State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board and Committee Meetings
January 29 – 30, 2015

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Four Points by Sheraton Sacramento
International Airport
4900 Duckhorn Drive
Sacramento, CA 95834

January 29-30, 2015

Thursday, January 29

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

- **8:30 a.m. – 11:45 a.m.** **Panel B (Room: Natomas)**
  (Members: GnanaDev (Chair), Krauss, Levine, Lui, Pines, Schipske)

- **11:45 a.m. – 1:00 p.m.** **Lunch Break**

- **1:00 p.m. – 2:00 p.m.** **Education and Wellness Committee Meeting (Room: Natomas)**
  (Members: Yaroslavsky (Chair), Pines, Krauss, Schipske)

- **2:00 p.m. – 3:00 p.m.** **Enforcement Committee Meeting (Room: Natomas)**
  (Members: Lewis (Chair), Krauss, Lui, Schipske, Serrano Sewell, Yaroslavsky, Yip)

- **3:15 p.m. – 5:30 p.m.** **Full Board Meeting (Room: Natomas)**
  (All Members)

Friday, January 30

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

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA

MEMBERS OF THE BOARD

President
David Serrano Sewell, J.D.
Vice President
Dev GnanaDev, M.D.
Secretary
Denise Pines

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.

Four Points by Sheraton
Sacramento International Airport
Natomas Room
4900 Duckhorn Drive
Sacramento, CA 95834
916-263-9000 (Directions Only)

Thursday January 29, 2015
3:15 p.m. – 5:30 p.m.
(or until the conclusion of business)

Friday, January 30, 2015
9:00 a.m. – 3:00 p.m.
(or until the conclusion of business)

Teleconference – See Attached
Meeting Information

ORDER OF ITEMS IS SUBJECT TO CHANGE

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.

Thursday, January 29, 2015

1. Call to Order/Roll Call

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

3. Approval of Minutes from the October 23-24 and December 1, 2014 Meetings

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

5. President's Report – Mr. Serrano Sewell
   A. Review and Consideration of Policy Compendium

6. Executive Management Reports – Ms. Kirchmeyer
   A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
   B. Administrative Summary
   C. Revision of 2015 Board Meeting Dates
   D. Enforcement Program Summary
   E. Licensing Program Summary
   F. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children

7. Update and Consideration of Recommendations from the Education and Wellness Committee Meeting – Ms. Yaroslavsky

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

9. 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

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

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

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

13. CLOSED SESSION
    Pursuant to Section 11126(e)(1) of the Government Code, the Board will meet in closed session to confer with its counsel regarding the following litigation:
    ***MIR v. KIRCHMEYER* CASE 12 cv 2340-GPC (DHB) UNITED STATES DISTRICT COURT; SOUTHERN DISTRICT OF CALIFORNIA**

Friday, January 30, 2015

14. Call to Order/Roll Call

15. 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)]

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

17. Designation of the *Decision In the Matter of the Accusation Against Gary Wayne Page, M.D.* (Case Number 02-2009-197437) as a Precedential Decision– Ms. Dobbs

18. Request Approval to Obtain an Attorney General Legal Opinion Regarding Clarification on Business and Professions Code Section 805 Reporting – Ms. Webb and Ms. Kirchmeyer

19. Discussion and Consideration of the Sunset Review Recommendation Regarding the Registered Dispensing Optician Program – Ms. Kirchmeyer and Ms. Simoes

20. Presentation on Telehealth – Patricia Conolly, M.D., Kaiser Permanente

21. Discussion and Consideration of the Interstate Compact – Ms. Kirchmeyer and Ms. Webb

22. Update on the Federation of State Medical Boards – Ms. Kirchmeyer

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

24. Discussion and Consideration of Midwifery Advisory Council Member Appointments – Mr. Worden

25. Special Faculty Permit Review Committee Recommendations: Approval of Applicants – Dr. Yip

26. Discussion and Adoption of Joint Protocols with the Board of Pharmacy – Ms. Herold
    A. Self-Administered Hormonal Contraception
    B. Nicotine Replacement Products
    C. Naloxone Hydrochloride

27. Discussion and Consideration of Legislation/Regulations – Ms. Simoes
    A. 2015 Legislation
    B. Status of Regulatory Actions

28. Agenda Items for the April/May 2015 Meeting in the Los Angeles Area

29. 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.

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.

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, January 29, 2015 – The call-in number for teleconference comments is:

1-800-230-1074

Friday, January 30, 2015 – The call-in number for teleconference comments is:

1-800-230-1766

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.

During Agenda Item 2 and 15 – Public Comments on Items Not on the Agenda, the Board has limited the total public comment period via teleconference to 20 minutes. Therefore, after 20 minutes, no further comments will be accepted. Each person will be limited to three minutes per agenda item.

During public comment on any other agenda item, a total of 10 minutes will be allowed for comments via the teleconference line. After 10 minutes, no further comments will be accepted. Each person will be limited to three minutes per agenda item.

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

QUARTERLY BOARD MEETING

Sheraton San Diego Hotel and Marina Agenda Item 3
1380 Harbor Island, Bay Tower
San Diego, CA 92101

October 23-24, 2014
MINUTES

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

Members Present:
David Serrano Sewell, J.D., President
Michael Bishop, M.D.
Dev GnanaDev, M.D., Vice President
Howard Krauss, M.D.
Sharon Levine, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.
Barbara Yaroslavsky

Members Absent:
Denise Pines, Secretary
Felix Yip, M.D.

Staff Present:
Ramona Carrasco, Staff Services Manager I
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Armando Melendez, Business Services Officer
Valerie Moore, Staff Services Manager I
Regina Rao, Associate Governmental Program Analyst
Paulette Romero, Staff Services Manager II
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
See Vang, Business Services Officer
Curt Worden, Chief of Licensing

Members of the Audience:
Theresa Anderson, California Academy of Physician Assistants
Kayti Buehler, California Association of Midwives
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul

Zennie Coughlin, Kaiser Permanente
Sara Davis, California Association of Midwives
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Laura Freedman, Legal Counsel, Department of Consumer Affairs
Jack French, Consumer's Union
Michael Gomez, Deputy Director, Department of Consumer Affairs
Marian Hollingsworth, Consumer's Union
Troy Holmes, Investigator, Health Quality Investigation Unit
Terry Jones, Supervising Deputy Attorney General, Attorney General's Office
Saylak Lee, Midwestern University
Mitchel Mendez, Midwestern University
Carol Moss, Consumer's Union
Ty Moss, Consumer's Union
Kathleen Nichols, Supervising Investigator, Health Quality Investigation Unit
Jose Partida, Investigator, Health Quality Investigation Unit
Eric Ryan, Supervising Investigator, Health Quality Investigation Unit
Jane Zack Simon, Attorney General's Office
Carrie Sparrevohn, Licensed Midwife
Renee Threadgill, Chief of Enforcement, Health Quality Investigation Unit
Abigail Vidikar, California Association of Midwives
Brian Yi, Midwestern University

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on Thursday, October 23, 2014 at 3:55 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

Genevieve Clavreul asked the Board to make a statement on what the Board is doing in regards to the Ebola issue.

Mr. French, Consumer's Union, feels the Board should make physician disciplinary actions as readily accessible to the public as possible. He stated the Board used to make this information available in its quarterly Newsletter and included a brief description of the disciplinary action along with a link to the public documents for review. He recommended the Board return to its previous policy of including in the Newsletter a paragraph description of the physician's offense in addition to the link to the disciplinary documents. He added this would improve transparency and the ability of the public and patients to understand the nature of offenses upon which the Board takes action.

He knows the Board routinely emails a list of actions it takes on the discipline of physicians, which includes a link. Unfortunately, the link takes one to a medical board page, which is a link to BreEZe, which then takes approximately six different clicks to get to the physician disciplinary record. The average consumer is confused by the new BreEZe system and does not find their way to the disciplinary documents. Mr. French recommended including a direct link to the public disciplinary records in the emails that are sent out.

Agenda Item 3 Approval of Minutes from the July 24-25, 2014 Meeting

Dr. Lewis made a motion to approve the July 24-25, 2014 Meeting Minutes as submitted; s/Ms. Yaroslavsky. Motion carried.

Agenda Item 4 Update and Consideration of Recommendations from the Midwifery Advisory Council Meeting

Ms. Sparrevohn, Chair of the Midwifery Advisory Council (MAC), stated the hospital transfer form is being used by the hospitals and discussions continue in interested parties meeting to determine if more information should be included on that form.

Ms. Sparrevohn stated licensed midwives (LM) continue to be challenged in the realm of obtaining drugs and testing deemed necessary for safe treatment. She added the task force on LM assistants' submitted language to the MAC based on language for medical assistants and naturopathic physician's assistants. The MAC voted to send this language to the full Board for legislative proposal in 2015. Ms. Simoes will present the LM assistant language as part of her presentation to the Board. Ms. Sparrevohn strongly urged the Board to consider the language as it is greatly needed. She pointed out the information packet for new Board Members is still in process as is certified nurse midwives (CNM) to LM licensure.

Ms. Sparrevohn stated the interested parties meeting regarding the creation of the list of medical conditions that would require an LM to refer a client to a physician for evaluation was held earlier in the month. There was good input from all parties, but no consensus was reached. It is expected that both the American Congress of Obstetricians and Gynecologists (ACOG) and the California Association of Midwives (CAM) will work on this issue prior to the next interested parties meeting.

Ms. Sparrevohn then requested Board approval for the following agenda items for the next MAC meeting scheduled for December 4, 2014: Update on the midwife assistant task force, the Board Member information task force, and the LM annual report data collection task force; an update on regulatory changes required by Assembly Bill (AB) 1308; an update on the October midwife interested parties meeting; and an update on the CNM to LM legislation.

Ms. Yaroslavsky made a motion to approve the MAC agenda items for the December 4, 2014 meeting/s; Mr. Lui. Motion carried.

Agenda Item 5 Board Member Communications with Interested Parties

Dr. GnanaDev stated he is on the American Medical Political Action Committee (AMPAC) Board and works a lot with California Medical Association (CMA), but Board issues are never discussed.

Dr. Krauss stated he sits on the Board of Directors of the California Ambulatory Surgery Association and is a trustee for the CMA. No parties have brought Board matters to him that are before the Board at this meeting.

Agenda Item 6 President's Report

Mr. Serrano Sewell reported he and Dr. GnanaDev continue to meet with the Board's Executive Staff twice a month to discuss the projects at the Board and to ensure everything is moving forward as needed. He thanked Dr. GnanaDev for being on those calls and feels they are very helpful.

Mr. Serrano Sewell announced Panel A elected a new chair, Ms. Wright and elected Dr. Lewis as Vice Chair. He congratulated Ms. Wright and Dr. Lewis, thanked Ms. Yaroslavsky for her great work as prior chair of that Panel, and stated everyone has benefited from her leadership.

Dr. GnanaDev announced Panel B voted to keep himself as Chair, and Dr. Krauss in now Vice Chair. Mr. Serrano Sewell thanked them for their work on the Panel.

Mr. Serrano Sewell announced the Executive Committee met in closed session to complete an Executive Director evaluation and will report the outcome to the Department of Consumer Affairs (DCA). He thanked the Executive Director, Ms. Kirchmeyer, for doing an outstanding job in all respects and stated she had the full confidence of the Board.

Agenda Item 7 Update and Consideration of Recommendations from the Executive Committee Meeting

Mr. Serrano Sewell stated at the Executive Committee meeting, there was discussion on a compendium of Board policies. At the previous Board meeting, Dr. Krauss had recommended, and the Board agreed, putting together a compendium of policies that can be used by staff as they review initial legislation and to assist as legislation is amended during the legislative process. Staff put together a draft compendium of policies based on input from the Members and previous experiences. At the Executive Committee meeting, Members discussed and approved the three policies as outlined on pages EXEC 4-1 through EXEC 4-5 in the Board packet. These three policies are pertaining to: 1) scope of practice, 2) continuing medical education (CME), and 3) funding for physician education. These policies will provide guidance for staff on any legislation that is received regarding these three topics. The Committee approved the policies as written with the exception to add the word "proctoring" to the policy on scope of practice.

Mr. Serrano Sewell requested a motion to approve the Executive Committee's recommendation to approve these three policies as written, including the amendment for the scope of practice and policy.

Ms. Yaroslavsky made a motion to approve the three policies; s/Dr. GnanaDev.

Dr. Krauss stated it is the Board's intention that these compendia be added to and modified over time and the purpose is so the Board's legislative advocate has positions that can be represented to the legislature between Board meetings.

Motion carried w/one abstention (Bishop).

Mr. Serrano Sewell continued with an update on the Board's committee structure, which was also discussed at the Executive Committee. In the Board's strategic plan, every other October the Board is to review the Committee Roster and identify committees that may no longer be needed. In August, he and Ms. Kirchmeyer met to discuss this issue. The recommendations from the meeting

are listed on pages EXEC 5-1 to EXEC 5-5 in the Board packet. The main goal in reviewing these committees is to find efficiencies, and to increase output from the committees. At the Executive Committee meeting, the Members approved, for recommendation to the full Board keeping the Enforcement, Licensing, Education and Wellness, and Executive Committees as standing committees and continue them for the next two years. In addition, it was recommended to make the Executive Committee comprised of Board officers (the President, Vice President, and Secretary), the immediate past president, and the chairs of the Enforcement, Licensing, and Education and Wellness Committees, which would bring the Executive Committee to seven Members. The Executive Committee also approved, to bring to the Full Board, keeping the Specialty Faculty Permit Review Committee, the Midwifery Advisory Council, the Application Review Committee, and the Special Programs Committee, as they are required by law. However, the Committee approved consolidation of the Application Review Committee and the Special Programs Committee as the duties and functions of these committees are very similar, and there is no prohibition in consolidation.

Lastly, the Executive Committee Members approved the elimination of the Access to Care/Cultural Linguistics Competency Committee and the Committee on Physician Supervisory Responsibilities. It was suggested that issues pertaining to these Committees be placed in the Enforcement or Licensing Committees as appropriate. If additional discussion is needed, it is better done through an interested parties meeting rather than within these Committees. The issue can then be brought back to the appropriate standing committee for action before coming to the full Board. The Executive Committee also eliminated the sub-committees and task forces with the exception of the Prescription Task Force.

Ms. Yaroslavsky made a motion to approve the committee changes as discussed; s/Dr. Lewis. Motion carried.

Agenda Item 8 Executive Management Reports

Ms. Kirchmeyer began by asking for approval of orders following completion of probation and orders for license surrender during probation.

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

Ms. Kirchmeyer stated she was not going to go over the summaries that are in the Board packet unless a Member had any questions. Ms. Kirchmeyer pointed out a couple of items from the summaries the Board should be made aware. She stated there was a significant increase in the number of complaints in fiscal year 13/14. This increase is being attributed to the new BreEZe system. The Board received over a thousand more complaints this year than last year. The other item she wanted to point out is, over the summer, the Board hired a student assistant who interviewed licensing staff, attended a licensing fair with Mr. Schunke, scripted, and produced a video tutorial to assist applicants with the licensing process. This video tutorial is posted on the Board's website, but more importantly, is posted on each page of the online application and has a link to instructions on how to fill out that specific page of the application. This tutorial is only for the printable and downloadable version of the application; it is not for the actual online BreEZe application.

Ms. Kirchmeyer announced that she and Ms. Simoes are working with the Business and Professions Committee staff of the Assembly and Senate to schedule a Board Legislative day. The Board

Members, in teams of two, along with a staff member, would meet with Legislative Members of these two Committees to provide information regarding the Board, its consumer protection roll and its functions, as well as answer any questions they may have regarding the Board. Although there is no date set at this time, it has been suggested this be scheduled to take place in February 2015. More information will be provided to the Members as soon as a specific date has been established.

Ms. Kirchmeyer noted that although the Board has been actively participating in outreach events, many of them have been in regards to fraud or senior scams. Staff would like to put together a health care outreach event. This idea was introduced to other allied health boards with a lot of interest. The idea is to have a presentation from each board to describe what they oversee and the overall importance of ensuring consumer safety. Consumers will learn where they can check to see if their health care professional is licensed and where to send a complaint. There will be more details to follow as plans come together.

Ms. Kirchmeyer added that as shown in the Board packet, the Board is now assisting with CURES registration, which took place at the Board meeting. In addition, she stated the Board will also be allowing individuals to come to the Board's office in Sacramento and to the probation offices in San Dimas and Cerritos to register. In addition, Mr. Schunke will be allowing two to three hours when possible during his outreach events.

Lastly, Ms. Kirchmeyer provided an update on the coordination with other state agencies regarding the issue of prescribing psychotropic medications to foster children. Based upon an investigative report regarding psychotropic medications, on August 25, 2014, Senator Lui sent a letter to the Board asking it to look into the inappropriate prescribing of psychotropic drugs. He wanted the Board to determine if psychotropic drugs, not approved for children, were being prescribed to them and to determine if these drugs were being prescribed without the review of the child's medical records or drug history. Senator Lui also asked the Board to identify recommendations to minimize these dangerous practices. Upon receipt of the letter, the Board began to look into the issue. Board staff first contacted the Department of Social Services (DSS) to request a meeting on this issue, which included staff from the Department of Health Care Services (DHCS). Since this meeting, the Board has become very involved in this issue. She and Ms. Simoes attended a meeting in San Francisco held by the Child Welfare Council where this issue was discussed. Board staff determined the best way to identify physicians who are inappropriately prescribing is to establish a memorandum of understanding (MOU) between the Board, the DHCS, and the DSS. A meeting has been scheduled between the Board, DSS, and DHCS to discuss this MOU.

In addition, Ms. Kirchmeyer and Paulette Romero are attending meetings on a quality improvement project that will put together guidelines for the use of psychotropic medication to children and youth in foster care. Ms. Romero will also be attending a data and tech workgroup on this issue. Once these guidelines are complete, they will be posted to the Board's website and an article will be included in the Board's Newsletter. The Board will continue to work with both agencies to obtain information necessary in order to identify physicians who may be inappropriately prescribing. Throughout this process, all stakeholders are being encouraged to report any physicians who they believe to be inappropriately prescribing to the Board.

Dr. GnanaDev thanked Ms. Kirchmeyer for what she had done in regard to the prescribing to foster children issue. He stated the real issue is that these kids need help. They need family

therapy, psychotherapy, and they need resources, all of which should come from the DSS. Those are the issues that need to be addressed, not just the type of drug that is being prescribed to these children.

Dr. Levine stated the speed of response to the Senator's inquiry was remarkable and is a great testament to the preparedness of the entire Board staff under Ms. Kirchmeyer's leadership. She was pleased that the Board staff responded by wanting to be part of the solution and not writing it off as not the Board's problem. She stated that approach was noticed by many people.

Ms. Kirchmeyer thanked Mr. Serrano Sewell for his leadership and participation in meeting with staff on this matter and assisting in providing direction as well.

Genevieve Clavreul stated she has voiced her opinion on the CURES system in the past. She is concerned about patient safety and how people can access the information and how long it is taking the system to get up and running efficiently.

Agenda Item 9 Federation of State Medical Boards Summary

Ms. Kirchmeyer referred Members to tab 9 in their Board packets. She stated the Federation of State Medical Board (FSMB) staff are planning to attend the July 2015 Board meeting to provide an update on the Federation and its activities.

Ms. Kirchmeyer stated the Interstate Compact is listed under agenda item 9C. Board staff will be providing an analysis at the January 2015 meeting on the complete Compact. Because this is an Interstate Compact, the language of the Compact as shown in 9C, must be adopted by the California Legislature precisely as written in order for the Compact to be valid. This is something that will be taken into consideration when the analysis is performed.

The Federation also sent notices that they are seeking resolutions by February 24, 2015 for their annual meeting. Ms. Kirchmeyer asked if a Member had any resolution they would like put forward, to contact her for discussion and presentation at the Board's January Board meeting for approval.

The Federation is also seeking nominations for elected officials. Information was sent to all Members regarding these positions, and Dr. Levine has decided to run for a Board of Director's position. Ms. Kirchmeyer asked for a motion to approve the preparation of a letter of recommendation and support for Dr. Levine's nomination.

Ms. Wright made a motion to approve a letter of recommendation and support for Dr. Levine; s/Ms. Yaroslavsky. Motion carried

Ms. Kirchmeyer stated the Federation is also seeking individuals interested in serving on committees within the Federation. Four Board Members have expressed interest in being appointed to a committee following the April 2015 Annual Meeting. Dr. Levine is interested in being appointed to the Ethics and Professionalism Committee, Dr. Lewis is interested in being appointed to the Education Committee, Ms. Wright is interested in being appointed to the Editorial Committee, and Dr. Krauss is interested in being appointed to the Bylaws Committee as well as any committee where his expertise would be beneficial.

Mr. Kirchmeyer asked for a motion for those letters of recommendations to the different committees.

Ms. Yaroslavsky made a motion to approve the letters of recommendations and support; s/Mr. Lui. Motion carried.

Yvonne Choong, CMA, stated that CMA would be doing an analysis on the Interstate Compact. As Ms. Kirchmeyer stated, it has to be passed in its entirety and that is an issue for the CMA. There are some inconsistencies with California standards versus what is in the Compact and there are uncertainties on how those issues are going to be resolved.

Marian Hollingworth, Consumer's Union Safe Patient Project, stated their initial review of the Interstate Compact raises concerns in four different areas. The first being the lack of requirement that the interstate commission include consumer patient representatives; second being the lack of reasonable access to public meetings of the commission; third, the lack of assurance of public access to information in the database that the interstate commission will maintain; and fourth, the lack of assurance of transparency of the investigative and disciplinary procedures of the commission. She noted they would be in touch with the Board in the future with future concerns and more detail.

Julie D'Angelo Fellmeth, Center for Public Interest Law (CPIL), stated they agree with both CMA, as well as Consumer's Union Safe Patient Project, in they also have concerns about the Interstate Compact as it is written. They have concerns about the Federation putting out this Compact without formal public comment period before releasing a final document. She stated CPIL would put their concerns in writing to the Board before the January Board meeting.

Dr. Levine noted one of the reasons she agreed to be a candidate for the Federation Board was after attending the Federation's annual meeting last year, and watching the process that occurred around the Interstate Compact and knowing that California is a large and important State, and the ability to influence this, once the Board approved it was essentially nil to make changes and recommendations, despite efforts from both Ms. Kirchmeyer and herself.

Dr. GnanaDev stated, he too was upset that California had no input on this Compact and that it has to be taken as it is presented. This Compact has to be looked at very carefully by all entities before it goes to the legislature. He is convinced that it will not happen without California's support.

Dr. Lewis stated when he looked at the different Federation committees, he was surprised at how few, if any, had representation from California. With California having one of the highest number of physicians, he was disappointed at how underrepresented California is with the Federation.

Ms. Kirchmeyer stated the Board had sent in feedback to the Federation. The one issue the Board stated was important was the fingerprinting of applicants on the Interstate Compact, which was added to the Compact for California.

Ms. Yaroslavsky stated the Interstate Compact conversation through the Federation has been going on for some time now. The issue when this conversation first began was if any Compact would meet the minimum level of what California licensure expects. She urged the entities that are doing their own analysis to think about what this means. Her concern is that California will be forced to participate once the Compact passes at the Federation level.

Agenda Item 10 Update and Consideration of Recommendations from the Enforcement Committee Meeting

Dr. Lewis provided an update from the Enforcement Committee. He stated Ms. Kirchmeyer and Ms. Zack Simon, from the AG's office provided information regarding the pain management expert reviewer policy. She stated in 2002, the Board established a policy on the review of cases involving pain management issues. At that time, the policy stated that in certain cases, the Board would require at least two expert reviewers, one physician certified in pain management, and one expert in the specialty of the physician being reviewed. Since the requirement for physicians to obtain CME has been in effect since January 2002, the Board and the Attorney General's office do not believe that policy should still be required. The Committee held a discussion regarding this matter and was seeking a motion to change the pain management expert reviewer policy to require one expert reviewer in the like specialty, rather than two expert reviewers.

Ms. Yaroslavsky made a motion to approve the change from two required expert reviewers to one expert reviewer in the specific area of practice; s/Dr. Krauss.

Dr. Bishop stated he has some concerns about this change. He feels the Board should be cautious that if the Board decides to go with a single reviewer that they are cognizant that expectations would differ between the ER physicians, the internal medicine physician, and the dedicated pain management specialist and the way they care for patients.

Dr. Krauss stated he would hope that all of the Board's reviewers are conscientious enough to know that if something should transcend, that they view as their specialty, that there would be a criticism of their colleague for having practiced without consultation.

Motion carried.

Dr. Lewis stated the Committee discussed the Board's statement on marijuana. The statement adopted by the Board on May 7, 2004, clarifies that the recommendation for marijuana by physicians in their medical practice will not have any effect against their physicians' license if they follow good medical practice. Board staff reviewed the current statement and believed that amendments need to be made to the statement, as some information is misleading and does not comport with the current law. The first series of edits pertain to the term "medical marijuana".

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. Another issue with the statement is the assertion that the initial examination for the condition for which marijuana is being recommended must be in-person. The 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 this examination be in person, and could be via the telehealth system. The Committee held a lengthy discussion on this matter and is seeking a motion to direct staff to update the statement on marijuana as amended by the Committee and post the new version to the Board's website.

Mr. Yaroslavsky made a motion to direct staff to update the statement on marijuana/s; Dr. Krauss. Motion carried.

Dr. Lewis noted that the Committee received a presentation from the University of California San Diego, Physician Assessment and Clinical Education Program (PACE) staff who talked about the redesign of the PACE program from its current seven-day program down to a three-to five-day program.

Ms. Carrasco from the Board's Central Complaint Unit gave a presentation on utilization review. Ms. Carrasco reported findings, following the Board's evaluation of the utilization review complaints, for approximately the last 18 months. It was found that 58% of the utilization review complaints received alleged the review resulted in a decision that affected patients' care. The Central Complaint Unit processed these complaints as quality of care issues and attempted to secure any additional information relevant to the case and had a review performed by a medical consultant. In all cases, the consultant found no evidence that the opinions reached by the reviewer were inappropriate or outside the standard of care. At this time, staff recommends the Board continue to perform preliminary analyses of the complaints involving the utilization review with emphasis on those related to quality of care.

Dr. Lewis continued by stating Mr. Gomez, from the Health Quality Investigation Unit (HQIU), provided an update on the transition of staff to the Department of Consumer Affairs (DCA). Mr. Gomez explained the difficulties faced by HQIU in retrieving data for statistical purposes due to the BreEZe database.

Dr. Lewis noted Ms. Kirchmeyer and Ms. Robinson presented the committee with information regarding the cultural background of those individuals who have had complaints filed against them, who have been investigated, and those who have had disciplinary action taken against them. Staff will consider a review of this type of data via a separate study in the future.

Dr. Krauss made a motion to move Board support for legislative action to require that a patient's evaluation by a physician for a marijuana recommendation be in-person.

Ms. Yaroslavsky made a motion to table Dr. Krauss's motion until the agenda item on legislative proposals.

Mr. Serrano Sewell agreed to table the motion until the appropriate agenda item.

Agenda Item 11 Vertical Enforcement Program Report

Mr. Gomez stated that the DCA and the Attorney General's (AG's) office was meeting on a revision to the current Vertical Enforcement (VE) manual, including looking at better protocols related to how to create efficiencies in the current process being used. Mr. Gomez stated a workgroup had been formed of several upper management from DCA as well as staff from the AG's office and Ms. Kirchmeyer. The workgroup has a partial revised document at this time. The roles of the VE team members previously did not include the medical consultants, but they are included in the newest version. The workgroup is now at the point where they will be discussing resolving disagreements in the investigation process. The goal is to have a completed draft document by the second week in December 2014. The workgroups next meeting is scheduled for October 29, 2014 in Sacramento.

Ms. Castro began by reminding the Board it has only been four months since the transition, which took place on July 1, 2014. There have been 236 cases opened under the new leadership. The rest of the cases were opened under the leadership of the Board. There are about 700 carry over cases

from the Board. She feels the carry over cases have to be completed in order to assess if HQIU are doing things better and/or differently, etc. She stated the heart of the VE is the cases and public safety. They are actively and constructively engaging in the transfer of knowledge and techniques to new management over those investigations. She believes they agree on the fact that the heart of the policy is public safety, which is achieved through high quality and efficient joint investigations. The product of their labor remains constant and focused, notwithstanding the change in leadership of the investigators, because, although the investigators are under new management, the Board is still present and demanding accountability.

Ms. Castro noted that Ms. Kirchmeyer is actively engaged in every aspect, and feels that she, Mr. Gomez and the Board are very lucky to have her Board knowledge and history involved.

In addition to the constant communication between Ms. Castro and Ms. Kirchmeyer, the AG's office is endeavoring to minimize the billable time relating to the transition, although some of the changes have resulted in additional billing, while the elementary concepts are taught to their new partners. However once those concepts are learned and they are better acquainted with each other, those billings will be reduced.

Ms. Castro stated as HQIU has become aware of the business process and the workflow with its investigators, HQIU has continued many of the technical aspects that were perfected by the Board over many years. She stated she is open-minded to new ideas for efficiencies that are being proposed by DCA's Executive staff. In the meantime, Ms. Castro's staff is following the July 2014 VE manual, which has a lot of efficiencies that she felt needed to happen and has shared those with Mr. Gomez. Discussions will begin at the next workgroup meeting.

Dr. GnanaDev thanked Mr. Gomez and Ms. Castro for coming. He requested Mr. Gomez provide a timeline by the January Board meeting. He wants to have up-to-date numbers to take to the legislature when that time comes.

Dr. Lewis requested statistics that detail the start date to the end of a case to be presented at a future Board meeting. He would like to learn what the delays are on some of the cases and to see where the delays are happening, whether it be with the AG's office or the HQIU.

Ms. Yaroslavky expressed her concerns about the relationship between the AG's office and the DCA staff that are working together.

Agenda Item 12 Update from the Attorney General's Office

Ms. Castro announced they have new hires in their Sacramento office, which is now fully staffed. Recently hired was: Demond Philson, who came from DHCS, is a former Fresno District Attorney, and prosecutor; Michael Brummel, who will be working in Fresno; Carolyne Sanin Evans will be joining their San Francisco office, and came from the United States AG's office; and Connie Broussard who will join the Sacramento office as a Supervising Deputy Attorney General.

Ms. Castro reported on the *Lewis* case that is being handled by Deputy Attorney General Edward Kim and Supervising Deputy Attorney General E.A. Jones. On September 17, 2014, the California Supreme Court granted petitioner Lewis a petition for review. The Court of Appeals had already ordered that the Board's access to CURES data was not a serious invasion of patient's privacy. That issue will be litigated in the Supreme Court. She believes CURES advances a compelling interest in

protecting the public against incompetent, impaired physicians, and if Dr. Lewis is successful in his petition before the Supreme Court and any judicial showing or good cause requirement is imposed prior to the Board being able to use CURES as an investigative tool, she believes more patient deaths could result.

Ms. Schipske asked Ms. Castro to provide more information on this case, as it came from a Board case. Ms. Castro stated that the attorney on this case is making the point that access to CURES would constitute a violation of patient privacy because the Board had to get additional records to show the medical conditions. She stated if the court does rule that it is a violation of privacy, then serious problems would occur in terms of being able to use CURES.

Mr. Serrano Sewell adjourned the meeting at 5:45pm, until the following morning, October 24, 2014 at 9:00 am.

Friday October 24, 2014

Members Present:
David Serrano Sewell, J.D., President
Michael Bishop, M.D.
Dev GnanaDev, M.D., Vice President
Howard Krauss, M.D.
Sharon Levine, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Gerrie Schipske, JP, R.N.P.
Jamie Wright, Esq.
Barbara Yaroslavsky

Members Absent:
Denise Pines, Secretary
Felix Yip, M.D.

Staff Present:
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
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
See Vang, Business Services Officer
Curt Worden, Chief of Licensing

Members of the Audience:
Jeremy Adler, California Academy of Physician Assistants
Mohammed Aly, Center for Public Interest Law
Theresa Anderson, California Academy of Physician Assistants
Gaye Breyn, California Academy of Physician Assistants

Kayti Buehler, California Association of Midwives
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Steve Cattolica, California Neurology Society, California Society of Physical Medicine & Rehabilitation
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Marian Hollingsworth, Consumer's Union
Troy Holmes, Investigator, Health Quality Investigation Unit
Terry Jones, Supervising Deputy Attorney General, Attorney General's Office
Christine Lally, Deputy Director, Boards and Bureaus, Department of Consumer Affairs
Carol Moss, Consumer's Union
Ty Moss, Consumer's Union
Hilary Nemchik, Senator Block's Office
Kathleen Nichols, Supervising Investigator, Health Quality Investigation Unit
Jose Partida, Investigator, Health Quality Investigation Unit
Eric Ryan, Supervising Investigator, Health Quality Investigation Unit
Laura Sweet, Deputy Chief of Enforcement
Renee Threadgill, Chief of Enforcement, Health Quality Investigation Unit
Jason Weisz, Assembly Member Atkins Office
Brian Yi, Midwestern University
Cesar Yuriar, Center for Public Interest Law
Charlene Zettel, Donate Life California

Agenda Item 13 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on Friday, October 24, 2014 at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 14 Public Comments on Items not on the Agenda

Genevieve Clavreul suggested including an update on what California has done in regard to the current Ebola outbreak.

Charlene Zettel, Donate Life California, thanked the Board for their public service. She also thanked the Board for being an unofficial sponsor of the Donate Life license plate. Since she appeared before the Board last, a few things have changed. They are now able to use the actual Donate Life logo, which is the national logo, as opposed to the pink dot that was originally planned. They are working on selling the 7,500 plates that need to be sold before the Department of Motor Vehicles will begin producing them.

In addition, Ms. Zettel then presented a framed photo of Ms. Kirchmeyer holding a mockup of what a personalized license plate would look like. She then encouraged everyone to go to their website and reserve their Donate Life license plate and reminded everyone that working together, we can help save lives with organ donations.

Agenda Item 15 Update from the Department of Consumer Affairs (DCA)

Christine Lally, Deputy Director of Board and Bureau Relations at DCA stated she, Director Kidane, Deputy Director Rhine and Deputy Director Gomez continue to meet with Ms. Kirchmeyer on a bi-weekly basis. She stated these meetings are very helpful in keeping DCA apprised of the issues that are facing the Board and where the DCA can be of assistance.

Ms. Lally then provided an update on the proposed Enforcement management position. She stated this position would be planning and organizing and directing the Board's overall enforcement program, which includes the Probation, Central Complaint, Complaint Investigation and the Discipline Coordination Units as well as providing settlement authority for the AG's office on disciplinary decisions. In May, Board staff submitted a proposal to establish the enforcement program manager position, which is a Career Executive Assignment (CEA), level A. In June, the DCA's Office of Human Resources approved the request and submitted it to CalHR. In early September and again in October, CalHR requested additional information, which DCA provided. She announced that CalHR has approved this position. The next step will be for the matter to go before the State Personnel Board for approval.

Dr. GnanaDev stated he is disappointed on how long the approval process has taken and how much work not having a Deputy Director or an Enforcement Manager has put on the Executive Director and requested a rush be put on this process, if possible. He also asked Ms. Lally if she knows when the BreEZe system and the AG's office system will be able to work together.

Ms. Lally stated, she has no specific time line to offer for that interface, but she noted there was recently some questions presented on the BreEZe project, specifically on the enforcement reports and when that will be fixed. She stated there is a phase 1 fix that is going to be submitted on November 7, 2014. She also wanted to make the Board aware of user group meetings that Ms. Kirchmeyer is involved in, where the enforcement staff from all the boards under DCA are providing information needed to assist in standardizing the enforcement reports. Once a consensus has been established on that, then that final fix will go into the system.

Agenda Item 16 Update and Consideration of Recommendations from the Prescribing Task Force

Ms. Yaroslavsky began by thanking Laura Sweet and Letitia Robinson for their outstanding work on the Board's version of the prescribing guidelines. In addition, she thanked every licensee, public entity, and other state agency that participated with input on these important guidelines. The Board received numerous comments on these guidelines and the document in the Board packets shows how much hard work went into it.

She stated on November 29, 2014, the Prescribing Task Force held a meeting to finalize the revisions to the Board's Guidelines for Prescribing Controlled Substances for Pain. Prior to this meeting, the Board staff had incorporated a significant amount of acquired information from other entities that participated. In addition, Board staff met with an expert in pain management, and an expert in emergency medicine. Board staff has posted information regarding these meetings on the Board's website, but also sent out over 100 emails to those who have shown interest in this topic, or whom the Board thought should be part of the process.

Dr. Bishop stated that this document is exactly what it is titled. It is a compendium of guidelines. The guidelines are intended to provide physicians with a framework to assist them as they prescribe controlled substances for pain. The document provides useful tools and links that can be used for this purpose. These guidelines are not regulations. The Board will not be going through the rulemaking process to adopt them as regulations. This document is also not intended to delineate the standard of care and simple deviation from these guidelines alone will not be a cause for discipline. The Board has several documents on its website that can be used to assist physicians and/or other allied health care providers. These documents include a statement on recommending marijuana as well as information on terminating a patient relationship. The Board also has guidelines for licensed midwives on the website. All of these documents were created to assistant the individual and are not enforceable regulations, but are useful to the providers. If any physician is brought to the Board's attention, the Board will submit the matter to an expert reviewer, at which time that expert will opine on whether the physician deviated from the standard of care. This document will provide much needed guidance for physicians.

Ms. Sweet went through the guidelines in more detail. She began by thanking everyone involved who gave up their time to assist in putting these guidelines together. It was clear that despite the diverse background of the many people involved, they all had patient safety in mind.

Ms. Sweet continued by explaining the methodology used to create these guidelines. The first draft consisted of a matrix that compared and contrasted numerous prescribing guidelines for pain management. From that matrix, staff were able to include in these guidelines, topics obtained from other medical boards, government agencies, and the Federation of State Medical Boards. The later iterations came from feedback received from letters, emails, phone conversations, the provisions of medical literature, meetings with experts, and comments during public meetings. Time was spent creating a Preamble that fully set forth the intent of the guidelines, with the primary objective being improved patient outcomes and the reduction of prescription overdose deaths. Ms. Sweet pointed out that the guidelines do not mandate the standard of care and wants to assuage physicians who are concerned that deviations from these guidelines might be cause for discipline. She stated that deviation from the guidelines will occur and may be appropriate depending on the needs of individual patients. The bottom line of the Preamble is that medicine is practiced one patient at a time.

Ms. Sweet stated the next section entitled Understanding Pain is included as educational information. The California Medical Association (CMA) shared several portions of its document on prescribing opioids and staff felt this was an important topic to include in the guidelines. In this section of the guidelines, pain, sub types of pain, and commonly referenced terminology, such as addiction, tolerance, etc., are defined.

Ms. Sweet noted the next section is devoted to special patient populations, such as patients suffering from acute pain, patients seen in the emergency room, pediatric patients, pregnant patients, patients with a history of substance abuse, psychiatric patients, etc. and treatment option considerations are offered for different patient populations or scenarios.

The next section is titled Patient Evaluation and Risk Stratification. Staff and experts agree that risk stratification is critical when initiating treatment for long-term opioid therapy for chronic non-cancer pain. Also included are helpful links to tools the physician can refer to when conducting a thorough evaluation as well as assessing risk.

She continued stating the next section addresses consultation and it was another example of the great feedback received by the Board. One of the partners suggested moving this toward the beginning of the patient relationship to highlight the benefit of consultation before issues develop.

Ms. Sweet then moved on to the sections for treatment plan and objectives, patient consent, and the pain management agreement. It is recommended that the patient and physician develop treatment goals together. The document shows items that are typically listed on a typical patient consent form, recommends use of a pain management agreement, and provides samples of such.

Ms. Sweet noted staff felt the next section was very important to include. That section is titled Counseling Patients on the Risk of Overdose and Response, and was included to further support one of the objectives cited in the Preamble and that is the prevention of overdose deaths.

The next section, Initiating an Opioid Trial, was included in hopes of highlighting the recommendation that all patients who initially receive opioids for chronic acute and non-cancer pain do so on a trial basis, with specific evaluation points in order to determine if opioids should continue to be prescribed past a certain point and time. Continued opioid therapy after an appropriate trial should be based on outcome such as the patient making progress towards specific functional goals and improvement in pain status, the lack of evidence of medication misuse, abuse or diversion, etc. Ongoing patient assessment emphasizes the importance of continuous monitoring after the opioid trial is considered successful and it should continue through the duration of the treatment. Again, there are helpful links to tools to assist the physician to measure the efficacy of opioid therapy.

Ms. Sweet continued with the next section titled Compliance Monitoring. This section provides guidance on how physicians can determine if provisions of a pain management agreement are being heeded, for example, the use of a CURES report, drug testing, and pill counting. Also included in this section is information and suggestions for physicians whose patients are not complying with the pain management agreement.

The next section, Discontinuing Opioid Therapy, addresses the circumstance that might require a physician to change the course of treatment. Included are strategies for tapering and weaning patients from opioids.

Ms. Sweet stated the next section addresses medical records, which she stated is self-explanatory. She noted the final two sections, Supervising Allied Health Professionals, and Compliance With Controlled Substances Laws, suggest physicians who supervise other healing art professionals be aware of the laws governing them and those whom they supervise. The section relative to Compliance with Controlled Substances Law has a link to the actual laws.

Ms. Sweet stated there is a significant amount of information in this 24-page document and it is supplemented with as many resources as practical via the appendices or links to websites that would further assist the physician by making it easily accessible.

Ms. Sweet concluded her report by again thanking all for the assistance received while putting this important document together. She added this collaborative effort would make tremendous strides in protecting medical consumers in the State of California.

Dr. Bishop stated what a pleasure it was to work with Ms. Sweet, her staff, and Ms. Kirchmeyer on these guidelines. H added the amount of work they put in was amazing and the document is a testament to their skills and hard work.

Ms. Yaroslavsky agreed with Dr. Bishop's comments. She added these guidelines have been a long time coming and are the evidence of staff's collaborative energy and efforts, in addition to doing their regular daily jobs. She suggested sending a link to the document to those that did participate in assisting the gathering of information in the guidelines. She thanked the staff for their hard work.

Dr. Lewis also thanked everyone involved in putting this document together stating he is pleased with it. He asked who the actual intended audience is for this document stating it is such a massive and complete document, he is wondering how it is going to be distributed to the general practitioners who treat a majority of patients with chronic and acute pain. He stated physicians have to realize there are realistic expectations of patients. They need to be reminded that they cannot treat 100% of patient pain and that 30% relief is a reasonable goal for chronic pain. He asked if there is anything that can handed out to the patient that can help them understand this and give them tips on how they, themselves, can help with their own pain management.

Ms. Sweet stated that as far as distribution of this document, there would be an article placed in the Board's next Newsletter to advise physicians of its existence. She noted the Board is also working with the California Department of Public Health (CDPH) on an informational campaign, using these guidelines as a starting point, to let people know, through articles and social media, the existence of these guidelines and other such informational documents.

Ms. Kirchmeyer spoke about a work group she is involved in with the CDPH stating they are working on a statewide initiative on the issue of the epidemic of drug misuse and abuse. She noted that CDPH has been waiting for these guidelines, so they can launch an outreach program. They have a press release that will go out as soon as the Board's release goes out. CDPH will then note where the other entities that are involved in this fit into the outreach to everyone, not just physicians. This is just the first step of a huge outreach program in the state on this issue.

Ms. Kirchmeyer announced that Board staff is working on making this document into an application that can be accessed on smart phones, so these guidelines are available anywhere at any time. She stated as far as outreach goes, these guidelines are just one of the many subjects the Prescribing Task Force has on its agenda. The next thing it will be working on is best practices. The goal is to put together a web page that is not only available to physicians, but also putting out information on best practices for the public as well.

Dr. GnanaDev thanked Ms. Sweet, Dr. Bishop, and Ms. Yaroslavsky for a wonderful job on the guidelines. He suggested another outreach option is to work with the agencies that provide continued medical education (CME) credits. They can take these guidelines and use them to create an exam to earn CME credits.

Dr. Levine stated there are three gaps between current practice and ideal practice and she feels that these guidelines are a beginning to help fill those gaps. The first gap being the "knowledge" gap and this document provides a great basis for identifying what knowledge currently exists. She stated the next gap is the "knowing" gap, meaning once the knowledge exists, getting it out, disseminating it, and insuring it is accessible to people at the point where they need the information. The last, and the hardest gap, is the "knowing/doing" gap. Therefore, incorporating

the information and making it easy to do the right thing at the point of care is not something the Medical Board can do, but by doing the first two pieces, an approach for that has been laid out.

Dr. Lewis made a motion to approved the Guidelines for Prescribing Controlled Substances for Pain as Provided in the Board Packet; s/Dr. Krauss.

Steve Cattolica, Director of Government Relations for the California Neurology Society, the California Society of Physical Medicine and Rehabilitation, and the California Society of Industrial Medicine and Surgery, stated the 800 plus members of these organizations commend the work of the Prescribing Task Force and strongly believe these guidelines will provide clarity necessary to allow physicians to practice medicine one patient at a time without undue fear of doing so. They also commend the living nature of the document that can be improved on for years to come. He stated these guidelines are only part of this issue. He stated their constituents treating injured workers face a difficult situation. The Division of Workers Compensation (DWC) recently pronounced the Board's guidelines being very consistent with those the DWC will propose as regulation. However, any inconsistency will cause all physicians to perhaps compromise because all of the DWC treatment guidelines have a long and proven track record of being misapplied by worker's compensation claims payers, primarily to control costs and access, and to identify physicians they no longer want in their provider networks. They urge the Board to anticipate the Worker's Compensation Utilization Review physicians will not authorize a controlled substance citing the DWC's guidelines. They also urge the Board to establish these guidelines, but more importantly use all of its authority and influence to assure that the phrase "very similar" be eliminated between the Board's and DWC's guidelines, in favor of the phrase that has the same meaning.

Jeremy Adler, President of the California Academy of Physician Assistants, commended the Task Force for a job well done and stated that they use the Board's current guidelines to train their physician assistants and will be adding these new guidelines into that training program.

Motion carried.

Agenda Item 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 stated in the Board packet is a memo providing an update on the status of these regulations. At the last meeting, it was approved that the Board would hold a hearing outside of the Board Meeting in order to expedite the regulations. A hearing was held and these regulations will be submitted to the DCA. The regulations were approved to be effective upon approval by the Office of Administrative Law (OAL). Staff hopes that these regulations would be put into effect by the end of the year

Agenda Item 18 Presentation on Fictitious Name Permits

Mr. Worden gave a presentation on fictitious name permits (FNP). The presentation included answers to questions, such as how long these permits have been around; who is and is not required to obtain one, etc. It also included the FNP requirements, program information, statistics, and information on the common sections of statute and regulation.

Ms. Yaroslavsky recommended putting the information shown in the presentation in the Newsletter on regular basis and maybe even sending this same information out with the renewal documents.

Dr. Lewis suggested included this information in the licensing fairs also.

Yvonne Choong, CMA, suggested adding the answer to the question: "What happens when a physician leaves a practice or the partnership changes?" This is a question that CMA is asked often, so she suggested it be put in the question and answer on this subject. Another issue they are having is in terms of being able to search on the Board's website. They are unable to see which physicians are associated with which practice and she stated she hopes BreEZe will fix that issue at some point.

Agenda Item 19 Discussion and Consideration of the Proposed Regulations to Amend the Continuing Medical Education Requirements

Mr. Worden stated that at the last Board meeting the Licensing Committee had a presentation from the American Board of Medical Specialties (ABMS) about maintenance of certification (MOC) requirements. During the presentation, it was noted that the MOC requires CME. The Board has CME requirements for physicians to meet as well, however, the MOC requirements may not meet the requirements for the Board's CME. The physicians would be doing double CME to meet the Board's requirements. The memo in the Board packet, pages BRD 19-1 through BRD 19-3, is an outline of what the Board could do to change the regulations so that physicians that are required to do MOC would not have to complete more CME. Those changes are noted on pages BRD 19-2 and BRD 19-3.

Mr. Worden asked for 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 approved for MOC as meeting the Board's CME requirements.

Ms. Dobbs noted that on section 1338(d), she believes the change should read just (a), not (a) and (g).

Dr. Levine made a motion to direct staff to notice the amended regulatory language as stated in the Board Packet and amended by Ms. Dobbs and hold a regulatory hearing; s/GnanaDev. Motion carried

Agenda Item 20 Special Faculty Permit Review Committee Recommendations; Approval of Applicants

Ms. Yaroslavky stated the Special Faculty Permit Review Committee held a teleconference meeting on August 14, 2014 and reviewed three applications: one from Stanford University for Dr. Maurice Ohayon; one from University of California San Diego for Dr. Miguel Del Campo Casanelles; and one from University of California San Francisco for Dr. Anthony T. Moore.

The first recommendation for a committee appointment was for Dr. Ohayon, who is a world-renowned scholar, and whose work is in the forefront at the field of epidemiology, encompassing sleep neuropsychiatric conditions and co-occurring disorders. In addition, he is an expert in forensic psychiatry and mental health. His skill set in complex patient evaluation, advanced psychotherapy models, and targeted psychopharmacology will significantly expand

the existing clinical programs in the Department of Psychiatry and Behavioral Sciences at Stanford University. He also holds a doctorate of science degree in mathematics and computer sciences from the University of Air- Marseille and a Ph.D. in human biology from the Claude Bernard Lyon 1 University.

Dr. Ohayon would hold a full-time faculty appointment as a Professor of Psychiatry and Behavioral Sciences. He would provide clinical care, including evaluations, psychotherapy, and psychopharmacology, in the adult outpatient psychiatry clinics in the Department of Psychiatry and Behavioral Sciences at Stanford. The Committee recommended the Board approve Dr. Ohayon for a special faculty permit.

Ms. Yarosalvsky made a motion for the Board to approve Dr. Ohayon for a Business and Professions Code section 2168.1(a)(1)(B)(5) special faculty appointment at the Stanford University of Medicine; s/Dr. Krauss. Motion carried.

The second recommendation was Dr. Del Campo Casanelles, who is the Director of the Scientific Advisory Committee of Orphanet-Spain. He is certified by the American Medical Board of Genetics and is one of Europe's foremost clinical geneticists and dysmorphologist. He is an outstanding clinician, specifically in the study of treatments and interventions for children suffering from fetal alcohol syndrome and fetal alcohol syndrome disorders. He also holds a Ph.D. in pediatrics from the Universidad Autonoma de Madrid. Dr. Del Campo Casanelles was first certified by the American Board of Medical Genetics in 1999 and his current certification is through 2019.

Dr. Del Campo Casanelles has 34 peer-reviewed research articles, is the co-author of one book, and has written chapters for five additional books. Dr. Del Campo Casanelles is the Director of the Scientific Advisory Committee of Orphanet-Spain. In addition, he is a leading contributor for a global health initiative on Fetal Alcohol Spectrum Disorders sponsored by the NIH and WHO.

Dr. Del Campo Casanelles would hold a full-time faculty appointment as an Associate Professor of Clinical Pediatrics at UC San Diego. Dr. Del Campo Casanelles would 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 would also be providing education instruction to fellows, residents, and medical students.

The Committee recommended the Board approve Dr. Del Campo Casanelles for a Special Faculty Permit appointment.

Ms. Yaroslavsky made the motion for the Board to approve Dr. Miguel Del Campo Casanelles for a Business and Professions Code Section 2168.1(a)(1)(B) Special Faculty Permit appointment at University of California San Diego School of Medicine; s/Dr. Krauss. Motion carried.

The third recommendation was for Dr. Moore who is an international leader in pediatric ophthalmology and a renowned expert in gene therapy for inherited retinal degenerations.

Dr. Moore has over 300 peer-reviewed publications, two books and 40 book chapters. Dr. Moore received the Franceshetti Medical of International Society of Genetic Eye Disease and the Claffy Memorial Medal from the University of Sydney awards in 2003.

