

State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board and Committee Meetings

October 29-30, 2015



**MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE**

The Westin San Diego
400 West Broadway
San Diego, CA 92101

October 29 – 30, 2015

Thursday, October 29, 2015

- **8:00 a.m. – 12:00 p.m.** **Panel A (Room: Diamond 1)**
(Members: Wright (Chair), Lewis, Bishop, Hawkins, Serrano Sewell, Yaroslavsky, Yip)
- **9:00 a.m. – 12:00 p.m.** **Panel B (Room: Diamond 2)**
(Members: GnanaDev (Chair), Bholat, Krauss, Levine, Pines, Schipske)
- **12:00 p.m. – 1:15 p.m.** **Lunch Presentation (Room: Diamond 2)**
- **1:30 p.m. – 3:00 p.m.** **Public Outreach, Education and Wellness Committee (Room: Diamond 1)**
(Members: Lewis (Chair), Hawkins, Krauss, Levine, Pines, Serrano Sewell, Yaroslavsky)
- **3:00 p.m. – 4:00 p.m.** **Enforcement Committee (Room: Diamond 1)**
(Members: Yip (Chair), Bholat, Krauss, Yaroslavsky)
- **4:00 p.m. – 6:00 p.m.** **Full Board Meeting (Room: Diamond 1)**
(All Members)

Friday, October 30, 2015

- **9:00 a.m. – 3:00 p.m.** **Full Board Meeting (Room: Diamond 1)**
(All Members)



MEDICAL BOARD OF CALIFORNIA

PANEL A MEETING AGENDA

MEMBERS OF PANEL A

Chair

Jamie Wright, J.D.

Vice Chair

Ronald Lewis, M.D.

Michael Bishop, M.D.

Randy Hawkins, M.D.

David Serrano Sewell

Barbara Yaroslavsky

Felix Yip, M.D.

The Westin San Diego

400 West Broadway

San Diego, CA 92101

(619) 239-4500

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

Thursday, October 29, 2015
Diamond I Conference Room
8:00 a.m. to 12:00 p.m.
(or until completion of business)

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

8:00 a.m. OPEN SESSION

1. Call to order/Roll Call
2. Election of Panel Chair and Vice Chair (Business and Professions Code section 2008)
3. **Oral Argument on Nonadopted Proposed Decision**

ATASHROO, David Abdullah

8:45 a.m. *CLOSED SESSION – Nonadopted Proposed Decision

ATASHROO, David Abdullah

9:15 a.m. OPEN SESSION

4. **Oral Argument on Petition for Reconsideration**

LIU, Samantha Landie

**The Panel of the Board will convene in Closed Session, as authorized by Government Code Section 11126(c)(3), to deliberate on disciplinary decisions and stipulations.*

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

Listed times are approximate and may be changed at the discretion of the President/Chair.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak. For additional information call (916) 263-2389.

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

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

10:00 a.m. CLOSED SESSION – Petition for Reconsideration

LIU, Samantha Landie

5. ***CLOSED SESSION**
Deliberation on disciplinary matters, including proposed decisions and stipulations
(Government Code §11126(c)(3))

6. **OPEN SESSION**

Adjournment



MEDICAL BOARD OF CALIFORNIA

PANEL B MEETING AGENDA



MEMBERS OF PANEL B

Chair

Dev GnanaDev, M.D.

Vice Chair

Howard Krauss, M.D.

Michelle Bholat, M.D.

Sharon Levine, M.D.

Denise Pines

Gerrie Schipske, R.N.P., J.D.

The Westin San Diego

400 West Broadway

San Diego, CA 92101

(619) 239-4500

Thursday, October 29, 2015

Diamond II Conference Room

9:00 a.m. to 12:00 p.m.

(or until completion of business)

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

1. Call to Order/Roll Call
2. Election of Panel Chair and Vice Chair (Business and Professions Code section 2008)
3. **Oral Argument on Judicial Remand**

MARKMAN, Robert Steven, M.D.

9:45 a.m.*CLOSED SESSION – Judicial Remand

MARKMAN, Robert Steven, M.D.

4. ***CLOSED SESSION**

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

5. **OPEN SESSION**

Adjournment

**The Panel of the Board will convene in Closed Session, as authorized by Government Code Section 11126(c)(3),
to deliberate on disciplinary decisions and stipulations.*

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

Listed times are approximate and may be changed at the discretion of the President/Chair.

Meetings of the Medical Board of California are open to the public except when specifically noticed otherwise in accordance with the Open Meetings Act. The audience will be given appropriate opportunities to comment on any issue presented in open session before the Board, but the President may apportion available time among those who wish to speak. For additional information call (916) 263-2389.

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

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



MEDICAL BOARD OF CALIFORNIA



PUBLIC OUTREACH, EDUCATION AND WELLNESS COMMITTEE MEETING AGENDA

COMMITTEE MEMBERS

Ronald Lewis, M.D., Chair
Randy Hawkins, M.D.
Howard Krauss, M.D.
Sharon Levine, M.D.
Denise Pines
David Serrano Sewell
Barbara Yaroslavsky

The Westin San Diego
400 W. Broadway
San Diego, CA, 92101
(619) 239-4500
(directions only)

Thursday, October 29, 2015
1:30 p.m. – 3:00 p.m.
(or until the conclusion of business)

Teleconference – See Attached
Meeting Information

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

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

Please see Meeting Information
Section for additional
information on public
participation

ORDER OF ITEMS IS SUBJECT TO CHANGE

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE.

If a quorum of the Board is present, Members of the Board who are not Members
of the Committee may attend only as observers.

1. Call to Order/Roll Call
2. Public Comments on Items Not on the Agenda
Note: The Committee may not discuss or take action on any matter raised during this public comment section that is not included on this agenda, except to decide to place the matter on the agenda of a future meeting. [Government Code §§11125, 11125.7(a)]
3. Approval of the Minutes from the July 30, 2015 Education and Wellness Committee Meeting
4. Presentation, Discussion and Possible Action of Elements of a Successful Physician Health Program – Ms. Kirchmeyer and Ms. Robinson
5. Presentation, Discussion and Possible Action of “Verify a License” Campaign and Public Outreach Plan – Ms. Kirchmeyer, Ms. Simoes, Ms. Hockenson
6. Future Agenda Items
7. 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.

Meeting Information

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

The call-in number for teleconference comments is: (888) 220-8450

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 – 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.

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 Committee, but the Chair may apportion available time among those who wish to speak.

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

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



MEDICAL BOARD OF CALIFORNIA
Executive Office



Education and Wellness Committee Meeting

San Francisco Airport Marriott Waterfront
180 Old Bay Shore Hwy
Burlingame, CA 94010
(650) 692-9100

Thursday, July 30, 2015
2:30 p.m. – 3:15 p.m.

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Education and Wellness Committee (Committee) of the Medical Board of California (Board) was called to order by Chair Barbara Yaroslavsky at 2:30 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:

Barbara Yaroslavsky, Chair
Howard Krauss, M.D.
Denise Pines

Members of the Committee Not Present:

Gerrie Schipske, R.N.P., J.D.

Other Members not on the Committee Present:

Michelle Bholat, M.D.
Dev GnanaDev, M.D.
Randy Hawkins, M.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.

Staff Present:

Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dennis Frankenstein, Business Services Officer
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Elizabeth Rojas, Business Services Officer
Regina Rao, Associate Governmental Program Analyst
Letitia Robinson, Research Program Specialist
Paulette Romero, Staff Services Manager II
Jennifer Simoes, Chief of Legislation

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 2

Lisa Toof, Administrative Assistant II
Kerrie Webb, Staff Counsel
Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Alternate Performance Assessment
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Lou Galiano, Videographer, Department of Consumer Affairs
Bridget Gramme, Center for Public Interest Law
Doug Grant, Investigator, Health Quality Investigation Unit
Dr. Greenberg, Monitored Aftercare Program
Marian Hollingsworth, Consumers Union
Todd Iriyama, Investigator, Health Quality Investigation Unit
Lisa McGiffert, Consumers Union
Michelle Monserrat-Ramos, Consumers Union
James O'Donnell, Pacific Assistance Group
Andres Sciolla, M.D., University of California, Davis
Dr. Sucher, Monitored Aftercare Program
Ashby Wolfe, M.D., Chief Medical Officer, Centers for Medicare and Medicaid Services
Dr. Zemansky, Pacific Assistance Group

Agenda Item 2 Public Comment on Items Not on the Agenda

No public comments were received.

Agenda Item 3 Approval of Minutes from the January 29, 2015, Education and Wellness Committee Meeting

Dr. Krauss made a motion to approve the minutes from the January 29, 2015 meeting; s/Pines. Motion carried.

Agenda Item 4 Presentation on Updates on the Affordable Care Act and Information on Physician Compliance Programs

Dr. Wolfe, Chief Medical Officer, Centers for Medicare and Medicaid Services (CMS) Region 9, presented updates on the Affordable Care Act (ACA) and information on the physician compliance programs.

Dr. Wolfe started by explaining that she had been asked to present some information regarding the provider compliance program as authorized by the ACA and to provide some updates on some key programs within the ACA itself.

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 3

Dr. Wolfe reviewed Section 6401 of the ACA stating that it is the legalizing portion of the statute that provides details around provider compliance programs with the intent to assist physicians and other clinicians in appropriately providing information when they are billing Medicare and Medicaid or the Children's Health Insurance Program (CHIP). She continued by stating that there have been no updates since the last presentation but she would review the key elements and talk about the published guidance that is available and then review some programs that are new and deal with value based payment. She also would provide a review of a new model out this summer that may be of interest.

