163,876	1-2
Major Equipment	0	0	1-2
Other Items of Expense (Law Enf. Materials/Lab, etc.)	0	14,770	1-2
Vehicle Operations	0,000	5,312	1-2
Minor Equipment	0	3,325	1-2
Court-Ordered Payments	0	0	current
TOTAL OPERATING EXPENSES & EQUIPMENT	39,006,429	7,557,170	
DISTRIBUTED COSTS	(744,054)	0	
TOTAL BUDGET/EXPENDITURES	**43,684,306**	**8,204,291**	
Unscheduled Reimbursements		0	
		8,204,291	

1/See next page for monthly billing detail

HQIU
FY 14/15
Budget Expenditure Report
(As of August 31, 2014)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENSES/ ENCUMB	PERCENT OF BUDGET EXP/ENCUMB	UNENCUMB BALANCE
PERSONAL SERVICES				
Salary & Wages	8,959,584	1,259,457	14.1	7,700,127
Temp Help	0	104,538	0.0	(104,538)
Overtime	0	164	0.0	(164)
Staff Benefits	3,836,533	690,778	18.0	3,145,755
TOTALS, PERS SERVICES	12,796,117	2,054,937	16.1	10,741,180
OPERATING EXP & EQUIP				
General Expense	210,000	78,314	37.3	131,686
Minor Equipment	0	561	0.0	(561)
Printing	68,000	75,952	111.7	(7,952)
Communications	171,000	13,398	7.8	157,602
Postage	35,000	5,154	14.7	29,846
Insurance	39,000	0	0.0	39,000
Travel In-State	222,000	7,195	3.2	214,805
Travel Out-of-State	7,000	0	0.0	7,000
Training	26,000	0	0.0	26,000
Facilities Operation (Rent)	1,574,000	26,520	1.7	1,547,480
Consult/Prof Services	91,000	70,560	77.5	20,440
Consolidated Data Center	14,000	0	0.0	14,000
Data Processing	0	10,427	0.0	(10,427)
Court Reporter Services	0	60,065	0.0	(60,065)
Other Items of Expense	28,000	29,650	105.9	(1,650)
Vehicle Operations	216,000	14,892	6.9	201,108
Court-ordered Payments	0	0	0.0	0
Board of Control Claim	0	0	0.0	0
TOTALS, OE&E	2,701,000	392,688	14.5	2,308,312
TOTALS, EXPENDITURES	15,497,117	2,447,625	15.8	13,049,492
Scheduled Reimbursements				
Distributed Costs				
NET TOTAL, EXPENDITURES	15,497,118	2,447,625	15.8	13,049,492
Unscheduled Reimbursements		0		
		2,447,625		

Budget Expenditure Report.xls
Date:10/8/14

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 14/15
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,050.50	170.00	1,028,585.00
	Paralegal Services	214.25	120.00	25,710.00
	Auditor/Analyst Services	117.75	99.00	11,657.25
	Cost of Suit			0.00
				1,065,952.25
August	Attorney Services	5,762.25	170.00	979,582.50
	Paralegal Services	229.50	120.00	27,540.00
	Auditor/Analyst Services	75.50	99.00	7,474.50
	Cost of Suit			929.00
				1,015,526.00
September	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
October	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Special Agent	0.00	120.00	0.00
	Cost of Suit			0.00
				0.00
November	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
December	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
			Total July-Dec =	**2,081,478.25**
			FY 13/14 Budget =	**13,157,280.00**

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 14/15
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

January				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
February				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
March				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
April				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
May				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00
June				
	Attorney Services	0.00	170.00	0.00
	Paralegal Services	0.00	120.00	0.00
	Auditor/Analyst Services	0.00	99.00	0.00
	Cost of Suit			0.00
				0.00

Revised 10/9/2014

FYTD Total =	**2,081,478.25**
FY 13/14 Budget =	**13,157,280.00**

ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2012 - JUNE 2015

	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	50	3,100
Criminal Cost Recovery	499	698	1,050	3,127	8,857	204	2,824	9,707	100	7,352	1,235	2,677	38,330
Probation Monitoring	69,560	54,598	28,303	0	100,901	115,137	439,694	161,273	109,197	136,412	63,742	65,414	1,344,231
Exam	7,232	6,164	4,537	0	5,568	1,500	7,328	3,075	4,929	5,784	3,953	9,338	59,408
Cite/Fine	2,850	5,450	2,000	4,925	2,975	2,850	1,100	1,100	0	750	1,850	5,500	31,350
MONTHLY TOTAL	80,791	67,460	36,440	8,052	118,301	119,741	451,996	175,205	114,226	150,398	70,830	82,979	1,476,418
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	1,476,418	

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FYTD Total
Invest Cost Recovery	0	50											50
Criminal Cost Recovery	844	29,175											30,019
Probation Monitoring	64,316	41,643											105,959
Exam	9,061	3,048											12,109
Cite/Fine	3,000	3,000											6,000
MONTHLY TOTAL	77,221	76,916	0	0	0	0	0	0	0	0	0	0	154,137
FYTD TOTAL	77,221	154,137	154,137	154,137	154,137	154,137	154,137	154,137	154,137	154,137	154,137	154,137	

excel:enfreceiptsmonthlyprofile.xls.revised 9/22/2014

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.

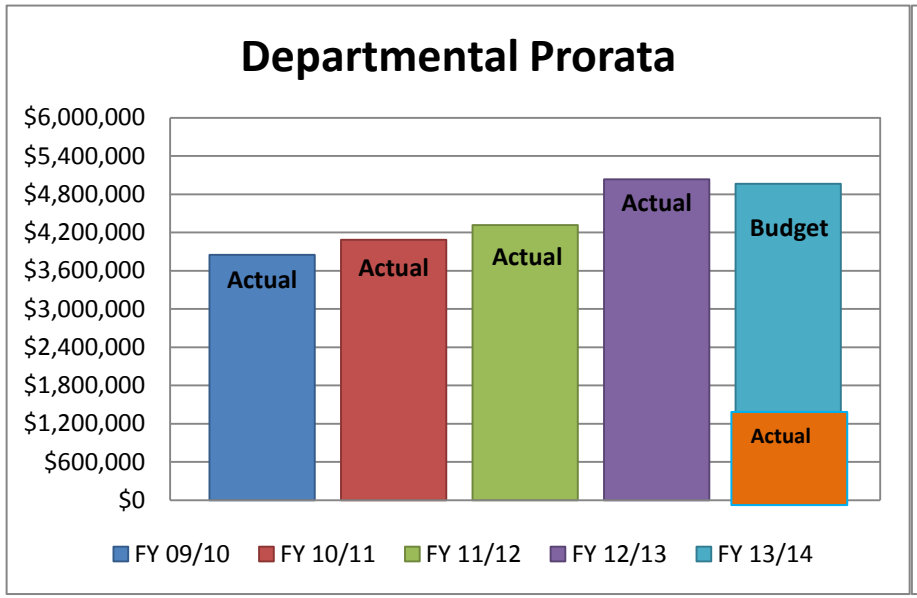
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

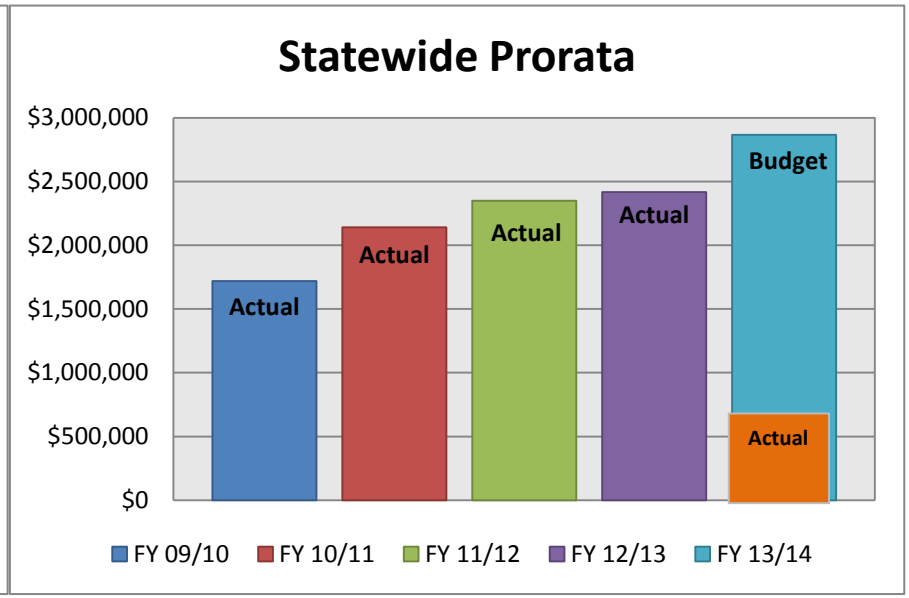
	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 11/12								
$ Budgeted	1,885,220	40,510,088		5,336,015	1,585,554	3,069,028	2,013,445	54,399,350
$ Spent *	1,775,576	33,754,208		4,745,127	1,543,636	2,810,667	503,487	45,132,701 *
Positions 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*	1,427,599	40,148,898	879,418	6,023,718	1,650,434	3,166,541	1,424,973	54,721,581 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 14/15								
$ Budgeted	1,846,133	43,684,306		6,356,475	1,517,338	3,076,473	1,993,364	58,474,089
$ Spent thru 08/31*	358,887	8,204,291		2,202,566	328,862	493,156	430,723	12,018,485 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

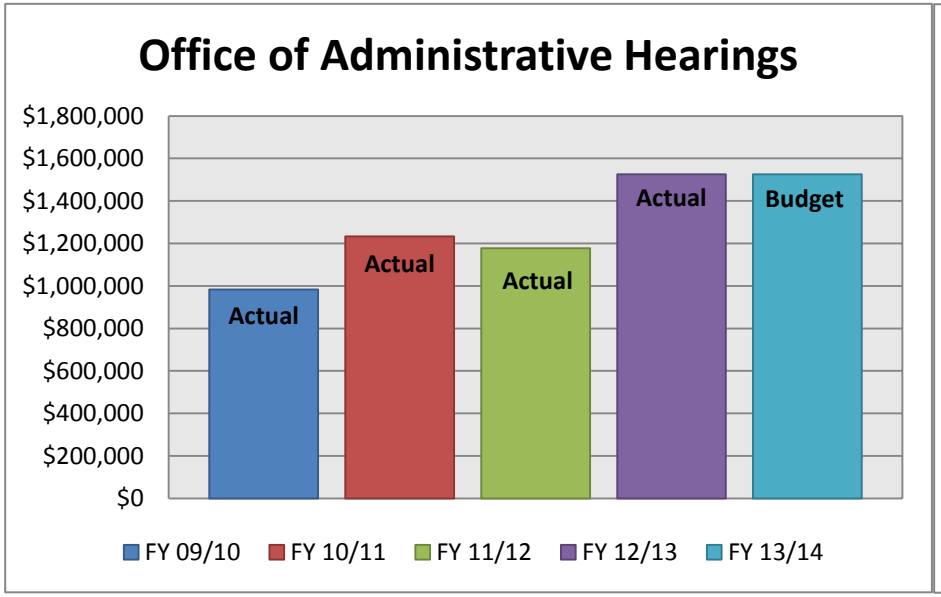
* net expenditures (includes unscheduled reimbursements)

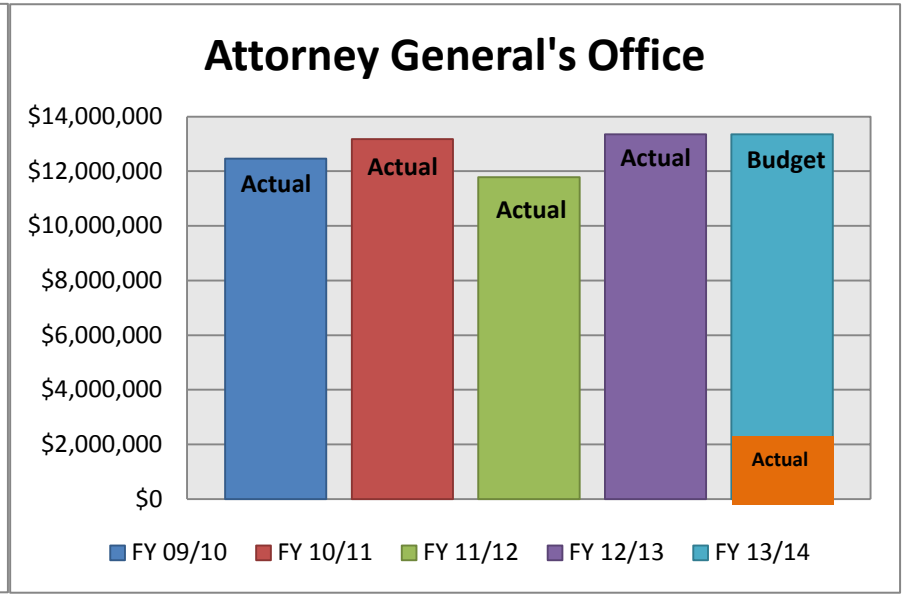
10/9/2014
Budget Overview by Program.xls

Strategic Plan Objective 5.3
External Agencies' Spending









Board Members' Expenditures - Per Diem/Travel
July 1, 2014 - June 30, 2015

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BISHOP - Per diem	$ 600.00	$ 200.00										$ -	$ 800.00
Travel	$ 875.32											$ -	$ 875.32
	$1,475.32	$ 200.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,675.32**
DR GNANADEV - Per diem	$1,400.00												$ 1,400.00
Travel	$ 823.38												$ 823.38
	$2,223.38	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,223.38**
DR. KRAUSS - Per diem	$1,400.00											$ -	$ 1,400.00
Travel												$ -	$ -
	$1,400.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,400.00**
DR. LEVINE - Per diem												$ -	$ -
Travel												$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LEWIS - Per diem	$1,500.00	$ 900.00										$ -	$ 2,400.00
Travel												$ -	$ -
	$1,500.00	$ 900.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,400.00**
MR. LUI - Per diem												$ -	$ -
Travel												$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
MS. PINES - Per diem	$1,300.00											$ -	$ 1,300.00
Travel	$ 677.46											$ -	$ 677.46
	$1,977.46	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,977.46**
MS.SCHIPSKE - Per diem	$1,600.00	$1,100.00											$ 2,700.00
Travel												$ -	$ -
	$1,600.00	$1,100.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,700.00**
MR. SERRANO SWELL- Per diem	$ 700.00	$ 700.00										$ -	$ 1,400.00
	$ 413.72											$ -	$ 413.72
	$1,113.72	$ 700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,813.72**
MS.WRIGHT - Per diem	$1,600.00	$1,400.00										$ -	$ 3,000.00
Travel	$ 210.03											$ -	$ 210.03
	$1,810.03	$1,400.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,210.03**
MS. YAROSLAVSKY - Per diem	$1,000.00	$ 700.00										$ -	$ 1,700.00
Travel	$ 799.36											$ -	$ 799.36
	$1,799.36	$ 700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,499.36**
DR. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of:10/06/2014

TOTAL PER DIEM	$ 16,100.00
TOTAL PER DIEM BUDGETED	$ 31,500.00
TOTAL TRAVEL	$ 3,799.27
TOTAL	**$ 19,899.27**

California State Board of Pharmacy
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BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
DEPARTMENT OF CONSUMER AFFAIRS
GOVERNOR EDMUND G. BROWN JR.

October 7, 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 August. During this meeting, the subcommittee heard reports from Consumers Union on their information about the dangers of prescription drug abuse, and the personal experiences of a newspaper writer on opioid addiction and recovery. Information also was presented on components for patient consultation for those taking opioids from a UCSD pharmacy resident.

The board and the DEA provided two six-hour continuing education seminars on prescription drug abuse, drug thefts and diversion, corresponding responsibility and the CURES program. These presentations were in Santa Barbara. A future presentation is planned for the San Fernando Valley.

The next meeting of the subcommittee is November 12 in the Oakland/Alameda area.

The Governor signed the Drug Overdose Prevention Bill (AB 1535, Bloom), which permits pharmacists to furnish naloxone to patients pursuant to a protocol that we will be working with the Medical Board on.

Patient-Centered Prescription Container Label Requirements:

On July 31 as part of its July board meeting, the board convened a day-long forum on patient-centered prescription label design to emphasize information most important to patients. Ten invited speakers, most representing national organizations and experts in the field, provided information on current thinking of the optimal design of prescription container labels for maximum patient reading ease and comprehension. The predominant concern expressed by the public present and the media coverage of the meeting stressed the need for translations to be available to those patients with limited English proficiency. The board will discuss possible

changes for future label design during the coming Communication and Public Education Meetings.

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.

Discussion and work on these two protocols will occur during the November 5 (Sacramento) and December 16 (Los Angeles) SB 493 Implementation Committee meetings. Medical Board staff will be invited to be part of the process as well.

The board will also initiate work on the naltrexone protocol during the same meetings.

The current plan is to bring the final protocols to both boards for action at their late January meetings.

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

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 8, 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 952 experts in the Board's expert database. 321 experts were utilized to review 490 cases in the first three quarters of calendar year 2014. **Attachment A** provides the Expert Reviewer Program statistics. Additional experts are needed in the following specialties:

- Addiction Medicine with additional certification in Family or Internal Medicine
- Addiction Psychiatry
- Dermatology
- Hematology/Oncology
- Hematology/Oncology with experience in stem cell transplantation
- Neurology
- Neurosurgery
- Pain Medicine
- Spine Surgery
- Urology
- Medical Toxicology
- Pathology (statewide)
- Pediatric Surgery
- Surgery
- Thoracic Surgery
- Vascular Surgery (Board Certified in Vascular Surgery)

Staffing Update:
The Enforcement Program, now consisting of the Central Complaint Unit, Complaint Investigation Office, Discipline Coordination Unit, and Probation Unit following the transition of the investigators to the Department of Consumer Affairs, is close to being fully staffed. The Central Complaint Unit currently has one vacant clerical position, and a vacant Staff Services Manager I position. The Discipline Coordination Unit is currently recruiting for three vacancies, one clerical support staff person, one Staff Services Analyst, and one Associate Analyst. The Probation Unit is attempting to fill one vacant clerical support position in Southern California, and a vacant Inspector I position in Northern California. The Complaint Investigation Office is fully staffed.

Susan Cady, Staff Services Manager II in the Enforcement Program, retired September 30, 2014. Ms. Cady's contributions to the Board's Enforcement Program were beyond compare and she will be greatly missed. Ms. Cady was instrumental in a reorganization of the Board's Central Complaint Unit, resulting in increased efficiencies and decreases in the complaint processing times. In addition, Ms. Cady has done a

significant amount of work in the Probation Unit ensuring policies and procedures were completed in order to ensure consistency statewide. The Board thanks Ms. Cady for her service to the Board.

Complaint Investigation Office (CIO):
The six (6) Special Investigators (non-sworn) within the Board's Complaint Investigation Office (CIO) are each currently assigned 25-30 cases. Since the establishment of the unit in June 2014, CIO staff has completed approximately ten (10) subject interviews and transmitted five (5) cases to the AG's office. All five (5) cases transmitted, two (2) convictions and three (3) Petitions for Reinstatement, have been accepted. The unit has closed 145 cases. CIO has also obtained access to DMV and Lexis Nexis, and secured an evidence account from DCA. The funds from the evidence account will be used to purchase documents such as death certificates, court documents, coroner's reports, medical records, etc., in order to assist the Special Investigators with their investigations.

In addition to accomplishing the tasks above, each Special Investigator has successfully completed two training courses, Regulatory Investigative Techniques presented by Los Rios Community College, and Interviewing Techniques for Investigators and Inspectors, which was conducted by DCA's SOLID Training Unit. The Special Investigators are also scheduled to attend the National Certified Investigator and Inspector Training organized by the Council on Licensure, Enforcement and Regulation (CLEAR), DCA's Enforcement Academy, and DCA's Property and Evidence Room Management. The Supervising Special Investigator has also conducted in-house training for staff on topics such as report writing, interviewing, the various Enforcement case types they will investigate (i.e., medical malpractice cases, arrests/convictions, Petitions for Reinstatement), the Administrative/Disciplinary process, and the Board's Enforcement Program as a whole.

Transition:
Board staff continues to work with DCA on the transition of the investigators to the Department of Consumer Affairs Health Quality Investigative Unit (HQIU) to ensure the Board and the DCA are in compliance with the Memorandum of Understanding.

Statistics:
Unfortunately the Board still does not have access to reports that identify timeframes for the processing of complaints, investigations, or disciplinary actions. However, the Board was able to obtain a report for the number of complaints received. In FY 13-14 the Board received 8,476 complaints. This is an increase of 1,017 complaints from FY 12-13. Although the exact reason for the significant increase cannot be determined, it could be due to several factors, most notably, the implementation of the BreEZe system. With the BreEZe system, individuals have the ability to submit a complaint online. This makes the filing of a complaint easier and therefore this could be one reason for the increase. Another reason that has been identified is that, due to some of the difficulty of using the system, individuals are submitting duplicate complaints. The individual may submit one complaint and then need to send more information on that complaint. Rather than adding to the previously submitted complaint, the individual sends in a whole new complaint. In addition, it appears that some individuals have submitted a complaint in writing and then submit one online. Whatever the reasons, this is a substantial increase in the staff's workload, as even duplicate complaints require staff time. The Board will monitor FY 14-15 to determine if this increase is an anomaly or if it is a continuing trend and, if necessary, the Board will submit a BCP for additional staff.

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
10/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-September)	Number of Experts Utilized (January-September)	Active List Experts 10.1.14 952↑
ADDICTION	4	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	9 ↓
ALLERGY & IMMUNOLOGY (A&I)			3 ↓
ANESTHESIOLOGY (Anes)	15	**12 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	75 ↑
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	3
COMPLEMENTARY/ALTERNATIVE MEDICINE ** COMPANION CASES*	9	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	21 ↑
CORRECTIONAL MEDICINE			25
DERMATOLOGY (D) ** COMPANION CASES*	13	**5 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES*	8 ↓
EMERGENCY (EM)	14	**9 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	50 ↑
FAMILY (FM) ** COMPANION CASES* *** INCLUDED PREPARATION/TESTIMONY OF CASES PREVIOUSLY REVIEWED*	59	**26 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 11 CASES**	79 ↑

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
10/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-September)	Number of Experts Utilized (January-September)	Active List Experts 10.1.14 952↑
INTERNAL (General Internal Med) **INVOLVED A COMPANIONS CASE; SUPPLEMENTAL WORK AND PREPARATION FOR HEARING*	53	**36 EXPERTS** 23 LIST EXPERTS REIEWED 1 CASE 9 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 7 CASES*	173 ↓
Cardiovascular Disease (Cv) **EXPERT WITH CONSISTENT POSITIVE FEEDBACK OF REVIEWS*	13	**12 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 7 CASES*	33
Endocrinology, Diabetes and Metabolism (EDM)	4	**2 EXPERTS** 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	6 ↓
Gastroenterology (Ge)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	19
Infectious Disease (Inf)	2	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	11
Medical Oncology (Onc)			11 ↓
Nephrology (Nep)			9
Rheumatology (Rhu)			7
MIDWIFE REVIEWER	3	**2 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6
NEUROLOGICAL SURGERY (NS) ** COMPANION CASES*	16	**7 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 OFF LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	9

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
10/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-September)	Number of Experts Utilized (January-September)	Active List Experts 10.1.14 952↑
NEUROLOGY (N)	14	**7 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	22 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3 ↑
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG) ** COMPANION CASES & PREPARATION FOR HEARING* ***EXPERT WITH CONSISTENT POSITIVE FEEDBACK OF REVIEWS*	55	**35 EXPERTS** 22 LIST EXPERTS REVIEWED 1 CASE 4 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES* 1 LIST EXPERT REVIEWED 7 CASES**	74 ↑
OCCUPATIONAL MEDICINE			8
OPHTHALMOLOGY (Oph)	9	**8 EXPERTS** 1 OFF LIST EXPERT REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	28 ↓
ORAL & MAXILLOFACIAL SURGERY			1
ORTHOPAEDIC SURGERY (OrS)	15	**12 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	31 ↑
OTOLARYNGOLOGY (Oto)	5	**3 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES	18

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
10/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-September)	Number of Experts Utilized (January-September)	Active List Experts 10.1.14 952↑
PAIN MEDICINE (PM) * *COMPANION CASES AND SHORT LIST OF REVIEWERS*	48	**18 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 5 LIST EXPERTS REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES* 2 LIST EXPERTS REVIEWED 6 CASES*	28 ↑
PATHOLOGY (Path)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	10 ↑
PEDIATRICS (Ped)	4	**4 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE	49 ↑
PHYSICAL MEDICINE & REHABILITATION (PMR)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	9
PLASTIC SURGERY (PIS)	19	**10 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES	48 ↓
PSYCHIATRY (Psyc) **INCLUDED FITNESS FOR DUTY EVALUATIONS*	79	**48 EXPERTS** 3 OFF LIST EXPERTS REVIEWED 1 CASE 22 LIST EXPERTS REVIEWED 1 CASE 14 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 8 CASES*	75 ↓
RADIOLOGY (Rad)	11	**8 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES	37

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
10/1/2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-September)	Number of Experts Utilized (January-September)	Active List Experts 10.1.14 952↑
RADIATION ONCOLOGY			4
SLEEP MEDICINE (S)			9
SURGERY (S)	27	**19 EXPERTS** 10 LIST EXPERTS REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	35
Vascular Surgery (VascS)	6	**4 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	9
THORACIC SURGERY (TS) **COMPANION CASES*	9	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 5 CASES*	15 ↓
(*MEDICAL) TOXICOLOGY*	3	**3 EXPERTS** 2 OFF LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 1 CASE	5
UROLOGY (U)	8	**7 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	16

TOTAL CASES SENT: JANUARY-SEPTEMBER, 2014	**490**
TOTAL LIST EXPERTS UTILIZED: JANUARY-SEPTEMBER, 2014	**321**
TOTAL ACTIVE LIST EXPERTS: OCTOBER 1, 2014	**952**

Expert Program/sg (9.30.2014)

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 6, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Licensing Program Summary
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
The Licensing Program staff, continued to work hard in the first quarter of FY 14/15 to meet the needs of applicants for Physician's and Surgeon's (P&S) Licenses or Postgraduate Training Authorization Letters (PTAL), licensees and consumers.

Licensing currently has the following vacancies:

- 1 OSS II – Call Center
- 1 OT - Call Center
- 1 OT - Application File Set-up
- 2 SSA - IMG P&S Application Reviewer

In addition, several staff were out on various types of leave, resulting in the remaining staff covering the absent staff workload as much as possible. One US/CAN P&S application reviewer has been in training and two IMG P&S application reviewers are currently in training.

STATISTICS:
The statistics are on pages BRD 8D - 4 through BRD 8D - 5. 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 on pages BRD 8D - 4 through BRD 8D - 5 have been obtained from an Excel spreadsheet or are call center phone system and are not part of the BreEZe system.

Notable statistics include:

- Consumer Information Unit, telephone calls answered - 22,092
- Consumer Information Unit, telephone calls abandoned - 9,204
    - 2,812 more abandon calls than the previous quarter
- Consumer Information Unit, telephone calls requesting a call back - 11,376
    - 3,600 more call back requests than the previous quarter
- P&S applications initial review completed - 1,303 per BreEZe report
- P&S applications not reviewed - 198 (includes PTAL, IMG & US) per BreEZe report
- P&S web applications not identified - 694 (P&S web applications are classified as unknown as they do not have a qualification method identified for one of the follow reasons: the Board has not received the application fees, or the required L1F form or the P&S web application is pending processing by the Board's front end staff) per BreEZe report

- P&S licenses issued - 1,235
    - This is a decrease of 734 licenses issued from the previous quarter.

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 three weeks of the 13 weeks in the first quarter of fiscal year 14/15. This was due to staff prioritizing applications from applicants who needed to be licensed or have a PTAL by July 1, 2014, that applied in late May and June. 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 - 5.
The review of International Medical Schools continues to be a demanding workload for the Board. The Board received one new Self-Assessment Report and there are currently six Self-Assessment Reports that are pending.

One of the Licensing Medical Consultants has resigned. The Board will be evaluating new applications to determine if the applicants meet the minimum qualifications for ranking on the Licensing Medical Consultant list. Staff will then request a list of eligible candidates in order to hire additional Licensing Medical Consultants.

OUTPATIENT SURGERY SETTINGS:
An interested parties meeting will need to be held to discuss possible legislative changes for accreditation of outpatient surgery settings to increase consumer protection.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:
The Board has two pending applications from physician specialty boards requesting approval by the Board.

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:

- July 28: San Joaquin General Hospital, grand rounds presentation to about 45 residents, as well as the program staff, program directors, GME Dean
- July 30: Alameda County/Highland Hospital/UCSF East Bay Surgery Program (Oakland), about 40 residents
- August 6: UCSF-Day 1, about 75 residents
- September 5: Cedars Sinai, about 50 residents
- September 11-12: UCSD (LaJolla and Hillcrest campuses), about 80 residents
- September 16: Cottage Hospital (Santa Barbara), first time visit, grand rounds presentation to about 40 residents, as well as to program staff, program directors, GME Dean

- September 16: Ventura County Medical Center, first time visit, Grand Rounds presentation to about 50 residents, as well as to program staff, program directors, GME Dean
- September 18: LAC and USC, about 45 residents
- September 24: California Pacific Medical Center (San Francisco), about 30 residents
- September 24: UCSF, presentation to about 40 program staff
- September 25: UCSF-Day 2, about 95 residents
- September 29: UC-Irvine, about 120 residents
- September 30: UC-Irvine, presentation to about 25 program staff, and presentation to about 40 medical students

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

WORKLOAD REPORT
as of September 30, 2014

CONSUMER INFORMATION UNIT FY 14/15					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**22,092**	22,092			
Calls Requesting Call Back	**11,376**	11,376			
Calls Abandoned	**9,204**	9,204			
Address Changes Completed	**5,231**	5,231			

CONSUMER INFORMATION UNIT FY 13/14					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**90,472**	24,897	21,921	19,896	23,758
Calls Requesting Call Back	**30,804**	3,861	8,542	10,625	7,776
Calls Abandoned	**27,182**	3,147	8,058	9,585	6,392
Address Changes Completed	**5,201**	1,674	1,140	2,387	

SR 2 - CATEGORIES FY 14/15					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**10**	10			
PG/Medical Knowledge	**42**	42			
Convictions	**14**	14			
Other	**34**	34			

SR 2 - CATEGORIES FY 13/14					
	FY 13/14	**Q1**	**Q2**	**Q3**	**Q4**
Alcohol/Drugs	**13**	5	0	4	4
PG/Medical Knowledge	**67**	19	9	18	21
Convictions	**29**	11	5	4	9
Other	**95**	29	16	24	26

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 14/15					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	101			
Pending Self-Assessment Reports (included above)	**N/A**	6			
New Self-Assessment Reports Received	**1**	1			
New Unrecognized Schools Received	**22**	22			
School Recognized Pursuant to CCR 1314(a)(1)	**18**	18			
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0			
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	106			

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	**2**	1	0	1	0
New Unrecognized Schools Received	**73**	21	25	10	17
School Recognized Pursuant to CCR 1314(a)(1)	**68**	18	23	7	20
School Recognized Pursuant to CCR 1314(a)(2)	**1**	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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 7, 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:
The Medical Board of California (Board) staff continue to participate in webinars held by the FSMB and communicate on common issues. Board staff recently attended a webinar on the Interstate Compact and will be attending a webinar on the Federation Credentials Verification Service 2020 project, Uniform Application for Physician State Licensure, and an overview of the new enhancements to the Physician Data Center user interface.

The Board has been notified by the FSMB of changes to the United States Medical Licensing Examination (USMLE). On page BRD 9-2 and BRD 9-3 is a document indicating these changes. The biggest change is that Step 3 will now be able to taken on two consecutive days or non-consecutive days. The two exam days are named Step 3 Foundations of Independent Practice and Step 3 Advanced Clinical Medicine. Fortunately, the Board was aware of these changes and made appropriate changes to the law to allow for this separation (this was an issue in the Sunset Review Report and was changed in the Board's Sunset Review Bill – Senate Bill 304).