Dr. Moore would hold a full-time faculty appointment as a Pediatric Ophthalmologist and Professor of Ophthalmology at University of California San Francisco. Dr. Moore would provide clinical care in pediatric ophthalmology in the outpatient services and inpatient pediatric ophthalmology consultative services. He would conduct research in the field of inherited retinal degeneration along with teaching medical students, residents, and fellows both in didactic and in the clinic.

The Committee recommended that the Board approve Dr. Moore for a Special Faculty Permit appointment.

Ms. Yaroslavsky made a motion for the Board to approve Dr. Anthony T. Moore for a Business and Professions Code Section 2168.1(a)(1)(A) Special Faculty Permit appointment at University of California San Francisco School of Medicine; s/Dr. Krauss. Motion carried.

Agenda Item 21 Discussion and Consideration of Legislation/Regulations

Ms. Simoes referred the Members to tab 21 in their packets. She stated she had contacted Legislative offices in the San Diego area and invited them to attend the Board Meeting. Ms. Simoes stated the 2014 Legislative session has ended and the Legislature does not reconvene until December 1, 2014. The Governor has taken action on all the bills the Board has taken positions. This is the last year of a two-year session, which means, if a bill did not pass this year, it is dead. She stated the tracker list could be found under tab 21. The bills in pink are Board-sponsored bills and the bills in blue are bills where the Board has taken a position. All bills on the list were signed into law by the Governor. She stated she would be giving a brief summary of each bill and then discussing the Board's implementation plan. She asked the Board Members to note that the implementation plan includes a Newsletter article in the Winter Newsletter and notifying or training of Board staff.

AB 1838 (Bonilla) 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). The Board implementation plan is to update the Board's website, publications, and forms.

AB 1886 (Eggman) is the internet posting bill that allows the Board to post the most serious disciplinary information, which is already public information, on the Board's website as long as it remains public. The Board's implementation plan is to 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 the documents back on the 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. In addition, send an email blast out to all physicians alerting them of this change in posting requirements and to update regulations through a Section 100 change for the citation posting changing to three years.

SB 1466 (Committee on Business, Professions, and Economic Development) was the Board's health omnibus bill and the provision that will impact the Board include making the American

Osteopathic Association-Healthcare Facilities Accreditation Program (AOA-HFAP) an approved accreditation agency for hospitals offering accredited postgraduate training programs, and also striking "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. The Board's implementation plan is to update the Board's website, publications, and forms.

AB 186 (Maienschein) 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. The implementation plan is for staff to process these temporary licenses, which would become full licenses once all of the documentation is received. In addition, to identify a licensing staff member to become the single point of contact for all temporary licenses, work with DCA on BreEZe changes, along with posting information for military spouses on the Board's website regarding how to apply for a temporary license and the eligibility requirements.

AB 496 (Gordon) amends the existing cultural competency 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. The implementation plan is to 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 the amended cultural and linguistic competency requirement, and to include information on the new requirement on the Board's CME webpage.

AB 809 (Logue) 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 took effect immediately upon being signed into law. The implementation plan is to notify/train Board staff and DCA/DOI staff, and update the Board's website and related publications.

AB 1535 (Bloom) allows pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Board, in consultation with the California Society of Addiction Medicine, the California Pharmacists Association and other appropriate entities. The implementation plan is to work with the BOP to develop standardized procedures and protocols for pharmacists to use when furnishing naloxone, bring standardized procedures and protocols to the Board for approval, and notify/train Board staff.

AB 1841 (Mullin) 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, nurse practitioner, or a certified nurse-midwife. The implementation plan is to notify/train Board staff and DCA/DOI staff, as well as update the Board's website and publications.

AB 2139 (Eggman) 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. The implementation plan is to notify/train Board staff and update the Board's website and publications.

AB 2214 (Fox) enacts the Dolores H. Fox Act and requires the Board, when determining CME requirements, to consider including a course in geriatric care for emergency room physicians. The implementation plan is to include a stand-alone Newsletter article geared toward emergency room physicians and geriatric care.

SB 1083 (Pavley) authorizes physician assistants (PA) to certify claims for disability insurance with the Employment Development Department. The PA would first have to perform a physical exam under the supervision of a physician, pursuant to existing law. The implementation plan is to notify/train Board and DCA/DOI staff and include an article in the Board's Newsletter.

SB 1116 (Torres) 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 Steven M. Thompson Loan Repayment Program (STLRP). The implementation plan is to update the Board's website to highlight the fact that physicians can donate more than the mandatory $25.00 to the STLRP and provide directions on how to do so. The Board will work with DCA on needed BreEZe enhancements, amend the licensing and renewal applications to include new information and provide an opportunity for them to do so on both forms, and to identify procedures for staff to process additional voluntary contributions to the STLRP.

SB 1243 (Lieu) is a sunset review bill for several boards under the DCA. In addition to the sunset review provisions, this bill also requires the DCA and of Office of Administrative Hearings to submit specified reports to the Legislature on an annual basis. The bill enhances unlicensed advertising enforcement, requires DCA to develop and offer enforcement training, and amends public meeting notice requirements. The implementation plan is to notify/train Board staff and include an article in the Board's Newsletter.

Agenda Item 21B 2015 Legislative Proposals

Ms. Simoes referred the Members to pages BRD 21B-1 through BRD 21B-3.

805 Reporting – In the Board's Sunset Review Report, the Board included information regarding a decline in 805 reporting. To address this decline in reporting, Board staff is proposing legislation that would require physicians to report to the Board when reportable actions occur within 30 days after they are finalized. This will enable the Board to ensure that peer review bodies are reporting appropriately, and ensure that the Board is aware when these actions are taken. This will allow for verification in 805 reporting.

Julie D'Angelo Fellmeth, Center for Public Interest Law, stated when she reviewed Board data, one of the things she was required to do was to determine which sources of information coming into the Board were the most reliable in enabling the Board to detect where consumer protection is at risk and stated the 805 reporting was at the top of the list. She believes the number of hospitals that are supposed to be reporting 805 reports to the Board has gone down tremendously over the years. She urged the Board to support this proposal.

Yvonne Choong, CMA, stated they have some concerns about this proposal. She noted that currently, the Chief of Staff at each hospital is responsible for reporting certain actions within 15 days and the staff reports show this reporting has declined and this change is needed. They are not convinced that it is because of under reporting by the hospitals. There are a number of reasons that could lead to under reporting, such as fewer physicians practicing in hospitals; fewer contracting arrangements between physicians and hospitals may influence this decline as well. They feel that adding another burden on to physicians to report will add confusion because of the types of reportable actions. It requires the physicians to be become experts in areas that must be reported, which they believe would add an additional level of education. She suggested the Board may consider if additional outreach and education is necessary before taking the step of placing another statutory responsibility upon physicians and would appreciate the Board's consideration of these recommendations.

Marianne Hollingsworth, Consumers Union Safe Patient Project, stated the Board staff has reported a historically low number of 805 reports made to the Board. She stated they support the Board staff's legislative proposal to require that physicians in addition to 805 reporters report to the Board when reportable actions occur. However, she noted they doubt this change will have much impact unless the Board takes additional action regarding section 805 requirements.

Dr. Krauss stated it is important to look at the numbers, but it is also important how those numbers are viewed. He recommended that when statistics are presented by the Board or to the Board that the Board asks for a statistical analysis of significance.

Dr. GnanaDev suggested staff get some input from the organized medical staff section of CMA as all of the hospital medical staff is represented there. He stated he agrees with going ahead with the legislative proposal, but to work with the medical staff sections in the process.

Dr. Levine also stated that there are two parts to this. It is critically important on how the data is interpreted. She feels this legislation would provide a way to verify that the numbers are accurate and validate the information. She noted if the bill is written carefully, it should not impose substantial burden on physicians.

A motion was made to approve the legislative proposal/second. Motion carried w/1 abstention (Krauss).

Ms. Simoes noted that staff would work with all interested parties on putting together this proposal.

Midwife Assistants – This issue was included in the Board's 2012 Sunset Review 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 assist in statute, or 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. The duties that a midwife assistant performs also vary greatly from LM to LM. Board staff believes 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 requirement for medical assistants, pursuant to Business and Professions Code 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 could perform technical support services only. The language should also allow the Board, through the Midwifery Advisory Council (MAC), to adopt regulations and standards for any additional midwife assistant technical support services. Ms. Simoes stated the Board would need to approve this legislative proposal.

Ms. Yaroslavsky made a motion to approve the legislative proposal: s/Dr. Lewis.

Sara Davis, California Association of Midwives expressed their support for this proposal.

Motion carried.

Outpatient Surgery Settings (OSS) Legislative Proposals – Ms. Simoes reminded the Board that there are three proposals that had been previously approved by the Board and had briefly been inserted into a bill last year, SB 966, but due to the lateness of the amendment to the bill, it was decided it would be taken up this year instead. Staff has already met with Senate Business and Professions Committee staff and they plan to propose legislation this year. The proposals that have already been approved are: data reporting to the Office of Statewide Health Planning and Development (OSHPD), unannounced inspections performed by the Accreditation Agencies, and physician peer review requirements.

Mr. Serrano Sewell stated for the Board that there would be no changes in the prior approvals of those three proposals.

Ms. Simoes continued with the one OSS proposal that had not been pre-approved by the Board. She stated 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. Board staff is suggesting Board language that would consider accredited OSSs as a peer review body and requires these setting to report specified actions to the Board. The language would also allow both CMS-certified ASCs and OSSs 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 proposal would enhance consumer protection. The Board would need to approve this legislative proposal.

Dr. Krauss made a motion to support this legislative proposal; s/Dr. Lewis.

Carol Moss, Consumers Union, stated they support this legislative proposal. They encourage the Board to expand the proposal to include all ASCs in order to get a full picture of the procedures being done in California. They are concerned about the part of the proposal to pursue a legislative requirement for peer review. She stated details were not included in the documentation. They are concerned that if the Board sponsors and passes legislation to put in place peer review in OSSs, this may give patients and policy makers a false sense of security, as many of the OSSs involve only one or two physicians, or involve multiple physicians, all of who are financially invested.

Motion carried.

Technical Clean-Up (Potential Omnibus) – Ms. Simoes stated there are provisions that are technical in nature and are potential candidates for the Board's omnibus bill, meaning the changes are purely technical and not controversial.

Ms. Simoes stated there are numerous clarifying changes 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 pertaining to unlicensed practice, probation, cite and fine, etc. In addition, for physicians and surgeons, there are a few technical, clarifying changes that are needed related to using "M.D.," denials, public letters or reprimand, etc. The Board would need to approve staff going forward with some technical changes.

Dr. Lewis made a motion to approve this legislative proposal; s/ Ms. Wright. Motion carried.

Medical Marijuana – Ms. Simoes noted this proposal was brought up and discussed at the Board's recent Enforcement Committee meeting. It was suggested that there be a legislative statute change pursued to require the initial examination be made in-person prior to the physician recommending marijuana.

Dr. Levine stated she agrees there should be some clarification about what constitutes the appropriate conditions under which a recommendation for marijuana can be made. She feels the Board needs to be very careful with what that is and does not believe it should be as simple as an in-person versus a non in-person examination. She stated she supports a legislative proposal with the intent of clarifying the situations under which a recommendation for marijuana is appropriate congruent with medical practice.

Dr. Krauss agreed with Dr. Levine, but feels that goal might be a hard one to accomplish within the next legislative cycle. His concern is a physician thinks of a physician/patient relationship as a circumstance where a patient has a symptom or problem and seeks a physician's evaluation and/or treatment. Marijuana or opioids are circumstances where the patient knows what they want and the reason that they want it, and will seek out a physician knowing that is the gateway to obtaining it. He is concerned that under existing law, people who desire to have marijuana, for whatever reason, can skype by telehealth to get a recommendation for marijuana. The recommendation as stated yesterday was to establish a Board policy position and to lobby for legislation to require that a recommendation for marijuana for medical purposes require an in-person good faith examination by a Californian licensed physician. He noted that would be something that would be easier to accomplish via legislation

Mr. Serrano Sewell stated this is a complicated issue. It covers federal, state and local municipalities and how they deal with marijuana for medical purposes. He proposed that Dr. Lewis create a working group though the Enforcement Committee to look at existing facts, existing law and be put on the next Enforcement Committee agenda for further discussion.

Dr. Bishop feels marijuana should be treated just like any other medical drug despite the emotional aspect of it, as people tend to forget there is existing law already.

Agenda Item 21C Status of Regulatory Actions

Ms. Simoes noted staff had just received notice from the OAL that the regulatory language that the Board submitted to implement SB 1441 was disapproved. However, the Board has 120 days to

make changes to the proposed regulations to address the concerns raised by the OAL. Ms. Webb is in the process of working on these changes. She announced there would need to be an interim

teleconference Board Meeting on this issue and Members will be contacted early next week seeking their availability for this interim meeting.

Mr. Serrano Sewell asked Ms. Kirchmeyer what the next steps are in getting this approved.

Ms. Kirchmeyer stated the next steps are to find out what changes OAL is requesting in order to come into compliance with their requirements. The Board staff will make the requested changes, as well as change the final statement of reasons. Then, an interim meeting will need to be held for the Board to approve those changes before it can be noticed. Once that meeting has taken place and the changes have been approved, staff will then notice it for a 15-day comment period.

Agenda Item 22 Update on the Physician Assistant Board

Dr. Bishop stated the PA Board's (PAB) website was updated recently to include an "about us" tab, which includes a history of the PAB. The page also contains a link to two historical documents regarding the creation of the PAB.

Dr. Bishop noted that recent federal regulation would transfer hydrocodone combination products from schedule III to schedule II. To ensure that licensees are aware of this change, staff is in the process of updating the website to include information about this change in law. This information will be placed on the home page under "highlights," and will be under the "licensee" tab. PAB is mirroring the Medical Board's information about this topic so the PAs will receive a similar message from both boards.

He continued stating PAB continues to work with the BreEZe team on BreEZe production stabilization issues. The main issues are with the enforcement and cashiering aspects and the generation of reports in BreEZe. The licensing functions are continuing to work appropriately and are not experiencing any delay in issuing PA licenses. PAB staff are routinely attending user group meetings and these meetings are helpful to the PAB in that staff are able to share their issues with BreEZe staff and other boards in order to assist in finding solutions. The next phase of the BreEZe implementation is on-line renewals. Staff is working to develop language that will be included in the on-line renewal pages.

Dr. Bishop noted PAB continues to receive support from the Medical Board's Information Systems Branch (ISB), since many of their data processing functions are similar. ISB is able to assist staff with many BreEZe issues. PAB is very appreciative and grateful for the professional attitude and support that is provided.

Dr. Bishop stated an important bill affecting PAs' practice is SB 1083 (Pavley). This bill authorizes a PA to certify a patient's disability after performance of a physical examination by the PA under the supervision of a physician and would correspondingly expand the definition of practitioner to include a PA. The Governor signed SB 1083 and it becomes law in 2015.

He announced the next PAB meeting is scheduled for November 3, 2014.

Agenda Item 23 Update on the Health Professions Education Foundation

Ms. Yaroslavsky stated there are not any new updates to be shared. As stated at the last meeting, about $32 million was distributed among loan repayments and scholarships this past year. The next meeting will be in early December, so there will be more to report at the next Board meeting.

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

Mr. Serrano Sewell announced some agenda items for the January Board meeting in Sacramento. One being a regulatory hearing on the CME requirements and a presentation by the University of California San Francisco regarding the study it performed using the Board's physician survey. He then asked Members if there were any additional item they would like added to the January 2015 Board meeting agenda.

Dr. Krauss suggested that at each quarterly meeting, the Executive Committee and the Board have a Board policy compendium update.

Ms. Wright suggested having a representative from the Office of Health Equity come and speak to the Board in regards to the specifics of what they do.

Ms. Kirchmeyer stated staff is looking into that and noted there are other entities as well that do research. She will look into those entities to see who could do such a report.

Dr. Levine suggested a presentation on the newest developments in telehealth, including where the technology is going in terms of safety, encryption, etc. She offered to assist in finding someone to attend the meeting to give such a presentation.

Agenda Item 25 Adjournment

Mr. Serrano Sewell adjourned the meeting at 11:38 am.

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2014/.

_____	_____
David Serrano Sewell, President	Date
_____	_____
Denise Pines, Secretary	Date
_____	_____
Kimberly Kirchmeyer, Executive Director	Date

MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING

Teleconference

Monday, December 1, 2014
4:00 p.m. – 5:00 p.m.

Meeting Minutes

Teleconference – See Attached
Meeting Information

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815
****
Kaiser Permanente
1950 Franklin Street
2nd Floor Conference Room 2-C
Oakland, CA. 94612
Note: Guests will have to check in with Lobby Security before entering the conference room floor.

Arrowhead Regional
Medical Center
400 North Pepper Avenue
Room #3M308-5
Colton, CA 92324
****
Hospital Council of
Northern CA
235 Montgomery Street,
Suite 1158
San Francisco, CA 94104
****
Grounds Bakery & Café
Conference Room
6277 E. Spring St. Long
Beach, CA 90808

11645 Wilshire Blvd.
First Floor Lobby
Los Angeles, CA. 90025

****

Cedars Sinai Lab Services
8711 West Third Street
Los Angeles, California
90048

****

600 N Garfield Ave. # 308
Monterey Park, CA. 91754
****
Jones Day
555 South Flower Street,
50th Floor
Los Angeles, CA 90071
Note: Guests will have to check in with Lobby Security before entering the conference room floor.

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., President
Dev GnanaDev, M.D., Vice President
Howard Krauss, M.D.
Sharon Levine, M.D.
Ronald H. Lewis, M.D.
Elwood Lui
Denise Pines, Secretary
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Member Absent:

Michael Bishop, M.D.

Staff Present:

Kimberly Kirchmeyer, Executive Director
See Vang, Business Services Analyst
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Michelle Monseratt Ramos, Consumer's Union, Safe Patient Network

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

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on December 1, 2014, at 4:08 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 comments were heard on this agenda item.

Agenda Item 3 Review and Consideration of Revised Regulatory Language Amending Section 1361 and Adding Sections 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 to Title 16, California Code of Regulations - Uniform Standards for Substance-Abusing Licensees – Ms. Webb

Ms. Webb reminded the Board that a regulation packet on these changes was sent to the Office of Administrative Law (OAL) for review and approval, however, it was disapproved. She referred Members to agenda item three in their packets and went over each change individually. She first referred to page BRD 3-24, A through D. In letter A, OAL requested the language change from "Number of licensees who successfully completed probation" to "Number of licensees who successfully returned to practice…" However, she stated this particular language change did not comply with the way the Board functions, since a licensee can be on probation and still be practicing. Upon meeting and conferring with the OAL, it was agreed that a change was not needed, so that particular change will not be reflected in the final document going to the OAL for final approval.

Ms. Webb advised that the changes requested in B through D, were made, and are reflected in the third modified language document that is in the Board packets, also on page BRD 3-24.

Ms. Webb continued with the additional changes that OAL had asked be made and were agreed upon. On page BRD 3-3, item 3B, OAL requested the words "in any order" be struck out. On page BRD 3-7, there were more substantive changes requested. Language struck out in Blue shows the difference in testing from the first year, versus the second year, versus after five years. The new language clearly reflects the differences. In section 3D, OAL requested the additional verbiage shown in blue be included. These changes comply with what the working group agreed upon. The next major changes are found on page BRD 3-8, referencing section 2, with the addition of the language in the last line of the paragraph, "and participate in the second-year testing frequency requirements." Also, in section 4, the addition of the last sentence in that paragraph that reads, "If the licensee returns to employment in a health care field, and has not previously met the first-year testing frequency requirements, the licensee shall be subject to completing a full year at the first-year testing frequency requirements, otherwise the second-year testing frequency requirement shall be in effect." These were edits requested by OAL.

Ms. Webb further noted the strikeout on page BRD 3-12, section 1, last line of the paragraph. OAL felt this was unnecessary language per the code and asked it be removed.

Ms. Webb stated the additional changes shown in the document were considered non-substantive changes by OAL and she will not go over them unless requested by the Members. She noted the Board has revised the language to meet OAL's requests.

She stated one written comment was received from Ms. D'Angelo Fellmeth prior to the meeting, who noted that one particular reporting requirement had not been changed, but Ms. Webb stated staff had met with the OAL whom stated the change did not have to be made.

Ms. Webb asked for a motion to approve the recommended changes to the proposed language to implement the Uniform Standards for Substance-Abusing Licensees and to further direct staff to notice the modified language for a third fifteen-day comment period. If no negative comments are received during the fifteen-day comment period, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rulemaking process and adopting Title 16, California Code of Regulations - Uniform Standards for Substance-Abusing Licensees Section 1361 and Adding Sections 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 with the modified text.

Dr. Lewis made a motion to approve the recommended changes to the proposed language to implement to Uniform Standards for Substance-Abusing Licensees and to further direct staff to notice the modified language for a third fifteen-day comment period. If no negative comments are received during the fifteen-day comment period, authorize the Executive Director to make any non-substantive changes to the proposed regulations before completing the rulemaking process and adopting Title 16, California Code of Regulations - Uniform Standards for Substance-Abusing Licensees Section 1361 and Adding Sections 1361.5, 1361.51, 1361.52, 1361.53, 1361.54, and 1361.55 with the modified text.; s/ Dr. GnanaDev.

Michelle Monseratt Ramos, Consumer's Union, Safe Patient Network, urged the Board to include language in Uniform Standard number four, to insure that the Board and the physician understand that in the event of suspicion, the Board has the power to take action. She feels this is an important consumer protection issue.

Motion carried unanimously.

Mr. Serrano Sewell adjourned the meeting at 4:32 pm.

_____ _____
David Serrano Sewell, President Date

_____ _____
Denise Pines, Secretary Date

_____ _____
Kimberly Kirchmeyer, Executive Director Date

The full meeting can be viewed at http://www.mbc.ca.gov/About_Us/Meetings/2014/

MEDICAL BOARD OF CALIFORNIA – POLICY COMPENDIUM

This policy compendium was approved by the Medical Board on October 24, 2014

POLICY AREAS:

Scope of Practice

Policy and Principles

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, proctoring, 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)

Policy Statement

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

Policy Statement

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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 14, 2015
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.

- Although a break was taken over the holidays, Mr. Serrano Sewell, Dr. GnanaDev and the Executive Staff continue to have conference calls to review the actions of the Board and ensure the requests of the Board are being completed. Board Members are receiving updates on activities at the Board as well as a pending projects list.
- Regular meetings were held with Director Awet Kidane, Chief Deputy Director Tracy Rhine, and Deputy Director Christine Lally 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 Controlled Substance Utilization Review and Evaluation System (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 DOJ, 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 12% vacancy rate which equates to 19 vacant positions. This is up from the report provided in the last Administrative Summary in part because of several retirements and promotions. However, of those 19 vacant positions, the Board has 3 individuals pending a start date or verification of eligibility. Therefore, the Board only has 16 positions that do not have an individual identified for the position. This equates to an 10% vacancy rate for the Board.

The Board hired a new Deputy Director, Liz Amaral, on December 5, 2014. Ms. Amaral has an extensive background in State administration and will be taking care of the Board's day-to-day operations.

On January 8, 2015 the State Personnel Board (SPB) heard the Board's request for a Career Executive Assignment position to fill the Board's Chief of Enforcement. This position was obtained through the Budget

Change Proposal process for Fiscal Year (FY) 14-15 due to the transition of the investigators to DCA pursuant to Senate Bill 304 and the loss of the Chief of Enforcement position. Board staff responded to questions from the SPB Members, however, they requested additional information be provided to them to further clarify the need for this position and the request was taken under submission. Staff are working with the DCA Office of Human Resources to provide documentation to the SBP for clarification and hopefully the position will come before the Board again on February 5, 2015.

Budget Update:
The Board's budget documents are attached, beginning on page BRD 8B-5 and continue to page BRD 8B-15. The Board's fund condition on page BRD 8B-5 identifies the Board's fund reserve was at 5.8 months at the end of FY 13-14. Although this shows an increase from last year (and last meeting), it is important to point out that due to BreEZe, the revenue collections for FY 13-14 included revenue in advance, thereby overstating the Board's revenue in FY 13-14. This should be realized in FY 14-15. As stated in the last report, the Board is working with DCA to resolve the issues with the Board's revenue. Once the overstated amount is known, a new fund condition will be presented.

Due to this overstated revenue, the fund condition report indicates that the Board's fund reserve will be below its mandated level in FY 17-18. However, depending upon the actual revenue and the FY 14-15 spending, this could occur in FY 16-17. The Board continues to have two outstanding loans to the General Fund and 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 within 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. Therefore, the Board should wait until the full year (or two) of the transition has been realized and a budget review is completed before any decisions on the Board's fund condition is made. The Board will continue to monitor its fund to determine any needed changes.

The Board's overall actual expenditures through November 30, 2014 can be found on page BRD 8B-7. Pages BRD 8B-8 to 8B-12 show the budget report specifically for licensing, enforcement, the Health Quality Investigation Unit (HQIU), and the AG expenditures. Page BRD 8B-15 provides the Board Members' expenditure report as of January 6, 2015.

BreEZe Update:
As previously stated, DCA is currently amending the contract 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. 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.

As has been continually stated, one of the biggest impacts to Board staff with the transition to BreEZe has been the lack of reports needed to identify the Board's workload and processing timeframes. This continues to be an issue. Although the Board's and DCA's staff are working on these reports, there are still no reports that identify the licensing and enforcement statistics previously reported to the Board by using the legacy databases.

Due to the lack of reports and the aforementioned revenue issue, the Board's annual report, which is usually released in October, was released January 14, 2015. Although Board staff finalized the document, the Board placed a caveat in the narrative that the information in the report is based upon reports that cannot be completely verified. The Executive Management prioritized the Information System Branch's report requests and placed the investigative timeframes as the number one priority in addition to all other enforcement reports. The currently available reports in the BreEZe system for the timeframes do not subtract any time when a case is closed and then reopened, so the Board does not believe these reports are accurate. Unfortunately, due to the volume of complaints, investigations, and disciplinary actions, the Board staff cannot individually verify all the reports.

Board staff continues to submit requests for changes/fixes to DCA for the BreEZe system. The Board still has over 180 outstanding requests for changes, including those 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. The Board has to prioritize all of its requests when a new release is being scheduled and identifies the top five items that need fixed. Usually the Board is looking at those items that are legislatively required (such as the new requirements for military individuals) and putting them first.

Board of Pharmacy Update:
Virginia Herold, Executive Officer of the Board of Pharmacy (BOP), will attend the January meeting and will provide an update to the Members. Ms. Herold will also be providing the BOP's joint protocols on self-administered hormonal contraception, nicotine replacement products, and naloxone hydrochloride for the Board's review and approval.

Legislative Day:
The plans for the upcoming "Legislative Day" at the Capitol are being finalized. At this time, the date has been set for February 26, 2015. Board staff is reaching out to Senate and Assembly Business and Professions Committee staff to assist in setting up meetings with the Legislative Members. The Board Members will be providing the Legislative Members with information about the Board and its mission, roles, and responsibilities. A packet of information will be provided to each Legislative Member.

Controlled Substance Utilization Review and Evaluation System (CURES) Update
The CURES project is moving into the design phase of this project. The requirements have been reviewed and approved. Board staff, as well as other healing arts board staff, reviewed the requirements provided by the DOJ. Upon review, and after numerous discussions and agreements, those requirements were approved by the Joint Executive Steering Committee (JESC), in addition to the project schedule. At this time, the design phase is scheduled for the next two months. The Board will be involved in the design of the system, as well as writing test scripts and then performing the user acceptance testing. This is scheduled for April and May 2015. As a member of the JESC, Ms. Kirchmeyer meets on a monthly basis on this project. In addition, the project management team has now set up weekly update meetings to provide updates on the project.

Board staff continues to assist DOJ with obtaining registration for the CURES system by offering physicians the ability to provide documentation at the Board meetings. In addition, an individual can come to the Board's headquarters office in Sacramento and its Probation Unit offices in San Dimas and Cerritos to register for CURES.

"Going Paperless"

In an effort to expedite and streamline the Board's licensing processes, in addition to finding efficiencies for both the Board and the applicant, the Board staff is looking at ways to go paperless wherever possible. This is a goal of the Board's Executive Management team. To meet that goal, the Board is currently working with one of the medical schools to develop a pilot process to receive e-diplomas. This would allow the applicant to send the Board a link where it can go and obtain a primary source verified diploma directly from the school. This eliminates the need for the school to send information and the possibility of it getting lost in the mail or accidentally misplaced. The Board also wants to look into a way to do the same for other schools as well as for other documents, such as the medical school transcripts.

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	$ 28,153	$ 22,832	$ 19,104	$ 11,759
Prior Year Adjustment		$ 234	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 26,732	$ 28,153	$ 22,832	$ 19,104	$ 11,759
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	$ 48,914	$ 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		$ 56,404	$ 53,153	$ 53,159	$ 53,134	$ 53,126
Transfers:						
TOTALS, REVENUES AND TRANSFERS		$ 56,404	$ 53,153	$ 53,159	$ 53,134	$ 53,126
TOTAL RESOURCES		$ 83,136	$ 81,306	$ 75,991	$ 72,238	$ 64,885
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 3	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 259	$ 48	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 54,721	$ 56,306	$ 56,354	$ 58,415	$ 59,625
	2014-15 and ongoing Approved Costs					
	BreEZe Costs		$ 1,531			
	Enforcement Enhancements		$ 471	$ 415	$ 415	$ 415
	SB 304		$ 118	$ 118	$ 118	$ 118
	Anticipated Future Costs					
	BreEZe Costs			$ 1,531	$ 1,531	$ 1,531
	Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
Totals, Disbursements		$ 54,983	$ 58,474	$ 56,887	$ 60,479	$ 61,689
FUND BALANCE						
Reserve for economic uncertainties		$ 28,153	$ 22,832	$ 19,104	$ 11,759	$ 3,196
Months in Reserve		5.8	4.8	3.8	2.3	0.6

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.

C. BreEZe revenue collections for FY 13/14 included revenue in advance, thereby overstating the Board's revenue in FY 13/14. This should be realized in FY 14/15.

D. FY 14/15 expenditures does not reflect pending current year adjustments, e.g. CURES funding.

1/8/2015

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)
Fund Condition with General Fund Loan Repayments

		ACTUAL 2013-14	CURRENT YEAR 2014-15	BY 2015-16	BY+1 2016-17	BY+2 2017-18
BEGINNING BALANCE		$ 26,498	$ 28,153	$ 22,832	$ 19,104	$ 17,759
Prior Year Adjustment		$ 234	$ -	$ -	$ -	$ -
Adjusted Beginning Balance		$ 26,732	$ 28,153	$ 22,832	$ 19,104	$ 17,759
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	$ 48,914	$ 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		$ 56,404	$ 53,153	$ 53,159	$ 53,134	$ 53,126
Transfers:					$ 6,000	$ 7,000
TOTALS, REVENUES AND TRANSFERS		$ 56,404	$ 53,153	$ 53,159	$ 59,134	$ 60,126
TOTAL RESOURCES		$ 83,136	$ 81,306	$ 75,991	$ 78,238	$ 77,885
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ 3	$ -	$ -	$ -	$ -
8880 FSCU (State Operations)		$ -	$ -	$ -	$ -	$ -
FISCAL		$ 259	$ 48	$ -	$ -	$ -
1110 Program Expenditures (State Operations)		$ 54,721	$ 56,306	$ 56,354	$ 58,415	$ 59,625
	2014-15 and ongoing Approved Costs					
	BreEZe Costs		$ 1,531			
	Enforcement Enhancements		$ 471	$ 415	$ 415	$ 415
	SB 304		$ 118	$ 118	$ 118	$ 118
	Anticipated Future Costs					
	BreEZe Costs			$ 1,531	$ 1,531	$ 1,531
	Establish Spending Authority for Midwifery			$ (13)	$ (13)	$ (13)
Totals, Disbursements		$ 54,983	$ 58,474	$ 56,887	$ 60,479	$ 61,689
FUND BALANCE						
Reserve for economic uncertainties		$ 28,153	$ 22,832	$ 19,104	$ 17,759	$ 16,196
Months in Reserve		5.8	4.8	3.8	3.5	3.2

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.

C. BreEZe revenue collections for FY 13/14 included revenue in advance, thereby overstating the Board's revenue in FY 13/14. This should be realized in FY 14/15.

D. FY 14/15 expenditures does not reflect pending current year adjustments, e.g. CURES funding.

1/8/2015

Medical Board of California
Fiscal Year 2014-15
Budget Expenditure Report
(As of November 30, 2014)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	9,272,626	3,376,137	36.4	5,896,489
Board Members	31,500	25,300	80.3	6,200
Temp Help	755,888	86,987	11.5	668,901
Overtime	44,433	10,594	23.8	33,839
Staff Benefits	4,564,227	1,847,312	40.5	2,716,915
BL 12-03 Blanket	0	234,329		0
TOTALS, PERS SERVICES	14,668,674	5,580,659	38.0	9,322,344
OPERATING EXP & EQUIP				
General Expense	72,874	153,538	210.7	(80,664)
Fingerprint Reports	333,448	118,293	35.5	215,155
Printing	194,755	99,151	50.9	95,604
Communications	106,190	40,023	37.7	66,167
Postage	149,511	52,470	35.1	97,041
Insurance	2,053	35,420	1725.3	(33,367)
Travel In-State	130,298	41,333	31.7	88,965
Travel Out-of-State	0	2,192	0.0	(2,192)
Training	54,895	7,532	13.7	47,363
Facilities Operation (Rent)	928,140	966,700	104.2	(38,560)
Consult/Prof Services	1,482,088	1,954,224	131.9	(472,136)
Departmental Prorata	4,968,849	2,481,860	49.9	2,486,989
HQIU	15,804,000	5,021,653	31.8	10,782,347
Consolidated Data Center	650,230	57,020	8.8	593,210
Data Processing	117,492	151,972	129.3	(34,480)
Central Admin Svcs (Statewide Prorata)	2,865,648	1,433,325	50.0	1,432,323
Major Equipment	57,180	48,893	85.5	8,287
Other Items of Expense	0	5,591	0.0	(5,591)
Vehicle Operations	31,925	17,385	54.5	14,540
Attorney General Services	13,347,280	5,056,098	37.9	8,291,182
Office of Administrative Hearings	1,525,080	381,796	25.0	1,143,284
Evidence/Witness	1,893,439	599,784	31.7	1,293,655
Court Reporter Services	225,000	178,119	79.2	46,881
Minor Equipment	28,950	76,851	265.5	(47,901)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	44,969,325	18,981,222	42.2	25,988,103
TOTALS, EXPENDITURES	59,638,000	24,561,881	41.2	35,076,119
Scheduled Reimbursements	(384,000)	(149,242)	38.9	(234,758)
Distributed Costs	(780,000)	(242,038)	31.0	(537,962)
NET TOTAL, EXPENDITURES	58,474,000	24,170,601	41.3	34,303,399
Unscheduled Reimbursements*		(8,000)		
		24,162,601		

** no authority to spend*

Medical Board of California
Fiscal Year 2014-15
Budget Expenditure Report - Licensing and Polysom
(As of November 30, 2014)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	2,656,772	1,026,548	38.6	1,630,224
Board Members	0	0	0.0	0
Temp Help	214,000	11,521	5.4	202,479
Overtime	17,825	904	5.1	16,921
Staff Benefits	727,215	573,482	78.9	153,733
BL 12-03 Blanket	0	13,790		0
TOTALS, PERS SERVICES	3,615,813	1,626,245	45.0	2,003,357
OPERATING EXP & EQUIP				
General Expense	15,345	7,322	47.7	8,023
Fingerprint Reports	333,448	117,958	35.4	215,490
Printing	99,876	74,387	74.5	25,489
Communications	25,000	7,271	29.1	17,729
Postage	78,111	26,373	33.8	51,738
Insurance	0	0	0.0	0
Travel In-State	9,758	8,046	82.5	1,712
Travel Out-of-State	0	0	0.0	0
Training	5,000	0	0.0	5,000
Facilities Operation (Rent)	226,000	322,274	142.6	(96,274)
Consult/Prof Services	1,227,873	971,271	79.1	256,602
Departmental Prorata	592,757	296,084	50.0	296,673
HQIU	0	0	0.0	0
Consolidated Data Center	0	0	0.0	0
Data Processing	3,000	16,010	533.7	(13,010)
Central Admin Svcs (Statewide Prorata)	341,872	170,996	50.0	170,876
Major Equipment	0	0	0.0	0
Other Items of Expense	0	0	0.0	0
Vehicle Operations	0	0	0.0	0
Attorney General Services	190,000	9,100	4.8	180,900
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	7,500	0	0.0	7,500
Court Reporter Services	250	0	0.0	250
Minor Equipment	0	0	0.0	0
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	3,155,790	2,027,092	64.2	1,128,698
TOTALS, EXPENDITURES	6,771,603	3,653,337	54.0	3,118,266
Scheduled Reimbursements	(384,000)	(149,242)	38.9	(234,758)
Distributed Costs	(31,131)	(7,348)	23.6	(23,783)
NET TOTAL, EXPENDITURES	6,356,472	3,496,747	55.0	2,859,725
Unscheduled Reimbursements*		0		
		3,496,747		

** no authority to spend*

Medical Board of California
Fiscal Year 2014-15
Budget Expenditure Report - Enforcement
(As of November 30, 2014)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	2,490,580	860,334	34.5	1,630,246
Board Members	0	0	0.0	0
Temp Help	200,000	53,054	26.5	146,946
Overtime	14,554	5,147	35.4	9,407
Staff Benefits	2,716,797	533,435	19.6	2,183,362
BL 12-03 Blanket	0	210,910		0
TOTALS, PERS SERVICES	5,421,931	1,662,880	30.7	3,969,961
OPERATING EXP & EQUIP				
General Expense	15,340	68,023	443.4	(52,683)
Fingerprint Reports	0	335	0.0	(335)
Printing	35,279	13,815	39.2	21,464
Communications	14,510	18,653	128.6	(4,143)
Postage	60,000	24,290	40.5	35,710
Insurance	0	30,030	0.0	(30,030)
Travel In-State	17,531	12,104	69.0	5,427
Travel Out-of-State	0	1,238	0.0	(1,238)
Training	31,000	3,645	11.8	27,355
Facilities Operation (Rent)	367,140	292,235	79.6	74,905
Consult/Prof Services	166,494	942,160	565.9	(775,666)
Departmental Prorata	3,646,494	1,821,434	50.0	1,825,060
HQIU	15,804,000	5,021,653	31.8	10,782,347
Consolidated Data Center		0	0.0	0
Data Processing	17,492	33,574	191.9	(16,082)
Central Admin Svcs (Statewide Prorata)	2,103,100	1,051,917	50.0	1,051,183
Major Equipment	0	0	0.0	0
Other Items of Expense	0	5,162	0.0	(5,162)
Vehicle Operations	0	5,368	0.0	(5,368)
Attorney General Services	13,157,280	5,046,998	38.4	8,110,282
Office of Administrative Hearings	1,525,080	381,796	25.0	1,143,284
Evidence/Witness	1,820,939	560,578	30.8	1,260,361
Court Reporter Services	224,750	178,119	79.3	46,631
Minor Equipment	0	5,394	0.0	(5,394)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	39,006,428	15,518,521	39.8	23,487,908
TOTALS, EXPENDITURES	44,428,359	17,181,401	38.7	27,246,958
Scheduled Reimbursements			0.0	0
Distributed Costs	(744,054)	(232,779)	31.3	(511,275)
NET TOTAL, EXPENDITURES	43,684,305	16,948,622	38.8	26,735,683
Unscheduled Reimbursements*				
		16,948,622		

** no authority to spend*

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 2014-15
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)

		Number of Hours	Rate	Amount
July	Attorney Services	6,051.00	170.00	1,028,670.00
	Paralegal Services	214.25	120.00	25,710.00
	Auditor/Analyst Services	117.75	99.00	11,657.25
	Cost of Suit			0.00
				1,066,037.25
August	Attorney Services	5,767.50	170.00	980,475.00
	Paralegal Services	228.75	120.00	27,450.00
	Auditor/Analyst Services	75.50	99.00	7,474.50
	Cost of Suit			929.00
				1,016,328.50
September	Attorney Services	6,069.50	170.00	1,031,815.00
	Paralegal Services	187.25	120.00	22,470.00
	Auditor/Analyst Services	91.00	99.00	9,009.00
	Cost of Suit			3.50
				1,063,297.50
October	Attorney Services	6,230.50	170.00	1,059,185.00
	Paralegal Services	208.00	120.00	24,960.00
	Auditor/Analyst Services	104.50	99.00	10,345.50
	Special Agent	0.00	120.00	0.00
	Cost of Suit			587.45
				1,095,077.95
November	Attorney Services	4,580.50	170.00	778,685.00
	Paralegal Services	162.50	120.00	19,500.00
	Auditor/Analyst	81.25	99.00	8,043.75
	Cost of Suit			26.95
				806,255.70
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 =	**5,046,996.90**
			FY 2014-15 Budget =	**13,157,279.00**

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	850	0								950
Criminal Cost Recovery	844	29,175	4,060	13,683	15,041								62,803
Probation Monitoring	64,316	41,643	52,840	73,499	56,938								289,236
Exam	9,061	3,048	7,438	13,718	26,715								59,980
Cite/Fine	3,000	3,000	1,000	5,000	0								12,000
MONTHLY TOTAL	77,221	76,916	65,388	106,750	98,694	0	0	0	0	0	0	0	424,969
FYTD TOTAL	77,221	154,137	219,525	326,275	424,969	424,969	424,969	424,969	424,969	424,969	424,969	424,969	

excel:enfreceiptsmonthlyprofile.xls.revised 12/17/2014

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.

Health Quality Investigation Unit (HQIU)
Fiscal Year 2014-15
Budget Expenditure Report
(As of November 30, 2014)

(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	7,941,974	3,188,688	40.1	4,753,286
Temp Help	1,073,743	404,969	0.0	668,774
Overtime	5,559	2,338	42.1	3,221
Staff Benefits	3,873,289	1,774,719	45.8	2,098,570
BL 12-03 Blanket	0	7,141	0.0	(7,141)
TOTALS, PERS SERVICES	12,894,565	5,377,856	41.7	7,516,709
OPERATING EXP & EQUIP				
General Expense	213,035	117,693	55.2	95,342
Printing	69,000	78,517	113.8	(9,517)
Communications	172,000	38,449	22.4	133,551
Postage	36,000	25,387	70.5	10,613
Insurance	39,000	0	0.0	39,000
Travel In-State	222,000	70,749	0.0	151,251
Travel Out-of-State	7,000	0	0.0	7,000
Training	27,000	7,061	0.0	19,939
Facilities Operation (Rent)	1,574,000	1,355,033	86.1	218,967
Consult/Prof Services	91,000	121,110	133.1	(30,110)
Departmental Prorata		0	0.0	0
Consolidated Data Center	15,000	0	0.0	15,000
Data Processing	0	19,277	0.0	(19,277)
Central Admin Svcs (Statewide Prorata)	0	0	0.0	0
Major Equipment	141,200	0	0.0	141,200
Other Items of Expense	28,000	76,027	0.0	(48,027)
Vehicle Operations	216,000	79,084	0.0	136,916
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	1,898	0.0	(1,898)
Court Reporter Services	0	218,322	0.0	(218,322)
Minor Equipment	59,200	22,042	0.0	37,158
Special Items of Expense	0	5,000	0.0	(5,000)
TOTALS, OE&E	0	0	0.0	0
	2,909,435	2,235,649	76.8	673,786
TOTALS, EXPENDITURES	15,804,000	7,613,505	48.2	8,190,495
Scheduled Reimbursements				
Distributed Costs				0
				0
NET TOTAL, EXPENDITURES				
Unscheduled Reimbursements*	15,804,000	7,613,505	48.2	8,190,495
		0		
		7,613,505		

** no authority to spend*

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	8,386,914	1,833,855	3,363,720	2,281,227	59,014,105
$ 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	43,684,305		6,356,472	1,517,253	3,076,473	1,993,364	58,474,000
$ Spent thru 11/30*	681,281	16,948,622		3,496,747	693,797	1,361,514	980,640	24,162,601 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

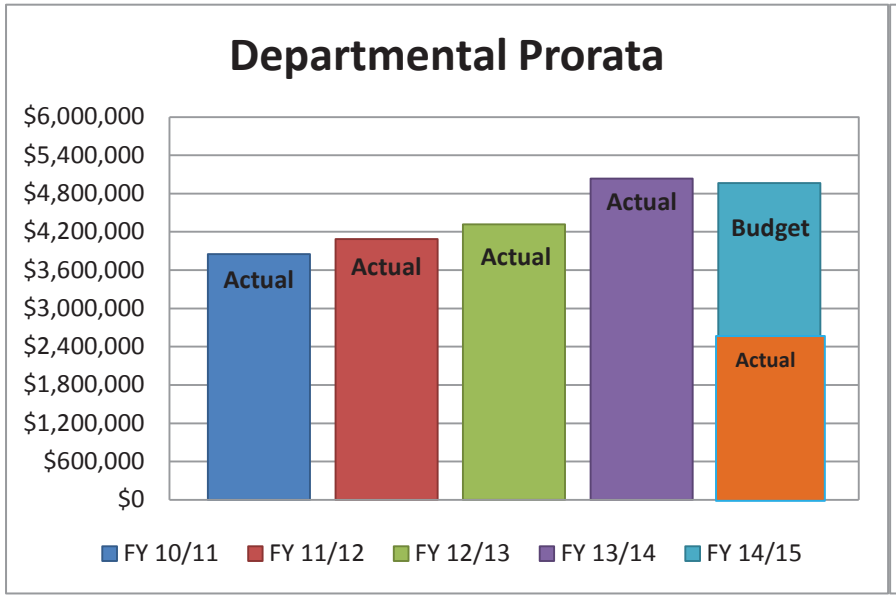
** net expenditures (includes unscheduled reimbursements)*

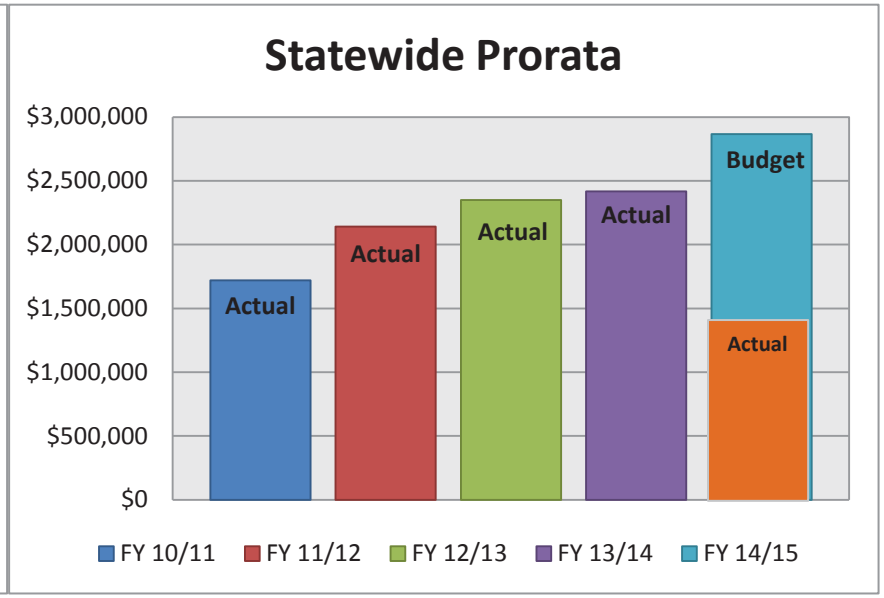
*** Budgeted does not include pending current year budget adjustments.*

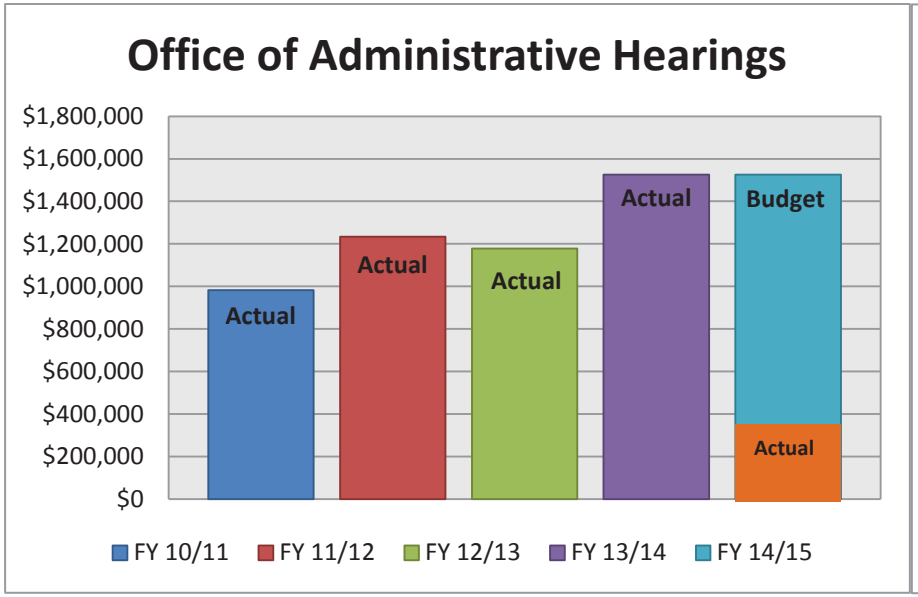
1/14/2015

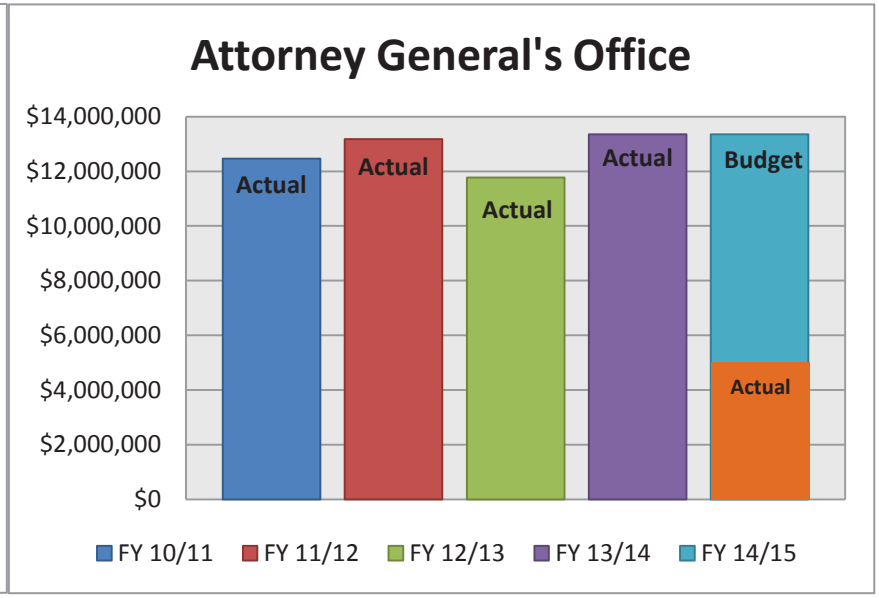
Budget Overview by Program.xls

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	$ 600.00									$ -	$ 1,400.00
Travel	$ 875.32		$ 511.52									$ -	$ 1,386.84
	$1,475.32	$ 200.00	$1,111.52	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,786.84**
DR GNANADEV - Per diem	$1,400.00		$1,100.00										$ 2,500.00
Travel	$ 823.38		$ 115.96										$ 939.34
	$2,223.38	$ -	$1,215.96	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,439.34**
DR. KRAUSS - Per diem	$1,400.00			$ 1,400.00								$ -	$ 2,800.00
Travel				$ 691.22								$ -	$ 691.22
	$1,400.00	$ -	$ -	$ 2,091.22	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,491.22**
DR. LEVINE - Per diem												$ -	$ -
Travel												$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LEWIS - Per diem	$1,500.00	$ 900.00	$1,000.00	$ 1,500.00	$ 900.00							$ -	$ 5,800.00
Travel				$ 858.62								$ -	$ 858.62
	$1,500.00	$ 900.00	$1,000.00	$ 2,358.62	$ 900.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 6,658.62**
MR. LUI - Per diem				$ 300.00								$ -	$ 300.00
Travel				$ 414.51								$ -	$ 414.51
	$ -	$ -	$ -	$ 714.51	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 714.51**
MS. PINES - Per diem	$1,300.00	$1,100.00	$1,100.00	$ 1,200.00	$ 1,000.00							$ -	$ 5,700.00
Travel	$ 677.46											$ -	$ 677.46
	$1,977.46	$1,100.00	$1,100.00	$ 1,200.00	$ 1,000.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 6,377.46**
MS.SCHIPSKE - Per diem	$1,600.00	$1,100.00	$1,200.00	$ 1,100.00	$ 800.00								$ 5,800.00
Travel				$ 166.36								$ -	$ 166.36
	$1,600.00	$1,100.00	$1,200.00	$ 1,266.36	$ 800.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 5,966.36**
MR. SERRANO SWELL- Per diem	$ 700.00	$ 700.00	$ 700.00	$ 800.00	$ 600.00							$ -	$ 3,500.00
	$ 413.72			$ 639.41								$ -	$ 1,053.13
	$1,113.72	$ 700.00	$ 700.00	$ 1,439.41	$ 600.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 4,553.13**
MS.WRIGHT - Per diem	$1,600.00	$1,400.00	$1,600.00	$ 1,600.00	$ 900.00							$ -	$ 7,100.00
Travel	$ 210.03			$ 669.34								$ -	$ 879.37
	$1,810.03	$1,400.00	$1,600.00	$ 2,269.34	$ 900.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 7,979.37**
MS. YAROSLAVSKY - Per diem	$1,000.00	$ 700.00	$1,200.00	$ 1,400.00	$ 700.00							$ -	$ 5,000.00
Travel	$ 799.36	$1,116.37	$ 462.44	$ 678.26								$ -	$ 3,056.43
	$1,799.36	$1,816.37	$1,662.44	$ 2,078.26	$ 700.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 8,056.43**
DR. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 1/6/2015

TOTAL PER DIEM	$ 39,900.00
TOTAL PER DIEM BUDGETED	$ 31,500.00
TOTAL TRAVEL	$ 10,123.28
TOTAL	**$ 50,023.28**

PROPOSED CHANGE TO SCHEDLE OF 2015 BOARD MEETING DATES

January 29 – 30	**Sacramento Area**
April 30 – May 1 **(FSMB Meeting April 22-26)**	**Los Angeles Area**
OR	
May 7-8	**Los Angeles Area**
July 30 – 31	**San Francisco Bay Area**
October 29 – 30	**San Diego Area**

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 29, 2015
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 904 experts in the Board's expert database. 391 experts were utilized to review 633 cases in 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
- Medical Toxicology
- Neurology
- Neurosurgery
- Pain Medicine
- Pathology (statewide)
- Pediatric Surgery
- Spine Surgery
- Surgery
- Thoracic Surgery
- Transplant Surgery
- Urology
- Vascular Surgery (Board Certified in Vascular Surgery)

Staffing Update:
The Enforcement Program presently has seven vacancies throughout its various units. A State Personnel Board (SPB) hearing for the Career Executive Assignment (CEA) position to establish an Enforcement Program Manager (Chief) has been rescheduled to February due to SPB requiring additional clarification regarding the position. The Central Complaint Unit (CCU) has recently seen an increase in its number of vacancies due to multiple staff members receiving promotions. As such CCU currently has four vacancies, one Management Services Technician (MST), two Staff Services Analysts, and one Staff Services Manager I. A candidate has been selected to fill the MST position and will report to work February 2, 2015. The three remaining vacancies have been advertised and interviews will be scheduled for the beginning of February. The Probation Unit is currently recruiting for one Inspector I position and one clerical position, both in Northern California. The Discipline Coordination Unit and the Complaint Investigation Office are both fully staffed.