Dr. Wolfe continued with the provider compliance programs, saying that no new updates to the current guidance is available and that an enforcement date has not been set for these programs. The authorizing portion of the ACA is Section 6401, which specifically directs the Department of Health and Human Services (DHHS), in consultation with the Office of the Inspector General (OIG), to establish core elements for provider and supplier compliance programs within the health industry in order to participate or as a condition of enrollment in Medicare, Medicaid or the CHIP program. Physicians, their associated clinicians and providers of medical supplies, must establish a compliance program to deal with proper claims billing as well as insuring that there is a minimized risk when it comes to fraud and abuse. The OIG has been providing guidance on these types of programs since the early 90's when they began a major initiative to support health care professions in establishing compliance programs throughout the organizations and practices. The OIG has been working with the DHHS, advising providers, physicians, clinicians and other organizations to voluntarily adopt compliance plans. The OIG has issued several helpful guidelines on this issue specifically as it pertains to physicians, hospitals, nursing homes, pharmaceutical manufactures and physician group practices. Section 6401 of the ACA specifically addresses solo and small physician groups; however, the intent of the legislation is that all physician groups are in compliance. The guidance for these programs is published at the OIG's website. CMS.gov has multiple webinars, as well as guidance, as it pertains to developing a compliance program and setting one up in an office or other entity.

Dr. Wolfe continued with putting the importance of fraud and abuse in perspective, stating that recoveries from the fiscal year 2013 totaled about 4.3 billion dollars and that this was one of the major areas that the CMS concentrates on in collaboration with the rest of DHHS and the OIG. She continued explaining that the intent of compliance programs is to minimize the risk to practices as it pertains to improper billing, fraud, and abuse, and there are websites that serve as excellent resources in terms of guidance, products and other information on compliance programs. Most health professionals are aware that there are compliance programs that are recommended for clinicians but there are no enforcement dates specifically for physician programs at this time.

Dr. Wolfe stated that the intent of this legislation is for all health professionals to implement a compliance program and continued with the seven core elements for an effective compliance program which is outlined in the guidance that the OIG provides. Dr. Wolfe stated the following items are what an effective compliance program includes:

1. Written policies and procedures and standards of conduct – establishing written policies and specific detail of procedures is necessary to promote consistency and uniformity in an office or practice as it pertains to proper billing and compliance. Written policy should be composed with the guidance of either an identified compliance officer or compliance committee. Details for set up is available on the OIG's website and the CMS' website.

Education and Wellness Committee

Meeting Minutes July 30, 2015

Page 4

2. Compliance oversight of the program – identifying a compliance officer or a compliance committee who can oversee the program, as an organizational watch dog to ensure that the policies are being implemented appropriately.
3. Training and education – training the physicians and staff within the organization to be able to comply with the compliance plan and to ensure everyone is aware of expectations and standards as they are written.
4. Communication – opening the lines of communication so that there are requirements for the employees to be proactive, providing a formal process for managers to communicate compliance issues as well as results, audits or investigations and a process to allow anonymous reporting without fear of retaliation.
5. Auditing and monitoring – provides assurance that the program is effective, and ensures that it is in compliance with CMS requirements, and identifies any risks to the organization. Ideally, the system should include a way to do internal audits for internal learning, as well as external audits if they are requested by OIG or CMS.
6. Consistent discipline – written policies should be available for review from all staff and physicians and it should be a plan that provides appropriate disciplinary sanctions on those who fail to comply with any requirements.
7. Use of corrective actions – consistent and corrective actions must be conducted, examples might include repayment of over payments, and or disciplinary action against responsible employees.

Dr. Wolfe provided four elements of information about the steps that physicians should take for an effective compliance program. The OIG has a specific guide for all physician groups in all modes of practice on its website. The HEAT Team (Healthcare Fraud Prevention and Enforcement Action Team) provides compliance training for providers. She commented that keeping a plan simple and readable will allow it to be useable and setting a date every 6 -12 months to review the compliance program was a suggestion.

Dr. Wolfe continued with programs authorized by the ACA that are in the process of changing as a result of the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Physician Quality Reporting System (PQRS) and the electronic health record (EHR) incentive program also known as Meaningful Use (MU) has been in place since 2007. This year, 2015, is important because if eligible physicians or their accompanying clinicians are eligible to participate and choose not to, they will potentially face a negative payment adjustment up to seven percent of the fees they bill under the part B fee schedule in 2017. Failure to participate as an eligible professional in PQRS and MU in 2015 results in a negative payment adjustment in 2017. CMS is not authorized to waive that negative payment adjustment, it is required by statute.

Dr. Wolfe said she brought up these two programs because under the MACRA multiple changes, which will include some changes to the PQRS, MU, and the MACRA, permanently repealed the sustainable growth rate and, in its place, instituted a stable period of annual updates to the reimbursement schedule

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 5

for physicians, which took effect July 1, 2015, with a .5% annual update and will continue once a year as a .5% update to the fee schedule through 2019. In 2019, CMS is required to implement a Merit-based Incentive Payments System (MIPS) which is a combination of the PQRS, MU and the Value Modifier Program (VMP). While there are no regulations yet, Congress has asked CMS by early 2016 to provide a basic outline of how this MIPS system will work. She stated that she would follow up with the Board as the details for those regulations are written.

The Regional Innovation Network (RIN) is something that Region 9 is trying through the Center for Medicare and Medicaid Innovation (CMMI). The idea is to have CMS provide a platform for both virtual and in-person collaboration amongst physicians and other providers in the state. With Region 9 being such a large and geographically diverse area, as well as ethnically diverse, CMS thought that it would be interesting to try the CMS website as a way of providing a way for people to connect and collaborate throughout the region. The kick-off event was in May and information is on the website to sign up to join the Regional Innovation Network.

Dr. Wolfe stated that finally she wanted to bring to the Board's attention a new pay for performance model that has just been announced this summer, which could potentially become the way that CMS introduces future pilots and demonstrations. It is known as the Million Hearts Cardiovascular Disease Risk Reduction Model, and it will test the concept of pain physicians reducing long term cardiovascular risk in their high risk patient populations. The idea is to provide a payment incentive or bonus payment for prevention rather than specific processes or outcomes like reducing blood pressure or LDL cholesterol levels. So essentially the predictive algorithm, ASCBD calculator, which is approved by the American College of Cardiology (ACC) and the American Heart Association (AHA), will give beneficiaries and patients within different practices their individual risks scores and over a period of five years, practices will receive a financial incentive, and bonus payments if they are able to reduce their beneficiaries or patients risk scores. This as something that CMS has never done before and they are looking for practices to participate. CMS is hoping to have about 300,000 medicare beneficiaries and about 720 physician practices involved.

Dr. Krauss asked if the Recovery Audit Contractors (RAC), who are private firms contracted with CMS that receive a percentage of the payments taken back as compensation for their work, also receive a percentage when they discover under payments.

Dr. Wolfe stated that she did not know, but would be happy to double check the under-payment process.

Dr. Krauss said that many of his colleagues simply pay the RAC or let the RAC take the money back because their administrative costs to contest it would be greater than the amounts of money that the RAC is asking for. He continued that the letters physicians receive whenever there is an adjustment include words like "fraud" and that every overpayment is not necessarily fraud. He said that he is concerned as to whether or not that is also communicated to the physician's patients that their doctor may be suspected of committing fraud.

Dr. Wolfe stated that the RAC is not authorized to communicate with any of the patients of the practice or hospitals they are evaluating; that it is monitored very carefully by CMS policy regulations committees and divisions.

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 6

Dr. Krauss stated that from reading the newspaper that there are very egregious cases of fraud and abuse, and that he would like to think that they occur at the hands of a minority of physicians and medical providers, but in his community there is this underlining sense of fear and trepidation in dealing with the federal government and in dealing with CMS, and that he is aware of physicians who intentionally under code services in an effort to stay under the radar. He asked if CMS might change their perception.

Dr. Wolfe stated that actually the fear is of accidentally up coding and therefore under coding so that they do not make that mistake. In that situation the physician is not getting paid the value for the work that they are providing and that is one of the reasons to actually develop a compliance program for the practice, because it will provide information to any external auditors, including CMS or OIG that there is a plan in place that is clearly written out and that people are proactively evaluating what they are doing. Certainly the intent is not to go after every accidental up code; the idea is to ensure that it is not a systemic process to defraud the federal government. So, having a compliance program in place, even a basic one that is structured on the guidance provided by the OIG, is actually a great way to protect a practice and to ensure that physicians are actually getting paid for the value of the work.

Dr. Krauss stated that the EHR was a help, because most of the software in the EHR lets a physician know what the proper level of coding is for the service provided. On the flip side of that there has been some EHR's that prompt for additional information and sometimes even cut and paste additional information. Dr. Krauss stated that as a Medical Board Member, it causes him to worry whether the medical record physicians review become an accurate representation of the service that was really provided on that day.

Dr. Wolfe said with respect to cutting and pasting, that it has potential to provide inaccurate information, so active documenting in real time is always the best idea.

Ms. Yaroslavsky asked if there is mandatory reporting for those individuals to report to the Medical Board.

Dr. Wolfe stated that she did believe there was, but she would check with her Legal Office of Legislation to see if there is a statute that directly addresses that issue.

Dr. Krauss said that he anticipated that ICD 10 will occur sometime in October. Physicians are worrying that this new system of coding and billing will have an adverse effect and scrutiny just because it is a new system and it is more complicated. He asked if CMS is willing to give the doctors a little more leeway as they learn how to use the system.

Dr. Wolfe stated with the MACRA there was some thought that there might be a delay in ICD 10 implementation. There was not and CMS expects the ICD 10 to be up and running by October 1, 2015. However, about 3-4 weeks ago, CMS, in conjunction with the AMA, issued additional information about the first year of ICD 10 implementation, specifically, stating that providers would not be penalized if they get the incorrect ICD 10 code as long as it is in the correct ICD 10 family of codes. There will not be any penalty provisions when using the system and there is specific information as well as a person that will be designated as the ICD 10 ombudsman who will be responsible for triaging physician issues with the implementation of ICD 10.

Agenda Item 5 Presentation on Trauma Informed Care and its Impact on Lifelong Health

Dr. Sciolla, Associate Professor of Clinical Psychiatry, Medical Director of Northgate Point Regional Support team at the University of California at Davis presented two issues; first, why Trauma Informed Care (TIC) is important and second, how to address TIC in terms of physician competence to improve health outcomes of patients with trauma.