Interstate Medical Licensure Compact:
As stated at the last meeting, it was reported that one of the most significant projects for the FSMB is the interstate compact. On September 3, 2014, the FSMB distributed the final version of the Interstate Medical Licensure Compact (Compact) (see BRD 9-4 to BRD 9-28 for a copy of the document). Information obtained by the Board indicates that the Compact must be adopted by the Legislature in its entirety. It cannot be changed or it would not meet the requirements of an across the states compact.

The important points of the Compact are that it still recognizes the right of states to regulate the practice of medicine, it allows the exchange of physician practice and disciplinary information between states, it preserves the vital funding of state-based licensure and regulation, and it allows an expedited licensure process for physicians who want to be licensed in more than one state. All of these are important points for the Board and other boards in the United States.

Board staff do have some minor concerns with the Compact, including the fact that an individual is not required to be fingerprinted in California and thus the Board would not have the benefit of subsequent arrest reports should the individual practice in California and get arrested.

The next step in the process is for legislation to be sought. The Board has been notified that approximately eight state boards have approved the Compact and approximately 15 states are looking to introduce legislation in 2015. At the January 2015 Board Meeting, staff will present a thorough review and analysis of the Compact and the options for the Board related to the Compact.

Changes to USMLE® 2014 – 2015

As medicine and medical education have changed over the years, so have USMLE examinations evolved since they were first administered in 1992. This is a brief summary of planned changes for the next few years.

USMLE STEP 3

What WILL change?	What WILL NOT change?
Beginning **November 3, 2014**, examinees will: • Be able to take the exam on two consecutive or non-consecutive days; • NOT need to apply for Step 3 under the eligibility requirements of a specific medical licensing authority; • See increased numbers of items that assess an expanded range of competency-based content, including foundational science essential for effective healthcare; biostatistics, epidemiology, and population health; literature interpretation; medical ethics; and patient safety. The two exam days will be named Step 3 Foundations of Independent Practice (FIP) and Step 3 Advanced Clinical Medicine (ACM).	The Step 3 exam will continue to: • Focus on knowledge and application of the biomedical and clinical sciences necessary for independent patient care; • Include multiple-choice questions and computer-based case simulations; • Be administered over two days, for a total time comparable to current testing time; • Result in a **single score** (with graphical performance profile information) and a **single pass/fail outcome** after completion of both examination days. • Be administered at Prometric test centers throughout the United States.

Important to Note

- Applications for the current Step 3 examination will not be accepted **after 5:00 p.m. (U.S. Central Time) on July 18, 2014**.
- Applications for the restructured Step 3 examination will be accepted starting on **August 4, 2014**.
- No Step 3 examinations will be administered during most or all of **October 2014**.
- Administration of the restructured Step 3 exam will begin on **November 3, 2014**.
- There will be a **score delay** following introduction of the restructured Step 3 examination on November 3, 2014. The duration of the score delay will be determined by examinee volume during the early months of exam administration. Based on historic trends, we estimate that scores for Step 3 exams taken on or after November 3, 2014 will be released in **April 2015**.
- Test date availability will be influenced by conditions at each Prometric test center; advance planning will enhance scheduling options.

USMLE STEP 2 Clinical Knowledge (CK)	
What WILL change?	**What WILL NOT change?**
In **2014 and 2015**, examinees will see an increased focus on quality improvement principles; safety science; epidemiology, biostatistics, and population health; professionalism; and interpersonal and communications skills. These may be tested using item formats currently under development. If new item types are introduced into the examination, sample materials will be available on the USMLE website for examinees to review well in advance.	Step 2 CK will continue to focus on patient care and diagnosis. The format will continue to be a computer-administered examination, using multiple-choice questions.

USMLE STEP 2 Clinical Skills (CS)	
What WILL change?	**What WILL NOT change?**
Further enhancements to the assessment of communications skills are being piloted. If the pilots are successful, these enhancements to Step 2 CS will be introduced into the exam no earlier than **2015**, and will be announced well in advance.	Step 2 CS will continue to focus on examinees' ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues. The examination will continue to use standardized patients to simulate patient encounters.

USMLE STEP 1	
What WILL change?	**What WILL NOT change?**
In **2014 and 2015**, examinees will see an increased focus on quality improvement principles and safety science.	Step 1 will continue to focus on traditional content areas in the basic sciences within a clinical context. The format will continue to be a computer-administered examination, using multiple-choice questions.

Important Note: Dates are subject to change. This fact sheet will be updated as new information becomes available. Please check the USMLE website (www.usmle.org) frequently.

More Information: Additional information, including a timeline of key dates for changes to Step 3, is available on the USMLE website at www.usmle.org/cru/. To receive updates as they become available, subscribe to the USMLE Announcements RSS feed at http://www.usmle.org/announcements/.

Questions: Contact the USMLE Program at http://www.usmle.org/contact/.

INTERSTATE MEDICAL LICENSURE COMPACT

The ideas and conclusions set forth in this document, 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 document has been prepared as part of a study of the feasibility of an interstate compact, and it 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, provides a streamlined process that allows physicians to become licensed in multiple states, thereby enhancing the portability of a medical license and ensuring the safety of patients. The Compact creates another pathway for licensure and does not otherwise change a state's existing Medical Practice Act. The Compact also adopts the prevailing standard for licensure and affirms 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. 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 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 medical school accredited by the Liaison Committee on Medical Education, the Commission on Osteopathic College Accreditation, or a medical school listed in the International Medical Education Directory or its equivalent;

(2) Passed each component of the United States Medical Licensing Examination (USMLE) or the Comprehensive Osteopathic Medical Licensing Examination (COMLEX-USA)

within three attempts, or any of its predecessor examinations accepted by a state medical board as an equivalent examination for licensure purposes;

(3) Successfully completed graduate medical education approved by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association;

(4) Holds specialty certification or a time-unlimited specialty certificate recognized by the American Board of Medical Specialties or the American Osteopathic Association's Bureau of Osteopathic Specialists;

(5) Possesses a full and unrestricted license to engage in the practice of medicine issued by a member board;

(6) Has never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;

(7) Has never held a license authorizing the practice of medicine subjected 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;

(8) Has never had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration; and

(10) 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 within 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.

(i) 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 license.

(ii) The member board within the state selected as the state of principal license shall, in the course of verifying eligibility, perform a criminal background check of an applicant, including the use of the results of fingerprint or other biometric data checks compliant with the requirements of the Federal Bureau of Investigation, with the exception of federal employees who have suitability determination in accordance with U.S. C.F.R. §731.202.

(iii) 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) Upon verification in subsection (b), physicians eligible for an expedited license shall complete the registration process established by the Interstate Commission to receive a license in a member state selected pursuant to subsection (a), including the payment of any applicable fees.

(d) After receiving verification of eligibility under subsection (b) and any fees under subsection (c), 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 period in the member state and in the same manner as required for other physicians holding a full and unrestricted 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, including payment of any applicable fees, 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; and

(4) Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

(b) Physicians shall comply with all continuing professional development or continuing medical education requirements for renewal of a license issued by a member state.

(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.

(d) Upon receipt of any renewal fees collected in subsection (c), a member board shall renew the physician's license.

(e) Physician information collected by the Interstate Commission during the renewal process will be distributed to all member boards.

(f) 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 licensed physician 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, then 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 in a manner consistent with the Medical Practice Act of that state.

(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 so long as such sanctions are consistent with the Medical Practice Act of that state;

(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, then 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 under the Medical Practice Act of that state. A member board may terminate the automatic suspension of the license it issued prior to the completion of the ninety (90) day suspension period in a manner consistent with the Medical Practice Act of that state.

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. When acting on behalf of the Interstate Commission, 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 shall 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 Commissioners 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 Commissioners 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 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 deemed appropriate for the operations of the Interstate Commission shall be made pursuant to a rulemaking process that substantially conforms to the "Model State Administrative Procedure Act" of 2010, and subsequent amendments thereto.

(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 not 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.

Guidelines for Prescribing Controlled Substances for Pain

Medical Board of California

October 2014
(DRAFT)

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Guidelines for Prescribing Controlled Substances for Pain

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PREAMBLE

Protection of the public is the highest priority for the Medical Board of California (Board) in exercising its licensing, regulatory, and disciplinary functions. The Board recognizes that principles of high-quality medical practice and California law dictate that the people of California have access to appropriate, safe and effective pain management. The application of up-to-date knowledge and treatment modalities can help to restore function and thus improve the quality of life for patients who suffer from pain, particularly chronic pain.

In 1994, the Medical Board of California formally adopted a policy statement titled, "Prescribing Controlled Substances for Pain." This was used to provide guidance to physicians prescribing controlled substances. Several legislative changes since 1994 necessitated revising these guidelines; most recently in 2007.

In November 2011, the Centers for Disease Control and Prevention declared prescription drug abuse to be a nationwide epidemic. Drug overdose is now the leading cause of accidental deaths, exceeding deaths due to motor vehicle accidents. A majority of those overdose deaths involved prescription drugs. The diversion of opioid medications to non-medical uses has also contributed to the increased number of deaths, although the problem is not limited to the aberrant, drug-seeking patient. Injuries are occurring among general patient populations, with some groups at high risk, (e.g., those with depression). Consequently, the Board called for revision of the guidelines to provide additional direction to physicians who prescribe controlled substances for pain.

These guidelines are intended to help physicians improve outcomes of patient care and to prevent overdose deaths due to opioid use. They particularly address the use of opioids in the long-term treatment of chronic pain. Opioid analgesics are widely accepted as appropriate and effective for alleviating moderate-to-severe acute pain, pain associated with cancer and persistent end-of-life pain [1] Although some of the recommendations cited in these guidelines might be appropriate for other types of pain, they are not meant for the treatment of patients in hospice or palliative care settings and are not in any way intended to limit treatment where improved function is not anticipated and pain relief is the primary goal. These guidelines underscore the extraordinary complexity in treating pain and how long-term opioid therapy should only be conducted in practice settings where careful evaluation, regular follow-up and close supervision are ensured. Since opioids are only one of many options to mitigate pain, and because prescribing opioids carries a substantial level of risk, these guidelines offer several non-opioid treatment alternatives. These guidelines are not intended to mandate the standard of care. The Board recognizes that deviations from these guidelines will occur and may be appropriate depending upon the unique needs of individual patients. Medicine is practiced one patient at a time and each patient has individual needs and vulnerabilities. Physicians are encouraged to document their rationale for each

[1] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

prescribing decision. Physicians should understand that if one is ever the object of a quality of care complaint, peer expert review will be sought by the Board. The expert reviewer must consider the totality of circumstances surrounding the physician's prescribing practice (e.g., issues relating to access of care, paucity of referral sources, etc.) Specifically, experts are instructed to define the standard of care in terms of the level of skill, knowledge and care in diagnosis and treatment ordinarily possessed and exercised by other reasonably careful and prudent physicians in the same or similar circumstances at the time in question."

In an effort to provide physicians with as many sources of information as possible, these guidelines link to numerous references relating to prescribing. Additionally, numerous appendices are attached. The Board recognizes that some of the links/appendices may not be consistent with either each other or the main text of the guidelines. The intent for including as many sources of information as practicable is so that physicians can consider varying perspectives to arrive at the best patient-appropriate treatment decision. The Board does not endorse one treatment option over another and encourages physicians to undertake independent research on this continuously evolving subject matter.

UNDERSTANDING PAIN

The diagnosis and treatment of pain is integral to the practice of medicine. In order to cautiously prescribe opioids, physicians must understand the relevant pharmacologic and clinical issues in the use of such analgesics, and carefully structure a treatment plan that reflects the particular benefits and risks of opioid use for each individual patient. Such an approach should be employed in the care of every patient who receives long-term opioid therapy.

The California Medical Association[2] has defined and clarified key concepts relating to pain excerpted below:

Pain: The definition of pain proposed by the International Association for the Study of Pain is "an unpleasant sensory and emotional experience associated with actual or potential tissue damage, or described in terms of such damage." It has also been said that "Pain is what the patient says it is." Both definitions acknowledge the subjective nature of pain and are reminders that, with the rare exception of patients who intentionally deceive, a patient's self-report and pain behavior are likely the most reliable indicators of pain and pain severity. As a guide for clinical decision-making, however, both of these definitions are inadequate. In addition, it is important to remember that the subjectivity of pain, particularly when the cause is not apparent, can lead to the stigmatization of those with pain.

[2] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

Acute and Chronic Pain: Traditionally, pain has been classified by its duration. In this perspective, "acute" pain is relatively short-duration, arises from obvious tissue injury, and usually fades with healing. "Chronic" pain, in contrast, has been variously defined as lasting longer than would be anticipated for the usual course of a given condition, or pain that lasts longer than arbitrary cut-off times, such as 3 or 6 months. Temporal pain labels, however, provide no information about the biological nature of the pain itself, which is often of critical importance.

Nociceptive and Neuropathic Pain: A more useful nomenclature classifies pain on the basis of its patho-physiological process. Nociceptive pain is caused by the activation of nociceptors, and is generally, though not always, short-lived and is associated with the presence of an underlying medical condition. It is a "normal" process; a physiological response to an injurious stimulus. Nociceptive pain is a symptom. Neuropathic pain, on the other hand, results either from an injury to the nervous system or from inadequately-treated nociceptive pain. It is an abnormal response to a stimulus; a pathological process. It is a neuro-biological disease. Neuropathic pain is caused by abnormal neuronal firing in the absence of active tissue damage. It may be continuous or episodic and varies widely in how it is perceived. Neuropathic pain is complex and can be difficult to diagnose and to manage because available treatment options are limited.

A key aspect of both nociceptive and neuropathic pain is the phenomenon of sensitization, which is a state of hyper excitability in either peripheral nociceptors or neurons in the central nervous system. Sensitization may lead to either hyperalgia or allodynia. Sensitization may arise from intense, repeated or prolonged stimulation of nociceptors, or from the influence of compounds released by the body in response to tissue damage or inflammation. Importantly, many patients – particularly those with persistent pain --- present with "compound" pain that has both nociceptive and neuropathic components, a situation which complicates assessment and treatment.

Differentiating between nociceptive and neuropathic pain is critical because the two respond differently to pain treatments. Neuropathic pain, for example, typically responds poorly to both opioid analgesics and non-steroidal anti-inflammatory (NSAID) agents. Other classes of medications, such as anti-epileptics, antidepressants or local anesthetics, may provide more effective relief for neuropathic pain.

Cancer and Non-Cancer Pain: Pain associated with cancer is sometimes given a separate classification, although it is not distinct from a patho-physiological perspective. Cancer-related pain includes pain caused by the disease itself and/or painful diagnostic or therapeutic procedures [and the sequelae of those processes]. The treatment of cancer-related pain may be influenced by the life expectancy of the patient, by co-morbidities and by the fact that such pain may be of exceptional severity and duration. A focus of recent attention by the public, regulators, legislators, and physicians has been chronic pain that is not associated with cancer. A key feature of such pain, which may be caused by conditions such as musculoskeletal injury, lower back trauma and dysfunctional wound healing, is that the severity of pain may not correspond well to identifiable levels of tissue damage.

Tolerance, Dependence and Addiction: Related to the nomenclature of pain itself is continuing confusion not only among the public, but also in the medical community, about terms used to describe the effects of drugs on the brain and on behavior. To help clarify and standardize understanding, the American Society of Addiction Medicine (ASAM), the American Academy of Pain Medicine (AAPM) and the American Pain Society (APS) have recommended the following definitions:

> *Tolerance:* A State of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drugs' effects over time.
>
> *Physical Dependence:* A state of adaptation that often includes tolerance and is manifested by a drug class-specific withdrawal syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug and/or administration of an antagonist.
>
> *Addiction:* A primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors influencing its development and manifestations. It is characterized by behaviors that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm and craving.

Pain as an Illness: Finally, it may be helpful to point out that pain can be regarded as an illness as well as a symptom or a disease. "Illness" defines the impact a disease has on an organism and is characterized by epiphenomena or co-morbidities with bio-psycho-social dimensions. Effective care of any illness, therefore, requires attention to all of these dimensions. Neuropathic pain, end-of-life pain and chronic pain should all be viewed as illnesses.

SPECIAL PATIENT POPULATIONS

All patients may experience pain. Below are treatment considerations for differing patient populations or scenarios. As previously addressed, these guidelines are intended to particularly address the use of opioids in the long-term treatment of chronic, non-cancer pain. However, since many of the recommendations cited in these guidelines might be appropriate for other types of pain, other scenarios are listed below to provide additional guidance in prescribing opioids, when appropriate.

Acute Pain[3]

Opioid medications should only be used for treatment of acute pain when the severity of the pain warrants that choice and after determining that other non-opioid pain medications or therapies likely will not provide adequate pain relief. When opioid medications are prescribed for treatment of acute pain, the number dispensed should

[3] Utah Department of Health (Utah Clinical Guidelines on Prescribing Opioids for Treatment of Pain, 2009).

be for a short duration and no more than the number of doses needed based on the usual duration of pain severe enough to require opioids for that condition.

Long (and intermediate) duration-of-action opioids or extended release/long acting opioids (ER/LA) should not be used for treatment of acute pain, including post-operative pain, except in situations where monitoring and assessment for adverse effects can be conducted. Methadone is rarely, if ever, indicated for treatment of acute pain. The use of opioids should be re-evaluated carefully, including the potential for abuse, if persistence of pain suggests the need to continue opioids beyond the anticipated time period of acute pain treatment for that condition.

It is important to emphasize that numerous (but not all) recommendations cited in these guidelines may not be relevant for the physician treating a patient for acute pain. For example, a physician treating a patient who presents to an Emergency Department or primary care physician with a medical condition manifested by objective signs (e.g., a fractured ulna or kidney stones discernible with imaging studies) would not necessarily need to undertake an opioid trial, perform a psychological assessment, utilize a pain management agreement, confer with the Prescription Drug Monitoring Program database, order a drug toxicology screen, etc.

Emergency Departments
Treating patients in an emergency department (ED) or urgent care clinic presents unique challenges in that, oftentimes there is limited ability to procure adequate patient history and the primary physician is not available. Drug seeking patients may take advantage of this in order to secure controlled substances.

The American College of Emergency Physicians (ACEP) Clinical Policy - Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department (Appendix 1) - identifies acute low back pain as a common presenting complaint in the ED. Opioids are frequently prescribed, expected or requested for such presentations. Consequently, ACEP clinical policy recommends:

(1) For the patient being discharged from the ED with acute low back pain, the emergency physician should ascertain whether non-opioid analgesics and non-pharmacologic therapies will be adequate for initial pain management.
(2) Given a lack of demonstrated evidence of superior efficacy of either opioid or non-opioid analgesics and the individual and community risks associated with opioid use, misuse, and abuse, opioids should be reserved for more severe pain or pain refractory to other analgesics rather than routinely prescribed.
(3) If opioids are indicated, the prescription should be for the lowest practical dose for a limited duration (e.g.,<1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

For patients presenting to the ED with an acute exacerbation of non-cancer chronic pain, ACEP recommends the following:

(1) Physicians should avoid the routine prescribing of outpatient opioids for a patient with an acute exacerbation of chronic non-cancer pain seen in the ED.

(2) If opioids are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (e.g., < 1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.
(3) The physician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and consider past prescription patterns from information sources such as prescription drug monitoring programs.

ACEP recommends that the use of a state prescription monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping.

End-of-Life Pain[4]
Pain management at the end of life seeks to improve or maintain a patient's overall quality of life in addition to relieving suffering. This focus is important because sometimes a patient may have priorities that compete with, or supersede, the relief of pain. For some patients, mental alertness sufficient to allow lucid interactions with loved ones may be more important than physical comfort. Optimal pain management, in such cases, may mean lower doses of an analgesic and the experience, by the patient, of higher levels of pain.

Fear of inducing severe or even fatal respiratory depression may lead to clinician[5] under-prescribing and reluctance by patients to take an opioid medication. Despite this fear, studies have revealed no correlation between opioid dose, timing of opioid administration and time of death in patients using opioids in the context of terminal illness. A consult with a specialist in palliative medicine in these situations may be advisable.

Cancer Pain
The California Medical Association writes that pain is one of the most common symptoms of cancer, as well as being one of the most-feared cancer symptoms. Opioid pain medications are the mainstay of cancer pain management and a trial of opioid therapy should be administered to all cancer patients with moderate or severe pain, regardless of the known or suspected pain mechanism. The American Academy of Pain Management advised the Board that some cancer survivors with moderate-to-severe pain benefit greatly from the use of non-opioid medications, and when these are effectively administered, opioids are unnecessary. Similarly, other treatments such as surgeries, radiation therapy, and other procedures may provide sufficient pain relief that opioids are not necessary.

Extended-release/long-acting (ER/LA) opioid formulations may lessen the inconvenience associated with the use of short-acting opioids. Patient-controlled analgesia using an ambulatory infusion device may provide optimal patient control and effective analgesia. The full range of adjuvant medications should be considered for patients with cancer pain, with the caveat that such patients are often on already

[4] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).
[5] The term "clinician" throughout the document means "physician."

complicated pharmacological regimens, which raises the risk of adverse reactions associated with polypharmacy.[6]

Older Adults
With appropriate precautions opioid therapy for elderly patients can be efficacious. It is important to begin with lower starting doses, slower titration, longer dosing intervals, and more frequent monitoring. Tapering of benzodiazepines is important to reduce the potential for respiratory depression.

For additional information, see Appendix 2.

Pediatric Patients
Extreme caution should be used in prescribing opioids for pediatric patients. A trial of opioid therapy may be considered with well-defined somatic or neuropathic pain conditions when non-opioid alternatives have failed or are unlikely to be effective for acute pain. Additionally, close monitoring and consultation should be undertaken.

For additional information, see Appendix 3.

Pregnant Women
Clinicians should encourage minimal or no use of opioids during pregnancy unless the potential benefits clearly outweigh risks. Pregnant patients taking long-term opioid therapy should be tapered to the lowest effective dose slowly enough to avoid withdrawal symptoms, and then therapy should be discontinued if possible.

Additional information on the appropriate use of opioids for pregnant patients is available: American Congress of Obstetricians and Gynecologists (ACOG) committee opinion titled *Opioid Abuse, Dependence, and Addiction in Pregnancy*.

Patients Covered by Workers' Compensation[7]
This population of patients presents its own unique circumstances. Injured workers are generally sent to an occupational medicine facility for treatment. Ideally, the injured worker recovers and returns to work in full capacity. If recovery or healing does not occur as expected, early triage and appropriate, timely treatment is essential to restore function and facilitate a return to work.

The use of opioids in this population of patients can be problematic. Some evidence suggests that early treatment with opioids may actually delay recovery and a return to work. Conflicts of motivation may also exist in patients on workers' compensation, such as when a person may not want to return to an unsatisfying, difficult or hazardous job. Clinicians are advised to apply the same careful methods of assessment, creation of treatment plans and monitoring used for other pain patients but with the added consideration of the psycho-social dynamics inherent in the workers' compensation

[6] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).
[7] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

system. Injured workers should be afforded the full range of treatment options that are appropriate for the given condition causing the disability and impairment.

For additional information on treating patients covered by Workers' Compensation please see *State of California Division of Workers' Compensation Guideline for the Use of Opioids to Treat Work-Related Injuries*.

Patients with History of Substance Use Disorder[8]

Use of opioids for patients with a history of substance use disorder is challenging because such patients are more vulnerable to drug misuse, abuse and addiction. In patients who are actively using illicit drugs, the potential benefits of opioid therapy are likely to be outweighed by potential risks, and such therapy should not be prescribed outside of highly controlled settings (such as an opioid treatment program with directly observed therapy). In other patients, the potential benefits of opioid therapy may outweigh potential risks. Although evidence is lacking on best methods for managing such patients, potential risks may be minimized by more frequent and intense monitoring compared with lower risk patients, authorization of limited prescription quantities and consultation or co-management with a specialist in addiction medicine. Clinicians should use the [Controlled Substance Utilization Review and Evaluation System (CURES) Prescription Drug Monitoring Program (PDMP)] CURES PDMP to identify patients who obtain drugs from multiple sources.

If either the patient's medical history, self-report or scores on screening assessment tools such as the Opioid Risk Tool suggest an above-average risk of substance abuse, clinicians should consider the following steps in proceeding with a pain management strategy:

- Exhaust all non-opioid pain management methodologies prior to considering opioid therapy;
- Consult with a specialist in addiction medicine;
- Create a written treatment plan and patient agreement and review carefully with the patient, obtaining their signed informed consent;
- Closely monitor and assess pain, functioning and aberrant behaviors;
- Regularly check with a PDMP for compliance with prescribed amounts of opioids (using cross-state PDMP systems whenever they are available);
- While the patient is on long-term opioid therapy, implement urine drug testing, if possible;
- If misuse or abuse of opioid analgesics is suspected or confirmed, initiate a non-confrontational in-person meeting, use a non-judgmental approach to asking questions, present options for referral, opioid taper/discontinuation or switching to non-opioid treatments, and avoid "abandoning" the patient or abruptly stopping opioid prescriptions.

[8] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

Psychiatric Patients
A higher risk for deleterious side effects exists for patients with psychiatric diagnoses who are receiving opioid treatment. Opioids should only be prescribed for well-defined somatic or neuropathic pain conditions. Physicians should titrate slowly, closely monitor the patient and seek consultation from the appropriate specialist.

Patients Prescribed Benzodiazepines
Patients taking benzodiazepines and opioids are at an increased risk for respiratory depression, particularly elderly patients. Physicians should consider a trial of benzodiazepine tapering in patients concomitantly using opioids or other respiratory depressant medications. If a trial of tapering is not indicated or is unsuccessful, opioids should be titrated more slowly and at lower doses. For additional information, see Benzodiazepines: How They Work and How to Withdraw.

Patients Prescribed Methadone or Buprenorphine for Treatment of a Substance Use Disorder
Patients prescribed methadone or buprenorphine for treatment of a substance use disorder may need relief of acute and/or chronic pain, beyond that provided by their maintenance medication. For more information on pain relief for persons on methadone or buprenorphine, see *Acute Pain Management for Patients Receiving Maintenance Methadone or Buprenorphine Therapy*.

PATIENT EVALUATION AND RISK STRATIFICATION

When considering long-term use of opioids for chronic, non-cancer pain, given the potential risks of opioid analgesics, careful and thorough patient assessment is critical. Risk stratification is one of the most important things a physician can do to mitigate potentially adverse consequences of opioid prescribing. The nature and extent of the clinical assessment depends on the type of pain and the context in which it occurs. This includes but is not limited to:

- Completing a medical history, and physical examination (Appendix 4).
- Performing a psychological evaluation.
    - Psychological assessment should include risk of addictive disorders. Screening tools that can be considered for use include:
        - CAGE-AID (Appendix 5);
        - PHQ-9 (Appendix 6);
        - Opioid Risk Tool (ORT) (Appendix 7); and
        - SOAPP®-R (Appendix 8)
        - Note: Although the above-listed assessment tools are well-established with proven effectiveness, physicians must be aware that seasoned diverters know the right answers to these tools so they look "normal."
- Establishing a diagnosis and medical necessity (review past medical records, laboratory studies, imaging studies, etc. and order new ones, if necessary or if

previous studies are outdated). Screening tools that can be considered for use include:
  - Pain Intensity and Interference (pain scale) (Appendix 9)
  - Sheehan Disability Scale (Appendix 10; permission for use pending)
- Exploring non-opioid therapeutic options.
  Opioid medications may not be the appropriate first line of treatment for a patient with chronic pain. Other measures, such as non-opioid analgesics, non-steroidal anti-inflammatory drugs (NSAIDS), antidepressants, antiepileptic drugs, and non-pharmacologic therapies (e.g., physical therapy), should be tried and the outcomes of those therapies documented first. Opioid therapy should be considered only when other potentially safer and more effective therapies have proven inadequate. Resources that can be consulted include:
  - Therapeutic Options for Pain Management (Appendix 11)
  - Non-Opioid Pain Management Tool (Appendix 12; permission for use pending)
- Evaluating both potential benefits and potential risks of opioid therapy.
- Being cognizant of aberrant or drug seeking behaviors.
- As a universal precaution, undertaking urine drug testing.
- Reviewing the Prescription Drug Monitoring Program (PDMP) report for the patient [Controlled Substance Utilization Review and Evaluation System (CURES)]. This allows a physician to check to see if a patient is receiving controlled substances from other prescribers in California (assuming the prescription is being filled at a California pharmacy).

CONSULTATION

The treating physician should seek a consultation with, or refer the patient to, a pain, psychiatry, or an addiction or mental health specialist as needed. For example, a patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment, if available.

Physicians who prescribe long-term opioid therapy should be familiar with treatment options for opioid addiction (including those available in licensed opioid treatment programs [OTPs]) and those offered by an appropriately credentialed and experienced physician through office-based opioid treatment [OBOT]), so as to make appropriate referrals when needed.

TREATMENT PLAN AND OBJECTIVES

When considering long-term use of opioids, for chronic, non-cancer pain, the physician and the patient should develop treatment goals together. The goals of pain treatment include reasonably attainable improvement in pain and function; improvement in pain-associated symptoms such as sleep disturbance, depression, and anxiety; and avoidance of unnecessary or excessive use of medications. Pain relief is important, but it is difficult to measure objectively. Therefore, it cannot be the primary indicator to assess the success of the treatment. Effective pain relief improves functioning,

whereas addiction decreases functionality. Effective means of achieving these goals vary widely, depending on the type and causes of the patient's pain, other concurrent issues, and the preferences of the physician and the patient.

The treatment plan and goals should be established as early as possible in the treatment process and revisited regularly, so as to provide clear-cut, individualized objectives to guide the choice of therapies. The treatment plan should contain information supporting the selection of therapies, both pharmacologic (including medications other than opioids) and non-pharmacologic. It also should specify measurable goals and objectives that will be used to evaluate treatment progress, such as relief of pain and improved physical and psychosocial function.

The plan should document any further diagnostic evaluations, consultations or referrals, or additional therapies that have been considered. The treatment plan should also include an "exit strategy" for discontinuing opioid therapy in the event the tapering or termination of opioid therapy becomes necessary.

PATIENT CONSENT

When considering long-term or chronic use of opioids, or in other medically appropriate situations, the physician should discuss the risks and benefits of the treatment plan with the patient, with persons designated by the patient, or with the patient's conservator if the patient is without medical decision-making capacity. If opioids are prescribed, the patient (and possibly family members, if appropriate) should be counseled on safe ways to store and dispose of medications. For convenience, patient consent and a pain management contract can be combined into one document.

Patient consent typically addresses:

- The potential risks and anticipated benefits of long-term opioid therapy.
- Potential side effects (both short-and long-term) of the medication, such as nausea, opioid-induced constipation, decreased libido, sexual dysfunction, hypogonadism with secondary osteoporosis (Gegmann et al., 2008) and cognitive impairment.
- The likelihood that some medications will cause tolerance and physical dependence to develop.
- The risk of drug interactions and over-sedation.
- The risk of respiratory depression.
- The risk of impaired motor skills (affecting driving and other tasks).
- The risk of opioid misuse, dependence, addiction, and overdose.
- The limited evidence as to the benefit of long-term opioid therapy.

PAIN MANAGEMENT AGREEMENT

Use of a pain management agreement is recommended for patients:

- On short-acting opioids at the time of third visit within two months;

- On long-acting opioids; or
- Expected to require more than three months of opioids.

Pain management agreements typically outline the joint responsibilities of the physician and the patient and should include:

- The physician's prescribing policies and expectations, including the number and frequency of prescription refills, as well as the physician's policy on early refills and replacement of lost or stolen medications.
- Specific reasons for which drug therapy may be changed or discontinued (including violation of the policies and agreements spelled out in the treatment agreement).
- The patient's responsibility for safe medication use (e.g., by not using more medication than prescribed or using the opioid in combination with alcohol or other substances; storing medications in a secure location; and safe disposal of any unused medication to prevent misuse by other household members).
- The patient's agreement to share information with family members and other close contacts on how to recognize and respond to an opiate overdose, including administering an opioid antagonist, such as naloxone, if necessary. (Appendix 13)
- The patient's responsibility to obtain his or her prescribed opioids from only one physician or practice and one pharmacy.
- The patient's agreement to periodic drug testing (blood, urine, hair, or saliva).
- The physician's responsibility to be available or to have a covering physician available to care for unforeseen problems and to prescribe scheduled refills, if appropriate and in accordance with the patient's pain management agreement.