Central Complaint Unit (CCU):
As a result of the vacant MST position in CCU, Enforcement staff was asked to assist with the initiation of all 2014 complaints received. Staff was successful in completing this task by December 31, 2014, before the BreEZe system automatically updated to 2015. Again faced with a shortage of analytical and managerial staff, CCU continues to make every effort to ensure complaint processing is done in a timely manner.

Complaint Investigation Office (CIO):
The Special Investigators (non-sworn) in the Complaint Investigation Office (CIO) have completed all scheduled training courses and are now applying their acquired knowledge to their daily tasks. Since October 2014, the caseload for each Special Investigator has increased to 30-35 cases. At the same time they have worked diligently to transmit ten (10) cases to the Attorney General's Office, four (4) convictions and six (6) Petitions for Reinstatement, and closed 50 cases. In addition, CIO recently sent their first medical malpractice case to a medical expert for review.

Discipline Coordination Unit (DCU):
The primary focus for DCU during the last months of 2014 has been to ensure compliance with Assembly Bill 1886, which went into effect January 1, 2015. This bill restructured the statute related to public disclosure information. Staff identified over 4,600 cases affected by this legislative change and has updated public disclosure for 3,432 records in BreEZe. DCU continues to update the remaining 1,209 records in BreEZe, and is also working to restore the public disclosure documents on the Board's website.

Probation Unit:
Supervisory staff for the Probation Unit is currently conducting case reviews for all Inspectors in the three Probation Unit offices. Case reviews for Inspectors in the San Dimas and Cerritos offices have been completed, and reviews for staff located in Northern California will be scheduled in the near future.

Statistics:
Unfortunately the Board still does not have access to reports that accurately identify timeframes for the processing of complaints, investigations, or disciplinary actions. At this time, the primary focus is on obtaining reports related to the investigative process.

Medical Board of California
Expert Reviewer Program Report

Attachment A

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
December 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-December)	Number of Experts Utilized (January-December)	Active List Experts 12/2014 904 ↓
ADDICTION	9	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 4 CASES	11 ↑
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes)	17	**15 EXPERTS** 11 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	71 ↓
COLON & RECTAL SURGERY (CRS)	1	**1 EXPERT** 1 LIST EXPERT	3
COMPLEMENTARY/ALTERNATIVE MEDICINE ** COMPANION CASES*	12	**5 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES*	21
CORRECTIONAL MEDICINE			24
DERMATOLOGY (D) ** COMPANION CASES*	15	**6 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES*	8
EMERGENCY (EM)	15	**10 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	48 ↓
FAMILY (FM) **COMPANION CASES* **PREPARATIONS/TESTIMONIES OF CASES PREVIOUSLY REVIEWED*	74	**30 EXPERTS** 14 LIST EXPERTS REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 5 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 7 CASES * 1 LIST EXPERT REVIEWED 15 CASES*	66 ↓

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
December 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-December)	Number of Experts Utilized (January-December)	Active List Experts 12/2014 904 ↓
INTERNAL (General Internal Med) **INVOLVED COMPANIONS CASES; SUPPLEMENTAL WORK AND PREPARATION FOR HEARING*	70	**45 EXPERTS** 28 LIST EXPERTS REIEWED 1 CASE 8 LIST EXPERTS REVIEWED 2 CASES 5 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 8 CASES*	166 ↓
Cardiovascular Disease (Cv)	15	**12 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 8 CASES	32 ↓
Endocrinology, Diabetes and Metabolism (EDM)	4	**2 EXPERTS** 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	5 ↓
Gastroenterology (Ge)	6	**6 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE	21 ↑
Infectious Disease (Inf)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	11
Medical Oncology (Onc)			9 ↓
Nephrology (Nep)	1	**2 EXPERTS** 2 LIST EXPERTS REVIEWED 1 CASE	8 ↓
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 AND SHORT LIST OF REVIEWERS*	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
NEUROLOGY (N)	19	**11 EXPERTS** 1 OFF LIST EXPERT REVIEWED 1 CASE 6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	23

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
December 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-December)	Number of Experts Utilized (January-December)	Active List Experts 12/2014 904 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			4
NUCLEAR MEDICINE (NuM)			5
OBSTETRICS & GYNECOLOGY (ObG) **INVOLVED COMPANION CASES & PREPARATION FOR HEARING*	66	**40 EXPERTS** 22 LIST EXPERTS REVIEWED 1 CASE 7 LIST EXPERTS REVIEWED 2 CASES 5 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERT REVIEWED 4 CASES 3 LIST EXPERTS REVIEWED 5 CASES* 1 LIST EXPERT REVIEWED 8 CASES**	73 ↓
OCCUPATIONAL MEDICINE	1	**1 EXPERT** 1 LIST EXPERT	8
OPHTHALMOLOGY (Oph)	10	**8 EXPERTS** 1 OFF LIST EXPERT REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	27 ↓
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)	6	**3 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	17
PAIN MEDICINE (PM) ** COMPANION CASES AND SHORT LIST OF REVIEWERS*	64	**24 EXPERTS** 9 LIST EXPERTS REVIEWED 1 CASE 5 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES* 2 LIST EXPERTS REVIEWED 6 CASES* 2 LIST EXPERTS REVIEWED 8 CASES*	30

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
December 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-December)	Number of Experts Utilized (January-December)	Active List Experts 12/2014 904 ↓
PATHOLOGY (Path)	5	**5 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	8 ↓
PEDIATRICS (Ped)	5	**5 EXPERTS** 5 LIST EXPERTS REVIEWED 1 CASE	50
PHYSICAL MEDICINE & REHABILITATION (PMR)	3	**3 EXPERTS** 3 LIST EXPERTS REVIEWED 1 CASE	8 ↓
PLASTIC SURGERY (PIS) **COMPANION CASES*	32	**15 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 9 CASES*	46 ↓
PSYCHIATRY (Psyc) **INCLUDED FITNESS FOR DUTY EVALUATIONS AND REVIEW OF COMPANION CASES*	122	**65 EXPERTS** 4 OFF LIST EXPERTS REVIEWED 1 CASE 25 LIST EXPERTS REVIEWED 1 CASE 21 LIST EXPERTS REVIEWED 2 CASES 6 LIST EXPERTS REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES 2 LIST EXPERTS REVIEWED 6 CASES* 1 LIST EXPERT REVIEWED 9 CASES* 1 LIST EXPERT REVIEWED 10 CASES*	69 ↓
RADIOLOGY (Rad)	13	**9 EXPERTS** 6 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	32 ↓
RADIATION ONCOLOGY			4
SLEEP MEDICINE (S)			7

Medical Board of California
Expert Reviewer Program Report

CASES BY SPECIALTY SENT FOR REVIEW
UTILIZATION OF EXPERTS BY SPECIALTY
ACTIVE LIST EXPERTS BY SPECIALTY
December 2014

SPECIALTY	Number of cases sent to Experts / reviewed (January-December)	Number of Experts Utilized (January-December)	Active List Experts 12/2014 904 ↓
SURGERY (S)	31	**20 EXPERTS** 12 LIST EXPERTS REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 4 CASES	33 ↓
Vascular Surgery (VascS)	8	**4 EXPERTS** 1 LIST EXPERT REVIEWED 1 CASE 2 LIST EXPERTS REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	8 ↓
THORACIC SURGERY (TS) **COMPANION CASES*	12	**6 EXPERTS** 4 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 6 CASES*	11 ↓
(MEDICAL) TOXICOLOGY	3	**3 EXPERTS** 2 OFF LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 1 CASE	4
UROLOGY (U)	10	**9 EXPERTS** 8 LIST EXPERTS REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	14 ↓

TOTAL CASES SENT: CALENDAR YEAR 2014	**633**
TOTAL EXPERTS UTILIZED: CALENDAR YEAR 2014	**391**
TOTAL ACTIVE LIST EXPERTS	**904**

Expert Program/sg (12/2014)

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: January 12, 2015
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 second quarter of fiscal year (FY) 2014-15 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 Office Technician (OT) - Call Center (will be vacant on February 10, 2015)
- 1 OT - Licensing Managers' Support
- 1 Management Services Technician (MST) - P&S License Processor
- 1 MST - US/CAN P&S Application Reviewer
- 1 Staff Services Analyst (SSA) - Cashiering Lead
- 2 SSA – International Medical Graduate (IMG) - P&S Application Reviewer
- 1 Associate Governmental Program Analyst - International Medical School Review

Two IMG P&S application reviewers are currently in training.

STATISTICS:
The statistics are on pages BRD 6E - 3 through BRD 6E - 4. Please note that most of the statistics normally provided are unavailable at this time due to the unavailability of reports in the BreEZe system. The statistics that have been provided on pages BRD 6E - 3 through BRD 6E - 4 have been obtained from the call center phone system or tracked manually, and are not part of the BreEZe system.

Notable statistics include:

- Consumer Information Unit telephone calls answered: 17,177
- Consumer Information Unit telephone calls abandoned: 7,193
    - 2,011 fewer abandon calls than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 9,081
    - 2,295 fewer call back requests than the previous quarter
- P&S applications initial review completed: 1,372 per BreEZe report
- P&S applications not reviewed: 599 (includes PTAL, IMG & US) per BreEZe report
- P&S licenses issued: 1,247
    - This is an increase of 25 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 receipt by the Board for three weeks in December 2014, out of the 13 weeks in the second quarter of FY 2014-15.

INTERNATIONAL MEDICAL SCHOOLS:
The statistics for the International Medical School Reviews are on page BRD 6E - 4.
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 seven Self-Assessment Reports that are pending.

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:
There are very few outreach events to report since the last Board meeting. The Licensing Outreach Manager has attended the following licensing workshops and when appropriate, residents from affiliated hospitals are invited to attend:

Nov 13: Loma Linda (about 100 residents)

Nov 14: Kaiser (all the hospitals in the LA area) (about 100 residents)

Time was also scheduled to assist licensees with CURES registration at both of the above events.

Travel for the Outreach Program has been approved for 2015. Several events are already scheduled through November 2015.

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

WORKLOAD REPORT
as of December 31, 2014

CONSUMER INFORMATION UNIT FY 14/15					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**39,269**	22,092	17,177		
Calls Requesting Call Back	**20,457**	11,376	9,081		
Calls Abandoned	**16,397**	9,204	7,193		
Address Changes Completed	**8,600**	5,231	3,369		

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	**14**	10	4		
PG/Medical Knowledge	**61**	42	19		
Convictions	**24**	14	10		
Other	**63**	34	29		

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

WORKLOAD REPORT
as of December 31, 2014

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 14/15					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	101	106		
Pending Self-Assessment Reports (included above)	**N/A**	6	7		
New Self-Assessment Reports Received	**2**	1	1		
New Unrecognized Schools Received	**34**	22	12		
School Recognized Pursuant to CCR 1314(a)(1)	**34**	18	16		
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0		
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	106	103		

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.

STATE OF CALIFORNIA
dca
DEPARTMENT OF CONSUMER AFFAIRS

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY • GOVERNOR EDMUND G. BROWN JR

LEGAL AFFAIRS DIVISION
1625 N. Market Blvd., Suite S 309, Sacramento, CA 95834
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ATTORNEY-CLIENT PRIVILEGED COMMUNICATION
ATTORNEY WORK PRODUCT

MEMORANDUM

DATE	January 30, 2015
TO	Members Medical Board of California
FROM	Dianne R. Dobbs, Senior Staff Counsel **Legal Affairs Division** **Department of Consumer Affairs** Dianne R. Dobbs
SUBJECT	**PROPOSED PRECEDENTIAL DECISION – In the Matter of Accusation Against Gary Page, M.D.; Case No. 02-2009-197437**

In accordance with the procedure adopted by the Division of Medical Quality in July 2004 (Exhibit 1), I recommend that several sections of the above-captioned decision be designated as precedential. The executive director and senior staff counsel agree with this recommendation.

Procedural Background

The Medical Board of California ("Board") filed an Accusation against Dr. Page alleging causes of discipline based on discipline imposed by other states and based on conviction for an offense which was substantially related to the qualifications, functions or duties of a physician and surgeon. The matter was heard before Administrative Law Judge ("ALJ") David B. Rosenman, who submitted a Proposed Decision which the Board rejected and remanded to the ALJ for the taking of additional evidence. Panel B of the Board adopted the Proposed Decision After Remand on November 26, 2014.

Facts/Findings of the Case

The relevant facts are as follows:

Respondent surrendered his physician and surgeon certificate issued January 8, 1999 in March of 2003 after the Board filed an accusation based on discipline imposed against his license in the state of Utah. Subsequently in July of 2006 Respondent petitioned for and was granted reinstatement of his California physician and surgeon certificate.

In June of 2002, Respondent signed a stipulation whereby he surrendered his license to administer and prescribe controlled substances in the state of Utah. The discipline was based on Respondent issuing prescriptions to website customers for medications including controlled substances for weight loss. Subsequently in January of 2003 Respondent's license to administer and prescribe controlled substances in Utah was reinstated, but his license to practice medicine was put on probation for one year. Respondent's Utah license was later reinstated in January of 2004.

In March of 2008, Respondent entered into a consent decree with the state of Arizona based on acts which were determined to be substantially related to the practice of medicine and which would have been grounds for discipline in California.

On July 15, 2011, Respondent was convicted of a class 6 felony in the state of Arizona for causing the death of a patient in July of 2007.

The state of Utah denied Respondent's renewal application in September of 2011 based on prior discipline in that state, the surrender of his California license in 2003, the 2007 surgery and death of a patient in Arizona, Respondent's subsequent criminal conviction, and denial of a license in the state of Nevada.

This Decision After Remand highlights the distinction between Business & Professions Code ("BPC") sections 141 and 2305, both of which relate to disciplinary action taken by another state. Specifically the decision notes that cause for discipline alleged under BPC section 141 is permissive in that discipline may be imposed if a licensee is disciplined by another state, while causes for discipline alleged under section 2305 is mandatory, compelling the MBC to take action if a license is disciplined by another state. Section 141 requires an act substantially related to the regulated practice, while section 2305 state that it is unprofessional conduct if the other state's discipline would have been grounds for the MBC to impose discipline in California.

For its explanation of the distinction between these two code sections, this decision warrants precedential designation.

Portions of Decision to be Designated as Precedential

The recommendation is that the following portions of the decision be designated as precedential:

Factual Findings , 2 - 32 and
Legal Conclusions 1 – 21, and 24 - 25.

If the Board approves the request to designate the above portions of the decision as precedential, those portions not accepted for publication will be redacted and replaced with asterisks. Exhibit 2 is the redacted version of the decision and is what those viewing the precedent decision would see. Exhibit 3 is the decision in its entirety.

Rationale

16 Cal. Code Regs. 1364.40(a) authorizes the division to designate, as a precedent decision, "any decision or part of any decision that contains a significant legal or policy determination of general application that is likely to recur."

Allegations charging discipline by another state are a common occurrence as many physicians are licensed in multiple states. Because the two code sections involved here rely on discipline or action taken by another state against a licensee, they are often treated the same. This decision clearly highlights the very important distinction between the two and will provide valuable guidance to all stakeholders.

The facts presented in this case are very likely to be a recurring issue. For this reason, we believe that the portions of the decision proposed to be designated as precedent contain significant legal determinations and would provide guidance to counsel for respondent and complainant as well as guidance to the Office of Administrative Hearings.

Attachments

EXHIBIT 1

Memorandum

To : **Carlos Ramirez, Asst. DAG**
Tom Reilly, DAG
Mary Agnes Matyszewski, DAG
Health Quality Enforcement Section
Office of the Attorney General

Date: July 28, 2004

From : **Joan M. Jerzak**
Chief, Enforcement Program

Subject: **Precedential Decisions Revised Procedures**

As a follow-up to our meeting on July 21, 2004, with DCA Legal Counsel Anita Scuri, Board Counsel Nancy Vedera, Interim Executive Director Dave Thornton and me, the attached Precedent Decision Procedure was revised. I believe it incorporates all the offered suggestions and will serve as a guide for Board staff as decisions are selected for precedential designation.

Thank you all for your assistance.

PRECEDENT DECISION PROCEDURE

July 2004

Introduction

The purpose of this policy is to establish a procedure for identifying potential precedential decisions and reviewing and acting upon recommendations to designate decisions as precedential. Under the Administrative Procedure Act (APA) a decision that contains a significant legal or policy determination of general application that is likely to recur may be designated as precedential. (See Government Code (GC) Section 11425.60; Attachment 1) Once a decision is designated as precedential, the Division of Medical Quality (hereinafter "Division") may rely on it, and parties may cite to such decision in their argument to the Division and courts. Furthermore, it helps ensure consistency in decision-making by institutionalizing rulings that the Board feels reflects its position on various issues. The Division has adopted section 1364.40, Title 16, California Code of Regulations, to implement its authority to designate decisions as precedential.

Step 1: Identifying Potential Precedential Decisions

A decision or part of a decision that contains significant legal or policy determination of general application that is likely to recur may be recommended for designation as a precedential decision. Section 11425.60 does not preclude the Board from designating as precedential a decision that is already in effect. The recommendation shall be made to Board Counsel, giving the reasons why the person believes the decision meets the criteria to be designated as a precedential decision. Their recommendation shall be accompanied by a copy of the decision.

Step 2: Review of Recommendation

If the Executive Director, after consultation with the Chief of Enforcement and the Board Counsel, concludes that the Division should consider the decision for precedential designation, the matter will be placed on the Division's agenda for action. The agenda serves as public notice that the Division will consider the decision as a precedential decision.

Step 3: Preparation for Board Review

Board Counsel will then prepare or will arrange with the appropriate staff to prepare the precedential designation proposal for presentation to the Division for review and consideration.

The Board's Discipline Coordination Unit shall maintain a log of the decisions proposed to the Division for precedential designation. The log shall show the date of the Board meeting, decision number, respondent's name, a general description of the legal or policy issue, and whether the precedential decision was approved or not. A copy of the Board Counsel memorandum and minutes of the Board meeting (when the decision was discussed) will be maintained with the log.

If the Division adopts a decision as precedential, it will be assigned a precedential designation number. The precedential designation number shall begin with "MBC" and uses the calendar year and sequential numbering beginning with "01" for each year, followed by lettering for the Division designating the decision, DMQ (Division of Medical Quality) and DOL (Division of Licensing), (i.e., MBC-2004-01-DMQ for year 2004).

Step 4: Designation of a Precedential Decision

Board Counsel will prepare an order designating the decision, or portion(s) of the decision, as precedential for signature by the Division President. The effective date is the date the date the decision was designated as a precedential decision. (See Attachment 2 for an example of a Designation as Precedential Decision.)

Board Counsel will send a copy of the signed Designation as a Precedential Decision, including a copy of the decision, to the Office of Administrative Hearings. (The Office of Administrative Hearings maintains a file of precedential designations for reference by Administrative Law Judges.)

Step 5: Indexing

Under Government Code section 11425.60(c), the Division is required to maintain an index of significant legal and policy determinations made in precedential decisions. The Board's Discipline Coordination Unit will maintain the index.

The index shall be divided into three sections (Attachment 3) :

1) Decisions by fiscal year, including: the precedential designation number, the respondent's name, the MBC case number, the OAH case number and the precedential designation date (effective date).

2) Subject matter, followed by a general description of legal and/or policy issue, the precedential designation number and the respondent's name.

3) Code section number, followed by a general description of the section, the precedential designation number and the respondent's name.

NOTE: As decisions are added to the index, an asterisk will be entered after the cases, showing if they were appealed to the Superior Court, Court of Appeals or Supreme Court. Two asterisks following the case, will reflect the case was reversed as a precedential decision by the Board.

A copy of each precedential designation shall be maintained with the index and on the Board's website. The index shall be updated every time a decision is designated as precedential. The index is a public record, available for public inspection and copying. It shall be made available to the public by subscription and its availability shall be published annually in the California Regulatory Notice Register. Each January, Board staff will submit the index to the Office of Administrative Law for publication in the California Regulatory Notice Register.

Step 6: Reversal of Precedential Designation

The Executive Director, after consultation with the Chief of Enforcement and Board Counsel, may recommend that the Division reverse its designation of all or portion(s) of the precedential designation on a decision. The matter will then be placed on the agenda for action. Board Counsel will prepare or arrange with the appropriate staff to prepare the order, "Reversal of Precedential Designation," (Attachment 4). Board Counsel will then send a copy of the signed Reversal of Precedential Designation, including a copy of the decision to the Office of Administrative Hearings.

§ 11425.60. Decisions relied on as precedents

(a) A decision may not be expressly relied on as precedent unless it is designated as a precedent decision by the agency.

(b) An agency may designate as a precedent decision a decision or part of a decision that contains a significant legal or policy determination of general application that is likely to recur. Designation of a decision or part of a decision as a precedent decision is not rulemaking and need not be done under Chapter 3.5 (commencing with Section 11340). An agency's designation of a decision or part of a decision, or failure to designate a decision or part of a decision, as a precedent decision is not subject to judicial review.

(c) An agency shall maintain an index of significant legal and policy determinations made in precedent decisions. The index shall be updated not less frequently than annually, unless no precedent decision has been designated since the last preceding update. The index shall be made available to the public by subscription, and its availability shall be publicized annually in the California Regulatory Notice Register.

(d) This section applies to decisions issued on or after July 1, 1997. Nothing in this section precludes an agency from designating and indexing as a precedent decision a decision issued before July 1, 1997.

HISTORY:

Added Stats 1995 ch 938 §21 (SB 523), operative July 1, 1997; Amended by Stats 1996 ch 390 §8 (SB 794), operative July 1, 1997.

Added "and indexing" in subd (d).

Law Revision Commission Comments:

1995_Section 11425.60 limits the authority of an agency to rely on previous decisions unless the decisions have been publicly announced as precedential.

The first sentence of subdivision (b) recognizes the need of agencies to be able to make law and policy through adjudication as well as through rulemaking. It codifies the practice of a number of agencies to designate important decisions as precedential. See Sections 12935(h) (Fair Employment and Housing Commission), 19582.5 (State Personnel Board); Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Section 11425.60 is intended to encourage agencies to articulate what they are doing when they make new law or policy in an adjudicative decision. An agency may not by precedent decision revise or amend an existing regulation or adopt a rule that has no adequate legislative basis.

Under the second sentence of subdivision (b), this section applies notwithstanding Section 11340.5 ("underground regulations"). See 1993 OAL Det. No. 1 (determination by Office of Administrative Law that agency designation of decision as precedential violates former Government Code Section 11347.5 [now 11340.5] unless made pursuant to rulemaking procedures). The provision is drawn from Government Code Section 19582.5 (expressly exempting the State Personnel Board's precedent decision designations from rulemaking procedures). See also Unemp. Ins. Code 409 (Unemployment Insurance Appeals Board). Nonetheless, agencies are encouraged to express precedent decisions in the form of regulations, to the extent practicable.

The index required by subdivision (c) is a public record, available for public inspection and copying.

Subdivision (d) minimizes the potential burden on agencies by making the precedent decision requirements prospective only.

Attachment 1

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

DESIGNATION AS A PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby designates as precedential Decision No. MBC-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

This precedential designation shall be effective July 30, 2004.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 2

SAMPLE

2004

Medical Board of California
Precedential Decisions

Index

MBC-2004-01-DMQ ***Ridgill, Edward***, MBC Case No. 06-1997-78021, OAH Number E-123545, July 30, 2004

Attachment 3
1 of 2 pages

SAMPLE

Medical Board of California
Precedential Decisions

Index 2004

by Subject Matter

Petition for Penalty Relief
Evidence of rehabilitation, or lack of, 2004-01-DMQ

Rehabilitation
Petitioner's burden, 2004-01-DMQ

by Code Section

Business and Professions Code

Section 2307 - Modification or Termination of Probation –
2004-01-DMQ, *Ridgill*

SAMPLE

BEFORE THE
DIVISION OF MEDICAL QUALITY
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: NAME	)	OAH No.
	)	MBC Case No.
Physician's and Surgeon's Certificate No.	)	PRECEDENTIAL DECISION No. MBC-2004-01-DMQ
Respondent.	)	

WITHDRAWAL OF PRECEDENTIAL DECISION

Pursuant to Government Code Section 11425.60, the Division of Medical Quality, Medical Board of California, hereby orders the withdrawal of precedential Decision No. DMQ-2004-01-DMQ (or those sections of the decision listed below) in the Matter of the Accusation Against NAME.

1) Findings of Fact Nos. 3-6; and
2) Determination of Issues No. 5.

The withdrawal of this precedential designation shall be effective July 30, 2005.

LORIE RICE, President
Division of Medical Quality
Medical Board of California

Attachment 4

EXHIBIT 2

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: GARY PAGE, M.D., Physician's and Surgeon's Certificate No. A67353 Respondent.	Case No. 02-2009-197437 OAH No. 2010080483

PROPOSED DECISION AFTER REMAND

This matter was first heard on May 11, 2011, at Los Angeles, California, before David B. Rosenman, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California. Evidence was presented, the record was closed and a Proposed Decision issued, dated June 29, 2011. (Exhibit 14.) The Medical Board of California (MBC) issued an Order of Remand to Administrative Law Judge dated November 10, 2011. (Order of Remand; Exhibit 15.)

The Order of Remand includes a factual finding and/or legal conclusion, a remand for taking additional evidence, and a request. The finding and/or legal conclusion is that the MBC "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (*Ibid.*)

The Order of Remand includes a remand in accordance with Government Code section 11517, subdivision (c), "for taking additional evidence and, as necessary, argument directed to the following:

"(1) The previous disciplinary action in California referenced in the Proposed Decision;
"(2) Respondent's credentials;
"(3) Further evidence regarding the underlying Arizona disciplinary action; and
"(4) Any other evidence that would assist the board in assessing Respondent's conduct and activities since his license was reinstated in California." (*Ibid.*)

The Order of Remand also requests that the ALJ "incorporate the additional evidence and recommendations into the Proposed Decision dated June 29, 2011." (*Ibid.*)

Subsequently, new hearing dates were set, continuances were granted, a proposed settlement was submitted, the proposed settlement was rejected by the MBC, amended pleadings were filed, both parties substituted new attorneys, and the matter was reset for hearing.

The matter on remand was heard on May 21, 2014, at Los Angeles, California, before David B. Rosenman, ALJ. Respondent Gary Page, M.D., was present and was represented by Rutan & Tucker, by Joseph D. Larsen, Attorney at Law. Complainant (initially Linda K. Whitney, subsequently Kimberly Kirchmeyer) Executive Officer of the MBC was represented by Deputy Attorney General Jannsen Tan.

At the hearing, the Second Amended Accusation was amended such that the reference to a second paragraph numbered 18 was changed to paragraph 19 (page 10, line 2). Oral and documentary evidence was presented. The record remained open for receipt of written closing arguments, received and marked for identification as follows: Complainant's Closing Brief, July 10, 2014, Exhibit 35; Respondent's Closing Brief, August 11, 2014, Exhibit U; and Complainant's letter that no reply brief would be filed, August 22, 2014, Exhibit 36.

The record was closed and the matter was submitted for decision on August 22, 2014.

FACTUAL FINDINGS

The Administrative Law Judge finds the following facts:

*****

2. On January 8, 1999, the Board issued Physician's and Surgeon's Certificate No. A67353 to Respondent. After an accusation was filed, Respondent surrendered his certificate, which was accepted by a Decision of the MBC effective on March 31, 2003. After a petition for reinstatement was filed, Respondent's certificate was reinstated by a Decision on the MBC effective on July 26, 2006. (2006 Decision; Exhibit 20, pp. 1-13.) the license surrender and reinstatement was described in more detail below. The certificate as renewed will expire on October 31, 2014.

The Surrender of Respondent's Arizona License, and its Effect at the First Hearing in this Pending Matter

3. Respondent was also licensed by the Arizona Board of Homeopathic Medical Examiners (Arizona Board).[1] The Arizona Board received complaints regarding Respondent's practice. Respondent denied the allegations. Respondent and the Arizona Board entered into a Consent Agreement in 2008 as the final disposition of the matter whereby Respondent voluntarily surrendered his Arizona license. Although the 2008 Consent Agreement was preceded by a Voluntary Interim Order of Summary Suspension filed September 6, 2007 (Exhibit 4, pp. 10-15), that Order included a stipulation that both parties agreed that it "may not be used as evidence or as an admission by either party in any other judicial or administrative

[1] Homeopathic and allopathic physicians are regulated by different licensing boards in Arizona.

proceeding." (*Id.*, p. 13.) Therefore, no reference can be made here to any substantive material in that Order.

4. On March 18, 2008, the Arizona Board adopted the Consent Agreement. (Exhibit 4, pp. 5-9, and Exhibit 5, pp. 2-6. Further references will be to Exhibit 4.) The Consent Agreement includes the following recital: "The Board received complaints alleging Dr. Page performed cosmetic surgeries, including tumescent liposuction and tumescent breast augmentation which were not specifically within the scope of homeopathic practice and which were allegedly performed without compliance with the applicable standards of homeopathic medical care." (Exhibit 4, p. 5.) There are no other acts of Respondent included in the Consent Agreement, which also states that Respondent did not admit any of the allegations and contended that he complied with applicable standards of care.

5. The Consent Agreement states: "Respondent does not admit, but does not contest that the allegations set forth in the Recitals would constitute a violation of A.R.S. § 32-2933 (1)(19) and (34)."[2] (*Id.*, p. 6.) The Consent Agreement also states that Respondent is entering into the agreement to avoid the expense and uncertainty of a hearing, and that the agreement is reached "in the interest of a prompt and judicious settlement of the case, consistent with the public interest, statutory requirements and responsibilities" of the Arizona Board. (*Ibid.*)

6. In the initial Accusation in this matter, Complainant contended that Respondent's license to practice medicine in California should be disciplined based on the disciplinary order from the Arizona Board, under Business and Professions Code section 141 and/or 2305, and that discipline could be imposed under the MBC's general discipline authority in section 2227.[3] In the Proposed Decision issued after the May 2011 hearing (2011 Proposed Decision; Exhibit 14), the ALJ concluded that no cause for discipline was proven and the Accusation was dismissed. As noted above, the MBC later issued its Order of Remand, including that it "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (Exhibit 15.)

The Second Amended Accusation in this Matter and Respondent's Criminal Conviction in Arizona

7. The First and Second Amended Accusations (Exhibit 17) were subsequently filed, July 24, 2012 and April 22, 2014, respectively. The Second Amended Accusation alleges three bases for discipline: (1) the disciplinary action by the Arizona Board; (2) conviction of a crime; and (3) a disciplinary action in Utah by the Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (Utah Division). Additional evidence was

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[2] At the May 2011 hearing, official notice was taken of Arizona Revised Statutes (A.R.S.) (see Exhibit B), in which section 32-2933 defines "unprofessional conduct" of a homeopathic physician to include, as relevant here, performing an invasive procedure not specifically permitted by law (subdivision (1)), conduct contrary to recognized standards of ethics or conduct that might constitute a danger to the health, welfare or safety of a patient (subdivision (19)), and failure to properly supervise another licensed health care provider or assistant to assist in patient care (subdivision (34)).

[3] All statutory references are to the Business and Professions Code unless otherwise indicated.

submitted at the May 2014 hearing on these new allegations as well as the subjects included in the MBC's Order of Remand.

8. There was no new evidence submitted relating to the disciplinary action by the Arizona Board.

9. On July 15, 2011, based on a plea agreement, Respondent entered a plea of guilty of violating A.R.S. section 13-1201, endangerment, a class 6 felony.[4] On September 12, 2011, Respondent was sentenced to serve three years of supervised probation and pay $14,000 in restitution. (Superior Court of Arizona, Maricopa County, Case No. CR2009-006062-01 DT.)

10. The Superior Court of Arizona issued an order granting Respondent's motion for early termination of probation on April 19, 2012, and an order granting Respondent's application to restore his civil rights on June 18, 2012. (Exhibits F and H.) Respondent intends to petition for an order setting aside the conviction when it is recommended by his attorney.

11. According to the indictment (Exhibit 22), it was alleged that Respondent caused the death of a patient on or between July 3 and 4, 2007. Respondent testified credibly, without contradiction, and consistent with his testimony when he pleaded guilty in Arizona (Exhibit 23). Another source of evidence is the findings of fact in the disciplinary decision by the Utah Division (Exhibit 32), discussed in more detail below. Respondent performed a tumescent liposuction procedure on patient L.R. on July 3, 2007, under local anesthesia, in a clinic operated by Dr. Peter Normann in Arizona. After the procedure the patient met the requirements for discharge, including a repeat physical examination and a conversation with the patient. Using a standard scoring methodology, Respondent concluded the patient scored nine out of ten, with nine being the minimum score for discharge. There was no answer at the phone number for the person designated by the patient to pick her up. Therefore, Dr. Normann offered to oversee the patient's care and Respondent discharged the patient to the care of Dr. Normann. Respondent was aware that two of Dr. Normann's patients had died within the prior six months and that Dr. Normann was under practice restrictions of the Arizona Board and could not perform certain office based procedures, cosmetic surgery, or conscious sedation. The patient became unconscious later that evening. Dr. Normann attempted to resuscitate the patient. The patient died the next day. Dr. Normann was found guilty of criminal charges relating to the event. The Arizona Board investigated and, as noted above, accepted Respondent's surrender of his license.

The Surrender of Respondent's License in Utah, and the MBC's Action Based on that Surrender

12. Respondent was initially licensed in Utah on March 9, 1999. For approximately six weeks in April and May 2002, Respondent was associated with MediScripts, L.L.C., which operated an internet website. During this association, Respondent issued prescriptions to website customers for medications, including a controlled substance for weight loss. The Utah Division alleged that Respondent failed to maintain adequate records. On June 11, 2002, Respondent

[4] The statute provides that a person commits endangerment "by recklessly endangering another person with a substantial risk of imminent death or physical injury," and that it is a class 1 misdemeanor except when the endangerment involves a substantial risk of imminent death, which is a class 6 felony. (A.R.S. § 13-1201; Exhibit 26.)

signed a Stipulation and Order before the Utah Division acknowledging that he had voluntarily surrendered his DEA Registration and represented that he wished to surrender his Utah license to administer and prescribe controlled substances. The Order became effective June 19, 2002.

13. On January 14, 2003, Respondent signed a Stipulation and Order before the Utah Division, whereby his license to administer and prescribe controlled substances in Utah was reinstated, but his license to practice medicine was put on probation for one year, commencing on January 17, 2003, on various terms and conditions, and he was assessed an administrative fine of $2,000. Among other things, under the probation terms Respondent was prohibited from employment with an internet company without Utah Division approval, he was required to complete an approved prescribing course, he was required to submit a proposed practice plan to the Utah Division for approval, he was required to write prescriptions in a manner directed by the Utah Division and to have his practice randomly sampled by a licensed physician to assure accuracy, he was required to practice under the supervision of a licensed physician in good standing who was to provide regular performance evaluations to the Utah Division, and he was required to submit a proposed practice plan to the Utah Division for approval, he was required to write prescriptions in a manner directed by the Utah Division and to have his practice randomly sampled by a licensed physician to assure accuracy, he was required to practice under the supervision of a licensed physician in good standing who was to provide regular performance evaluations to the Utah Division, and he was required to advise employers of the discipline imposed and to notify other jurisdictions of the discipline imposed. Respondent paid his fine on February 21, 2003. He completed the approved prescribing course and complied with all other terms and conditions of probation.

On January 21, 2004, the Utah Division reinstated Respondent's medical license with full privileges.[5]

14. Based on the discipline by the Utah Division, the MBC filed an Accusation in 2002 and a First Amended Accusation in 2003. The matter was resolved by a stipulation in 2003 which recited, among other things, that Respondent resided and practiced medicine in Utah, did not intend to practice medicine in California at that time, agreed that cause existed to discipline his California license, and agreed to surrender his California license. The stipulated surrender was accepted by the MBC and because effective on March 31, 2003.

New Findings Regarding Arizona, Utah and Nevada

15. Respondent moved to Arizona sometime in 2005. On August 18, 2005, Respondent sent a letter to the Arizona Board, inquiring as to the meaning of "minor surgery" as permitted relative to the practice of homeopathic medicine. (Exhibit M.) The letter sought to confirm information from a prior telephone conversation discussing, among other things, the types of anesthesia and ambulatory surgeries permissible under Respondent's license. The Arizona Board discussed the issue at a meeting and responded, generally agreeing with Respondent's letter but requesting further clarification that Respondent did not intend to use general anesthesia and requesting that Respondent provide a written informed consent form for

[5] Factual Findings 12 and 13 are based on the MBC's 2006 Decision (Exhibit 20) and the records of the Utah Division (Exhibit 32).

Board review. (Exhibits M and N.) Respondent confirmed he would not use general anesthesia and provided the form, which the Arizona Board approved. (Exhibits O and P.)

16. Respondent maintained his license to practice medicine in Utah by submitting a renewal application every two years. He submitted a renewal application in January 2010 which was denied by the Utah Division on September 29, 2011, resulting in a hearing in February 2012, a proposed decision also in February 2012, and an Order dated March 1, 2012, denying the application.[6] (Exhibit 32.) The Order is based on some of the events noted above, and other events noted below.

17. More specifically, the Utah Division's Order refers to Respondent's earlier discipline in Utah, the surrender of his license in California in 2003 and the reinstatement of the California license in 2006, the 2007 surgery and patient death in Arizona, and the criminal convictions of Dr. Normann on five counts and Respondent on one count. The Order also refers to the denial of Respondent's application for a medical license in Nevada in 2005, based on his "false, misleading and/or inaccurate statements on his license application and his prior problems with prescribing controlled substances." (Exhibit 32, Findings of Fact, etc., p. 5, para. 4.) Further information about the Nevada proceedings is in Factual Finding 19 below. The Order also finds that Respondent was then providing care in Arizona through Indian Healthcare Services of the federal government, hoped to practice in Utah, and was willing to do so under license restrictions. (*Id.*, p. 8, para. 17.)

18. The following allegations in paragraph 18 of the Second Amended Accusation in the pending MBC matter (Exhibit 17) are established by similar or identical conclusions of law in the Utah Division's Order.

"J. Following the [Utah Division hearing on February 8, 2012], the Utah Board found that Respondent had engaged in unprofessional conduct based on his September 12, 2011 conviction of endangerment. Specifically, the Utah Board asserts that the Arizona criminal proceeding was prompted by LR's death and Respondent's conviction directly bears a reasonable relationship to his ability to safely and competently practice as a physician and surgeon in this state.

"K. The Utah Board also held that Respondent has been subject to disciplinary licensure action in various states since 2002. The Utah Board asserted that such convictions [sic] are defined as unprofessional conduct under Utah law and provide a further basis for the denial of Respondent's request to renew his license in Utah. The Utah Board held that it has concerns with Respondent's conduct and his serving the public.

"L. The Utah Board also found that Respondent engaged in unprofessional conduct as defined under Utah statutes because Respondent's conduct as to LR clearly bears a reasonable relationship to both Respondent's ability to competently practice as a surgeon/physician and also his ability to safely engage in that practice. Specifically, the liposuction procedures which Respondent performed on LR did not constitute minor surgery. Moreover, the Utah Board held that it seriously doubted whether Respondent adequately understood the basic use of anesthesia

[6] Respondent had conditional approval of his Utah license during the pendency of the proceedings.

in that context and the manner in which LR's sleep apnea would have likely impacted her recovery from that procedure. The Utah Board added that serious concerns exist that Respondent performed the liposuction procedures in an office setting where there was a lack of staff to adequately monitor LR, both during and after the procedures in question.

"M. The Utah Board held that Respondent repeatedly exercised exceedingly poor clinical judgment. The Utah Board held that it is further disturbing that Respondent minimized his own deficiencies, while suggesting measurable responsibility be placed on Dr. Normann for his conduct in this case.

"N. The Utah Board also found that Respondent had engaged in unprofessional conduct under Utah statutes when he was denied a license by Nevada on December 3, 2005. The Utah Board found a factual and legal basis in the denial and found it an aggravating circumstance in that it revealed Respondent's entirely misguided submission of false information in an effort to obtain a license in that state."

19. In his application for a license to practice medicine in Nevada in 2005, Respondent denied being investigated for a crime.[7] He revealed information about his license restrictions and the surrender of his California License. The Nevada State Board of Medical Examiners (Nevada Board) had information to the effect that Respondent had been investigated for using the credit card of another person in June 1993, his last year at Brigham Young University, and it asked Respondent to provide further information. As noted in the MBC's 2006 Decision:

"With regard to the previously undisclosed criminal investigation, Dr. Page provided a carefully drafter written statement in which he admitted that when he was a college student he found a wallet belonging to another which had credit cards in it, that charges for gas, food, school supplies, and two new tires were billed to that credit card and that the credit card holder claimed those charges were unauthorized. Dr. Page indicated the police scheduled an appointment to meet with him at the police station and when Dr. Page met with the police, he was fingerprinted, after which he 'immediately paid off the balance that had been allegedly charged on the card and nothing else was ever done.' Dr. Page represented he was unaware at the time that the police contact amounted to a formal investigation. He was never charged with any crime. The issue of his investigation or arrest for any criminal matter had not been raised in the 12 years preceding his Nevada application.

"On Saturday, December 3, 2005, Dr. Page (and others) appeared before the Nevada State Board of Medical Examiners concerning his application for licensure. It was not a judicial-like proceeding. According to the Nevada Board's minutes, he was questioned by Board members about his application, his practice history, the incident at BYU involving a credit card, and an incident occurring during residency. Dr. Page was not represented by counsel. He was not under oath. According to the Nevada Board's minutes, the application was denied in executive sessions 'based upon his false, misleading and/or inaccurate statements on his application for licensure, and his past problems with prescribing of controlled substances . . .' No written reasoned decision by an independent adjudicator was adopted by the Board. Dr. Page

[7] This Factual Finding is based on information in the MBC's 2006 Decision, Exhibit 20.

was instructed by the Nevada Board to wait an additional three years before reapplying. The Nevada Board's minutes were not formal findings and conclusions, and the decision was not the result of the Nevada Board acting in a judicial capacity in which Dr. Page had the opportunity to litigate the issues." (Footnote omitted." (Exhibit 20, Proposed Decision, pp. 6 and 7 (handwritten page numbers added at hearing), para. 5.)

20. At the hearing in 2006 on his reinstatement petition in California, Respondent testified further about the Nevada incident. In summary, he did not recall many of the details of the BYU credit card incident when he filed his application in Nevada. The events had occurred 12 years prior to the application. Respondent was found credible in explaining that the incident was not on his mind and he was not certain that there had been an investigation, as called for by the question in the application. He described his involvement as a lapse in judgment and was remorseful. The ALJ concluded that this incident was remote in time, and of a minor nature. Although it raised initial questions about Respondent's character, "his candid testimony overcame any concerns about his honesty." (*Id.*, p. 10.)

Other Relevant Information From the MBC's 2006 Decision Reinstating Respondent's License

21. The 2006 Decision (Exhibit 20) includes the following information about Respondent's credentials, conduct and activities. Respondent was born on October 12, 1965. He [was] graduated from Brigham Young University in Provo, Utah, in 1993. He was admitted to the Creighton University School of Medicine in Omaha, Nebraska, where he received a medical degree on May 17, 1997. Respondent completed a three-year Family Medicine residency at St. Joseph Hospital in Omaha, which was affiliated with the Creighton University School of Medicine. He became board-certified in Family Medicine in September 1999.

After completing his residency, Respondent worked in a clinic in Ogden, Utah, from July 1999 through October 2000, and he then worked as a solo practitioner specializing in emergency room care in the Ogden area from November 2000 through July 2005. It was during this period when, for approximately six weeks in April and May 2002, he was associated with MediScripts, L.L.C., which operated an internet website, and the actions occurred that were the basis for his license discipline, first in Utah and then in California. As of the 2006 Decision, Respondent was also licensed to practice medicine in Nebraska and Iowa, those licenses were inactive and they had not been subject to any license discipline.

Respondent is a Diplomate of the American Board of Family Medicine, a Diplomate of the American Board of Laser Surgery, an Associate Member of the American Society for Dermatologic Surgery, an Associate Member of the American Academy of Cosmetic Surgery, a Member of the American Society for Laser Medicine and Surgery, and a Member of the American College of Phlebology.

22. At the time of the 2006 hearing, Respondent submitted, among other things, supporting declarations of two physicians licensed in California and evidence of 320 hours of continuing education. No malpractice claims had been filed against him. His candid testimony established: he moved from Utah to Arizona to be closer to his wife's family; his two shifts at the emergency room of the Indian Hospital in Parker, Arizona, allowed him to spend more time

with his family; his prescribing over the internet occurred after he checked with the Utah authorities and believes that there were no applicable guidelines; his total work for MediScripts encompassed 35 hours, at which time a DEA agent informed him that the prescribing was illegal; he cooperated with the DEA and voluntarily surrendered his DEA registration; he had taken a two-day prescribing practices course in Oregon; he demonstrated an acceptable working knowledge of general prescribing requirements in California; he cooperated with the agencies that had contacted him; and he wanted his California license to be reinstated to clear his record, to be able to report the reinstatement to other states' licensing boards, and to resolve questions from insurance companies.

23. In evaluating the evidence and the law in 2006, the ALJ determined that it was consistent with the public interest to reinstate Respondent's license. It was not necessary to require Respondent to take a prescribing practices course or an ethics course, as such conditions would not serve to protect the public. In other words, they were not necessary. The denial of his application in Nevada did not involve a judicial proceeding and had virtually no bearing on his good moral character or on the petition for reinstatement. The ALJ found that Respondent was fully rehabilitated and that the reoccurrence of prescribing problems was highly unlikely. Respondent met his burden of proof and his license was reinstated, without conditions. The Proposed Decision was adopted by the MBC. (Exhibit 20.)

New Findings Regarding Respondent's Credentials and Conduct, and Other Relevant Evidence

24. Respondent resides in Arizona.[8] He confirmed his history and credentials as set forth in the written evidence (summarized above). With respect to his practice in Arizona, Respondent had inquired of the Arizona Board about the scope of practice almost two years before he treated patient L.R. He understood that under his license as a homeopathic physician, he could perform minor surgery if it did not penetrate muscle or invade a body cavity and used local or regional anesthesia but not general anesthesia. This is supported by the statute, A.R.S. section 32-2901 (Exhibit B, pp. 60 and 61). After his contacts with the Arizona Board he held a reasonable belief that he could perform tumescent liposuction under his license. Respondent had received training in this procedure from the American Society of Dermatologic Surgery, had worked with many physicians who performed the procedure, and had performed about 100 of these procedures, in California, Arizona and Utah.

25. Before the procedure on patient L.R. on July 3, 2007, Respondent had performed a physical examination and obtained a history. Respondent believed the surgery was appropriate for the office setting. He administered local anesthesia and the patient was awake for the procedure. The patient was monitored by a blood pressure cuff, pulse oxymeter and for heart rate and pulse. Emergency medical equipment in the form of a standard "crash cart" was present, and Respondent was both trained and experienced in emergency medicine.

26. Dr. Normann was licensed as an allopathic/general physician in Arizona. Although Respondent was aware that Dr. Normann was under practice restrictions of the Arizona

[8] Throughout their closing briefs, both parties referred to the transcript of the proceedings on May 21, 2014. No transcript was lodged with the ALJ who, by necessity and experience, relies upon his notes and recall of the proceedings. In no instance does the ALJ doubt the accuracy of the transcript references made by the parties.

Board governing allopathic physicians, related to two patients that had died in the prior six months, Respondent was not aware of the details of those deaths. He was aware of prohibitions on Dr. Normann's ability to perform certain surgeries or use conscious sedation. Respondent did not believe that any such practices or procedures would be necessary for the post-surgery care of this patient. As noted, the patient met the criteria for discharge and, if her contact person was available, the patient would have been discharged and not placed in the care of Dr. Normann. Respondent acknowledged, both at the hearing and at the time of his criminal sentencing in Arizona that he could have been more discerning in researching the restrictions placed on Dr. Normann and in releasing the patient to Dr. Normann's care under all of the circumstances.