Dr. Sciolla stated that his objective was to provide an overview of epidemiologic and neuroscience research on the prevalence of adverse and traumatic experiences across the lifespan and the mechanism underlying their association with poor health outcomes. Also, to propose measurable patient-physician communication attitudes and skills that can enhance health outcomes in patients with trauma histories.

He stated that childhood maltreatment appears to be a risk factor in the history of patients having many different psychiatric outcomes and that it is more difficult to identify a disorder to which childhood maltreatment is not linked, than to identify a disorder to which it is linked. He also stated that childhood maltreatment raises risk for a particular psychiatric disorder because maltreatment exacerbates the ability to experience any disorder at all.

Dr. Sciolla presented a chart that showed over the years how the incident of diabetes increased steadily and that even people with trauma symptoms, but no history of Post-Traumatic Stress Disorder (PTSD) have an increased risk for developing diabetes. The behavioral and health manifestations of trauma are many fold and are not encapsulated only by PTSD and not only by mental health issues, but by physical health issues, also. He stated that the main killers of people in the nation are all related to a history of trauma, especially trauma that happens early in life. There is a hallmark study, the Adverse Childhood Experiences (ACE) Study, that was conducted by Kaiser San Diego. They measured 10 childhood adverse experiences with over 17,000 patients, from zero to ten. The reality is that ACE impacts every person in California and that trauma exposure across the lifespan is prevalent in the general population and all clinical settings. Patients want to be asked about trauma and are not harmed when asked about it; for many patients, disclosure of traumatic experiences is therapeutic in itself. Many patients are unaware that their health problems are linked to ACE.

Dr. Sciolla continued saying that trauma exposure is associated with increased morbidity, premature mortality, treatment-resistant chronic conditions, health risk behaviors, and difficulty trusting healthcare systems and providers. It is also associated with increased sensitivity to power differentials and authority figures, problematic clinical encounters, difficulty engaging in preventive care, and increased physical and behavioral health and co-morbidity, including substance use disorders.

Dr. Sciolla stated that some of the challenges of TIC are that it requires excellent patient-centered communication skills; it may imply changes in certain billing and reimbursement procedures, and it works best when care is collaborative and integrated; and some of the billing practices might need to be modified. Also, the new generation of providers needs to be educated in an inter-professional setting. It also needs to be included in medical school curriculum and assessment of competency.

Opportunities of TIC are that it fits naturally with cultural competence, it is congruent with inter-professional practice, it works synergistically with ACA supported patient-centered medical homes, it takes into account social determinants of health, and it is aligned with the goal of eliminating health disparities.

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 8

Dr. Sciolla spoke about the proposed TIC for physicians and stated that board certified physicians should be able to elicit regularly, histories of exposure to traumatic experiences across the lifespan in patients and caregivers in all clinical settings, and they should be able to adjust interviewing in response to patient's demographics, e.g., sex, age, religious, practices/beliefs, race/ethnicity, socioeconomic status, and sexual orientation or gender identity. He continued with physicians should be able to respond with compassion, normalization and education to a patient's disclosure of traumatic or adverse experiences. They should identify and advocate for resources and refer patients to appropriate psychosocial services in the clinical setting and community in which they work. Also, physicians should determine their patients' strengths, life goals and values that can sustain recovery and healing from trauma and integrate the trauma and resilience information gathered in patient-centered, culturally-responsive treatment plans to enhance health outcomes.

Dr. Krauss asked Dr. Sciolla if he found similar problems with children who witnessed trauma, but are not the recipients of the trauma.

Dr. Sciolla stated that one of the main findings of this research in the neurobiology of stress is that it does not matter what the stress is. The final pathway is a stress response system, in that the system is blind to whether a patient is a recipient or witness of the trauma.

Dr. Krauss asked if in that sense should a physician inquire about the domestic situation and the neighborhood situation in terms of neighborhood violence?

Dr. Sciolla responded affirmatively, and stated one of the limitations of the original ACE study is that the study was conducted mostly in white, middle class neighborhoods with privately insured patients, and they did not consider any other determinants of health, such as community violence. Newer versions of the ACE study are considering those factors.

Ms. Pines asked if Dr. Sciolla sees ACE increasing and if he sees more incidences.

Dr. Sciolla replied that it depends on the location. The data shows that in some locales, because of concentrated poverty in urban settings, there are epidemics of violence. There are also studies that show there are transgenerational transmissions of trauma, for instance with the survivors of the Jewish Holocaust, there are some abnormalities in the stress response system that can happen in generations after, that were not exposed to the actual trauma.

Ms. Pines asked if Dr. Sciolla thought the time frame that a general physician has to see a patient (approximately 15 minutes) is enough time to help them move through that trauma.

Dr. Sciolla stated that this is a challenging question and that physicians need to approach this issue by building a therapeutic alliance, a trusting relationship first, which are the tenants of patient centered care that can lead to improvement and changes in lifestyle when you treat patients with respect and empower them.

Dr. Hawkins commented that in his own practice he has patients that are very difficult to treat and even going through all the levels of evaluation and treatment cannot seem to get there. Then sometime later, six

Education and Wellness Committee
Meeting Minutes July 30, 2015
Page 9

months, sometimes longer, he finds there is an underlying thing, maybe trauma, that has been there all along. Sometimes it seems to take time to get there.

Agenda Item 6 Future Agenda Items

No future agenda items were provided.

Agenda Item 7 Adjournment

Ms. Yaroslavsky adjourned the meeting at 3:15 p.m.

The complete webcast can be viewed at: http://www.mbc.ca.gov/About_Us/Meetings/2015/

DRAFT

Elements of a Successful Physician Health Program

**Medical Board of California
Board Meeting
(Thursday, October 29, 2015)**

Purpose

To discuss what elements are necessary in a Physician Health Program in order for it to be a program that assists physicians with substance abuse problems, while still meeting the Board's mission of consumer protection.

Uniform Standards

ANY Physician Health Program would need to comply with the Uniform Standards for Substance Abusing Physicians (require regulatory changes)

- Background:

- SB 1441 Ridley-Thomas (Chapter 548, Statutes of 2008)
- Created the Substance Abuse Coordination Committee (SACC)
- Required the SACC to formulate uniform and specific standards in specified areas that each healing arts board shall use in dealing with substance-abusing licensees, whether or not a board chooses to have a formal program.

Uniform Standards

Standard 1

Specific requirements for a clinical diagnostic evaluation of the licensee, including, but not limited to, required qualifications for the providers evaluating the licensee.

Uniform Standards

Standard 2

Specific requirements for the temporary removal of the licensee from practice, in order to enable the licensee to undergo the clinical diagnostic evaluation and specific criteria that the licensee must meet before being permitted to return to practice on a full-time or part-time basis.

- Cease practice during the clinical diagnostic evaluation pending the results of the clinical diagnostic evaluation and review by board staff.
- While awaiting the results of the clinical diagnostic evaluation, the licensee shall be randomly drug tested at least two (2) times per week.
- No licensee shall be returned to practice until he or she has at least 30 days of negative drug tests.

Uniform Standards

Standard 3

If the licensee who is either in a board program or whose license is on probation has an employer, the licensee shall provide to the board the names, physical addresses, mailing addresses, and telephone numbers of all employers and supervisors and shall give specific, written consent that the licensee authorizes the board and the employers and supervisors to communicate regarding the licensee's work status, performance, and monitoring.

Uniform Standards

Standard 4

Standards governing all aspects of required testing, including, but not limited to, frequency of testing, method of notice to the licensee.

- A board may order a licensee to drug test at any time.
- Each licensee shall be tested at a minimum range of number of random test are 36-104 per year depending on certain factors.
- There are some exceptions to the testing frequency schedule with certain events occurring.
- Collection of specimens shall be observed.
- Prior to vacation or absence, alternative drug testing location(s) must be approved by the Board.

Uniform Standards

Standard 5

Standards governing all aspects of group meeting attendance requirements, including, but not limited to, required qualifications for group meeting facilitators, frequency of required meeting attendance, and methods of documenting and reporting attendance or nonattendance by licensees.

Standard 6

Standards used in determining whether inpatient, outpatient, or other type of treatment is necessary.

Standard 7

Worksite monitoring requirements and standards, including, but not limited to, required qualifications of worksite monitors, required methods of monitoring by worksite monitors, and required reporting by worksite monitors.

Uniform Standards

Standard 8

Procedures to be followed when a licensee tests positive for a banned substance:

- The board shall order the licensee to cease practice;
- The board shall contact the licensee and instruct the licensee to leave work; and
- The board shall notify the licensee's employer, if any, and worksite monitor, if any, that the licensee may not work.

Standard 9

Procedures to be followed when a licensee is confirmed to have ingested a banned substance.

- When a board confirms that a positive drug test is evidence of use of a prohibited substance, the licensee has committed a major violation as defined and applicable consequences shall be imposed.

Uniform Standards

Standard 10

Specific consequences for major and minor violations. In particular, consider the use of a “deferred prosecution” stipulation described in Section 1000 of the Penal Code, in which the licensee admits to self-abuse of drugs or alcohol and surrenders his or her license. That agreement is deferred by the agency until or unless licensee commits a major violation, in which case it is revived and license is surrendered.

Standard 11

The licensee shall meet the following criteria before submitting a request (petition) to return to full time practice:

- Demonstrated sustained compliance with current recovery program.
- Demonstrated the ability to practice safely as evidenced by current work site reports, evaluations, and any other information relating to the licensee’s substance abuse.
- Negative drug screening reports for at least six (6) months, two (2) positive Worksite monitor reports, and complete compliance with other terms and conditions of the program.

Uniform Standards

Standard 12

The licensee must meet the following criteria to request (petition) for a full and unrestricted license.