Samples of pain management agreements:

- Patient Pain Medication Agreement and Consent (Appendix 14)
- Treatment Plan Using Prescription Opioids (Appendix 15)

COUNSELING PATIENTS ON OVERDOSE RISK AND RESPONSE

Empirical evidence has shown that lay persons can be trained to recognize the signs of an opiate overdose and to safely administer naloxone, an opiate antagonist. Programs that have trained lay persons in naloxone administration have reported more than 10,000 overdose reversals.[9]

It is important to educate patients and family/caregivers about the danger signs of respiratory depression. Everyone in the household should know to summon medical help immediately if a person demonstrates any of the following signs while on opioids:

[9] Centers for Disease Control and Prevention. Community-based opioid overdose prevention programs providing naloxone-United States, 2010. Morbidity and mortality weekly report, February 17, 2012 / 61(06);101-105

- Snoring heavily and cannot be awakened.
- Periods of ataxic (irregular) or other sleep-disordered breathing.
- Having trouble breathing.
- Exhibiting extreme drowsiness and slow breathing.
- Having slow, shallow breathing with little chest movement or no breathing.
- Having an increased or decreased heartbeat.
- Feeling faint, very dizzy, confused or has heart palpitations.
- Blue skin/lips
- Non-responsiveness to painful stimulation.

Effective January 1, 2015, California pharmacists will be able to furnish an opioid overdose reversal drug, naloxone to family members of patients at risk for overdose, those who might be in contact with an individual at risk for overdose, or anyone who requests the drug without a prescription.

SAMHSA's Opiate Overdose Toolkit and Prescribe to Prevent contain numerous documents relating to overdose prevention and management.

INITIATING OPIOID TRIAL

Safer alternative treatments should be considered before initiating opioid therapy for chronic pain. Opioid therapy should be presented to the patient as a therapeutic trial or test for a defined period of time (usually no more than 45 days) and with specific evaluation points. The *Long-Term Chronic Opioid Therapy Discontinuation Rates from the TROUP Study*[10] reveals that "[o]ver half of persons receiving 90 days of continuous opioid therapy remain on opioids years later. Factors most strongly associated with continuation were intermittent prior opioid exposure, daily opioid dose≥120 mg MED, and possible opioid misuse. Since high dose and opioid misuse have been shown to increase the risk of adverse outcomes, special caution is warranted when prescribing more than 90 days of opioid therapy in these patients."

The physician should explain that progress will be carefully monitored for both benefit and harm in terms of the effects of opioids on the patient's level of pain, function, and quality of life, as well as to identify any adverse events or risks to safety.

According to the California Medical Association[11]:

> Oral administration, especially for the treatment of chronic pain, is generally preferred because it is convenient, flexible and associated with stable drug levels. Intravenous administration provides rapid pain relief and, along with rectal, sublingual and subcutaneous administration, may be useful in patients who cannot take medications by mouth. Continuous infusions produce consistent drug blood

[10] Journal of General Internal Medicine article (December 2011, Volume 26, Issue 12, pp 1450-1457).
[11] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

levels but are expensive, require frequent professional monitoring and may limit patient mobility.

Transdermal administration is a convenient alternate means of continuous drug delivery that does not involve needles or pumps. Patient-controlled analgesia (PCA) allows patients to self-administer pain medications and may be useful if analgesia is required for 12 hours or more and mobility is not required. Intrathecal delivery of opioids is a viable option for patients with chronic pain who have not responded to other treatment options, or for whom the required doses result in unacceptable side-effects. Patients with intrathecal delivery systems typically require ongoing ambulatory monitoring and supportive care.

Patients on a steady dose of an opioid medication may experience pain that breaks through the analgesic effects of the steady-state drug. Paper or electronic pain diaries may help patients track these breakthrough episodes and spot correlations between the episodes and variables in their lives. A short-acting opioid is typically prescribed for treatment by patients with breakthrough pain.

Continuation of opioid therapy after an appropriate trial should be based on outcomes such as: making progress toward functional goals; presence and nature of side effects; pain status; and a lack of evidence of medication misuse, abuse, or diversion. Patients with no, or modest, previous opioid exposure should be started at the lowest appropriate initial dosage of a short-acting opioid and titrated upward to decrease the risk of adverse effects. The selection of a starting dose and manner of titration are clinical decisions made on a case-by-case basis because of the many variables involved. Some patients, such as frail older persons or those with comorbidities, may require an even more cautious therapy initiation. Short-acting opioids are usually safer for initial therapy since they have a shorter half-life and may be associated with a lower risk of overdose from drug accumulation. The general approach is to “start low and go slow.”

Since opioids are known in some circumstances to worsen pain (hyperalgesia), instances of ongoing pain may suggest opioid insensitivity (or an inadequate dose). Careful assessment must be undertaken. If hyperalgesia is suspected, a dose reduction, opioid rotation or tapering to cessation could be considered.

Dosing Recommendations For Opioid Naïve Patients

There is a plethora of data available regarding recommended dosages for various analgesics. Because this is continuously evolving, physicians are encouraged to review the Food and Drug Administration’s website and other relevant information sources.

Morphine Equivalent Dose (MED)

There are differing opinions among reputable experts and organizations as to what MED should trigger a consultation. The Board recommends that physicians proceed cautiously (yellow flag warning) once the MED reaches 80 mg/day. Referral to an appropriate specialist should be considered when higher doses are contemplated.

There is no absolute safe ceiling dose of opioids, however, and caution and monitoring are appropriate for applications of these medications.

The patient should be seen more frequently while the treatment plan is being initiated and the opioid dose adjusted. As the patient is stabilized in the treatment regimen, follow-up visits may be scheduled less frequently.

ONGOING PATIENT ASSESSMENT

When a trial of an opioid medication is successful and the physician and patient decide to continue opioid therapy, regular review and monitoring should be undertaken for the duration of treatment.

Continuation, modification or termination of opioid therapy for pain should be contingent on the physician's evaluation of (1) evidence of the patient's progress toward treatment objectives and (2) the absence of substantial risks or adverse events, such as overdose or diversion. A satisfactory response to treatment would be indicated by a reduced level of pain, increased level of function, and/or improved quality of life. Validated brief assessment tools that measure pain and function, such as the three-question "Pain, Enjoyment and General Activity" (PEG) scale or other validated assessment tools, may be helpful and time effective.

Consider the 5-As method for chronic pain management assessment:

Analgesia:	the patient is experiencing a reduction in pain.
Activity:	the patient is demonstrating an improvement in level of function.
Adverse:	the patient is not experiencing side effects.
Aberrance:	the patient is complying with the pain management agreement and there are no signs of medication abuse or diversion.
Affect:	the patient's behavior and mood are appropriate.

"Opioid rotation," the switching from one opioid to another in order to better balance analgesia and side effects, may be used if pain relief is inadequate, if side effects are bothersome or unacceptable, or if an alternative route of administration is suggested. Opioid rotation must be done with great care, particularly when converting from an immediate-release formulation to an Extended Release (ER)/Long Acting (LA) product. Equianalgesic charts, conversion tables and calculators must be used cautiously with titration and appropriate monitoring. Patients may exhibit incomplete cross-tolerance to different types of opioids because of differences in the receptors or receptor sub-types to which different opioids bind, hence physicians may want to use initially lower-than-calculated doses of the switched-to opioid.

COMPLIANCE MONITORING

Physicians who prescribe opioids or other controlled substances for pain should ensure the provisions of a pain management agreement are being heeded. Strategies for monitoring compliance may include:

- *CURES Report*
  The CURES report can be useful in establishing whether or not an individual is receiving controlled substances from multiple prescribers. The CURES report should be requested frequently for patients who are being treated for pain as well as addiction.

- *Drug Testing*
  A patient's report of medication use is not always reliable; therefore, drug testing can be an important monitoring tool.

  Physicians need to be aware of the limitations of available tests (such as their limited sensitivity for many opioids) and take care to order tests appropriately. For example, when a drug test is ordered, it is important to specify that it include the opioid being prescribed. Because of the complexities involved in interpreting drug test results, it is advisable to confirm significant or unexpected results with the laboratory toxicologist or a clinical pathologist. Urine toxicology tests can be compromised by variability and limitations in obtaining specimens, custody of specimens, laboratory methodologies and interpreting laboratory data. Laboratories vary in their testing methodologies, thresholds and standards. Results from drug screens may involve diverse drug classes and interpreting them requires clinical understanding well beyond opioids.

  "Variability may result from differences between laboratories. Some labs, for example, only report values above a certain preset threshold. So, a patient might have a measureable level of drug, but since it does not exceed the given threshold, it is reported as "negative" finding. This might lead the physician to suspect that a prescribed drug, which should be present at the time of testing, is absent."[12]

  "Limitations to Urine Drug Testing (UDT): There is currently no way to tell from a urine drug test the exact amount of drug ingested or taken, when the last dose was taken, or the source of the drug. A recent systematic review of the use of drug treatment agreements and urine drug testing to discourage misuse when opioids are prescribed for chronic non-cancer pain, found weak, heterogeneous evidence that these strategies were associated with less misuse. Limited research did find that UDT was a valuable tool to detect use of non-prescribed drugs and confirm adherence to prescribed medications beyond that identified by

[12] Responsible Opioid Prescribing, A Clinician's Guide, Second Edition, 2012, Scott Fishman, M.D.; Federation of State Medical Boards (FSMB), FSMB Foundation, and University of Nebraska Medical Center.

patient self-report or impression of the treating physician."[13] "Consequently, additional testing, including quantitative blood levels of prescribed medications and other laboratory testing, may be deemed necessary to monitor and treat patients receiving chronic opioid treatment and is considered part of a medically necessary treatment and monitoring program."[14]

It is important to be aware of cost barriers related to a patient's ability to pay for the testing. There are numerous CLIA-waived office drug testing kits which are inexpensive and which physicians may wish to consider for use for initial drug testing, however unexpected results from office-based testing should be confirmed by the more-sensitive laboratory testing before the patient's plan of care is changed.

- *Pill Counting*
  Periodic pill counting can be a useful strategy to confirm medication adherence and to minimize diversion (selling, sharing or giving away medications).

The physician must decide whether or not to revise or augment a pain management agreement and/or treatment plan if the patient's progress is unsatisfactory.
If it is suspected that a patient may be abusing or diverting prescribed medications, or using "street" drugs, a careful re-assessment of the treatment plan must be undertaken. A patient's failure to adhere to a pain management agreement is not necessarily proof of abuse or diversion. Failure to comply may be the consequence of inadequate pain relief, confusion regarding the prescription, a language barrier or economic concerns. A physician should arrange for an in-person meeting in order to have a non-judgmental conversation to clarify his or her concerns. If abuse is confirmed, minimally, consultation with an addiction medicine specialist or mental health specialist trained in substance abuse disorders and/or referral to a substance use disorder treatment program that provides medication-assisted therapy (MAT) should be immediately facilitated. Physicians who prescribe long-term opioid therapy should be knowledgeable in the diagnosis of substance use disorders and able to distinguish such disorders from physical dependence—which is expected in chronic therapy with opioids and many sedatives.

Documented drug diversion or prescription forgery, obvious impairment, and abusive or assaultive behaviors usually require a firmer, immediate response. The degree to which the patient has breached the pain agreement and/or the presence of criminal activity should govern the physician's response. Although an immediate face-to-face meeting with the patient to re-evaluate the treatment plan may be appropriate, in some instances it may be necessary to taper opioid therapy and/or terminate the physician patient

[13] State Of California Division Of Workers' Compensation Guideline For The Use Of Opioids To Treat Work-Related Injuries (Forum Posting, April 2014) Part D: Comparison Of Recommendations From Existing Opioid Guidelines.
[14] State Of California Division Of Workers' Compensation Guideline For The Use Of Opioids To Treat Work-Related Injuries (Forum Posting, April 2014) Part B Recommendations.

relationship. In situations where the patient has engaged in criminal behavior (e.g., prescription forgery or assaultive behaviors), the physician is strongly encouraged to contact the police/ Drug Enforcement Agency (DEA). Failing to respond can place the patient and others at significant risk of adverse consequences, including accidental overdose, suicide attempts, arrests and incarceration, or even death.

DISCONTINUING OPIOID THERAPY

Discontinuation or tapering of opioid therapy may be required for many reasons and ideally, an "exit strategy" should be included in the treatment plan for all patients receiving opioids at the outset of treatment.[15] Reasons may include:

- Resolution or healing of the painful condition;
- Intolerable side effects;
- Failure to achieve anticipated pain relief or functional improvement (although ensure that this failure is not the result of inadequate treatment);
- Evidence of non-medical or inappropriate use;
- Failure to comply with monitoring, such as urine drug screening (although ensure that this failure is not the result of a cost issue);
- Failure to comply with pain management contract;
- Exhibition of drug-seeking behaviors (although ensure this behavior is not the result of inadequate treatment) or diversion, such as:
    - Selling prescription drugs;
    - Forging prescriptions;
    - Stealing or borrowing drugs;
    - Aggressive demand for opioids;
    - Injecting oral/topical opioids;
    - Unsanctioned use of opioids;
    - Unsanctioned dose escalation;
    - Concurrent use of illicit drugs;
    - Getting opioids from multiple prescribers and/or multiple pharmacies;
    - Recurring Emergency department visits for chronic pain management.

If opioid therapy is discontinued, the patient who has become physically dependent should be provided with a safely-structured tapering regimen. Opioid withdrawal symptoms are uncomfortable, but are generally not life threatening. Opioids can be stopped abruptly when the risks outweigh the benefits. This is not true for benzodiazepine withdrawals, which can be life threatening. Withdrawal can be managed either by the prescribing physician or by referring the patient to an addiction specialist. "Approaches to weaning range from a slow 10% reduction per week to a more aggressive 25 to 50% reduction every few days. In general, a slower taper will produce fewer unpleasant symptoms of withdrawal."[16] For strategies on tapering and weaning, see Appendix 16. The termination of opioid therapy should not mark the end

[15] Responsible Opioid Prescribing, A Clinician's Guide, Second Edition, 2012, Scott Fishman, M.D.; Federation of State Medical Boards (FSMB), FSMB Foundation, and University of Nebraska Medical Center.
[16] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

of treatment, which should continue with other modalities, either through direct care or referral to other health care specialists, as appropriate.

If complete termination of care is necessary (as opposed to termination of a specific treatment modality), physicians should treat the patient until the patient has had a reasonable time to find an alternative source of care, and ensure that the patient has adequate medications, if appropriate, to avoid unnecessary risk from withdrawal symptoms. Physicians can be held accountable for patient abandonment if medical care is discontinued without justification or adequate provision for subsequent care. If a patient is known to be abusing a medication, initiating a detoxification protocol may be appropriate. Consultation with an attorney and/or one's malpractice insurance carrier may be prudent in such cases. Physicians may want to also consult health plan contracts to ensure compliance. The Board provides guidance on how to terminate/sever the patient relationship.

If a patient is dismissed for not honoring treatment agreements, consider referral to addiction resources. This can also include a 12-step program.

MEDICAL RECORDS

Every physician must maintain adequate and accurate medical records. The content of a patient's medical record may vary considerably, depending on numerous factors. For a physician treating a patient with opioids for chronic, non-cancer pain, an adequate medical record includes, but is not limited to, the documentation of:

- the patient's medical history;
- results of the physical examination and all laboratory tests ordered by the physician;
- patient consent;
- pain management agreement;
- results of the risk assessment, including results of any screening instruments used;
- description of the treatments provided, including all medications prescribed or administered (including the date, type, dose and quantity);
- instructions to the patient, including discussions of risks and benefits with the patient and any significant others;
- results of ongoing monitoring of patient progress (or lack of progress) in terms of pain management and functional improvement;
- notes on evaluations by and consultations with specialists;
- any other information used to support the initiation, continuation, revision, or termination of treatment and the steps taken in response to any aberrant medication use behaviors (these may include actual copies of, or references to, medical records of past hospitalizations or treatments by other providers);
- authorization for release of information to other treatment providers as appropriate and/or legally required; and
- results of CURES data searches.

The medical record should include all prescription orders for opioid analgesics and other controlled substances, whether written, telephoned or electronic. In addition, written instructions for the use of all medications should be given to the patient and documented in the record. The name, telephone number, and address of the patient's pharmacy also should be recorded to facilitate contact as needed, if the pharmacy that the patient will use is known. Records should be up-to-date and maintained in an accessible manner so as to be readily available for review.

Good records demonstrate that a service was provided to the patient and establish that the service provided was medically necessary. Even if the outcome is less than optimal, thorough records protect the physician as well as the patient.

SUPERVISING ALLIED HEALTH PROFESSIONALS

Physicians who supervise physician assistants or nurse practitioners who prescribe opioids should be aware of the specific regulations and requirements.

COMPLIANCE WITH CONTROLLED SUBSTANCES LAWS

California laws:

- California laws regarding controlled substances
- Guide to the Laws Governing the Practice of Medicine

Federal laws:

- Title 21 United States Code (USC) Controlled Substances Act

Other information:

- Pharmacist corresponding responsibilities

Appendix 1 - Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the ED

Please see pages BRD 16-59 to BRD 16-85.

Appendix 2 - Older Adults

Older Adults[17]

The prevalence of pain among older adults has been estimated between 25% and 50%. The prevalence of pain in nursing homes is even higher. Unfortunately, managing pain in older adults is challenging due to: underreporting of symptoms; presence of multiple medical conditions; polypharmacy; declines in liver and kidney function; problems with communication, mobility and safety; and cognitive and functional decline in general.

Acetaminophen is considered the drug of choice for mild-to-moderate pain in older adults because it lacks the gastrointestinal, bleeding, renal toxicities, and cognitive side-effects that have been observed with NSAIDs in older adults (although acetaminophen may pose a risk of liver damage). Opioids must be used with particular caution and clinicians should "start low, go slow" with initial doses and subsequent titration. Clinicians should consult the American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults for further information on the many medications that may not be recommended.

The various challenges of pain management in older adults, only sketched here, suggest that early referral and/or consultation with geriatric specialists or pain specialists may be advisable.

[17] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

Appendix 3 - Pediatric Patients

Pediatric Patients[18]

Children of all ages deserve compassionate and effective pain treatment. In fact, due to their more robust inflammatory response and immature central inhibitory influences, infants and young children actually may experience greater pain sensations and pain-related distress than adults. Effective pain management in the pediatric population is critical since children and adolescents experience a variety of acute and chronic pain conditions associated with common childhood illnesses and injuries, as well as some painful chronic diseases that typically emerge in childhood such as sickle cell anemia and cystic fibrosis.

The same basic principles of appropriate pain management for adults apply to children and teens, which means that opioids have a place in the treatment armamentarium. Developmental differences, however, can make opioid dosing challenging, especially in the first several months of life. In the first week of a newborn's life, for example, the elimination half-life of morphine is more than twice as long as that in older children and adults, as a result of delayed clearance. For older children, dosing must be adjusted for body weight.

Although a thorough discussion of this topic is not possible in this document, the following are summary recommendations for pain management in children and teens from the American Pain Society and the American Academy of Pediatrics:

- Provide a calm environment for procedures that reduce distress-producing stimulation;
- Use age-appropriate pain assessment tools and techniques;
- Anticipate predictable painful experiences, intervene and monitor accordingly;
- Use a multimodal approach (pharmacologic, cognitive, behavioral and physical) to pain management and use a multidisciplinary approach when possible;
- Involve families and tailor interventions to the individual child; and
- Advocate for the effective use of pain medication for children to ensure compassionate and competent management of their pain.

[18] California Medical Association (Prescribing Opioids: Care amid Controversy, March 2014).

Appendix 4 - Patient Evaluation and Risk Stratification

Patient Evaluation and Risk Stratification[19]

The medical record should document the presence of one or more recognized medical indications for prescribing an opioid analgesic and reflect an appropriately detailed patient evaluation. Such an evaluation should be completed before a decision is made as to whether to prescribe an opioid analgesic.

The nature and extent of the evaluation depends on the type of pain and the context in which it occurs. For example, meaningful assessment of chronic pain, including pain related to cancer or non-cancer origins, usually demands a more detailed evaluation than an assessment of acute pain. Assessment of the patient's pain typically would include the nature and intensity of the pain, past and current treatments for the pain, any underlying or co-occurring disorders and conditions, and the effect of the pain on the patient's physical and psychological functioning.

For every patient, the initial work-up should include a systems review and relevant physical examination, as well as laboratory investigations as indicated. Such investigations help the physician address not only the nature and intensity of the pain, but also its secondary manifestations, such as its effects on the patient's sleep, mood, work, relationships, valued recreational activities, and alcohol and drug use.

Social and vocational assessment is useful in identifying supports and obstacles to treatment and rehabilitation; for example: Does the patient have good social supports, housing, and meaningful work? Is the home environment stressful or nurturing?.

Assessment of the patient's personal and family history of alcohol or drug abuse and relative risk for medication misuse or abuse also should be part of the initial evaluation, and ideally should be completed prior to a decision as to whether to prescribe opioid analgesics. This can be done through a careful clinical interview, which also should inquire into any history of physical, emotional or sexual abuse, because those are risk factors for substance misuse. Use of a validated screening tool (such as the Screener and Opioid Assessment for Patients with Pain [SOAPP-R] or the Opioid Risk Tool [ORT]), or other validated screening tools, can save time in collecting and evaluating the information and determining the patient's level of risk.

All patients should be screened for depression and other mental health disorders, as part of risk evaluation. Patients with untreated depression and other mental health problems are at increased risk for misuse or abuse of controlled medications, including addiction, as well as overdose.

[19] Federation of State Medical Boards - Model Policy on the Use of Opioid Analgesics in the Treatment of Chronic Pain, July 2013.

Patients who have a history of substance use disorder (including alcohol) are at elevated risk for failure of opioid analgesic therapy to achieve the goals of improved comfort and function, and also are at high risk for experiencing harm from this therapy, since exposure to addictive substances often is a powerful trigger of relapse. Therefore, treatment of a patient who has a history of substance use disorder should, if possible, involve consultation with an addiction specialist before opioid therapy is initiated (and follow-up as needed). Patients who have an active substance use disorder should not receive opioid therapy until they are established in a treatment/recovery program or alternatives are established such as co-management with an addiction professional. Physicians who treat patients with chronic pain should be encouraged to also be knowledgeable about the treatment of addiction, including the role of replacement agonists such as methadone and buprenorphine. For some physicians, there may be advantages to becoming eligible to treat addiction using office-based buprenorphine treatment.

Information provided by the patient is a necessary but insufficient part of the evaluation process. Reports of previous evaluations and treatments should be confirmed by obtaining records from other providers, if possible. Patients have occasionally provided fraudulent records, so if there is any reason to question the truthfulness of a patient's report, it is best to request records directly from the other providers.

If possible, the patient evaluation should include information from family members and/or significant others. Where available, the state prescription drug monitoring program (PDMP) should be consulted to determine whether the patient is receiving prescriptions from any other physicians, and the results obtained from the PDMP should be documented in the patient record.

In dealing with a patient who is taking opioids prescribed by another physician—particularly a patient on high doses—the evaluation and risk stratification assume even greater importance. With all patients, the physician's decision as to whether to prescribe opioid analgesics should reflect the totality of the information collected, as well as the physician's own knowledge and comfort level in prescribing such medications and the resources for patient support that are available in the community.

Appendix 5 - CAGE-AID

CAGE-AID Questionnaire

CAGE-AID Questionnaire

Patient Name _____ Date of Visit _____

When thinking about drug use, include illegal drug use and the use of prescription drug other than prescribed.

Questions:	YES	NO
1. Have you ever felt that you ought to cut down on your drinking or drug use?	☐	☐
2. Have people annoyed you by criticizing your drinking or drug use?	☐	☐
3. Have you ever felt bad or guilty about your drinking or drug use?	☐	☐
4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	☐	☐

Scoring
Regard one or more positive responses to the CAGE-AID as a positive screen.

Psychometric Properties

The CAGE-AID exhibited:	Sensitivity	Specificity
One or more Yes responses	0.79	0.77
Two or more Yes responses	0.70	0.85

(Brown 1995)

Appendix 6 - PHQ-9 Nine Symptom Checklist

PHQ-9 — Nine Symptom Checklist

Patient Name _____ **Date** _____

1. Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.

   a. Little interest or pleasure in doing things
   Not at all **Several days** **More than half the days** **Nearly every day**

   b. Feeling down, depressed, or hopeless
   Not at all **Several days** **More than half the days** **Nearly every day**

   c. Trouble falling asleep, staying asleep, or sleeping too much
   Not at all **Several days** **More than half the days** **Nearly every day**

   d. Feeling tired or having little energy
   Not at all **Several days** **More than half the days** **Nearly every day**

   e. Poor appetite or overeating
   Not at all **Several days** **More than half the days** **Nearly every day**

   f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down
   Not at all **Several days** **More than half the days** **Nearly every day**

   g. Trouble concentrating on things such as reading the newspaper or watching television
   Not at all **Several days** **More than half the days** **Nearly every day**

   h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual
   Not at all **Several days** **More than half the days** **Nearly every day**

   i. Thinking that you would be better off dead or that you want to hurt yourself in some way
   Not at all **Several days** **More than half the days** **Nearly every day**

2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

   Not Difficult at All **Somewhat Difficult** **Very Difficult** **Extremely Difficult**

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PHQ-9 — Scoring Tally Sheet

Patient Name _____ **Date** _____

1. **Over the last 2 weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling asleep, staying asleep, or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
g. Trouble concentrating on things such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual				
i. Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not Difficult At All	Somewhat Difficult	Very Difficult	Extremely Difficult
0	1	2	3

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How to Score PHQ-9

Scoring Method For Diagnosis

Major Depressive Syndrome is suggested if:

- Of the 9 items, 5 or more are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Minor Depressive Syndrome is suggested if:

- Of the 9 items, b, c, or d are circled as at least "More than half the days"
- Either item 1a or 1b is positive, that is, at least "More than half the days"

Scoring Method For Planning And Monitoring Treatment

Question One

- To score the first question, tally each response by the number value of each response:

  Not at all = 0

  Several days = 1

  More than half the days = 2

  Nearly every day = 3
- Add the numbers together to total the score.
- Interpret the score by using the guide listed below:

Score	Action
≤4	The score suggests the patient may not need depression treatment.
> 5-14	Physician uses clinical judgment about treatment, based on patient's duration of symptoms and functional impairment.
≥15	Warrants treatment for depression, using antidepressant, psychotherapy and/or a combination of treatment

Question Two

In question two the patient responses can be one of four: not difficult at all, somewhat difficult, very difficult, extremely difficult. The last two responses suggest that the patient's functionality is impaired. After treatment begins, the functional status is again measured to see if the patient is improving.

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Appendix 7 - Opioid Risk Tool (ORT)

Date _____

Patient Name _____

OPIOID RISK TOOL

		Mark each box that applies	Item Score If Female	Item Score If Male
1. Family History of Substance Abuse	Alcohol	[ ]	1	3
	Illegal Drugs	[ ]	2	3
	Prescription Drugs	[ ]	4	4
2. Personal History of Substance Abuse	Alcohol	[ ]	3	3
	Illegal Drugs	[ ]	4	4
	Prescription Drugs	[ ]	5	5
3. Age (Mark box if 16 – 45)		[ ]	1	1
4. History of Preadolescent Sexual Abuse		[ ]	3	0
5. Psychological Disease	Attention Deficit Disorder Obsessive Compulsive Disorder Bipolar Schizophrenia	[ ]	2	2
	Depression	[ ]	1	1
TOTAL		[ ]		

Total Score Risk Category Low Risk 0 – 3 Moderate Risk 4 – 7 High Risk ≥ 8

Appendix 8 - SOAPP®-R

Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R)

The Screener and Opioid Assessment for Patients with Pain- Revised (SOAPP®-R) is a tool for clinicians to help determine how much monitoring a patient on long-term opioid therapy might require. This is an updated and revised version of SOAPP V.1 released in 2003.

Physicians remain reluctant to prescribe opioid medication because of concerns about addiction, misuse, and other aberrant medication-related behaviors, as well as liability and censure concerns. Despite recent findings suggesting that most patients are able to successfully remain on long-term opioid therapy without significant problems, physicians often express a lack of confidence in their ability to distinguish patients likely to have few problems on long-term opioid therapy from those requiring more monitoring.

SOAPP-R is a quick and easy-to-use questionnaire designed to help providers evaluate the patients' relative risk for developing problems when placed on long-term opioid therapy. SOAPP-R is:

- A brief paper and pencil questionnaire
- Developed based on expert consensus regarding important concepts likely to predict which patients will require more or less monitoring on long-term opioid therapy (content and face valid)
- Validated with 500 chronic pain patients
- Simple to score
- 24 items
- <10 minutes to complete
- Ideal for documenting decisions about the level of monitoring planned for a particular patient or justifying referrals to specialty pain clinic.
- The SOAPP-R is for clinician use only. The tool is not meant for commercial distribution.
- The SOAPP-R is NOT a lie detector. Patients determined to misrepresent themselves will still do so. Other clinical information should be used with SOAPP-R scores to decide on a particular patient's treatment.
- The SOAPP-R is NOT intended for all patients. The SOAPP-R should be completed by chronic pain patients being considered for opioid therapy.
- It is important to remember that all chronic pain patients deserve treatment of their pain. Providers who are not comfortable treating certain patients should refer those patients to a specialist.

SAMPLE

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SOAPP®-R

The following are some questions given to patients who are on or being considered for medication for their pain. Please answer each question as honestly as possible. There are no right or wrong answers.

	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
1. How often do you have mood swings?	○	○	○	○	○
2. How often have you felt a need for higher doses of medication to treat your pain?	○	○	○	○	○
3. How often have you felt impatient with your doctors?	○	○	○	○	○
4. How often have you felt that things are just too overwhelming that you can't handle them?	○	○	○	○	○
5. How often is there tension in the home?	○	○	○	○	○
6. How often have you counted pain pills to see how many are remaining?	○	○	○	○	○
7. How often have you been concerned that people will judge you for taking pain medication?	○	○	○	○	○
8. How often do you feel bored?	○	○	○	○	○
9. How often have you taken more pain medication than you were supposed to?	○	○	○	○	○
10. How often have you worried about being left alone?	○	○	○	○	○
11. How often have you felt a craving for medication?	○	○	○	○	○
12. How often have others expressed concern over your use of medication?	○	○	○	○	○

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	Never	Seldom	Sometimes	Often	Very Often
	0	1	2	3	4
13. How often have any of your close friends had a problem with alcohol or drugs?	○	○	○	○	○
14. How often have others told you that you had a bad temper?	○	○	○	○	○
15. How often have you felt consumed by the need to get pain medication?	○	○	○	○	○
16. How often have you run out of pain medication early?	○	○	○	○	○
17. How often have others kept you from getting what you deserve?	○	○	○	○	○
18. How often, in your lifetime, have you had legal problems or been arrested?	○	○	○	○	○
19. How often have you attended an AA or NA meeting?	○	○	○	○	○
20. How often have you been in an argument that was so out of control that someone got hurt?	○	○	○	○	○
21. How often have you been sexually abused?	○	○	○	○	○
22. How often have others suggested that you have a drug or alcohol problem?	○	○	○	○	○
23. How often have you had to borrow pain medications from your family or friends?	○	○	○	○	○
24. How often have you been treated for an alcohol or drug problem?	○	○	○	○	○

Please include any additional information you wish about the above answers.
Thank you.

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Scoring Instructions for the SOAPP®-R

All 24 questions contained in the SOAPP®-R have been empirically identified as predicting aberrant medication-related behavior six months after initial testing.

To score the SOAPP, add the ratings of all the questions. A score of 18 or higher is considered positive.