27. Respondent accepted the criminal plea bargain in Arizona based on the advice of his attorney and considering, among other things, that he wanted to move on in his life and with his wife, it was the lowest class of felony, and he was concerned about the risks, expense and uncertainties of going to trial. Of significance, the plea agreement states that Respondent's violation "is a non-dangerous, non-repetitive offense under the criminal code." (Exhibit 22, p. 1.) The language of the plea agreement appears to be specifically crafted, so as to resolve the criminal matter. Nevertheless, the statute of which Respondent was convicted (see footnote 1) includes felony endangerment involving a substantial risk of imminent death.

28. Respondent has completed many hours of continuing medical education, much of it in online courses. The certificates from 2011 and 2012 confirm 40 and 36 hours, respectively, in a number of courses spanning a wide range of subjects. (Exhibits C and D.) For 2013, Respondent submitted a certificate for 40 hours related to the UC San Diego Physician Assessment and Clinical Education (PACE) program, discussed in more detail below, certificates for another eight hours of online courses, and one certificate that is partly illegible. There are certificates for one hour of online courses in 20143. (Exhibit I.)

29. In part to assist in resolving the pending matter, and to also establish his competency to practice, Respondent participated in the PACE program: Phase I, October 16-17, 2012, and Phase II, January 14-18, 2014. He received credit for 40 hours of continuing medical education for Phase II. (Exhibit I.) A comprehensive report was issued by William Norcross, M.D., the Director, and Kate Seippel, MPH, Administrative Director of Assessment, for PACE. (Exhibit J.) The PACE report includes that Respondent has practiced most recently (without dates) in the emergency room in Parker, Arizona, at an ambulatory clinic in St. George, Utah, and at a clinic in Coronado, California. While practicing in Ogden, Utah, Respondent obtained an M.B.A. in leadership studies from Baker College and became certified as a life coach.

30. Each element of Phases I and II is described generally in the report. In PACE Phase I, Respondent's performance in the various areas was usually scored as adequate or satisfactory, occasionally as superior and very good to excellent, and occasionally as below average. Respondent's overall performance was assessed as varied. He performed a limited yet satisfactory history and physical examination on a mock patient, his oral clinical exam results were satisfactory, with a lack of current knowledge in some disease subjects. His performance on the PRIMUM examination and interview was acceptable. He scored in the 11th percentile on the ethics and communication exam, in the 3rd percentile on the family medicine exam, and in the 5th percentile in the mechanisms of disease exam.

31. In PACE Phase II, Respondent was an active participant, showed good medical knowledge, good communication skills, and up to date knowledge in the usage of electronic media and medical records. Overall, Respondent's performance was satisfactory. He received positive evaluations from most of the faculty (one report was not yet received), and obtained a passing score on the standardized patient evaluation. Please I and Phase II overall performance was "Pass-Category 1," signifying "good to excellent performance in more or all areas measured and is consistent with safe practice and competency. No significant deficiencies are noted." (Exhibit J, p. 12.)

32. Respondent testified that he would like to keep his California license and is willing to accept limitations, restrictions and monitoring if ordered by the MBC.

LEGAL CONCLUSIONS

Based upon the foregoing factual findings, the Administrative Law Judge makes the following legal conclusions:

1. The standard of proof to be used for the proceedings on an Accusation is "clear and convincing proof to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests on Complainant to establish the charging allegations in the accusation by proof that is clear, explicit and unequivocal; "so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind." (Citations omitted.) (*In re Marriage of Weaver* (1990) 24 Cal.App.3d 478, 484.)

2. Section 141 states, in pertinent part, that "a disciplinary action taken by another state . . . for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action" by the MBC. "A certified copy of the record of the disciplinary action taken against the licensee by another state . . . shall be conclusive evidence of the events related therein.

3. Section 2305 states, in pertinent part: "The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state . . . that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

4. Under section 2227, a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended or placed on probation. Under section 2234, the MBC shall take action against a licensee charged with unprofessional conduct.

5. The first cause for discipline alleges, in summary, that Respondent's license should be disciplined because the discipline against his Arizona license is a violation of sections 141 and 2305. Certain overlaps and distinctions between these two statutes are the basis of the Court of Appeal decision in *Medical Board of California v. Superior Court; Lam, Real Party In*

Interest (2001) 88 Cal.App.4th 1001 (*Lam*), and are relevant here. Section 141 applies generally to licensees of a number of agencies governed by the Business and Professions Code, while section 2305 applies specifically to licensees of the MBC. Section 141 is permissive – discipline may be imposed, while section 2305 is mandatory – the MBC shall take action. Section 141 requires an act substantially related to the regulated practice, while section 2305 states that it is unprofessional conduct if the other state's discipline would have been grounds for the MBC to impose discipline in California. Of significance, the California action against Dr. Lam was based on section 141 but not section 2305. Based on Dr. Lam's arguments, the appellate court needed to consider whether section 2305, supposedly a more specific statute because it applies to doctors, was the exclusive basis for discipline based on another state's discipline and impliedly repealed the more general application of section 141. The Court answered no, and suggested that section 2305 could prevail over section 141 only when both would apply to a scenario, for the reasons more specifically noted in the decision. Again, the discipline in *Lam* was based on section 141 only, and the appellate court rejected the contention that only section 2305 could apply to out-of-state discipline against a doctor.

6. The basic facts in *Lam* are that the Wisconsin Medical Examining Board "initiated an investigation, following an allegation that 'Dr. Lam was premature in his attempt to repair a rectovaginal fistula which developed following repair of a fourth degree tear which occurred at the time of a vaginal delivery.' (*Id.*, p. 1006.) The investigation was concluded by a stipulation under which Dr. Lam denied any wrongdoing and the board ordered that he would not treat patients with this condition but, rather, would refer them to a gynecologist for evaluation and treatment. Later, the decision notes that the record did not contain the charging documents against Dr. Lam in Wisconsin. (*Id.*, p. 1019.) Under all of the circumstances, the Court determined that section 2305 did not apply, as there was no evidence that Dr. Lam's discipline in Wisconsin would have been grounds for discipline by the MBC in California. However, section 141 did provide a basis for discipline in California as the evidence established that the Wisconsin discipline was for an act substantially related to the practice of medicine in California.

7. Similarly to the stipulation in *Lam*, under the Consent Agreement with the Arizona Board, Respondent did not admit that he had taken any actions that violated Arizona law. Nor does the Consent Agreement include any findings or conclusions that any such violations took place. It is clear from the language of the Consent Agreement that the Arizona Board received complaints against Respondent and investigated them. Respondent denied the allegations against him. Without any admissions that the alleged acts took place or any findings that there was cause for discipline, Respondent and the Arizona Board agreed to resolve the matters with a voluntary surrender of Respondent's Arizona license.

8. There is a distinction between the two statutes that is not addressed in *Lam*. Section 141 is based on another state's discipline for "any act" substantially related to the regulated practice of medicine in California. If so, that act "may be ground for disciplinary action . . ." However, section 2305 makes no reference to acts of a licensee in another state. Rather, it focuses on the nature of the out-of-state discipline and provides that any out-of-state discipline "that would have been grounds for discipline in California . . . shall constitute grounds for discipline for unprofessional conduct" in California.

9. Further analysis of the facts and law is therefore necessary. Admittedly, the Order of Remand includes that the MBC "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (Exhibit 15.) The MBC clearly has authority to issue an order of remand under Government Code section 11517, subdivision (c)(2)(D), "to take additional evidence." A portion of the Order of Remand properly requests the ALJ to take additional evidence under this authority. However, that authority is separate and distinct from the MBC's authority to reject the [ALJ's] proposed decision, and decide the case upon the record" found in subdivision (c)(2)(E). These two options are mutually exclusive. The MBC can make its own factual findings and legal conclusions only if the MBC rejects the ALJ's proposed decision, which has not occurred here. The inclusion in the Order of Remand of the MBC's factual and/or legal determination noted above is beyond the authority of the MBC for purposes of this remand to take additional evidence. Therefore, it must be determined whether there is a basis for discipline for any substantially related act under section 141, and/or whether there is out-of-state discipline that would be grounds for California discipline under section 2305.

10. It is concluded that there is a basis for discipline under section 2305 as well as a basis for discipline under section 141. Section 141 requires out-of-state discipline for an act that would be substantially related to California's bases for discipline. Admittedly, there was no evidence of any acts by respondent found as a basis for the Arizona Consent Decree, which has a single factual recital to the effect that complaints were made about his practice. There was no conclusion that the complaints were supported by any evidence, proof, or admission, and there was no hearing. However, the "act" in Arizona that forms the basis for discipline under section 141 is the existence of a Consent Decree as the basis for Arizona discipline. A licensing agency has the implied power to settle a case, and the settlement may include any terms voluntarily agreed on by the parties that do not violate public policy. (*Rich Vision Ctrs. V. Board of Med. Examiner* (1983) 144 Cal.App.3d 110, 115-116.) Numerous license disciplinary cases settle in California, including before the MBC, with no admission of culpability but with an agreed outcome. This statement is based upon the ALJ's experience and specialized knowledge, which may be used to evaluate evidence under Government Code section 11425.50, subdivision (c). Therefore, the Arizona Consent Decree accepting the surrender of Respondent's license in Arizona is the type of act which "may be a ground for disciplinary action" in California, as that phrase is used in section 141. As in *Lam*, the out-of-state discipline including no admissions can form a basis for discipline under section 141.

11. Cause exists to suspend or revoke Respondent's California license for violation of section 141, as there was an "act substantially related to the practice regulated by the California license," as required by section 141, as set forth in Factual Findings 1 through 8 and Legal Conclusions 2 through 10.

12. Discipline under section 2305 was the subject of *Marek v. Board of Podiatric Medicine* (1993) 16 Cal.App.4th 1089, which involved two podiatrists who entered into a consent decree in Nevada whereby the Nevada State Board of Podiatry (Nevada Board) issued an order which revoked their licenses to practice and placed them on three years' probation upon certain

terms and conditions. In the consent decree, the podiatrists made no admission of wrongdoing, and the Nevada Board imposed discipline solely pursuant to their consent, without formally presenting evidence. The Court of Appeal determined that section 2305 "requires only that the California Board determine that disciplinary action by another state as to a license to practice medicine issued by that other state had occurred and that the California Board need not take evidence on or establish the factual predicate for that other state's disciplinary action, a full and fair hearing as required by due process occurred as to the limited factual question of whether discipline was imposed by another state." (*Id.*, p. 1093.) The California Board of Podiatry revoked the licenses, stayed the revocations and placed the podiatrists on probation for three years. The appellate court supported that outcome, stating that "the focus of section 2305 is the mere fact that a measure of discipline was imposed on the licensee and not how it was imposed by the foreign jurisdiction," and that the podiatrists' unprofessional conduct was not based on a finding of any misfeasance in Nevada but, rather, the fact that discipline was imposed on their right to practice there. (*Id.*, pp. 1096-1097.) In other words section 2305 liability was triggered by the fact that discipline was imposed by the Nevada Board that could have been imposed in California had the allegations of misfeasance occurred in California, rather than whether the misfeasance itself had occurred. Further, the appellate court rejected the podiatrists' contention that no discipline should be imposed based on their evidence of rehabilitation, as California is entitled to protect its citizens and to ensure the high quality of medical practice to the same extent as Nevada, the California Board's probationary constraints and restrictions are not inappropriate, and the California Board did not abuse its broad discretion in imposing its disciplinary order." (*Id.*, pp. 1099-1100.)

13. Respondent here contends that his alleged acts in Arizona are not grounds for discipline in California because MBC licensees can perform the type of surgery he performed on patient L.R. This contention is not convincing, as the gravamen of the Arizona Board's action was the Respondent was acting outside the scope of his practice, which allegations could also form the basis of license discipline in California.

14. Cause exists to suspend or revoke Respondent's California license for violation of section 2305, as the Arizona Board imposed discipline on Respondent for acts "that would have been grounds for discipline in California of a licensee under this chapter," as required by that section, as set forth in Factual Findings 1 through 8 and Legal Conclusions 2 through 13.

15. A licensee of the MBC may have the license disciplined for conviction of a crime under the authority of sections 490, 493, 2227, 2234 (defining unprofessional conduct), and 2236 (determining that conviction of a crime that is substantially related to the qualifications, functions and duties of a physician and surgeon constitutes unprofessional conduct). "Substantial relationship" is established under California Code of Regulations, title 16, section 1360 if the crime "to a substantial degree . . . evidences present or potential unfitness of the [licensee] to perform the functions authorized by the [license] in a manner consistent with the public health, safety or welfare."

16. Endangering a patient, the basis of Respondent's felony conviction, meets the requirements to establish substantial relationship. The conviction is *prima facie* proof of the elements of the statute of which Respondent was convicted: he recklessly endangered another

person with the substantial risk of imminent death or physical injury. Respondent's rehabilitation, including early termination of his criminal probation and completion of the PACE program establishes that he has taken appropriate action to address concerns about his actions and poor judgment underlying the conviction. However, the MBC met its burden to establish that Respondent's conviction meets the substantial relationship criteria.

17. Cause exists to suspend or revoke Respondent's California license for violation of sections 490, 493, 2227, 2234, and 2236, for conviction of a crime that is substantially related to the qualifications, functions and duties of a physician and surgeon, as set forth in Factual Findings 9 through 11 and Legal Conclusions 15 and 16.

18. The third cause for discipline relates to Respondent's discipline by the Utah Division. There were two such incidents, which must be analyzed separately. As discussed in more detail below, the MBC is barred by the statute of limitations to seek discipline based on the Utah Division's 2002 and 2003 orders. However, cause for discipline is established based on the Utah Division's 2012 order denying Respondent's application for license renewal.

19. Under section 2230.5, any accusation must be filed within three years after the MBC discovers the act of omission alleged as a ground for disciplinary action, or within seven years of the actual act or omission, whichever occurs first. None of the statutory exceptions to these time limits apply to the Utah Division's 2002 and 2003 orders related to his internet prescriptions. In 2002, Respondent voluntarily surrendered his prescribing privileges, and in 2003 his license was placed on probation for one year, as set forth in Factual Findings 12 and 13. The statute of limitations based on the actual acts therefore expired in 2009 and 2010, respectively. The MBC was aware of the 2002 and 2003 Utah disciplinary actions when it filed an accusation against Respondent in 2002 and an amended accusation in 2003, as set forth in Factual Finding 14. The statute of limitations based on the MBC's discovery of actual acts therefore expired in 2005 and 2006. The 2002 and 2003 Utah disciplinary actions were first alleged as a basis for discipline in California in the Second Amended Accusation, filed April 22, 2014. (Compare the initial Accusation (Exhibit 1), and First Amended Accusation (Exhibit 17) to the Second Amended Accusation (Exhibit 17), and see Factual Finding 7.) Further, as a practical matter, the MBC was fully aware of the 2002 and 2003 Utah discipline, which was described in some detail in the 2006 Decision reinstating Respondent's California license, when it considered and adopted the ALJ's proposed decision recommending reinstatement. It is inconsistent to now consider that same Utah discipline as a basis for new discipline in California.

20. Cause does not exist to suspend or revoke Respondent's California license for violation of sections 141, 2227, 2234 or 2305, based on the 2002 and 2003 Utah disciplinary orders, for the reasons set forth in Factual Findings 7, 12 and 14 and Legal Conclusions 18 and 19.

21. The Utah decision denying Respondent's license renewal occurred in 2012 and, therefore, is within the statutes of limitations. It fits within the analyses of sections 141 and 2305, above. Cause exists to suspend or revoke Respondent's California license for violation of sections 141, 2227, 2234 and 2305, based on the 2012 Utah disciplinary order for the reasons set forth in Factual Findings 16, 17 and 18 and Legal Conclusions 2 through 12 and 18. However,

relatively little weight is attributed to this discipline, as it is based on, among other things, the earlier Utah disciplinary orders which are barred by the statute of limitations, and is duplicative to the extent it is based on the Arizona discipline and the Arizona conviction, already established above as bases for discipline in this matter.

22. The MBC's Manual of Disciplinary Orders and Disciplinary Guidelines (Guidelines, Exhibit 11) has been considered. The relevant maximum penalties for the violations here are revocation. The minimum penalty for sections 141 and 2305, discipline by another state, is to refer to the recommended minimum as for a similar offense in California. This is not practicable here as the other states' disciplines were issued with no admissions of any acts or violations. The minimum penalty for section 2236, conviction of a felony, is seven years' probation with various terms.

23. Also considered is section 2229, which states in pertinent part that protection of the public shall be the MBC's highest priority and that an ALJ when exercising his disciplinary authority "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . ."

24. When all the dust has settled, what may be considered here is that the MBC previously disciplined Respondent in 2003 for the Internet prescriptions. However, this discipline is of little or no weight because it is too old to form a basis for new discipline and because the MBC adopted a Proposed Decision in 2006 which found that Respondent was rehabilitated. Respondent's care of a patient in 2007 in Arizona resulted in a low-level felony conviction for endangerment from which Respondent obtained early release from probation. The Arizona Board entered a Consent Decree with no findings or admissions of guilt, accepting Respondent's voluntary surrender of his license there. The Utah Division denied renewal of Respondent's license, for the reasons noted above; and due to a minor issue which arose in Utah in 1997, which was also included in Proposed Decision in 2006 which found that Respondent was rehabilitated; due to an issue in Nevada that dates back to 1993, which was also included in Proposed Decision in 2006 which found that Respondent was rehabilitated. In other words, much of what is presently before the MBC are matters that were previously adjudicated.

25. This should not obscure the fact that the 2012 Arizona conviction and 2008 Arizona Consent Decree are of major concern and clearly establish a basis for imposition of discipline. It is significant that Respondent recently took and passed the PACE program with a grade indicating good to excellent performance consistent with safe practice and competency. He has taken numerous continuing education courses. In the present hearing he did not demonstrate evasion or failure to take responsibility for his actions, exhibiting a demeanor appropriate to the circumstances. Under all of the relevant circumstances, it would be punitive to revoke his license outright. The public will be adequately protected by a probationary order with standard conditions and a practice monitor, as there is no sufficient reason to impose anything more. The purpose of proceedings of this type is to protect the public, and not to punish an errant licensee, which is the province of the courts. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476; *Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164.)

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Dated: September 2, 2014.

DAVID B. ROSENMAN
Administrative Law Judge
Office of Administrative Hearings

EXHIBIT 3

BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: GARY PAGE, M.D., Physician's and Surgeon's Certificate No. A67353 Respondent.	Case No. 02-2009-197437 OAH No. 2010080483

PROPOSED DECISION AFTER REMAND

This matter was first heard on May 11, 2011, at Los Angeles, California, before David B. Rosenman, Administrative Law Judge (ALJ), Office of Administrative Hearings, State of California. Evidence was presented, the record was closed and a Proposed Decision issued, dated June 29, 2011. (Exhibit 14.) The Medical Board of California (MBC) issued an Order of Remand to Administrative Law Judge dated November 10, 2011. (Order of Remand; Exhibit 15.)

The Order of Remand includes a factual finding and/or legal conclusion, a remand for taking additional evidence, and a request. The finding and/or legal conclusion is that the MBC "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (*Ibid.*)

The Order of Remand includes a remand in accordance with Government Code section 11517, subdivision (c), "for taking additional evidence and, as necessary, argument directed to the following:

"(1) The previous disciplinary action in California referenced in the Proposed Decision;

"(2) Respondent's credentials;

"(3) Further evidence regarding the underlying Arizona disciplinary action; and

"(4) Any other evidence that would assist the board in assessing Respondent's conduct and activities since his license was reinstated in California." (*Ibid.*)

The Order of Remand also requests that the ALJ "incorporate the additional evidence and recommendations into the Proposed Decision dated June 29, 2011." (*Ibid.*)

Subsequently, new hearing dates were set, continuances were granted, a proposed settlement was submitted, the proposed settlement was rejected by the MBC, amended pleadings were filed, both parties substituted new attorneys, and the matter was reset for hearing.

The matter on remand was heard on May 21, 2014, at Los Angeles, California, before David B. Rosenman, ALJ. Respondent Gary Page, M.D., was present and was represented by Rutan & Tucker, by Joseph D. Larsen, Attorney at Law. Complainant (initially Linda K. Whitney, subsequently Kimberly Kirchmeyer) Executive Officer of the MBC was represented by Deputy Attorney General Jannsen Tan.

At the hearing, the Second Amended Accusation was amended such that the reference to a second paragraph numbered 18 was changed to paragraph 19 (page 10, line 2). Oral and documentary evidence was presented. The record remained open for receipt of written closing arguments, received and marked for identification as follows: Complainant's Closing Brief, July 10, 2014, Exhibit 35; Respondent's Closing Brief, August 11, 2014, Exhibit U; and Complainant's letter that no reply brief would be filed, August 22, 2014, Exhibit 36.

The record was closed and the matter was submitted for decision on August 22, 2014.

FACTUAL FINDINGS

The Administrative Law Judge finds the following facts:

1. The Accusation and First Amended Accusation were brought by Linda K. Whitney solely in her capacity as Executive Officer of the MBC. The Second Amended Accusation was brought by Kimberly Kirchmeyer solely in her capacity as Executive Officer of the MBC.

2. On January 8, 1999, the Board issued Physician's and Surgeon's Certificate No. A67353 to Respondent. After an accusation was filed, Respondent surrendered his certificate, which was accepted by a Decision of the MBC effective on March 31, 2003. After a petition for reinstatement was filed, Respondent's certificate was reinstated by a Decision of the MBC effective on July 26, 2006. (2006 Decision; Exhibit 20, pp. 1-13.) The license surrender and reinstatement are described in more detail below. The certificate as renewed will expire on October 31, 2014.

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The Surrender of Respondent's Arizona License, and its Effect at the First Hearing in this Pending Matter

3. Respondent was also licensed by the Arizona Board of Homeopathic Medical Examiners (Arizona Board).[1] The Arizona Board received complaints regarding Respondent's practice. Respondent denied the allegations. Respondent and the Arizona Board entered into a Consent Agreement in 2008 as the final disposition of the matter whereby Respondent voluntarily surrendered his Arizona license. Although the 2008 Consent Agreement was preceded by a Voluntary Interim Order of Summary Suspension filed September 6, 2007 (Exhibit 4, pp. 10-15), that Order included a stipulation that both parties agreed that it "may not be used as evidence or as an admission by either party in any other judicial or administrative proceeding." (*Id.*, p. 13.) Therefore, no reference can be made here to any substantive material in that Order.

4. On March 18, 2008, the Arizona Board adopted the Consent Agreement. (Exhibit 4, pp. 5-9, and Exhibit 5, pp. 2-6. Further references will be to Exhibit 4.) The Consent Agreement includes the following recital: "The Board received complaints alleging Dr. Page performed cosmetic surgeries, including tumescent liposuction and tumescent breast augmentation which were not specifically within the scope of homeopathic practice and which were allegedly performed without compliance with the applicable standards of homeopathic medical care." (Exhibit 4, p. 5.) There are no other acts of Respondent included in the Consent Agreement, which also states that Respondent did not admit any of the allegations and contended that he complied with applicable standards of care.

5. The Consent Agreement states: "Respondent does not admit, but does not contest that the allegations set forth in the Recitals would constitute a violation of A.R.S. §32-2933 (1) (19) and (34)."[2] (*Id.*, p. 6.) The Consent Agreement also states that Respondent is entering into the agreement to avoid the expense and uncertainty of a hearing, and that the agreement is reached "in the interest of a prompt and judicious settlement of the case, consistent with the public interest, statutory requirements and responsibilities" of the Arizona Board. (*Ibid.*)

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[1] Homeopathic and allopathic physicians are regulated by different licensing boards in Arizona.

[2] At the May 2011 hearing, official notice was taken of Arizona Revised Statutes (A.R.S.) (see Exhibit B), in which section 32-2933 defines "unprofessional conduct" of a homeopathic physician to include, as relevant here, performing an invasive procedure not specifically permitted by law (subdivision (1)), conduct contrary to recognized standards of ethics or conduct that might constitute a danger to the health, welfare or safety of a patient (subdivision (19)), and failure to properly supervise another licensed health care provider or assistant to assist in patient care (subdivision (34)).

6. In the initial Accusation in this matter, Complainant contended that Respondent's license to practice medicine in California should be disciplined based on the disciplinary order from the Arizona Board, under Business and Professions Code sections 141 and/or 2305, and that discipline could be imposed under the MBC's general discipline authority in section 2227.[3] In the Proposed Decision issued after the May 2011 hearing (2011 Proposed Decision; Exhibit 14), the ALJ concluded that no cause for discipline was proven and the Accusation was dismissed. As noted above, the MBC later issued its Order of Remand, including that it "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (Exhibit 15.)

The Second Amended Accusation in this Matter and Respondent's Criminal Conviction in Arizona

7. The First and Second Amended Accusations (Exhibit 17) were subsequently filed, July 24, 2012 and April 22, 2014, respectively. The Second Amended Accusation alleges three bases for discipline: (1) the disciplinary action by the Arizona Board; (2) conviction of a crime; and (3) a disciplinary action in Utah by the Division of Occupational and Professional Licensing of the Department of Commerce of the State of Utah (Utah Division). Additional evidence was submitted at the May 2014 hearing on these new allegations as well as the subjects included in the MBC's Order of Remand.

8. There was no new evidence submitted relating to the disciplinary action by the Arizona Board.

9. On July 15, 2011, based on a plea agreement, Respondent entered a plea of guilty of violating A.R.S. section 13-1201, endangerment, a class 6 felony.[4] On September 12, 2011, Respondent was sentenced to serve three years of supervised probation and pay $14,000 in restitution. (Superior Court of Arizona, Maricopa County, Case No. CR2009-006062-01 DT.)

10. The Superior Court of Arizona issued an order granting Respondent's motion for early termination of probation on April 19, 2012, and an order granting Respondent's application to restore his civil rights on June 18, 2012. (Exhibits F and H.) Respondent intends to petition for an order setting aside the conviction when it is recommended by his attorney.

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[3] All statutory references are to the Business and Professions Code unless otherwise indicated.

[4] The statute provides that a person commits endangerment "by recklessly endangering another person with a substantial risk of imminent death or physical injury," and that it is a class 1 misdemeanor except when the endangerment involves a substantial risk of imminent death, which is a class 6 felony. (A.R.S. § 13-1201; Exhibit 26.)

11. According to the indictment (Exhibit 22), it was alleged that Respondent caused the death of a patient on or between July 3 and 4, 2007. Respondent testified credibly, without contradiction, and consistent with his testimony when he pleaded guilty in Arizona (Exhibit 23). Another source of evidence is the findings of fact in the disciplinary decision by the Utah Division (Exhibit 32), discussed in more detail below. Respondent performed a tumescent liposuction procedure on patient L.R. on July 3, 2007, under local anesthesia, in a clinic operated by Dr. Peter Normann in Arizona. After the procedure the patient met the requirements for discharge, including a repeat physical examination and a conversation with the patient. Using a standard scoring methodology, Respondent concluded the patient scored nine out of ten, with nine being the minimum score for discharge. There was no answer at the phone number for the person designated by the patient to pick her up. Therefore, Dr. Normann offered to oversee the patient's care and Respondent discharged the patient to the care of Dr. Normann. Respondent was aware that two of Dr. Normann's patients had died within the prior six months and that Dr. Normann was under practice restrictions of the Arizona Board and could not perform certain office based procedures, cosmetic surgery, or conscious sedation. The patient became unconscious later that evening. Dr. Normann attempted to resuscitate the patient. The patient died the next day. Dr. Normann was found guilty of criminal charges relating to the event. The Arizona Board investigated and, as noted above, accepted Respondent's surrender of his license.

The Surrender of Respondent's License in Utah, and the MBC's Action Based on That Surrender

12. Respondent was initially licensed in Utah on March 9, 1999. For approximately six weeks in April and May 2002, Respondent was associated with MediScripts, L.L.C., which operated an internet website. During this association, Respondent issued prescriptions to website customers for medications, including a controlled substance for weight loss. The Utah Division alleged that Respondent failed to maintain adequate records. On June 11, 2002, Respondent signed a Stipulation and Order before the Utah Division acknowledging that he had voluntarily surrendered his DEA Registration and represented that he wished to surrender his Utah license to administer and prescribe controlled substances. The Order became effective June 19, 2002.

13. On January 14, 2003, Respondent signed a Stipulation and Order before the Utah Division, whereby his license to administer and prescribe controlled substances in Utah was reinstated, but his license to practice medicine was put on probation for one year, commencing on January 17, 2003, on various terms and conditions, and he was assessed an administrative fine of $2,000. Among other things, under the probation terms Respondent was prohibited from employment with an internet company without Utah Division approval, he was required to complete an approved prescribing course, he was required to submit a proposed practice plan to the Utah Division for approval, he was required to write prescriptions in a manner directed by the Utah Division and to have his practice randomly sampled by a licensed physician to assure accuracy, he was required to practice under the supervision of a licensed physician in good standing who was to provide regular performance evaluations to the Utah Division, and he was required to advise employers of the discipline

imposed and to notify other jurisdictions of the discipline imposed. Respondent paid his fine on February 21, 2003. He completed the approved prescribing course and complied with all other terms and conditions of probation.

On January 21, 2004, the Utah Division reinstated Respondent's medical license with full privileges.[5]

14. Based on the discipline by the Utah Division, the MBC filed an Accusation in 2002 and a First Amended Accusation in 2003. The matter was resolved by a stipulation in 2003 which recited, among other things, that Respondent resided and practiced medicine in Utah, did not intend to practice medicine in California at that time, agreed that cause existed to discipline his California license, and agreed to surrender his California license. The stipulated surrender was accepted by the MBC and became effective on March 31, 2003.

New Findings Regarding Arizona, Utah and Nevada

15. Respondent moved to Arizona sometime in 2005. On August 18, 2005, Respondent sent a letter to the Arizona Board, inquiring as to the meaning of "minor surgery" as permitted relative to the practice of homeopathic medicine. (Exhibit M.) The letter sought to confirm information from a prior telephone conversation discussing, among other things, the types of anesthesia and ambulatory surgeries permissible under Respondent's license. The Arizona Board discussed the issue at a meeting and responded, generally agreeing with Respondent's letter but requesting further clarification that Respondent did not intend to use general anesthesia and requesting that Respondent provide a written informed consent form for Board review. (Exhibits M and N.) Respondent confirmed he would not use general anesthesia and provided the form, which the Arizona Board approved. (Exhibits O and P.)

16. Respondent maintained his license to practice medicine in Utah by submitting a renewal application every two years. He submitted a renewal application in January 2010 which was denied by the Utah Division on September 29, 2011, resulting in a hearing in February 2012, a proposed decision also in February 2012, and an Order dated March 1, 2012, denying the application.[6] (Exhibit 32.) The Order is based on some of the events noted above, and other events noted below.

17. More specifically, the Utah Division's Order refers to Respondent's earlier discipline in Utah, the surrender of his license in California in 2003 and the reinstatement of the California license in 2006, the 2007 surgery and patient death in Arizona, and the criminal convictions of Dr. Normann on five counts and Respondent on one count. The

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[5] Factual Findings 12 and 13 are based on the MBC's 2006 Decision (Exhibit 20) and the records of the Utah Division (Exhibit 32).

[6] Respondent had conditional approval of his Utah license during the pendency of the proceedings.

Order also refers to the denial of Respondent's application for a medical license in Nevada in 2005, based on his "false, misleading and/or inaccurate statements on his license application and his prior problems with prescribing controlled substances." (Exhibit 32, Findings of Fact, etc., p. 5, para. 4.) Further information about the Nevada proceedings is in Factual Finding 19 below. The Order also finds that Respondent was then providing care in Arizona through Indian Healthcare Services of the federal government, hoped to practice in Utah, and was willing to do so under license restrictions. (*Id.*, p. 8, para. 17.)

18. The following allegations in paragraph 18 of the Second Amended Accusation in the pending MBC matter (Exhibit 17) are established by similar or identical conclusions of law in the Utah Division's Order.

"J. Following the [Utah Division hearing on February 8, 2012], the Utah Board found that Respondent had engaged in unprofessional conduct based on his September 12, 2011 conviction of endangerment. Specifically, the Utah Board asserts that the Arizona criminal proceeding was prompted by LR's death and Respondent's conviction directly bears a reasonable relationship to his ability to safely and competently practice as a physician and surgeon in this state.

"K. The Utah Board also held that Respondent has been subject to disciplinary licensure action in various states since 2002. The Utah Board asserted that such convictions [sic] are defined as unprofessional conduct under Utah law and provide a further basis for the denial of Respondent's request to renew his license in Utah. The Utah Board held that it has concerns with Respondent's conduct and his serving the public.

"L. The Utah Board also found that Respondent engaged in unprofessional conduct as defined under Utah statutes because Respondent's conduct as to LR clearly bears a reasonable relationship to both Respondent's ability to competently practice as a surgeon/physician and also his ability to safely engage in that practice. Specifically, the liposuction procedures which Respondent performed on LR did not constitute minor surgery. Moreover, the Utah Board held that it seriously doubted whether Respondent adequately understood the basic use of anesthesia in that context and the manner in which LR's sleep apnea would have likely impacted her recovery from that procedure. The Utah Board added that serious concerns exist that Respondent performed the liposuction procedures in an office setting where there was a lack of staff to adequately monitor LR, both during and after the procedures in question.

"M. The Utah Board held that Respondent repeatedly exercised exceedingly poor clinical judgment. The Utah Board held that it is further disturbing that Respondent minimized his own deficiencies, while suggesting measurable responsibility be placed on Dr. Normann for his conduct in this case.

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"N. The Utah Board also found that Respondent had engaged in unprofessional conduct under Utah statutes when he was denied a license by Nevada on December 3, 2005. The Utah Board found a factual and legal basis in the denial and found it an aggravating circumstance in that it revealed Respondent's entirely misguided submission of false information in an effort to obtain a license in that state."

19. In his application for a license to practice medicine in Nevada in 2005, Respondent denied being investigated for a crime.[7] He revealed information about his license restrictions and the surrender of his California License. The Nevada State Board of Medical Examiners (Nevada Board) had information to the effect that Respondent had been investigated for using the credit card of another person in June 1993, his last year at Brigham Young University, and it asked Respondent to provide further information. As noted in the MBC's 2006 Decision:

"With regard to the previously undisclosed criminal investigation, Dr. Page provided a carefully drafted written statement in which he admitted that when he was a college student he found a wallet belonging to another which had credit cards in it, that charges for gas, food, school supplies, and two new tires were billed to that credit card and that the credit card holder claimed those charges were unauthorized. Dr. Page indicated the police scheduled an appointment to meet with him at the police station and when Dr. Page met with the police, he was fingerprinted, after which he 'immediately paid off the balance that had been allegedly charged on the card and nothing else was ever done.' Dr. Page represented he was unaware at the time that the police contact amounted to a formal investigation. He was never charged with any crime. The issue of his investigation or arrest for any criminal matter had not been raised in the 12 years preceding his Nevada application.

"On Saturday, December 3, 2005, Dr. Page (and others) appeared before the Nevada State Board of Medical Examiners concerning his application for licensure. It was not a judicial-like proceeding. According to the Nevada Board's minutes, he was questioned by Board members about his application, his practice history, the incident at BYU involving a credit card, and an incident occurring during residency. Dr. Page was not represented by counsel. He was not under oath. According to the Nevada Board's minutes, the application was denied in executive session 'based upon his false, misleading and/or inaccurate statements on his application for licensure, and his past problems with prescribing of controlled substances . . .' No written reasoned decision by an independent adjudicator was adopted by the Board. Dr. Page was instructed by the Nevada Board to wait an additional three years before reapplying. The Nevada Board's minutes were not formal findings and conclusions, and the decision was not the result of the Nevada Board acting in a judicial capacity in which Dr. Page had the opportunity to litigate the issues." (Footnote omitted.) (Exhibit 20, Proposed Decision, pp. 6 and 7 (handwritten page numbers added at hearing), para. 5.)

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[7] This Factual Finding is based on information in the MBC's 2006 Decision, Exhibit 20.

20. At the hearing in 2006 on his reinstatement petition in California, Respondent testified further about the Nevada incident. In summary, he did not recall many of the details of the BYU credit card incident when he filed his application in Nevada. The events had occurred 12 years prior to the application. Respondent was found credible in explaining that the incident was not on his mind and he was not certain that there had been an investigation, as called for by the question in the application. He described his involvement as a lapse in judgment and was remorseful. The ALJ concluded that this incident was remote in time, and of a minor nature. Although it raised initial questions about Respondent's character, "his candid testimony overcame any concerns about his honesty." (*Id.*, p. 10.)

Other Relevant Information From the MBC's 2006 Decision Reinstating Respondent's License

21. The 2006 Decision (Exhibit 20) includes the following information about Respondent's credentials, conduct and activities. Respondent was born on October 12, 1965. He [was] graduated from Brigham Young University in Provo, Utah, in 1993. He was admitted to the Creighton University School of Medicine, in Omaha, Nebraska, where he received a medical degree on May 17, 1997. Respondent completed a three-year Family Medicine residency at St. Joseph Hospital in Omaha, which was affiliated with the Creighton University School of Medicine. He became board-certified in Family Medicine in September 1999.

After completing his residency, Respondent worked in a clinic in Ogden, Utah, from July 1999 through October 2000, and he then worked as a solo practitioner specializing in emergency room care in the Ogden area from November 2000 through July 2005. It was during this period when, for approximately six weeks in April and May 2002, he was associated with MediScripts, L.L.C., which operated an internet website, and the actions occurred that were the basis for his license discipline, first in Utah and then in California. As of the 2006 Decision, Respondent was also licensed to practice medicine in Nebraska and Iowa, those licenses were inactive and they had not been subject to any license discipline.

Respondent is a Diplomate of the American Board of Family Medicine, a Diplomate of the American Board of Laser Surgery, an Associate Member of the American Society for Dermatologic Surgery, an Associate Member of the American Academy of Cosmetic Surgery, a Member of the American Society for Laser Medicine and Surgery, and a Member of the American College of Phlebology.

22. At the time of the 2006 hearing, Respondent submitted, among other things, supporting declarations of two physicians licensed in California and evidence of 320 hours of continuing education. No malpractice claims had been filed against him. His candid testimony established: he moved from Utah to Arizona to be closer to his wife's family; his two shifts at the emergency room of the Indian Hospital in Parker, Arizona, allowed him to spend more time with his family; his prescribing over the internet occurred after he checked with the Utah authorities and believed that there were no applicable guidelines; his total work for MediScripts encompassed 35 hours, at which time a DEA agent informed him that the

prescribing was illegal; he cooperated with the DEA and voluntarily surrendered his DEA registration; he had taken a two-day prescribing practices course in Oregon; he demonstrated an acceptable working knowledge of general prescribing requirements in California; he cooperated with the agencies that had contacted him; and he wanted his California license to be reinstated to clear his record, to be able to report the reinstatement to other states' licensing boards, and to resolve questions from insurance companies.

23. In evaluating the evidence and the law in 2006, the ALJ determined that it was consistent with the public interest to reinstate Respondent's license. It was not necessary to require Respondent to take a prescribing practices course or an ethics course, as such conditions would not serve to protect the public. In other words, they were not necessary. The denial of his application in Nevada did not involve a judicial proceeding and had virtually no bearing on his good moral character or on the petition for reinstatement. The ALJ found that Respondent was fully rehabilitated and that the reoccurrence of prescribing problems was highly unlikely. Respondent met his burden of proof and his license was reinstated, without conditions. The Proposed Decision was adopted by the MBC. (Exhibit 20.)

New Findings Regarding Respondent's Credentials and Conduct, and Other Relevant Evidence

24. Respondent resides in Arizona.[8] He confirmed his history and credentials as set forth in the written evidence (summarized above). With respect to his practice in Arizona, Respondent had inquired of the Arizona Board about the scope of practice almost two years before he treated patient L.R. He understood that under his license as a homeopathic physician, he could perform minor surgery if it did not penetrate muscle or invade a body cavity and used local or regional anesthesia but not general anesthesia. This is supported by the statute, A.R.S. section 32-2901 (Exhibit B, pp. 60 and 61). After his contacts with the Arizona Board he held a reasonable belief that he could perform tumescent liposuction under his license. Respondent had received training in this procedure from the American Society of Dermatologic Surgery, had worked with many physicians who performed the procedure, and had performed about 100 of these procedures, in California, Arizona and Utah.

25. Before the procedure on patient L.R. on July 3, 2007, Respondent had performed a physical examination and obtained a history. Respondent believed the surgery was appropriate for the office setting. He administered local anesthesia and the patient was awake for the procedure. The patient was monitored by a blood pressure cuff, pulse

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[8] Throughout their closing briefs, both parties referred to the transcript of the proceedings on May 21, 2014. No transcript was lodged with the ALJ who, by necessity and experience, relies upon his notes and recall of the proceedings. In no instance does the ALJ doubt the accuracy of the transcript references made by the parties.

oxymeter and for heart rate and pulse. Emergency medical equipment in the form of a standard "crash cart" was present, and Respondent was both trained and experienced in emergency medicine.

26. Dr. Normann was licensed as an allopathic/general physician in Arizona. Although Respondent was aware that Dr. Normann was under practice restrictions of the Arizona Board governing allopathic physicians, related to two patients that had died in the prior six months, Respondent was not aware of the details of those deaths. He was aware of prohibitions on Dr. Normann's ability to perform certain surgeries or use conscious sedation. Respondent did not believe that any such practices or procedures would be necessary for the post-surgery care of this patient. As noted, the patient met the criteria for discharge and, if her contact person was available, the patient would have been discharged and not placed in the care of Dr. Normann. Respondent acknowledged, both at the hearing and at the time of his criminal sentencing in Arizona that he could have been more discerning in researching the restrictions placed on Dr. Normann and in releasing the patient to Dr. Normann's care under all of the circumstances.

27. Respondent accepted the criminal plea bargain in Arizona based on the advice of his attorney and considering, among other things, that he wanted to move on in his life and with his wife, it was the lowest class of felony, and he was concerned about the risks, expense and uncertainties of going to trial. Of significance, the plea agreement states that Respondent's violation "is a non-dangerous, non-repetitive offense under the criminal code." (Exhibit 22, p. 1.) The language of the plea agreement appears to be specifically crafted, so as to resolve the criminal matter. Nevertheless, the statute of which Respondent was convicted (see footnote 1) includes felony endangerment involving a substantial risk of imminent death.

28. Respondent has completed many hours of continuing medical education, much of it in online courses. The certificates from 2011 and 2012 confirm 40 and 36 hours, respectively, in a number of courses spanning a wide range of subjects. (Exhibits C and D.) For 2103, Respondent submitted a certificate for 40 hours related to the UC San Diego Physician Assessment and Clinical Education (PACE) program, discussed in more detail below, certificates for another eight hours of online courses, and one certificate that is partly illegible. There are certificates for one hour of online courses in 2014. (Exhibit I.)

29. In part to assist in resolving the pending matter, and to also establish his competency to practice, Respondent participated in the PACE program: Phase I, October 16-17, 2012, and Phase II, January 14-18, 2014. He received credit for 40 hours of continuing medical education for Phase II. (Exhibit I.) A comprehensive report was issued by William Norcross, M.D., the Director, and Kate Seippel, MPH, Administrative Director of Assessment, for PACE. (Exhibit J.) The PACE report includes that Respondent has practiced most recently (without dates) in the emergency room in Parker, Arizona, at an ambulatory clinic in St. George, Utah, and at a clinic in Coronado, California. While practicing in Ogden, Utah, Respondent obtained an M.B.A. in leadership studies from Baker College and became certified as a life coach.

30. Each element of Phases I and II is described generally in the report. In PACE Phase I, Respondent's performance in the various areas was usually scored as adequate or satisfactory, occasionally as superior and very good to excellent, and occasionally as below average. Respondent's overall performance was assessed as varied. He performed a limited yet satisfactory history and physical examination on a mock patient; his oral clinical exam results were satisfactory, with a lack of current knowledge in some disease subjects. His performance on the PRIMUM examination and interview was acceptable. He scored in the 11th percentile on the ethics and communication exam, in the 3rd percentile on the family medicine exam, and in the 5th percentile in the mechanisms of disease exam.

31. In PACE Phase II, Respondent was an active participant, showed good medical knowledge, good communication skills, and up to date knowledge in the usage of electronic media and medical records. Overall, Respondent's performance was satisfactory. He received positive evaluations from most of the faculty (one report was not yet received), and obtained a passing score on the standardized patient evaluation. Phase I and Phase II overall performance was "Pass-Category 1," signifying "good to excellent performance in most or all areas measured and is consistent with safe practice and competency. No significant deficiencies are noted." (Exhibit J, p. 12.)

32. Respondent testified that he would like to keep his California license and is willing to accept limitations, restrictions and monitoring if ordered by the MBC.

LEGAL CONCLUSIONS

Based upon the foregoing factual findings, the Administrative Law Judges makes the following legal conclusions:

1. The standard of proof to be used for the proceedings on an Accusation is "clear and convincing proof to a reasonable certainty." (*Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853.) This means the burden rests on Complainant to establish the charging allegations in the accusation by proof that is clear, explicit and unequivocal; "so clear as to leave no substantial doubt; sufficiently strong to command the unhesitating assent of every reasonable mind." (Citations omitted.) (*In re Marriage of Weaver* (1990) 224 Cal.App.3d 478, 484.)

2. Section 141 states, in pertinent part, that "a disciplinary action taken by another state . . . for any act substantially related to the practice regulated by the California license, may be a ground for disciplinary action" by the MBC. "A certified copy of the record of the disciplinary action taken against the licensee by another state . . . shall be conclusive evidence of the events related therein."

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3. Section 2305 states, in pertinent part: "The revocation, suspension, or other discipline, restriction, or limitation imposed by another state upon a license or certificate to practice medicine issued by that state . . . that would have been grounds for discipline in California of a licensee under this chapter, shall constitute grounds for disciplinary action for unprofessional conduct against the licensee in this state."

4. Under section 2227, a licensee who is found guilty under the Medical Practice Act may have his or her license revoked, suspended or placed on probation. Under section 2234, the MBC shall take action against a licensee charged with unprofessional conduct.

5. The first cause for discipline alleges, in summary, that Respondent's license should be disciplined because the discipline against his Arizona license is a violation of sections 141 and 2305. Certain overlaps and distinctions between these two statutes are the basis of the Court of Appeal decision in *Medical Board of California v. Superior Court; Lam, Real Party In Interest* (2001) 88 Cal.App.4th 1001 (*Lam*), and are relevant here. Section 141 applies generally to licensees of a number of agencies governed by the Business and Professions Code, while section 2305 applies specifically to licensees of the MBC. Section 141 is permissive—discipline may be imposed, while section 2305 is mandatory—the MBC shall take action. Section 141 requires an act substantially related to the regulated practice, while section 2305 states that it is unprofessional conduct if the other state's discipline would have been grounds for the MBC to impose discipline in California. Of significance, the California action against Dr. Lam was based on section 141 but not section 2305. Based on Dr. Lam's arguments, the appellate court needed to consider whether section 2305, supposedly a more specific statute because it applies to doctors, was the exclusive basis for discipline based on another state's discipline and impliedly repealed the more general application of section 141. The Court answered no, and suggested that section 2305 could prevail over section 141 only when both would apply to a scenario, for the reasons more specifically noted in the decision. Again, the discipline in *Lam* was based on section 141 only, and the appellate court rejected the contention that only section 2305 could apply to out-of-state discipline against a doctor.

6. The basic facts in *Lam* are that the Wisconsin Medical Examining Board "initiated an investigation, following an allegation that 'Dr. Lam was premature in his attempt to repair a rectovaginal fistula which developed following repair of a fourth degree tear which occurred at the time of a vaginal delivery.' (*Id.*, p. 1006.) The investigation was concluded by a stipulation under which Dr. Lam denied any wrongdoing and the board ordered that he would not treat patients with this condition but, rather, would refer them to a gynecologist for evaluation and treatment. Later, the decision notes that the record did not contain the charging documents against Dr. Lam in Wisconsin. (*Id.*, p. 1019.) Under all of the circumstances, the Court determined that section 2305 did not apply, as there was no evidence that Dr. Lam's discipline in Wisconsin would have been grounds for discipline by the MBC in California. However, section 141 did provide a basis for discipline in California as the evidence established that the Wisconsin discipline was for an act substantially related to the practice of medicine in California.

7. Similarly to the stipulation in *Lam*, under the Consent Agreement with the Arizona Board, Respondent did not admit that he had taken any actions that violated Arizona law. Nor does the Consent Agreement include any findings or conclusions that any such violations took place. It is clear from the language of that Consent Agreement that the Arizona Board received complaints against Respondent and investigated them. Respondent denied the allegations against him. Without any admissions that the alleged acts took place or any findings that there was cause for discipline, Respondent and the Arizona Board agreed to resolve the matters with a voluntary surrender of Respondent's Arizona license.

8. There is a distinction between the two statutes that is not addressed in *Lam*. Section 141 is based on another state's discipline for "any act" substantially related to the regulated practice of medicine in California. If so, that act "may be ground for disciplinary action . . . ." However, section 2305 makes no reference to acts of a licensee in another state. Rather, it focuses on the nature of the out-of-state discipline and provides that any out-of-state discipline "that would have been grounds for discipline in California . . . shall constitute grounds for discipline for unprofessional conduct" in California.

9. Further analysis of the facts and law is therefore necessary. Admittedly, the Order of Remand includes that the MBC "has determined that Respondent's license is subject to discipline in that the acts described in the Arizona Consent Agreement are substantially related to the practice of medicine and would have been grounds for discipline in California of a physician's and surgeon's certificate." (Exhibit 15.) The MBC clearly has authority to issue an order of remand under Government Code section 11517, subdivision (c)(2)(D), "to take additional evidence." A portion of the Order of Remand properly requests the ALJ to take additional evidence under this authority. However, that authority is separate and distinct from the MBC's authority to "reject the [ALJ's] proposed decision, and decide the case upon the record" found in subdivision (c)(2)(E). These two options are mutually exclusive. The MBC can make its own factual findings and legal conclusions only if the MBC rejects the ALJ's proposed decision, which has not occurred here. The inclusion in the Order of Remand of the MBC's factual and/or legal determination noted above is beyond the authority of the MBC for purposes of this remand to take additional evidence. Therefore, it must be determined whether there is a basis for discipline for any substantially related act under section 141, and/or whether there is out-of-state discipline that would be grounds for California discipline under section 2305.

10. It is concluded that there is a basis for discipline under section 2305 as well as a basis for discipline under section 141. Section 141 requires out-of-state discipline for an act that would be substantially related to California's bases for discipline. Admittedly, there was no evidence of any acts by Respondent found as a basis for the Arizona Consent Decree, which has a single factual recital to the effect that complaints were made about his practice. There was no conclusion that the complaints were supported by any evidence, proof, or admission, and there was no hearing. However, the "act" in Arizona that forms the basis for discipline under section 141 is the existence of a Consent Decree as the basis for Arizona discipline. A licensing agency has the implied power to settle a case, and the settlement may include any terms voluntarily agreed on by the parties that do not violate public policy.

(*Rich Vision Ctrs. v. Board of Med. Examiner* (1983) 144 Cal.App.3d 110, 115-116.) Numerous license disciplinary cases settle in California, including before the MBC, with no admission of culpability but with an agreed outcome. This statement is based upon the ALJ's experience and specialized knowledge, which may be used to evaluate evidence under Government Code section 11425.50, subdivision (c). Therefore, the Arizona Consent Decree accepting the surrender of Respondent's license in Arizona is the type of act which "may be a ground for disciplinary action" in California, as that phrase is used in section 141. As in *Lam*, the out-of-state discipline including no admissions can form a basis for discipline under section 141.

11. Cause exists to suspend or revoke Respondent's California license for violation of section 141, as there was an "act substantially related to the practice regulated by the California license," as required by section 141, as set forth in Factual Findings 1 through 8 and Legal Conclusions 2 through 10.