- Demonstrated sustained compliance with the terms of the disciplinary order, if applicable.
- Demonstrated successful completion of recovery program, if required.
- Demonstrated a consistent and sustained participation in activities that promote and support their recovery including, but not limited to, ongoing support meetings, therapy, counseling, relapse prevention plan, and community activities.
- Demonstrated that he or she is able to practice safely.
- Continuous sobriety for three (3) to five (5) years.

Uniform Standards

Standard 13

If a board uses a private-sector vendor that provides services, that vendor must have:

- standards for immediate reporting by the vendor to the board of any and all noncompliance with process for providers or contractors that provide services, including, but not limited to, specimen collectors, group meeting facilitators, and worksite monitors;
- standards requiring the vendor to disapprove and discontinue the use of providers or contractors that fail to provide effective or timely services; and
- standards for a licensee's termination from the program and referral to enforcement.

Uniform Standards

Standard 14

If a board uses a private-sector vendor that provides services, the board shall disclose the following information to the public for licensees who are participating in a board monitoring program regardless of whether the licensee is a self-referral or a board referral. However, the disclosure shall not contain information that the restrictions are a result of the licensee's participation in a program.

- Licensee's name;
- Whether the licensee's practice is restricted, or the license is on inactive status;
- A detailed description of any restriction imposed.

Uniform Standards

Standard 15

If a board uses a private-sector vendor that provides services, an external independent audit must be:

- conducted at least once every three (3) years
- by a qualified, independent reviewer or review team from outside the department with no real or apparent conflict of interest with the vendor providing the monitoring services.

In addition, the reviewer shall not be a part of or under the control of the board. The independent reviewer or review team must consist of individuals who are competent in the professional practice of internal auditing and assessment processes and qualified to perform audits of monitoring programs.

Uniform Standards

Standard 16

There must be measurable criteria and standards to determine whether each board's method of dealing with substance-abusing licensees protects patients from harm and is effective in assisting its licensees in recovering from substance abuse in the long term.

The board shall use the following criteria to determine if protecting patients from harm and is effective in assisting in recovery.

- All licensees who either entered a program or whose license was placed on probation as a result of a substance abuse problem successfully completed either the program or the probation, or had their license to practice revoked, surrendered, or placed on probation in a timely basis based on noncompliance with those programs.
- At least 75 percent of licensees who successfully completed a program or probation did not have any substantiated complaints related to substance abuse for at least five (5) years after completion.

Board Staff Recommendations

- Program should not reside within the Board.
- Program should be run by a private/contracted non-profit entity.
- Adequate protocols for the Program's communication with the Board.
- Regularly scheduled meetings with the Board.
- Allows both self-referrals and probationers to participate.
- Report to the Board any physician who is terminated from the program, for any reason.
- No diversion – if a complaint/report is received, enforcement process will be followed.

Board Staff Recommendations

- Clear and regular communication to the Board on the status of probationers in the Program.
- Participant to share in cost of administering the Program.
- If the required audit finds the Program is not in compliance, there must be repercussions.
- Sufficient resources to perform clinical roles and case management roles, with sufficient expertise and experience (50 physicians per case manager).
- Should only be provided for substance-abusing licensees.
- Strict documentation of monitoring is necessary.

Consumers Group

Recommendations/Concerns

- Is there a need for a program, as there are numerous private entities already within California who provide treatment/monitoring services?
- An analysis needs to be completed to determine if there is a need for a Program.
- Is such a Program a “penalty” for physicians? If a physician was in a private program, he/she would not be reported to the Board for termination, no matter what the reason. Therefore why would individuals go into the Program?
- No need for the Board to be engaged in such a Program (especially in light of the recent adoption of the Uniform Standards and inherent conflict between consumer protection and confidentiality).

Consumers Group

Recommendations/Concerns

- Concept: a) Board involvement would be limited to placing Probationers into a Program; b) criteria and standards would be set for Programs; c) a list would be established of entities that met these standards for all self-referrals (outside of the Board's involvement).
- No confidentiality.
- Any non-compliant participants must be reported to the Board immediately and removed from practice.
- Two-strike policy: entering the Program constitutes one strike; strike two (non-compliance) would result in termination from the Program.
- Any new program cannot be controlled by the same program, organizations or individuals that were connected to the old diversion program.

Consumers Group

Recommendations/Concerns

- California Medical Association should not be eligible to contract for services.
- Audits must include checking the records to ensure all violations are being reported to the Board.
- If an audit identifies issues with the Program, the contract should cease immediately.
- Mandatory practice cessation period for participants upon entry of the Program.
- Under certain circumstances, termination from the Program should trigger revocation of the license.
- A complete financial analysis of revenue and amount of funding needed for each aspect of a Program should be completed prior to a Program being initiated.

Physicians Group Recommendations

- Education and promotion of awareness of the Program, with information for hospitals, training programs, medical groups, etc., about how to identify potential impairment, services available, policies and procedures, what to expect from the program, how to contact it, how to enter it, how to refer to it, how to use it.
- Consultation and intervention services (receive and respond to inquiry calls, give advice, provide assistance with intervention, etc.).

Physicians Group Recommendations

- Documentation of monitoring: documentation of compliance with requirements, documentation of status in recovery, documentation of health status, with reporting to appropriate agencies (groups, hospitals, regulatory board).
- Adequate stable funding – funding primarily from license fees, with additional funds from other sources such as fees from participants, fees from educational or other services, fundraising, etc.
- Sufficient number of staff in both clinical and administrative roles who have sufficient expertise and experience with treating physicians as patients to run the program effectively and in the way that meets the standards.

Physicians Group Recommendations

- Ongoing quality assurance - internal audit process integrated into the functioning of the Program.
- Compliance with standards of the Federation of State Physician Health Programs, where applicable.
- To promote the earliest possible referral, option for a self-referral track where participants can enter without having their identity made public and where medical/clinical oversight determines Program in line with the clinical standards and the protection of the public.
- Immunity from liability for those who function for the Program.

“Verify a License” Campaign Outreach Plan

Goal: To reach as many patients in California as possible to make them aware of the Medical Board of California (Board) and the ability to verify a physician’s license on the Board’s website. This will allow patients to ensure a physician is licensed and in good standing with the Board and to view the physician’s full licensure history.

Benchmark: The Board will measure the success of this campaign by the number of hits to the Board’s physician profiles.

Situational Analysis: The assumption is that most Californians are not aware of the Medical Board and have no knowledge of the information available to them about their physician.

Target Audience: Every patient in California. The Board should target patients before and at the time when they are accessing healthcare services, e.g. at the pharmacy, in the physician’s office, at health care events, giving blood, etc. Target groups are parents, seniors, students, teachers, ethnic groups, communities, Legislators, general consumers in California.

Call to Action: Before any patient obtains healthcare services they need to know to go to the Board’s website and verify the physician’s license.

Challenges: The Board has limited financial resources to spend on outreach and must have approval from the Department of Consumer Affairs and other oversight agencies in order to obtain services for outreach, e.g. billboards, PSA airing, etc. In addition, the Governor’s Office has an Executive Order that does not allow employees to incur significant travel expenses (such as flights) for outreach events. Therefore, the Board must have staff in those areas to provide outreach or attend the events around other approved Board events, such as a Board Meeting.

Strategies: The Board has two strategies to implement this campaign: 1) Current and ongoing event participation and outreach; and 2) Partner with numerous organizations with the end goal being to focus on the month of March as the Board’s “Verify a Physician’s License” month.

Tactics: In order to reach the above two strategies the Board will perform the following tasks.

- 1) Current and ongoing events: The Board will identify outreach opportunities throughout the State to attend. These events include Legislative Member town halls, walks and fairs related to healthcare, information disseminated at malls, etc. At these events, Board staff and Members will have the ability to hand out brochures, discuss the Board’s functions, and walk patients through looking up their physician on the Board’s website (computers will be available). In addition, the Board will seek to provide literature (brochures and posters) and articles to entities who provide healthcare services and related entities (pharmacies, Bloodsource, gyms, etc.) for posting and dissemination.
- 2) March Focus: The Board will develop a plan of action, which will include contacting organizations that have the ability to reach a wide audience of patients throughout California with the intent of having this month be a focused effort to inform patients of the Medical Board’s website. The concentration of this plan will be to inundate the market

across multiple venues that all target patients throughout California with information about the Medical Board.

Proposed outreach includes:

- ✓ Develop a PSA that can be provided to entities to air
- ✓ Develop a tutorial for the website on how to lookup a physician's license and what the information means on the website
- ✓ Billboards/jumbotrons at sporting events and located near freeways
- ✓ Ads on mass transit throughout the states
- ✓ Information about the Board on store coupons and receipts throughout the state
- ✓ Information about the Board on utility bills throughout the state
- ✓ State employee paystubs
- ✓ Working with the AARP to provide information at a statewide teleconference
- ✓ Ads in community newspapers and school publications
- ✓ Provide information to Teachers Associations
- ✓ Commercials on Facebook, Google, Pandora, YouTube, Twitter
- ✓ Provide an interview and the PSA to iHeart Radio
- ✓ PSA to run on Sirius XM radio
- ✓ Interview/PSA on NPR and Capitol Public Radio
- ✓ Provide a TEDx talk
- ✓ Work with other DCA regulatory boards to explore ways to leverage community health workers to assist in the outreach campaign
- ✓ Air PSA on three television markets
- ✓ Invite third party commentaries who have established relationships with target groups who can speak to the importance of checking a physician's license. Use social media to get these commentaries posted.
- ✓ Contact the Governor's Office to seek interest/support with a quote and a link on the Board's home page in March
- ✓ Seek a Legislative Resolution to proclaim March as "Verify a Physician's License" month
- ✓ Issue a Press Release on the month
- ✓ Encourage Legislative Members to Tweet the Board's link and post the link on their websites about the Board
- ✓ Hold a Legislative Day at the Capitol where Board staff passes out brochures and Members meet with key Legislators
- ✓ Invite media to all events held during the month of March and provide them with information on the campaign
- ✓ In March on one day, host a two to six hour satellite radio tour (hit ethnic communities as well). This is where Board staff, Members, and others speak for 2 to 5 minutes on as many radio shows as possible to let patients know how to look up their physician and the importance of making informed decisions.
- ✓ In March, host a 15 to 30 minute virtual health Bloggers press conference