Sum of Questions	SOAPP-R Indication
> or = 18	+
< 18	-

What does the Cutoff Score Mean?

For any screening test, the results depend on what cutoff score is chosen. A score that is good at detecting patients at-risk will necessarily include a number of patients that are not really at risk. A score that is good at identifying those at low risk will, in turn, miss a number of patients at risk. A screening measure like the SOAPP-R generally endeavors to minimize the chances of missing high-risk patients. This means that patients who are truly at low risk may still get a score above the cutoff. The table below presents several statistics that describe how effective the SOAPP-R is at different cutoff values. These values suggest that the SOAPP-R is a sensitive test. This confirms that the SOAPP-R is better at identifying who is at high risk than identifying who is at low risk. Clinically, a score of 18 or higher will identify 81% of those who actually turn out to be at high risk. The Negative Predictive Values for a cutoff score of 18 is .87, which means that most people who have a negative SOAPP-R are likely at low-risk. Finally, the Positive likelihood ratio suggests that a positive SOAPP-R score (at a cutoff of 18) is 2.5 times (2.53 times) as likely to come from someone who is actually at high risk (note that, of these statistics, the likelihood ratio is least affected by prevalence rates). All this implies that by using a cutoff score of 18 will ensure that the provider is least likely to miss someone who is really at high risk. However, one should remember that a low SOAPP-R score suggests the patient is very likely at low-risk, while a high SOAPP-R score will contain a larger percentage of false positives (about 30%); at the same time retaining a large percentage of true positives. This could be improved, so that a positive score has a lower false positive rate, but only at the risk of missing more of those who actually do show aberrant behavior.

SOAPP-R Cutoff Score	Sensitivity	Specificity	Positive Predictive Value	Negative Predictive Value	Positive Likelihood Ratio	Negative Likelihood Ratio
Score 17 or above	.83	.65	.56	.88	2.38	.26
Score 18 or above	.81	.68	.57	.87	2.53	.29
Score 19 or above	.77	.75	.62	.86	3.03	.31

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How does the SOAPP-R help determine appropriate treatment?
The SOAPP-R should only be one step in the assessment process to determine which patients are high-risk for opioid misuse. The following discussion examines the assessment and treatment options for chronic pain patients who are at risk (high risk or medium risk) and those who are likely not at risk.

Who is at a high risk for opioid misuse? (SOAPP-R score = 22 or greater*)

Patients in this category are judged to be at a high risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at a higher risk for opioid misuse. Some examples of these behaviors or beliefs include a current or recent history of alcohol or drug abuse, being discharged from another physician' care because of his/her behavior, and regular noncompliance with physicians' orders. These patients may have misused other prescription medications in the past. It is a good idea to review the SOAPP-R questions with the patient, especially those items the patient endorsed. This will help flesh out the clinical picture, so the provider can be in the best position to design an effective, workable treatment plan.

Careful and thoughtful planning will be necessary for patients in this category. Some patients in this category are probably best suited for other therapies or need to exhaust other interventions prior to entering a treatment plan that includes chronic opioid therapy. Others may need to have psychological or psychiatric treatment prior to or concomitant with any treatment involving opioids. Patients in this category who receive opioid therapy should be required to follow a strict protocol, such as regular urine drug screens, opioid compliance checklists, and counseling.

Specific treatment considerations for patients in this high-risk category:

- Past medical records should be obtained and contact with previous and current providers should be maintained.
- Patients should also be told that they would be expected to initially give a urine sample for a toxicology screen during every clinic visit. They should also initially be given medication for limited periods of time (e.g., every 2-weeks).
- Ideally, family members should be interviewed and involvement with an addiction medicine specialist and/or mental health professional should be sought.
- Less abusable formulations should be considered (e.g., long-acting versus short-acting opioids, transdermal versus oral preparation, tamper-resistant medications).
- Early signs of aberrant behavior and a violation of the opioid agreement should result in a change in treatment plan. Depending on the degree of violation, one might consider more restricted monitoring, or, if resources are limited, referring the patient to a program where opioids can be prescribed under stricter conditions. If violations or aberrant behaviors persist, it may be necessary to discontinue opioid therapy.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

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Who is at a moderate risk for opioid misuse? (SOAPP-R score = 10 to 21*)

Patients in this category are judged to be at a medium or moderate risk for opioid misuse. These patients have indicated a history of behaviors or beliefs that are thought to place them at some risk for misuse. Some examples of these behaviors or beliefs are family history of drug abuse, history of psychological issues such as depression or anxiety, a strong belief that medications are the only treatments that will reduce pain and a history of noncompliance with other prescription medications. It is a good idea to review the SOAPP-R items the patient endorsed with the patient present.

Some of these patients are probably best treated by concomitant psychological interventions in which they can learn to increase their pain-coping skills, decrease depression and anxiety, and have more frequent monitoring of their compliance. They may need to be closely monitored until proven reliable by not running out of their medications early and having appropriate urine drug screens.

Additional treatment considerations for patients in this category:

- Periodic urine screens are recommended.
- After a period in which no signs of aberrant behavior are observed, less frequent clinic visits may be indicated. If there are any violations of the opioid agreement, then regular urine screens and frequent clinic visits would be recommended.
- After two or more violations of the opioid agreement, an assessment by an addiction medicine specialist and/or mental health professional should be mandated.
- After repeat violations referral to a substance abuse program would be recommended. A recurrent history of violations would also be grounds for tapering and discontinuing opioid therapy

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

Who is at a low risk for opioid misuse? (SOAPP-R score < 9*)

Patients in this category are judged to be at a low risk for opioid misuse. These patients have likely tried and been compliant with many other types of therapies. They should be able to handle their medication safely with minimal monitoring. They are apt to be responsible in their use of alcohol, not smoke cigarettes, and have no history of previous difficulties with alcohol, prescription drugs, or illegal substances. This patient probably reports few symptoms of affective distress, such as depression or anxiety.

As noted previously, the SOAPP-R is not a lie detector. The provider should be alert to inconsistencies in the patient report or a collateral report. Any sense that the patient's story "doesn't add up" should lead the provider to take a more cautious approach until experience suggests that the person is reliable.

Patients in this category would be likely to have no violations of the opioid treatment agreement. These patients are least likely to develop a substance abuse disorder. Additionally, they may not require special monitoring or concomitant psychological treatment.

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Additional treatment considerations for patients in this category:

- Review of SOAPP-R questions is not necessary, unless the provider is aware of inconsistencies or other anomaly in patient history/report.
- Frequent urine screens are not indicated.
- Less worry is needed about the type of opioid to be prescribed and the frequency of clinic visits.
- Efficacy of opioid therapy should be re-assessed every six months, and urine toxicology screens and update of the opioid therapy agreement would be recommended annually.

** Note these are general ranges. Clinicians should also complement SOAPP scores with other clinical data such as urine screens and psychological evaluations.*

SAMPLE

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IMPROVING PAIN TREATMENT THROUGH EDUCATION

Appendix 9 - Pain Intensity and Interference (pain scale)

Pain Intensity and Interference (pain scale)[20]

Pain intensity and interference

In the last month, on average, how would you rate your pain? Use a scale from 0 to 10, where 0 is "no pain" and 10 is "pain as bad as could be"? [*That is, your usual pain at times you were in pain.*]

No pain										Pain as bad as could be
0	1	2	3	4	5	6	7	8	9	10

In the last month, how much has pain interfered with your daily activities? Use a scale from 0 to 10, where 0 is "no interference" and 10 is "unable to carry on any activities"?

No interference										Unable to carry on any activities
0	1	2	3	4	5	6	7	8	9	10

Interpretation of the Two Item Graded Chronic Pain Scale – This two item version of the Graded Chronic Pain Scale is intended for brief and simple assessment of pain severity in primary care settings. Based on prior research, the interpretation of scores on these items is as follows:

Pain Rating Item	Mild	Moderate	Severe
Average/Usual Pain Intensity	1–4	5–6	7–10
Pain-related interference with activities	1–3	4–6	7–10

Although pain intensity and pain-related interference with activities are highly correlated and tend to change together, it is recommended that change over time be tracked for pain intensity and pain-related interference with activities separately when using these two items.

For an individual patient, a reduction in pain intensity and improvement in pain-related interference with activities of two points is considered moderate but clinically significant improvement.

Similar pain ratings have been widely used in the Brief Pain Inventory, the Multidimensional Pain Inventory, and the Pain Severity Scale of the SF-12.

There is extensive research on the reliability, validity and responsiveness to change of these pain severity ratings, which is summarized in the following reference:

Von Korff M. Chronic Pain Assessment in Epidemiologic and Health Services Research: Empirical Bases and New Directions. Handbook of Pain Assessment: Third Edition. Dennis C. Turk and Ronald Melzack, Editors. Guilford Press, New York., In press

[20] Interagency Guideline on Opioid Dosing for Chronic Non-cancer Pain: An educational aid to improve care and safety with opioid therapy (Washington State Agency Medical Directors' Group)

Appendix 10 - Sheehan Disability Scale

Sheehan Disability Scale - permission for use pending

Appendix 11 - Therapeutic Options for Pain Management

Therapeutic Options for Pain Management[21]

In treating pain, clinicians can avail themselves of five basic modalities of pain-management tools:

1. Cognitive-behavioral approaches
2. Rehabilitative approaches
3. Complementary and alternative therapies
4. Interventional approaches
5. Pharmacotherapy

Not all of these options are necessary or appropriate for every patient, but clinical guidelines suggest that all options should be considered every time a health care provider decides to treat a patient with chronic pain. These options can be used alone or in combinations to maximize pain control and functional gains. Only one of these options involves medications and opioids are only one of many types of medications with potential analgesic utility. Which options are used in a given patient depends on factors such as the type of pain, the duration and severity of pain, patient preferences, co-occurring disease states or illnesses, patient life expectancy, cost and the local availability of the treatment option.

Cognitive-behavioral Approaches

The brain plays a vitally important role in pain perception and in recovery from injury, illness or other conditions involving pain. Psychological therapies of all kinds, therefore, may be a key element in pain management. At the most basic level, such therapy involves patient education about disease states, treatment options or interventions, and methods of assessing and managing pain. Cognitive therapy techniques may help patients monitor and evaluate negative or inaccurate thoughts and beliefs about their pain. For example, some patients engage in an exaggeration of their condition called “catastrophizing” or they may have an overly passive attitude toward their recovery which leads them to inappropriately expect a physician to “fix” their pain with little or no work or responsibility on their part. Another way to frame this is to assess whether a patient has an internal or external “locus of control” relative to their pain. Someone with an external locus of control attributes the cause/relief of pain to external causes and they expect that the relief comes from someone else. Someone with an internal locus of control believes that they are responsible for their own well being; they own the experience of pain and recognize they have the ability and obligation to undertake remediation, with the help of others.

Some chronic pain patients have a strong external locus of control, and successful management of their pain hinges, in part, on the use of cognitive or other types of

[21] California Medical Association (Prescribing Opioids: Care amid Controversy March 2014)

therapy to shift the locus from external to internal. Individual, group or family psychotherapy may be extremely helpful for addressing this and other psychological issues, depending on the specific needs of a patient.

In general, psychological interventions may be best suited for patients who express interest in such approaches, who feel anxious or fearful about their condition, or whose personal relationships are suffering as a result of chronic or recurrent pain. Unfortunately, the use of psychological approaches to pain management can be hampered by such barriers as provider time constraints, unsupportive provider reimbursement policies, lack of access to skilled and trained providers, or a lack of awareness on the part of patients and/or physicians about the utility of such approaches for improving pain relief and overall function.

Rehabilitative Approaches

In addition to relieving pain, a range of rehabilitative therapies can improve physical function, alter physiological responses to pain and help reduce fear and anxiety. Treatments used in physical rehabilitation include exercises to improve strength, endurance, and flexibility; gait and posture training; stretching; and education about ergonomics and body mechanics. Exercise programs that incorporate Tai Chi, swimming, yoga or core-training may also be useful. Other noninvasive physical treatments for pain include thermotherapy (application of heat), cryotherapy (application of cold), counter-irritation and electroanalgesia (e.g., transcutaneous electrical stimulation). Other types of rehabilitative therapies, such as occupational and social therapies, may be valuable for selected patients.

Complementary and Alternative Therapies

Complementary and alternative therapies (CAT) of various types are used by many patients in pain, both at home and in comprehensive pain clinics, hospitals or other facilities.27 These therapies seek to reduce pain, induce relaxation and enhance a sense of control over the pain or the underlying disease. Meditation, acupuncture, relaxation, imagery, biofeedback and hypnosis are some of the therapies shown to be potentially helpful to some patients. CAT therapies can be combined with other pain treatment modalities and generally have few, if any, risks or attendant adverse effects. Such therapies can be an important and effective component of an integrated program of pain management.

Interventional Approaches

Although beyond the scope of this paper, a wide range of surgical and other interventional approaches to pain management exist, including trigger point injections, epidural injections, facet blocks, spinal cord stimulators, laminectomy, spinal fusion, deep brain implants and neuro-augmentative or neuroablative surgeries. Many of these approaches involve some significant risks, which must be weighed carefully against the potential benefits of the therapy.

Pharmacotherapy

Many types of medications can be used to alleviate pain, some that act directly on pain signals or receptors, and others that contribute indirectly to either reduce pain or improve function. For patients with persistent pain, medications may be used concurrently in an effort to target various aspects of the pain experience.

NSAIDs and Acetaminophen

Non-steroidal anti-inflammatory drugs (NSAIDs), which include aspirin and other salicylic acid derivatives, and acetaminophen, are categorized as non-opioid pain relievers. They are used in the management of both acute and chronic pain such as that arising from injury, arthritis, dental procedures, swelling or surgical procedures. Although they are weaker analgesics than opioids, acetaminophen and NSAIDs do not produce tolerance, physical dependence or addiction. Acetaminophen and NSAIDs are also frequently added to an opioid regimen for their opioid-sparing effect. Since non-opioids and opioids relieve pain via different mechanisms, combination therapy can provide improved relief with fewer side effects.

These agents are not without risk, however. Adverse effects of NSAIDs as a class include gastrointestinal problems (e.g., stomach upset, ulcers, perforation, bleeding, liver dysfunction), bleeding (i.e., antiplatelet effects), kidney dysfunction, hypersensitivity reactions and cardiovascular concerns, particularly in the elderly. The threshold dose for acetaminophen liver toxicity has not been established, although the FDA recommends that the total adult daily dose should not exceed 4,000 mg in patients without liver disease (although the ceiling may be lower for older adults).

In 2009, the FDA required manufacturers of products containing acetaminophen to revise their product labeling to include warnings of the risk of severe liver damage associated with its use. In 2014, new FDA rules went into effect that set a maximum limit of 325 mg of acetaminophen in prescription combination products (e.g. Vicodin and Percocet) in an attempt to limit liver damage and other ill effects from the use of these products. Of note, aspirin (> 325 mg/d), ibuprofen, ketoprofen, naproxen and other non-cyclooxygenase-selective NSAIDs, are listed as “potentially inappropriate medications” for use in older adults in the American Geriatrics Society 2012 Beers Criteria because of the range of adverse effects they can have at higher doses.

Nonetheless, with careful monitoring, and in selected patients, NSAIDs and acetaminophen can be safe and effective for long-term management of persistent pain.

Opioids

Opioids can be effective pain relievers because, at a molecular level, they resemble compounds, such as endorphins, which are produced naturally in the human central nervous system. Opioid analgesics work by binding to one or more of the three major

types of opioid receptors in the brain and body: mu, kappa and delta receptors. The most common opioid pain medications are called “mu agonists” because they bind to and activate mu opioid receptors. The binding of mu agonist opioids to receptors in various body regions results in both therapeutic effects (such as pain relief) and side effects (such as constipation).

Physical tolerance develops for some effects of opioids, but not others. For example, tolerance develops to respiratory suppressant effects within 5-7 days of continuous use, whereas tolerance to constipating effects is unlikely to occur. Tolerance to analgesia may develop early, requiring an escalation of dose, but tolerance may lessen once an effective dose is identified and administered regularly, as long as the associated pathology or condition remains stable.

Opioids, as a class, comprise many specific agents available in a wide range of formulations and routes of administration. Short-acting, orally-administered opioids typically have rapid onset of action (10-60 minutes) and a relatively short duration of action (2-4 hours). They are typically used for acute or intermittent pain, or breakthrough pain that occurs against a background of persistent low-level pain. Extended-release/long-acting (ER/LA) opioids have a relatively slow onset of action (typically between 30 and 90 minutes) and a relatively long duration of action (4 to 72 hours). The FDA states that such drugs are “indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.”

These agents achieve their extended activity in various ways. Some have intrinsic pharmacokinetic properties that make their effects more enduring than short-acting opioids, while others are modified to slow their absorption or to slow the release of the active ingredient. A given patient might be appropriate for ER/LA therapy only, short-acting only or a combination of an ER/LA opioid with a short-acting opioid. Note that patients may respond in very different ways to any given medication or combination of medications. One size does not fit all, and treatment is best optimized by titrating a given regimen on an individual basis. Combination products that join an opioid with a non-opioid analgesic entail the risk of increasing adverse effects from the non-opioid co-analgesic as doses are escalated, even if an increase of the opioid dose is appropriate.

In response to concerns about opioid misuse and abuse, abuse-deterrent and tamper-resistant opioid formulations have been developed. One class of deterrent formulation incorporates an opioid antagonist into a separate compartment within a capsule; crushing the capsule releases the antagonist and neutralizes the opioid effect. Another strategy is to modify the physical structure of
tablets or incorporate compounds that make it difficult or impossible to liquefy, concentrate, or otherwise transform the tablets. Although abuse-deterrent opioid formulations do not prevent users from simply consuming too much of a medication, they may help reduce the public health burden of prescription opioid abuse.

Patients who receive opioids on a long-term basis to treat pain are considered to be receiving long-term opioid analgesic therapy, which is differentiated from opioid use by patients who have an established opioid use disorder who use an opioid (e.g. methadone) as part of their treatment program.

Potential Adverse Effects of Opioids

Although opioid analgesics (of all formulations) may provide effective relief from moderate-to-severe pain, they also entail the following significant risks:

• Overdose
• Misuse and diversion
• Addiction
• Physical dependence and tolerance
• Potentially grave interactions with other medications or substances
• Death

At the heart of much of the current controversy over the use of opioid analgesics for chronic pain are beliefs about the degree to which these pain medications are potentially addicting. Unfortunately, it is difficult to quantify the degree of addictive risk associated with opioid analgesics, either for an individual patient or the population of pain patients in general.

In this context, it is critical to differentiate addiction from tolerance and physical dependence which are common physiological responses to a wide range of medications and even to widely-consumed non-prescription drugs (e.g. caffeine). Physical dependence and tolerance alone are not synonymous with addiction. Addiction is a complex disease state that severely impairs health and overall functioning. Opioid analgesics may, indeed, be addicting, but they share this potential with a wide range of other drugs such as sedatives, alcohol, tobacco, stimulants and anti-anxiety medications.

Rigorous, long-term studies of both the potential effectiveness and potential addictive risks of opioid analgesics for patients who do not have co-existing substance-use disorders have not been conducted. The few surveys conducted in community practice settings estimate rates of prescription opioid abuse of between 4% to 26%. A 2011 study of a random sample of 705 patients undergoing long-term opioid therapy for non-cancer pain found a lifetime prevalence rate of opioid-use disorder of 35%.41 The variability in results reflect differences in opioid treatment duration, the short-term nature of most studies and disparate study populations and measures used to assess abuse or addiction. Although precise quantification of the risks of abuse and addiction among patients prescribed opioids is not currently possible, the risks are large enough to underscore the importance of stratifying patients by risk and providing proper monitoring and screening when using opioid analgesic therapy.

Particular caution should be exercised when prescribing opioids to patients with conditions that may be complicated by adverse effects from opioids, including chronic obstructive pulmonary disease (COPD), congestive heart failure, sleep apnea, current or past alcohol or substance misuse, mental illness, advanced age or patients with a history of kidney or liver dysfunction.

In addition, opioids generally should not be combined with other respiratory depressants, such as alcohol or sedative-hypnotics (benzodiazepines or barbiturates) unless these agents have been demonstrated to provide important clinical benefits, since unexpected opioid fatalities can occur in these combination situations at relatively low opioid doses.

In addition to the potential risks just described, opioids may induce a wide range of side effects including respiratory depression, sedation, mental clouding or confusion, hypogonadism, nausea, vomiting, constipation, itching and urinary retention. With the exception of constipation and hypogonadism, many of these side effects tend to diminish with time. Constipation requires prophylaxis that is prescribed at the time of treatment initiation and modified as needed in response to frequent monitoring. With the exception of constipation, uncomfortable or unpleasant side effects may potentially be reduced by switching to another opioid or route of administration (such side effects may also be alleviated with adjunctive medications). Although constipation is rarely a limiting side effect, other side effects may be intolerable. Because it is impossible to predict which side effects a patient may experience, it is appropriate to inquire about them on a regular basis.

Patients should be fully informed about the risk of respiratory depression with opioids, signs of respiratory depression and about steps to take in an emergency. Patients and their caregivers should be counseled to immediately call 911 or an emergency service if they observe any of these warning signs.

As of January 2014, a California physician may issue standing orders for the distribution of an opioid antagonist to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist a person at risk of an opioid-related overdose. A physician may also issue a standing order for the administration of an opioid antagonist to a person at risk of an opioid-related overdose to a family member, friend, or other person in a position to assist a person experiencing or reasonably suspected of experiencing an opioid overdose.

The potential of adverse effects and the lack of data about the addictive risks posed by opioids do not mean these medications should not be used. Common clinical experience and extensive literature document that some patients benefit from the use of opioids on a short or long term basis. Existing guidelines from many sources, including physician specialty societies (American Academy of Pain Medicine, The American Pain Society), various states (Washington, Colorado, Utah), other countries (Canada) and federal agencies (Department of Defense, Veterans Administration), reflect this potential clinical utility.

Recommendations from authoritative consensus documents have been summarized in concise, user-friendly formats such as: Responsible Opiate Prescribing: A Clinician's Guide for the Federation of State Medical Boards; the 2013 Washington State Labor and Industries Guideline for Prescribing Opioids to Treat Pain in Injured Workers; and the Agency Medical Directors' Group 2010 Opioid Dosing Guideline for Chronic Non-Cancer Pain.

Methadone

Particular care must be taken when prescribing methadone. Although known primarily as a drug used to help patients recovering from heroin addiction, methadone can be an effective opioid treatment for some pain conditions. Methadone is a focus of current debate because it is frequently involved in unintentional overdose deaths. These deaths have escalated as methadone has increasingly been used to treat chronic pain.

Methadone must be prescribed even more cautiously than other opioids and with full knowledge of its highly variable pharmacokinetics and pharmacodynamics. Of critical importance is the fact that methadone's analgesic half-life is much shorter than its elimination half-life. This can lead to an accumulation of the drug in the body. In addition, methadone is metabolized by a different group of liver enzymes than most other opioids, which can lead to unexpected drug interactions.

When rotating from another opioid to methadone, extreme caution must be used when referring to equianalgesic conversion tables. Consensus recommendations suggest a 75 to 90% decrement in the equianalgesic dose from conventional conversion tables when a switch is made from another opioid to methadone.

Because the risk of overdose is particularly acute with methadone, patients should be educated about these risks and counseled to use methadone exactly as prescribed. They should also be warned about the dangers of mixing unauthorized substances, especially alcohol and other sedatives, with their medication. This should be explicitly stated in any controlled substance agreement that the patient receives, reads and signs before the initiation of treatment […].

Although uncommon, potentially lethal cardiac arrhythmias can be induced by methadone. The cardiac health of patients who are candidates for methadone should be assessed, with particular attention paid to a history of heart disease or arrhythmias. An initial ECG may be advisable prior to starting methadone, particularly if a patient has a specific cardiac disease or cardiac risk factors or is taking agents that may interact with methadone. In addition, it is important that an ECG be repeated periodically, because QT interval prolongation has been demonstrated to be a function of methadone blood levels and/or in response to a variety of other medications.

Adjuvant Pain Medications

Although opioid medications are powerful pain relievers, in the treatment of neuropathic pain and some other centralized pain disorders such as fibromyalgia, they are of limited effectiveness and are not preferred. Other
classes of medications, however, may provide relief for pain types or conditions that do not respond well to opioids. Some of these adjuvant medications exert a direct analgesic effect mediated by non-opioid receptors centrally or peripherally. Others have no direct analgesic qualities but may provide pain relief indirectly via central or peripheral affects.

Commonly-used non-opioid adjuvant analgesics include antiepileptic drugs (AEDs), tricyclic antidepressants (TCAs) and local anesthetics (LAs). AEDs, such as gabapentin and pregabalin, are used to treat neuropathic pain, especially shooting, stabbing or knife-like pain from peripheral nerve syndromes.TCAs and some newer types of antidepressants may be valuable in treating a variety of types of chronic and neuropathic pain, including post-herpetic neuralgia and diabetic neuropathy. LAs are used to manage both acute and chronic pain. Topical application provides localized analgesia for painful procedures or conditions with minimal systemic absorption or side effects. Topical Las are also used to treat neuropathic pain. Epidural blocks with LAs, with or without opioids, play an important role in managing postoperative and obstetrical pain.

Appendix 12 - Non-Opioid Pain Management Tool

Non-Opioid Pain Management Tool - permission for use pending

Appendix 13 – Suggested Language on Naloxone for Pain Management Agreement

- I understand that "overdose" is a risk of opioid therapy which can lead to death. I understand and can recognize the signs and symptoms of overdose including respiratory depression.

- I understand that I will be prescribed naloxone because overdose is a risk of opioid therapy. I understand that naloxone is a drug that can reverse opioid overdose. I understand when and how to use naloxone.
  - I understand it is strongly encouraged to share information about naloxone with my family and friends.
  - I understand it is strongly encouraged to teach family and friends how to respond to an overdose.

Appendix 14 – Suggested Patient Pain Medication Agreement and Consent

PATIENT PAIN MEDICATION AGREEMENT AND CONSENT

This agreement is important for you:

- *You will have a safe and controlled pain treatment plan.*
- *Your medicines have a high potential for abuse. They can be dangerous if used in the wrong way. You need to understand the risks that come from use of pain medicines.*

Please read and make sure you understand each statement here. Here are rules about refills and health risks. Here are also reasons for stopping your pain control treatment.

I WILL:

- ☐ I will only get my pain medicine from this clinic during scheduled appointments.
- ☐ I will take my pain medicine the way that my healthcare provider has ordered.
- ☐ I will be honest with all my healthcare providers if I am using street drugs.
- ☐ I will be honest about all the medicine I use. This includes medicine from stores and herbal medicines.
- ☐ I will be honest about my full health history.
- ☐ I will tell my healthcare provider if I go to an emergency room for any reasons.
- ☐ If I get pain medicine from an emergency room, I will tell my healthcare provider.
- ☐ I will call this office if I am prescribed any new medicine.
- ☐ I will call this office if I have a reaction to any medicine.
- ☐ I will tell all other healthcare providers that I have a pain medication agreement.
- ☐ I will tell the emergency room people that I have a pain medication agreement.
- ☐ I will take drug tests and other tests when I am told to do so.
- ☐ I will go to office visits when I am told to do so.
- ☐ I will go to physical therapy when I am told to do so.
- ☐ I will go to counseling when I am told to do so.
- ☐ I will follow directions for all treatment.
- ☐ I will show up on time for all appointments.
- ☐ I will make an appointment for refills before I run out of medicine.
- ☐ I will tell my health provider if I will be out of town so that I can get my refills.
- ☐ I will get past health records from other offices when needed.
- ☐ I will deliver these records by hand if needed. I will do this within one month of being asked. I will pay for these records if needed.
- ☐ I will give permission to this clinic to talk about my treatment with pharmacies, doctors, nurses, and others who are helping me.
- ☐ I will give permission to any healthcare provider to get information from this clinic about my health and my pain treatment.
- ☐ I will take responsibility if I overdose myself accidentally or on purpose.
- ☐ I will tell my healthcare provider if I plan to become pregnant.
- ☐ I will tell my healthcare provider if I am pregnant while I am taking pain medicine.
- ☐ I will only take this medicine the way I was told to take it.

CONTINUED ON NEXT PAGE

I WILL NOT:

- ☐ I will not share or sell, or trade any of my medicine.
- ☐ I will not drink alcohol or take street drugs while I am taking pain medicine.
- ☐ I know that I cannot call the office to have my medicine refilled over the phone.
- ☐ I will not go to the emergency room or other doctors for more pain medicine or other drugs.
- ☐ I know that when I drive a car, I must be fully alert. I know that when I use machines, I must also be fully alert. Pain medicines can make me less alert. When I am taking pain medicines, I need to be sure that I am alert. I need to be sure that it is safe for me to drive a car or use a machine.
- ☐ I will not stand in high places or do anything to hurt others after I have taken pain medicine.
- ☐ I will not leave my medicine where it can be stolen or where others can take it.
- ☐ I will not leave my medicine where children can find it.
- ☐ I will not suddenly stop taking my medicine. I know that if I do this, I can have withdrawals.

WHEN USING A PHARMACY, I WILL:

- ☐ I will use the same pharmacy for all my medicines. This is the pharmacy that I have picked: _____
- ☐ I will not ask for early refills or more pain medicine, even if I lose my medicine.

I KNOW THAT

- ☐ Pain management may include other treatment. Some treatment may not include medicine.
- ☐ Pain medicine will probably not get rid of all of my pain. Pain medicine can reduce my pain so that I can do more and have a better life.
- ☐ Part of my treatment is to reduce my need for pain medicine.
- ☐ If the pain medicines work, I will continue to use them. If the pain medicine does not help me, it will be stopped.
- ☐ My medicines will not be replaced if any of these things happen: Medicine is lost. Medicine gets wet. Medicine is destroyed
- ☐ If my medicine is stolen, I might be able to get more medicine if I get a report from the police about the medicine being stolen.
- ☐ Any of my healthcare providers can find out from the California Prescription Drug Monitoring Program about any other medicines I get from any other pharmacy in California. This is called a CURES report.
- ☐ My healthcare provider may contact the drug enforcement agency, if I try to get other doctors to give me pain medicine.
- ☐ Healthcare providers may contact the drug enforcement agency if I am not honest about how I take pain medicine.
- ☐ My doctor and my clinic will help with any investigation if I am suspected of prescription drug abuse.
- ☐ I may be sent somewhere else for drug abuse or addiction help if I need it.
- ☐ Pain medicine can be addictive. This means that my body may need more and more pain medicine or that it can be hard for me to stop taking this medicine.
- ☐ If I suddenly stop using the medicine, I can get withdrawals.
- ☐ If I use too much pain medicine, I can end up with health problems. I could die.
- ☐ If I mix medicines, I could also end up with health problems. I could die.
- ☐ Here are some things that could go wrong if I use too much medicine or mix medicines:

Overdose	Addiction	Constipation	Vomiting	Sleepiness
Slower reflexes	Nausea	Difficulty with urination	Confusion	Itching
Problems with sex	Dry mouth	Depression	Trouble breathing	Death

CAUSE FOR DISMISSAL FROM THIS CLINIC

- ☐ I know that the pain medicines may be stopped if I break any part of this contract.

My signature below means that I have read this contract. I am signing this to say that I understand all of this contract.

Patient Name _____ Doctor Name _____

Patient Signature _____ Doctor Signature_____

Date: _____

Appendix 15 – Suggested Treatment Plan Using Prescription Opioids

Treatment Plan Using Prescription Opioids

Patient name: _____

Prescriber name: _____

THE PURPOSE OF THIS AGREEMENT IS TO STRUCTURE OUR PLAN TO WORK TOGETHER TO TREAT YOUR CHRONIC PAIN. THIS WILL PROTECT YOUR ACCESS TO CONTROLLED SUBSTANCES AND OUR ABILITY TO PRESCRIBE THEM TO YOU.

I (patient) understand the following (initial each):

_____ Opioids have been prescribed to me on a trial basis. One of the goals of this treatment is to improve my ability to perform various functions, including return to work. If significant demonstrable improvement in my functional capabilities does not result from this trial of treatment, my prescriber may determine to end the trial.