12. Discipline under section 2305 was the subject of *Marek v. Board of Podiatric Medicine* (1993) 16 Cal.App.4th 1089, which involved two podiatrists who entered into a consent decree in Nevada whereby the Nevada State Board of Podiatry (Nevada Board) issued an order which revoked their licenses to practice and placed them on three years' probation upon certain terms and conditions. In the consent decree, the podiatrists made no admission of wrongdoing, and the Nevada Board imposed discipline solely pursuant to their consent, without formally presenting evidence. The Court of Appeal determined that section 2305 "requires only that the California Board determine that disciplinary action by another state as to a license to practice medicine issued by that other state had occurred and that the California Board need not take evidence on or establish the factual predicate for that other state's disciplinary action, a full and fair hearing as required by due process occurred as to the limited factual question of whether discipline was imposed by another state." (*Id.*, p. 1093.) The California Board of Podiatry revoked the licenses, stayed the revocations and placed the podiatrists on probation for three years. The appellate court supported that outcome, stating that "the focus of section 2305 is the mere fact that a measure of discipline was imposed on the licensee and not how it was imposed by the foreign jurisdiction," and that the podiatrists' unprofessional conduct was not based on a finding of any misfeasance in Nevada but, rather, the fact that discipline was imposed on their right to practice there. (*Id.*, pp. 1096-1097.) In other words section 2305 liability was triggered by the fact that discipline was imposed by the Nevada Board that could have been imposed in California had the allegations of misfeasance occurred in California, rather than whether the misfeasance itself had occurred. Further, the appellate court rejected the podiatrists' contention that no discipline should be imposed based on their evidence of rehabilitation, as California is entitled to protect its citizens and to ensure the high quality of medical practice to the same extent as Nevada, the California Board's probationary constraints and restrictions are not inappropriate, and the California Board did not abuse its broad discretion in imposing its disciplinary order." (*Id.*, pp. 1099-1100.)

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13. Respondent here contends that his alleged acts in Arizona are not grounds for discipline in California because MBC licensees can perform the type of surgery he performed on patient L.R. This contention is not convincing, as the gravamen of the Arizona Board's action was that Respondent was acting outside the scope of his practice, which allegations could also form the basis of license discipline in California.

14. Cause exists to suspend or revoke Respondent's California license for violation of section 2305, as the Arizona Board imposed discipline on Respondent for acts "that would have been grounds for discipline in California of a licensee under this chapter," as required by that section, as set forth in Factual Findings 1 through 8 and Legal Conclusions 2 through 13.

15. A licensee of the MBC may have the license disciplined for conviction of a crime under the authority of sections 490, 493, 2227, 2234 (defining unprofessional conduct), and 2236 (determining that conviction of a crime that is substantially related to the qualifications, functions and duties of a physician and surgeon constitutes unprofessional conduct). "Substantial relationship" is established under California Code of Regulations, title 16, section 1360 if the crime "to a substantial degree . . . evidences present or potential unfitness of the [licensee] to perform the functions authorized by the [license] in a manner consistent with the public health, safety or welfare."

16. Endangering a patient, the basis of Respondent's felony conviction, meets the requirements to establish substantial relationship. The conviction is *prima facie* proof of the elements of the statute of which Respondent was convicted: he recklessly endangered another person with the substantial risk of imminent death or physical injury. Respondent's rehabilitation, including early termination of his criminal probation and completion of the PACE program establishes that he has taken appropriate action to address concerns about his actions and poor judgment underlying the conviction. However, the MBC met its burden to establish that Respondent's conviction meets the substantial relationship criteria.

17. Cause exists to suspend or revoke Respondent's California license for violation of sections 490, 493, 2227, 2234, and 2236, for conviction of a crime that is substantially related to the qualifications, functions and duties of a physician and surgeon, as set forth in Factual Findings 9 through 11 and Legal Conclusions 15 and 16.

18. The third cause for discipline relates to Respondent's discipline by the Utah Division. There were two such incidents, which must be analyzed separately. As discussed in more detail below, the MBC is barred by the statute of limitations to seek discipline based on the Utah Division's 2002 and 2003 orders. However, cause for discipline is established based on the Utah Division's 2012 order denying Respondent's application for license renewal.

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19. Under section 2230.5, any accusation must be filed within three years after the MBC discovers the act or omission alleged as a ground for disciplinary action, or within seven years of the actual act or omission, whichever occurs first. None of the statutory exceptions to these time limits apply to the Utah Division's 2002 and 2003 orders related to his internet prescriptions. In 2002, Respondent voluntarily surrendered his prescribing privileges, and in 2003 his license was placed on probation for one year, as set forth in Factual Findings 12 and 13. The statute of limitations based on the actual acts therefore expired in 2009 and 2010, respectively. The MBC was aware of the 2002 and 2003 Utah disciplinary actions when it filed an accusation against Respondent in 2002 and an amended accusation in 2003, as set forth in Factual Finding 14. The statute of limitations based on the MBC's discovery of actual acts therefore expired in 2005 and 2006. The 2002 and 2003 Utah disciplinary actions were first alleged as a basis for discipline in California in the Second Amended Accusation, filed April 22, 2014. (Compare the initial Accusation (Exhibit 1) and First Amended Accusation (Exhibit 17) to the Second Amended Accusation (Exhibit 17), and see Factual Finding 7.) Further, as a practical matter, the MBC was fully aware of the 2002 and 2003 Utah discipline, which was described in some detail in the 2006 Decision reinstating Respondent's California license, when it considered and adopted the ALJ's proposed decision recommending reinstatement. It is inconsistent to now consider that same Utah discipline as a basis for new discipline in California.

20. Cause does not exist to suspend or revoke Respondent's California license for violation of sections 141, 2227, 2234 or 2305, based on the 2002 and 2003 Utah disciplinary orders, for the reasons set forth in Factual Findings 7, 12 and 14 and Legal Conclusions 18 and 19.

21. The Utah decision denying Respondent's license renewal occurred in 2012 and, therefore, is within the statutes of limitations. It fits within the analyses of sections 141 and 2305, above. Cause exists to suspend or revoke Respondent's California license for violation of sections 141, 2227, 2234 and 2305, based on the 2012 Utah disciplinary order for the reasons set forth in Factual Findings 16, 17 and 18 and Legal Conclusions 2 through 12 and 18. However, relatively little weight is attributed to this discipline, as it is based on, among other things, the earlier Utah disciplinary orders which are barred by the statute of limitations, and is duplicative to the extent it is based on the Arizona discipline and the Arizona conviction, already established above as bases for discipline in this matter.

22. The MBC's Manual of Disciplinary Orders and Disciplinary Guidelines (Guidelines, Exhibit 11) has been considered. The relevant maximum penalties for the violations here are revocation. The minimum penalty for sections 141 and 2305, discipline by another state, is to refer to the recommended minimum as for a similar offense in California. This is not practicable here as the other states' disciplines were issued with no admissions of any acts or violations. The minimum penalty for section 2236, conviction of a felony, is seven years' probation with various terms.

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23. Also considered is section 2229, which states in pertinent part that protection of the public shall be the MBC's highest priority and that an ALJ when exercising his disciplinary authority "shall, wherever possible, take action that is calculated to aid in the rehabilitation of the licensee . . . ."

24. When all the dust has settled, what may be considered here is that the MBC previously disciplined Respondent in 2003 for the internet prescriptions. However, this discipline is of little or no weight because it is too old to form a basis for new discipline and because the MBC adopted a Proposed Decision in 2006 which found that Respondent was rehabilitated. Respondent's care of a patient in 2007 in Arizona resulted in a low-level felony conviction for endangerment from which Respondent obtained early release from probation. The Arizona Board entered a Consent Decree with no findings or admissions of guilt, accepting Respondent's voluntary surrender of his license there. The Utah Division denied renewal of Respondent's license, for the reasons noted above; and due to a minor issue which arose in Utah in 1997, which was also included in Proposed Decision in 2006 which found that Respondent was rehabilitated; due to an issue in Nevada that dates back to 1993, which was also included in Proposed Decision in 2006 which found that Respondent was rehabilitated. In other words, much of what is presently before the MBC are matters that were previously adjudicated.

25. This should not obscure the fact that the 2012 Arizona conviction and 2008 Arizona Consent Decree are of major concern and clearly establish a basis for imposition of discipline. It is significant that Respondent recently took and passed the PACE program with a grade indicating good to excellent performance consistent with safe practice and competency. He has taken numerous continuing education courses. In the present hearing he did not demonstrate evasion or failure to take responsibility for his actions, exhibiting a demeanor appropriate to the circumstances. Under all of the relevant circumstances, it would be punitive to revoke his license outright. The public will be adequately protected by a probationary order with standard conditions and a practice monitor, as there is no sufficient reason to impose anything more. The purpose of proceedings of this type is to protect the public, and not to punish an errant licensee, which is the province of the courts. (*Hughes v. Board of Architectural Examiners* (1998) 17 Cal.4th 763, 784-786; *Bryce v. Board of Medical Quality Assurance* (1986) 184 Cal.App.3d 1471, 1476; *Camacho v. Youde* (1979) 95 Cal.App.3d 161, 164.)

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ORDER

Physician's and Surgeon's Certificate No. A67353 issued to Respondent Gary Page, M.D., is revoked pursuant to legal conclusions determination of Issues 8, 9, 12 and 16, separately and for all of them. However, revocation stayed and Respondent is placed on probation for three years upon the following terms and conditions.

1. Practice Monitoring: Within 30 calendar days of the effective date of this Decision, Respondent shall submit to the Medical Board of California (Board) or its designee for prior approval as a practice monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified. A monitor shall have no prior or current business or personal relationship with Respondent, or other relationship that could reasonably be expected to compromise the ability of the monitor to render fair and unbiased reports to the Board, including but not limited to any form of bartering, shall be in Respondent's field of practice, and must agree to serve as Respondent's monitor. Respondent shall pay all monitoring costs.

The Board or its designee shall provide the approved monitor with copies of the Decision and Second Amended Accusation, and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision, Second Amended Accusation, and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision and Second Amended Accusation, fully understands the role of a monitor, and agrees or disagrees with the proposed monitoring plan. If the monitor disagrees with the proposed monitoring plan, the monitor shall submit a revised monitoring plan with the signed statement for approval by the Board or its designee.

Within 60 calendar days of the effective date of this Decision, and continuing throughout probation, Respondent's practice shall be monitored by the approved monitor. Respondent shall make all records available for immediate inspection and copying on the premises by the monitor at all times during business hours and shall retain the records for the entire term of probation.

If Respondent fails to obtain approval of a monitor within 60 calendar days of the effective date of this Decision, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a monitor is approved to provide monitoring responsibility.

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of Respondent's performance, indicating whether Respondent's practices are within the standards of practice of medicine, and whether Respondent is practicing medicine safely. It shall be the sole responsibility of Respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, Respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If Respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, Respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

In lieu of a monitor, Respondent may participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, that includes, at minimum, quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at Respondent's expense during the term of probation.

2. Notification: Within seven days of the effective date of this Decision, Respondent shall provide a true copy of this Decision and the Second Amended Accusation to the Chief of Staff or the Chief Executive Officer at every hospital where privileges or membership are extended to respondent, at any other facility where respondent engages in the practice of medicine, including all physician and locum tenens registries or other similar agencies, and to the Chief Executive Officer at every insurance carrier which extends malpractice insurance coverage to respondent. Respondent shall submit proof of compliance to the Medical Board of California (Board) or its designee within 15 calendar days. This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

3. Supervision of Physician Assistants: During probation, Respondent is prohibited from supervising physician assistants.

4. Obey All Laws: Respondent shall obey all federal, state and local laws, all rules governing the practice of medicine in California and remain in full compliance with any court ordered criminal probation, payments, and other orders.

5. Quarterly Declarations: Respondent shall submit quarterly declarations under penalty of perjury on forms provided by the Board, stating whether there has been compliance with all the conditions of probation. Respondent shall submit quarterly declarations not later than 10 calendar days after the end of the preceding quarter.

6. General Probation Requirements:

Compliance with Probation Unit: Respondent shall comply with the Board's probation unit and all terms and conditions of this Decision.

Address Changes: Respondent shall, at all times, keep the Board informed of Respondent's business and residence addresses, email address (if available), and telephone number. Changes of such addresses shall be immediately communicated in writing to the Board or its designee. Under no circumstances shall a post office box serve as an address of record, except as allowed by Business and Professions Code section 2021, subdivision (b).

Place of Practice: Respondent shall not engage in the practice of medicine in Respondent's or patient's place of residence, unless the patient resides in a skilled nursing facility or other similar licensed facility.

License Renewal: Respondent shall maintain a current and renewed California physician's and surgeon's license.

Travel or Residence Outside California: Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty calendar days. In the event Respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

7. Interview with the Board or its Designee: Respondent shall be available in person upon request for interviews either at Respondent's place of business or at the probation unit office, with or without prior notice throughout the term of probation.

8. Non-practice While on Probation: Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" prior to resuming the practice of medicine.

Respondent's period of non-practice while on probation shall not exceed two (2) years. Periods of non-practice will not apply to the reduction of the probationary term. Periods of non-practice will relieve Respondent of the responsibility to comply with the

probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

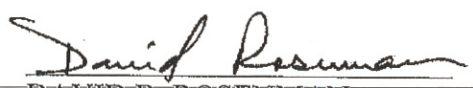
9. Completion of Probation: Respondent shall comply with all financial obligations (e.g., restitution, probation costs) not later than 120 calendar days prior to the completion of probation. Upon successful completion of probation, respondent's certificate shall be fully restored.

10. Violation of Probation: Failure to fully comply with any term or condition of probation is a violation of probation. If Respondent violates probation in any respect, the Board, after giving Respondent notice and the opportunity to be heard, may revoke probation and carry out the disciplinary order that was stayed. If an Accusation, or Petition to Revoke Probation, or an Interim Suspension Order is filed against Respondent during probation, the Board shall have continuing jurisdiction until the matter is final, and the period of probation shall be extended until the matter is final.

11. License Surrender: Following the effective date of this Decision, if Respondent ceases practicing due to retirement or health reasons or is otherwise unable to satisfy the terms and conditions of probation, respondent may request to surrender his license. The Board reserves the right to evaluate Respondent's request and to exercise its discretion in determining whether or not to grant the request, or to take any other action deemed appropriate and reasonable under the circumstances. Upon formal acceptance of the surrender, Respondent shall within 15 calendar days deliver Respondent's wallet and wall certificate to the Board or its designee and Respondent shall no longer practice medicine. Respondent will no longer be subject to the terms and conditions of probation. If Respondent re-applies for a medical license, the application shall be treated as a petition for reinstatement of a revoked certificate.

12. Probation Monitoring Costs: Respondent shall pay the costs associated with probation monitoring each and every year of probation, as designated by the Board, which may be adjusted on an annual basis. Such costs shall be payable to the Medical Board of California and delivered to the Board or its designee no later than January 31 of each calendar year.

DATED: September 2, 2014.



DAVID B. ROSENMAN
Administrative Law Judge
Office of Administrative Hearings

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 15, 2015
ATTENTION:	Board Members
SUBJECT:	Request for Attorney General Opinion on Business and Professions Code section 805(b) Reporting Deadline
FROM:	Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration, make a motion to authorize the Executive Director to request a formal legal opinion from the Attorney General's Office (AGO) with regard to when Business and Professions Code (B&P) section 805(b) reports must be filed.

BACKGROUND:

Pursuant to B&P section 805(b), a report must be filed with the Medical Board of California (Board) within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

1) A licentiate's application for staff privileges of membership is denied or rejected for a medical disciplinary cause or reason.
2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.
3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12 month period, for a medical disciplinary cause or reason.

There is a difference of opinion as to how the phrase "within 15 days after the effective date" is interpreted. Some individuals and entities have interpreted this phrase as applying only after the licentiate has been afforded a hearing, if requested, pursuant to B&P section 809.2. Other individuals and entities have argued that the 15-day deadline starts to run as soon as one of the three actions taken above occurs, regardless of whether the licentiate has requested and been afforded a hearing.

B&P section 805.5 requires that 805 reports be shared upon a request made on behalf of certain institutions, such as hospitals, before they grant a licentiate staff privileges. Therefore, the timing and credibility of 805 reports is of paramount concern to all parties involved.

The reporting entities, the physicians, the Board, investigators and Deputy Attorneys General would benefit from a formal legal opinion from the AGO to achieve clarity on this important issue. In addition, a legal opinion could also be used to prompt legislation to clarify this issue, once the legal opinion has been received.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 12, 2015
ATTENTION: Members, Medical Board of California
SUBJECT: Registered Dispensing Optician Program
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

After review and discussion, make a motion to keep the Registered Dispensing Optician Program as a program within the Medical Board of California (Board) and inform the Senate Business, Professions, and Economic Development Committee of such decision.

BACKGROUND:

In November 2012, the Board presented the 2012 Sunset Review Report to the Legislature. In the section regarding the Registered Dispensing Optician (RDO) Program, the Board discussed a new issue pertaining to the RDO Program and the indication that the State Board of Optometry (SBO) was interested in having the program transferred to their authority. The reason behind the proposed transfer was that the public may be confused as to where to file a complaint because they may not know the difference between an Optometrist's office and an RDO's office. In addition, two agencies may be investigating the same facility when an Optometrist is in the same office with an RDO. The Board recommended the RDO Program be moved to either the SBO or to another entity within the Department of Consumer Affairs. The latter option was added after representatives from the RDOs indicated to the Board their opposition to having the RDO moved to the SBO.

In the recommendations from the Senate and Assembly Business and Professions Committees to the Board, they pointed out that if the RDO Program were moved, it would demand more staff and escalate costs and registration fees. However, they also pointed out that there had been some successful consolidations of programs over the years at the Department of Consumer Affairs (DCA). The final recommendation was that the Board initiate discussions with DCA, the SBO, stakeholders from each of the interested professional groups and interested consumer representatives to discuss the potential need, usefulness, or problems with transferring the regulation from the Board to another board or program.

In meetings with DCA, SBO, and interested parties to discuss future legislation regarding regulation and investigation of these facilities, the topic of moving the RDO Program to SBO or another entity has been discussed. While all parties understand some of the issues surrounding the entities being under different regulatory boards, the professional groups are very concerned and continue to oppose the movement of the RDO Program to SBO.

Board staff has discussed this issue and believes that at this time, the Board should continue to regulate and provide oversight over the RDO Program. Now that the investigation process of the Board's cases is under the DCA, Division of Investigation, staff believes that a more coordinated effort can be made for the investigation and prosecution of these facilities. In addition, there are currently discussions being held on legislative proposals that would change the laws regarding co-location of an optometrist and an RDO. While it is important to work together on these issues, this can be done without having the two licensees under one board.

Video Visits: Supporting 21st Century Care

Patricia Conolly, MD
Associate Executive Director
The Permanente Medical Group

January 2015

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- Teledermatology consultation
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Medical Practice – Ongoing Evolution

- Within our profession – major focus has been on advances in diagnostics and therapeutics which have changed the way we practice
- Externally, technology has dramatically changed the way our patients live their lives
- Increasing trend in patient empowerment is driving us to adapt our practice to address the ways in which our patients want to receive care.

In the past, we often came to the patient…

More recently, our patients come to us….

Our patients' lives are changing

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Technology to support personalized care

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Video – the next step in enhancing access to high quality healthcare

Features of Video Visits

- High quality face-to-face interaction between the patient and his/her physician
- Synchronous, real-time
- Free of charge to the patient
- Access from a location of the patient's choice using a webcam-equipped computer, tablet or smartphone
- Patient may include designated family members or guests who may join a patient video appointment from a different remote site,
- Full integration of the video visit in the electronic medical record, KP HealthConnect

How We Utilize Video

- Expand Choice
- Make care more Convenient
- Make care more Continuous
- When visualization aids assessment
- Build on the personal relationship of patient and physician

How Video Works: Patient Desktop Experience

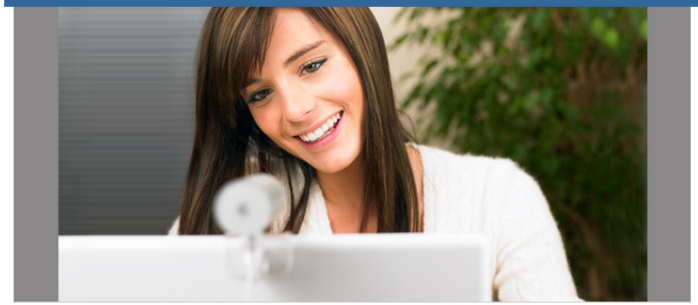
1 Email reminder with link

You have the following Kaiser Permanente video appointment:

Date: Wednesday March 5, 2014
Time: 11:15 a.m.
With: Dr. Young
Department: PEDIATRICS - WALNUT CREEK
VIDEO APPOINTMENT

This is a video appointment. Please join the visit 15 minutes prior to your appointment time by clicking this link Video Visit

2 Website with log-in



Get Prepared Before Your Visit
Check your computer and surroundings before your visit.
Get Prepared

Join Your Visit
Use a computer or mobile device. See our help section for details.
Join Your Video Visit

3 Appt details

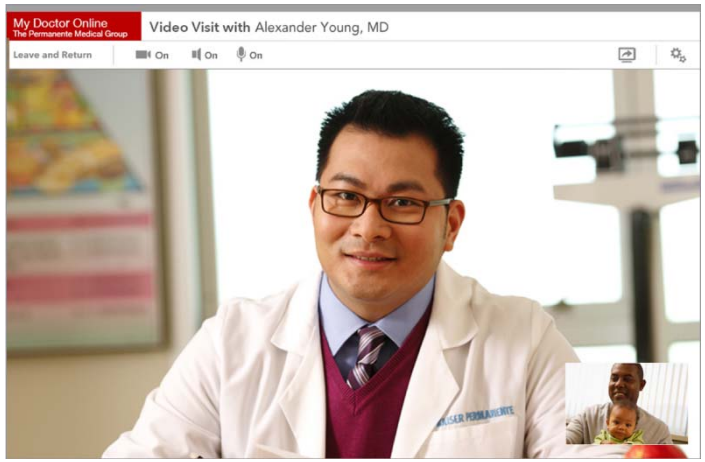
Your visit is scheduled for 11:15 AM PST

Meeting with Alexander Young, MD

Click here to join now

You may be joining before your clinician. Please be patient.

4 Video visit



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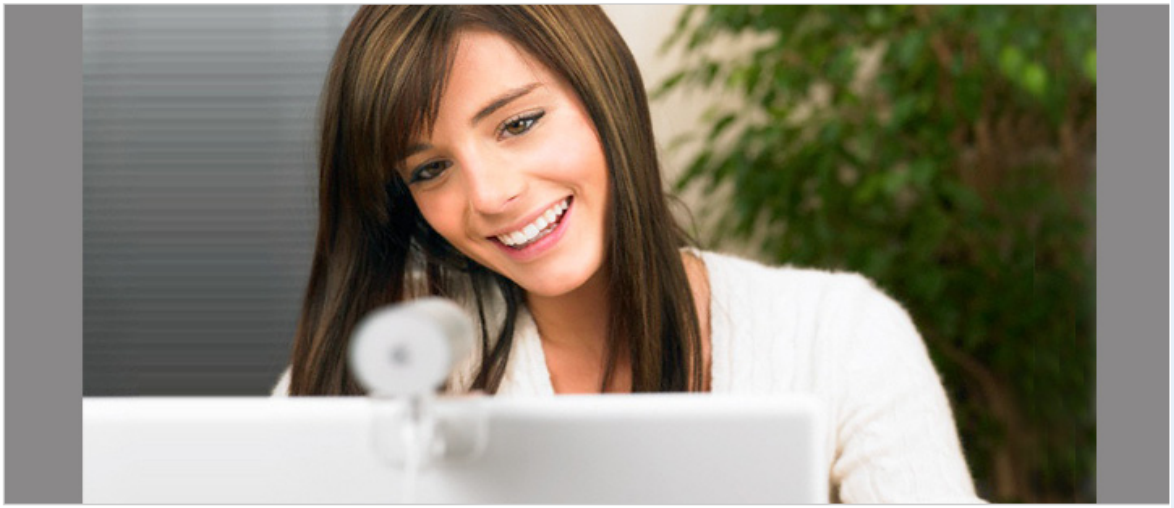
See your doctor from the convenience of your home or office.



Get Prepared Before Your Visit

Check your computer, webcam, and surroundings before your visit.

Get Prepared

Join Your Visit

Join your visit from a desktop or laptop computer.

Join Your Video Visit

New to Video Visits?
Video Visits is a convenient, secure way to meet with your doctor online, using your computer or webcam.
More>

Help Joining Your Visit
Are you having trouble joining your visit? Try these tips.
More>

Need Help?
Questions about your video appointment? Visit our help section for answers.
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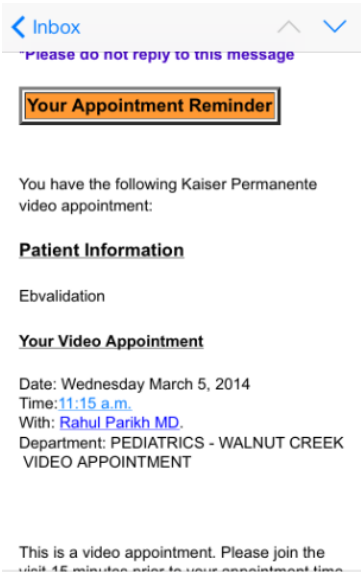
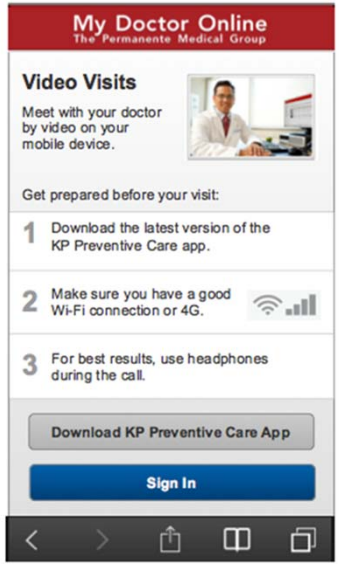
How Video Visits work: Patient Smartphone Experience

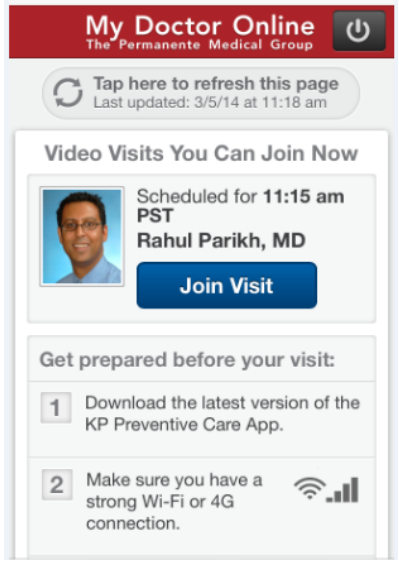
1 Email reminder with link



2 Website

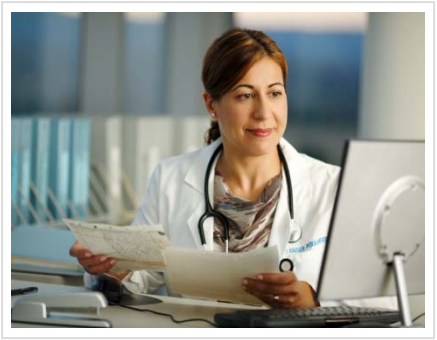


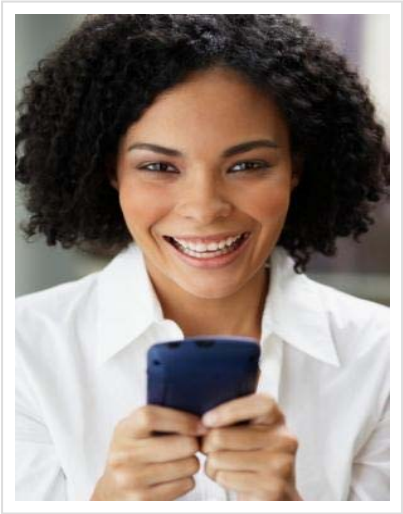
4 Appointment details



5 Video Visit

Our Goal –Deliver the right care, at the right time, at the right place





Interstate Compact

Purpose: Provides a streamlined process for physicians who want to be licensed in multiple states.

Licensure Requirements

Medical Board of California (MBC)	Interstate Compact
Graduated from a medical school approved by the Board (LCME/CACMS or Board approved) or meet the timeframe requirements for non-approved or disapproved schools	Graduated from a LCME medical school or a medical school listed in the International Medical Education Directory or its equivalent
Postgraduate Training Program in the US (ACGME or RCPSC approved) • 1 year for US medical school graduate • 2 years for international medical school graduate	Completion of a Postgraduate Training Program in the US (ACGME or RCPSC approved) • 3 years is the least for completion
Passage of USMLE (Step 3 within 4 attempts) or other previously approved exams	Passage of USMLE (all steps within 3 attempts) or other previously approved exams by the state board
Not required	Board certification by an ABMS board
Not required	Full and unrestricted license to practice issued by a member board
Not required, but MBC looks at each conviction to determine if licensure can be issued, if a probationary license is warranted, or if the application should be denied	Never been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction
Not required, but MBC looks at each disciplinary action to determine if licensure can be issued, if a probationary license is warranted, or if the application should be denied	Never held a license subjected to discipline by a licensing agency in any state, federal, or foreign jurisdiction
Not required	Never had a controlled substance license or permit suspended or revoked by a state or US DEA
If known, MBC may pend the application awaiting outcome of investigation	Not under any active investigation by a licensing agency or law enforcement authority in any state, federal, or foreign jurisdiction

Definitions

“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

“Commissioner” means the voting representative appointed by each member board pursuant to Section 11.

"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.

“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.

"Member State" means a state that has enacted the Compact.

"Offense" means a felony, gross misdemeanor, or crime of moral turpitude.

“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.

"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.
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.

A physician may re-designate a member state as state of principal license at any time, as long as the state meets the requirements above.

"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.

Licensure Process

Dr. Smith decides to apply for licensure

Dr. Smith first determines if she only wants to practice in STATE ONE (the state of principal license) or in additional states.

A

If Dr. Smith decides to only be licensed in STATE ONE then she submits a normal application, documents and fees to STATE ONE.

Dr. Smith gets licensed and holds a license in STATE ONE.

B

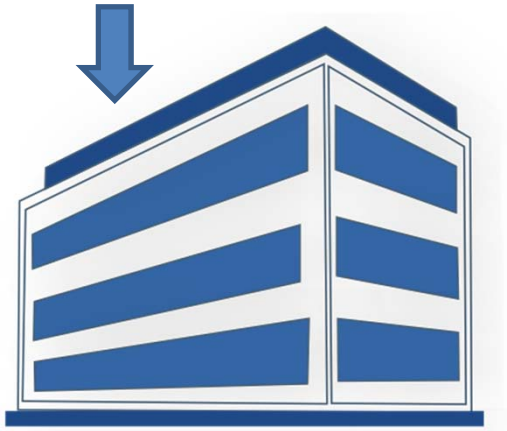
Dr. Smith decides she wants to practice not only in STATE ONE, her state of principal license, but in other states within the Compact, she submits the normal application and documents for STATE ONE (and follows their licensure process), **plus** she files an application for an expedited license for additional states licenses (STATE TWO and STATE THREE). She submits only the check for her normal application to STATE ONE.

Dr. Smith's applications (both for STATE ONE and expedited licensure) are evaluated by STATE ONE. If she meets the qualifications for each, she is issued a license by STATE ONE and a letter of qualification verifying Dr. Smith's eligibility for expedited licensure is sent to the Interstate Commission**

** STATE ONE must perform primary source verification of meeting the requirements and also fingerprint the individual through FBI to verify the criminal background check of the applicant.

Licensure Process

After receipt of eligibility, Dr. Smith must also complete the registration process with the Interstate Commission to receive a license in STATE TWO and STATE THREE and submit payment of any applicable fees.



Upon receiving verification of eligibility and fees, STATE TWO shall issue Dr. Smith an expedited license. ★

Upon receiving verification of eligibility and fees, STATE THREE shall issue Dr. Smith an expedited license. ★

★This license authorizes Dr. Smith to practice medicine in the state consistent with STATE TWO's and STATE THREE's Medical Practice Act and all applicable laws and regulations. Dr. Smith's license is valid for a period consistent with STATE TWO's and STATE THREE's normal licenses. If Dr. Smith fails to maintain a license in STATE ONE, her state of principal licensure, for a non-disciplinary reason, without re-designation of a new state of principal licensure, the expedited licenses shall be terminated.

RENEWAL OF EXPEDITED LICENSES*

Physician completes renewal process with Interstate Commission

- Physician must meet the following:
  - Maintains a full and unrestricted license in a state of principal license;
  - Has not been convicted, received adjudication, deferred adjudication, community supervision, or deferred disposition for any offense by a court of appropriate jurisdiction;
  - 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
  - Has not had a controlled substance license or permit suspended or revoked by a state or the United States Drug Enforcement Administration.

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

- The Interstate Commission shall collect any renewal fees charged for the renewal of a license and distribute the fees to the applicable member board.

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

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

*California specific issue – for a California license financial interest information is collected. However, if the individual is not residing in California, which they may not be if California was not the principal license, then this would not apply.

Disciplinary Proceedings

Dr. Smith's state of principal license is STATE ONE. If Dr. Smith's license is revoked, surrendered, relinquished in lieu of discipline, or suspended by the STATE ONE MEDICAL BOARD (SMB-1), it notifies the Interstate Commission.

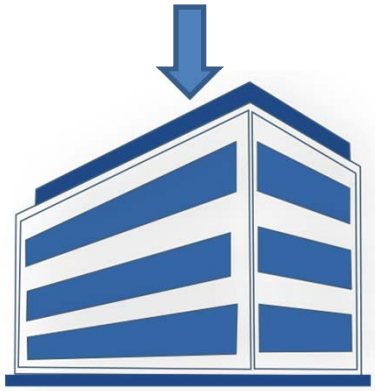
The Interstate Commission notifies the STATE TWO MEDICAL BOARD (SMB-2). Dr. Smith's expedited license in STATE TWO is placed in the same status by the SMB-2, without further action necessary by SMB-2.*

The Interstate Commission notifies the STATE THREE MEDICAL BOARD (SMB-3). Dr. Smith's expedited license in STATE THREE is placed in the same status by the SMB-3, without further action necessary by SMB-3.*

* If SMB-1 reinstates Dr. Smith's STATE ONE license, Dr. Smith's STATE TWO and STATE THREE licenses remain encumbered until SMB-2 and SMB-3 take action to reinstate the license in a manner consistent with the Medical Practice Act in their respective states.

Disciplinary Proceedings

If disciplinary action is taken by SMB-2 against Dr. Smith's license (not Dr. Smith's state of principal license), it notifies the Interstate Commission.



The Interstate Commission notifies the SMB-1.*

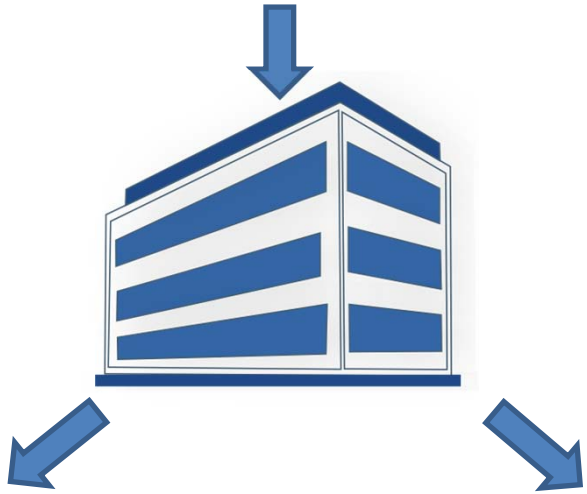
The Interstate Commission notifies the SMB-3.*

* SMB-1 and SMB-3 may deem the action conclusive as to matter of law and fact decided, and:

- 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; or
- pursue separate disciplinary action against the physician under its respective Medical Practice Act, regardless of the action taken in other member states.

Disciplinary Proceedings

If Dr. Smith's STATE TWO license is revoked, surrendered, relinquished in lieu of discipline, or suspended by the SMB-2, it notifies the Interstate Commission.



The Interstate Commission notifies the SMB-1.*

The Interstate Commission notifies the SMB-3.*

* Dr. Smith's STATE ONE and STATE THREE licenses must be suspended, automatically and immediately without further action necessary, for ninety (90) days upon entry of the order by SMB-2, to permit the SMB-1 and the SMB-3 to investigate the basis for the action under the Medical Practice Act of their respective states. SMB-1 and SMB-3 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 their respective states.

Data Sharing (including Enforcement Documents)

- Interstate Commission shall establish a database of all physicians licensed, or who have applied for licensure. **[Medical Board of California would still list these individuals within the Board's online physician profiles and list the information required pursuant to California laws and regulations.]**
- 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
- Member boards shall report disciplinary or investigatory information determined as necessary and proper by rule of the Interstate Commission
- Member boards may report any non-public complaint, disciplinary, or investigatory information not required above to the Interstate Commission
- Member boards shall share complaint or disciplinary information about a physician upon request of another member board

Data Sharing (including Enforcement Documents)

- 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
- Licensure and disciplinary records of physicians are deemed investigative
- Member boards may participate with each other in joint investigations of physicians licensed by the member boards
- A subpoena issued by a member state shall be enforceable in other member states
- Member boards may share any investigative, litigation, or compliance materials in furtherance of any joint or individual investigation initiated under the Compact
- 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

Interstate Commission

Purpose:	Administration of the Interstate Medical Licensure Compact
Composition:	• Two voting representatives for each member state (for California – 1 Medical Board and 1 Osteopathic Board) • Commissioner shall be: ✓ Physician Member appointed to a member board; ✓ Public Member appointed to a member board; or ✓ Executive Director from the member board
Voting:	Each Commissioner is entitled to 1 vote
Meetings:	Noticed public meetings with limited exceptions for closed meetings
Committees:	Executive Committee (which can act on the Commission's behalf) and other committees will be established as needed

Medical Board Impact

Benefits	Concerns
It is voluntary for the State	Costs to be a member state (see Federation note in Finance Powers slide)
The Commission cannot make substantive changes to the Compact without unanimous consent by all state legislatures	The "unknown" – Compact allows the Commission to make rules regarding certain procedural aspects of the Compact, as needed, with only one vote from the MBC
Does not change the Board's Medical Practice Act, but allows another licensure pathway	Smaller states have the same level of representation as large states
Maintains that the practice of medicine is where the patient is located	Requires adoption of the Compact "as is" by the legislature
State Boards can still take disciplinary action as warranted	Renewal fees are processed through the Commission
Proactive, expedited exchange of complaints regarding physicians licensed in member states	
Preserves the funding of state-based licensure and regulations	
The licensure requirements are more stringent than California's	
A California subpoena is enforceable in other member states	

Physician Impact

Pros	Cons
It is voluntary for the physician to be licensed through the Compact (still preserves the pathway for individual state licensure)	Additional costs for the processing fee (this con may be outweighed by the savings to the physician for not having to obtain duplicative primary source documents)
Saves time to obtain multiple duplicative documents for licenses in individual states	Complaints are shared with member states
Expedites the licensure process for physicians obtaining licenses in multiple states (i.e. only the principal state verifies and process primary source documents)	
Saves money (depending upon the Compact processing fee) for physicians to obtain documents for individual licenses	

Powers and Duties of the Commission

(highlights, not all inclusive)

- Oversee and maintain the administration of the Compact
- Promulgate the rules
- Enforce compliance with Compact provisions, using all necessary means, including but not limited to the use of judicial process
- Appoint committees
- Accept donations and grants of money, equipment, etc.
- Establish a budget and make expenditures
- Adopt a seal and bylaws governing the management and operation of the Commission
- Report annually to the legislatures and governors on Commission activities, including financial reports
- Perform such functions as may be necessary or appropriate to achieve the purposes of the Compact

Finance Powers
(highlights, not all inclusive)

- 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.
  - Information from the Federation indicates:
    Throughout the discussion of the Compact and the Compact Commission it has been clear that in order to succeed, the Compact must be as close to budget neutral as possible, and thus, self-sustaining. This guided the drafting committee in its choices on how to allocate powers to the Commission. The Interstate Compact empowers the Commission to secure outside funding, through private grants, federal appropriations in support of license portability, or other similar sources to off-set the need for any appropriation from states. Additionally, the processing fees for expedited licensure is expected to largely offset, if not totally eliminate, the burden on the member states.
- 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 Commission.

Organization and Operation of the Commission

(highlights, not all inclusive)

- ✓ 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.

- ✓ The Interstate Commission shall elect or appoint annually a chairperson, vice-chairperson, and a treasure.

Rulemaking Functions of the Commission

(highlights, not all inclusive)

- The Commission shall promulgate reasonable rules in order to effectively and efficiently achieve the purposes of the Compact.
- Rules deemed appropriate for the operations of the 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.
- 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 Commission has its principal offices.

Oversight of the Commission
(highlights, not all inclusive)

- 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**.

Enforcement of the Interstate Compact
(highlights, not all inclusive)

- The Commission, in the reasonable exercise of its discretion, shall enforce the provisions and rules of the Compact.

- The Commission may, by majority vote of the Commissioners, initiate legal action to enforce compliance with the provisions of the Compact, and its promulgated rules and bylaws, against a member state in default.

---Specific procedures are set out in the Compact for member states in default and for dispute resolution

Member States
(highlights, not all inclusive)

- 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.

- The Commission may propose amendments to the Compact for enactment by the member states. No amendment shall become effective and binding upon the Commission and the member states unless and until it is enacted into law by unanimous consent of the member states.

Withdrawal from Interstate Compact

(highlights, not all inclusive)

- A member state may withdraw from the Compact by specifically repealing the statute which enacted the Compact into law.
- Withdrawal from the Compact shall not take effect until one year after the effective date of the repeal of the enacting statute and until written notice of the withdrawal has been given to the governor of each other member state.
- The Interstate Commission may 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.

Binding Effect of Compact and Other Laws

(highlights, not all inclusive)

- ✓ Nothing herein prevents the enforcement of any other law of a member state that is not inconsistent with the Compact.
- ✓ All laws in a member state in conflict with the Compact are superseded to the extent of the conflict.
- ✓ All lawful actions of the Interstate Commission, including all rules and bylaws promulgated by the Commission, are binding upon the member states.

Medical Board Options

- ✓ Support the Interstate Compact and sponsor legislation
- ✓ Support the Interstate Compact, but do not sponsor legislation
- ✓ Do nothing, wait for legislation to be introduced
- ✓ Oppose the Interstate Compact

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.

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: January 8, 2015
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 March 19, 2015 MAC meeting:

- Task Force Update:
  - Licensed Midwife Annual Report (LMAR) Data Collection Tool
- Update on continuing regulatory efforts required by Assembly Bill (AB) 1308
- Update on midwife assistant legislation
- Update on interested parties meeting held December 15, 2014
- Presentation by Diane Holzer on Home Birth Summit recommendations regarding best practices for home to hospital transfer by midwives

BACKGROUND:

The last MAC meeting was held on December 4, 2014. At this meeting, the MAC heard updates on the continuing efforts to craft regulations required by AB 1308 (Bonilla, Chapter 665, Statutes of 2013). The interested parties will continue to meet privately to come to an agreement on language required by Business and Professions Code Section 2507 (b)(1)(A)(i) and (ii); essentially the development of a list of conditions requiring a referral to a physician for consultation prior to the midwife continuing care for a particular client. After the interested parties meeting on December 15, 2014, agreement was reached with only a few minor points of unresolved conflict. It is hoped these issues will be resolved between the parties, namely the California Association of Midwives and the American Congress of Obstetricians and Gynecologists. Discussion surrounding the Hospital Reporting form continues with general agreement as to what the form should contain.

A one page reference document (Attachment A) has been developed that compares Licensed Midwives (LM) with Certified Nurse Midwives (CNM). The chart reflects education and licensing requirements as well as the scope of practice, prescriptive authority, and provides a quik comparison between LMs and CNMs. This document will also be provided to new Board Members in the future.

MAC was advised that discussion surrounding the creation of a pathway for CNM to LM licensure has been aborted, in large part because it appears that CNMs will seek legislation this year to remove physician supervision from their statute on their own.

The Board's recognition of needed language to legitimize midwife assistants and the Board's consideration to move that language forward to the legislature is appreciated by the MAC.

MEDICAL BOARD OF CALIFORNIA

Licensing Program

COMPARISON CHART BETWEEN CALIFORNIA LICENSED MIDWIVES and CERTIFIED NURSE MIDWIVES

SCOPE OF PRACTICE and PRESCRIPTIVE AUTHORITY	
Licensed Midwife	**Certified Nurse-Midwife**
Scope of Practice Licensed midwives (LM) provide the necessary supervision, care and advice to women prior to and during pregnancy, labor, postpartum and the inter-conceptional period and care for the well newborn and infant. They provide care as independent care providers and without physician supervision in homes, birth centers, offices, clinics and hospitals. This care includes preventive measures, the detection of abnormal conditions and complications in the mother and child, and the procurement of medical assistance when necessary. They provide emergency care until medical help can be obtained. ***Prescriptive Authority*** LMs have the authority to directly obtain and administer drugs that are necessary to their practice of midwifery and consistent with their scope of practice. LMs do not administer schedule II controlled substances and do not require "standardized procedures."	***Scope of Practice*** Certified nurse midwives (CNM) provide the necessary supervision, care and advice to women during pregnancy, labor, postpartum and inter-conceptional periods under physician supervision. They conduct deliveries and care for the well newborn and infant. They provide this care in homes, birth centers, offices, clinics and hospitals. This includes preventive measures, the detection of abnormal conditions in mother and child, and procurement of physician assistance and consultation when indicated. They provide emergency care until physician assistance can be obtained. For additional care the CNM utilizes standardized procedures as described in Section 2725 of the Business and Professions Code. (Title 16 California Code of Regulations section 1463) ***Prescriptive Authority*** CNMs have authority to furnish drugs, including schedule II controlled substances, under "standardized procedures." CNMs do not have the authority to obtain these medications directly.

EDUCATION and LICENSURE REQUIREMENTS	
Licensed Midwife	**Certified Nurse-Midwife**
Education Education prepares LMs for the management of reproductive health care, pregnancy, birth, and postpartum care of the otherwise well woman and immediate care (up to 6 weeks) of the well, newborn infant. ***Licensure Requirements*** Graduation from a midwifery school that meets the following criteria: "The midwifery education program shall provide both academic and clinical preparation equivalent, but not identical to that provided in programs accredited by the American College of Nurse Midwives..." [Business & Professions Code (B&P) section 2512.5 (a) (3)] OR "An approved midwifery education program shall offer the opportunity for students to obtain credit by examination for previous midwifery education and clinical experience. …Beginning January 1, 2015, new licensees shall not substitute clinical experience for formal didactic education." [B&P section 2513 (a)] AND "...the applicant shall successfully complete a comprehensive licensing examination adopted by the board which is equivalent, but not identical, to the examination given by the American College of Nurse Midwives." [B&P section 2512.5 (a)(1)]	***Education*** Education prepares CNMs for the management of primary care for women throughout the lifespan, including reproductive health care, pregnancy, birth and postpartum care for the otherwise well woman. ***Licensure Requirements*** The applicant must hold a valid license as a registered nurse in California and be a graduate of an approved nurse-midwifery program. The attainment of clinical skills must meet Core Competencies for Basic Midwifery Education (American College of Nurse-Midwives 2012). All California Nurse-Midwifery education programs approved by the Board of Registered Nursing are Master degree programs within Schools of Nursing. [B&P section 2746]

Agenda Item 24

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 12, 2015
ATTENTION:	Members, Medical Board of California
SUBJECT:	Midwifery Advisory Council Member Appointments
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Approve the extension of all current Midwifery Advisory Council Member appointments for one year.

BACKGROUND AND ANALYSIS:

California Business and Professions Code (BPC) Section 2509 was added to statute in 2006, effective January 1, 2007. BPC Section 2509 authorized the Medical Board of California (Board) to create and appoint a Midwifery Advisory Council (MAC).

BPC Section 2509 - Midwifery Advisory Council states:

> The board shall create and appoint a Midwifery Advisory Council consisting of licensees of the board in good standing, who need not be members of the board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the council members shall be California licensed midwives. The council shall make recommendations on matters specified by the board.

Although the size of the MAC was not specified in law, after the law went into effect, staff recommended that the MAC consist of six members (3 licensees and 3 public members). Applications for appointment to the MAC were solicited from all licensed midwives and others who had an interest in home births and the practice of midwifery. Based on the applications received, staff made recommendations for appointments for MAC membership to the Division of Licensing (Division). The recommendations for public members included a current member of the Board, as well as a representative from the American Congress of Obstetricians and Gynecologists (ACOG) and the California Medical Association (CMA) as was suggested by the Midwifery Committee at its November 2, 2006 meeting. During public comment, members of the midwifery community voiced concern with the interpretation of “public member” as the recommendations included physicians, but excluded non-professional consumers who have received midwifery care. Dr. Fantozzi, chair of the Midwifery Committee, and the Division, clarified that there was no intent to exclude consumers and other interested parties from attending the publicly held meetings and voicing their concerns. The Division adopted the recommendations made by staff for the size, terms, and membership of the MAC at its February 2007 meeting.

At the February 3, 2012 Board Meeting, the Board approved the MAC to proceed with replacing two vacant positions, due to resignations, with one physician Obstetrician/Gynecologist (OB/GYN) and one public member (a consumer who has used midwifery services). These vacant positions were filled for three year terms expiring June 30, 2015.

The following is a brief summary of the process for filling vacant/expiring MAC Member terms.

1. Call for applications:
    - A MAC Member interest letter and application form is posted to the Board's website.
    - An analyst sends the MAC Member interest letter and application form requesting applications for vacant/expiring positions to all Licensed Midwives for the Licensed Midwife position and to all interested parties (ACOG, CMA, mailing list, and those who have previously applied) for the Public Member position.
2. Applications are collected by staff:
    - An analyst checks for disciplinary action on any licensee applicants.
    - All applications (appropriately redacted) are for forwarded to the MAC Members for consideration.
3. Applicants are invited to address the MAC at the appropriate meeting.
4. At the MAC meeting:
    - Candidates are given the opportunity to address the Council.
    - Individual MAC Members nominate candidates for vote by the MAC.
5. The MAC's approved candidates' names, along with a brief synopsis of the candidate(s), is included in the Board packet at the next scheduled Board Meeting and recommended to the Board for appointment (or reappointment),.
6. The Board votes to accept or reject the MAC's recommended candidate for appointment (or reappointment) to the MAC.

The MAC currently has six members; three licensed midwives and three members of the public. The current public members consist of: one Board Member; one licensed physician who is an obstetrician/gynecologist; and one public member who has used the services of a licensed midwife.

In reviewing the MAC Member terms, it was determined there had been an oversight on the term expiration date for two members. Two members' terms expired June 30, 2014 while the remaining members all have term expiration dates of June 30, 2015 or later. The following is a listing of MAC Members and the expiration date of their terms and the proposed new expiration date for each MAC Member:

Name	Term Length	Term Expires	Proposed Expiration
James Byrne, M.D.	3 Years	June 30, 2015	June 30, 2016
Karen Ehrlich, L.M.	3 Years	June 30, 2015	June 30, 2016
Tosi Marceline, L. M.	3 Years	June 30, 2016	June 30, 2017
Carrie Sparrevohn, L.M.	3 Years	June 30, 2014	June 30, 2015
Monique Webster	3 Years	June 30, 2015	June 30, 2016
Barbara Yaroslavsky	3 Years	June 30, 2014	June 30, 2015

To provide an equitable solution for all MAC Members and to maintain full MAC appointments, staff is recommending the Board approve a one-year extension of all MAC Member terms. If the one-year extension is approved by the Board, a notification will be prepared in February for the two expiring positions (one Licensed Midwife and one public).

If the Board does not approve the one-year term extensions, a notification will be prepared in February for the two expired positions (one Licensed Midwife and one public) and three positions expiring on June 30, 2015 (one Licensed Midwife and two public). Without Board approval for the one-year term extensions, the MAC will only have four MAC Members for the March 2015 MAC meeting. All four MAC Members need to be in attendance to have a quorum. A quorum is needed to vote on the recommendations to the Board for the expired and expiring MAC Member positions. In addition, without an extension of the terms, this would place five positions expiring at the same, rather than staggering the terms. By having five terms expiring at the same time, it is possible the MAC could have as many as five new members at one time, resulting in only one experienced MAC Member.