Resources: The Board will need staff time to attend events (this will include public affairs staff as well as other programs within the Board); Board Member time; funding for any ads/air time/billboards;

Work Plan: Attached

Month	Activity to Implement	Deadline	Responsible Party	Status
October 2015	<ul style="list-style-type: none"> - Develop and print "Verify a License" brochures - Meet with Pandora on advertising - Attend Mall Outreach and Education in Sacramento - Attend Mall Outreach and Education in San Diego - Tweet Mall appearances, begin Twitter campaign - Reach out to San Diego Media about Campaign - Order Posters from DCA - Contact all health care events in November for potential attendance 	<ul style="list-style-type: none"> - October 9, 2015 - October 15, 2015 - October 23-24, 2015 - October 28-30, 2015 - October 23, 2015 - October 21, 2015 - October 12, 2015 - October 31, 2015 	<ul style="list-style-type: none"> - C. Hockenson - C. Hockenson - Board staff - Board staff - ISB - C. Hockenson - C. Hockenson - C. Hockenson 	<ul style="list-style-type: none"> Completed Pending Pending Pending Pending Pending Completed Pending
November 2015	<ul style="list-style-type: none"> - Golden Future 50+ event at Angel Stadium - Attend Mall Outreach and Education in Roseville - Attend Mall Outreach and Education in Santa Clara - Begin work on "How to Verify a License" tutorial - Begin work on PSA - Contact healthcare services and related entities to display Board poster and brochures - Develop content for school districts online parent newsletter and contact school districts - Contact all health care events in December for potential attendance 	<ul style="list-style-type: none"> - November 7, 2015 - November 14, 2015 - November 30, 2015 	<ul style="list-style-type: none"> - Board staff - Board staff - Board staff - C. Hockenson - C. Hockenson - C. Hockenson - C. Hockenson 	<ul style="list-style-type: none"> Pending
December 2015	<ul style="list-style-type: none"> - Contact mass transit for signage and display - Contact utility companies to place Board information on bills in March - Contact retail associations to place Board information on store receipts/coupons in March - Contact State Controller's Office to place Board information on employee pay stubs in March - Research cost of billboards for March - Determine feasibility of procuring jumbotrons for sports events - Finalize the tutorial and post on Board website - Contact all health care events in January for potential attendance - Host an interested parties meeting, that will be teleconferenced, with patient advocates to get their input on best practices for educating patients on the Board's outreach campaign. 	<ul style="list-style-type: none"> - December 31, 2015 	<ul style="list-style-type: none"> - C. Hockenson 	<ul style="list-style-type: none"> Pending

<p>January 2016</p>	<ul style="list-style-type: none"> - Contact Ted Talk to determine if Board talk is possible - Work on securing an author for Legislative resolution declaring March "Verify a Physician's License" month - Begin contract process to air PSA in March - Contact all health care events in February for potential attendance 	<ul style="list-style-type: none"> - January 31, 2016 - January 31, 2016 - January 31, 2016 - January 31, 2016 	<ul style="list-style-type: none"> - C. Hockenson - J. Simoes - C. Hockenson - C. Hockenson 	<p>Pending</p>
<p>February 2016</p>	<ul style="list-style-type: none"> - Contact iHeart to schedule an interview on the "PSA Show" - Set Date for Board Members to visit Legislative Members in March and begin scheduling meetings with legislators and secure booth for outside of Capitol - Finalize the PSA - Contact radio stations about airing PSA in March - Contact NPR and Capitol Radio about an interview and airing PSA in March - Contact all health care events in March for potential attendance 	<ul style="list-style-type: none"> - February 29, 2016 	<ul style="list-style-type: none"> - C. Hockenson - J. Simoes - C. Hockenson - C. Hockenson - C. Hockenson 	<p>Pending</p>
<p>March 2016</p>	<ul style="list-style-type: none"> - Confirm all events/ads/interviews are on target for dissemination, publication, and airing - Confirm appointments with Legislative Staff - Contact media outlets to provide press release and seek coverage of events, including the Board's Legislative Day - Attend Legislative Day, including board staff at booth - Attend identified outreach events and interviews - Contact all health care events in April for potential attendance 	<ul style="list-style-type: none"> - March 5, 2016 - March 5, 2016 - March 5, 2016 - March 10-20, 2016 - March 31. 2016 - March 31, 2016 	<ul style="list-style-type: none"> - C. Hockenson 	<p>Pending</p>
<p>April 2016 and ongoing</p>	<ul style="list-style-type: none"> - Contact all health care events in May for potential attendance - Prepare for March 2017 in same manner as above 	<ul style="list-style-type: none"> - April 30, 2016 	<ul style="list-style-type: none"> - C. Hockenson 	



MEDICAL BOARD OF CALIFORNIA



ENFORCEMENT COMMITTEE MEETING AGENDA

COMMITTEE MEMBERS

Felix Yip, M.D., Chair
Michelle Bholat, M.D.
Howard Krauss, M.D.
Barbara Yaroslavsky

The Westin San Diego
400 West Broadway
San Diego, CA 92101
(619) 239-4500 (Directions Only)

Thursday, October 29, 2015
3:00 p.m. – 4:00 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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

If a quorum of the Board is present, Members of the Board who are not Members of the Committee may attend only as observers.

1. Call to Order / Roll Call
2. Public Comment on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125 and 11125.7(a)]
3. Approval of Minutes from January 29, 2015 Meeting
4. Presentation and Discussion on Utilization Review and Possible Action on Recommendations – Ms. Webb
5. Update on Demographic Study – Ms. Robinson
6. Enforcement Program Update – Ms. Delp
7. Update Regarding Meeting with the Office of Administrative Hearings – Ms. Kirchmeyer and Ms. Delp
8. Update Regarding Expert Reviewer Training – Ms. Delp
9. Update Regarding Psychotropic Medications being Prescribed to Children in Foster Care – Ms. Delp
10. Future Agenda Items
11. Adjournment

Meeting Information

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

The call-in number for teleconference comments is: (888) 220-8450

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 – 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.

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 Committee, but the Chair may apportion available time among those who wish to speak.

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

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



MEDICAL BOARD OF CALIFORNIA



ENFORCEMENT COMMITTEE MEETING

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

Thursday, January 29, 2015
2:00 pm – 3:00 pm

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Enforcement Committee (Committee) of the Medical Board of California (Board) was called to order by Dr. Lewis, Chair. With due notice having been mailed to all interested parties, the meeting was called to order at 2:00 p.m.

Members Present:

Ronald Lewis, M.D., Chair
Howard Krauss, M.D.
David Serrano Sewell, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:

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

Staff Present:

Liz Amaral, Deputy Director
Nichole Bowles, Staff Services Analyst
Erika Calderon, Associate Government Program Analyst
Ramona Carrasco, Staff Services Manager I
Charlotte Clark, Staff Information System Analyst
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dev GnanaDev, M.D., Board Member
Rashya Henderson, Special Investigator Supervisor
Cassandra Hockenson, Public Information Officer II
Kimberly Kirchmeyer, Executive Director
Nicole Kraemer, Staff Services Manager I
Sharon Levine, M.D., Board Member
Ian McGlone, Associate Government Program Analyst
Armando Melendez, Business Services Officer
Dino Pierni, Business Services Officer

Enforcement Committee Meeting Minutes**January 29, 2015****Page 2**

Denise Pines, Board Member
 Regina Rao, Associate Government Program Analyst
 Paulette Romero, Staff Services Manager II
 Kevin Schunke, Staff Services Manager I
 Jennifer Simoes, Chief of Legislation
 Lisa Toof, Administrative Assistant II
 Kerrie Webb, Staff Counsel
 Susan Wolbarst, Public Information Officer
 Christopher Wong, Associate Government Program Analyst
 Curt Worden, Chief of Licensing

Members of the Audience:

Lee Adamson, Supervising Investigator, Health Quality Investigation Unit
 Teresa Anderson, California Academy Physician Assistant
 Connie Broussard, Senior Deputy Attorney General, Department of Justice
 Gloria Castro, Senior Assistant Attorney General, Department of Justice
 Yvonne Choong, California Medical Association
 Zennie Coughlin, Kaiser
 Julie D'Angelo Fellmeth, Center for Public Interest Law
 Karen Ehrlich, L.M., Midwifery Advisory Council
 Stephen Ellis, M.D.
 Carlyne Evans, Deputy Attorney General, Department of Justice
 Michael Gomez, Deputy Director, Department of Consumer Affairs
 Bridget Gramme, Center of Public Interest Law
 Marian Hollingworth, Consumers Union Safe Patient Project
 Sarah Huchel, Assembly Business & Professions Committee
 Christine Lally, Deputy Director, Department of Consumer Affairs
 Mark Loomis, Supervising Investigator, Health Quality Investigation Unit
 Leslie Lopez, Deputy Director, Business, Consumer Services and Housing Agency
 Roberto Moya, Investigator, Health Quality Investigation Unit
 Bryce Penney, Department of Consumer Affairs
 Patrick Rogers, California Research Bureau
 Brian Sala, California Research Bureau
 Anita Scuri, Department of Consumer Affairs
 Laura Sweet, Deputy Chief, Health Quality Investigative Unit

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were provided.

Agenda Item 3 Approval of Minutes from October 23, 2014 Meeting

*Ms. Yaroslavsky made a motion to approve the minutes from the October 23, 2014 meeting;
 s/Dr. Krauss. Motion carried.*

Enforcement Committee Meeting Minutes**January 29, 2015****Page 3****Agenda Item 4 Update on the Investigative Process at the Department of Consumer Affairs**

Ms. Sweet stated that Investigators at the Health Quality Investigative Unit (HQIU) continue to work on the joint Vertical Enforcement (VE) Manual. She continued with commending the participation of Ms. Scuri, retired annuitant and former legal counsel, who has attended every meeting and allowed her expertise, knowledge and demeanor to affect the nature of the meetings.