Goal for improved function: _____

_____ Opioids are being prescribed to make my pain tolerable but may not cause it to disappear entirely. If that goal is not reached, my physician may end the trial.

Goal for reduction of pain: _____

_____ Drowsiness and slowed reflexes can be a temporary side effect of opioids, especially during dosage adjustments. If I am experiencing drowsiness while taking opioids, I agree not to drive a vehicle nor perform other tasks that could involve danger to myself or others.

_____ Using opioids to treat chronic pain will result in the development of a physical dependence on this medication, and sudden decreases or discontinuation of the medication will lead to symptoms of opioid withdrawal. These symptoms can include: runny nose, yawning, large pupils, goose bumps, abdominal pain and cramping, diarrhea, vomiting, irritability, aches and flu-like symptoms. I understand that opioid withdrawal is uncomfortable but not physically life threatening.

_____ There is a small risk that opioid addiction can occur. Almost always, this occurs in patients with a personal or family history of other drug or alcohol abuse. If it appears that I may be developing addiction, my physician may determine to end the trial.

Continued on other side.

I agree to the following (initial each):

_____ I agree not to take more medication than prescribed and not to take doses more frequently than prescribed.

_____ I agree to keep the prescribed medication in a safe and secure place, and that lost, damaged, or stolen medication will not be replaced.

_____ I agree not to share, sell, or in any way provide my medication to any other person.

_____ I agree to obtain prescription medication from one designated licensed pharmacist. I understand that my doctor may check the Utah Controlled Substance Database at any time to check my compliance.

_____ I agree not to seek or obtain **ANY** mood-modifying medication, including pain relievers or tranquilizers from **ANY** other prescriber without first discussing this with my prescriber. If a situation arises in which I have no alternative but to obtain my necessary prescription from another prescriber, I will advise that prescriber of this agreement. I will then immediately advise my prescriber that I obtained a prescription from another prescriber.

_____ I agree to refrain from the use of **ALL** other mood-modifying drugs, including alcohol, unless agreed to by my prescriber. The moderate use of nicotine and caffeine are an exception to this restriction.

_____ I agree to submit to random urine, blood or saliva testing, at my prescriber's request, to verify compliance with this, and to be seen by an addiction specialist if requested.

_____ I agree to attend and participate fully in any other assessments of pain treatment programs which may be recommended by the prescriber at any time.

I understand that ANY deviation from the above agreement may be grounds for the prescriber to stop prescribing opioid therapy at any time.

_____ _____

Patient Signature Date

_____ _____

Prescriber Signature Date

Appendix 16 – Suggested Strategies for Tapering and Weaning

Strategies for Tapering & Weaning

Strategies for tapering:

From a medical standpoint, weaning from opioids can be done safely by slowly tapering the opioid dose and taking into account the following issues:

- A decrease by 10% of the original dose per week is usually well tolerated with minimal physiological adverse effects. Some patients can be tapered more rapidly without problems (over 6 to 8 weeks).
- If opioid abstinence syndrome is encountered, it is rarely medically serious although symptoms may be unpleasant.
- Symptoms of an abstinence syndrome, such as nausea, diarrhea, muscle pain and myoclonus can be managed with clonidine 0.1 – 0.2 mg orally every 6 hours or clonidine transdermal patch 0.1mg/24hrs (Catapres TTS-1™) weekly during the taper while monitoring for often significant hypotension and anticholinergic side effects. In some patients it may be necessary to slow the taper timeline to monthly, rather than weekly dosage adjustments.
- Symptoms of mild opioid withdrawal may persist for six months after opioids have been discontinued.
- Consider using adjuvant agents, such as antidepressants to manage irritability, sleep disturbance or antiepileptics for neuropathic pain.
- Do not treat withdrawal symptoms with opioids or benzodiazepines after discontinuing opioids.
- Referral for counseling or other support during this period is recommended if there are significant behavioral issues.
- Referral to a pain specialist or chemical dependency center should be made for complicated withdrawal symptoms.

Recognizing and managing behavioral issues during opioid weaning:

Opioid tapers can be done safely and do not pose significant health risks to the patient. In contrast, extremely challenging behavioral issues may emerge during an opioid taper.

Behavioral challenges frequently arise in the setting of a prescriber who is tapering the opioid dose and a patient who places great value on the opioid he/she is receiving. In this setting, some patients will use a wide range of interpersonal strategies to derail the opioid taper. These may include:

- Guilt provocation ("You are indifferent to my suffering")
- Threats of various kinds
- Exaggeration of their actual suffering in order to disrupt the progress of a scheduled taper

There are no fool-proof methods for preventing behavioral issues during an opioid taper, but strategies implemented at the beginning of the opioid therapy are most likely to prevent later behavioral problems if an opioid taper becomes necessary.

TOOLS

Clinical Policy: Critical Issues in the Prescribing of Opioids for Adult Patients in the Emergency Department

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Approved by the ACEP Board of Directors, June 14, 2012

Supported by the Emergency Nurses Association, July 18, 2012

This clinical policy was funded under contract 200-2011-M-38670 with the Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury.

DISCLAIMER: The findings and conclusions in this report are those of the authors and do not necessarily represent the official position of the Centers for Disease Control and Prevention/the Agency for Toxic Substances and Disease Registry, or the Food and Drug Administration.

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0196-0644/$-see front matter
Copyright © 2012 by the American College of Emergency Physicians.
http://dx.doi.org/10.1016/j.annemergmed.2012.06.013

[Ann Emerg Med. 2012;60:499-525.]

ABSTRACT

This clinical policy deals with critical issues in prescribing of opioids for adult patients treated in the emergency department (ED). This guideline is the result of the efforts of the American College of Emergency Physicians, in consultation with the Centers for Disease Control and Prevention, and the Food and Drug Administration. The critical questions addressed in this clinical policy are: (1) In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse? (2) In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications? (3) In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids? (4) In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

INTRODUCTION

Pain is a major symptom of many patients presenting to the emergency department (ED), with up to 42% of ED visits being related to painful conditions.[1] Pain management has received increased emphasis in the past decade, including The Joint Commission's focus on patient analgesia[2] and increasing institutional emphasis placed on patient satisfaction surveys covering pain management. Much literature, including the most recent Institute of Medicine report on this topic, has stressed that health care providers have not done as well as possible in the area of pain management.[3] A possible unintended consequence of these efforts is the increase in prescription drug abuse, especially opioid abuse, the fastest-growing drug abuse problem in the United States.[4]

As part of this issue, there has been a startling increase in unintentional drug overdoses and related deaths since the late 1990s.[5,6] Reported overdose deaths involving opioid analgesics increased from 4,030 in 1999 to 14,800 in 2008.[7,8] Data from 2008 reveal that drug overdoses were the second leading cause of injury death in the United States, after motor vehicle crashes.[9] Currently, deaths from opioid analgesics are significantly greater in number than those from cocaine and heroin combined.[8]

The efforts of clinicians to improve their treatment of pain, along with pharmaceutical industry marketing, have been factors in contributing to a significant increase in the sale and distribution of opioids in the United States. For example, the sales of opioid analgesics to hospitals, pharmacies, and practitioners quadrupled between 1999 and 2010.[8] Drug sales and distribution data of opioids show an increase from 180 mg morphine equivalents per person in the United States in 1997 to 710 mg per person in 2010.[8,10] This is the equivalent of 7.1 kg of opioid medication per 10,000 population, or enough to supply every American adult with 5 mg of hydrocodone every 4 hours for a month.[8]

The dilemma of treating pain appropriately while avoiding adverse events is further complicated by insufficient data supporting the long-term use of opioids in the treatment of chronic noncancer pain. Although selective use of opioids in the treatment of acute pain is traditionally accepted, the treatment of chronic noncancer pain is more complex. Many authors have begun to question the routine long-term use of opioids for the treatment of chronic noncancer pain.[11-13] Multiple practice guidelines have been developed to address this issue.[14-19] However, most recommendations in this area are of a consensus nature, being based on experiential or low-quality evidence.

Data from 2009 show that there were more than 201.9 million opioid prescriptions dispensed in the United States during that year.[20] It is difficult to obtain reliable data concerning the degree to which this is an emergency medicine issue, but during 2009, in the 10- to 19-year-old and 20- to 29-year-old patient groups, emergency medicine ranked third among all specialties in terms of number of opioid prescriptions, writing approximately 12% of the total prescriptions in each age group. In the 30- to 39-year-old group, emergency medicine ranked fourth.[20] Although these data do not deal with total doses dispensed by specialty, it is commonly postulated that the population served in EDs as a whole is at high risk for opioid abuse.[21]

The significant increase in opioid-related deaths has raised the concern of many.[5,6,8] This problem has also been observed in the pediatric population.[22-24] Action at the national level includes the recent proposal from the Food and Drug Administration for the establishment of physician education programs for the prescribing of long-acting and extended-release opioids as part of their national opioid risk evaluation and mitigation strategy (the REMS program).[25] State efforts to address this issue have included the development of statewide opioid prescribing guidelines, such as those developed by the Utah Department of Health[17] and statewide ED opioid prescribing guidelines, such as those developed in Washington State by the Washington chapter of the American College of Emergency Physicians (ACEP) working with other state organizations.[16] Some individual EDs and emergency physician groups have also promulgated opioid prescribing guidelines. Some of these policies also deal with the necessity of patient education about the safe use and proper disposal of opioid medications. Early data indicate that, in some cases, these guidelines may decrease prescription opioid overdose.[26] Anecdotal experience suggests that public policies such as these may change patient perceptions of appropriate prescribing and mitigate complaints arising from more stringent prescribing practices. ACEP has approved related policy statements about optimizing the treatment of pain in patients with acute presentations and the implementation of electronic prescription drug monitoring programs.[27,28]

This clinical policy addresses several issues believed to be important in the prescribing of opioids by emergency physicians for adult patients treated and released from the ED for whom opioids may be an appropriate treatment modality. Although relieving pain and reducing suffering are primary emergency physician responsibilities, there is a concurrent duty to limit the personal and societal harm that can result from prescription drug misuse and abuse. Because long-acting or extended-release opioids are not indicated for the treatment of acute pain, the aim of this clinical policy is to provide evidence-based recommendations for prescribing short-acting opioids for adult ED patients with painful acute or chronic conditions while attempting to address the increasing frequency of adverse events, abuse, and overdose of prescribed opioid analgesics.

METHODOLOGY

This clinical policy was created after careful review and critical analysis of the medical literature. The critical questions were formulated in the PICO (patient, intervention, comparison, outcome)[29] format to strengthen the clarity and scientific rigor of the questions. Searches of MEDLINE, MEDLINE InProcess, and the Cochrane Library were performed. All searches were limited to English-language sources, human studies, adults, and years 2000 to 2011. Specific key words/phrases and years used in the searches are identified under each critical question. In addition, relevant articles from the bibliographies of included studies and more recent articles identified by committee members were included.

This policy is a product of the ACEP clinical policy development process, including expert review, and is based on the literature; when literature was not available, consensus of panel members was used. Expert review comments were received from emergency physicians, toxicologists, pain and addiction medicine specialists, pharmacologists, occupational medicine specialists, and individual members of the American Academy of Clinical Toxicology, American Academy of Family Physicians, American Academy of Pain Medicine, American Chronic Pain Association, American College of Occupational and Environmental Medicine, American College of Osteopathic Emergency Physicians, American College of Physicians, American Pain Society, American Society of Health-System Pharmacists, American Society of Interventional Pain Physicians, Emergency Medicine Resident's Association, and Emergency Nurses Association. Their responses were used to further refine and enhance this policy; however, their responses do not imply endorsement of this clinical policy. Clinical policies are scheduled for revision every 3 years; however, interim reviews are conducted when technology or the practice environment changes significantly. The Centers for Disease Control and Prevention was the funding source for this clinical policy.

All articles used in the formulation of this clinical policy were graded by at least 2 subcommittee members for quality and strength of evidence. The articles were classified into 3 classes of evidence on the basis of the design of the study, with design 1 representing the strongest evidence and design 3 representing the weakest evidence for therapeutic, diagnostic, and prognostic studies, respectively (Appendix A). Articles were then graded on dimensions related to the study's methodological features: blinded versus nonblinded outcome assessment, blinded or randomized allocation, direct or indirect outcome measures (reliability and validity), biases (eg, selection, detection, transfer), external validity (ie, generalizability), and sufficient sample size. Articles received a final grade (Class I, II, III) on the basis of a predetermined formula, taking into account the design and study quality (Appendix B). Articles with fatal flaws or that were not relevant to the critical question were given an "X" grade and were not used in formulating recommendations for this policy. Evidence grading was done with respect to the specific data being extracted and the specific critical question being reviewed. Thus, the level of evidence for any one study may have varied according to the question, and it is possible for a single article to receive different levels of grading as different critical questions were answered. Question-specific level of evidence grading may be found in the Evidentiary Table included at the end of this policy. Evidence grading sheets may be viewed at http://www.acep.org/clinicalpolicies/?pg=1.

Clinical findings and strength of recommendations about patient management were then made according to the following criteria:

Level A recommendations. Generally accepted principles for patient management that reflect a high degree of clinical certainty (ie, based on strength of evidence Class I or overwhelming evidence from strength of evidence Class II studies that directly address all of the issues).

Level B recommendations. Recommendations for patient management that may identify a particular strategy or range of management strategies that reflect moderate clinical certainty (ie, based on strength of evidence Class II studies that directly address the issue, decision analysis that directly addresses the issue, or strong consensus of strength of evidence Class III studies).

Level C recommendations. Other strategies for patient management that are based on Class III studies, or in the absence of any adequate published literature, based on panel consensus.

There are certain circumstances in which the recommendations stemming from a body of evidence should not be rated as highly as the individual studies on which they are based. Factors such as heterogeneity of results, uncertainty about effect magnitude and consequences, and publication bias, among others, might lead to such a downgrading of recommendations.

This policy is not intended to be a complete manual on the evaluation and management of adult ED patients with painful conditions where prescriptions for opioids are being considered, but rather is a focused examination of critical issues that have

particular relevance to the current practice of emergency medicine.

The goal of the ACEP Opioid Guideline Panel is to provide an evidence-based recommendation when the medical literature provides enough quality information to answer a critical question. When the medical literature does not contain enough quality information to answer a critical question, the members of the ACEP Opioid Guideline Panel believe that it is equally important to alert emergency physicians to this fact.

Recommendations offered in this policy are not intended to represent the only management options that the emergency physician should consider. ACEP clearly recognizes the importance of the individual physician's judgment. Rather, this guideline defines for the physician those strategies for which medical literature exists to provide support for answers to the critical questions addressed in this policy.

Scope of Application. This guideline is intended for physicians working in hospital-based EDs.

Inclusion Criteria. This guideline is intended for adult patients presenting to the ED with acute noncancer pain or an acute exacerbation of chronic noncancer pain.

Exclusion Criteria. This guideline is not intended to address the long-term care of patients with cancer or chronic noncancer pain.

CRITICAL QUESTIONS

1. In the adult ED patient with noncancer pain for whom opioid prescriptions are considered, what is the utility of state prescription drug monitoring programs in identifying patients who are at high risk for opioid abuse?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. The use of a state prescription monitoring program may help identify patients who are at high risk for prescription opioid diversion or doctor shopping.

Key words/phrases for literature searches: opioid, drug prescriptions, drug monitoring, drug utilization review, substance abuse detection, drug-seeking behavior, drug and narcotic control, substance-related disorders, physician's practice patterns, program evaluation, emergency service, and variations and combinations of the key words/phrases with exclusion of cancer.

Emergency physicians must balance oligoanalgesia (undertreatment or ineffectual treatment of pain) with concerns about drug diversion* and doctor shopping.[†30-33] Therefore, the development of mechanisms to address these issues is justified. The expanded use of prescription drug monitoring programs to curb prescription opioid misuse was recommended in the 2011 Prescription Drug Abuse Prevention Plan released by the White House Office of National Drug Control Policy.[34] Prescription drug monitoring programs are state-based monitoring programs for certain controlled substances that are prescribed by licensed practitioners and dispensed by pharmacies. Although existing in various forms for more than 3 decades, the first effort to standardize prescription drug monitoring practice was the passage in 2005 of the National All Schedules Prescription Electronic Reporting Act (NASPER). Unfortunately, this federal legislative mandate that intended to harmonize prescription drug monitoring programs across the various states has yet to be fully funded.

Prescription drug monitoring programs ideally serve multiple functions, including identifying patients who engage in doctor shopping, and patients, providers, or pharmacies who engage in diversion of controlled substances and providing information about prescribing trends for surveillance and evaluation purposes. Such information may serve to benefit the patients, the health care system, epidemiologists, policymakers, regulatory agencies, and law enforcement.[35] Certain large health care systems, particularly closed prescribing systems such as the Veterans Administration and health maintenance organizations, maintain databases that allow prescribers to view recent prescriptions of enrolled clients or patients. Forty-one states have operational prescription drug monitoring programs of various complexity and capability, with an additional 7 states having prescription drug monitoring program legislation in place but with programs that are not yet operational. [36] Most states allow health care providers and pharmacists to access the programs for patients under their care. Other groups such as law enforcement and regulatory boards may also have access. One program tracks only schedule II drug prescriptions, whereas most track drug prescriptions of schedule II to IV or II to V drugs.

Despite prescription drug monitoring programs providing an intuitive perception of benefit for the medical community, there are limited data to indicate any benefit of these programs for improving patient outcomes or reducing the misuse of prescription drugs.[37] In part, this relates to the limited optimization of and standardization between the programs and the lack of a mechanism to allow interstate communication.[35]

*Drug diversion: The diversion of drugs for nonmedical use through routes that do not involve the direct prescription of the drug by a provider. Diverted drugs might be provided by family or friends, purchased on the street market, or obtained through fraudulent prescription. Epidemiologic data suggest that most opioids used nonmedically are obtained through these means.

†Doctor shopping: The practice of obtaining prescriptions for controlled substances from multiple providers, which is regarded as a possible indication of abuse or diversion. There is no rigorous definition, and various authors have defined it in different ways, from 2 or more prescribers within 30 days, greater than 4 during 1 year, and greater than 5 during 1 year.[30-32] It has also been defined as the amount of drug obtained through doctor shopping compared with the amount intended to be prescribed.[33] The use of "pill mills," in which a prescriber provides ready access to prescriptions or pills, can be considered a form of doctor shopping.

One study has demonstrated that compared with states without a prescription monitoring program, those with such a program had a slower rate of increase in opioid misuse.[38]

In an attempt to quantify the effect of a prescription drug monitoring program, Baehren et al[39] conducted a prospective study (Class III) of 18 providers who cared for a convenience sample of adult patients with pain in a single Ohio ED. After the clinical assessment of a patient, the researchers queried the providers about 3 patient-specific issues: (1) the likelihood of querying the state's prescription drug monitoring program, called Ohio Automated Rx Reporting System; (2) the likelihood of providing an opioid prescription at discharge; and (3) if yes, which opioid and what quantity. They were then provided with a printout of the patient data from the prescription drug monitoring program and asked to reassess the same questions. Of the 179 patients with complete data, information from the Ohio Automated Rx Reporting System altered prescribing practice in 74 of 179 (41%). The majority (61%) of these patients received fewer or no opioids, whereas 39% received more. The change in management was attributed to the number of previous prescriptions, 30 of 74 (41%); number of previous prescribers, 23 of 74 (31%); number of pharmacies used, 19 of 74 (26%); and number of addresses listed, 12 of 74 (16%). A limitation of this study was that 4 prescribers accounted for almost two thirds of the total patient encounters. In this study, knowledge of the information provided by a prescription drug monitoring program had an important impact on the prescription practices for controlled substances in an ED, although the actual effect of prescription drug monitoring program data on patient outcomes in this study is unknown.

Although not specifically evaluating the benefit of prescription drug monitoring programs on identifying high-risk patients, Hall et al,[32] in a Class III study, reviewed characteristics of decedents who died of prescription drugs in West Virginia and reported that opioid analgesics accounted for 93% of deaths. Cross-referencing the medical examiner's detailed analysis of the cause of death with the West Virginia prescription monitoring program, the authors determined the prescription history of the drug associated with each fatality. Patients who had received controlled drugs from 5 or more prescribers in the year before death were defined as engaging in "doctor shopping," whereas those whose death was not associated with a valid prescription were considered to have obtained their drugs through "diversion." Of the 295 deaths that were reviewed, the mean age of patients who died was 39 years, and 92% were between ages 18 and 54 years. Diversion was associated with 186 (63%) of the fatalities, and doctor shopping was associated with 63 (21%) of the fatalities. Of the 295 total decedents, 279 (95%) had at least 1 indicator of substance abuse, and these differed according to whether the drug was obtained through diversion or doctor shopping. Deaths involving diversion were associated with a history of substance abuse (82.3% versus 71.6%; odds ratio [OR] 1.8; 95% confidence interval [CI] 1.0 to 3.4), nonmedical route of pharmaceutical administration (26.3% versus 15.6%; OR 1.9; 95% CI 1.0 to 3.8), and a contributory illicit drug (19.4% versus 10.1%; OR 2.1; 95% CI 1.0 to 4.9). Patients with evidence of doctor shopping were significantly more likely to have had a previous overdose (30.2% versus 13.4%; OR 2.8; 95% CI 1.4 to 5.6) and significantly less likely to have used contributory alcohol (7.9% versus 19.8%; OR 0.3; 95% CI 0.1 to 0.9). Few patients (8.1%) were involved in both doctor shopping and diversion. The study suggests that the information provided by a prescription drug monitoring program, with correct interpretation and action based on that knowledge, might have prevented some inappropriate prescribing and poor outcomes in this patient population.

In another Class III study, Pradel et al[33] monitored prescribing trends for buprenorphine in a select area of France, using a prescription drug database during a multiple-year period. During this time, a prescription drug monitoring program was implemented, allowing a before-after comparison of the buprenorphine prescribing pattern for more than 2,600 patients. The doctor shopping drug quantity, which was defined as the total drug quantity received by the patient minus the quantity prescribed by an individual provider, increased from 631 g in the first 6 months of 2000 to a peak of 1,151 g in the first 6 months of 2004, equivalent to 143,750 days of treatment at 8 mg/day. The doctor shopping ratio, determined as the ratio of the quantity delivered to the quantity prescribed, increased steadily from early 2000 (14.9% of the grams of drug prescribed) to a peak value in the first 6 months of 2004 (21.7%). After implementation of the prescription drug monitoring program in early 2004, this value decreased rapidly, in fewer than 2 years reaching the value observed in 2000. The points of inflection of the doctor shopping curves (quantity and ratio) coincided with the implementation of the prescription drug monitoring program, suggesting an immediate benefit of this program. The prescribed quantity did not change after the implementation, indicating that access to treatment may not have changed. Eighty percent of the total doctor shopping quantity of buprenorphine was obtained by approximately 200 (8%) of the total patients. However, it is difficult to make any inferences about the effect of a decrease in doctor shopping, given the fractional amount of total prescribing accounted for by this practice.[33] The authors suggested that the doubling in the street price of buprenorphine after the prescription drug monitoring program implementation was an indicator of success.

An observational study of opioid-related deaths by Paulozzi et al[37] highlights some important considerations in the assessment of the effectiveness of prescription drug monitoring programs. The authors assessed the mortality rate from 1999 to 2005 from schedule II and III prescription opioids in the United States and compared states that had prescription drug monitoring programs with those that did not. They further divided states with prescription drug monitoring programs into those that proactively informed prescribers, generally by mail, of potential

misuse and those that did not. This study found no difference in the mortality rates over time for states with and without a prescription drug monitoring program, nor did states with proactive prescription drug monitoring programs perform better than those with programs that were not proactive. There was a nonsignificantly lower rate of consumption of schedule II opioids and a significantly higher rate of consumption of hydrocodone (schedule III) in states that had a prescription drug monitoring program. A major limitation of this study is that the variability in the prescription drug monitoring program structure, including the ability of health care providers to access the database, was not considered. Current applicability is somewhat limited by substantial changes in the manner in which prescription drug monitoring programs function since the study was conducted, including the extent of physician access and the definition of patient inclusion criteria. Because of the practical limitation of the delay in informing the prescriber of a patient's potential drug misuse, the proactive notification aspect of these programs would have minimal effect on emergency medical practice in states that cannot provide prescription drug monitoring program data in real time.

In conclusion, there are no studies that directly evaluate the effect of real-time, voluntary access to a prescription drug monitoring program on prescribing practices of emergency physicians. In addition, the broader effect of such access on diversion, abuse, doctor shopping, mortality, and the possibility of pain undertreatment remains undefined. Prescription drug monitoring programs have many limitations in their current format, including complex access issues, limitations on access permission, thresholds for patient listing, timeliness, interstate communication, and whether the data are presented to the physician automatically or require physician effort to retrieve. Furthermore, the recent addition of prescription drug monitoring programs in several states and continuing changes in the structure or function of existing programs limit the direct application of even recently published research. Legislation designed to improve prescription drug monitoring program operation (eg, NASPER) has stalled or remained underfunded, and concerns over patient confidentiality have often trumped public health concerns. Until an interstate, frequently updated, multiple-drug-schedule, easily accessible, widely used prescription drug monitoring system is implemented, the likelihood of success is limited.[35]

2. In the adult ED patient with acute low back pain, are prescriptions for opioids more effective during the acute phase than other medications?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. (1) For the patient being discharged from the ED with acute low back pain, the emergency physician should ascertain whether nonopioid analgesics and nonpharmacologic therapies will be adequate for initial pain management.

(2) Given a lack of demonstrated evidence of superior efficacy of either opioid or nonopioid analgesics and the individual and community risks associated with opioid use, misuse, and abuse, opioids should be reserved for more severe pain or pain refractory to other analgesics rather than routinely prescribed.

(3) If opioids are indicated, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

Key words/phrases for literature searches: acute low back pain, opioid, and variations and combinations of the key words/phrases.

Acute low back pain is a common ED presenting complaint. Opioids are frequently prescribed, expected, or requested for such presentations.[40,41] In a recent study, it was estimated that low back pain–related disorders result in approximately 2.6 million annual ED visits in the United States. Of medications either administered in the ED or prescribed at discharge, the most frequently used classes were opioids (61.7%; 95% CI 59.2% to 64.2%), nonsteroidal anti-inflammatory drugs (NSAIDs) (49.6%; 95% CI 46.7% to 52.3%), and muscle relaxants (42.8%; 95% CI 40.2% to 45.4%).[41] The opioid analgesics most commonly prescribed for low back pain, hydrocodone and oxycodone products, are also those most prevalent in a Government Accountability Office study of frequently abused drugs.[42] Low back pain as a presenting complaint was also observed in a recent study to be associated with patients at higher risk for opioid abuse.[43] Low back pain, although a common acute presentation, is also often persistent and recurrent, with 33% of patients continuing to complain of moderate-intensity pain and 15% of severe pain at 1 year from initial presentation. Symptoms recur in 50% to 80% of people within the first year.[44] In one study, 19% reported opioid use at a 3-month follow-up.[40] Emergency physicians, as a specialty, are among the higher prescribers of opioid pain relievers for patients aged 10 to 40 years.[20] Recent data show simultaneous increases in overall opioid sales rates and prescription opioid–related deaths and addiction rates and suggest that widespread use of opioids has adverse consequences for patients and communities.[8]

There is a paucity of literature that addresses the use of opioids after ED discharge for acute low back pain versus the use of NSAIDs or the combination of NSAIDs and muscle relaxants. Two meta-analyses published in the last 5 years identified relatively few valid studies that address the use of opioids for low back pain.[45,46]

In a Class III 2008 Cochrane review, NSAIDs were compared with opioids and muscle relaxants for the treatment of low back pain.[46] Three studies were reviewed that compared opioids (2 of which are no longer in use) with NSAIDs for treatment of acute low back pain, including 1 study considered by the Cochrane reviewers to be of higher quality.[47] None of

the individual studies found statistically significant differences in pain relief. A Class III review by McIntosh and Hall[45] of clinical evidence for treatment of acute low back pain similarly found no evidence for superiority of opioids over other therapies and no direct information to demonstrate that opioids were better than no active therapy; however, the authors concluded that the opioid-related studies were too small to detect any clinically important differences.

A Class III Cochrane review of NSAID treatment for acute low back pain evaluated 65 studies (including more than 11,000 patients) of mixed methodological quality that compared various NSAIDs with placebo, other drugs, other therapies, and other NSAIDs.[46] The review authors concluded that NSAIDs are slightly effective for short-term symptomatic relief in patients with acute and chronic low back pain without sciatica (pain and tingling radiating down the leg). In patients with acute sciatica, no difference in effect between NSAIDs and placebo was found but moderate efficacy was found for opioids. The systematic review also reported that NSAIDs are no more effective than other drugs (acetaminophen, opioids, and muscle relaxants). Placebo and acetaminophen had fewer adverse effects than NSAIDs, and NSAIDS had fewer adverse effects than muscle relaxants or opioids.

A 2003 Cochrane review of muscle relaxants for low back pain (Class X because it did not address the role of opioids) found that muscle relaxants were effective for short-term symptomatic relief in patients with acute and chronic low back pain.[48] However, muscle relaxants were associated with a high incidence of adverse effects. This study cited strong evidence in 4 trials involving a total of 294 people that oral nonbenzodiazepine muscle relaxants are more effective than placebo in patients with acute low back pain for short-term pain relief, global efficacy, and improvement of physical outcomes.

Although no superiority has been demonstrated for opioids over other therapies for treatment of acute low back pain, groups have recommended against use of opioids as first-line therapy for treatment of this problem.[49,50] A guideline for diagnosis and treatment of low back pain endorsed by the American College of Physicians and the American Pain Society recommends opioids only for severe, disabling pain that is not controlled or not likely to be controlled with acetaminophen or NSAIDs.[49] In their 2007 guidelines, the American College of Occupational and Environmental Medicine stated that routine use of opioids for acute, subacute, or chronic low back pain is not recommended.[50]

Several observational non-ED studies also suggest caution with regard to opioid prescribing for back pain. Franklin et al,[51] in a retrospective study (Class X because of the non-ED patient population), found that workers with acute low back injury and worker's compensation claims who were treated with prescription opioids within 6 weeks of acute injury for more than 7 days had a significantly higher risk for long-term disability. In a subsequent Class III population-based prospective study of opioid use among injured Washington State workers with low back pain, Franklin et al[52] observed a strong association between the amount of prescribed opioids received early after injury and long-term use of prescription opioids. A retrospective study of 98 workers with acute low back pain and subsequent disability claims by Mahmud et al[53] found that patients whose treatment of new work-related low back pain involved opioid use for 7 days or more were more likely to have long-term disability (relative risk 2.58; 95% CI 1.22 to 5.47); however, the direct applicability of this study (Class X) was limited because most patients were not seen in the ED. In another study that addressed associations of long-term outcome with opioid therapy for nonspecific low back pain, Volinn et al[54] found that the odds of chronic work loss were 11 to 14 times greater for claimants treated with schedule II ("strong") opioids compared with those not treated with opioids at all. They further observed that the strong associations between schedule II use and long-term disability suggest that for most workers, opioid therapy did not arrest the cycle of work loss and pain. Although this study was also graded as Class X because of the population selected and failure to directly address acute or immediate benefit, the results highlight potential problems of treating acute low back pain with opioids.[54] Unfortunately, causation cannot be directly inferred from these studies because of possible confounding.

In summary, although opioids currently offer the most potent form of pain relief, there is essentially no published evidence that the prescription of opioid analgesics for acute low back pain provides benefit over other available medications or vice versa. Several observational studies suggest associations of both prescription of "strong" opioids or longer prescription duration (greater than 7 days) and early opioid prescribing with worsened functional outcomes. Additionally, as noted, the overall increased rate of opioid sales has been strongly associated with adverse effects in the community (overdose, addiction, aberrant use, and death).[8] Therefore, it can be recommended that opioids not be routinely prescribed for acute low back pain but reserved for select ED patients with more severe pain (eg, sciatica) or pain refractory to other drug and treatment modalities. Prescriptions for opioids should always be provided for limited amounts and for a limited period. Extra caution (such as use of prescription drug monitoring programs and seeking of collateral patient information such as patient visit history) may be indicated for patients identified as possibly having an increased risk for substance dependence or abuse.