Agenda Item 25

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 12, 2015
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 Hideho Okada, M.D., Ph.D., and Rene J. Sotelo, M.D., 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 December 4, 2014 meeting, the SFPRC reviewed the qualifications of two applicants: one applicant from the University of California San Francisco (UCSF) and one applicant from Keck School of Medicine, University of Southern California (USC).

Hideho Okada, M.D., Ph.D. - UCSF:
Neal Cohen, M.D., M.S., M.P.H., Vice Dean, UCSF, presented UCSF's request for Hideho Okada, M.D., Ph.D., to receive an SFP and provided the SFPRC with Dr. Okada's qualifications. Dr. Okada's area of expertise is Neurosurgery, specifically in the area of brain cancer immunotherapy.

Dr. Okada has held the following positions: tenured professor at the University of Pittsburgh, School of Medicine; and Visiting Research Instructor and Visiting Research Associate at the University of Pittsburgh. Dr. Okada was one of the co-leaders for the international working group, Immunotherapy Response Assessment in Neuro-Oncology. Dr. Okada has published 67

publications, 137 invited published papers and has been invited to lecture at several seminars. Dr. Okada has an in-depth understanding of immunology in central nervous systems tumors, and has unique expertise and experience in both the clinical and basic research aspects of medical science. Dr Okada's national and international reputation as a leader in this field is reinforced by his outstanding clinical investigations.

Dr. Okada will hold a full-time faculty appointment as a Professor of Neurological Surgery, Step 1 in the Department of Neurological Surgery at UCSF, if approved for an SFP appointment by the Board. Dr. Okada will provide instruction as part of the medical school's education program and see patients to fulfill his clinical teaching responsibilities at UCSF. Dr. Okada will be instrumental to the mission of neurological surgery at UCSF, developing novel and promising therapeutic strategies to treat patients with brain tumors.

Dr. Okada's application is complete except for the final fee for the permit. 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. Okada's Medical Education

Medical School:

Nagoya University School of Medicine Graduated March 25, 1991	Japan	1987 - 1991
Nagoya University School of Medicine Doctorate of Philosophy	Japan	1992 - 1996

Postgraduate Training:

➢ Handa Municipal Hospital Internship	Japan	06/91 - 03/92
➢ Nagoya University Hospital Neurological Surgery	Japan	04/92 - 03/96

Rene J. Sotelo, M.D. - USC

Frank Sinatra, M.D., Assistant Dean for Faculty Development, USC, presented USC's request for Rene J. Sotelo, M.D., to receive an SFP and provided the SFPRC with Dr. Sotelo's qualifications. Dr. Sotelo's area of expertise is in minimally invasive urologic surgery.

Dr. Sotelo is currently the Professor and Chairman of the Department of Urology and Director of Minimally Invasive Surgery at Clinica Floresta in Venezuela. Dr. Sotelo has also held the following positions: Director, Minimally Invasive Surgery in Urology, Universidad Santa Maria;

Director of Fellowship in Urologic Minimally Invasive Surgery, Universidad Central de Venezuela; Assistant Professor, Universidad Nacional de Colombia; and Visiting Professor, Sociedad de Cirugia de Bogota, Hospital de San Jose. Dr. Sotelo has published over 60 peer reviewed articles, 3 textbooks and over 27 book chapters, and has lectured in major scientific societies in over 24 countries. Dr. Sotelo is an expert in robotic surgery in South America and is a pioneer in single-port laparoscopic and robotic surgery. Dr. Sotelo is an internationally known pioneer who led the development of laparoscopic and robotic techniques for urinary fistula surgery.

Dr. Sotelo will hold a full time faculty appointment as a Professor of Clinical Urology at USC, if approved for an SFP appointment by the Board. Dr. Sotelo will be providing medical instruction to medical students, residents and fellows and will conduct research in the development of novel robotic and single-port techniques. Dr. Sotelo will also provide clinical care, outpatient services and inpatient services at USC clinical sites and at Los Angeles County/USC Medical Centers. Dr. Sotelo has the credentials to guide the USC program to the highest levels of excellence and will enhance USC's robotic enterprise, given his unique, cutting edge talents.

EDUCATION:

Medical School:

Universidad Central de Venezuela, 1981 thru 1987 Escuela de Medicina - Luis Razetti Graduated July 29, 1988	Venezuela	1981 - 1987

Postgraduate Training:

➢ Hospital General Del Este Dr. Domingo Luciani Surgery	Venezuela	1989 - 1992
➢ Hospital General Del Este Dr. Domingo Luciani Urology	Venezuela	1992 - 1995

Fellowship:

➢ Hospital Oncologico Padre Machado	Venezuela	07/96 – 07/97

Dr. Renee J. Sotelo's application is complete except for the copy of the U.S. social security card, copy of his visa and the final fee for the permit. The copy of the U.S. social security card, 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.

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Okada for an SFP at UCSF pursuant to B&P Section 2168.1 (a)(1)(A).

The SFPRC recommended approval of Dr. Sotelo for an SFP at USC pursuant to B&P Section 2168.1 (a)(1)(B).

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

January 14, 2015

To: Medical Board of California

From: California State Board of Pharmacy, Virginia Herold

Subject: Request for Review and Approval by the Medical Board of California Protocols to Permit Pharmacists to Provide:

1. Self-Administered Hormonal Contraception,
2. Nicotine Replacement Products, and
3. Naloxone Hydrochloride

At your January 30 board meeting, representatives of the Board of Pharmacy will appear to formally request the Medical Board's approval of the three protocols indicated above. We are grateful for this opportunity to work together again with your board on major public health initiatives.

Legislation enacted in 2013 and 2014 (SB 493, Hernandez, Chapter 469, Statutes of 2013; and AB 1535, Bloom, Chapter 326, Statutes of 2014), directed our two boards to develop and approve the protocols. Copies of each of the proposed protocols are provided as attachments to this letter.

Over the last year, the board has convened five public committee meetings to develop these protocols and other components specified in the legislation:

- February 2014: Licensing Committee
- June 2014: SB 493 Implementation Committee
- August: Meeting SB 493 Implementation Committee
- November: Meeting SB 493 Implementation Committee
- December: Meeting SB 493 Implementation Committee

These meetings were well attended and provided opportunities for public comments and participation. Staff of the Medical Board attended some of these meetings. Meeting materials and minutes of these meetings are available from the Pharmacy Board's Web site at www.pharmacy.ca.gov (under about the board, and then board and committee meetings).

The protocols will be formally reviewed and I expect approved by the Board of Pharmacy during the January 28 Meeting. An update on the actions of the Board of Pharmacy will be provided at the Medical Board meeting. If the protocols are approved by both boards, the Board of Pharmacy will initiate rulemakings to adopt the protocols in regulation. The protocol for naloxone is planned to be adopted as an emergency regulation, pursuant to the provisions in the enacting legislation (AB 1535).

If additional review is needed, the protocols will be brought to both boards so that the same version of each protocol is approved by both boards. Comments made during rulemakings that result in changes in the text of any protocol will be returned to the Medical Board for approval.

The California HealthCare Foundation has provided support to the board to develop various components that board needs to meet the requirements of SB 493 and AB 1535. This support was in way of a researcher to develop draft components. One such product is the development of a protocol for self-administered hormonal contraception.

1. **FOR REVIEW AND POSSIBLE ACTION** **Protocol for Pharmacists who Furnish Self-Administered Hormonal Contraceptives**

Attachment 1

SB 493 provides for the development of a protocol for self-administered hormonal contraception. The protocol must be developed and approved by both the Medical Board and the Board of Pharmacy, in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association and other appropriate entities. It requires a self-screening tool for use by patients based on the current United States Medical Eligibility Criteria (USMEC). A pharmacist must also provide to the patient a fact sheet approved by the same group identified above and the CA Department of Public Health.

Attachment 1 contains the draft protocol for hormonal contraception. The board's SB 493 Implementation Committee believes this draft is ready for final review and referral to adoption as a regulation.

The related statutory provisions are provided below:

SEC. 7.
Section 4052.3 of the Business and Professions Code is amended to read:

4052.3.

(a) (1) Notwithstanding any other law, a pharmacist may furnish self-administered hormonal contraceptives in accordance with standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The standardized procedure or protocol shall require that the patient use a self-screening tool that will identify patient risk factors for use of self-administered hormonal contraceptives, based on the current United States Medical Eligibility Criteria (USMEC) for Contraceptive Use developed by the federal Centers for Disease Control and Prevention, and that the pharmacist refer the patient to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics, upon furnishing a self-administered hormonal contraceptive pursuant to this subdivision, or if it is determined that use of a self-administered hormonal contraceptive is not recommended.

(2) The board and the Medical Board of California are both authorized to ensure compliance with this subdivision, and each board is specifically charged with the enforcement of this subdivision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(b) (1) Notwithstanding any other law, a pharmacist may furnish emergency contraception drug therapy in accordance with either of the following:

(A) Standardized procedures or protocols developed by the pharmacist and an authorized prescriber who is acting within his or her scope of practice.

(B) Standardized procedures or protocols developed and approved by both the board and the Medical Board of California in consultation with the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other appropriate entities. The board and the Medical Board of California are both authorized to ensure compliance with this clause, and each board is specifically charged with the enforcement of this provision with respect to its respective licensees. This subdivision does not expand the authority of a pharmacist to prescribe any prescription medication.

(2) Prior to performing a procedure authorized under this subdivision, a pharmacist shall complete a training program on emergency contraception that consists of at least one hour of approved continuing education on emergency contraception drug therapy.

(3) A pharmacist, pharmacist's employer, or pharmacist's agent shall not directly charge a patient a separate consultation fee for emergency contraception drug therapy services initiated pursuant to this subdivision, but may charge an administrative fee not to exceed ten dollars ($10) above the retail cost of the drug. Upon an oral, telephonic, electronic, or written request from a patient or customer, a pharmacist or pharmacist's employee shall disclose the total retail price that a consumer would pay for emergency contraception drug therapy. As used in this paragraph, total retail price includes providing the consumer with specific information regarding the price of the emergency contraception drugs and the price of the administrative fee charged. This limitation is not intended to interfere with other contractually agreed-upon terms between a pharmacist, a pharmacist's employer, or a pharmacist's agent, and a health care service plan or insurer. Patients who are insured or covered and receive a pharmacy benefit that covers the cost of emergency contraception shall not be required to pay an administrative fee. These patients shall be required to pay copayments pursuant to the terms and conditions of their coverage. This paragraph shall become inoperative for dedicated emergency contraception drugs if these drugs are reclassified as over-the-counter products by the federal Food and Drug Administration.

(4) A pharmacist shall not require a patient to provide individually identifiable medical information that is not specified in Section 1707.1 of Title 16 of the California Code of Regulations before initiating emergency contraception drug therapy pursuant to this subdivision.

(c) For each emergency contraception drug therapy or self-administered hormonal contraception initiated pursuant to this section, the pharmacist shall provide the recipient of the drug with a standardized factsheet that includes, but is not limited to, the indications and contraindications for use of the drug, the appropriate method for using the drug, the need for medical followup, and other appropriate information. The board shall develop this form in consultation with the State Department of Public Health, the American Congress of Obstetricians and Gynecologists, the California Pharmacists Association, and other health care organizations. This section does not preclude the use of existing publications developed by nationally recognized medical organizations.

2. FOR REVIEW AND POSSIBLE ACTION: Draft Protocol for Pharmacists Who Furnish Nicotine Replacement Products

Attachment 2

SB 493 provides that a pharmacist may furnish nicotine replacement products approved by the FDA for use by prescription in accordance with standardized protocols. Implementation of this provision requires:

- Certification of the pharmacist in smoking cessation therapy by an organization recognized by the board

- Development of a protocol developed and approved by this board and the Medical Board of California with other "appropriate entities"
- The pharmacist maintain records of all prescription drugs and devices furnished for at least three years
- The patient's primary care provider is notified of any drugs or devices furnished, or information is added to a shared patient record. If the patient has no primary care provider, the pharmacist provides the patient with a written record and advises the patient to consult a physician of the patient's choice
- The pharmacist completes one hour of CE on smoking cessation therapy biennially.

A draft protocol for nicotine replacement products is provided in **Attachment 2.**

The related statutory provisions from SB 493 are provided below:

SEC. 10.
Section 4052.9 is added to the Business and Professions Code, to read:

4052.9.

(a) A pharmacist may furnish nicotine replacement products approved by the federal Food and Drug Administration for use by prescription only in accordance with standardized procedures and protocols developed and approved by both the board and the Medical Board of California in consultation with other appropriate entities and provide smoking cessation services if all of the following conditions are met:
  (1) The pharmacist maintains records of all prescription drugs and devices furnished for a period of at least three years for purposes of notifying other health care providers and monitoring the patient.
  (2) The pharmacist notifies the patient's primary care provider of any drugs or devices furnished to the patient, or enters the appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider. If the patient does not have a primary care provider, the pharmacist provides the patient with a written record of the drugs or devices furnished and advises the patient to consult a physician of the patient's choice.
  (3) The pharmacist is certified in smoking cessation therapy by an organization recognized by the board.
  (4) The pharmacist completes one hour of continuing education focused on smoking cessation therapy biennially.
(b) The board and the Medical Board of California are both authorized to ensure compliance with this section, and each board is specifically charged with the enforcement of this section with respect to their respective licensees. Nothing in this section shall be construed to expand the authority of a pharmacist to prescribe any other prescription medication.

3. FOR DISCUSSION AND POSSIBLE ACTION: <u>Pharmacy Protocols for Naloxone, as Provided by AB 1535 (Bloom, Chapter 326, Statutes of 2014)</u>

Attachment 3

Last year's AB 1535 authorizes the Board of Pharmacy to work with the Medical Board to develop a jointly approved protocol for pharmacists. The California Pharmacists Association and California Society of Addiction Medicine are specifically mentioned to participate in this

process. The board is also authorized to pursue an emergency rulemaking to secure the benefits of this law as soon as possible.

A draft protocol has been vetted publicly and with various experts and is provided in **Attachment 3.** Because the enabling legislation authorizes an emergency rulemaking, the board will file this regulation protocol with the Office of Administrative Law once the same version is approved by the requisite entities. The board will then institute the required (and routine) procedures to adopt the regulation permanently.

The specific statutory authorization for this protocol is provided in section 4052.01 of the Business and Professions Code:

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).

On behalf of the Board of Pharmacy, we look forward to collaborating with the Medical Board and moving forward with these protocols.

Attachment 1

Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraception

(a) A pharmacist furnishing self-administered hormonal contraception pursuant to Section 4052.3 of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraception

(1) Authority: Section 4052.3(a)(1) of the California Business and Professions code authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol in this section satisfies that requirement.

(2) Purpose: To provide timely access to self-administered hormonal contraception medication and to ensure that the patient receives adequate information to successfully comply with therapy.

(3) Definition of Self-Administered Hormonal Contraception: Hormonal contraception products with the following routes of administration are considered self-administered:

- Oral;
- Transdermal;
- Vaginal;
- Depot Injection.

(4) Procedure: When a patient requests self-administered hormonal contraception, the pharmacist shall complete the following steps:

- Ask the patient to use and complete the self-screening tool;
- Review the self-screening answers and clarify responses if needed;
- Measure and record the patient's seated blood pressure if combined hormonal contraceptives are requested or recommended.
- Before furnishing self-administered hormonal contraception, the pharmacist shall ensure that the patient is properly and appropriately trained in administration of the requested or recommended contraceptive medication.
- When a self-administered hormonal contraceptive is furnished, the patient shall be provided with appropriate counseling and information on the product furnished, including:
    - Dosage;
    - Effectiveness;
    - Potential side effects;
    - Safety;
    - The importance of receiving recommended preventative health screenings;
    - That self-administered hormonal contraption does not protect against sexually transmitted infections (STIs).

(5) Self-Screening Tool: The pharmacist shall provide the patient with a self-screening tool containing the list of questions specified in this protocol. The patient shall complete the self-screening tool, and the pharmacist shall use the answers to screen for all Category 3 and 4 conditions and characteristics for self-administered hormonal contraception from the current United States Medical Eligibility Criteria for Contraceptive Use (USMEC) developed by the federal Centers for Disease Control and Prevention (CDC). The patient shall complete the self-screening tool annually, or whenever the patient indicates a major health change.

A copy of the most recently completed self-screening tool shall be securely stored within the originating pharmacy for a period of at least three years from the date when the last self-administered hormonal contraception product was furnished.

This self-screening tool should be made available in alternate languages for patients whose primary language is not English.

(6) Fact Sheet: The pharmacist shall provide the patient with the FDA-required patient product information leaflet included in all self-administered hormonal contraception products, as required by the Business and Professions code Section 4052.3(c). The pharmacist shall review any questions the patient may have regarding self-administered hormonal contraception.

Pharmacists are encouraged to provide the patient with a copy of the current consumer-friendly birth control guide, and method-specific factsheet from the Association of Reproductive Professionals, all available on the Board of Pharmacy's website.

(7) Follow-Up Care: Upon furnishing a self-administered hormonal contraceptive, or if is determined that use of a self-administered hormonal contraceptive is not recommended, the pharmacist shall refer the patient for appropriate follow-up care to the patient's primary care provider or, if the patient does not have a primary care provider, to nearby clinics. A patient who is determined not to be an appropriate candidate for self-administered hormonal contraceptive shall be advised of the potential risk and referred to an appropriate health care provider for further evaluation.

(8) Notifications: The pharmacist shall notify the patient's primary care provider of any drug(s) or device(s) furnished to the patient, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider. If the patient does not have a primary care provider, or is unable to provide contact information for his or her primary care provider, the pharmacist shall provide the patient with a written record of the drug(s) or device(s) furnished and advise the patient to consult a physician of the patient's choice.

(9) Referrals and Supplies: If self-administered hormonal contraception services are not immediately available at the pharmacy or the pharmacist declines to furnish pursuant to conscience clause, the pharmacist shall refer the patient to another self-administered hormonal contraception provider. The pharmacist shall comply with all state mandatory reporting laws, including sexual abuse laws.

(10) Product Selection: The pharmacist may select any hormonal contraceptive listed in the current version of the USMEC as Category 1 or 2, based on the information reported in the self-screening tool and the blood pressure if recorded by the pharmacist. The USMEC shall be kept current and maintained in the pharmacy. Furthermore, generic equivalent products may be furnished.

(11) Documentation: Each self-administered hormonal contraceptive furnished by a pharmacist pursuant to this protocol shall be documented in a patient medication record and securely stored within the originating pharmacy for a period of at least three years from the date when the last self-administered hormonal contraceptive was furnished. A patient medication record shall be maintained in an automated data processing or manual record mode such that the required information under title 16, sections 1717 and 1707.1 of the California Code of Regulations is readily retrievable during the pharmacy's normal operating hours.

(12) Training: Prior to furnishing self-administered hormonal contraception, pharmacists who participate in this protocol must have completed a minimum of one hour of a Board-approved continuing education program specific to self-administered hormonal contraception, application of the USMEC, and other CDC guidance on contraception. An equivalent curriculum-based training program completed on or after the year 2010 in a California School of Pharmacy is also sufficient training to participate in this protocol.

(13) Patient Privacy: All pharmacists furnishing self-administered hormonal contraception in a pharmacy shall operate under the pharmacy's policies and procedures to ensure that patient confidentiality and privacy are maintained.

(14) Self-Screening Tool Questions

HORMONAL CONTRACEPTION SELF-SCREENING TOOL QUESTIONS

1	What was the first date of your last menstrual period?	/ /	
2	Have you ever taken birth control pills, or used a birth control patch, ring, or shot/injection? (If no, go to question 3)	Yes ☐	No ☐
	Did you ever experience a bad reaction to using hormonal birth control?	Yes ☐	No ☐
	Are you currently using birth control pills, or a birth control patch, ring, or shot/injection?	Yes ☐	No ☐
3	Have you ever been told by a medical professional not to take hormones?	Yes ☐	No ☐
4	Do you smoke cigarettes?	Yes ☐	No ☐
5	Do you think you might be pregnant now?	Yes ☐	No ☐
6	Have you given birth within the past 6 weeks?	Yes ☐	No ☐
7	Are you currently breastfeeding an infant who is less than 1 month of age?	Yes ☐	No ☐
8	Do you have diabetes?	Yes ☐	No ☐
9	Do you get migraine headaches, or headaches so bad that you feel sick to your stomach, you lose the ability to see, it makes it hard to be in light, or it involves numbness?	Yes ☐	No ☐
10	Do you have high blood pressure, hypertension, or high cholesterol?	Yes ☐	No ☐
11	Have you ever had a heart attack or stroke, or been told you had any heart disease?	Yes ☐	No ☐
12	Have you ever had a blood clot in your leg or in your lung?	Yes ☐	No ☐
13	Have you ever been told by a medical professional that you are at a high risk of developing a blood clot in your leg or in your lung?	Yes ☐	No ☐
14	Have you had bariatric surgery or stomach reduction surgery?	Yes ☐	No ☐
15	Have you had recent major surgery or are you planning to have surgery in the next 4 weeks?	Yes ☐	No ☐
16	Do you have or have you ever had breast cancer?	Yes ☐	No ☐
17	Do you have or have you ever had hepatitis, liver disease, liver cancer, or gall bladder disease, or do you have jaundice (yellow skin or eyes)?	Yes ☐	No ☐
18	Do you have lupus, rheumatoid arthritis, or any blood disorders?	Yes ☐	No ☐
19	Do you take medication for seizures, tuberculosis (TB), fungal infections, or human immunodeficiency virus (HIV)?	Yes ☐	No ☐
	If yes, list them here:		
20	Do you have any other medical problems or take regular medication?	Yes ☐	No ☐
	If yes, list them here:		

Note: Authority cited: Section 4052.3, Business and Professions Code. Reference: Section 4052(a)(10), Business and Professions Code.

December 16, 2014

Protocol Sources

Centers for Disease Control and Prevention, "United States Medical Eligibility Criteria for Contraceptive Use," (2010) *available at* http://www.cdc.gov/reproductivehealth/unintendedpregnancy/USMEC.htm.

This resources serves as the basis for which self-administered hormonal contraception medications from which a pharmacist may select.

Centers for Disease Control and Prevention, "U.S. Selected Practice Recommendations for Contraceptive Use, 2013," *available at* http://www.cdc.gov/mmwr/preview/mmwrhtml/rr6205a1.htm.

This document from the CDC offers guidance on how to use contraceptive methods most effectively. It is adapted from a World Health Organization (WHO) publication, and endorsed by the American College of Obstetricians and Gynecologists (ACOG).

S. Shotorbani, et al., "Agreement Between Women's and Providers' Assessment of Hormonal Contraceptive Risk Factors," 73 CONTRACEPTION 501, 501-506 (2006).

This article provided a Medical History Questionnaire that was used in the development of the protocol's self-assessment tool. The article's research found 96% agreement between women's self-administered risk factor questionnaire and their providers' evaluation of their medical eligibility for hormonal contraceptive use.

CPhA/CSHP, "Protocol for Pharmacists Furnishing Self-Administered Hormonal Contraceptives."

This draft protocol was consulted in development of the Board's recommended protocol.

Food and Drug Administration Office of Women's Health, "HPV, HIV, Birth Control" (last updated June 24, 2014), *available at* http://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm117971.htm

This site contains a consumer-friendly birth control guide recommended for patient education.

Office on Women's Health, U.S. Department of Health and Human Services, "Birth Control Methods" (last updated Nov. 21, 2011), *available at* http://www.womenshealth.gov/publications/our-publications/fact-sheet/birth-control-methods.pdf.

This fact sheet was consulted in development of the Board's recommended fact sheet.

Division of Reproductive Health, Centers for Disease Control and Prevention, "Contraception" (last updated Oct. 14, 2014), http://www.cdc.gov/reproductivehealth/unintendedpregnancy/contraception.htm.

This website, especially the chart, is recommended as a resource for pharmacists choosing to provide additional user-friendly information on various birth control methods.

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The American College of Obstetricians and Gynecologists, "Birth Control - Especially for Teens," FAQ112 (Dec. 2013), *available at* http://www.acog.org/Patients/FAQs/Birth-Control-Especially-for-Teens.

This fact sheet was consulted in development of the Board's recommended fact sheet.

J. McIntosh et al., "Changing Oral Contraceptives from Prescription to Over-the-Counter Status: An Opinion Statement of the Women's Health Practice and Research Network of the American College of Clinical Pharmacy," Pharmacotherapy Vol. 31, Number 4, 424-437 (2011).

This opinion paper discusses pharmacist training on page 432. Both pharmacists and pharmacy students generally expressed interest in more education specifically on appropriate product selection.

Fatim Lakha, et al., "The Acceptability of Self-Administration of Subcutaneous Depo-Provera," 72 CONTRACEPTION 14-18 (2005).

This research finds that subcutaneous self-injectable hormonal contraception is beneficial for many women with appropriate training and reminder system.

Nicole J. Monastersky Maderas & Sharon Cohen Landau, "Pharmacy and Clinic Partnerships To Expand Access to Injectable Contraception," 47 J. AM. PHARM. ASSOC. 527-531 (2007).

This research finds that pharmacy reinjection of contraception is a viable option for many women, and is most successful when combined with primary care provider support and integration.

Sujatha Prabhakaran & Ashley Sweet, "Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate for Contraception: Feasibility and Acceptability," 85 CONTRACEPTION 453-457 (2012).

This research article finds that self-administration injections were easy and convenient for women with training from two Planned Parenthood health centers.

Sharon T. Cameron, et al., "Pilot Study of Home Self-Administration of Subcutaneous Depo-Medroxyprogesterone Acetate for Contraception," 85 CONTRACEPTION 458-464 (2012).

This research concludes that self-administration is feasible and has similar continuation and satisfaction rates to clinician-administration injections.

Rebekah L. Williams, et al., "Self-Administration of Subcutaneous Depot Medroxyprogesterone Acetate by Adolescent Women," 88 CONTRACEPTION 401-407 (2013).

This research concludes that many adolescents are interested in and capable of self-administration with brief education and minimal assistance.

S. Vinker, et al., "The Effect of Drug Information Leaflets on Patient Behavior," ISR. MED. ASSOC. J. 9(5) 383-4386 (May 2007).

This research concludes that reading the leaflet did not greatly affect adherence but aroused anxiety and decreased adherence in some patients.

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21 C.F.R §§ 201 "Labeling," *available at*
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?CFRPart=201.
These FDA regulations require manufacturers to include comprehensive patient leaflets in both prescription-only and OTC products.

21 C.F.R. § 310.501 "Patient Package Inserts for Oral Contraceptives," (Apr. 1, 2014), *available at*
http://www.accessdata.fda.gov/scripts/cdrh/cfdocs/cfCFR/CFRSearch.cfm?fr=310.501.
These FDA regulations are specific to leaflet requirements for oral contraceptives.

Medicines To Help You

BIRTH CONTROL GUIDE

Office of Women's Health

Most Effective

Methods	Number of pregnancies expected per 100 women*	Use	Some Risks
Sterilization Surgery for Women	less than **1**	Onetime procedure Permanent	• Pain • Bleeding • Infection or other complications after surgery • Ectopic (tubal) pregnancy
Surgical Sterilization Implant for Women	less than **1**	Onetime procedure Waiting period before it works Permanent	• Mild to moderate pain after insertion • Ectopic (tubal) pregnancy
Sterilization Surgery for Men	less than **1**	Onetime procedure Waiting period before it works Permanent	• Pain • Bleeding • Infection
Implantable Rod	less than **1**	Inserted by a healthcare provider Lasts up to 3 years	• Changes in bleeding patterns • Weight gain • Breast and abdominal pain
IUD Copper	less than **1**	Inserted by a healthcare provider Lasts up to 10 years	• Cramps • Bleeding • Pelvic inflammatory disease • Infertility • Tear or hole in the uterus
IUD w/ Progestin	less than **1**	Inserted by a healthcare provider Lasts up to 3-5 years, depending on the type	• Irregular bleeding • No periods • Abdominal/pelvic pain • Ovarian cysts
Shot/Injection	**6**	Need a shot every 3 months	• Bone loss • Bleeding between periods • Weight gain • Nervousness • Abdominal discomfort • Headaches
Oral Contraceptives (Combined Pill) "The Pill"	**9**	Must swallow a pill every day	• Nausea • Breast Tenderness • Headache • Rare: high blood pressure, blood clots, heart attack, stroke
Oral Contraceptives (Progestin only) "The MiniPill"	**9**	Must swallow a pill every day	• Irregular bleeding • Headache • Breast tenderness • Nausea • Dizziness
Oral Contraceptives Extended/Continuous Use "The Pill"	**9**	Must swallow a pill every day.	• Risks are similar to other oral contraceptives (combined) • LIght bleeding or spotting between periods
Patch	**9**	Put on a new patch each week for 3 weeks (21 total days). Don't put on a patch during the fourth week.	• Exposure to higher average levels of estrogen than most oral contraceptives
Vaginal Contraceptive Ring	**9**	Put the ring into the vagina yourself. Keep the ring in your vagina for 3 weeks and then take it out for one week.	• Vaginal discharge • Discomfort in the vagina • Mild irritation • Risks are similar to oral contraceptives (combined)
Diaphragm with Spermicide	**12**	Must use every time you have sex.	• Irritation • Allergic reactions • Urinary tract infection • Toxic shock
Sponge with Spermicide	**12-24**	Must use every time you have sex.	• Irritation • Allergic reactions • Hard time removing • Toxic shock
Cervical Cap with Spermicide	**17-23**	Must use every time you have sex.	• Irritation • Allergic reactions • Abnormal Pap test • Toxic shock
Male Condom	**18**	Must use every time you have sex. Except for abstinence, latex condoms are the best protection against HIV/AIDS and other STIs.	• Allergic reactions
Female Condom	**21**	Must use every time you have sex. May give some protection against STIs.	• Irritation • Allergic reactions
Spermicide Alone	**28**	Must use every time you have sex.	• Irritation • Allergic reactions • Urinary tract infection
Emergency Contraception — If your primary method of birth control fails			
Plan B Plan B One Step Next Choice	7 out of every 8 women who would have gotten pregnant will not become pregnant after taking Plan B, Plan B One-Step, or Next Choice	Swallow the pills within 3 days after having unprotected sex.	• Nausea • Vomiting • Abdominal pain • Fatigue • Headache
Ella	6 or 7 out of every 10 women who would have gotten pregnant will not become pregnant after taking Ella.	Swallow the pill within 5 days after having unprotected sex.	• Headache • Nausea • Abdominal pain • Menstrual pain • Tiredness • Dizziness

Least Effective

*effectiveness of the different methods during typical/actual use (including sometimes using a method in a way that is not correct or not consistent)

http://www.fda.gov/birthcontrol

Association of Reproductive Health Professionals

ASUNTOS DE SALUD
Preguntas frecuentes sobre el parche anticonceptivo

www.arhp.org/healthmatters

¿Qué es el parche anticonceptivo?

El parche anticonceptivo es un parche hormonal semanal muy efectivo que se pone sobre la piel para prevenir el embarazo. El parche se usa por una semana y se cambia siempre el mismo día cada semana durante tres semanas. La cuarta semana esta "libre de parche".

¿Que tan effectivo es el parche anticonceptivo?

El parche anticonceptivo es 99 por ciento efectivo cuando se usa correctamente.

¿Cómo previene el embarazo el parche anticonceptivo?

El parche anticonceptivo previene el embarazo de la misma forma que las píldoras anticonceptivas. Funciona principalmente previniendo la ovulación, o que el ovario no libera un óvulo que pueda ser fertilizado. El parche también causa cambios en el moco cervical (haciendo más difícil para que el espermatozoide entre en el útero).

¿Dónde puedo usar el parche anticonceptivo?

Usted puede usar el parche en una de las siguientes cuatro áreas de su cuerpo: las nalgas o caderas, el abdomen, la parte superior del tronco (pecho y espalda, excluyendo los senos o pechos) o en la parte superior externa del brazo. Usted no debería colocar el parche sobre piel que esté roja, irritada o tenga alguna cortada. No debería colocarlo en áreas de su cuerpo donde se vaya a aplicar maquillaje, lociones, cremas, polvos u otros productos.

¿Como se mantiene pegado el parche?

El parche anticonceptivo tiene una capa que contiene tanto la medicina como un adhesivo que mantiene el parche pegado a la piel durante una semana entera.

¿Cuáles son los beneficios de usar el parche anticonceptivo?

Mujeres que usan el parche anticonceptivo pueden beneficiarse en tener un periodo mas liviano y menos doloroso. El parche anticonceptivo puede proteger contra algunos canceres y enfermedades de los cenos.

¿Quien no debe de usar el parche anticonceptivo?

Algunas mujeres no deben de usar el parche anticonceptivo, incluyendo mujeres que tengan cuagulos de sangre, ciertos canceres, o que tengan antecedentes de ataques del corazon o de celebro, y aquellas mujeres que podrian estar embarazadas.

¿Cuáles son las desventajas?

Algunas mujeres usando el parche anticonceptivo pueden sentir leves dolores en los cenos, dolor de cabeza, y reacciones dermatologicas en el lugar donde ha colocado el parche. La mayoría de effectos secundarios no son serios, y los que son, no son muy comunes. La prevención de un embarazo no planeado con anticonceptivos aprobados

Health Matters es una publicación de ARHP para el público general que presenta un breve repaso de datos sobre varios temas con relación a la salud reproductiva

por el FDA es mas sano que un parto or el aborto. Fumar cigaros aumenta los riesgos seriamente.

Algunas drogas pueden hacer los anticonceptivos hormonales, incluyendo el parche anticonceptivo, menos effectivos. Al igual que con cualquier otro producto pharmaceutico, usted debe informar su proveedor o proveedora de la salud de cualquier otro medicamento que usted este tomando. Es posible que usted tenga que usar un anticonceptivo adicional como el condón, espermicida, o diafragma si usted toma medicamentos que pueden reducir la efectividad del parch anticonceptivo.

¿Dónde puedo conseguir el parch anticonceptivo?

Un proveedor or proveedora de servicios de salud (doctor o doctora, enfermera o asistente médico) te puede dar una receta para el parche anticonceptivo.

Association of Reproductive Health Professionals

HEALTH MATTERS

Frequently Asked Questions About the Contraceptive Patch

www.arhp.org/healthmatters

What is the contraceptive patch?

The contraceptive patch is a highly effective, weekly hormonal birth control patch that is worn on the skin to prevent pregnancy. The patch is worn for one week and replaced on the same day of the week for three consecutive weeks, with the fourth week "patch-free." Your menstrual period should start during the "patch-free" week. The contraceptive patch available in the United States is called OrthoEvra®.

How effective is contraceptive patch?

The contraceptive patch is 99 percent effective when used correctly.

How does it work?

The contraceptive patch prevents pregnancy the same way that birth control pills do. It works primarily by preventing the ovary from releasing an egg to be fertilized. The patch also causes changes to the cervical mucus (making it more difficult for sperm to enter the uterus).

The contraceptive patch keeps you from becoming pregnant by delivering hormones (norelgestromin and ethinyl estradiol) through the skin and into the bloodstream. This is called transdermal administration.

Where can I wear the contraceptive patch?

You can wear the contraceptive patch on one of four areas of the body: your buttocks, abdomen, upper torso (front and back, excluding the breasts), or upper outer arm. The patch should not be worn on any other areas of the body. You should not place the patch on skin that is red, irritated, or cut. You should not place it on areas of your skin where makeup, lotions, creams, powders, or other products are or will be applied.

How does the patch stay on?

The contraceptive patch has a layer containing both the medication and an adhesive that keeps the patch on the skin for an entire week. The patch adheres well to the skin, allowing you to perform your daily activities such as bathing, showering, swimming, and exercising without interruption.

What are the benefits of using the contraceptive patch?

Women who use the contraceptive patch are likely to have lighter and less painful periods. The contraceptive patch may protect against some cancers and breast disease.

Who should not use the contraceptive patch?

Some women should not use the contraceptive patch, including women who have blood clots, certain cancers, or a history of heart attack or stroke, as well as those who are or may be pregnant.

Health Matters is a publication of ARHP for the general public that provides a brief overview of existing facts and data on various topics related to reproductive health.

What are the downsides?

Some women using the contraceptive patch experience breast tenderness, headache, and reactions at the application. Most side effects are not serious, and those that are, are very rare. Prevention of an unintended pregnancy with FDA-approved contraceptives is always safer than childbirth or abortion. Serious risks are increased if you smoke cigarettes.

Certain drugs may interact with hormonal birth control, including the contraceptive patch, to make them less effective in preventing pregnancy. As with all prescription products, you should tell your health care professional about any other medications you are taking. You may need to use a non-hormonal backup contraceptive, such as a condom, spermicide, or diaphragm, when you take drugs that can make the contraceptive patch less effective.

Where can I get the contraceptive patch?

A trained health care professional (including doctors, nurses, and nurse midwives) can provide you with the contraceptive patch.

Association of Reproductive Health Professionals

ASUNTOS DE SALUD
Las píldoras anticonceptivas

www.arhp.org/healthmatters

¿Qué son las píldoras anticonceptivas?

Las píldoras anticonceptivas son una medicina que tomas todos los días para prevenir el embarazo. A veces se les llama "la píldora" o anticonceptivos orales. La mayoría de mujeres que usan la píldora toman "píldoras combinadas". Estas contienen dos hormonas —estrógeno y progestina—.

Alguna píldoras anticonceptivas contienen solo una hormona, la progestina. Estas son llamadas a veces "mini píldoras". Las píldoras solo de progestina son buenas para las mujeres que no pueden usar el estrógeno.

¿Qué tan efectivas son las píldoras anticonceptivas?

Si las píldoras anticonceptivas se usan correctamente siempre, menos de 1 de cada 100 mujeres que las usen quedará embarazada cada año. Si no siempre se usan correctamente, 8 de cada 100 mujeres que las usen quedarán embarazadas cada año.

Las píldoras anticonceptivas funcionan mejor si las tomas a la misma hora todos los días. Puedes encontrar que te ayude tomar la píldora cuando hagas algo más cada día —como cepillarte los dientes o cenar—. Esto es muy importante con la píldora solo de progestina.

Cuando comiences a tomar la píldora, esta puede tomar varios días para comenzar a funcionar. Asegúrate de usar un anticonceptivo de respaldo (como un condón) durante los primeros 7 días de la píldora combinada o 2 días de la píldora solo de progestina.

¿Cómo funcionan?

Las hormonas en la píldora impiden que tus ovarios liberen óvulos y espesan tu moco cervical para impedir que el esperma entre al útero.

¿Cuáles son los beneficios del uso de las píldoras anticonceptivas?

- Las píldoras anticonceptiva son seguras, convenientes y muy efectivas.
- No tienes que pensar en el control de la natalidad cada vez que tengas relaciones sexuales.
- La mayoría de mujeres pueden quedar embarazadas rápidamente cuando dejan de usar la píldora.
- Tus menstruaciones puede hacerse más ligeras y menos dolorosas si tomas la píldora.
- Las hormonas en las píldoras ofrecen beneficios a la salud. La píldora puede ofrecer cierta protección contra el acné, los tumores no cancerosos del pecho, el embarazo ectópico, los cánceres endometrial y ovárico, la anemia por deficiencia de hierro, los quistes en los ovarios, la enfermedad inflamatoria pélvica, los síntomas del síndrome premenstrual y las migrañas relacionadas con la menstruación.

¿Cuáles son los aspectos negativos del uso de las píldoras anticonceptivas?

- Las píldoras anticonceptivas no protegen contra las infecciones de transmisión sexual (ITS).

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- Necesitas una receta para obtener las píldoras anticonceptivas. Esto requiere una visita a tu proveedor de atención a la salud.
- Algunas mujeres pueden tener efectos secundarios al uso de las píldoras anticonceptivas. Estos incluyen sangrado entre las menstruaciones, sensibilidad en los pechos y náusea. Algunos de los efectos más comunes solo duran los primeros meses.
- Es fácil olvidarse de tomar la píldora todos los días. Podrías necesitar usar anticoncepción de respaldo o tomar anticoncepción de emergencia si te olvidas de tomar una píldora o la tomas tarde. Asegúrate de hablar con tu proveedor de atención a la salud si te olvidas de tomar alguna píldora.
- Mujeres con ciertas condiciones de salud no deberían usar píldoras combinadas. Tu proveedor de atención a la salud te ayudará a decidir si la píldora es apropiada para ti.

¿Dónde puedo obtener las píldoras anticonceptivas?

Un proveedor de atención a la salud puede darte una receta para las píldoras anticonceptivas. Las puedes comprar con una receta en una farmacia, un centro de salud o una clínica.

¿Dónde puedo obtener más información?

Para mayor información sobre las píldoras anticonceptivas, habla con tu proveedor de atención a la salud.

Compara las píldoras anticonceptivas con otras opciones anticonceptivas y ve un corto video sobre cada método, en inglés o en español, en Method Match de ARHP (www.arhp.org/MethodMatch).

Association of Reproductive Health Professionals

HEALTH MATTERS

Birth Control Pills

www.arhp.org/healthmatters

What are birth control pills?

Birth control pills are a medication you take every day to prevent pregnancy. They are sometimes called "the pill" or oral contraception. Most women using the pill take "combination pills." These contain two hormones - estrogen and progestin.

Some birth control pills contain only one hormone - progestin. These are sometimes called "mini-pills". Progestin-only pills are good for women who cannot use estrogen.

How effective are birth control pills?

If birth control pills are always used correctly, less than 1 out of 100 women using them will get pregnant each year. If they are not always used correctly, 8 out of 100 women using them will get pregnant each year.

Birth control pills work best if you take them at the same time every day. You might find it helpful to take the pill when you do something else every day — like brushing your teeth or eating dinner. This is very important with the progestin-only pill.

When you first start the pill, it takes several days to begin working. Be sure to use backup birth control (like a condom) for the first 7 days on the combination pill or 2 days with the progestin-only pill.

How do they work?

The hormones in the pill keep your ovaries from releasing eggs and thicken your cervical mucus to block sperm from getting into the uterus.

What are the benefits of using birth control pills?

- Birth control pills are safe, convenient, and very effective.
- You don't have to think about birth control each time you have sex.
- Most women can get pregnant quickly when they stop using the pill.
- Your periods may become lighter and less painful if you take the pill.
- The hormones in pills offer health benefits. The pill can offer some protection against acne, non-cancerous breast growths, ectopic pregnancy, endometrial and ovarian cancers, iron deficiency anemia, ovarian cysts, pelvic inflammatory disease, PMS symptoms, and menstrually-related migraine headaches.

What are the downsides of using birth control pills?

- Birth control pills do not protect against sexually transmitted infections (STIs).
- You need a prescription to get birth control pills. This requires a visit to a health care provider.
- Some women may have side effects while using birth control pills. They include bleeding between periods, breast tenderness, and nausea. Some of the most common side effects only last for the first few months.

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- It is easy to forget to take the pill every day. You may need to use backup birth control or take emergency contraception if you miss a pill or take it late. Make sure to talk with your health care provider if you miss any pills.
- Women with certain health conditions should not use combination pills. Your healthcare provider will help you decide if the pill is right for you.

Where can I get birth control pills?

A health care provider can give you a prescription for birth control pills. You can purchase birth control pills at a drugstore, health center, or clinic with a prescription.

Where can I get more information?

For more information on the birth control pill, talk to your health care provider.

Compare the pill to other birth control options using ARHP's Method Match at www.arhp.org/MethodMatch.

Association of Reproductive Health Professionals

ASUNTOS DE SALUD
La inyección anticonceptiva

www.arhp.org/healthmatters

¿Qué es la inyección?

La inyección anticonceptiva es una inyección de una hormona llamada progestina. Cada inyección previene el embarazo por aproximadamente tres meses.

¿Qué tan efectiva es la inyección?

La inyección anticonceptiva es muy efectiva. Si se usa correctamente siempre, menos de 1 de cada 100 mujeres quedarán embarazadas usando la inyección. Si no siempre se usa correctamente, 3 de cada 100 mujeres quedarán embarazadas cada año usando la inyección.

Cuando comiences a usar la inyección, esta toma varios días para comenzar a funcionar. Usa otra forma de anticoncepción de respaldo durante 7 días después que recibas la inyección.

¿Cómo funciona?

Un proveedor de atención a la salud te administrará la inyección en el brazo cada 12 semanas. La hormona en la inyección impide que tus ovarios liberen óvulos y espesa tu moco cervical para impedir que el esperma entre al útero.

¿Cuáles son los beneficios del uso de la inyección?

- La inyección es segura, conveniente y muy efectiva.
- Si usas la inyección, no tienes que pensar en el control de la natalidad cada día o cada vez que tengas una relación sexual.
- La progestina en la inyección ofrece varios beneficios a la salud, incluyendo menos calambres menstruales y menstruaciones más ligeras, o ausentes del todo. También reduce el riesgo de enfermedad inflamatoria pélvica y cáncer endometrial.
- La inyección puede ser un buen método anticonceptivo para mujeres que no pueden usar el estrógeno.

¿Cuáles son los aspectos negativos del uso de la inyección?

- La inyección no protege contra las infecciones de transmisión sexual (ITS).
- Debes visitar a tu proveedor de atención a la salud cada 12 semanas.
- Algunas mujeres pueden tener efectos secundarios al usar la inyección. El sangrado irregular es el efecto secundario más común, especialmente en los primeros 6 a 12 meses. Otros efectos secundarios menos comunes incluyen cambios de apetito o aumento de peso, sensibilidad en los pechos y náusea y vómitos.
- Las mujeres que usan la inyección anticonceptiva pueden tener adelgazamiento temporal de los huesos. El crecimiento de los huesos comienza nuevamente cuando dejas de usar la inyección. Tú puedes ayudar a proteger tus huesos haciendo ejercicio regularmente y tomando suplementos de calcio y vitamina D.
- Las mujeres pueden quedar embarazadas al dejar de usar la inyección, pero esto puede tomar aproximadamente un año después de la última inyección.

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- Mujeres con ciertas condiciones (cáncer del pecho, anorexia y uso de esteroides actuales o historia de los mismos) no deberían usar la inyección.

¿Dónde puedo obtener la inyección?

Un profesional de atención a la salud puede administrarte la inyección en un consultorio médico o una clínica.

¿Dónde puedo obtener más información?

Para mayor información sobre la inyección anticonceptiva, habla con tu proveedor de atención a la salud.

Compara la inyección con otras opciones anticonceptivas y ve un corto video sobre cada método, en inglés o en español, en Method Match de ARHP (www.arhp.org/MethodMatch).

Association of Reproductive Health Professionals

HEALTH MATTERS

Birth Control Shot

www.arhp.org/healthmatters

What is the shot?

The birth control shot is an injection of a hormone called progestin. Each shot prevents pregnancy for about three months.

How effective is the shot?

The birth control shot is very effective. If always used correctly, less than 1 out of 100 women will get pregnant each year using the shot. If not always used correctly, 3 out of 100 women will get pregnant each year using the shot.

When you first start on the shot, it takes several days to begin working. Use a backup form of birth control for 7 days after you get the first shot.

How does it work?

A health care provider will give you the shot in your arm every 12 weeks. The hormone in the shot keeps your ovaries from releasing eggs and thickens your cervical mucus to block sperm from getting into the uterus.

What are the benefits of using the shot?

- The shot is safe, convenient, and very effective.
- If you use the shot, you don't have to think about birth control every day or each time you have sex.
- The progestin in the shot offers several health benefits, including fewer menstrual cramps, lighter or no periods. It also reduces the risk of pelvic inflammatory disease and endometrial cancer.
- The shot can be a good birth control method for women who cannot use estrogen.

What are the downsides of using the shot?

- The shot does not protect against sexually transmitted infections (STIs).
- You must visit your health care provider every 12 weeks.
- Some women may have side effects while using the shot. Irregular bleeding is the most common side effect, especially in the first 6 to 12 months. Other, less common, side effects include changes in appetite or weight gain, breast tenderness, and nausea and vomiting.
- Women who use the birth control shot may have temporary bone thinning. Bone growth begins again when you stop using the shot. You can help protect your bones by exercising regularly and getting extra calcium and vitamin D.
- Women can get pregnant after they stop using the shot, but it may take about a year after the last shot.
- Women with certain conditions (history of or current breast cancer, anorexia, and steroid use) should not use the shot.

Health Matters is a publication of ARHP for the general public that provides a brief overview of existing facts and data on various topics related to reproductive health.

Where can I get the shot?

A health care professional can give you the shot in a medical office or clinic.

Where can I get more information?

For more information on the birth control shot, talk to your health care provider.

Compare the shot to other birth control options using ARHP's Method Match at www.arhp.org/MethodMatch.

Association of Reproductive Health Professionals

ASUNTOS DE SALUD
El anillo vaginal

www.arhp.org/healthmatters

¿Qué es el anillo vaginal?

El anillo vaginal es un pequeño anillo flexible que tú pones en tu vagina una vez al mes para prevenir el embarazo. El anillo es fácil de poner y un tamaño le queda a la mayoría de mujeres. El anillo contiene hormonas llamadas estrógeno y progestina. Estas son las mismas hormonas que tienen la mayoría de píldoras anticonceptivas.

¿Qué tan efectivo es el anillo vaginal?

Si se usa correctamente siempre, menos de 1 de cada 100 mujeres quedará embarazada usando el anillo. Si no siempre se usa correctamente, 8 de cada 100 mujeres quedarán embarazadas usando el anillo.

Cuando comienzas a usar el anillo, este toma varios días para comenzar a funcionar. Asegúrate de usar un anticonceptivo de respaldo (como un condón) durante los primeros siete días.

¿Cómo funciona?

Las hormonas en el anillo vaginal impiden que tus ovarios liberen óvulos y espesan tu moco cervical para impedir que el esperma entre al útero.

Introduce el anillo en tu vagina. El anillo permanece en su lugar durante tres semanas seguidas. Tú lo extraes en la cuarta semana y tienes tu menstruación. Después de la semana de descanso, simplemente insertas un nuevo anillo y comienzas el ciclo de nuevo.

Si deseas, puedes saltarte la semana de descanso y mantener el anillo por cuatro semanas seguidas. Esto eventualmente hará que tus menstruaciones sean muy ligeras o desaparezcan del todo. Esto se llama anticoncepción de uso continuo. Si estás interesada en esta opción, habla con tu proveedor de atención a la salud.

Algunas veces el anillo puede salirse de la vagina al remover un tampón, al ir al baño o al tener relaciones sexuales. La mayoría de mujeres usan el anillo durante la relación sexual sin problemas y sin que lo sientan sus parejas. Si el anillo se sale o tú lo sacas, lávalo con agua tibia y póntelo de nuevo en las primeras tres horas.

¿Cuáles son los beneficios del uso del anillo vaginal?

- El anillo vaginal es seguro, conveniente y muy efectivo.
- Si usas el anillo, no tienes que pensar en el control de la natalidad cada día o cada vez que tengas una relación sexual.
- Muchas mujeres que usan el anillo, tienen menstruaciones más ligeras, más cortas y más regulares.
- La mayoría de mujeres pueden quedar embarazadas rápidamente después de dejar de usar el anillo.
- Las hormonas en el anillo ofrecen beneficios a la salud. El anillo puede ofrecer cierta protección contra el acné, los tumores no cancerosos del pecho, el embarazo ectópi-

Health Matters es una publicación de ARHP para el público general que presenta un breve repaso de datos sobre varios temas con relación a la salud reproductiva.

co, los cánceres endometrial y ovárico, la anemia por deficiencia de hierro, los quistes en los ovarios, la enfermedad inflamatoria pélvica, los síntomas del síndrome premenstrual y las migrañas relacionadas con la menstruación.

¿Cuáles son los aspectos negativos del uso del anillo vaginal?