Ms. Sweet pointed out that once the whole draft is finished it needs to follow the chain of command and will be sent to the Attorney General's Office (AGO) for adoption as the protocol.

Ms. Sweet wanted the committee to understand that the purpose in all of the manuals has been to set forth the procedures by which the investigations will be directed by the assigned Deputy Attorney Generals (DAGs) and will entail the legal review and provision of legal advice in investigations. Specifically, the manual will cover other important aspects of efficiencies that have been offered by the Department of Consumer Affairs (DCA), some of which already were in the July 2014 VE Manual.

Mr. Gomez stated that he wanted to speak about the VE Manual and the progress that the DCA and the AGO have made regarding the creation of the new VE Manual. He stated that the draft represents a collaborative effort and the participation of the DAGs. The investigative interview is the one outstanding component that needs to be agreed upon in the draft.

Mr. Gomez wanted to briefly explain the most important differences between this protocol and the current Third Edition of the VE Manual, stating that at the onset, the DCA believed the previous versions of the manual have served their purpose.

Mr. Gomez continued by stating that the primary goal was to create a product that reduced delays in the enforcement process and increased accountability, thereby, enhancing consumer protection in California. The secondary goal was to create a product that eliminated the confusion caused by the significant redundancies in the Third Edition, create greater clarity in the organizational product chronologically, make it more user friendly, and to have a neutral tone. This product allows the user to find all the information on one topic in one area and it recognizes that both the investigators and DAGs are trained professionals with separate areas of expertise that should be recognized and respected by each other. In addition, working with the AGO on the manual, DCA has been communicating with Ms. Castro on a regular basis to address current process issues and to ensure that enforcement cases continue progressing in the most efficient and effective manner possible in the absence of a joint manual.

Mr. Gomez continued by stating that HQIU is currently in discussion with the AGO on the creation of an IT cloud that would allow documents and evidence in joint case work to be conveniently available. He noted that Ms. Sweet is working with the AGO to assist in the IT cloud development.

Mr. Gomez provided information on staffing, caseloads and case aging. He stated that there has been no significant change in case handling at this stage and that cases that are being proposed for closure

Enforcement Committee Meeting Minutes**January 29, 2015****Page 4**

or transmittal are sent electronically to Ms. Kirchmeyer for approval. As of this report, there are 17 vacant sworn positions. There are candidates in background to fill at least six of those vacancies. There is heavy competition with other agencies who offer different pay and benefits.

Mr. Gomez continued, stating that several of the Southern California offices are having difficulty recruiting medical consultants. Commander Kathleen Nichols is going to send letters to experts and place articles in newsletters in the San Bernardino, Rancho Cucamonga, and San Diego areas to encourage interested individuals to apply for these positions. Alternative work schedules and more training opportunities in terms of leadership development and management have been offered to the investigators to offset some of the recruitment problems.

Ms. Sweet stated there continues to be a few challenges extracting complete and accurate data from BreZE, but significant improvement is being made. She said that BreZE is not yet able to calculate the time between when a case is closed and when it is reopened and there is also a problem calculating cases that have been reassigned. The BreZE team is aware, and the programmers anticipate a resolution by April 2015.

Ms. Sweet presented the charts in her presentation that explained case timelines, annual productivity and pitfalls, stating that an unintended consequence could be that the average time it takes to close a case in the field office could potentially rise. The cases the investigators are working on are the most difficult and complicated cases. There have been 62 fewer cases closed, 14 fewer cases referred for citation and fine, 50 fewer cases referred to the AGO, and 15 more cases referred for criminal action. VE has presented its own unique challenges, in addition to challenges with the transition. Staff also had to adapt to a different computer system and has not been able to get the usual information to track case progress. The data that is manually extracted, has not been vetted and has not been verified. This information has been maintained in the district offices to track progress.

Ms. Sweet continued talking about the Aged Case Council that was instituted to troubleshoot cases that seem to be languishing. The first demarcation line was cases over 700 days old, but throughout the years, because of the elimination of these old cases, the threshold keeps coming down. The number of days is now 550 when a case comes to the attention of management and to the council.

Ms. Sweet stated that these are the cases that the Medical Board of California (Board) has reviewed in the past. Looking at cases that are 550 days old, there has been improvement. The cases over 550 days have been lowered from January 2014, to January 2015 have been reduced by two. Cases over one year old have seen little improvement, but nothing significant. She provided data by district office. In the offices where there has been stable supervision and staffing, the case aging is generally lower.

She stated the transition has been a great opportunity to review policies and procedures. In the midst of that project there is hope to yield some suggestions for operational efficiencies that have not been considered. Lastly, in a renewed effort to focus attention on the case-aging issue, staff were challenged to reduce cases over 365 days by 20 percent between November 1 and December 31, 2014, with a contest. Six offices were successful, and the contest was reinstated to encourage staff to reduce cases over 365 days by 25 percent by April 1, 2015.

Enforcement Committee Meeting Minutes**January 29, 2015****Page 5**

Ms. Sweet spoke on the significant successes in the criminal arena during the past quarter. A former physician, who surrendered his license, was recently convicted for involuntary manslaughter and is awaiting sentencing. This case was handled by Supervising Investigator Julie Escat from the Valencia office. She stated the former doctor used a combination of lidocaine, fentanyl, oxycodone, and other drugs in a liposuction procedure that lasted more than 14 hours. The cause of death was multiple drug toxicity. The procedure was performed in an unaccredited surgery center, and the physician had no licensed assistants, and no lifesaving equipment in the office. Sentencing is pending.

Ms. Sweet added that in a case managed out of the Glendale Field Office by Investigator Ken Buscarino, a physician was sentenced to prison for prescribing narcotics without a legitimate medical need. He was ordered to spend two years in jail after originally being sentenced to a total of seven years in prison.

The efforts of Investigator Brian Ansay in the Fresno Field Office, who worked as part of a multi-agency taskforce, led to a physician pleading guilty to federal charges for the distribution and dispensing of oxycodone. He was sentenced to almost five years in federal prison.

Ms. Sweet stated the efforts of Larry Bennett in the San Dimas office led to a physician being convicted of distribution of hydrocodone, alprazolam, carisoprodol, promethazine, and money laundering. He was sentenced to over five years in federal prison. There have been quite a few successes, fighting prescription drug abuse.

Ms. Sweet continued, stating the HQIU remains within its budget and on course to do so. However, due to several retirements and some significant payouts, it is a little tighter than anticipated, but not problematic. It means close attention is being paid to the budget and that asset forfeiture monies are being utilizing for training for the HQIU staff.

Ms. Sweet concluded her report by commending the investigative staff for their ability to keep the work moving.

Dr. Lewis praised Ms. Sweet for the progress made and the transitions and improvements that have occurred.

Ms. Castro stated that she wanted to cover a couple of points on operational issues, training, the aspect of criminal cases, conviction case monitoring, and finally the IT cloud. The July 2014 VE Manual is becoming more akin to an operational manual that directs staff and implements what the AGO sees as the directing authority over this program and the provision of legal advice. Staff continues to operate in a transitional period where HQIU is actively interfacing with the AG on a daily basis, and currently, the number of pending investigations is about 1,100. Staff continues to inform HQIU of the best way to present cases to the AGO, such that transition, transmittal guidelines and other operational communications are robust from Mr. Gomez and Ms. Sweet.

Staff continues to work on the transfer of knowledge, techniques, and history between agencies. It is always with the joint goal of protection of the public through high-quality and efficient joint investigations. She stated she and Mr. Gomez continue to discuss ideas for joint training for both

Enforcement Committee Meeting Minutes**January 29, 2015****Page 6**

agencies to improve the quality of investigations. They take very seriously that the VE statutes actually require joint training, so staff will continue to talk about those ideas.

Ms. Castro stated AGO staff continues to follow the July 2014 manual, which already implemented some efficiencies that make it into the joint manual protocol.

There is one major change regarding criminal cases that HQIU will be instituting. The increase in the number of criminal referrals by HQIU. The criminal referrals are sent for consideration to the Deputy Attorney's Office. Ms. Castro stated the AGO is going to start tracking criminal cases more closely after the conclusion of Penal Code Section 23, bail restrictions, specifically due to statutes of limitations issues. In order to be helpful in that regard, those cases will be monitored through lead prosecutors. HQIU has increased the identification of disciplinary matters as criminal cases, and referring cases to the DA's Office.

Ms. Kirchmeyer let the committee know that since removal of the Chief of Enforcement, she has been reviewing the cases.

Ms. Kirchmeyer also stated regarding the budget, the new Deputy Director will be looking at the budget with staff and making sure that the appropriate charges are going to the Board and the HQIU.

Dr. Lewis thanked the presenters and asked for questions from the committee.

Ms. Yaroslavsky asked how the problems in hiring are affecting the caseload, the case closures and the case process times.

Ms. Sweet responded stating that the primary disadvantage is that cases get reassigned causes a loss of continuity and an increase in case aging, and can also increase the caseloads.

Ms. Yaroslavsky asked if cases being closed and reopened changes the bottom line and wanted to know if this is actually manipulating data.

Ms. Sweet replied, stating that there are all types of scenarios. One scenario might be where a case has been closed because there is insufficient evidence to proceed. For example, there is a case where it is a simple departure from the standard of care and the case cannot be acted upon so it is set aside; it's maintained for a period of time. Then there is another complaint with a simple departure from the standard of care, those two cases are combined and the case then moves forward through the disciplinary process. That is not manipulating the data.

Ms. Yaroslavsky reminded the committee about the possibility of taking the numbers as a congruent number out of the statistics as a whole, so that there is a real understanding of how long cases are taking.

Ms. Sweet replied that cases are being closed and not accruing time, but BreZE has not yet learned how to extract that time. The prior system is being used to accomplish this. The BreZE system does not know how to recognize that closure and reopen code, so it computes all that time.