3. In the adult ED patient for whom opioid prescription is considered appropriate for treatment of new-onset acute pain, are short-acting schedule II opioids more effective than short-acting schedule III opioids?

Recommendations

Level A recommendations. None specified.

Level B recommendations. For the short-term relief of acute musculoskeletal pain, emergency physicians may prescribe short-acting opioids such as oxycodone or hydrocodone

products while considering the benefits and risks for the individual patient.

Level C recommendations. Research evidence to support superior pain relief for short-acting schedule II over schedule III opioids is inadequate.

Key words/phrases for literature searches: opioids, schedule II narcotics, schedule III narcotics, acute pain, acute disease, emergency service, and variations and combinations of the key words/phrases.

Schedules II and III are classifications established by the Comprehensive Drug Abuse Prevention and Control Act of 1970 and determined by the Drug Enforcement Administration. Among other criteria, classification decisions for specific drugs are based on judgments about the potential for their abuse. Schedule II opioids include morphine (eg, MS Contin), oxymorphone (eg, Opana), oxycodone (eg, Roxicodone) and oxycodone combination products (eg, Percocet, Percodan), as well as hydromorphone (eg, Dilaudid) and fentanyl (eg, Duragesic patch, Actiq). Schedule III opioids include combination products, such as hydrocodone (15 mg or less) combined with acetaminophen (eg, Vicodin, Lortab) or ibuprofen (eg, Vicoprofen), as well as some of the codeine combination products.[55] Schedule classifications for opioids may change over time in response to a number of factors, including their perceived risk of abuse. Calls to reclassify hydrocodone combination products (eg, Vicodin, Lortab) from schedule III to schedule II have increased in recent years in response to increasing levels of abuse of these substances.

These recommendations address only new-onset acute pain. Long-acting or extended-released schedule II products such as oxycodone ER (OxyContin), methadone, fentanyl patches, or morphine extended-release (MS Contin) are indicated for chronic pain and should not be used for acute pain.[56] Long-acting and extended-release opioids are for use in opioid-tolerant patients only and are not intended for use as an "as-needed" analgesic. In addition, the immediate-release oral transmucosal formulations of fentanyl are indicated only for breakthrough pain relief in cancer patients who are already taking sustained-release medications and are opioid tolerant. These formulations should not be used for acute new-onset pain.

As part of the decision to prescribe opioids for new onset of acute pain, the care provider can select between short-acting schedule II or III agents (Table). In general, equianalgesic doses of opioids are equally efficacious in relieving pain. Therefore, *a priori*, there is no reason to consider an equianalgesic dose of a short-acting schedule II opioid more effective in providing pain relief than a short-acting schedule III opioid. However, some studies have compared schedule II and III opioids combined with nonopioid analgesics with one another. Two prospective randomized controlled trials have compared the efficacy of short-acting oxycodone, a schedule II drug, with hydrocodone combination products (schedule III) and found them to be equal.[57,58] In 2005, Marco et al[57] compared single doses of oxycodone 5 mg with hydrocodone 5 mg (both combined with 325 mg acetaminophen). In this single-site Class II study of 67 adolescent and adult subjects with acute fractures, no differences in analgesic efficacy were observed at 30 or 60 minutes. Constipation rates were higher for hydrocodone. In a 2002 Class I study, Palangio et al[58] compared oxycodone 5 mg combined with acetaminophen 325 mg (schedule II) with hydrocodone 7.5 mg combined with ibuprofen 200 mg (schedule III) in a prospective, multicenter, multidose, randomized controlled trial of 147 adults with acute or recurrent low back pain. During an 8-day study period, no differences were found in pain relief, doses taken, global evaluations of efficacy, health status, or pain interference with work. As noted above, equianalgesic doses of opioids have similar efficacy in the treatment of acute pain, no matter their Drug Enforcement Administration classification. Given this understanding, it was not unexpected that 2 randomized controlled trials comparing schedule II with III agents found no differences in analgesic efficacy.

Table. Short-acting oral opioid formulations. Dose and interval are recommended starting dosing ranges.

Medication	Initial Dose/Interval	Schedule
Codeine/APAP	30-60 mg* PO Q4-6h PRN	III
Codeine	30-60 mg PO Q4-6h PRN	II
Hydrocodone/APAP	5-15 mg* PO Q4-6h PRN	III
Hydromorphone	2-4 mg PO Q4-6h PRN	II
Morphine	15-30 mg PO Q4-6h PRN	II
Oxycodone/APAP	5-15 mg* PO Q4-6h PRN	II
Oxycodone	5-15 mg PO Q4-6h PRN	II
Oxymorphone	10-20 mg PO Q4-6h PRN	II

APAP, acetaminophen; *h*, hour; *mg*, milligram; *PO*, by mouth; *PRN*, as needed; *Q*, every.
*Listed dose is of the opioid component. Note that the acetaminophen component is now limited to 325 mg or less per pill.

4. In the adult ED patient with an acute exacerbation of noncancer chronic pain, do the benefits of prescribing opioids on discharge from the ED outweigh the potential harms?

Recommendations

Level A recommendations. None specified.

Level B recommendations. None specified.

Level C recommendations. (1) Physicians should avoid the routine prescribing of outpatient opioids for a patient with an acute exacerbation of chronic noncancer pain seen in the ED.

(2) If opioids are prescribed on discharge, the prescription should be for the lowest practical dose for a limited duration (eg, <1 week), and the prescriber should consider the patient's risk for opioid misuse, abuse, or diversion.

(3) The clinician should, if practicable, honor existing patient-physician pain contracts/treatment agreements and

consider past prescription patterns from information sources such as prescription drug monitoring programs.

Key words/phrases for literature searches: opioid, patient discharge, pain, emergency service, and variations and combinations of the key words/phrases with exclusion of cancer.

Patients with chronic noncancer pain, either already taking opioids or not, commonly present to the ED for treatment of acute exacerbation of their pain. There have been no studies that evaluate the efficacy or potential harms of prescribing opioids specifically for these patients on discharge from the ED. Thus, given the paucity of evidence, this critical question cannot be definitively answered. Despite the biological plausibility that treating any acute exacerbation of pain with parenteral or oral opioids should decrease pain intensity, no studies were found to support this hypothesis.

Only 2 randomized controlled trials were identified that addressed the use of short-acting opioids for the treatment of breakthrough pain in patients taking opioids for chronic noncancer pain; transmucosal fentanyl was the intervention for both trials.[59,60] Because of methodological problems, valid estimates for efficacy of the intervention could not be determined, but adverse event rates among both treated populations were common and similar (range 63% to 65%) (Class III).

A systematic review of nonrandomized studies by Devulder et al[61] examined the effect of rescue medications on overall analgesic efficacy and adverse events. They examined 48 studies of patients treated with long-acting opioids for chronic noncancer pain and compared the analgesic efficacy and adverse events among those that allowed short-acting opioid rescue medications for breakthrough pain with those that did not allow such rescue medications. Although graded Class X because of lack of randomized studies and the limitation of harms studied to adverse effects only, no significant difference in the analgesic efficacy between the rescue and nonrescue studies was found. There was also no difference between these 2 groups in the incidence of nausea, constipation, or somnolence. Kalso et al,[62] in a Class III systematic review, found that 80% of patients receiving opioids for chronic noncancer pain had at least 1 adverse event, including nausea (32%), constipation (41%), and somnolence (29%).

Studies of the use of opioids for chronic pain indicate that adverse effects of these drugs are common. Several studies assessed the adverse effects with the use of tramadol with acetaminophen in the treatment of patients with chronic low back pain.[63-65] All of the studies had high dropout rates and reported adverse event rates of nausea, dizziness, and somnolence between 8% and 17%. Allan et al,[66] in a nonblinded Class III study comparing transdermal fentanyl versus oral morphine, found a constipation rate of 48% in the morphine-treated patients compared with a rate of 31% in the fentanyl-treated patients. Constipation was also the major adverse effect in a Class III study by Hale et al[67] comparing oxymorphone extended release, oxycodone controlled release, and placebo. Furlan et al,[68] in a Class II meta-analysis of 41 randomized studies of opioid use in the treatment of chronic noncancer pain, found that constipation and nausea were the only significant adverse effects. Holmes et al,[69] however, in a Class III study, assessed an opioid screening instrument, the Pain Medication Questionnaire, in chronic noncancer pain patients and found that those patients with a higher score were more likely to have a substance abuse problem or request early refills of their opioid prescription. In a retrospective Class III cohort study, Jensen et al[70] conducted a 10-year follow-up on patients discharged from a pain clinic and found that chronic opioid treatment may put patients at risk for chronic depression. Unfortunately, near-universal shortcomings of these studies include the exclusion of patients with a history of substance abuse, other significant medical problems, or psychiatric disease, and lack of follow-up to detect long-term effects such as aberrant drug-related behaviors, addiction, or overdose. Therefore, studies such as these can be confounded, making the ability to draw conclusions about causality difficult.

Questions of opioid effectiveness involve the assessment of reduction in pain and improvement in function for the patient, potential patient adverse effects, and the potential harm to the community (eg, opioid diversion and abuse) from the drugs prescribed. Hall et al,[32] in a Class III retrospective analysis of 295 unintentional prescription overdose deaths, found that 93% were due to opioids, 63% represented pharmaceutical drug diversion, 21% of the patients had engaged in doctor shopping, and 95% of the patients had a history of substance abuse. Although no studies have addressed the effects related to dose and duration of prescribed opioids in this specific patient population, 2 general studies have shown a correlation between high daily opioid dose and overdose death.[71,72]

Patient assessment tools such as the Screener and Opioid Assessment for Patients with Pain (SOAPP), Opioid Risk Tool (ORT), Diagnosis, Intractability, Risk, and Efficacy (DIRE), and others to assess the risk of prescription opioid misuse and abuse have yet to be fully validated in the ED in terms of sensitivity, specificity, and utility.[73] Many, however, believe that use of these tools, as imperfect as they are, represents a beginning in the ability to better quantify potential risks related to opioid prescribing for outpatients.

Many patients undergoing treatment for chronic noncancer pain have pain contracts/treatment agreements with their primary care providers. These should be honored if possible in treating any acute exacerbation of their pain.[74,75] As discussed in critical question 1, use of prescription drug monitoring programs may also assist the emergency physician in making appropriate clinical decisions about the use of outpatient opioid prescriptions for these patients.

FUTURE RESEARCH

Provider pain management practices related to opioids are highly variable. In part, this variability reflects the lack of evidence to guide many of these therapeutic decisions.[76]

Although there is high-quality research assessing the treatment of acute pain with opioid analgesics during the ED encounter, there is a paucity of studies assessing the benefits of prescribing opioids for discharged ED patients with acute pain and chronic noncancer pain, especially in comparison to other analgesic drugs and pain treatment modalities. Therefore, clinical decisions and practice recommendations must rely on practice experience and consensus rather than research evidence.

ED populations typically include patients with unmet substance abuse treatment needs and psychiatric comorbidities, and many of these patients present with acute pain.[77] In almost all pain studies, these patients are excluded, leaving clinicians with little evidence-based guidance for their pain management. There are also significant research gaps in clearly understanding the long-term harms of opioids, including drug abuse and addiction, aberrant drug-related behaviors, and diversion. As mentioned above, further research and validation is needed on ED patient abuse and addiction-related assessment tools. Additional studies to characterize individual patient-related risks for opioid abuse are also greatly needed.

Although there has been recent widespread adoption of prescription monitoring programs, there remains a dearth of evidence about the effectiveness of these programs in altering physician prescribing patterns or diminishing the adverse effects of opioids in the community. For research in this area to advance, further refinement of prescribing metrics (quantity, duration, and frequency) and public health measures is required. Comparison of the functionality and effectiveness of the various state prescription drug monitoring program models may provide additional insight into developing best practices that could be adopted nationally, including the sharing of data between states. Important distinctions among the states, such as immediate online prescriber access to the prescription monitoring program, should be examined for their relative contributions. However, this type of analysis must consider baseline variability among states for prescription opioid misuse (versus heroin or methadone, for example) and other state-specific issues (such as prescription-writing regulations).

With respect to the treatment of acute low back pain in the ED, there is a need for quality studies comparing the effectiveness of the more commonly prescribed opioids (hydrocodone and oxycodone congeners and other semisynthetic opioids) and nonopioid therapies, with attention to confounding variables such as depression or other psychopathology. Further study is needed to validate or refute the reported associations of early or potent opioid prescribing with increased rates of disability.[51] Given the frequency of acute low back pain as an ED presentation and its association with perceived drug-seeking behavior,[78] and with apparent higher risk for misuse,[43] more attention needs to be paid to discriminatory historical or physical factors that may be predictive of drug-seeking or abuse to allow better matching of treatment modality for individual patients.

Future studies should include additional multiple-dose analgesic protocols to better understand the postdischarge experience of patients with acute pain and what would constitute optimum patient follow-up provisions. Investigators should include clinically relevant study periods (days to weeks), which vary by diagnosis; thus, trials should be stratified by specific presenting complaints, pain site, discharge diagnosis, and classification of pain type, ie, nociceptive, neuropathic, and visceral pain. In addition to measuring pain and adverse effects, functional outcomes, such as return to work or pain-related quality-of-life measures, should be included.[79] Straightforward observational studies are needed to determine the relative duration of different acute pain presentations, thus informing decisions to prescribe an appropriate number of opioid doses per prescription. Current prescribing practice often involves a "one size fits all" pattern that is encouraged by electronic prescribing software. Prescribing practices that ignore variable durations of acute pain syndromes will predictably result in undertreatment for some patients and overtreatment for others. The latter increases the likelihood that unused opioids will be diverted into nonmedical use in communities at risk.

Additional research should include evaluation of the appropriateness of patient satisfaction as a quality metric as related to patient expectations of opioids and the prevalence of providers reporting pressure through low patient satisfaction scores or administrative complaints to provide opioids when the providers believe these drugs are not medically indicated. This issue may gain increased importance with the institution of the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, which may tie some reimbursement to patient satisfaction scores. Additional work is needed to investigate what constitutes an appropriate educational curriculum in both medical school and residency for physician education concerning safe, appropriate, and judicious use of opioids.

Research addressing the treatment of chronic noncancer pain would be enhanced by the use of accepted case definitions, standardized definitions of adverse events, and validated pain measurements. Case definitions should use a similar definition of chronic, nociceptive (musculoskeletal or visceral) versus neuropathic pain, or pain by disease type (headache, low back pain, etc). Research reporting also requires more refined descriptions of opioid potency and routes of administration.

Although opioids represent a treatment modality that has long been used in patient care, it is clear by the paucity of definitive answers to the questions posed in this document and the significant number of future research issues that much work remains to be done to clarify the best use of opioids in the care of patients.

Relevant industry relationships/potential conflicts of interest: *Dr. Sporer is a consultant to Alcomed, a pharmaceutical company. Dr. Todd serves on the Professional Advisory Board of the*

American Chronic Pain Association and has previously been a consultant to the pharmaceutical industry.

Relevant industry relationships are those relationships with companies associated with products or services that significantly impact the specific aspect of disease addressed in the critical questions.

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Evidentiary Table.

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Hall et al[32]	2008	Retrospective, population based, observational study	Comparison of West Virginia medical examiner data with patient data from the state prescription monitoring program and opioid abuse treatment program records	Behaviors of those who died of a pharmaceutical overdose; diversion; doctor shopping; substance abuse history; type of drug	295 deaths; 67% male; 92% aged 18-54 y; 63% pharmaceutical diversion; 21% doctor shopping; 95% substance abuse history; 93% opioids	Actual source of opioids involved in death not known; single state; not validated definitions; retrospective	III
Pradel et al[33]	2009	Database	Review of prescription drug database (not prescription monitoring program) to identify amount of buprenorphine delivered, prescribed, and obtained by doctor shopping; extension of 2004 study, used multiple time period comparisons; evaluation of trends in doctor shopping over time	Determined prescribed quantity of buprenorphine, delivered quantity, and the doctor shopping quantity	Although there was some variation over time, the trend for prescribing stayed constant overall and doctor shopping decreased after 2004, associated with the change in the mechanism by which prescriptions are monitored	Reasons for multiple providers or overlapping or interrupted prescriptions unclear; did not examine risk factors for abuse	III
Baehren et al[39]	2010	Prospective, uncontrolled	Physicians prescribing analgesics for nonacute pain were asked details about the patient's prescription and then again after being informed of the prescription monitoring program search result for that patient	Change in prescription for the specific patient	179 enrolled; management changed in 41%; 61% received fewer opioids, 39% received more	Convenience sample; majority of data from 4 prescribers	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
McIntosh and Hall[45]	2011	Review of randomized controlled trials, systematic reviews, and observational studies found searching MEDLINE 1966-12/2009, EMBASE 1980 to 12/2009, and Cochrane database up to 12/2009; 49 studies met inclusion criteria	Multiple treatment modalities for acute low back pain, including oral drugs, local injections, and nondrug treatment	Clinical improvement of low back pain	NSAIDs shown to effectively improve symptoms compared with placebo, but use associated with gastrointestinal adverse effects; muscle relaxants may reduce pain and improve clinical assessment but are associated with adverse effects including drowsiness, dizziness, nausea	The studies examining the effects of analgesics such as acetaminophen or opioids were generally too small to detect any clinically important differences	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Roelofs et al[46]	2008	Cochrane review: search of MEDLINE, EMBASE, and Cochrane central registry of controlled trials up to 7/2007; 65 trials qualified for review	NSAIDs and COX-2 inhibitors administered to treat low back pain	Clinical improvement of low back pain	Review authors found NSAIDs are not more effective than other drugs (acetaminophen, opioids, and muscle relaxants); placebo and acetaminophen had fewer adverse effects than NSAIDs, although the latter had fewer adverse effects than muscle relaxants and opioids; the new COX-2 NSAIDs do not seem to be more effective than traditional NSAIDs but are associated with fewer adverse effects, particularly stomach ulcers, although other literature has shown that some COX-2 NSAIDs are associated with increased cardiovascular risk	7 studies reported on acute low back pain, 5 of which, including 1 higher-quality study, did not find any statistical differences between NSAIDs and opioids or muscle relaxants; there is moderate evidence that NSAIDs are not more effective than other drugs for acute low back pain	III
Videman et al[47]	1984	Double-blind parallel study	70 patients; comparative trial of meptazinol vs diflunisal for up to 3 wk	Patients examined at 1-wk intervals for task capability, range of motion, and subjective pain self-assessment	Both regimens produced marked improvement in most parameters, similar adverse effect profiles	No mention of patient randomization	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Franklin et al[52]	2009	Prospective cohort; Washington State workers with back injury; n=1,883	Prospective cohort of workers with back injuries interviewed at 18 days (medial) and 1 y after injury; pharmacy data obtained from computerized records; analyzed for demographic and covariates	Injury severity, pain, function, and quantities of opioids used	For long-term users total number of medications increased significantly (*P*=.01) from the first to the fourth quarter; after adjustment for baseline pain, function, and injury severity, the strongest predictor of longer-term opioid prescriptions was total number of medications in the first quarter; receipt of ≥10 mg/day medicine in first quarter more than tripled the odds of receiving opioids long term, and receipt of ≥40 mg/day medicine in first quarter had 6-fold odds of receiving long-term opioids; amount of prescribed opioid received early after injury predicts long-term use	Addressed progression to long-term use according to initial treatment and continuation of same	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Marco et al[57]	2005	Single site; prospective; double blind; randomized controlled trial; concealment method described; ED patients with fractures	Single dose of oxycodone 5 mg/acetaminophen 325 mg schedule II vs hydrocodone 5 mg/acetaminophen 325 mg schedule III	Primary outcomes were numeric pain scores (0-10) at 30 and 60 min	88 subjects evaluated, 73 enrolled, 67 completed ED study period, 35 to oxycodone, 32 to hydrocodone; no baseline differences, no differences in outcomes at 30 min: -0.6 (95% CI -1.8 to 0.5); 60 min -0.5 (95% CI -2.0 to 1.0); adverse effects higher for constipation with hydrocodone (21% vs 0%; (95% CI 3% to 39%)	Small sample size powered to address acute pain during the first 30 to 60 min in the ED; study also assessed adverse effects during a longer period of time; excluded history of alcohol or opioid or other substance abuse; limited time period	II
Palangio et al[58]	2002	Prospective multicenter (18 sites), randomized controlled trial, sequential assignment by computer-generated randomization schedule	Hydrocodone 7.5 mg/ibuprofen 200 mg (schedule III) vs oxycodone 5 mg/acetaminophen 325 mg (schedule II)	Primary outcome was mean daily pain relief score at endpoint (day 8 or day of discontinuation), study period up to 8 days, intention-to-treat analysis	147 subjects enrolled (75 hydrocodone/ibuprofen, 72 oxycodone/acetaminophen), adults with acute or recurrent low back pain requiring opioids, 85% completed study in both groups, mean days to endpoint 6.5 vs 6.9 days, no baseline differences, no differences in pain relief, number of pills, global evaluations, SF-36, pain interference with work, adverse events	Excluded drug or alcohol abuse, concealment methods described	I

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Portenoy et al[59]	2007	Randomized, double blind, placebo controlled	Fentanyl buccal tablet for breakthrough pain in chronic low back pain patients	Pain before treatment and for 2 h after treatment	Fentanyl buccal tablet effective for breakthrough pain in chronic low back pain; adverse effects in 65%; 34% during double-blind phase	Severe selection bias in initial screening; industry sponsored	III for adverse effects
Simpson et al[60]	2007	Randomized, double blind, placebo controlled	Fentanyl buccal tablet for breakthrough pain in chronic pain patients	Pain before treatment and for 2 h after treatment	Fentanyl buccal tablet effective for breakthrough pain; adverse effects in 63%; 22% dropout	Severe selection bias in initial screening; industry sponsored	III for adverse effects
Kalso et al[62]	2004	Systematic review	Randomized trials in chronic noncancer pain comparing potent opioids with placebo	Pain intensity outcomes	15 randomized trials were included; 11 studies compared oral opioids for 4 wk; pain intensity decrease was 30% compared with placebo; only 44% were taking opioids by mo 7 to 24; 80% of patients experienced at least 1 adverse event: constipation (41%), nausea (32%), somnolence (29%)	4-wk duration on average; differing causes of pain; open label in many of the studies; limited power calculations; concealment not maintained in some studies	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Peloso et al[63]	2004	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Pain VAS; pain relief rating scale; Short Form Magill Pain Questionnaire SF-36; 3-mo trial	336 patients randomized; improved mean final pain scores (47 vs 63; *P*<.001), adverse effects: nausea 12%, dizziness 11%, constipation 10%, somnolence 9%	35%-40% dropout rate; pharmaceutical-sponsored research	II
Ruoff et al[64]	2003	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Pain VAS; pain relief rating scale; Short Form Magill Pain Questionnaire SF-36; Roland Disability Questionnaire	318 patients randomized; tramadol improved pain VAS (*P*=.15) and final Pain Relief Rating Scale (*P*<.001); adverse effects: nausea 13%, somnolence 12%, constipation 11%, dizziness 8%	153 of 318 dropped out; pharmaceutical-sponsored research	II

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Schnitzer et al[65]	2000	Prospective, randomized, blinded study	Tramadol/acetaminophen vs placebo; patients with chronic low back pain requiring daily medication for at least 3 mo	Time to discontinuation because of inadequate pain relief; Short Form Magill Pain Questionnaire; Roland Disability Questionnaire	380 patients in open-label phase; 254 entered into blinded phase; time to therapeutic failure was greater in the placebo group (P<.0001); other parameters showed improvement; adverse effects: nausea 17%, dizziness 15%, somnolence 14%, headache 12%	The dropout rate was the primary outcome; pharmaceutical-sponsored research	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Allan et al[66]	2005	Nonblinded, randomized comparison of 2 treatments in patients with chronic low back pain	Transdermal fentanyl vs sustained-release oral morphine; 680 total patients; dose titrated to effect; followed for 13 mo; outpatient setting; not applicable to ED	Pain relief (VAS scale); bowel function (validated questionnaire); quality of life (SF-36); disease, progression (3-point scale), days not working, adverse events all during 13 mo	Comparable pain relief, noninferior, VAS score for fentanyl (56) vs morphine (55); fentanyl had lower constipation rate: fentanyl (31%) vs morphine (48%)	Both groups had half of the participants drop out; vague definition of chronic low back pain; not blinded	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Hale et al[67]	2005	Randomized trial, blinded	Comparison of oxymorphone extended-release vs oxycodone controlled release vs placebo in patients with chronic low back pain who were taking a stable dose of opioids	VAS of pain score 4 h after morning dose; use of breakthrough pain medications; categorical pain intensity, pain intensity, global assessment, adverse events	Opioids were superior to placebo at reducing VAS for pain compared with placebo, oxymorphone (-27), oxycodone (-36); oxymorphone was comparable to oxycodone in pain efficacy and adverse effects; sedation and constipation were more common with opioids (35% vs 29% vs 11%)	Only 22 of 75 patients in the placebo group completed the study; included only patients receiving stable opioids and then randomized to opioids or placebo; baseline characteristics between groups not specified; pharmaceutical-sponsored research	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/ Comments	Class
Furlan et al[68]	2006	Meta-analysis	Study included randomized trials of any opioid for chronic noncancer pain (defined as pain for longer than 6 mo) vs placebo or some other nonopioid treatment	41 randomized studies with 6,019 patients evaluated for effectiveness and adverse effects; most (80%) had nociceptive pain	81% of the studies were believed to be of high quality; dropout rates were 33% in the opioid group and 38% in the placebo group; opioids improved pain and functional outcomes compared with placebo in nociceptive and neuropathic pain; strong opioids were superior to naproxen and nortriptyline for pain relief; weak opioids were not superior; constipation and nausea were the only significant adverse effects observed	Average duration of the study was 5 wk (range 1-16 wk); adequate random patient assignment in only 17 of 41 trials; 90% of trials were pharmaceutical-sponsored research	II

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Holmes et al[69]	2006	Prospective cohort	Convenience sample of patients who were new at a pain clinic; Pain Medication Questionnaire was administered; patients were treated with interdisciplinary treatment and/or medications alone, depending on the results of an initial evaluation	Beck Depression Inventory; Confidential Pain questionnaire; SF-36; Million VAS; Oswestry Disability Questionnaire; Physician Risk Assessment; VAS	271 patients, divided into low-, medium-, and high-score pain medication questionnaire; high-score group was more likely to have a known substance use problem (OR 2.6), request early refills (OR 3.2), or drop out of treatment (OR 2.3)	Only 26% of patients completed the full treatment program; heterogeneous types of pain diagnosis; differing treatment plans	III

Evidentiary Table (continued).

Study	Year	Design	Intervention(s)/Test(s)/Modality	Outcome Measure/Criterion Standard	Results	Limitations/Comments	Class
Jensen et al[70]	2006	Retrospective review of cohort	Patients who were treated and discharged from a pain clinic 10 y ago; medical records were abstracted and questionnaires were sent to willing participants	Demographics, health care utilization, SF-36; Hospital Anxiety and Depression Scale; Coping Strategy Questionnaire; CAGE* test	160 patients; 60% of patients were still taking long-acting opioids; dose escalation was unusual; chronic users had lower health-related quality of life and higher occurrence of depression	160 of 279 possible patients participated; no control group	III

COX-2, cyclooxygenase-2; *ED*, emergency department; *h*, hour; *mg*, milligram; *min*, minute; *mo*, month; *NSAID*, nonsteroidal anti-inflammatory drug; *OR*, odds ratio; *SF-36*, Short-Form Health Survey; *VAS*, visual analog scale; *vs*, versus; *wk*, week; *y*, year.

*CAGE (Cutting down, Annoyed, Guilty, Eye-opener) test is a method of screening for alcoholism.

Appendix A. Literature classification schema.*

Design/Class	Therapy†	Diagnosis‡	Prognosis§
1	Randomized, controlled trial or meta-analysis of randomized trials	Prospective cohort using a criterion standard or meta-analysis of prospective studies	Population prospective cohort or meta-analysis of prospective studies
2	Nonrandomized trial	Retrospective observational	Retrospective cohort Case control
3	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)	Case series Case report Other (eg, consensus, review)

*Some designs (eg, surveys) will not fit this schema and should be assessed individually.
†Objective is to measure therapeutic efficacy comparing interventions.
‡Objective is to determine the sensitivity and specificity of diagnostic tests.
§Objective is to predict outcome, including mortality and morbidity.

Appendix B. Approach to downgrading strength of evidence.

	Design/Class		
Downgrading	**1**	**2**	**3**
None	I	II	III
1 level	II	III	X
2 levels	III	X	X
Fatally flawed	X	X	X

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 15, 2014
ATTENTION: Members, Medical Board of California
SUBJECT: Citation Regulations
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

This report is intended to provide the Members with an update on regulatory hearing and the status of the amendments Title 16 California Code of Regulations (CCR) section 1364.10, 1364.12, 1364.13, and 1364.14.

UPDATE:

After the 45-day public comment period, a regulatory hearing was held on September 24, 2014, and October 14, 2014, to hear public comment on the amendments to Title 16 California Code of Regulations (CCR) sections 1364.10, 1364.12, 1364.13, and 1364.14.

No public comment was provided during the 45-day public comment period or at either hearing. Therefore, the Board will finalize the rulemaking package and submit it to the Department of Consumer Affairs (DCA) for approval. Once approved by DCA, it will be submitted to the Office of Administrative Law. The Board hopes to submit the package to DCA by the end of October. The Board will be requesting these regulations go into effect immediately upon approval by the Office of Administrative Law and filing with the Secretary of State.

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, the Board needed to amend these regulations to allow the Executive Director or his or her designee to issue citations and perform other functions associated with the citation process.

Medical Board of California

FICTITIOUS NAME PERMITS (FNP)

FNP Q & A

How long has there been a requirement for a FNP?

- Almost 35 years, since January 1, 1980.

When do I need a fictitious name permit?

- If you are a licensed physician and surgeon, or podiatrist, and want to practice under a name other than the name on your license.
- If you have a professional corporation in a name other than your own.
- If you have a partnership or group practice or are using a name other than the name on your license, in any public communication, advertisement, sign or announcement.

FNP Q & A

Is the FNP the same as having the name registered as a trademarked name?

- No.

I have a city and/or county issued fictitious business name. Therefore, I do not need an FNP from the Board, correct?

- No. A city/county fictitious business name is not the same as the Board's FNP.

FNP Q & A

Why do physicians get into trouble when they do not have an FNP?

- Some physicians incorrectly believe that having a city/county fictitious business name is all that they need to practice under a name other than their own.

- It is unprofessional conduct to practice without an FNP when one is required.

FNP Q & A

Does each physician need a separate FNP?

- No. However, each physician owner will need to be listed on the FNP application. If the application is approved, only one FNP is issued.

Do I have to have an FNP if I am just working at a facility and I am not the owner?

- No. However, there are restrictions in statute as to who can employee a physician.

FNP Q & A

I am a licensed physician. Do I need an FNP if I am working for a partnership, group or professional corporation?

- No. Physicians who are employed by a partnership, a group, or a professional corporation that holds an FNP that is in a renewed and current status do not need an FNP.

EXAMPLE

Jane Doe, M.D.

Does not need an FNP to practice under her own name

Jane Doe, M.D., Inc.