- El anillo vaginal no protege contra las infecciones de transmisión sexual (ITS).
- Para obtener el anillo necesitas visitar a tu proveedor de atención a la salud por una receta.
- Algunas mujeres pueden tener efectos secundarios al usar el anillo. Algunos de los efectos secundarios más comunes generalmente desparecen a los dos o tres meses. Estos incluyen, sangrado entre menstruaciones, sensibilidad en los pechos y náusea y vómitos. El anillo también puede aumentar el flujo vaginal.
- Puede ser dificil recordar retirar el anillo después de las tres semanas e insertar un anillo nuevo después de la semana de descanso. Para ayudarte a recordar, puedes programar la alarma en tu teléfono celular y marcar la "fecha de cambio" en tu calendario.
- Mujeres con ciertas condiciones de salud no deberían usar el anillo. Tu proveedor de atención a la salud te puede ayudar a decidir si el anillo es apropiado para ti.
- Algunas drogas pueden interactuar con el anillo y hacerlo menos efectivo para prevenir el embarazo. Habla con tu proveedor de atención a la salud sobre cualquier medicina, con o sin receta, que estés tomando.

¿Dónde puedo obtener el anillo vaginal?

Tu proveedor de atención a la salud te mostrará como colocar y extraer el anillo y te dará una receta para reemplazos mensuales. Tú puedes comprar el anillo con una receta en una farmacia, un centro de salud o una clínica.

¿Dónde puedo obtener más información?

Para mayor información sobre el anillo vaginal, habla con tu proveedor de atención a la salud.

Compara el anillo vaginal con otras opciones anticonceptivas y ve un corto video sobre cada método, en inglés o en español, en Method Match de ARHP (www.arhp.org/MethodMatch).

Association of Reproductive Health Professionals

HEALTH MATTERS

Vaginal Ring

www.arhp.org/healthmatters

What is the vaginal ring?

The vaginal ring is a small, flexible ring that you put into your vagina once a month to prevent pregnancy. The ring is easy to put in and one size fits most women. The ring contains hormones called estrogen and progestin. These are the same hormones that are in most birth control pills.

How effective is the vaginal ring?

If always used correctly, less than 1 out of 100 women will get pregnant each year using the ring. If not always used correctly, 8 out of 100 women will get pregnant each year using the ring.

When you first start using the ring, it takes several days to begin working. Be sure to use backup birth control (like a condom) for the first seven days.

How does it work?

The hormones in the vaginal ring keep your ovaries from releasing eggs and thicken your cervical mucus to block sperm from getting into the uterus.

Insert the ring into your vagina. The ring stays in place for three weeks straight. You take it out the fourth week and you have your period. After the week off, you simply insert a new ring and start the cycle again.

If you want to, you can skip the one week break and keep the ring in for four weeks straight. This will eventually make your period very light or disappear totally. This is called continuous-use contraception. If you are interested in this option, talk to your health care provider.

The ring can sometimes fall out of the vagina when removing a tampon, going to the bathroom, or having sex. Most women wear the ring during sex with no problems and without their partners feeling it. If the ring falls out or you remove it, rinse it with warm water and put it back in within three hours.

What are the benefits of using the vaginal ring?

- The vaginal ring is safe, convenient, and very effective.
- If you use the ring, you don't have to think about birth control every day or every time you have sex.
- Many women who use the ring have lighter, shorter, and more regular periods.
- Most women can get pregnant quickly after they stop using the ring.
- The hormones in the ring offer health benefits. The ring can offer some protection against acne, non-cancerous breast growths, ectopic pregnancy, endometrial and ovarian cancers, iron deficiency anemia, ovarian cysts, pelvic inflammatory disease, PMS symptoms, and menstrually-related migraine headaches.

Health Matters is a publication of ARHP for the general public that provides a brief overview of existing facts and data on various topics related to reproductive health.

What are the downsides of using the vaginal ring?

- The vaginal ring does not protect against sexually transmitted infections (STIs).
- Getting the ring requires a visit to a health care provider for a prescription.
- Some women may have side effects while using the ring. Some of the most common side effects usually go away after two or three months. They include bleeding between periods, breast tenderness, and nausea and vomiting. The ring may also increase vaginal discharge.
- It can be challenging to remember to remove the ring after three weeks and then insert a new ring after the one-week break. To help you remember, you may want to set the alarm on your cell phone and mark the "change date" on your calendar.
- Women with certain health conditions should not use the ring. Your healthcare provider will help you decide if the ring is right for you.
- Certain drugs may interact with the ring to make it less effective in preventing pregnancy. Talk with your health care provider about any over the counter or prescription medications you are taking

Where can I get the vaginal ring?

Your health care provider will show you how to insert and remove the ring and give you a prescription for monthly refills. You can purchase the ring at a drugstore, health center, or clinic with a prescription.

Where can I get more information?

For more information on the vaginal ring, talk to your health care provider.

Compare the ring to other birth control options using ARHP's Method Match at www.arhp.org/MethodMatch.

Attachment 2

Protocol for Pharmacists Furnishing Nicotine Replacement Products

(a) A pharmacist furnishing nicotine replacement products pursuant to Section 4052.9 of the Business and Professions code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Nicotine Replacement Products

(1) Authority: Section 4052.9(a) of the California Business and Professions code authorizes a pharmacist to furnish nicotine replacement products approved by the federal Food and Drug Administration for use by prescription-only in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol in this section satisfies that requirement.

(2) Purpose: To provide timely access to nicotine replacement products and to ensure that the patient receives information to appropriately initiate smoking cessation medication therapy.

(3) Explanation of Products Covered: Nicotine replacement products approved by the federal Food and Drug Administration and prescribed by a pharmacist for smoking cessation are covered under this protocol.

(4) Procedure: When a patient requests nicotine replacement therapy or other smoking cessation medication, or when a pharmacist in his or her professional judgment decides to initiate smoking cessation treatment and counseling, the pharmacist shall complete the following steps:

- Review the patient's current tobacco use and past quit attempts.
- Ask the patient the following screening questions:
    - Are you pregnant or plan to be pregnant? (If yes, do not furnish and refer to an appropriate health care provider)
    - Have you had a recent heart attack within the last 2 weeks? (If yes, furnish with caution and refer to an appropriate health care provider)
    - Do you have any history of heart palpitations, irregular heartbeats, or have you been diagnosed with a serious arrhythmia? (If yes, furnish with caution and refer to an appropriate health care provider)
    - Do you currently experience frequent chest pain or have you been diagnosed with unstable angina? (If yes, furnish with caution and refer to an appropriate health care provider)
    - Do you have any history of allergic rhinitis (e.g., nasal allergies)? (If yes, avoid nasal spray)
    - Have you been diagnosed with temporal mandibular joint (TMJ) dysfunction? (If yes, avoid nicotine gum)
- When a nicotine replacement product is furnished:

  - The pharmacist shall review the instructions for use with every patient using a nicotine replacement product.
  - Pharmacists should recommend the patient seek additional assistance for behavior change, including but not limited to the California Smokers' Helpline (1-800-NO-BUTTS), web-based programs (e.g., http://smokefree.gov), apps, and local cessation programs.
- The pharmacist shall review any questions the patient may have regarding smoking cessation therapy and/or nicotine replacement products.

(5) Product Selection: Based on the information gathered from the patient during the Procedure outlined above, the pharmacist may select any nicotine replacement product (alone or in combination) from the list of therapies specified in this protocol in the Table "Nicotine Replacement Therapy Medications for Smoking Cessation." This list shall be kept current and maintained in the pharmacy. Furthermore, generic equivalent products may be furnished.

(6) Notifications: The pharmacist shall notify the patient's primary care provider of any prescription drug(s) and/or device(s) furnished to the patient, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by that primary care provider. If the patient does not have a primary care provider, or is unable to provide contact information for his or her primary care provider, the pharmacist shall provide the patient with a written record of the prescription drug(s) and/or device(s) furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

(7) Documentation: Each nicotine replacement product prescribed for smoking cessation and furnished by a pharmacist pursuant to this protocol shall be documented in a patient medication record and securely stored within the originating pharmacy for a period of at least three years from the date when the last nicotine replacement product was furnished. A patient medication record shall be maintained in an automated data processing or manual record mode such that the required information under title 16, sections 1717 and 1707.1 of the California Code of Regulations is readily retrievable during the pharmacy's normal operating hours.

(8) Training: Prior to furnishing prescription nicotine replacement products, pharmacists who participate in this protocol must have completed a minimum of two hours of a Board-approved continuing education program specific to smoking cessation therapy and nicotine replacement therapy, or an equivalent curriculum-based training program completed on or after the year 2000 in a California School of Pharmacy.

Additionally, pharmacists who participate in this protocol must complete ongoing continuing education focused on smoking cessation therapy from a Board-approved provider once every two years.

(9) Patient Privacy: All pharmacists furnishing nicotine replacement products in a pharmacy shall operate under the pharmacy's policies and procedures to ensure that patient confidentiality and privacy are maintained.

10) Nicotine Replacement Therapy Medications for Smoking Cessation
Insert chart

Note: Authority cited: Section 4052.9, Business and Professions Code. Reference: Section 4052(a)(10), Business and Professions Code.

Protocol Sources

Centers for Disease Control and Prevention, "Quitting Smoking," *available at* http://www.cdc.gov/tobacco/data_statistics/fact_sheets/cessation/quitting/index.htm.
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CPhA/CSHP, "Pharmacists Protocol for Dispensing Nicotine Replacement Products."
This draft protocol was consulted in development of the Board's recommended protocol.

Frank Vitale, "Brief Intervention Protocol for Assisting Patients with Tobacco Cessation," 64 AM. J. HEALTH-SYST PHARM. 2583 (2007).
This commentary provides important resources and specific dialogue for a pharmacists' procedure for assisting patients with tobacco cessation.

Nicole Van Hoey, "Opportunities for Smoking Cessation Services in Emerging Models of Care," America's Pharmacist (Oct. 2014).
This Continuing Education provided helpful referral resources, especially smartphone resources.

University of California, San Francisco, "Smoking Cessation Leadership Center," http://smokingcessationleadership.ucsf.edu/.
This site offers evidence-based resources for providers as well as continuing education opportunities in smoking cessation for CME and CEU credit.

University of California, San Francisco, "Rx for Change," http://rxforchange.ucsf.edu/.
This site offers evidence-based resources for providers and non-providers.

Accreditation Council for Pharmacy Education, "Basic Tobacco Intervention Workshop," P.L.A.N. Search Detail, *available at* https://www.acpe-accredit.org/pwtool/plan/DetailResultsPLAN.aspx?progtype=1&id=267501&cosp=289079&fromdate=10/27/2014.
This website shows ACPE-approved education involving smoking cessation.

Agency for Healthcare Research and Quality, "Treating Tobacco Use and Dependence: 2008—Clinical Practice Guideline," *available at*

http://www.ahrq.gov/professionals/clinicians-providers/guidelines-recommendations/tobacco/clinicians/index.html.

This site provides tobacco reference materials and guides for health care providers.

NICOTINE REPLACEMENT THERAPY MEDICATIONS FOR SMOKING CESSATION

	NICOTINE REPLACEMENT THERAPY (NRT) FORMULATIONS USED AS MONOTHERAPY					COMBINATION NRT
	GUM	LOZENGE	PATCH	NASAL SPRAY	INHALER	
PRODUCT	Nicorette[1], Generic OTC 2 mg, 4 mg original, cinnamon, fruit, mint	Nicorette Lozenge,[1] Nicorette Mini Lozenge,[1] Generic OTC 2 mg, 4 mg cherry, mint	NicoDerm CQ[1], Generic OTC (NicoDerm CQ, generic) Rx (generic) 7 mg, 14 mg, 21 mg (24-hour release)	Nicotrol NS[2] Rx Metered spray 0.5 mg nicotine in 50 mcL aqueous nicotine solution	Nicotrol Inhaler[2] Rx 10 mg cartridge delivers 4 mg inhaled nicotine vapor	Combinations with demonstrated efficacy Nicotine patch + nicotine gum Nicotine patch + nicotine lozenge Nicotine patch + nicotine nasal spray Nicotine patch + nicotine oral inhaler
PRECAUTIONS	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Temporomandibular joint disease ▪ Pregnancy[3] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[3] and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Pregnancy[3] (Rx formulations, category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Underlying chronic nasal disorders (rhinitis, nasal polyps, sinusitis) ▪ Severe reactive airway disease ▪ Pregnancy[3] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ Recent (≤ 2 weeks) myocardial infarction ▪ Serious underlying arrhythmias ▪ Serious or worsening angina pectoris ▪ Bronchospastic disease ▪ Pregnancy[3] (category D) and breastfeeding ▪ Adolescents (<18 years)	▪ See precautions for individual agents
DOSING	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 piece q 1–2 hours Weeks 7–9: 1 piece q 2–4 hours Weeks 10–12: 1 piece q 4–8 hours ▪ Maximum, 24 pieces/day ▪ Chew each piece slowly ▪ Park between cheek and gum when peppery or tingling sensation appears (~15–30 chews) ▪ Resume chewing when tingle fades ▪ Repeat chew/park steps until most of the nicotine is gone (tingle does not return; generally 30 min) ▪ Park in different areas of mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*1st cigarette ≤30 minutes after waking:* 4 mg *1st cigarette >30 minutes after waking:* 2 mg Weeks 1–6: 1 lozenge q 1–2 hours Weeks 7–9: 1 lozenge q 2–4 hours Weeks 10–12: 1 lozenge q 4–8 hours ▪ Maximum, 20 lozenges/day ▪ Allow to dissolve slowly (20–30 minutes for standard; 10 minutes for mini) ▪ Nicotine release may cause a warm, tingling sensation ▪ Do not chew or swallow ▪ Occasionally rotate to different areas of the mouth ▪ No food or beverages 15 minutes before or during use ▪ Duration: up to 12 weeks	*>10 cigarettes/day:* 21 mg/day x 4–6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks *≤10 cigarettes/day:* 14 mg/day x 6 weeks 7 mg/day x 2 weeks ▪ May wear patch for 16 hours if patient experiences sleep disturbances (remove at bedtime) ▪ Duration: 8–10 weeks	1–2 doses/hour (8–40 doses/day) One dose = 2 sprays (one in each nostril); each spray delivers 0.5 mg of nicotine to the nasal mucosa ▪ Maximum – 5 doses/hour or – 40 doses/day ▪ For best results, initially use at least 8 doses/day ▪ Do not sniff, swallow, or inhale through the nose as the spray is being administered ▪ Duration: 3–6 months	6–16 cartridges/day Individualize dosing; initially use 1 cartridge q 1–2 hours ▪ Best effects with continuous puffing for 20 minutes ▪ Initially use at least 6 cartridges/day ▪ Nicotine in cartridge is depleted after 20 minutes of active puffing ▪ Inhale into back of throat or puff in short breaths ▪ Do NOT inhale into the lungs (like a cigarette) but "puff" as if lighting a pipe ▪ Open cartridge retains potency for 24 hours ▪ No food or beverages 15 minutes before or during use ▪ Duration: 3–6 months	*Reserve for patients smoking ≥10 cigarettes/day:* Long-acting NRT: to prevent onset of severe withdrawal symptoms ▪ Nicotine patch 21 mg/day x 4-6 weeks 14 mg/day x 2 weeks 7 mg/day x 2 weeks PLUS Short-acting NRT: used as needed to control breakthrough withdrawal symptoms and situational urges for tobacco ▪ Nicotine gum (2 mg) 1 piece q 1–2 hours as needed *OR* ▪ Nicotine lozenge (2 mg) 1 lozenge q 1–2 hours as needed *OR* ▪ Nicotine nasal spray 1 spray in each nostril q 1–2 hours as needed *OR* ▪ Nicotine inhaler 1 cartridge q 1–2 hours as needed

	Nicotine Replacement Therapy (NRT) Formulations Used as Monotherapy					Combination NRT
	Gum	Lozenge	Patch	Nasal Spray	Inhaler	
Adverse Effects	▪ Mouth/jaw soreness ▪ Hiccups ▪ Dyspepsia ▪ Hypersalivation ▪ Effects associated with incorrect chewing technique: – Lightheadedness – Nausea/vomiting – Throat and mouth irritation	▪ Nausea ▪ Hiccups ▪ Cough ▪ Heartburn ▪ Headache ▪ Flatulence ▪ Insomnia	▪ Local skin reactions (erythema, pruritus, burning) ▪ Headache ▪ Sleep disturbances (insomnia, abnormal/vivid dreams); associated with nocturnal nicotine absorption	▪ Nasal and/or throat irritation (hot, peppery, or burning sensation) ▪ Rhinitis ▪ Tearing ▪ Sneezing ▪ Cough ▪ Headache	▪ Mouth and/or throat irritation ▪ Cough ▪ Headache ▪ Rhinitis ▪ Dyspepsia ▪ Hiccups	▪ See adverse effects listed for individual agents
Advantages	▪ Might satisfy oral cravings ▪ Might delay weight gain ▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Variety of flavors are available	▪ Might satisfy oral cravings ▪ Might delay weight gain ▪ Easy to use and conceal ▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Variety of flavors are available	▪ Provides consistent nicotine levels over 24 hours ▪ Easy to use and conceal ▪ Once daily dosing associated with fewer compliance problems ▪ FDA-approved for use in combination with bupropion SR	▪ Patients can titrate therapy to rapidly manage withdrawal symptoms	▪ Patients can titrate therapy to manage withdrawal symptoms ▪ Mimics hand-to-mouth ritual of smoking (could also be perceived as a disadvantage)	▪ Provides consistent nicotine levels over 24 hours and patients can titrate therapy to manage withdrawal symptoms and situational urges for tobacco ▪ Research studies suggest combination therapy provides a small, but meaningful increase in success rates compared to NRT monotherapy ▪ Attractive option for patients who have previously failed treatment with NRT monotherapy ▪ See advantages listed for individual agents
	▪ Need for frequent dosing can compromise compliance ▪ Might be problematic for patients with significant dental work ▪ Proper chewing technique is necessary for effectiveness and to minimize adverse effects ▪ Gum chewing may not be acceptable or desirable for some patients	▪ Need for frequent dosing can compromise compliance ▪ Gastrointestinal side effects (nausea, hiccups, heartburn) might be bothersome	▪ When used as monotherapy, cannot be titrated to acutely manage withdrawal symptoms ▪ Not recommended for use by patients with dermatologic conditions (e.g., psoriasis, eczema, atopic dermatitis)	▪ Need for frequent dosing can compromise compliance ▪ Nasal administration might not be acceptable or desirable for some patients; nasal irritation often problematic ▪ Not recommended for use by patients with chronic nasal disorders or severe reactive airway disease	▪ Need for frequent dosing can compromise compliance ▪ Cartridges might be less effective in cold environments (≤60°F)	▪ Increased cost of therapy ▪ See disadvantages listed for individual agents

[1] Marketed by GlaxoSmithKline.
[2] Marketed by Pfizer.
[3] The U.S. Clinical Practice Guideline states that pregnant smokers should be encouraged to quit without medication based on insufficient evidence of effectiveness and theoretical concerns with safety. Pregnant smokers should be offered behavioral counseling interventions that exceed minimal advice to quit.

Abbreviations: NRT, nicotine replacement therapy; OTC, over-the-counter (non-prescription product); Rx, prescription product.

For complete prescribing information, please refer to the manufacturers' package inserts.

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Attachment 3

Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(a) A pharmacist furnishing naloxone hydrochloride pursuant to Section 4052.01 of the Business and Professions Code shall follow the protocol specified in subdivision (b) of this section.

(b) Protocol for Pharmacists Furnishing Naloxone Hydrochloride

(1) Authority: Section 4052.01(a) of the California Business and Professions Code authorizes a pharmacist to furnish naloxone hydrochloride in accordance with a protocol approved by the California State Board of Pharmacy and the Medical Board of California. Use of the protocol in this section satisfies that requirement.

(2) Purpose: To provide access to naloxone hydrochloride via standardized procedures so that pharmacists may educate about and furnish naloxone hydrochloride to decrease harm from opioid[1] overdose.

(3) Procedure: When someone requests naloxone hydrochloride, or when a pharmacist in his or her professional judgment decides to advise of the availability and appropriateness of naloxone hydrochloride, the pharmacist shall complete the following steps:

- Screen for the following conditions:[2]

i. Whether the potential recipient[3] currently uses or has a history of using illicit or prescription opioids—especially long acting or extended release opioids (If yes, skip question ii and continue with Procedure);

ii. Whether the potential recipient is in contact with anyone who uses or has a history of using illicit or prescription opioids—especially long acting or extended release opioids (If yes, continue with Procedure);

iii. Whether the person to whom the naloxone hydrochloride would be administered has a known hypersensitivity to naloxone? (If yes, do not furnish).

- Provide training in opioid overdose prevention, recognition, response, and administration of the antidote naloxone.
- When naloxone hydrochloride is furnished:
    - The pharmacist shall provide the recipient with appropriate counseling and information on the product furnished, including dosing, effectiveness, adverse effects, storage conditions, shelf-life, and safety. The recipient is not permitted to waive the required consultation.

[1] For purposes of this protocol, "opioid" is used generally to cover both naturally derived opiates and synthetic and semi-synthetic opioids.
[2] These screening questions shall be made available in alternate languages for patients whose primary language is not English.
[3] For purposes of this protocol, "recipient" means the person to whom naloxone hydrochloride is furnished.

- The pharmacist shall provide the recipient with any informational resources on hand and/or referrals to appropriate resources if the recipient indicates interest in chemical dependency treatment, recovery services, or medication disposal resources at this time.

- The pharmacist shall answer any questions the recipient may have regarding naloxone hydrochloride.

(4) Product Selection: Naloxone hydrochloride may be supplied as an intramuscular injection, intranasal spray, and auto-injector. Other FDA approved products may be used. Those administering naloxone should choose the route of administration based on the formulation available, how well they can administer it, the setting, and local context.

(5) Suggested Kit Labeling:

Intramuscular	Intranasal	Auto-Injector
Naloxone 0.4mg/1ml single dose vial, # 2 vials SIG: Inject 1 ml intramuscularly upon signs of opioid overdose. Call 911. May repeat x 1. Syringe 3ml 25G X 1” # 2 SIG: Use as directed for naloxone administration. Kit should contain 2 vials and 2 syringes.	2ml needleless syringe prefilled with naloxone (1mg/1ml concentration), # 2 syringes SIG: Spray one-half (1ml) of the naloxone into each nostril upon signs of opioid overdose. Call 911. May repeat x 1. Mucosal Atomization Device (MAD) # 2 SIG: Use as directed for naloxone administration. Kit should contain 2 prefilled needleless syringes and 2 atomizers.	Naloxone 0.4 mg/0.4 ml #1 twin pack SIG: Use one auto-injector upon signs of opioid overdose. Call 911. May repeat x 1. Kit is commercially available as a twin pack with directions for administration included.

Optional items for the kits include alcohol pads, rescue breathing masks, and rubber gloves.

Kit labels shall include an expiration date for the naloxone hydrochloride furnished. An example of appropriate labeling is available on the Board of Pharmacy website.

(6) Fact Sheet: The pharmacist shall provide the recipient a copy of the current naloxone fact sheet approved by the Board of Pharmacy. This fact sheet shall be made available in alternate languages for patients whose primary language is not English.

(7) Notifications: If the recipient of the naloxone hydrochloride is also the person to whom the naloxone hydrochloride would be administered, then the naloxone recipient is considered a patient for purposes of this protocol and notification may be required under this section.

If the patient gives verbal or written consent, then the pharmacist shall notify the patient's primary care provider of any drug(s) and/or device(s) furnished, or enter the appropriate information in a patient record system shared with the primary care provider, as permitted by the patient and that primary care provider.

If the patient does not have a primary care provider, or chooses not to give notification consent, then the pharmacist shall provide a written record of the drug(s) and/or device(s) furnished and advise the patient to consult an appropriate health care provider of the patient's choice.

(8) Documentation: Each naloxone hydrochloride product furnished by a pharmacist pursuant to this protocol shall be documented in a medication record for the naloxone recipient, and securely stored within the originating health care facility for a period of at least three years from the date of dispense. The medication record shall be maintained in an automated data processing or manual record mode such that the required information under title 16, sections 1717 and 1707.1 of the California Code of Regulations is readily retrievable during the facility's normal operating hours.

(9) Training: Prior to furnishing naloxone hydrochloride, pharmacists who participate in this protocol must have successfully completed a minimum of one hour of an approved continuing education program specific to the use of naloxone hydrochloride, or an equivalent curriculum-based training program completed in a board recognized school of pharmacy.

(10) Privacy: All pharmacists furnishing naloxone hydrochloride in a health care facility shall operate under the facility's policies and procedures to ensure that recipient confidentiality and privacy are maintained.

Note: Authority cited: Section 4052.01, Business and Professions Code.

Protocol Sources

Scott Burris, et al., "Stopping an Invisible Epidemic: Legal Issues in the Provision of Naloxone To Prevent Opioid Overdose," DREXEL L. REV. 1(2):273-339, 326 (2009).
This law review article recommends fostering naloxone distribution through pharmacies, and using EC statutes as a model.

Substance Abuse and Mental Health Services Administration, "Opioid Overdose Toolkit," *available at* http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742.
This resource provides materials to develop policies to prevent opioid overdose.

The Network for Public Health Law, "Legal Interventions To Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws" (Aug. 2014), *available at* https://www.networkforphl.org/_asset/qz5pvn/naloxone-_FINAL.pdf.
This article describes naloxone access nationwide.

Harm Reduction Coalition, "Guide to Developing and Managing Overdose Prevention and Take-Home Naloxone Projects" (2012), *available at* http://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/.
This manual outlines the process of developing an overdose prevention program, including with a take-home naloxone component.

Northeast Behavioral Health, "Opioid Overdose Prevention and Reversal via Peer-Administered Narcan" (2012), *available at* http://harmreduction.org/wp-content/uploads/2012/02/od-train-the-trainer-parents.pdf.
This PowerPoint presentation provides information to educate peers on opioid prevention and reversal.

CA Department of Health Care Services, "Pharmacist Protocol for Furnishing Naloxone for the Prevention of Opioid Overdose" (last updated Oct. 29, 2014).
This draft protocol was consulted in development of the Board's recommended protocol.

World Health Organization, "Community Management of Opioid Overdose" (2014).
This resource provides materials to develop policies to prevent opioid overdose.

Drug Policy Alliance, "What Is Naloxone?" (Aug. 2014), *available at* http://www.drugpolicy.org/resource/what-naloxone.
This fact sheet provides comprehensives information on naloxone.

Massachusetts Department of Health and Human Services, "Dispensing of Naloxone by Standing Order" (2014), *available at* http://www.mass.gov/eohhs/gov/departments/dph/programs/hcq/dhpl/pharmacy/dispensing-of-naloxone-by-standing-order-.html.
This site contacts a pamphlet recommended as the base for the Board's factsheet.

N. Zaller, et al., "The Feasibility of Pharmacy-Based Naloxone Distribution Interventions: A Qualitative Study with Injection Drug Users and Pharmacy Staff in Rhode Island," 48 SUBST. USE MISUSE 8 (2013).

This research supports pharmacy-based naloxone intervention, but notes barriers including misinformation and costs.

Traci C. Green, et al., "Responding to Opioid Overdose in Rhode Island: Where the Medical Community Has Gone and Where We Need To Go," R.I. MED. J. 29-33 (Oct. 2014), *available at* http://www.rimed.org/rimedicaljournal/2014/10/2014-10-29-dadt-green.pdf.

This article gives an overview of opioid overdose, provides guidance resources, and emphasizes the importance of Good Samaritan Laws.

MEDICAL BOARD OF CALIFORNIA - 2015 TRACKER LIST
January 21, 2015

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 26	Jones-Sawyer	Medical Cannabis	Introduced	Reco: Support	
AB 34	Bonta	Medical Cannabis: State Regulation	Introduced	Reco: No Position, Intent Language Only	
SB 19	Wolk	Physician Orders for Life Sustaining Treatment Form: Statewide Registry	Introduced	Reco: Support in Concept	
SB 22	Roth	Medical Residency Training Program Grants	Introduced	Reco: Support	

Blue – For Discussion

2015 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE
10/16/2014

JANUARY

S	M	T	W	TH	F	S
				1	2	3
4	5	6	7	8	9	10
11	12	13	14	15	16	17
18	19	20	21	22	23	24
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FEBRUARY

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MARCH

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APRIL

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MAY

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DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 5 Legislature **reconvenes** (J.R. 51(a)(1)).

Jan. 10 Budget must be submitted by Governor (Art. IV, Sec. 12 (a)).

Jan. 19 Martin Luther King, Jr. Day.

Jan. 30 Last day to submit **bill requests** to the Office of Legislative Counsel.

Feb. 16 Presidents' Day.

Feb. 27 Last day for bills to be **introduced** (J.R. 61(a)(1), (J.R. 54(a)).

Mar. 26 **Spring Recess** begins at end of this day's session (J.R. 51(a)(2)).

Mar. 30 Cesar Chavez Day.

Apr. 6 Legislature reconvenes from **Spring Recess** (J.R. 51(a)(2)).

May 1 Last day for **policy committees** to hear and report to Fiscal Committees **fiscal bills** introduced in their house (J.R. 61(a)(2)).

May 15 Last day for **policy committees** to hear and report to the Floor **non-fiscal** bills introduced in their house (J.R. 61(a)(3)).

May 22 Last day for **policy committees** to meet prior to June 8 (J.R. 61(a)(4)).

May 25 Memorial Day.

May 29 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61 (a)(5)). Last day for **fiscal committees** to meet prior to June 8 (J.R. 61 (a)(6)).

2015 TENTATIVE LEGISLATIVE CALENDAR

COMPILED BY THE OFFICE OF THE SECRETARY OF THE SENATE
10/16/2014

JUNE						
S	M	T	W	TH	F	S
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June 1 – 5 **Floor Session only.** No committee may meet for any purpose (J.R. 61(a)(7)).

June 5 Last day for bills to be **passed out of the house of origin** (J.R. 61(a)(8)).

June 8 Committee meetings may resume (J.R. 61(a)(9)).

June 15 Budget must be passed by **midnight** (Art. IV, Sec. 12(c)(3)).

JULY						
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July 3 Independence Day observed.

July 17 Last day for **policy committees** to meet and report bills (J.R. 61(a)(10)). **Summer Recess** begins at the end of this day's session, provided Budget has been enacted (J.R. 51(a)(3)).

AUGUST						
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Aug. 17 Legislature reconvenes from **Summer Recess** (J.R. 51(a)(3)).

Aug. 28 Last day for **fiscal committees** to meet and report bills to the Floor (J.R. 61(a)(11)).

Aug. 31 – Sept. 11 **Floor Session only.** No committees, other than conference committees and Rules Committee, may meet for any purpose (J.R. 61(a)(12)).

SEPTEMBER						
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Sept. 4 Last day to **amend** bills on the Floor (J.R. 61(a)(13)).

Sept. 7 Labor Day.

Sept. 11 Last day for **each house to pass bills** (J.R. 61(a)(14)). **Interim Study Recess** begins at end of this day's session (J.R. 51(a)(4)).

IMPORTANT DATES OCCURRING DURING INTERIM STUDY RECESS

2015

Oct. 11 Last day for Governor to sign or veto bills passed by the Legislature on or before Sept. 11 and in the Governor's possession after Sept. 11 (Art. IV, Sec.10(b)(1)).

2016

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51 (a)(4)).

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 26
Author: Jones-Sawyer
Bill Date: December 1, 2014, Introduced
Subject: Medical Cannabis
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would enact the Medical Cannabis Regulation and Control Act and would create the Division of Medical Cannabis Regulation and Enforcement within the Department of Alcoholic Beverage. However, this analysis will only cover the portion of the bill related to the requirements on physicians recommending medical marijuana and the Medical Board of California (Board).

This bill would include in the Board's priorities, cases that allege a physician has recommended marijuana to patients for medical purposes without a good faith prior examination and medical reason therefor. This bill would require physicians to perform an appropriate prior examination before recommending marijuana for a medical purpose, which must include an in-person examination; a violation of this would constitute unprofessional conduct. This bill also specifies that recommending marijuana for a non-medical purpose constitutes unprofessional conduct. Lastly, this bill would not allow a marijuana clinic or dispensary to directly or indirectly employ physicians to provide marijuana recommendations.

BACKGROUND:

In 1996, California voters approved the Compassionate Use Act (Proposition 215), which allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making marijuana recommendations. SB 420 (Vasconcellos, Chapter 875, Statutes of 2003), the Medical Marijuana Program Act, included issuance of identification cards for qualified patients, and allowed patients and their primary caregivers to collectively or cooperatively cultivate marijuana for medical purposes.

In 2014, AB 1894 (Ammiano) was amended on May 23, 2014 and the amendments basically included the same language as the language included in this bill. The Board took a support position on AB 1894.

ANALYSIS:

This bill would give the Board some much needed enforcement tools to more efficiently regulate physicians who recommend marijuana for a medical purpose. This bill expressly requires a physician to perform an appropriate prior examination before recommending marijuana for a medical purpose, which must include an in-person

examination. This is an important amendment because the prescribing requirements in existing law do not necessarily apply to marijuana recommendations. This bill would make it clear that recommending marijuana for a non-medical purpose constitutes unprofessional conduct. This bill would also make marijuana recommendation cases a priority of the Board, which will help to ensure consumer protection. Lastly, this bill would not allow physicians to be employed by marijuana clinics or dispensaries, which will help to ensure that physicians are not making marijuana recommendations for financial or employment reasons.

Last year, the Board supported AB 1894 (Ammiano), which included essentially the same language that is included in this bill. The Board supported AB 1894 because it would have provided the Board with enforcement tools that would help ensure consumer protection and it would have ensured that physicians are not making marijuana recommendations for financial or employment reasons. As such, Board staff is suggesting that the Board take a support position on this bill.

FISCAL: None to the Board

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

california legislature— 2015–16 regular session

ASSEMBLY BILL No. 26

Introduced by Assembly Member Jones-Sawyer

December 1, 2014

An act to amend Sections 2220.05, 2242, and 2264 of, and to add Chapter 18 (commencing with Section 26000) to Division 9 of, the Business and Professions Code, to add Section 23028 to the Government Code, and to amend Section 11362.7 of, and to amend and repeal Section 11362.775 of, the Health and Safety Code, relating to medical cannabis, and making an appropriation therefor.

legislative counsel's digest

AB 26, as introduced, Jones-Sawyer. Medical cannabis.

(1) Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature, commonly referred to as the Medical Marijuana Program Act, requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use.

The Medical Practice Act provides for the regulation and licensing of physicians and surgeons by the Medical Board of California and requires the board to prioritize investigations and prosecutions of physicians and surgeons representing the greatest threat of harm, as specified. Existing law identifies the cases that are to be given priority, which include cases of repeated acts of excessively prescribing, furnishing, or administering controlled substances without a good faith

prior examination of the patient. Existing law makes it unprofessional conduct for a physician and surgeon to prescribe, dispense, or furnish dangerous drugs without an appropriate prior examination and medical indication. Existing law also makes it unprofessional conduct to employ, aid, or abet an unlicensed person in the practice of medicine. Existing law generally makes any person who violates these provisions guilty of a misdemeanor.

This bill would enact the Medical Cannabis Regulation and Control Act and would create the Division of Medical Cannabis Regulation and Enforcement within the Department of Alcoholic Beverage Control, to be administered by a person exempt from civil service who is appointed by the Director of Alcoholic Beverage Control. The bill would grant the department the power to register persons for the cultivation, manufacture, testing, transportation, storage, distribution, and sale of medical cannabis within the state provided that the authority of a city or county to adopt ordinances inconsistent with the requirements of the act that ban, regulate, or tax medical cannabis activities, and to enforce those ordinances, would not be affected by the act. The bill would provide that the director and persons employed by the department to administer and enforce its provisions are peace officers. The bill would prescribe requirements for the issuance, renewal, suspension, and revocation of mandatory commercial registrations and fees in relation to these activities. The bill would permit the department to assist statewide taxation authorities in the development of uniform policies for state taxation of mandatory commercial medical cannabis registrants and to assist in the development of regulation in connection with work safety in this industry. The bill would authorize the division to establish a grant program for the purpose of funding medical cannabis regulation and enforcement.

The bill would establish the Medical Cannabis Regulation Fund and would require deposit of fees into the fund. The bill would continuously appropriate moneys within the fund to the division for the purposes of administering the program. The bill would require the deposit of penalty money into the General Fund.

The bill would require the department, on or before January 1, 2017, to issue regulations as necessary for the implementation and enforcement of mandatory commercial medical cannabis registration, as specified, including requirements analogous to statutory environmental, agricultural, consumer protection, and food and product safety requirements. The bill would require the department to administer and

enforce these requirements. The bill would prescribe requirements for provisional registrations to be operative January 1, 2016. The bill would prohibit approval of a mandatory commercial registration for specified reasons, including if a licensed physician making patient recommendations for medical cannabis is an interested party in the proposed operation, and would prohibit a physician from recommending medical cannabis to a patient while he or she is a mandatory commercial registrant, or associated, as specified, with a mandatory commercial registrant. The bill would prohibit a registrant from holding a registration in more than one class of medical cannabis activities.

The bill would require a registrant to keep various records in connections with medical cannabis activities and would prescribe requirements for making records available to the department and any state or local agency. The bill would provide that certain patient and caregiver information is excluded from disclosure to the public. The bill would provide that the act does not apply to the protections granted to a patient or primary caregiver acting pursuant to the Compassionate Use Act of 1996 and would exempt these parties from the application of the act, provided they act consistently with specified requirements. The bill would provide that the actions of a mandatory commercial registrant or provisional registrant, its employees, and its agents that are permitted pursuant to a valid mandatory commercial registration issued by the division and that are conducted in accordance with the requirements of the act are not unlawful under state law, as specified. The bill would provide a similar state law immunity for a property owner who allows his or her property to be used by a mandatory commercial registrant or provisional registrant.

The bill would require the department to work in conjunction with law enforcement entities throughout the state to implement and enforce the rules and regulations regarding medical cannabis and to take appropriate action against businesses and individuals that fail to comply with the law. The bill would prohibit, on and after January 1, 2017, a person other than a mandatory commercial registrant from selling cannabis or cannabis products or performing other actions related to cannabis, except as specified. The bill would provide that its provisions do not prevent specified city or county actions, including zoning ordinances banning or regulating the location, operation, or establishment of a commercial registrant. The bill would make certain violations of its provisions a crime, thereby imposing a state-mandated local program. The bill would establish requirements for the

transportation of medical cannabis. The bill would specify that its provisions are severable.

The bill would specify that recommending marijuana to patients without a good faith examination and medical reason or recommending marijuana for nonmedical purposes is unprofessional conduct. The bill would provide that specified acts of recommending marijuana without a good faith examination are among the types of cases that should be given priority for investigation and prosecution by the Medical Board of California, as described above. The bill would also specify that employment by, or an agreement with, a mandatory medical cannabis registrant to provide recommendations for medical marijuana constitutes unprofessional conduct. By broadening the definition of a crime, the bill would impose a state-mandated local program. The bill would repeal, 90 days after the department posts a specified notice on its Internet Web site, the provisions described above prohibiting prosecution of qualified patients, persons with valid identification cards, and designated primary caregivers who associate in California, collectively or cooperatively, to cultivate marijuana for medical purposes.

(2) Existing law authorizes the board of supervisors of a county and the governing body of a city to impose various taxes, including a transactions and use tax at a rate of 0.25%, or a multiple thereof, if approved by the required vote of the board or governing body and the required vote of qualified voters, and limits the combined rate of transactions and use taxes within a city or county to 2%.

This bill would authorize the board of supervisors of a county to impose, by ordinance, a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing cannabis or cannabis products, including a transactions and use tax at any rate specified by the board. The bill would authorize the tax to be imposed for either general or specific governmental purposes. The bill would require a tax imposed pursuant to this authority to be subject to any applicable voter approval requirement.

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

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

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

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

SECTION 1. This act shall be known, and may be cited, as the Medical Cannabis Regulation and Control Act.

SEC. 2. (a) The Legislature finds and declares all of the following:

(1) In 1996, the people of the State of California enacted the Compassionate Use Act of 1996, codified in Section 11362.5 of the Health and Safety Code. The people of the State of California declared that their purpose in enacting the measure was, among other things, "to ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief."

(2) The Compassionate Use Act of 1996 called on state government to implement a plan for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

(3) In 2003, the Legislature enacted the Medical Marijuana Program Act (MMPA), codified in Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code.

(4) Greater certainty and minimum statewide standards are urgently needed regarding the obligations of medical marijuana facilities and for the imposition and enforcement of regulations to prevent unlawful cultivation and the diversion of marijuana to nonmedical use.

(5) Despite the passage of the Compassionate Use Act of 1996 and the MMPA, because of the lack of an effective statewide system for regulating and controlling medical marijuana, local law enforcement officials have been confronted with uncertainty about the legality of some medical marijuana cultivation and distribution activities. The current system of collectives and cooperatives makes law enforcement difficult and endangers patient safety because of an inability to monitor the supply of medical marijuana in the state and the lack of quality control, testing, and labeling requirements.

(6) For the protection of all Californians, the state must act to regulate and control medical marijuana and not preempt local government ordinances. Cities and counties should be allowed to impose local taxes and enact zoning regulations and other restrictions, including bans, applicable to the commercial cultivation and distribution of medical marijuana based on a local governing body's determination of local needs. In order to provide patients with access to safe medical marijuana products, while at the same time preventing diversion of marijuana to nonmedical uses and protecting the public, it is necessary to amend the MMPA and to establish a comprehensive structure for regulating the cultivation, production, and distribution of medical marijuana products.

(7) A state entity shall be created to regulate and control the mandatory registration of all entities involved in the commercial cultivation, processing, manufacturing, testing, transportation, distribution, provision, donation, and sale of medical marijuana in this state. Patients and their primary caregivers who cultivate medical marijuana for the personal medical purposes of individual patients shall not be subject to the statewide system of regulation established by this act but only medical marijuana produced in compliance with this act may be sold or commercially distributed.

(8) This act is not intended to prevent cities and counties from imposing local taxes and enacting zoning regulations and other restrictions, including bans, applicable to the commercial cultivation and distribution of medical marijuana based on a local governing body's determination of local needs.

(9) It is the intent of the Legislature that the state entity created to regulate and control medical marijuana solicit input from cities and counties in the process of promulgating standards and regulations pursuant to this act.

(10) It is the intent of the Legislature that entities provided immunity under Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, shall be considered the equivalent of entities that are registered, permitted, or licensed as a medical marijuana business, dispensary, or other entity involved in providing medical marijuana to patients under a local ordinance and shall be considered in compliance with a local ordinance for the purposes of the implementation of this act

and any regulations promulgated by the Department of Alcoholic Beverage Control.

(11) The provisions of this act are enacted pursuant to the powers reserved to the State of California and its people under the Tenth Amendment to the United States Constitution.

(12) Nothing in this act is intended to require any individual or entity to engage in any conduct that violates federal law or to exempt anyone from any requirement of federal law or to pose any obstacle to federal enforcement of federal law.

(b) It is therefore the intent of the Legislature, in enacting this act, to accomplish all of the following:

(1) To establish a statewide system for regulating and controlling commercial medical cannabis activities by creating a state entity to enact and enforce regulations governing the cultivation, processing, manufacturing, testing, transportation, distribution, provision, donation, and sale of commercial medical cannabis.

(2) To allow cities and counties to enact zoning regulations or other restrictions, including bans, applicable to the cultivation, processing, manufacturing, testing, and distribution of commercial medical cannabis based on a local governing body's determination of local needs.

(3) To establish the Division of Medical Cannabis Regulation and Enforcement to be located within the Department of Alcoholic Beverage Control to provide a governmental agency that will ensure the strict, honest, impartial, and uniform administration and enforcement of the statewide regulatory system established by this act throughout the state.

(4) To enact legislation in furtherance of the Compassionate Use Act of 1996, which provides for the Legislature to "implement a plan for the safe and affordable distribution of marijuana to all patients in medical need of marijuana."

(5) To establish a statewide registration process for commercial medical cannabis activities to identify for law enforcement which entities are exempt from state criminal penalties for the cultivation, processing, manufacturing, testing, transportation, distribution, provision, donation, and sale of medical cannabis solely on the basis of their activities conducted in compliance with this act.

(6) To reduce the cost of commercial medical cannabis enforcement by controlling commercial medical cannabis production and distribution through comprehensive statewide

regulation and providing law enforcement guidelines to more easily determine whether or not a person is acting in conformance with the state's medical cannabis laws.

SEC. 3. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled ~~substances~~ *substances, or recommending marijuana to patients for medical purposes,* without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Sexual misconduct with one or more patients during a course of treatment or an examination.

(5) Practicing medicine while under the influence of drugs or alcohol.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 4. Section 2242 of the Business and Professions Code is amended to read:

2242. (a) Prescribing, dispensing, or furnishing dangerous drugs as defined in Section ~~4022~~ *4022, or recommending marijuana to a patient for a medical purpose,* without an appropriate prior examination and a medical indication, *including an in-person examination when recommending marijuana, or recommending marijuana for a nonmedical purpose,* constitutes unprofessional conduct.

(b) No licensee shall be found to have committed unprofessional conduct within the meaning of this section if, at the time the drugs were prescribed, dispensed, or furnished, any of the following applies:

(1) The licensee was a designated physician and surgeon or podiatrist serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and if the drugs were prescribed, dispensed, or furnished only as necessary to maintain the patient until the return of his or her practitioner, but in any case no longer than 72 hours.

(2) The licensee transmitted the order for the drugs to a registered nurse or to a licensed vocational nurse in an inpatient facility, and if both of the following conditions exist:

(A) The practitioner had consulted with the registered nurse or licensed vocational nurse who had reviewed the patient's records.

(B) The practitioner was designated as the practitioner to serve in the absence of the patient's physician and surgeon or podiatrist, as the case may be.

(3) The licensee was a designated practitioner serving in the absence of the patient's physician and surgeon or podiatrist, as the case may be, and was in possession of or had utilized the patient's records and ordered the renewal of a medically indicated prescription for an amount not exceeding the original prescription in strength or amount or for more than one refill.

(4) The licensee was acting in accordance with Section 120582 of the Health and Safety Code.

SEC. 5. Section 2264 of the Business and Professions Code is amended to read:

2264. The employing, directly or indirectly, the aiding, or the abetting of any unlicensed person or any suspended, revoked, or unlicensed practitioner to engage in the practice of ~~medicine~~ *medicine, including employment by, other agreement with, a mandatory commercial registrant acting pursuant to the Medical Cannabis Regulation and Control Act or a dispensary to provide recommendations for medical marijuana,* or any other mode of treating the sick or afflicted which requires a license to practice constitutes unprofessional conduct.

SEC. 6. Chapter 18 (commencing with Section 26000) is added to Division 9 of the Business and Professions Code, to read:

Chapter 18. Medical Cannabis Regulation

Article 1. General Provisions

26000. (a) It is the intent of the Legislature in enacting this chapter to provide for the comprehensive regulation of the commercial cultivation, manufacturing, testing, transportation, distribution, provision, donation, and sale of medical cannabis and the enforcement of laws relating to commercial medical cannabis activities without preempting city or county ordinances regulating or banning these activities.

(b) This chapter is an exercise of the police powers of the state for the protection of the safety, welfare, health, peace, and morals of the people of the state.

26001. Without limiting the authority of a city or county pursuant to Section 7 of Article XI of the California Constitution or any other provision of law, and subject to that authority, the state shall have the right and power to regulate and register persons for the cultivation, manufacture, testing, transportation, storage, distribution, provision, donation, sale, purchase, and possession of medical cannabis within the state. In the exercise of these rights and powers, the Legislature shall not constitute the state or any of its agencies as a cultivator, manufacturer, transporter, tester, or seller of medical cannabis.

26002. For the purpose of this chapter:

(a) "Cannabis" means all parts of the plant Cannabis sativa, cannabis indica, or cannabis ruderalis, whether growing or not; the seeds thereof; the resin, whether crude or purified, extracted from any part of the plant; and every compound, manufacture, salt, derivative, mixture, or preparation of the plant, its seeds, or resin. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture, or preparation of the mature stalks (except the resin extracted therefrom), fiber, oil, or cake, or the sterilized seed of the plant which is incapable of germination. "Cannabis" also means marijuana as defined by Section 11018 of the Health and Safety Code as enacted by Chapter 1407 of the Statutes of 1972.

(b) "Commercial" means any cultivation, processing, possession, storage, manufacturing, testing, transportation, distribution, provision, donation, or sale of cannabis or cannabis product, whether or not gratuitous, except as provided in subdivision (b) of Section 26052.

(c) "Department" means the Department of Alcoholic Beverage Control.

(d) "Dispensary" means a mandatory commercial registrant that dispenses cannabis or medical cannabis products through a retail storefront.

(e) "Division" means the Division of Medical Cannabis Regulation and Enforcement.

(f) "Edible cannabis product" means a cannabis product that is used or intended for use in whole or in part for human consumption and includes chewing gum.

(g) "Fund" means the Medical Cannabis Regulation Fund established pursuant to Section 26028.

(h) "Identification program" means the universal identification certificate program for mandatory commercial registrants.

(i) "Mandatory commercial registrant" or "registrant" means any individual, partnership, joint venture, association, limited liability company, corporation, estate, trust, receiver, syndicate, or any other group or combination thereof acting as a unit to cultivate, process, possess, store, manufacture, test, transport, distribute, provide, donate, or sell medical cannabis in compliance with this chapter, other than a patient or a patient's primary caregiver, as defined by the Compassionate Use Act of 1996,

growing, possessing, storing, manufacturing, transporting, or providing medical cannabis exclusively for the personal medical purposes of individual patients as defined in subdivision (b) of Section 26052.

(j) "Medical cannabis product" or "cannabis product" means any product containing cannabis, including concentrates and extractions, that is cultivated, manufactured, processed, packaged, and distributed in full compliance with the requirements of this chapter and with any regulations adopted by the department pursuant to its rulemaking authority. "Medical cannabis product" includes products that contain medical cannabis and are intended for oral or topical consumption by a qualified patient.

(k) "Person" includes any individual, firm, copartnership, joint venture, association, corporation, estate, trust, business trust, receiver, syndicate, or any other group or combination acting as a unit and includes the plural as well as the singular number.

(*l*) "Testing and labeling" means mandatory labeling and a quality assurance plan in place that addresses all of the following:

(1) Potency.

(2) Chemical residue.

(3) Microbiological contaminants.

(4) Random sample testing of medical cannabis and medical cannabis products.

(5) Handling, care, and storage.

(6) Date and location of production and manufacturing.

26010. This chapter and Article 2 (commencing with Section 11357) and Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code do not prevent a city or county from doing any of the following:

(a) Adopting local ordinances inconsistent with this chapter that ban or regulate the location, operation, or establishment of a mandatory commercial registrant or other individual, partnership, joint venture, association, limited liability company, corporation, estate, trust, receiver, syndicate, or any other group or combination thereof acting as a unit, that cultivates, processes, possesses, stores, manufactures, tests, transports, distributes, provides, donates, or sells medical cannabis.

(b) The civil or criminal enforcement of the ordinances described in subdivision (a).

(c) Establishing a fee or tax for the operation of a mandatory commercial registrant within its jurisdiction.

(d) Enacting and enforcing other laws or ordinances pursuant to the authority granted by Section 7 of Article XI of the California Constitution.

Article 2. Administration

26020. (a) There is hereby created in the Department of Alcoholic Beverage Control the Division of Medical Cannabis Regulation and Enforcement. The division shall be administered by a person exempt from the civil service who is appointed by the director.

(b) The department shall have the power, consistent with the provisions of this chapter, to register persons for the cultivation, manufacture, testing, transportation, storage, distribution, and sale of medical cannabis within the state and to collect registration fees in connection with these actions.

26022. The department shall have all power necessary for administration of this chapter, including, but not limited to, the following:

(a) Establishing statewide minimum standards for the commercial cultivation, manufacturing, testing, transportation, storage, distribution, provision, donation, and sale of medical cannabis and medical cannabis products and procedures for the issuance, renewal, suspension, and revocation of registrations of mandatory commercial registrants.