Enforcement Committee Meeting Minutes**January 29, 2015****Page 7**

Ms. Yaroslavsky asked when can the Board expect that BreZE is going to be able to deliver statistics that are timely. Ms. Sweet stated that she had been advised the reports would be available April 2015.

Mr. Gomez added that this close/open-reassignment issue has been one of the focal points in the last rendition of fixes and that staff said it would be corrected by April of this year and at that point the right data points will be counted.

Ms. Yaroslavsky asked if there will be an opportunity to have joint efforts, so that simultaneously there is no time lost.

Ms. Castro responded that if a case is criminal and is under consideration by a DA's office, neither HQUI nor the AGO can make the case proceed faster. She added, they want to operate in a collaborative capacity with our law enforcement partners, but would be proceeding with a parallel investigation.

Ms. Castro stated that a placeholder accusation can always be put in place. This does not jeopardize the criminal case, but puts the public on notice that there is something being filed. If the doctor decides to try his administrative case first, it may have an effect on the criminal case.

Agenda Item 5 Update and consideration of Recommendations from the Marijuana task Force

Dr. Lewis stated that after discussion at the last meeting, regarding changes to the Board's marijuana statement, several members had concerns about removing the requirement for an in-person examination. Therefore, at the full Board meeting, it was determined that a task force of two members would be established to discuss this issue. Mr. Serrano Sewell identified the Chair of the Enforcement Committee, Dr. Lewis, and the Licensing Committee, Dr. Bishop to this task force.

On December 12, 2014, Dr. Lewis and Dr. Bishop met with Board staff in Sacramento to review the Board's current laws, the current marijuana statement, the precedential decision the Board had adopted on this issue and in addition, they reviewed new legislation that had been introduced on this issue on December 1, 2014.

The task force fully reviewed the laws pertaining to an appropriate examination and also reviewed the telehealth laws. Based on discussion and review, there are recommendations that the Committee needs to review and approve, so it can move to the full Board for an approval. The first recommendation is to amend the Board's marijuana statement to address the telehealth issue. Based upon the Task Force review, the law authorizes the initial examination to be performed by telehealth. However, the standard of care must be followed, as do the requirements in Business and Professions Code Section 2290.5, which is the telehealth law. In the section of the marijuana statement on important points to consider when recommending marijuana for medical purposes, the task force recommends the following additional statement: "Telehealth, in compliance with the Business and Professions Code Section 2290.5, is a tool in the practice of medicine and does not change the standard of care."

Enforcement Committee Meeting Minutes**January 29, 2015****Page 8**

The Task Force thought it was important to point this out and draw attention to it, so if a physician expert were to review a physician's care and treatment when recommending marijuana for medical purposes, it must meet the standard of care, whether telehealth is used or not.

Ms. Yaroslavsky made a motion to approve this additional statement and to recommend this change to the full /board for approval; s/Dr. Yip.

Dr. Ellis, a cannabis physician from San Francisco, stated that he has been recommending marijuana for about 15 years and that he has greater than 10,000 patients. Average patient is 49 years old, and seventy-two percent are male.

Dr. Ellis said he believes the idea of opening up to allow telehealth, or telemedicine, for cannabis recommendations will be a disaster. He recommended that the committee state in the case of marijuana recommendations, the standard of care requires an in-person evaluation, for the initial visit at least.

Motion passed.

Dr. Lewis continued with the second recommendation from the Task Force. They determined it was necessary to amend Business and Profession Code Section 2242 to state, "a recommendation for marijuana must have an appropriate prior examination." Currently, this section of law states in part, "Prescribing, dispensing, or furnishing dangerous drugs as defined in Section 4022 without an appropriate prior examination and a medical indication constitutes unprofessional conduct." In the precedential decision the Task Force reviewed, it stated that a recommendation is not a prescription. Therefore, the Court did not find a violation of Section 2242. The Task Force recommends a modification to Section 2242 to require an appropriate examination prior to recommending marijuana. During a review of the new legislation, it was found that this amendment is currently in Assembly Bill (AB) 26.

Dr. Lewis stated the Task Force recommendation is to have staff continue to meet with the bill's author's office and to be sure that they are aware of how important this amendment is to the law. The recommendation is also to have staff monitor this bill throughout the legislative process. If the legislation does not move through this year, then the recommendation would be to put this amendment forward as a Board-sponsored legislative proposal for 2016. At this time, the Task Force would ask to continue this discussion to tomorrow's legislative agenda item when the Board will be taking a position on AB 26.

Ms. Yaroslavsky made a motion to recommend to the full Foard that Section 2242 be amended either via AB 26 or via Board legislation; s/Dr. Krauss. Motion carried.

Dr. Lewis stated, lastly, the Task Force recommends watching both AB 26 and AB 34. AB 34 is currently a spot bill. AB 26 changes the law to require an in-person examination for any recommendation for marijuana. If this legislation passes, staff will need to amend the Board's marijuana statement to comply with the new statutory requirements. Therefore, the Task Force is recommending waiting until this legislative year is complete before any changes are made.

Enforcement Committee Meeting Minutes**January 29, 2015****Page 9**

Dr. Lewis asked if there were any additional questions from members of the committee.

Dr. Krauss said while it is not the Enforcement Committee that determines Board policy, he still has concerns about telehealth being utilized for this purpose, and looks forward to the Board establishing policy on that matter.

Agenda Item 6 Update and Consideration of Next Steps Regarding the Disciplinary Action Demographics Study

Ms. Kirchmeyer stated that previously an issue of disciplinary demographics came before the Board and the Board asked that the statistics be reviewed again and they were presented in October. Based on the comments that were received at the last meeting, once those statistics were presented, the Members directed staff to go back and research a potential third-party organization that could analyze the data that was provided. One of the organizations mentioned was the Office of Health Equity, (OHE) which is under the Department of Public Health.

Ms. Simoes stated she spoke to OHE regarding their role and based upon their response decided to move in a different direction. Ms. Simoes stated that she did contact the California Department of Public Health's OHE, she found out that when recommendations come from the community they are forwarded to the Director of the Department of Public Health where policy changes could be made. She stated that when she explained what the Board was looking at doing, OHE said that they do not have the staff to do a statistical kind of review. They also said that they are very interested in collaborating with the Board on this project but it does not fall in line with the mission of the OHE.

Ms. Kirchmeyer stated that once she and Ms. Simoes received the previous information they discussed other entities that have done studies for state organizations and agencies such as the California Research Bureau (CRB). She stated the CRB is required by law to assist with state studies. Ms. Kirchmeyer then introduced Brian Sala and Patrick Rogers from the CRB. She asked Mr. Sala to give the Board a short update on the duties of the CRB. She also asked the Board to authorize staff to do a memorandum of understanding (MOU) with the CRB to be the third-party entity to gather the data that the Board has regarding this issue, interview the individuals who have come forward on this issue, and prepare a report after their research. Ms. Kirchmeyer also asked the Committee to authorize Dr. Krauss to look at the methodology behind the study working with the CRB.

Mr. Sala introduced himself as the acting Director of the CRB which is a division of the California State Library. He stated that the CRB was created in 1991 to provide independent, nonpartisan policy research and reference services for the Legislature, the Governor's Office, and other executive branch entities. He continued stating the CRB is a central services agency and is funded through the general fund and the central services cost recovery fund.

Mr. Sala reminded the Committee that the CRB conducted an analysis of the Medical Board's enforcement activities and disclosure policies in 2008 at the direction of the Legislature and that the project required the Board to provide CRB with full access to its confidential licensing and disciplinary data. Mr. Sala stated that if CRB were to take on this project they would need full access to the confidential data, both the survey data and the licensing and disciplinary data in order to develop a clear understanding of the statistical properties of that data as related to the questions of interest.

Enforcement Committee Meeting Minutes**January 29, 2015****Page 10**

This would require an MOU or an Interagency Agreement (IA) between the Board and the State Library.

The CRB does not have an exemption on the Public Records Act. It would be necessary that confidentiality is addressed in the MOU. Mr. Sala emphasized that CRB services are provided under the understanding that CRB retains full editorial control and independence. CRB works for its clients, but all conclusions belong to CRB. CRB takes direction from the client on the nature of the product, but retains full control over the actual analysis and delivery of that product.

Ms. Kirchmeyer stated that she had mentioned the CRB to the Governor's Office and they were supportive.

Dr. Lewis asked, who owns the data, who has access to it, and what can the Board do with the data when there is a third party performing statistical analysis and/or collecting the data.

Mr. Sala replied, in the prior project relating to Board data, the statute specified that CRB would have full access to the confidential data, and the same confidentiality restrictions on the data will be applied. All the necessary protections for the data are put in place. The only data that is presented publicly, is in aggregate form making sure that the potential for revelation of identifiable information about any individual licensee is treated very carefully.

Ms. Kirchmeyer commented that it would be the Board's data that they would actually be analyzing.

Dr. Krauss stated that it is important to also look ahead as to the distribution of the report, because it should be reported first and only to the Board, and to allow the Board to be the releasing organization of the analysis, so it is not viewed by the public as something that the Board may not have solicited, then released to the public.

Dr. Sala stated this is a matter for specification in the MOU. CRB is pleased to work with the Board to specify the format it would prefer for public release.

Dr. Sala noted the key point that CRB wants to make regarding their work is that CRB has expectations of retaining full editorial control over content, and that is the assurance that CRB wants to give to the Board's interested parties. He added stating the Board is receiving CRB's unbiased best analysis.

Mr. Serrano Sewell recommended CRB work with Ms. Kirchmeyer in release of the report in a way that is open and transparent but provides the reviewer and the reviewee the opportunity to have a report that is beneficial and serves its purpose.

Ms. Yaroslavsky made a motion to request approval from the Board to enter into an MOU with the CRB to complete the study, working with Dr. Krauss on the methodology; s/Dr. Krauss.

Ms. Choong, California Medical Association, stated that the California Medical Association is supportive of the recommendation to have CRB perform this analysis. She added that they are supporters of ethnic diversity within the physician population.