Does not need an FNP to practice under her own name with Inc. or Inc., A Professional Corporation added after her name

EXAMPLE

My name is John Smith, M.D., I am a licensed Physician and Surgeon in California, but I want to practice under the name "Sunrise Medical Group"

Needs an FNP to practice under "Sunrise Medical Group"

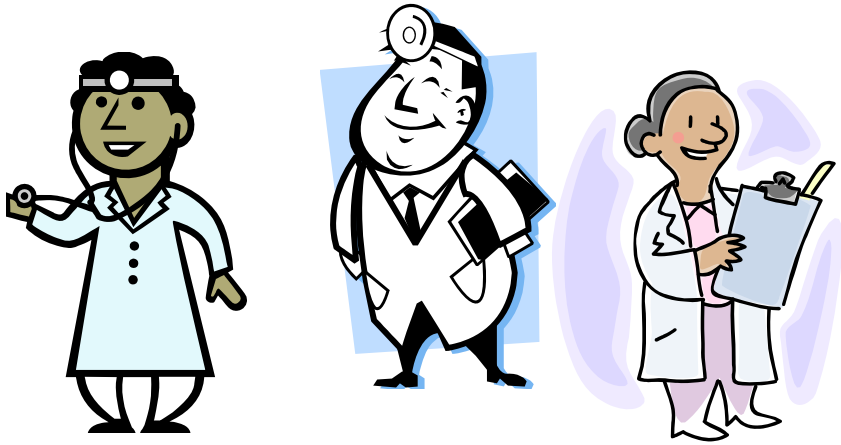
EXAMPLE

John Doe, M.D., Inc., A Professional Corp.
Specializing in Family Medicine

Does not need an FNP to practice under his own name with Inc. or Inc. A Professional Corporation added after his name

EXAMPLE

X, Y, & Z, Physician Partnership



These licensed physicians need an FNP to practice under "X, Y, & Z, Physician Partnership"

Are there laws or regulations that I should know about? Yes!!!

- Business and Professions Code (BPC)
- Corporation Code (CORP)
- Insurance Code (INS)
- Penal Code (PEN)
- Welfare and Institution Code (WIC)
- California Code of Regulations (CCR)

Common Sections of statutes and regulations relating to FNPs:

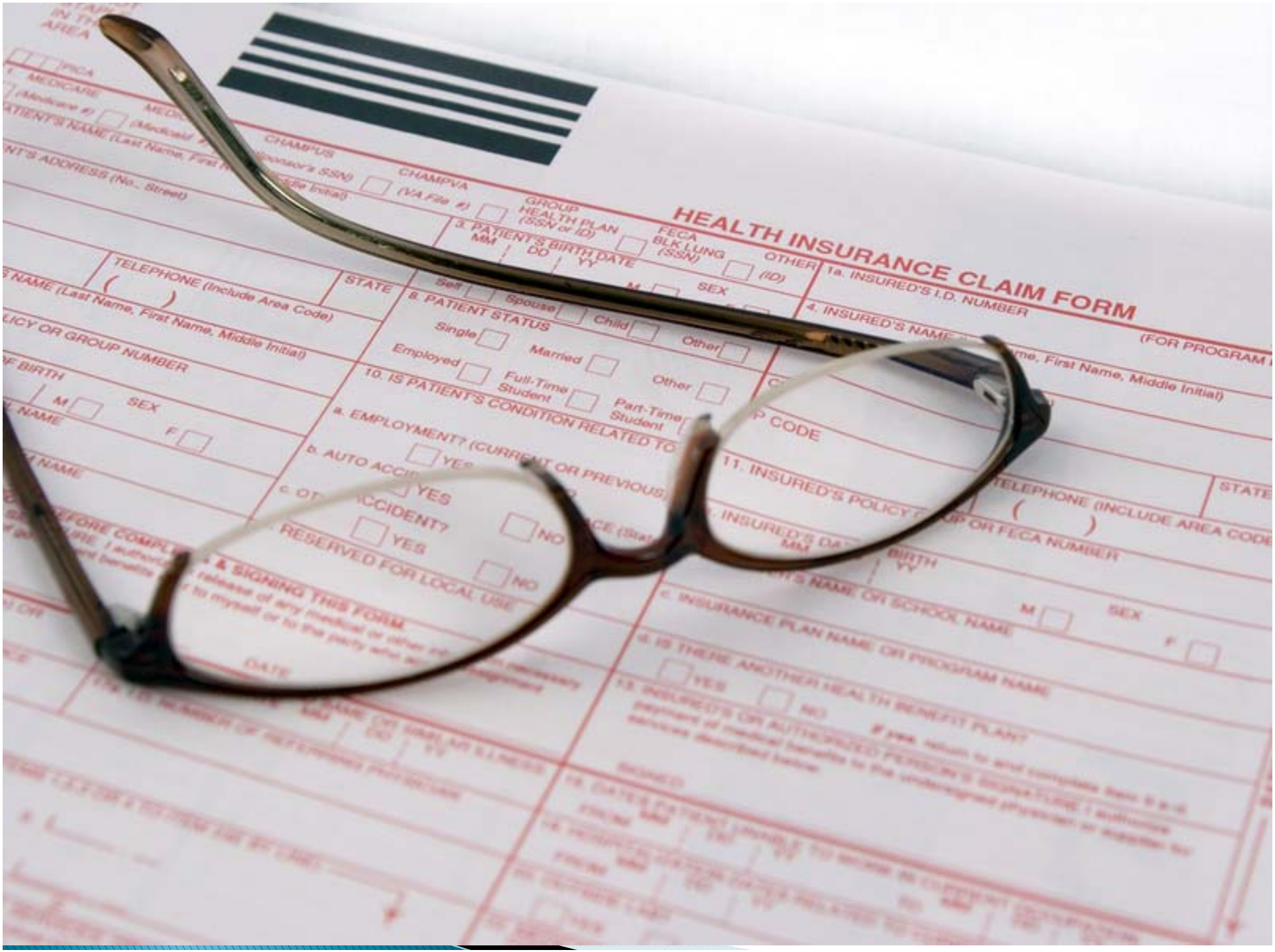
- BPC Sections: 2285– 2286, 2415 – 2417.5
- CORP Sections: 13400 – 13410
- INS Section: 1871.4
- PEN Sections: 549 – 550
- WIC Sections: 14107 or 14107.2
- CCR Sections: 1350 – 1350.
- Note: This is not an all inclusive list.

Do I need a lawyer to help me with FNP issues?

You decide! The Board cannot make that decision for you.

What happens if I do not have a renewed and current FNP when I am required to have a valid FNP?

At a minimum you would be in violation of BPC Section 2285 and it is considered unprofessional conduct!


HEALTH INSURANCE CLAIM FORM
1a. INSURED'S I.D. NUMBER
(FOR PROGRAM
4. INSURED'S NAME
TELEPHONE (Include Area Code)
STATE
8. PATIENT STATUS
Single
Married
Other
Employed
Full-Time Student
Part-Time Student
10. IS PATIENT'S CONDITION RELATED TO
11. INSURED'S POLICY
TELEPHONE (INCLUDE AREA CODE
RESERVED FOR LOCAL USE
SIGNING THIS FORM
c. INSURANCE PLAN NAME OR PROGRAM NAME
14. IS THERE ANOTHER HEALTH BENEFIT PLAN?

Insurance companies are not required to reimburse for services rendered if you do not have an FNP when one is required.

FNP REQUIREMENTS

The Licensing Program will issue an FNP if the following is satisfied:

- The applicant or shareholders of the professional corporation hold valid and current licenses as physicians and surgeons, or doctors of podiatric medicine.
- The professional practice of the applicant(s) is wholly owned and entirely controlled by the applicant(s) or meets the requirements pursuant to Corporations Code Sections 13401 and 13401.5.
- The name under which the applicant(s) proposes to practice is not deceptive, misleading, or confusing.

FNP REQUIREMENTS CONT'D

- Each permit shall be accompanied by a notice that shall be displayed in a location readily visible to patients and staff.
- The notice shall be displayed at each place of business identified in the permit.
- The Licensing Program may revoke or suspend any permit issued if it finds that the holder(s) of the permit is not in compliance with the provisions of the law and regulations.
- An FNP issued to any licensee in a sole practice becomes invalid in the event the licensee's certificate to practice medicine or podiatric medicine is revoked.

PROGRAM INFORMATION

- The initial application and permit fee is $50.
- An FNP has a 2-year renewal cycle.
- The renewal fee is $40.

FNP Statistics

FY 13/14 FNPs Issued:

- Physicians/Surgeons – 1,104
- Podiatric – 26

FY 13/14 FNPs Renewed:

- Physicians/Surgeons – 64,714

Agenda Item 19

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 7, 2014
ATTENTION:	Members, Medical Board of California
SUBJECT:	Continuing Medical Education Requirements
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:
After review and consideration of the attached proposed amendments to the continuing medical education (CME) regulatory language, make a motion to direct staff to notice the amended regulatory language and hold a hearing to amend Title 16, Division 13, California Code of Regulations (CCR), sections 1337 and 1338. The amendments would allow CME that is approved for specialty board maintenance of certification (MOC) as meeting the Medical Board of California's (Board) CME requirements for licensed physicians and surgeons.

BACKGROUND AND ANALYSIS:
California Business and Professions Code (B&P) Section 2190 requires licensed physicians and surgeons to complete CME in order to ensure continuing competence. In addition B&P Section 2190 requires the board to adopt standards for CME.

CCR section 1336(d) requires licensed physicians and surgeons to complete a minimum of 50 hours of approved CME during the two-year period immediately preceding the expiration date of the license to be eligible for renewal of their license.

CCR section 1337 identifies the requirements for approved CME programs. Currently physicians who pass a certifying or recertifying examination administered by an approved specialty board shall be granted 100 hours of CME credit. However, most approved specialty boards are requiring physicians to participate in a required MOC process to maintain specialty board certification. Some of the required CME in a MOC may not meet the current definition of the Board's approved CME. Therefore, CCR section 1337 needs to be amended to include approved specialty board CME used for MOC to meet the Board's CME requirements.

CCR section 1338 states the Board may obtain CME records directly from the approved CME sponsor for physicians who have been selected for a CME compliance audit. Therefore, CCR section 1338 needs to be amended to include the new CCR section 1337, subsection (a)(g).

The Board will need to authorize staff to proceed with preparing the necessary regulatory documents to amend CCR sections 1337 and 1338, and hold a hearing. The proposed language to amend CCR sections 1337 and 1338 has been included for the Board's review. The suggested amended language is identified with underline or ~~strikethrough~~ text.

California Code of Regulations
Title 16, Division 13, Chapter 1, Article 11

Section 1337. Approved Continuing Education Programs.
(a) The following programs are approved by the division for continuing education credit:
(1) Programs which qualify for Category I credit from the California Medical Association or the American Medical Association;
(2) Programs which qualify for prescribed credit from the American Academy of Family Physicians;
(3) Programs offered by other organizations and institutions acceptable to the division.
(b) Only those courses and other educational activities that meet the requirements of Section 2190.1 of the code which are offered by these organizations shall be acceptable for credit under this section.
(c) A maximum of one-third of the required hours of continuing education may be satisfied by teaching or otherwise presenting a course or program approved under this section.
(d) Any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board shall be granted credit for four (4) consecutive years (100 hours) of continuing education credit for relicensure purposes. Such credit may be applied retroactively or prospectively.
(e) A maximum of sixty (60) hours of continuing education shall be granted to a physician for receiving the Physician's Recognition Award.
(f) A maximum of six (6) hours of continuing education shall be granted for each month that a physician is engaged in an approved postgraduate residency training program or approved clinical fellowship program accredited by the Accreditation Council for Graduate Medical Education (ACGME) for relicensure purposes.
(g) Continuing education that is required for maintenance of certification by American Board of Medical Specialties affiliate boards or other specialty boards approved by the Medical Board of California.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2190, Business and Professions Code.
HISTORY
1. Amendment filed 8-23-77; effective thirtieth day thereafter (Register 77, No. 35).
2. Amendment filed 5-29-81; effective thirtieth day thereafter (Register 81, No. 22).
3. New subsection (b) and subsection relettering filed 8-26-93; operative 9-27-93 (Register 93, No. 35).
4. Change without regulatory effect amending subsection (a)(2) filed 6-18-97 pursuant to section 100, title 1, California Code of Regulations (Register 97, No. 25).
5. New subsections (e)-(f) filed 9-14-98; operative 9-14-98 pursuant to Government Code section 11343.4(d) (Register 98, No. 38).
This database is current through 9/26/14 Register 2014, No. 39
16 CCR § 1337, 16 CA ADC § 1337

California Code of Regulations
Title 16, Division 13, Chapter 1, Article 11

Section1338. Audit and Sanctions for Noncompliance.
(a) The Board shall audit during each year a random sample of physicians who have reported compliance with the continuing education requirement. No physician shall be subject to audit more than once every four (4) years. Those physicians selected for audit shall be required to document their compliance with the continuing education requirements of this article on a form provided by the Board.
(b) Any physician who is found not to have completed the required number of hours of approved continuing education will be required to make up any deficiency during the next biennial renewal period. Such physician shall document to the Board the completion of any deficient hours identified by audit. Any physician who fails to make up the deficient hours during the following renewal period shall be ineligible for renewal of his or her license to practice medicine until such time as the deficient hours of continuing education are documented to the Board.
(c) It shall constitute unprofessional conduct for any physician to misrepresent his or her compliance with the provisions of this article.
(d) Any physician selected for audit who has been certified as complying with the continuing education requirements of this article by those organizations listed in Section 1337, subsections (a)(1), ~~and~~ (a)(2)~~,~~ and (a)(g), will not be required to submit documentation or records of continuing education coursework received, but the Board may obtain such records directly from the certifying organizations.
(e) The Board requires that each physician retain records for a minimum of four years of all continuing education programs attended which indicate the title of the course or program attended, dates of attendance, the length of the course or program, the sponsoring organization and the accrediting organization, if any, which may be needed in the event of an audit by the Board.
Note: Authority cited: Section 2018, Business and Professions Code. Reference: Section 2190, Business and Professions Code.
HISTORY
1. Amendment filed 9-1-77; effective thirtieth day thereafter (Register 77, No. 36).
2. Repealer and new section filed 11-17-78; effective thirtieth day thereafter (Register 78, No. 46).
3. Amendment of NOTE filed 8-5-81; effective thirtieth day thereafter (Register 81, No. 32).
4. Amendment of subsections (b) and (e) filed 9-21-83; effective thirtieth day thereafter (Register 83, No. 39).
5. Amendment filed 12-3-2009; operative 1-2-2010 (Register 2009, No. 49).
This database is current through 9/26/14 Register 2014, No. 39
16 CCR § 1338, 16 CA ADC § 1338

Agenda Item 20

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	October 7, 2014
ATTENTION:	Members, Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee Recommendations
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve the recommendations of the Special Faculty Permit Review Committee (SFPRC) for appointments for Maurice M. Ohayon, M.D., D.SC., Ph.D.; Miguel Del Campo Casanelles, M.D., Ph.D.; and Anthony Thomas Moore, BM Bch; pursuant to Section 2168.1 of the California Business and Professions Code (B&P).

BACKGROUND AND ANALYSIS:

The Medical Board of California (Board) is authorized to issue a Special Faculty Permit (SFP) to a person who is academically eminent and meets all of the other requirements pursuant to Section 2168.1 of the B&P.

An individual who holds a valid SFP is authorized to practice medicine only within the medical school itself and any affiliated institutions in which the SFP holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility.

The SFPRC is comprised of two Board Members, one who is a physician and one who is a public member, and one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to Section 2168.1 of the B&P.

At the SFPRC's August 14, 2014 meeting, the SFPRC reviewed the qualifications of three applicants: one applicant from Stanford University (Stanford), one applicant from the University of California San Diego (UCSD), and one applicant from the University of California San Francisco (UCSF).

Maurice M. Ohayon, M.D., D.Sc., Ph.D., Stanford:
Laurence Katznelson, M.D., Professor of Neurosurgery and Medicine, Associate Dean of Graduate Medical Education, presented Stanford's request for Maurice M. Ohayon, M.D., D.Sc., Ph.D., to receive a SFP and provided the SFPRC with Dr. Ohayon's qualifications.

Dr. Ohayon has outstanding knowledge in epidemiology, neuropsychiatry and artificial intelligence tools that allow psychiatric diagnoses using several classifications systems, along with his academic eminence, and clinical expertise. Stanford has a strong clinical need for Dr. Ohayon's particular

expertise in psychiatry and his programmatic leadership. Specifically, Dr. Ohayon's skill set in complex patient evaluations, advanced psychotherapy models, and targeted psychopharmacology will significantly expand the existing clinical programs in the Department of Psychiatry and Behavioral Sciences at Stanford University.

Dr. Ohayon has been a highly successful leader in academic medicine throughout his career. Dr. Ohayon was the Director of Philippe Pinel Research Center in Montreal, Canada which specializes in psycho-legal research, such as violent and criminal behaviors, and their treatment and prevention. He was previously the Scientific Director of the Fernand Seguin Research Center at the Louis H. Lafontaine Hospital in Montreal, Canada. He has been invited to speak at national and international professional meetings. Dr. Ohayon has made extensive national and international contributions of editorial and peer-review service, as well as his numerous national leadership roles on broad psychiatric and medical issues.

Dr. Ohayon is an exceptionally capable physician-scientist-administrative leader, his skill set in complex patient evaluations, advanced psychotherapy models, and targeted psychopharmacology will significantly expand the existing clinical programs at SUSM. Dr. Ohayon will hold a full time faculty appointment as a Professor in the Department of Psychiatry and Behavioral Sciences. Dr. Ohayon will provide clinical care, including evaluations, psychotherapy, and psychopharmacology, in the adult outpatient psychiatry clinics in the Department of Psychiatry and Behavioral Sciences at SUSM.

The Board previously granted Dr. Ohayon a B&P 2113 faculty position, which was valid from September 11, 2004 through September 11, 2008. It has been more than two years since Dr. Ohayon has held a B&P 2113 appointment and now is eligible to be considered for a 2168 appointment pursuant to B&P Section 2168.1(a)(1)(B)(5).

<u>Dr. Ohayon's Medical Education</u>
Medical School:

University of Aix-Marseille II U.F.R. of Medicine Graduated March 26, 1979	France	1968 - 1979

Postgraduate Training:

➢ University Hospital La Timone, Marseille Pediatric Surgery	France	1972-1974
➢ University Hospital La Timone, Marseille Psychiatry and Neurology	France	1974-1980

Fellowship:

➢ Stanford University School of Medicine, Stanford Sleep Disorders Clinic	California	1997

Miguel Del Campo Casanelles, M.D., Ph.D., UCSD:
Andrew L. Ries, M.D., M.P.H., Associate Vice Chancellor for Academic Affairs, UCSD, presented UCSD's request for Miguel Del Campo Casanelles, M.D. to receive a SFP and provided the SFPRC with Dr. Del Campo Casanelles' qualifications.

Dr. Del Campo Casanelles has held the following positions concurrently since 2004 in Barcelona: Senior Consultant in the Department of Genetics and Molecular Medicine at Hospital Vall d'hebron; Senior Consultant in Genetics in the Department of Obstetrics, Gynecology and Reproduction, Institut Universitari Dexeus; and Assistant Professor in the Department of Genetics at Universidad Pompeu Fabra. Dr. Del Campo Casanelles has published 34 research articles in peer-review journals, which have made major contributions to the understanding of genetic diseases and has developed and coordinated the first Genetic Counseling Program in Spain. He is the Director of the Scientific Advisory Committee of Orphanet-Spain. Dr. Del Campo Casanelles is certified by the American Board of Medical Genetics and is one of Europe's foremost clinical geneticists and dysmorphologist. Dr. Del Campo Casanelles' teaching and work with underrepresented and underprivileged students and countries are in line with the UCSD respective missions in education and diversity.

Dr. Del Campo Casanelles will hold a full time faculty appointment as an Associate Professor of Clinical Pediatrics, Step 2 at UCSD, if approved for a SFP appointment by the Board. Dr. Del Campo Casanelles will be caring for patients with dysmorphologic, genetic and teratologic conditions at Rady Children's Hospital, along with collaborating or leading clinical research projects. Dr. Del Campo Casanelles will also be providing educational instruction to fellows, residents and medical students.

Dr. Del Campo Casanelles' application is complete except for the copy of the U.S. social security card, copy of the visa, clear fingerprint responses from the Department of Justice (DOJ) and Federal Bureau of Investigation (FBI) and the final fee for the permit. The copy of the U.S. social security card, copy of the visa, clear responses from DOJ and FBI and the final fee for the permit will be required prior to issuing the SFP if the Board adopts the Committee's recommendation for approval.

Dr. Del Campo Casanelles Medical Education
Medical School:

Complutense University of Madrid Graduated August 14, 1990	Spain	1984 - 1990

Postgraduate Training:

➢ Hospital Universitario La Paz Pediatrics	Spain	1992 - 1995

Fellowship:

➢ University of California San Diego School of Medicine Dysmorphology and Medical Genetics	California	1996 - 1999

Anthony T. Moore, BM Bch, UCSF:
Neal Cohen, M.D., M.S., M.P.H., Vice Dean, UCSF, presented UCSF's request for Anthony T. Moore, BM Bch to receive a SFP and provided the SFPRC with Dr. Moore's qualifications.

Dr. Moore has held the following positions: President of European Pediatric Ophthalmology Society between 1998 and 2000 and Chairman of Scientific Committee and Vice President of the Royal College of Ophthalmology. Dr. Moore has published over 300 peer-reviewed publications, two books and over 40 book chapters, along with being invited to chair sessions on pediatric ophthalmology at international meetings. Dr. Moore has been awarded the following prestigious awards in 2003: Franceshetti Medical of the International Society of Genetic Eye Disease and the Claffy Memorial Medal from the University of Sydney. Dr. Moore brings together administrative skill, remarkable records of scientific discovery and is an internationally renowned expert in gene therapy for inherited retinal degenerations.

Dr. Moore will hold a full time faculty appointment as a Pediatric Ophthalmologist and Professor of Ophthalmology at UCSF if approved for a SFP appointment by the Board. Dr. Moore will provide clinical care for pediatric ophthalmology in the outpatient services and inpatient pediatric ophthalmology consultative services. He will conduct research in the field of inherited retinal degeneration along with teaching medical students, residents and fellows both didactic and in the clinic.

Dr. Moore's application is complete except for the copy of the U.S. social security card, copy of the visa, and the final fee for the permit. The copy of the U.S. social security card, copy of the visa, and the final fee for the permit will be required prior to issuing the SFP if the Board adopts the Committee's recommendation for approval.

Dr. Moore's Medical Education
Medical School:

University of Oxford Graduated December 14, 1974	United Kingdom	1968 - 1974

Postgraduate Training:

➢ Royal United Hospital, Bath Surgery	United Kingdom	1975
➢ Radcliffe Infirmary, Oxford Medicine	United Kingdom	1975 - 1976
➢ Radcliffe Infirmary, Oxford Accident and Emergency Medicine	United Kingdom	1976
➢ North London Blood Blood Transfusion	United Kingdom	1976 - 1977

➢ St. Bartholomew's Hospital, London Ophthalmology	United Kingdom	1977
➢ Radcliffe Infirmary, Oxford Ophthalmology	United Kingdom	1977 - 1979
➢ Moorfields Eye Hospital, London Ophthalmology	United Kingdom	1979 - 1982

Fellowship Training:

➢ Hospital for Sick Children, London Ophtalmolgy	United Kingdom	1982 - 1983
➢ Hospital for Sick Children, Toronto Pediatric Ophthalmology	Canada	1983 - 1984

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Ohayon for an SFP at Stanford pursuant to B&P Section 2168.1 (a)(1)(B)(5).

The SFPRC recommended approval of Dr. Del Campo Casanelles for a SFP at UCSD pursuant to B&P Section 2168.1 (a)(1)(B) contingent upon receipt of follow-up documentation from UCSF regarding why a great need exists to fill the appointment as a SFP holder. The Board received the requested follow-up documentation from UCSD. Therefore, SFPRC recommends approval for Dr. Del Campo Casanelles.

The SFPRC recommended approval of Dr. Moore for an SFP at Stanford pursuant to B&P Section 2168.1 (a)(1)(A).

MEDICAL BOARD OF CALIFORNIA - 2014 TRACKER LIST
October 9, 2014

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 186	Maienschein	Professions & Vocations: Military Spouses: Temporary Licenses	Chaptered, #640	Support	8/20/14
AB 496	Gordon	CME: Sexual Orientation, Gender Identity, and Gender Expression	Chaptered, #630	Support	6/25/14
AB 809	Logue	Healing Arts: Telehealth	Chaptered, #404		8/7/14
AB 1535	Bloom	Pharmacists: Naloxone Hydrochloride	Chaptered, #326	Support	6/24/14
AB 1838	Bonilla	Accelerated Medical School Programs	Chaptered, #143	Sponsor/Support	5/14/14
AB 1841	Mullin	Medical Assistants	Chaptered, #333	Support	6/2/14
AB 1886	Eggman	Medical Board Internet Posting: 10-year Restriction	Chaptered, #285	Sponsor/Support	6/26/14
AB 2139	Eggman	End-of-Life Care: Patient Notification	Chaptered, #568	Neutral	8/18/14
AB 2214	Fox	Emergency Room Physicians: CME	Chaptered, #422	Neutral	6/26/14
SB 1083	Pavley	Physician Assistants: Disability Certifications	Chaptered, #438	Support	8/18/14
SB 1116	Torres	Physicians and Surgeons: STLRP	Chaptered, #439	Support	6/19/14
SB 1243	Lieu	Professions and Vocations	Chaptered, #395	Support	8/18/14
SB 1466	Sen. B&P	Omnibus	Chaptered, #316	Sponsor/Support MBC Provisions	8/18/14

Pink – Sponsored Bill, Blue – Chaptered Bill

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 186
Author: Maienschein
Chapter: 640
Subject: Military Spouses: Temporary Licenses
Sponsor: Author
Position: Support

DESCRIPTION OF LEGISLATION:

This bill allows 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 temporary licensing requirements, complete an application, and provide specified information.

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. This person must 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 requires specified boards under DCA, including the Board, to issue a 12-month temporary license to spouses of military personnel that have moved to California based upon active duty orders of the military spouse, who hold a current, active, and unrestricted license to practice in another state. The applicant can not have committed an act in any jurisdiction that would have constituted grounds for denial, suspension, or revocation of the license, can not have been disciplined by a licensing entity in another jurisdiction, and can not be the subject of an unresolved complaint, review procedure, or disciplinary proceeding conducted by a licensing entity in another jurisdiction. This bill requires 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 expires 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 allows the Board to conduct an investigation of applicants and allows the Board to require the applicant to submit fingerprints and conduct a criminal background check. This bill allows the Board to adopt necessary regulations. This bill specifies that the bill does not apply to boards that already have a temporary licensing process.

In addition, this bill allows 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 requires the Board to issue a notice of termination that requires 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 will allow military spouses to look for employment on a more immediate basis, while still ensuring consumer protection. This bill requires fingerprints to be cleared, requires 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 can be issued. For these reasons, the Board supported this bill.

FISCAL: Minor and absorbable

SUPPORT: American Legion – Department of California; AMVETS – Department of California; California Association for Health Services at Home; California State Commanders Veterans Council; Department of Defense; Easter Seals Disability Services; Marine Corps Installations West; Medical Board of California; National Military Family Association; San Diego Military Advisory Council; Veterans Caucus of the California Democratic Party; VFW – Department of California; and Vietnam Veterans of America-California State Council

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Develop procedures for staff to process these temporary licenses, which would become full, unrestricted licenses once all documentation is received
- Identify a licensing staff member to be the single point of contact for all temporary licenses
- Work with DCA on BreEZe processes
- Post information for military spouses on the Board's website regarding how to apply for a temporary license and the eligibility requirements

Assembly Bill No. 186

CHAPTER 640

An act to add Section 115.6 to the Business and Professions Code, relating to professions and vocations, and making an appropriation therefor.

[Approved by Governor September 27, 2014. Filed with Secretary of State September 27, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 186, 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 specified licensed professions for an applicant who holds a 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 issued pursuant to these provisions 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 also 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.

Because the bill would authorize the expenditure of continuously appropriated funds for a new purpose, the bill would make an appropriation.

Appropriation: yes.

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 the following eligible temporary licenses to an applicant if he or she meets the requirements set forth in subdivision (c):

(1) Registered nurse license by the Board of Registered Nursing.

(2) Vocational nurse license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(3) Psychiatric technician license issued by the Board of Vocational Nursing and Psychiatric Technicians of the State of California.

(4) Speech-language pathologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(5) Audiologist license issued by the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board.

(6) Veterinarian license issued by the Veterinary Medical Board.

(7) All licenses issued by the Board for Professional Engineers, Land Surveyors, and Geologists.

(8) All licenses issued by the Medical Board of California.

(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, active, and unrestricted license that confers upon him or her the authority to practice, in another state, district, or territory of the United 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 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 the licensed profession 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 temporary license issued pursuant to this section 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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 496
Author: Gordon
Chapter: 630
Subject: CME: Sexual Orientation, Gender Identity, and Gender Expression
Sponsor: Equality California
Position: Support

DESCRIPTION OF LEGISLATION:

This bill amends 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:

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 adds 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 will 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 requires 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 only needs to include an agenda item at a future Board Meeting to hear from the CME accrediting organizations on how they have addressed this amended cultural and linguistic competency curriculum requirement.

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, the Board supported this bill.

FISCAL: Minimal and absorbable

SUPPORT: Equality California (Sponsor)
AFSCME
Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify agencies that accredit CME of this new requirement
- Include an agenda item at a future Licensing Committee Meeting to hear from CME accrediting organizations on how they have addressed this amended cultural and linguistic competency requirement
- Include information on this new requirement on the Board's CME webpage

Assembly Bill No. 496

CHAPTER 630

An act to amend Section 2190.1 of the Business and Professions Code, relating to medicine.

[Approved by Governor September 26, 2014. Filed with Secretary of State September 26, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 496, 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.

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 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 or a course offered by a continuing medical education provider that is not located in this state 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 update these 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, 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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 809
Author: Logue
Chapter: 404
Subject: Healing Arts: Telehealth
Sponsor: Author

DESCRIPTION OF LEGISLATION:

This bill revises the informed consent requirements relating to the delivery of health care via telehealth by permitting consent to be made verbally or in writing, and by deleting the requirement that the health care provider who obtains the consent be at the originating site where the patient is physically located. This act is an urgency statute, which means it takes effect immediately upon being signed into law.

ANALYSIS:

The Telehealth Advancement Act of 2011 was signed into law as a result of AB 415 (Logue, Chapter 547). 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.

This bill would now require health care providers, prior to initiating the use of telehealth, to inform the patient about the use of telehealth and obtain verbal or written consent from the patient, and the consent must be documented. This bill deletes the requirement in existing law that the health care provider who obtains the consent be at the originating site where the patient is physical located. This bill took effect immediately upon signature by the Governor.

Although the Medical Board of California (Board) previously had a support position on this bill, the Board did not consider the most recent amendment that no longer requires a health care provider who obtains consent to be at the originating site where the patient is physically located.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
Board of Behavioral Sciences
National Multiple Sclerosis Society
Occupational Therapy Association of California
Planned Parenthood Affiliates of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff and Department of Consumer Affairs, Division of Investigation staff
- Update the Board's website and related publications

Assembly Bill No. 809

CHAPTER 404

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.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 809, 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 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.

This bill would declare that it is to take effect immediately as an urgency statute.

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 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. The consent shall be documented.

(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 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.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1535
Author: Bloom
Chapter: 326
Subject: Pharmacists: Naloxone Hydrochloride
Sponsor: Drug Policy Alliance
California Pharmacists Association
Position: Support

DESCRIPTION OF LEGISLATION:

This bill allows 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 specifies 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 requires 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 allows 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

This bill increases 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.

This bill allows 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 specifies 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 requires 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 authorizes 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. This bill will increase at-risk patients access to naloxone, while at the same time ensuring standardized procedures and protocols are in place. For these reasons, the Board supported 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 Association of Alcohol and Drug Program Executives, Inc.; California Hospital Association; California Mental Health Directors

Association; California Narcotic Officers' Association; California Opioid Maintenance Providers; California Retailers Association; California Society of Addiction Medicine; California United for a Responsible Budget; 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; Homeless Health Care Los Angeles; 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; Paramedics Plus; Paving the Way Foundation; Phoenix House of Los Angeles; Primary Purpose Sober Living Homes; Safer Alternatives thru Networking and Education; San Fernando Recovery Center;; SHIELDS For Families; Soberspace; and Solace

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Work with BOP to develop standardized procedures and protocols for pharmacists to use when furnishing naloxone
- Bring standardized procedures and protocols to the Board for approval

Assembly Bill No. 1535

CHAPTER 326

An act to add Section 4052.01 to the Business and Professions Code, relating to pharmacists.