(b) Establishing a scale of application, registration, and renewal fees, to be imposed by the state, for mandatory commercial registrants for the cultivation, manufacturing, testing, transportation, distribution, and sale of medical cannabis and medical cannabis products. The department may charge separate fees for each mandatory commercial registration application for cultivation, manufacturing, transportation, distribution, and sale. The total fees imposed pursuant to this chapter shall be based on the actual costs of administering and enforcing this chapter.

(c) The department shall make and prescribe those rules as may be necessary or proper to carry out the purposes and intent of this chapter and to enable it to exercise the powers and perform the duties conferred upon it by this chapter and in accordance with

Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code. For the performance of its duties, the department has the powers as set forth in Article 2 (commencing with Section 11180) of Chapter 2 of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Approving or denying mandatory commercial registration applications for cultivation, manufacturing, testing and labeling, transportation, distribution, provision, donation, and sale of medical cannabis pursuant to this chapter.

(e) The department shall have the power, in its discretion, to deny, suspend, revoke, or fine any registration issued pursuant to this chapter if the department determines that the granting or continuance of the registration would be contrary to public welfare or morals or that a person holding or seeking a registration has violated any law prohibiting conduct involving moral turpitude or an applicable local ordinance.

(f) Imposing any penalty authorized by this chapter or any rule or regulation adopted pursuant to this chapter.

(g) Taking any action with respect to a mandatory commercial registration application in accordance with procedures established pursuant to this chapter.

(h) Upon the denial of any application for a registration, the department shall notify the applicant in writing. After service of the notice and within the time prescribed by the department, the applicant may present his or her written petition for a registration to the department. Upon receipt by the department of a petition for a registration in proper form, the petition shall be set for hearing.

(i) (1) For any hearing held pursuant to this chapter, the department may delegate the power to hear and decide to an administrative law judge appointed by the director. Any hearing before an administrative law judge shall be pursuant to the procedures, rules, and limitations prescribed in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) Prior to suspending, revoking, or fining any registration, the department shall file an accusation as provided for in Section 11503 of the Government Code, and the registrant may request a hearing. If the department determines that the public interest requires that a registration be summarily suspended pending hearing on charges

of misconduct that include any of the causes for suspension or revocation specified in this chapter, or if the department has information that leads it to believe that a registrant has violated any law prohibiting conduct involving moral turpitude or any applicable local ordinance, the department may, without hearing, temporarily suspend the registration for a period not exceeding 60 days pending a hearing and decision on the charges.

(j) Developing any forms, identification certificates, and applications that are necessary or convenient in the discretion of the department for the administration of this chapter or any of the rules or regulations adopted pursuant to this chapter.

(k) Overseeing the operation of the Medical Cannabis Regulation Fund established pursuant to Section 26028.

(*l*) Establishing fees for processing all applications, registrations, notices, or reports required to be submitted to the department. The amount of the fees shall reflect, but shall not exceed, the direct and indirect costs of the department for the administration of this chapter and the rules or regulations adopted pursuant to this chapter.

(m) The department may consult with other state agencies, departments, or public or private entities for the purposes of establishing statewide standards and regulations.

26024. (a) The department may assist state taxation authorities in the development of uniform policies for the state taxation of mandatory commercial registrants.

(b) The department shall assist the Division of Occupational Safety and Health in the Department of Industrial Relations in the development of industry-specific regulations related to commercial medical cannabis activities.

26028. (a) The Medical Cannabis Regulation Fund is hereby established within the State Treasury. Notwithstanding Section 16305.7 of the Government Code, the fund shall include any interest and dividends earned on the money in the fund.

(b) All fees collected pursuant to this chapter shall be deposited into the Medical Cannabis Regulation Fund. Notwithstanding Section 13340 of the Government Code, all moneys within the fund are hereby continuously appropriated, without regard to fiscal year, to the department solely for the purposes of fully funding and administering this chapter, including, but not limited to, the costs incurred by the department for its administrative expenses.

(c) All moneys collected pursuant to this chapter as a result of penalties imposed under this division shall be deposited directly into the General Fund, to be available upon appropriation.

(d) The department may establish and administer a grant program to allocate moneys from the Medical Cannabis Regulation Fund to state and local entities for the purpose of assisting with medical cannabis regulation and the enforcement of this chapter and other state and local laws applicable to registrants.

26030. (a) The director and the persons employed by the department for the administration and enforcement of this chapter are peace officers in the enforcement of the penal provisions of this chapter, the rules of the department adopted under the provisions of this chapter, and any other penal provisions of law of this state prohibiting or regulating the cultivation, processing, storing, manufacturing, testing, transporting, or selling of medical cannabis, and these persons are authorized, while acting as peace officers, to enforce any penal provisions of law while in the course of their employment.

(b) The director, the persons employed by the department for the administration and enforcement of this chapter, peace officers listed in Section 830.1 of the Penal Code, and those officers listed in Section 830.6 of the Penal Code while acting in the course and scope of their employment as peace officers may, in enforcing the provisions of this chapter, visit and inspect the premises of any mandatory commercial registrant at any time during which the registrant is acting pursuant to the registration.

(c) Peace officers of the Department of the California Highway Patrol, members of the University of California and California State University police departments, and peace officers of the Department of Parks and Recreation, as defined in subdivisions (a), (b), (c), and (f) of Section 830.2 of the Penal Code, may, in enforcing this chapter, visit and inspect the premises of any mandatory commercial registrant located on state property at any time during which the registrant is acting pursuant to the registration.

26034. (a) Information identifying the names of patients, their medical conditions, or the names of their primary caregivers received and contained in records kept by the department for the purposes of administering this chapter are confidential and exempt from the California Public Records Act (Chapter 3.5 (commencing

with Section 6250) of Division 7 of Title 1 of the Government Code) and are not subject to disclosure to any individual or private entity, except as necessary for authorized employees of the State of California to perform official duties pursuant to this chapter:

(b) (1) Nothing in this section precludes the following:

(A) Division employees notifying state or local agencies about information submitted to the division that the employee suspects is falsified or fraudulent.

(B) Notifications from the division to state or local agencies about apparent violations of this chapter or any applicable local ordinance.

(C) Verification of requests by state or local agencies to confirm registrants and certificates issued by the division or other state agency.

(D) Provision of information requested pursuant to a court order or subpoena issued by a court or an administrative agency or local governing body authorized by law to issue subpoenas.

(2) Information shall not be disclosed beyond what is necessary to achieve the goals of a specific investigation or notification or the parameters of a specific court order or subpoena.

Article 3. Mandatory Commercial Registration

26040. (a) On or before January 1, 2017, the department shall promulgate regulations necessary for the implementation and enforcement of this chapter. These regulations shall include:

(1) Procedures for the issuance, renewal, suspension, and revocation of mandatory commercial registrations.

(2) Application, registration, and renewal forms and fees consistent with this act.

(3) Time periods, not to exceed 90 days, by which the department shall approve or deny an application for medical cannabis registration.

(4) Qualifications for registrants.

(5) Security requirements, including, but not limited to, procedures for limiting access to facilities and for the screening of employees. The department shall require all registrants to maintain an accurate roster of any employee's name, date of birth, and relevant personally identifying information, which shall be

available for inspection by the department or state or local law enforcement upon demand.

(6) Testing and labeling requirements, including, but not limited to, disclosure of the active cannabinoid profile, constituent elements, active ingredients, and results of testing for contaminants.

(7) Health and safety requirements, including, but not limited to, prohibitions on shipping or distribution of products containing microbiological, bacterial, pathogenic yeast or mold counts, or any adulterant or contaminant, that exceed levels to be determined by the department.

(8) Inspection and tracking requirements, including, but not limited to, an electronic production and inventory tracking system that will allow the department to monitor inventory data at every level of the cultivation, processing, and distribution system through a secure, Internet Web site-based portal.

(9) Storage, packaging, and transportation procedures and protocols.

(10) Advertising restrictions and requirements.

(11) Requirements to ensure conformance with standards analogous to state statutory environmental, agricultural, consumer protection, and food and product safety requirements. These standards shall be administered and enforced by the department and shall be in addition to, and not limit, any other state requirements. At a minimum, these standards shall:

(A) Prescribe sanitation standards analogous to the California Retail Food Code for food preparation, storage, and handling and sale of edible cannabis products.

(B) Require that edible cannabis products produced, distributed, provided, donated, or sold by mandatory commercial registrants shall be limited to nonpotentially hazardous food as established by the State Department of Public Health pursuant to Section 114365.5 of Health and Safety Code.

(C) Provide standards for labeling edible cannabis products to ensure that the products cannot be mistaken as food not containing cannabis.

(D) Require that facilities where edible cannabis products are prepared shall be constructed in accordance with applicable building standards, health and safety standards, and other state laws.

(E) Ensure that edible products distributed or sold by dispensaries are not produced or stored in private homes.

(F) Provide that any weighing or measuring devices used in connection with the sale or distribution of cannabis are required to meet standards analogous to Division 5 (commencing with Section 12001).

(G) Require that any application of pesticides or other pest control in connection with the indoor or outdoor cultivation of cannabis shall meet standards analogous to Division 6 (commencing with Section 11401) of the Food and Agricultural Code and its implementing regulations.

(H) Protect the state's clean water and environment, including, but not limited to, protections related to land conversion, grading, water diversion and pond development, and agricultural discharges.

(12) Requirements to prevent the diversion of cannabis to nonmedical use, including procedures and protocols for disposal of excess, contaminated, adulterated, or deteriorated products.

(13) Civil penalties for the failure to comply with regulations adopted pursuant to this chapter.

(b) A mandatory commercial registration application or renewal shall not be approved if the department determines any of the following:

(1) The applicant fails to meet the requirements of this chapter or any regulation adopted pursuant to this chapter or any applicable city or county ordinance or regulation.

(2) The applicant, or any of its officers, directors, owners, members, or shareholders is under 21 years of age.

(3) The applicant has knowingly answered a question or request for information falsely on the application form or failed to provide information requested.

(4) The applicant, or any of its officers, directors, owners, members, or shareholders has been convicted in the previous five years of a violent felony, as specified in subdivision (c) of Section 667.5 of the Penal Code, a serious felony as specified in subdivision (c) of Section 1192.7 of the Penal Code, a felony offense involving fraud or deceit, or any other felony that, in the department's estimation, would impair the applicant's ability to appropriately operate as a mandatory commercial registrant.

(5) The applicant, or any of its officers, directors, owners, members, or shareholders is a licensed physician making patient recommendations for medical cannabis.

(6) The applicant, or any of its officers, directors, owners, members, or shareholders has been sanctioned by the department, a city, or a county for cannabis activities conducted in violation of this chapter or any applicable local ordinance or has had a mandatory commercial registration revoked in the previous three years.

(7) A sufficient number of mandatory commercial registrants already exists in the state, a city, or a county to provide a sufficient amount of medical cannabis to satisfy patients' medical use in that jurisdiction.

(8) The proposed cultivation, processing, possession, storage, manufacturing, testing, transporting, distribution, provision, donation, or sale of medical cannabis will violate any applicable local law or ordinance.

(c) (1) In order to protect the public safety and provide patients with prompt, safe access to medical cannabis during implementation of this chapter, within 180 days of January 1, 2016, the department shall issue emergency regulations consistent with this chapter that allow a qualified applicant for mandatory commercial registration to apply, be reviewed, and be registered to cultivate, process, manufacture, store, and transport medical cannabis so as to ensure an adequate supply of medical cannabis upon full implementation of this chapter.

(2) The department shall establish appropriate fees as part of its emergency regulations adopted pursuant to this chapter.

26042. For the purpose of regulating the commercial cultivation, manufacturing, testing, transportation, distribution, provision, donation, and sale of medical cannabis, the department shall establish various classes or types of registration for specific commercial medical cannabis-related activities, as set forth in this chapter. At a minimum, registrants engaged in the cultivation and processing of cannabis shall be in a different class from those registrants operating dispensaries.

26043. (a) Each mandatory commercial registration application approved by the department pursuant to this chapter is separate and distinct. A registrant shall not hold a mandatory commercial registration in more than one class of specified medical cannabis

activities. A registrant shall not be an officer, director, member, owner, or shareholder registrant in another class. The officers, directors, owners, members, or shareholders of a registrant in one class may not hold a registration in another class, shall not be an officer, director, member, owner, or shareholder of a registrant in another class.

(b) A mandatory commercial registration application approved by the department pursuant to this chapter shall be valid for a period not to exceed one year from the date of approval unless revoked or suspended earlier than that date pursuant to this chapter or the rules or regulations adopted pursuant to this chapter.

26044. (a) The department shall limit the number of registrations statewide for the cultivation, processing, extraction, packaging, and transportation of medical cannabis to a number no greater than what is necessary to meet statewide need. In determining the appropriate number of registrations, the department may take into account information obtained from sources that include, but need not be limited to, municipalities, patients, and registrants.

(b) The department shall ensure that the number of registrations that it approves does not exceed the ability of the department to enforce the provisions of this chapter, particularly with respect to ensuring patient safety and preventing illegal diversion of cannabis.

(c) In establishing limits pursuant to this section, the department shall consider the following:

(1) The purposes and intent of the Compassionate Use Act of 1996 to ensure an adequate supply of medical cannabis while endeavoring to prevent an oversupply of cannabis that may result in diversion.

(2) The number of applicants for mandatory commercial registrations whose application demonstrates that they will be able to produce consistent products with strict quality controls, in full compliance with this chapter and with all applicable state and local regulations, and the amount of medical cannabis those applicants will be able to provide.

26045. Every mandatory commercial registration is renewable unless the registration has been revoked if the renewal registration is made and the fee for it is paid. A registration that has been suspended, but not revoked, may be renewed under this section, provided that the suspension shall remain in effect upon renewal.

All registrations expire at 12 midnight on the last day of the month posted on the registration. All registrations issued shall be renewed as follows:

(a) The application to renew the registration may be filed before the registration expires upon payment of the annual fee.

(b) For 60 days after the registration expires, the registration may be renewed upon payment of the annual renewal fee plus a penalty fee that shall be equal to 50 percent of the annual fee.

(c) Unless otherwise terminated, or unless renewed pursuant to subdivision (a) or (b), a registration that is in effect on the month posted on the registration continues in effect through 12 midnight of the 60th day following the month posted on the registration, at which time it is automatically canceled.

(d) A registration that has been canceled pursuant to subdivision (c) may be reinstated during the 30 days immediately following cancellation upon payment by cashier's check or money order of the annual renewal fee, plus a penalty fee that shall be equal to 100 percent of the annual fee. A registration that has been canceled pursuant to subdivision (c) and that has not been reinstated within 30 days pursuant to this subdivision is automatically revoked on the 31st day after the registration has been canceled.

(e) A renewal application shall not be deemed filed within the meaning of this section unless the document itself has been actually delivered to, and the required renewal fee has been paid at, any office of the department during office hours, or unless both the document and fee have been filed and remitted pursuant to Section 11003 of the Government Code.

26046. An application for mandatory commercial registration shall include, but shall not be limited to, all of the following:

(a) For all applicants:

(1) The legal name and proposed physical addresses of the mandatory commercial registrant.

(2) The name, address, and date of birth of each principal officer and board member.

(3) Operating and inventory control procedures to ensure security and prevent diversion.

(4) Detailed operating procedures for the proposed facility, which shall include, but not be limited to, provisions for facility and operational security, prevention of diversion, employee

screening, storage of medical cannabis, personnel policies, and recordkeeping procedures.

(5) A list of all persons or entities having an ownership interest other than a security interest, lien, or encumbrance on any property that will be used by the applicant.

(6) Evidence of the legal right to occupy and use an established location, or an immunity from prosecution for that occupancy or use pursuant to a local ordinance or ordinances, including, but not limited to, Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, for the activities to be conducted if the desired registration is granted consistent with the provisions of this chapter and the regulations developed by the department.

(7) Documentation that the applicant will be in compliance with all local ordinances and regulations, including an entity granted immunity under Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election.

(8) Evidence that officers and owners of the applicant organization are citizens of the United States and residents of the State of California.

(b) For applications for cultivation and processing, in addition to the requirements of subdivision (a), the application shall also include detailed operating procedures for cultivation, extraction and infusion methods, transportation of products, inventory procedures, procedures for quality control, and onsite testing of product for potential contaminants.

26047. Upon receipt of an application for a registration and the applicable fee, the department shall make a thorough investigation to determine whether the applicant and the premises for which a registration is applied qualify for the registration and whether the provisions of this chapter have been complied with, and shall investigate all matters connected therewith which may affect the public welfare and morals. The department shall deny an application for a registration if either the applicant or the premises for which a registration is applied do not qualify for a registration under this chapter. The department further shall deny an application for a registration if the department finds that issuance of that registration would create a law enforcement problem. The department may place conditions upon registrations if grounds exist for denial of the registration, and the department finds those

grounds may be removed by the imposition of those conditions, provided that the requirements set forth in paragraphs (6) and (8) of subdivision (b) of Section 26040 shall not be waived.

26048. A physician shall not recommend medical cannabis to a patient while the physician is a mandatory commercial registrant, or an officer, director, owner, member, shareholder, employee, or financial beneficiary of a mandatory commercial registrant.

26049. (a) The actions of a mandatory commercial registrant or provisional registrant, its employees, and its agents, permitted pursuant to a mandatory commercial registration or provisional registration issued by the department or otherwise permitted by this chapter, that are conducted in accordance to the requirements of this chapter and regulations adopted pursuant to the authority granted by this chapter, are not unlawful under state law and shall not be an offense subject to arrest, prosecution, or other sanction under state law, or be subject to a civil fine or be a basis for seizure or forfeiture of assets under state law.

(b) The actions of a person who, in good faith and upon investigation, allows his or her property to be used by a mandatory commercial registrant or provisional registrant, its employees, and its agents, as permitted pursuant to a mandatory commercial registration or provisional registration issued by the department or otherwise permitted by this chapter, are not unlawful under state law and shall not be an offense subject to arrest, prosecution, or other sanction under state law, or be subject to a civil fine or be a basis for seizure or forfeiture of assets under state law.

(c) This section shall not be deemed to limit the authority or remedies of a city or county under any provision of law, including, without limitation, Section 26010 or 26060 of this code or Section 7 of Article XI of the California Constitution.

26050. (a) A registrant shall not cultivate, process, store, manufacture, test, transport, or sell medical cannabis in the state unless accurate records are kept at the registered premises of the growing, processing, storing, manufacturing, testing, transporting, or selling by the registrant in the state. These records shall include the name and address of the supplier of any cannabis or cannabis products received or possessed by the registrant, the location at which the cannabis was cultivated, the amount of cannabis received, the form in which it is received, the name of the employee receiving it, and the date of receipt. These records shall further

include receipts for all expenditures incurred by the registrant and banking records, if any, for all funds obtained or expended in the performance of any activity under the authority of the registration, provided that a registrant registered to act at more than one premises may keep all records at one of the registered premises. Required records shall be kept for a period of seven years from the date of the transaction.

(b) The department and any state or local agency may make any examination of the books and records of any registrant and may visit and inspect the premises of any registrant that the department may deem necessary to perform its duties under this chapter.

(c) Any books or records requested by the department or any state or local agency shall be provided by the registrant no later than at the end of the next business day after the request is made.

(d) The department or any state or local agency may enter and inspect the premises of any facility operated by a registrant between the hours of 8 a.m. and 8 p.m. on any day that the facility is open, or at any reasonable time, to ensure compliance and enforcement of the provisions of this chapter or any local ordinance.

(e) In the event that the registrant or any employee of the registrant refuses, impedes, obstructs, or interferes with an inspection pursuant to this chapter or local ordinance, or if the registrant fails to maintain or provide the books and records required by this section, the registration may be summarily suspended pursuant to paragraph (2) of subdivision (i) of Section 26022 and the department shall directly commence proceedings for the revocation of the registration in accordance with this chapter.

26052. (a) This chapter shall not apply to, and shall have no diminishing effect on, the rights and protections granted to a patient or a primary caregiver pursuant to the Compassionate Use Act of 1996.

(b) (1) A patient who cultivates, possesses, stores, manufactures, or transports cannabis exclusively for his or her personal medical use and who does not sell, distribute, donate, or provide cannabis to any other person is not considered a commercial registrant and is exempt from mandatory commercial registration under this chapter.

(2) A primary caregiver who cultivates, possesses, stores, manufactures, transports, or provides cannabis exclusively for the

personal medical purposes of a specified qualified patient for whom he or she is the primary caregiver within the meaning of Section 11362.7 of the Health and Safety Code and who does not receive remuneration for these activities except for compensation in full compliance with subdivision (c) of Section 11362.765 of the Health and Safety Code is not considered a commercial registrant and is exempt from mandatory commercial registration under this chapter.

26054. Beginning January 1, 2015, the department shall provide for provisional registrations as follows:

(a) The department shall request that every city or county provide the department with a list of approved entities providing medical cannabis to qualified patients and caregivers within the city or county's jurisdiction, if any, the location at which the entity is operating, and the names of the persons who operate the entity. If the jurisdiction represents that the entity has been operating in compliance with local laws and regulations, or has limited immunity under local laws, including, but not limited to, Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, the department shall issue a provisional registration to the entity until the time that the entity's application for mandatory commercial registration has been approved or denied under this chapter, but no later than 90 days after the department begins accepting applications for mandatory commercial registration.

(b) The department shall issue a provisional registration to individuals and entities that the department determines were, during the six months prior to January 1, 2016, regularly cultivating or distributing medical cannabis collectively or cooperatively in full compliance with paragraphs A and B of Section IV of the Guidelines for Security and Non-Diversion of Marijuana Grown for Medical Use, issued by the Department of Justice in August 2008, and any applicable local ordinance, to continue to do so until such time as the registrant's application for mandatory commercial registration has been approved or denied under this chapter, but no later than 90 days after the department begins accepting applications for mandatory commercial registration. To qualify, provisional registrants shall be required to disclose to the department the following information in writing on or before January 20, 2016, in order to obtain provisional registration:

(1) The names, addresses, and dates of birth of each principal officer, owner, or board member.

(2) The common street address and assessor's parcel number of the property at which the registrant conducts any activity under the authority of the registration.

(3) The common street address and assessor's parcel number of the property at which any cultivation activity was or is to be conducted.

(4) For the six months prior to January 1, 2016, the quantity of cannabis cultivated at a location and the quantity expected to be cultivated from January 1, 2016, to June 30, 2016, inclusive. The registrant shall make its records of current activity and activity for the six months prior to January 1, 2016, available to the department upon request.

(c) The department shall charge an application fee of five thousand dollars ($5,000) for each provisional registration.

(d) Notwithstanding any other provision of this section, the department shall not issue a provisional registration to any individual or entity, or for any premises, against whom there are pending state or local administrative or judicial proceedings or actions initiated by a city or county under any applicable local ordinance or who has been determined through those proceedings to have violated any applicable local ordinance.

26055. Entities that are provided immunity under Measure D, approved by the voters of the City of Los Angeles at the May 21, 2013, general election, shall be considered the equivalent of entities that are registered, permitted, or licensed as a medical marijuana business, dispensary, or other entity involved in providing medical marijuana to patients under a local ordinance and shall be considered in compliance with a local ordinance for the purposes of the implementation of the act adding this section and any regulations promulgated by the department.

26056. In addition to other regulations adopted by the department pertaining to mandatory commercial registrants and without limiting the authority of a city or a county pursuant to Section 7 of Article XI of the California Constitution or any other law, the department shall adopt regulations regarding the minimum standards for the operation of dispensaries that establish all of the following:

(a) Standards for labeling of products, including the name of the mandatory commercial registrant from which the product was obtained, and a requirement that dispensaries provide patients with detailed written information about the contents of the cannabis and medical cannabis products they obtain.

(b) Requirements for inventory control and reporting that require all dispensaries to be able to demonstrate the present location, amounts, and descriptions of all medical cannabis products from the time of delivery to the dispensary until purchase by a qualified patient or primary caregiver.

(c) The maximum number of dispensaries that may operate in a city or county or the unincorporated areas of a county based on population, taking into consideration the distances that patients in rural areas may need to travel in order to reach a dispensary and the availability of public transportation in both rural and urban areas. The number established by the department for any city or county may not exceed the number of dispensaries allowed by any applicable local ordinance.

(d) Minimum educational and testing requirements for dispensary staff, including background checks, and a requirement that every dispensary maintain dedicated, licensed security staff both inside and outside the dispensary.

(e) Maximum hours of operation for every dispensary.

(f) Minimum standards governing signage and advertising for dispensaries.

26057. The department shall make recommendations to the Legislature pertaining to the establishment of an appeals and judicial review process for persons aggrieved by a final decision of the department.

Article 4. Enforcement

26060. (a) The department shall work in conjunction with law enforcement entities throughout the state for the purpose of implementing and enforcing the rules and regulations regarding commercial medical cannabis and taking appropriate action against businesses and individuals who fail to comply with the law.

(b) Nothing in this chapter or in Article 2 (commencing with Section 11357) or Article 2.5 (commencing with Section 11362.7) of Chapter 6 of Division 10 of the Health and Safety Code shall

prevent a city, county, or city and county from adopting or enforcing a zoning ordinance or other law, ordinance, or regulation that bans or regulates the location, operation, or establishment of a mandatory commercial registrant or other individual, partnership, joint venture, association, limited liability company, corporation, estate, trust, receiver, syndicate, or any other group or combination thereof acting as a unit, that cultivates, processes, possesses, stores, manufactures, tests, transports, distributes, provides, donates, or sells medical cannabis.

26062. Except for a person identified in Section 26052, a person shall not exercise the privilege or perform any act that a registrant may exercise or perform under the authority of a registration unless the person is acting pursuant to a registration, including a provisional registration, issued pursuant to this chapter.

26063. (a) Commencing January 1, 2017, any product containing cannabis that is distributed, except in the case of a primary caregiver distributing to a qualified patient, or offered for sale shall comply with the testing, labeling, and food safety requirements established through regulation by the department.

(b) No person shall steal or fraudulently use a mandatory commercial registrant identification certificate or registration or other registrant's identification card or registration issued by the department to acquire, cultivate, transport, produce, possess for sale, sell, provide, donate, or distribute cannabis.

(c) No person shall counterfeit, tamper with, or fraudulently produce an identification card or registration status.

(d) Any person who violates this section, or Section 26062, is guilty of a misdemeanor and shall be subject to the following penalties:

(1) For the first offense, imprisonment in a county jail for no more than six months or a fine not to exceed five thousand dollars ($5,000), or both.

(2) For a second or subsequent offense, imprisonment in a county jail for no more than one year or a fine not to exceed eight thousand dollars ($8,000), or both.

(e) Any person who is charged, prosecuted, or subjected to a civil penalty under this chapter shall not also be charged or prosecuted pursuant to the Health and Safety Code for conduct arising from the same set of facts.

26064. Any person operating an unregistered facility, building, structure, or location where cannabis is being commercially cultivated, manufactured, or possessed for sale in violation of this chapter may be subject to civil penalties of up to twenty-five thousand dollars ($25,000) for each violation, and the department may order the destruction of any cannabis associated with that violation. Each day of operation shall constitute a separate violation of this section. Any civil fines collected pursuant to this section shall be deposited into the General Fund pursuant to Section 26028.

26066. The director or any district attorney, county counsel, city attorney, or city prosecutor may bring an action in the name of the people of the State of California to enjoin a violation or the threatened violation of any provision of this chapter, including, but not limited to, a registrant's failure to correct objectionable conditions following notice or as a result of any rule promulgated pursuant to this chapter. The action shall be brought in the county in which the violation occurred or is threatened to occur. Any proceeding brought pursuant to this chapter shall conform to the requirements of Chapter 3 (commencing with Section 525) of Title 7 of Part 2 of the Code of Civil Procedure.

26068. A state or local law enforcement agency shall immediately notify the department of any arrests made for violations over which the department has jurisdiction which involve a registrant or registered premises. Notice shall be given within 10 days of the arrest. The department shall promptly cause an investigation to be made as to whether grounds exist for suspension or revocation of a registration of the registrant.

26070. This chapter shall not be construed to limit a law enforcement agency's ability to investigate unlawful activity in relation to a mandatory commercial registrant.

26072. The department shall create and maintain a searchable database that will allow state and local law enforcement to verify a mandatory commercial registration.

Article 5. Transportation of Medical Cannabis

26100. To claim the protections of this chapter and to maintain a valid mandatory commercial registration, a registrant shall transport medical cannabis products only to the registered facilities

of a mandatory commercial registrant and only in response to a request for a specific quantity and variety from that registrant.

26102. (a) Prior to transporting any medical cannabis product, a mandatory commercial registrant shall do the following:

(1) Complete a shipping manifest using a form prescribed by the department.

(2) Securely transmit a copy of the manifest to the mandatory commercial registrant that will receive the medical cannabis product and to the department prior to transport.

(b) The mandatory commercial registrant shipping and the registrant receiving shall maintain each shipping manifest and make it available to the department upon request.

26104. (a) Transported medical cannabis products shall:

(1) Be transported only in a locked, safe and secure storage compartment that is securely affixed to the interior of the transporting vehicle.

(2) Not be visible from outside the vehicle.

(b) Any vehicle transporting medical cannabis products shall travel directly from the facilities of the mandatory commercial registrant to the registered facilities of the registrant authorized to receive the shipment.

26106. (a) A mandatory commercial registrant shall staff all transport vehicles with a minimum of two employees. At least one delivery team member shall remain with the vehicle at all times that the vehicle contains medical cannabis.

(b) Each delivery team member shall have access to a secure form of communication by which each member can communicate with personnel at the mandatory commercial registrant facility at all times that the vehicle contains medical cannabis.

(c) Each delivery team member shall possess documentation of mandatory commercial registration and a government-issued identification card at all times when transporting or delivering medical cannabis and shall produce it to any representative of the department or law enforcement official upon request.

26107. This chapter shall not be construed to authorize or permit any registrant to transport, or cause to be transported, cannabis or cannabis products outside the state.

SEC. 7. Section 23028 is added to the Government Code, to read:

23028. (a) (1) In addition to any authority otherwise provided by law, the board of supervisors of any county may impose, by ordinance, a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing cannabis or cannabis products by a mandatory commercial registrant operating pursuant to Chapter 18 (commencing with Section 26000) of Division 9 of the Business and Professions Code. The tax may be imposed for general governmental purposes or for purposes specified in the ordinance by the board of supervisors.

(2) The board of supervisors shall specify in the ordinance proposing the tax the activities subject to the tax, the applicable rate or rates, the method of apportionment, and the manner of collection of the tax. A tax imposed pursuant to this section is a tax and not a fee or special assessment, and the tax is not required to be apportioned on the basis of benefit to any person or property or be applied uniformly to all taxpayers or all real property.

(3) A tax imposed by a county pursuant to this section by a county may include a transactions and use tax imposed solely for cannabis or cannabis products, which shall otherwise conform to Part 1.6 (commencing with Section 7251) of Division 2 of the Revenue and Taxation Code. Notwithstanding Section 7251.1 of the Revenue and Taxation Code, the tax may be imposed at any rate specified by the board of supervisors, and the tax rate authorized by this section shall not be considered for purposes of the combined tax rate limitation established by that section.

(4) The tax authorized by this section may be imposed upon any or all of the activities set forth in paragraph (1), regardless of whether the activity is undertaken individually, collectively, or cooperatively, and regardless of whether the activity is for compensation or gratuitously, as determined by the board of supervisors.

(5) The board of supervisors shall specify whether the tax applies throughout the entire county or within the unincorporated area of the county.

(b) In addition to any other method of collection authorized by law, the board of supervisors may provide for collection of the tax imposed pursuant to this section in the same manner, and subject to the same penalties and priority of lien, as other charges and taxes fixed and collected by the county.

(c) Any tax imposed pursuant to this section shall be subject to applicable voter approval requirements imposed by any other law.

(d) For purposes of this section, "cannabis" and "cannabis products" shall have the meanings set forth in Section 26001 of the Business and Professions Code.

(e) This section does not limit or prohibit the levy or collection or any other fee, charge, or tax, or any license or service fee or charge upon, or related to, the activities set forth in subdivision (a) as otherwise provided by law. This section shall not be construed as a limitation upon the taxing authority of any county as provided by other law.

SEC. 8. Section 11362.7 of the Health and Safety Code is amended to read:

11362.7. For purposes of this article, the following definitions shall apply:

(a) "Attending physician" means an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Medical Board of California or the Osteopathic Medical Board of California and who has taken responsibility for an aspect of the medical care, treatment, diagnosis, counseling, or referral of a patient and who has ~~conducted a medical examination of~~ *performed an appropriate prior examination, found* that ~~patient before recording in the patient's medical record the physician's assessment of whether~~ the patient has a ~~serious medical condition and whether the~~ *medical indication, and recommends marijuana for* medical ~~use of marijuana is appropriate.~~ *purposes to treat a serious medical condition.*

(b) "Department" means the State Department of ~~Health Services.~~ *Public Health.*

(c) "Person with an identification card" means an individual who is a qualified patient who has applied for and received a valid identification card pursuant to this article.

(d) "Primary caregiver" means the individual, designated by a qualified patient or by a person with an identification card, who has consistently assumed responsibility for the housing, health, or safety of that patient or person, and may include any of the following:

(1) In any case in which a qualified patient or person with an identification card receives medical care or supportive services, or both, from a clinic licensed pursuant to Chapter 1 (commencing

with Section 1200) of Division 2, a health care facility licensed pursuant to Chapter 2 (commencing with Section 1250) of Division 2, a residential care facility for persons with chronic life-threatening illness licensed pursuant to Chapter 3.01 (commencing with Section 1568.01) of Division 2, a residential care facility for the elderly licensed pursuant to Chapter 3.2 (commencing with Section 1569) of Division 2, a hospice, or a home health agency licensed pursuant to Chapter 8 (commencing with Section 1725) of Division 2, the owner or operator, or no more than three employees who are designated by the owner or operator, of the clinic, facility, hospice, or home health agency, if designated as a primary caregiver by that qualified patient or person with an identification card.

(2) An individual who has been designated as a primary caregiver by more than one qualified patient or person with an identification card, if every qualified patient or person with an identification card who has designated that individual as a primary caregiver resides in the same city or county as the primary caregiver.

(3) An individual who has been designated as a primary caregiver by a qualified patient or person with an identification card who resides in a city or county other than that of the primary caregiver, if the individual has not been designated as a primary caregiver by any other qualified patient or person with an identification card.

(e) A primary caregiver shall be at least 18 years of age, unless the primary caregiver is the parent of a minor child who is a qualified patient or a person with an identification card or the primary caregiver is a person otherwise entitled to make medical decisions under state law pursuant to Sections 6922, 7002, 7050, or 7120 of the Family Code.

(f) "Qualified patient" means a person who is entitled to the protections of Section 11362.5, but who does not have an identification card issued pursuant to this article.

(g) "Identification card" means a document issued by the State Department of *Public* Health ~~Services~~ that document identifies a person authorized to engage in the medical use of marijuana and the person's designated primary caregiver, if any.

(h) "Serious medical condition" means all of the following medical conditions:

(1) Acquired immune deficiency syndrome (AIDS).

(2) Anorexia.
(3) Arthritis.
(4) Cachexia.
(5) Cancer.
(6) Chronic pain.
(7) Glaucoma.
(8) Migraine.
(9) Persistent muscle spasms, including, but not limited to, spasms associated with multiple sclerosis.
(10) Seizures, including, but not limited to, seizures associated with epilepsy.
(11) Severe nausea.
(12) Any other chronic or persistent medical symptom that either:
(A) Substantially limits the ability of the person to conduct one or more major life activities as defined in the Americans with Disabilities Act of 1990 (Public Law 101-336).
(B) If not alleviated, may cause serious harm to the patient's safety or physical or mental health.
(i) "Written documentation" means accurate reproductions of those portions of a patient's medical records that have been created by the attending physician, that contain the information required by paragraph (2) of subdivision (a) of Section 11362.715, and that the patient may submit to a county health department or the county's designee as part of an application for an identification card.

SEC. 9. Section 11362.775 of the Health and Safety Code is amended to read:

11362.775. *(a)* Qualified patients, persons with valid identification cards, and the designated primary caregivers of qualified patients and persons with identification cards, who associate within the State of California in order collectively or cooperatively to cultivate marijuana for medical purposes, shall not solely on the basis of that fact be subject to state criminal sanctions under Section 11357, 11358, 11359, 11360, 11366, 11366.5, or 11570.

(b) This section shall remain in effect only until 90 days after the Department of Alcoholic Beverage Control posts a notice on its Internet Web site that it began accepting applications for mandatory commercial registration pursuant to Article 3

(commencing with Section 26040) of Chapter 18 of Division 9 of the Business and Professions Code, and as of that date is repealed.

SEC. 10. The provisions of this act are severable. If any provision of this act or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

SEC. 11. The Legislature finds and declares that Section 3 of this act imposes a limitation on the public's right of access to documents in the possession of a public agency within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following finding to demonstrate the interest protected by this limitation and the need for protecting that interest:

It is necessary to maintain the confidentiality of patient and physician information provided to the Division of Medical Cannabis Regulation and Enforcement in order to protect the private medical information of patients who use medical cannabis and to preserve the essential confidentiality of the physician and patient relationship.

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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california legislature— 2015–16 regular session

ASSEMBLY BILL No. 34

Introduced by Assembly Member Bonta

December 1, 2014

An act relating to medical cannabis.

legislative counsel's digest

AB 34, as introduced, Bonta. Medical cannabis: state regulation.

Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature, commonly referred to as the Medical Marijuana Program Act, requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use.

This bill would declare the intent of the Legislature to enact legislation that would establish a comprehensive and uniform state regulatory structure to govern the cultivation, processing, testing, and distribution of medical cannabis.

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

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

SECTION 1. It is the intent of the Legislature to enact legislation that would establish a comprehensive and uniform state

regulatory structure to govern the cultivation, processing, testing, and distribution of medical cannabis.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 19
Author: Wolk
Bill Date: December 1, 2014, Introduced
Subject: Physician Orders for Life Sustaining Treatment Form: Statewide Registry
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the California Physician Orders for Life Sustaining Treatment (POLST) statewide registry by January 1, 2016.

BACKGROUND

In the early 1990's, Congress passed the federal Patient Self-Determination Act and the POLST program was developed to address challenges related to advance care planning, most commonly used for frail and elderly patients. In 2008, AB 3000 (Wolk) created the California POLST, a standardized form that helps to ensure patient's wishes are honored regarding medical treatment towards the end of life. The POLST form is not an advance directive, it compliments an advance directive by identifying the patient's treatment preferences. Currently, the POLST form is a paper document.

ANALYSIS

This bill would enact the California POLST Registry Act. This bill would require the California Health and Human Services Agency (CHHS) to establish and operate the California POLST statewide registry (Registry), for the purpose of collecting a POLST form received from a health care provider and disseminating the information in the form to an authorized user. CHHS would be allowed to utilize a contractor to operate and maintain the Registry. CHHS would be required to adopt all rules necessary for the operation of the Registry, which shall include, but not be limited to, the following:

- The means by which a POLST form may be submitted to the Registry, may be revised, and may be revoked, which shall include a method for electronic delivery of this information and the use of legally sufficient electronic signatures.
- Appropriate and timely methods by which the information in the Registry may be disseminated to an authorized user.
- Procedures for verifying the identity of an authorized user.
- Procedures to ensure the accuracy of, and to appropriately protect the confidentiality of, POLST forms submitted to the Registry.
- The requirement that a patient, or his or her legally recognized health care decision maker, receive confirmation or receipt that the patient's POLST form has been received by the Registry.

- The ability of a patient, or his or her legally recognized health care decision maker, to review the information in the POLST form for accuracy.
- The ability of a patient, or his or her legally recognized health care decision maker, to amend or withdraw a POLST form from the Registry.

This bill would require a health care provider who completes a POLST form with a patient or his or her legally recognized health care decision maker to include the POLST form in the patient's official medical record. The health care provider is also required to submit a copy of the POLST form to the Registry, unless the patient chooses not to participate in the Registry. This bill includes liability protections for authorized users acting upon information obtained from the Registry.

According to the author's office, the POLST form is currently a paper document and a key barrier to the effectiveness of the POLST is inaccessibility of the document, which is intended to guide care. This bill would allow medical personnel to access a patient's POLST form in a timely manner in emergency medical situations, when they are most needed.

Although the idea of making the POLST form available electronically is a good one, many of the details on how this will happen are not included in this bill. This bill does not currently address funding, who will have access to the POLST forms as authorized users, and how the electronic registry will operate. This bill tasks CHHS with establishing, operating, and maintaining the registry, and also deciding who will become authorized users. For this Registry to be effective, all emergency medical personnel should have access, which may create confidentiality concerns. Without the details on how this Registry will operate, it is hard to take a position at this time. However, staff is recommending that the Board support the concept of this bill, and then take a stronger position once the details are clear regarding how the Registry will work for health care providers who will be required to enter POLST information into the Registry, how the Registry will be funded, and who will have access to the Registry.

FISCAL: None to the Board

SUPPORT: Coalition for Compassionate Care of California

OPPOSITION: None on file

POSITION: Recommendation: Support in Concept

SENATE BILL No. 19

Introduced by Senator Wolk
(Coauthors: Senators Monning and Vidak)
(Coauthors: Assembly Members Bonilla and Eggman)

December 1, 2014

An act to add Section 4788 to the Probate Code, relating to resuscitative measures.

legislative counsel's digest

SB 19, as introduced, Wolk. Physician Orders for Life Sustaining Treatment form: statewide registry.

Existing law defines a request regarding resuscitative measures as a written document, signed by an individual with capacity, or a legally recognized health care decisionmaker, and the individual's physician, directing a health care provider regarding resuscitative measures. Existing law defines a Physician Orders for Life Sustaining Treatment form, which is commonly referred to as a POLST form, and provides that a request regarding resuscitative measures includes a POLST form. Existing law requires that a POLST form and the medical intervention and procedures offered by the form be explained by a health care provider. Existing law distinguishes a request regarding resuscitative measures from an advance health care directive.

This bill would enact the California POLST Registry Act. The bill would require the California Health and Human Services Agency to establish and operate a statewide registry system, to be known as the California POLST Registry, for the purpose of collecting POLST forms received from health care providers. Health care providers who complete a POLST form would be required to include the POLST form in the patient's medical record and would be required to submit the form to the registry, unless a patient or his or her health care decisionmaker

chooses not to participate in the registry. The bill would require the agency to disseminate the information in the POLST form to an authorized user. The bill defines "authorized user" to include a health care provider. The bill would require the agency to adopt rules for, among other things, the operation of the registry, including the means by which POLST forms would be submitted electronically, revised, and revoked, the capability to check the POLST form for accuracy prior to it being made available, the appropriate and timely methods for dissemination of POLST form information, the procedures for verifying the identity of an authorized user, and rules for maintaining the confidentiality of a POLST form received by the registry. The bill would require that any disclosure of POLST form information in the registry be made in accordance with applicable federal privacy laws. The bill would provide immunity for an authorized user who acts upon information obtained from the registry and acts in good faith.

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

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

SECTION 1. This act shall be known, and may be cited, as the California POLST Registry Act.

SEC. 2. Section 4788 is added to the Probate Code, to read:

4788. (a) For purposes of this section:

(1) "Agency" means the California Health and Human Services Agency.

(2) "Authorized user" means a person authorized by the agency to submit information to, or to receive information from, the POLST registry, including health care providers.

(3) "Health care provider" has the meaning provided in Section 4621.

(4) "POLST form" means a Physician Orders for Life Sustaining Treatment form that fulfills the requirements of Section 4780.

(5) "Registry" means the California POLST Registry established by the agency pursuant to this section.

(b) The agency shall establish and operate a statewide registry system, to be known as the California POLST Registry, for the purpose of collecting a POLST form received from a health care provider and disseminating the information in the form to an authorized user. The registry may be operated and maintained by

a contractor of the agency. The agency shall adopt all rules necessary for the operation of the registry, which shall include, but not be limited to, the following:

(1) The means by which a POLST form may be submitted to the registry, may be revised, and may be revoked, which shall include a method for electronic delivery of this information and the use of legally sufficient electronic signatures.

(2) Appropriate and timely methods by which the information in the registry may be disseminated to an authorized user.

(3) Procedures for verifying the identity of an authorized user.

(4) Procedures to ensure the accuracy of, and to appropriately protect the confidentiality of, POLST forms submitted to the registry.

(5) The requirement that a patient, or his or her legally recognized health care decisionmaker, receive a confirmation or a receipt that the patient's POLST form has been received by the registry.

(6) The ability of a patient, or his or her legally recognized health care decisionmaker, to review the information in the patient's POLST form after it has been entered into the registry, and to confirm that it is accurate, prior to the information being available to an authorized user.

(7) The ability of a patient, or his or her legally recognized health care decisionmaker, to amend or withdraw a POLST form from the registry.

(c) The registry and the information it contains shall be the property of the state and any disclosure of information in a POLST form received by the registry shall be made in a manner consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(d) A health care provider who completes a POLST form with a patient or his or her legally recognized health care decisionmaker shall include the POLST form in the patient's official medical record. The health care provider shall submit a copy of the POLST form to the registry unless the patient or the legally recognized health care decisionmaker chooses not to participate in the registry.

(e) An authorized user acting upon information obtained from the registry is not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the person acted in good faith and had no

knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the POLST form would have made on his or her own behalf, or on behalf of the patient, under the circumstances.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 22
Author: Roth
Bill Date: December 1, 2014, Introduced
Subject: Medical Residency Training Program Grants
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Graduate Medical Education Trust Fund (GMETF) to fund grants to residency programs in California. The funds shall consist of public-private partnerships and any interest that accrues on amounts in the fund.

ANALYSIS

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

This bill would establish the GMETF and require the Office of Statewide Health Planning and Development (OSHPD), in consultation with the California Healthcare Workforce Policy Commission, to develop criteria for distribution of the money in the GMETF. OSHPD would only be required to develop criteria if donations are received that are sufficient to cover the costs of developing the criteria. In developing the criteria, OSHPD shall give priority to programs that meet the following specifications:

- Are located in medically underserved areas;
- Have a proven record of placing graduates in those medically underserved areas;
- Place an emphasis on training primary care providers; and
- Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

This bill would allow moneys in the GMETF to also be used to fund existing graduate medical education residency slots, as well as new graduate medical education residency slots. This bill would also specify that when applicable, OSHPD shall utilize moneys appropriated from the GMETF to provide a match for available federal funds for graduate medical education.

This bill would increase funding for residency programs in California, which will help promote the Board's mission of increasing access to care for consumers. This bill would also allow more physicians to receive residency training and potentially end up practicing in California. This bill is in line with the Board's adopted policy compendium and Board staff is suggesting that the Board take a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

SENATE BILL No. 22

Introduced by Senator Roth

December 1, 2014

An act to add Article 4 (commencing with Section 128310) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to health care.

legislative counsel's digest

SB 22, as introduced, Roth. Medical residency training program grants.

Existing law, the Song-Brown Family Physician Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission, among other things, to identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist, establish standards for family practice training programs, family practice residency programs, primary care physician assistants programs, and programs that train primary care nurse practitioners, and review and make recommendations to the Director of the Office of Statewide Health Planning and Development concerning the funding of those programs that are submitted to the Healthcare Workforce Development Division for participation in the state medical contract program.

The bill would create the Graduate Medical Education Trust Fund in the State Treasury, to consist of funds from public-private partnerships created to fund grants to graduate medical residency training programs and any interest that accrues on those moneys, and would require that moneys in the fund be used, upon appropriation by the Legislature, for those purposes, as specified. The bill would require the Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, to develop criteria, upon receipt of private donations of sufficient moneys to develop the criteria, for distribution of available funds.

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

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

SECTION 1. Article 4 (commencing with Section 128310) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 4. Medical Residency Training Program Grants

128310. (a) The Graduate Medical Education Trust Fund is hereby created in the State Treasury.

(b) Moneys in the fund, upon appropriation by the Legislature, shall be used solely for the purpose of funding grants to graduate medical education residency programs in California.

(c) Notwithstanding Section 16305.7 of the Government Code, all interest earned on the moneys that have been deposited into the fund shall be retained in the fund and used for purposes consistent with the fund.

(d) The fund shall consist of all of the following:

(1) Funds from public-private partnerships created for the purpose of funding grants to graduate medical education residency programs in California.

(2) Any interest that accrues on amounts in the fund.

(e) (1) The Office of Statewide Health Planning and Development, in consultation with the California Healthcare Workforce Policy Commission, shall develop criteria for distribution of available moneys in the fund.

(2) The office shall develop criteria only upon receipt of donations sufficient to cover the costs of developing the criteria.

(f) In developing the criteria, the office shall give priority to programs that meet the following specifications:

(1) Are located in medically underserved areas, as defined in Section 128552.

(2) Have a proven record of placing graduates in those medically underserved areas.

(3) Place an emphasis on training primary care providers.

(4) Place an emphasis on training physician specialties that are most needed in the community in which the program is located.

(g) Moneys appropriated from the fund may also be used to fund existing graduate medical education residency slots as well as new graduate medical education residency slots.

(h) Whenever applicable, the office shall utilize moneys appropriated from the fund to provide a match for available federal funds for graduate medical education.

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MBC TRACKER II BILLS
1/21/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	Gonzalez	Employment: Paid Sick Days: In-Home Supportive Services	Asm. Labor & Employment	
AB 12	Cooley	State Government: Administrative Regulations: Review	Asm. Admin. Review	
AB 19	Chang	State Government: Regulations	Introduced	
AB 41	Chau	Health Care Coverage: Discrimination	Introduced	
AB 50	Mullin	Nurse-Family Partnership	Introduced	
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Introduced	
AB 68	Waldron	Medi-Cal	Introduced	
AB 70	Waldron	Medi-Cal: Hospital Reimbursement	Introduced	
AB 72	Bonta	Medi-Cal: Demonstration Project	Introduced	
AB 73	Waldron	Medi-Cal: Benefits: Prescription Drugs	Introduced	
AB 83	Gatto	Information Practices Act of 1977	Introduced	
AB 85	Wilk	Open Meetings	Introduced	
SB 3	Leno	Minimum Wage: Adjustment	Asm. Labor & Ind. Relations	
SB 4	Lara	Health Care Coverage: Immigration Status	Introduced	
SB 10	Lara	Immigration: Governor's Office of New Americans	Sen. Gov. Org.	
SB 11	Beall	Peace Officer Training: Mental Health	Introduced	
SB 26	Hernandez	California Health Care Cost and Quality Database	Sen. Health	
SB 29	Beall	Employment: Sick Leave	Introduced	
SB 36	Hernandez	Medi-Cal: Demonstration Project	Sen. Health	
SB 43	Hernandez	Health Care Coverage: Essential Health Benefits	Sen. Health	
SB 58	Knight	Public Employees' Retirement System	Introduced	
SB 128	Wolk	End of Life	Introduced	
SCR 4	Pan	Physician Anesthesiologist Week	Assembly	

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	Disapproved by OAL. Third Modified Text and Addendum to Economic Impact Statement posted to MBC website 12/8/14; public comment period closed 12/29/2014; staff must complete the file for resubmission	7/19/13	9/06/13	10/25/13	7/28/14		8/26/14 Disapproved by OAL on 10/09/14; 120 days to re-submit (2/6/15)	
PA – Supervision Requirements	Approved by OAL	10/25/13	12/13/13	2/07/14	5/02/14	To DCA: 8/12/14	11/05/14	12/17/14; eff: 4/1/15
Issuance of Citations	15-day notice is pending, public comment period closes 1/23/2015	7/25/14	8/08/14	9/24/14; continued 10/14/14	7/25/14 (if no adverse comments)			
Section 100 (non-substantive changes): Free Health Care Events	Staff to prepare documents and then file with OAL							
CME Requirements	Licensing Staff preparing documents for publication	10/24/14		5/1/2015				
Disciplinary Guidelines	Pending completion of SB 1441 regs (above)	7/25/14						

Prepared by Kevin Schunke
Updated on January 13, 2015
For questions, call (916) 263-2368

* **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.