[Approved by Governor September 15, 2014. Filed with Secretary of State September 15, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1535, 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.

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

SECTION 1. Section 4052.01 is added to the Business and Professions Code, to read:

4052.01. (a) Notwithstanding any other provision of law, a pharmacist may 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 the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. In developing those standardized procedures or protocols, the board and the Medical Board of California shall include the following:

(1) Procedures to ensure education of the person to whom the drug is furnished, including, but not limited to, opioid overdose prevention, recognition, and response, safe administration of naloxone hydrochloride, potential side effects or adverse events, and the imperative to seek emergency medical care for the patient.

(2) Procedures to ensure the education of the person to whom the drug is furnished regarding the availability of drug treatment programs.

(3) Procedures for the notification of the patient's primary care provider with patient consent of any drugs or devices furnished to the patient, or entry of appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider, and with patient consent.

(b) A pharmacist furnishing naloxone hydrochloride pursuant to this section shall not permit the person to whom the drug is furnished to waive the consultation required by the board and the Medical Board of California.

(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 1838
Author: Bonilla
Chapter: 143
Subject: Accelerated Medical School Programs
Sponsor: Medical Board of California and University of California
Position: Sponsor/Support

DESCRIPTION OF LEGISLATION:

AB 1838 allows 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.

There are 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 were 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 allows 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 allows 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; California Academy of Family Physicians; California Children's Hospital Association; California Healthcare Institute; California Hospital Association; Kaiser Permanente; Los Medanos Community Healthcare District; Osteopathic Physicians and Surgeons of California; and Tenet Healthcare

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Update the Board's website, publications, and forms

Assembly Bill No. 1838

CHAPTER 143

An act to add Section 2084.5 to the Business and Professions Code, relating to healing arts.

[Approved by Governor July 18, 2014. Filed with Secretary of State July 18, 2014.]

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.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1841
Author: Mullin
Chapter: 333
Subject: Medical Assistants
Sponsor: Planned Parenthood
Position: Support

DESCRIPTION OF LEGISLATION:

This bill allows 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 requires 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 excludes controlled substances.

ANALYSIS

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 supported this bill.

FISCAL: None

SUPPORT: Planned Parenthood (Sponsor); Association of California Healthcare Districts; California Academy of Physician Assistants; California Association for Nurse Practitioners; California Family Health Council; California Nurse-Midwives Association; California Primary Care Association; Medical Board of California; Planned Parenthood Advocacy Project Los Angeles County; Planned Parenthood Mar Monte; Planned Parenthood of Orange and San Bernardino Counties; Planned Parenthood of Santa Barbara, Ventura, and San Luis Obispo Counties, Inc.; Planned Parenthood of the Pacific Southwest; Planned Parenthood

Pasadena and San Gabriel Valley; Planned Parenthood Shasta Pacific Action Fund; and Six Rivers Planned Parenthood

OPPOSITION: California Right to Life Committee, Inc.
California Society of Health-System Pharmacists (unless amended)

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff and Department of Consumer Affairs, Division of Investigation staff
- Update the Board's website and publications

Assembly Bill No. 1841

CHAPTER 333

An act to amend Section 2069 of the Business and Professions Code, relating to medicine.

[Approved by Governor September 15, 2014. Filed with Secretary of State September 15, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1841, 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.

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 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 1886
Author: Eggman
Chapter: 285
Subject: Medical Board Internet Posting: 10-Year Restriction
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF 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 allows 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 restructures the statute to reflect the current and historical information that can be posted to the Board's website related to physicians. This bill now allows the Board to post the most serious disciplinary information on the Board's website for as long as it remains public. This bill does change website posting requirements, as follows: requires 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); requires public letters of reprimand to be posted for 10 years, instead of indefinite posting; and requires 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
Consumer Union's Safe Patient Project

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Update the Board's website and publications
- Identify documents that were taken off the Board's website due to the 10-year rule and place these public documents back on the Board's website

- Work on processes and procedures to identify malpractice settlements over 5 years for posting and over 10 years to be available to the public if requested (not on the website)
- Send an email blast out to all physicians alerting them of this change in posting requirements
- Update regulations through a Section 100 change for the citation posting to three years

Assembly Bill No. 1886

CHAPTER 285

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.

[Approved by Governor August 25, 2014. Filed with Secretary of State August 25, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1886, 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.

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

SECTION 1. Section 2027 of the Business and Professions Code is repealed.

SEC. 2. Section 2027 is added to the Business and Professions Code, to read:

2027. (a) The board shall post on its Internet Web site the following information on the current status of the license for all current and former licensees:

(1) Whether or not the licensee is presently in good standing.

(2) Current American Board of Medical Specialties certification or board equivalent as certified by the board.

(3) Any of the following enforcement actions or proceedings to which the licensee is actively subjected:

(A) Temporary restraining orders.

(B) Interim suspension orders.

(C) Revocations, suspensions, probations, or limitations on 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 (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: AB 2139
Author: Eggman
Chapter: 568
Subject: End-of-Life Care: Patient Notification
Sponsor: Author
Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill requires 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 specifies 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. This bill also specifies that it shall not be construed to interfere with the clinical judgment of a health care provider in recommending the course of treatment.

ANALYSIS

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 (Health and Safety Code Section 442.5) 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 had a neutral position on this bill.

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, Northern California; and National Association of Social Workers, California Chapter

OPPOSITION: California Right to Life Committee

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Update the Board's website and publications

Assembly Bill No. 2139

CHAPTER 568

An act to amend Sections 442.5 and 442.7 of the Health and Safety Code, relating to terminal illness.

[Approved by Governor September 25, 2014. Filed with Secretary of State September 25, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2139, 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.

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 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 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 people of the State of California do enact as follows:

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 do both of the following:

(1) Notify the patient of his or her right, or when applicable, the 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 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.

(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 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.

(b) If 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) 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.

(c) The information described in subdivision (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 (b).

(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 (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.

(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, another person authorized to make health care decisions for the patient, can easily understand. If the patient or 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 other authorized person shall be referred to the appropriate entity for that information.

(f) The notification made pursuant to 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.

(h) This section shall not be construed to interfere with the clinical judgment of a health care provider in recommending the course of treatment.

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 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 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
Chapter: 422
Subject: Continuing Medical Education: Geriatric Care
Sponsor: Author
Position: Neutral

DESCRIPTION OF LEGISLATION:

This bill enacts the Dolores H. Fox Act and requires 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.

This bill requires 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 only requires 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 had a neutral position on this bill.

FISCAL: None

SUPPORT: California Commission on Aging
California Long-Term Care Ombudsman Association

OPPOSITION: None on file

IMPLEMENTATION

- Newsletter article (a stand-alone article geared towards emergency room physicians and geriatric care)

Assembly Bill No. 2214

CHAPTER 422

An act to amend Section 2191 of the Business and Professions Code, relating to physicians and surgeons.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2214, 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 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.

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 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 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 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 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 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 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 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 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 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 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 board shall give its highest priority to considering a course on pain management.

(k) In determining its continuing education requirements, the board shall consider including a course in geriatric care for emergency room physicians and surgeons.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1083
Author: Pavley
Chapter: 438
Subject: Physician Assistants: Disability Certifications
Sponsor: California Academy of Physician Assistants (CAPA)
Position: Support

DESCRIPTION OF LEGISLATION:

This bill authorizes physician assistants (PAs), on or before January 1, 2017, 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.

This bill allow PAs, on or before January 1, 2017, 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 supported this bill because it believed 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 the Physician Assistant Board

OPPOSITION: None on file

IMPLEMENTATION

- Newsletter article
- Notify/train Board staff and Department of Consumer Affairs, Division of Investigation staff

Senate Bill No. 1083

CHAPTER 438

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.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1083, 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. This bill would require the Employment Development Department to implement these provisions on or before January 1, 2017.

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. The Employment Development Department shall implement this paragraph on or before January 1, 2017.

(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) (A) "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, 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.

(B) "Practitioner" also means a physician assistant who has performed a physical examination under the supervision of a physician and surgeon. Funds appropriated to cover the costs required to implement this subparagraph shall come from the Unemployment Compensation Disability Fund. This subparagraph shall be implemented on or before January 1, 2017.

(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
Chapter: 439
Subject: Steven M. Thompson Loan Repayment Program (STLRP)
Sponsor: Author

DESCRIPTION OF LEGISLATION:

This bill requires 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.

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 requires 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 will further the Board's mission of promoting access to care and the Board supported this bill and will continue to support 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; California Primary Care Association; California Rheumatology Alliance; and the Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Update the Board's website to highlight the fact that physicians can donate more than the mandatory $25 to the STLRP and provide directions on how to do so

- Work with Department of Consumer Affairs on needed BreEZe enhancements
- Amend the licensing and renewal applications to include information that physicians can donate more than the mandatory $25 to the STLRP and provide an opportunity for them to do so on both forms
- Identify procedures for staff to process additional voluntary contributions to the STLRP

Senate Bill No. 1116

CHAPTER 439

An act to amend Sections 2436.5 and 2455.1 of the Business and Professions Code, relating to physicians and surgeons.

[Approved by Governor September 18, 2014. Filed with Secretary of State September 18, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1116, 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, 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 require each of those boards, on or before July 1, 2015, to develop a mechanism for a physician and surgeon or an osteopathic physician and surgeon, respectively, to pay a voluntary contribution, at the time of application for initial licensure or biennial renewal, for those purposes.

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) On or before July 1, 2015, the board shall develop a mechanism for a physician and surgeon 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 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) On or before July 1, 2015, the board shall develop a mechanism for an osteopathic physician and surgeon to pay 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
Chapter: 395
Subject: Professions and Vocations
Sponsor: Author

DESCRIPTION OF LEGISLATION:

This bill is a sunset review bill for several boards under the Department of Consumer Affairs (DCA). In addition to the sunset review provisions, this bill also requires the Department of Consumer Affairs (DCA) and the Office of Administrative Hearings (OAH) to submit specified reports to the Legislature on an annual basis. This bill enhances unlicensed advertising enforcement, requires DCA to develop and offer enforcement training, and amends public meeting notice requirements.

ANALYSIS:

This bill requires 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 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 expands 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 and provides this authority to all agencies under and within DCA (not just those listed in existing law).

This bill requires DCA to continue to develop and make available training courses for employees who perform enforcement functions. This bill requires DCA to encourage staff to attend enforcement training courses and requires DCA to develop the enforcement training curricula in consultation and cooperation with the AG's Office and OAH.

This bill requires 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 requires DCA to conduct a one-time 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, (omitting any confidential information) 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 regarding the activities of DCA and its constituent entities for the previous fiscal year. This bill requires the report to include information relative to the performance of each constituent entity on the length of time to reach each of the following milestones in the enforcement process:

- Average number of days from when a constituent entity receives a compliant until the constituent entity assigns an investigator;
- Average number of days from a constituent entity or DCA's Division of Investigation opening an investigation to closing the investigation, regardless of the outcome; and
- Average number of days from a constituent entity closing an investigation to imposing formal discipline.

This bill also requires 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.

This bill increases transparency and enhances enforcement processes, procedures, and training. 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. For these reasons the Board supported this bill.

FISCAL: Minimal and absorbable

SUPPORT: California Association of Community Managers and the Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff

Senate Bill No. 1243

CHAPTER 395

An act to amend Sections 101.7, 149, 201, 312, 4800, 4804.5, 4836.2, 4841.5, 4844, 11506, and 22259 of, and to add Sections 154.1, 211, and 312.1 to, the Business and Professions Code, relating to professions and vocations.

[Approved by Governor September 17, 2014. Filed with Secretary of State September 17, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1243, 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 submit an annual 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. The bill would require the department to conduct a one-time study of its system for prorating

administrative excesses, and to include the findings of the study in the report it is required to submit on or before July 1, 2015. 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, 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 and make available training courses for employees who perform enforcement functions to develop knowledge of enforcement practices for all employees who perform enforcement functions.

(4) Existing law requires an agency comprising the 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 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 Office of Administrative Hearings 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 Administrative Hearings pertaining to accusations and cases relating to consumer complaints against a person whose profession or vocation is licensed by an agency comprising the department.

(5) 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.

(6) Existing law, beginning January 1, 2015, requires a veterinary assistant to obtain a controlled substance permit from the board in order to administer a controlled substance, and requires the board to revoke a veterinary controlled substance permit upon notification that the veterinary assistant has been convicted of a state or federal felony controlled substance violation.

This bill would, instead, beginning July 1, 2015, authorize the board to deny, suspend, or revoke the controlled substance permit of a veterinary assistant after notice and hearing if the veterinary assistant has been convicted of a state or federal felony controlled substance violation.

(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.

(9) This bill would make technical, nonsubstantive, and conforming changes.

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

SECTION 1. Section 101.7 of the Business and Professions Code is amended to read:

101.7. (a) Notwithstanding any other provision of law, boards shall meet at least three times each calendar year. Boards shall meet at least once each calendar year in northern California and once each calendar year in southern California in order to facilitate participation by the public and its licensees.

(b) The director at his or her discretion may exempt any board from the requirement in subdivision (a) upon a showing of good cause that the board is not able to meet at least three times in a calendar year.

(c) The director may call for a special meeting of the board when a board is not fulfilling its duties.

(d) An agency within the department that is required to provide a written notice pursuant to subdivision (a) of Section 11125 of the 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 email. The agency shall comply with the requester's chosen form or forms of notice.

(e) 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 entry level enforcement academy.

(2) It is in the best interest of consumers in the state for the department to continue to provide ongoing training opportunities for employees performing enforcement functions for each agency comprising the department.

(b) The department shall continue to develop and make available training courses for employees who perform enforcement functions. The purpose of the training courses is to develop knowledge of enforcement 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 enforcement training courses.

(c) The department shall develop the enforcement training curricula in consultation and cooperation with the office of the Attorney General and the Office of Administrative Hearings.

SEC. 4. Section 201 of the Business and Professions Code is amended to read:

201. (a) (1) 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.

(2) 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 one-time 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 the findings in its report pursuant to paragraph (2) of subdivision (a) that it is required to submit on or before July 1, 2015.

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 after omitting any information that is not subject to disclosure under the California Public Records Act (Chapter 3.5 commencing with Section 6250) of Division 7 of Title 1 of the Government Code.

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 for the previous fiscal year. 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.

(b) The report shall include information relative to the performance of each constituent entity, including, but not limited to, length of time for a constituent entity to reach each of the following milestones in the enforcement process:

(1) Average number of days from when a constituent entity receives a complaint until the constituent entity assigns an investigator to the complaint.

(2) 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.

(3) Average number of days from a constituent entity closing an investigation to imposing formal discipline.

(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. 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 for the previous fiscal year:

(a) Number of cases referred by each constituent entity to each office of the Office of Administrative Hearings for a hearing.

(b) Average number of days from receiving a request to setting a hearing date at each office of the Office of Administrative Hearings.

(c) Average number of days from setting a hearing to conducting the hearing.

(d) 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 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. 9. 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. 10. Section 4836.2 of the Business and Professions Code is amended to read:

4836.2. (a) Applications for a veterinary assistant controlled substance permit shall be upon a form furnished by the board.

(b) The fee for filing an application for a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed one hundred dollars ($100).

(c) The board may deny, suspend, or revoke the controlled substance permit of a veterinary assistant after notice and hearing for any cause provided in this subdivision. The proceedings under this section shall be conducted in accordance with the provisions for administrative adjudication in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein. The board may revoke or suspend a veterinary assistant controlled substance permit for any of the following reasons:

(1) The employment of fraud, misrepresentation, or deception in obtaining a veterinary assistant controlled substance permit.

(2) Chronic inebriety or habitual use of controlled substances.

(3) The veterinary assistant to whom the permit is issued has been convicted of a state or federal felony controlled substance violation.

(4) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, or of the regulations adopted under this chapter.

(d) The board shall not issue a veterinary assistant controlled substance permit to any applicant with a state or federal felony controlled substance conviction.

(e) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining information as to the existence and content of a record of state or federal convictions and state or federal arrests and information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information that it receives pursuant to this section. The Department of Justice shall review any information returned to it from the Federal Bureau of Investigation and compile and disseminate a response to the board summarizing that information.

(3) The Department of Justice shall provide a state or federal level response to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The Department of Justice shall charge a reasonable fee sufficient to cover the cost of processing the request described in this subdivision.

(f) The board shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1) of subdivision (e).

(g) This section shall become operative on July 1, 2015.

SEC. 11. Section 4841.5 of the Business and Professions Code is amended to read:

4841.5. To be eligible to take the written and practical examination for registration as a registered veterinary technician, the applicant shall:

(a) Be at least 18 years of age.

(b) (1) Furnish satisfactory evidence of graduation from, at minimum, a two-year curriculum in veterinary technology, in a college or other postsecondary institution approved by the board, or the equivalent thereof as determined by the board. In the case of a private postsecondary institution, the institution shall also be approved by the Bureau for Private Postsecondary Education.

(2) For purposes of this subdivision, education or a combination of education and clinical practice experience may constitute the equivalent of the graduation requirement imposed under this subdivision, as determined by the board.

SEC. 12. Section 4844 of the Business and Professions Code is amended to read:

4844. A person who fails to renew his certificate of registration within five years after its expiration may not renew it, and it shall not be restored, reissued, or reinstated thereafter, but that person may apply for and obtain a new certificate of registration if:

(a) He or she is not subject to denial of registration under Section 480.

(b) No fact, circumstance, or condition exists which, if the certificate of registration were issued, would justify its revocation or suspension.

(c) He or she takes and passes the examination, if any, that would be required of him or her if he or she were then applying for a certificate of registration for the first time, or otherwise establishes to the satisfaction of the board that, with due regard for the public interest, he or she is qualified to be a registered veterinary technician.

(d) He or she pays all of the fees that would be required of him or her if he or she were applying for the certificate of registration for the first time.

The board may, by regulation, provide for the waiver or refund of all or any part of the examination fee when a certificate of registration is issued without an examination pursuant to this section.

SEC. 13. 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. 14. 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 1466
Author: Committee on Business, Professions, and Economic Development
Chapter: 316
Subject: Omnibus
Sponsor: Committee, Medical Board of California (Board) and other affected regulatory health boards
Position: Support provisions related to the Board

DESCRIPTION OF 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 making the American Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP) an approved accreditation agency for hospitals offering accredited postgraduate training programs. This bill would also strike "scheduled" from existing law that requires physicians who perform a "scheduled" medical procedure outside of a hospital, that results in a death, to report the occurrence to the Board within 15 days.

ANALYSIS:

BPC Section 2089.5 – AOA-HFAP

Currently, the Board recognizes Accreditation Council Graduate for Medical Education (ACGME) accredited postgraduate training for the purposes of allopathic medical school students' clinical clerkship training and for the required postgraduate training for licensure as a physician and surgeon. ACGME accredited postgraduate training programs are at institutions that are accredited by the Joint Commission. Recently, ACGME has accredited postgraduate training programs in hospitals that are accredited by the AOA-HFAP. However, existing law (BPC 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 amends 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 (BPC 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 strikes "scheduled" from this provision.

FISCAL: None to the Board

SUPPORT: Board of Psychology
Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article
- Notify/train Board staff
- Update the Board's website, relevant publications, and forms

Senate Bill No. 1466

CHAPTER 316

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, 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.

[Approved by Governor September 9, 2014. Filed with Secretary of State September 9, 2014.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1466, 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.

(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 as a marriage and family therapist to complete 75 hours of client centered advocacy or face-to-face counseling, as specified.

This bill would authorize an applicant for licensure as a marriage and family therapist to meet this requirement by completing 75 hours of client centered advocacy or face-to-face counseling, or any combination thereof.

(8) 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) Existing law requires an applicant for licensure 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 licensure 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 professional clinical counselor.

The bill would also make other technical, conforming, and clarifying changes.

(10) This bill would incorporate additional changes to Sections 4980.72, 4980.78, 4999.58, 4999.59, and 4999.60 of the Business and Professions Code proposed by AB 2213, to be operative only if AB 2213 and this bill are both chaptered and become effective on or before January 1, 2015, and this bill is chaptered last.

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

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

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

SECTION 1. Section 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 2023.5 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. 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. 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. 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.

MBC TRACKER II BILLS
10/10/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 357	Pan	Medi-Cal Children's Health Advisory Panel	Chaptered, #376	08/05/14
AB 369	Pan	Continuity of Care	Chaptered, #4	02/18/14
AB 467	Stone	Prescription Drugs: Collection and Distribution Program	Chaptered, #10	03/11/14
AB 1559	Pan	Newborn Screening Program	Chaptered, #565	08/21/14
AB 1575	Pan	Public Contracts for Services	Vetoed	05/20/14
AB 1577	Atkins	Certificates of Death: Gender Identity	Chaptered, #631	08/22/14
AB 1592	Gaines	California Diabetes Program	Vetoed	08/19/14
AB 1612	Donnelly	State Government: Regulations	Vetoed	05/23/14
AB 1650	Jones-Sawyer	Public Contracts: Bidders	Chaptered, #880	08/18/14
AB 1702	Maienschein	Professions and Vocations: Incarceration	Chaptered, #410	04/23/14
AB 1727	Rodriguez	Prescription Drugs: Collection and Distribution Program	Chaptered, #155	06/15/14
AB 1735	Hall	Nitrous Oxide: Dispensing and Distributing	Chaptered, #458	07/01/14
AB 1743	Ting	Hypodermic Needles and Syringes	Chaptered, #331	05/27/14
AB 1755	Gomez	Medical Information	Chaptered, #412	08/04/14
AB 1812	Pan	Health Facilities: Information: Disclosure	Chaptered, #265	06/17/14
AB 1822	Bonta	Tissue Banks	Vetoed	08/21/14
AB 1843	Jones	Child Custody Evaluations: Confidentiality	Chaptered, #283	07/01/14
AB 1890	Chau	Athletic Trainers	Vetoed	05/13/14
AB 1898	Brown	Public Health Records: Reporting: HIV/AIDS	Chaptered, #566	08/18/14
AB 2032	Bonta	Civil Service: Employee Hearings	Vetoed	08/04/14
AB 2052	Gonzalez	Worker's Compensation	Vetoed	08/18/14
AB 2062	Hernandez	Health Facilities: Surgical Technologists	Vetoed	08/21/14
AB 2069	Maienschein	Immunizations: Influenza	Chaptered, #357	04/24/14
AB 2102	Ting	Licensees: Data Collection	Chaptered, #420	08/04/14
AB 2143	Williams	Clinical Laboratories: Chiropractors	Chaptered, #269	05/27/14

MBC TRACKER II BILLS
10/10/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2198	Levine	Mental Health Professionals: Suicide Prevention Training	Vetoed	08/04/14
AB 2374	Mansoor	Substance Abuse: Recovery and Treatment Services	Chaptered, #815	08/22/14
AB 2387	Pan	Public Contracts	Chaptered, #504	08/22/14
AB 2396	Bonta	Convictions: Expungement: Licenses	Chaptered, #737	08/19/14
AB 2399	Perez	Organ and Tissue Donor Registry: Driver's License	Chaptered, #569	08/21/14
AB 2418	Bonilla	Health Care Coverage: Prescription Drug Refills	Vetoed	08/19/14
AB 2605	Bonilla	Pharmacy: Third-Party Logistics Providers	Chaptered, #507	08/22/14
AB 2612	Dababneh	Medi-Cal	Vetoed	08/19/14
AB 2616	Skinner	Workers Compensation: Hospital Employers	Vetoed	08/18/14
AB 2675	Lowenthal	State Agency: Public Contracts	Chaptered, #617	08/22/14
AB 2720	Ting	State Agencies: Meetings: Record of Action Taken	Chaptered, #510	08/07/14
AB 2723	Medina	Administrative Procedure: Small Business	Vetoed	08/21/14
ACR 93	Buchanan	Prescription Drug Abuse Awareness Month	Chaptered, #23	03/24/14
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	Chaptered, #143	07/03/14
SB 18	Leno	Medi-Cal Renewal	Chaptered, #551	08/18/14
SB 20	Hernandez	Individual Health Care Coverage: Enrollment Periods	Chaptered, #24	05/08/14
SB 204	Corbett	Prescription Drugs: Labeling	Vetoed	06/10/14
SB 266	Lieu	Prevailing Wages	Chaptered, #916	08/22/14
SB 577	Pavley	Autism & Other Developmental Disabilities: Employment	Chaptered, #431	08/21/14
SB 600	Lieu	Drugs	Chaptered, #492	08/22/14
SB 852	Leno	Budget Act of 2014	Chaptered, #25	05/14/14

MBC TRACKER II BILLS
10/10/2014

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 906	Correa	Elective Percutaneous Coronary Intervention Offsite Program	Chaptered, #368	08/18/14
SB 973	Hernandez	Narcotic Treatment Programs	Chaptered, #484	08/14/14
SB 1004	Hernandez	Health Care: Palliative Care	Chaptered, #574	08/22/14
SB 1039	Hernandez	Pharmacy: Third-Party Logistics Providers	Chaptered, #319	08/04/14
SB 1052	Torres	Health Care Coverage	Chaptered, #575	08/18/14
SB 1053	Mitchell	Health Care Coverage: Contraceptives	Chaptered, #576	08/18/14
SB 1135	Jackson	Inmates: Sterilization	Chaptered, #558	08/11/14
SB 1159	Lara	Professions and Vocations: Federal Tax ID Number	Chaptered, #752	08/22/14
SB 1226	Correa	Veterans: Professional Licensing	Chaptered, #657	08/19/14
SB 1256	Mitchell	Medical Services: Credit	Chaptered, #256	06/25/14
SB 1266	Huff	Pupil Health: Epinephrine Auto-Injectors	Chaptered, #321	08/21/14
SB 1315	Monning	Medi-Cal: Providers	Chaptered, #844	06/30/14
SB 1337	DeSaulnier	Reports	Vetoed	05/27/14
SB 1340	Hernandez	Health Care Coverage: Provider Contracts	Chaptered, #83	03/24/14
SB 1438	Pavley	Controlled Substances: Opioid Antagonists	Chaptered, #491	08/22/14
SB 1445	Evans	Developmental Services: Telehealth	Chaptered, #260	06/25/14
SB 1457	Evans	Medical Care: Electronic Treatment Authorization Requests	Chaptered, #849	06/30/14
SR 36	Walters	Relative to Prescription Drug Abuse Awareness	Adopted	03/25/14

LEGISLATIVE PROPOSALS 2015

805 Reporting

Pursuant to Business and Professions (B&P) Code Section 805, certain peer review bodies must report actions pertaining to staff privileges, membership, or employment. Specifically, the chief of staff of a medical or professional staff or other chief executive officer, medical director or administrator of any peer review body, or a chief executive officer or administrator of any licensed health care facility or clinic must report the following within 15 days of the action:

- A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason;
- A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason;
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons;
- A resignation, leave of absence, or a withdrawal or abandonment of an application for, or renewal of, privileges that occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason; or
- A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

In the Board's Sunset Report, the Board included information regarding a decline in 805 reporting. The following chart identifies the decline in reporting:

	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
805 reports received	151	162	157	110	138	126	138	122	99	93	114

To address this decline in reporting, Board staff is proposing that the Board sponsor legislation that would require physicians to report to the Board when reportable actions occur (as identified in the above list). This will enable the Board to ensure that peer review bodies are reporting appropriately, and also ensure that the Board is aware when these actions are taken. This will allow for verification in 805 reporting. **The Board would need to approve this legislative proposal.**

Licensed Midwives (LMs) – Midwife Assistants

This issue was included in the Board's 2012 Sunset Report. It has been brought to the attention of the Board that LMs need to use assistants. Currently, there is no definition for a midwife assistant in statute, or the specific training requirements or duties that a midwife assistant may perform. Some LMs use other LMs as assistants, while some use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student

and midwifery school to provide clinical training to the student midwife. Other LMs use someone who may or may not have formal midwifery training and/or someone that the LM has trained. The duties that a midwife assistant performs also varies greatly from LM to LM. Board staff believe that this is a serious consumer protection issue and that legislation should be pursued to define midwife assistants and define the services they can provide. Board staff is proposing that language be pursued to ensure that midwife assistants meet minimum training requirements, the same requirements for medical assistants, pursuant to BPC Section 2069. The statute should also set forth the duties that a midwife assistant could perform, which should be at the same level as duties that a medical assistant can perform; technical support services only. The language should also allow the Board, through the Midwifery Advisory Council, to adopt regulations and standards for any additional midwife technical support services. **The Board would need to approve this legislative proposal.**

Outpatient Settings Legislative Proposals

- Per existing law, Health and Safety Code Section 1216, clinics licensed by the California Department of Public Health (CDPH), including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Before *Capen v. Shewry*, this data was being collected for the majority of outpatient settings, as they were licensed as surgical clinics. However, when physician-owned outpatient settings fell under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data. Board staff is suggesting that the data collection requirements be put into place for accredited outpatient settings; the data required for reporting would be very similar to the data that surgical clinics are required to report to OSHPD. **The Board would work closely with OSHPD on this proposal. This was previously approved by the Board.**

- Currently, inspections performed by the Accreditation Agencies are announced and initial certificates of accreditation are good for three years. The Board is proposing that the inspections be unannounced and that the initial accreditation only be valid for up to two years. This will help to ensure consumer protection as it will ensure that outpatient settings will not know when their inspections will occur. In addition, newly accredited settings will get renewed in a shorter period of time, so the renewal inspection will occur sooner. **This proposal was previously approved by the Board.**

- Currently, a physician who owns his or her own outpatient setting may choose not to have peer review of his or her practice. The Board is suggesting language to require peer review evaluations for all outpatient settings to ensure that all physicians who are performing procedures in an outpatient setting are subject to peer review. **This proposal was previously approved by the Board.**

- Currently, a CMS-certified ambulatory surgical center (ASC) is considered a peer review body that is required to report specified actions to the Board. However, a CMS-certified ASC is not authorized to request peer review reports from the Board prior to granting or

renewing staff privileges for a physician. In addition, accredited outpatient settings are not required to report to the Board nor are they authorized to request peer review reports. Board staff is suggesting language that would consider accredited outpatient settings as a peer review body and require these settings to report specified actions to the Board. The language would also allow both CMS-certified ASCs and outpatient settings to be authorized to request peer review reports from the Board prior to granting or renewing staff privileges for a physician, since they are or would be reporting these actions to the Board. This will enhance consumer protection. **The Board would need to approve this legislative proposal.**

Technical Clean-Up (Potential Omnibus)

The following provisions are technical in nature and are potential candidates for the Board's omnibus bill, meaning the changes are purely technical and not controversial. **The Board would need to approve staff going forward with these technical changes.**

- Allied Health – Numerous clarifying changes are needed for the allied health licensure sections to allow the Board to take similar discipline for these license types, as it does for physician and surgeons. The Board has recently had obstacles in taking actions because the statute is not clear in the Board's authority pertaining to unlicensed practice, probation, cite and fine, etc. There also some clarifying changes needed regarding reinstatement for these license types. If approved, the Board would model the wording on existing law in the code sections related to physicians and surgeons.

- For physicians and surgeons, there are a few technical, clarifying changes that are needed related to using "M.D.", denials, public letters of reprimand, etc. The changes needed are purely technical in nature.

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	Amending file to address OAL concerns for re-submission	7/19/13	9/06/13	10/25/13	5/02/14	Sent to DCA on 6/19/14 Sent to OAL on 8/26/14	Pending final disapproval by OAL – notified via email on 10/7/14	
PA – Supervision Requirements	DCA for review	10/25/13	12/13/13	2/07/14	5/02/14	Sent to DCA on 8/12/14		
Issuance of Citations	Hearing set for 10/14/14	7/25/14	8/08/14	9/24/14 10/14/14				
Update of Disciplinary Guidelines	Pending SB 1441 Regulations	7/25/14						

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Updated October 7, 2014
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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.