Enforcement Committee Meeting Minutes**January 29, 2015****Page 11**

Ms. D'Angelo Fellmeth, Center for Public Interest Law, stated that the CRB and Dr. Sala, completed an excellent report in 2008. That report, was the subject of successful legislation last year, AB 1886, Eggman, which has now improved the Board's public disclosure policy to the benefit of patients. Dr. Sala and CRB has made an important contribution to the Board already, and this would be another important contribution in the area of physician diversity.

Motion carried.

Agenda Item 7 Future Agenda Items

Dr. Lewis asked for future agenda items.

Dr. Krauss suggested that the Board discuss marijuana and schedule drugs as they relate to telehealth, and the need for an in-person evaluation. Dr. Krauss explained that as he previously expressed he has reservations about individuals using telehealth as a first examination for recommendations for marijuana, he also has similar concerns about telehealth potentially being an avenue for first prescription for schedule drugs. He believes it is a subject for the Enforcement Committee.

Dr. Lewis stated that the last agenda item is adjournment and asked for a motion to adjourn.

Motion made by Ms. Yaroslavsky; s/Dr. Lewis. Motion carried.

Agenda Item 8 Adjournment

There being no further business, the meeting was adjourned at 3:00 p.m.

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



UTILIZATION REVIEW

Kerrie Webb, Senior Staff Counsel

GOALS OF PRESENTATION

Review and discuss:

Brief overview of utilization review (UR);

- ➔ The Board's historical position on UR;
- ➔ The complaint and investigation process relating to UR;
- ➔ The statutes and regulations impeding investigations relating to UR complaints; and
- ➔ Suggestions for changes in the law and in outreach.



Utilization Review Overview

Workers' Compensation System

- ➔ UR functions to prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, treatment recommendations by physicians based in whole or in part on medical necessity to cure and relieve a patient's condition.
 - Labor Code section 4610.



Utilization Review Overview

Workers' Compensation System (cont.):

- ➔ “Medical necessity” means medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury...
 - Labor Code section 4610.5(c)(2).



Utilization Review Overview

Workers' Compensation System (cont.):

- ➔ Treatment must be based on the following standards, which shall be applied in the order listed, allowing reliance on a lower ranked standard only if every higher ranked standard is inapplicable to the employee's medical condition:
 - A) The guidelines adopted by the administrative director pursuant Section 5307.27.
 - B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.
 - C) Nationally recognized professional standards.
 - D) Expert opinion.
 - E) Generally accepted standards of medical practice.
 - F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.
 - Labor Code section 4610.5(c)(2).

Utilization Review Overview

Managed Health Care System

- ➔ Insurance plans are required to define and disclose their utilization review process.
- ➔ The criteria used by plans to determine whether to authorize, modify, or deny health care services shall, among other things:
 - (1) Be developed with involvement from actively practicing health care providers.
 - (2) Be consistent with sound clinical principles and processes.
 - Health and Safety Code section 1363.5.

The Board's Historical Position on Utilization Review

- ➔ On May 9, 1998, the Board adopted a resolution declaring, among other things, that:
 - The making of a decision regarding the medical necessity or appropriateness, for an individual patient, of any treatment or other medical service, constitutes the practice of medicine.
- ➔ During the April 25, 2013 Quarterly Board Meeting, the Board reaffirmed that utilization review is the practice of medicine.



Complaints Involving UR Decisions

- ➔ The Board receives complaints from:
 - Patients whose recommended treatments were delayed, modified, or denied;
 - Treating physicians whose recommended treatments for their patients were delayed, modified, or denied;
 - Representatives of managed care plans whose denial of benefit decisions have been overturned by UR reviewers.



Review of UR Complaints

- ➔ Where the complaint alleges that the UR physician's opinion resulted in the wrongful delay, modification, denial, or granting of treatment, the Central Complaint Unit treats this as a quality of care case.
- ➔ The patient's medical records are obtained from the treating providers, along with any correspondence relating to the UR review and findings.



Review of UR Complaints (Cont.)

- ➔ The UR physician, if known, is provided a summary of the complaint, is asked for a certified copy of any related records in his or her possession, including a copy of the report sent to the patient and treating physician, and is asked to provide a statement or explanation.
- ➔ The case is reviewed by a medical consultant.



Review of UR Complaints (Cont.)

- ➔ If the medical consultant determines that further investigation is required to determine whether deviations from the standard of care occurred in reaching the opinion that a patient's treatment should be delayed, modified, denied, or granted, the case is referred to the Health Quality Investigation Unit and the Attorney General's Office.



The Board's Jurisdiction in UR Cases

➔ When reviewing UR cases, it is important to distinguish:

1) A UR reviewer's decision regarding medical necessity of a treatment

FROM

2) An insurance provider's determination regarding benefits based on a UR reviewer's decision regarding medical necessity.

The Board's Jurisdiction in UR Cases (Cont.)

- ➔ The Board has jurisdiction over the known California-licensed physician determining medical necessity, but not over whether benefits will be provided.



Impediments to Board Oversight Workers' Compensation System

- ➔ An expert reviewer does NOT have to be licensed in California.
 - Labor Code section 4610(e).

- ➔ Once a workers comp matter is elevated to the independent medical review (IMR) level, the name of the expert reviewer is required to be kept confidential.
 - Labor Code section 4610.6(f).



Impediments to Board Oversight Health Plans

- ➔ Physicians providing an independent medical review do not have to be licensed in California, although the independent medical review organization (IMRO) is required to give preference to a California-licensed physician.
 - Health & Safety Code section 1374.32(d)(4)(B).
- ➔ The IMRO shall keep the name of the reviewing physician confidential except where the reviewer is called to testify and in response to court orders.
 - Health & Safety Code section 1374.33(e).

ATTENTION ALL MEDICAL DIRECTORS!!!

Workers' Compensation System

- ➔ The medical director for the insurance company has to hold an unrestricted license to practice medicine in California.
 - Labor Code section 4610(d).

ATTENTION ALL MEDICAL DIRECTORS!!!

Workers' Compensation System (Cont.)

- ➔ The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.
 - Labor Code section 4610(d).

ATTENTION ALL MEDICAL DIRECTORS!!!

Workers' Compensation System (Cont.)

- ➔ **“Medical Director” is the physician and surgeon licensed by the Medical Board of California or the Osteopathic Board of California who holds an unrestricted license to practice medicine in the State of California. The Medical Director is responsible for all decisions made in the utilization review process.**
 - 8 California Code of Regulations section 9792.6(m).

ATTENTION ALL MEDICAL DIRECTORS!!!

Health Plans

- ➔ Are required to employ or designate a medical director who holds an unrestricted license to practice medicine in California.
- ➔ The medical director shall ensure that the process by which the plan reviews and approves, modifies, or denies care based on medical necessity complies with the law.
 - Health and Safety Code section 1367.01(c).

ATTENTION ALL MEDICAL DIRECTORS!!!

Health Plans (Cont.)

- ➔ The criteria used by the plan to determine whether to approve, modify, or deny requests by providers shall be consistent with clinical principles and processes.
 - Health and Safety Code section 1367.01(f).

Suggestions for Change:

- ➔ Support legislative changes to require UR/IMR physicians:
 1. To be licensed in California;
 2. To be actively practicing;
 3. To have similar board certification and/or training as the treating physician; and
 4. To identify themselves in their reports.

- ➔ Support outreach efforts to educate medical directors about the Board's oversight in the UR review process.

QUESTIONS???





MEDICAL BOARD OF CALIFORNIA QUARTERLY BOARD MEETING AGENDA



MEMBERS OF THE BOARD

President

David Serrano Sewell

Vice President

Dev GnanaDev, M.D.

Secretary

Denise Pines

Michelle Bholat, M.D.

Michael Bishop, M.D.

Randy Hawkins, M.D.

Howard Krauss, M.D.

Sharon Levine, M.D.

Ronald Lewis, M.D.

Gerrie Schipske, R.N.P, J.D.

Jamie Wright, Esq.

Barbara Yaroslavsky

Felix Yip, M.D.

The Westin San Diego
400 West Broadway
San Diego, CA 92101
619-239-4500 (directions only)
Diamond 1 Room

Thursday October 29, 2015

12:00 p.m. – 1:15 p.m.

4:00 p.m. – 6:00 p.m.

(or until the conclusion of business)

Friday, October 30, 2015

9:00 a.m. – 3:00 p.m.

(or until the conclusion of business)

Teleconference – See Attached
Meeting Information

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

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

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

ORDER OF ITEMS IS SUBJECT TO CHANGE

Thursday, October 29, 2015

12:00 p.m.

1. Call to Order
Luncheon Presentation – Physician Burnout – Christina Maslach, Ph.D., Professor of Psychology, University of California, Berkeley

4:00 p.m.

2. Call to Order/Roll Call
3. 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)]*
4. Approval of Minutes from the July 30-31, 2015 Meeting
5. Board Member Communications with Interested Parties – Mr. Serrano Sewell
6. Update, Discussion and Possible Action on Recommendations from the Public Outreach, Education, and Wellness Committee – Dr. Lewis
7. President’s Report – Mr. Serrano Sewell
 - A. Committee Roster Updates

8. Executive Management Reports – Ms. Kirchmeyer
 - A. Approval of Orders Following Completion of Probation and Orders for License Surrender During Probation
 - B. Administrative Summary
 - C. Enforcement Program Summary
 - D. Licensing Program Summary
 - E. Update on the CURES Program
 - F. Update on the Federation of State Medical Boards
9. Update on the Physician Assistant Board – Dr. Bishop
10. Update on the Health Professions Education Foundation – Ms. Yaroslavsky and Dr. Yip

Friday, October 30, 2015

11. Call to Order/Roll Call
12. 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)]
13. 9:00 a.m. REGULATIONS – PUBLIC HEARING
 Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines). Amendment to Section 1361 of Title 16, California Code of Regulations. This proposal would amend the Disciplinary Guidelines to make amendments to conform to changes that have occurred in the educational and probationary environments, clarify some conditions of probation, and strengthen consumer protection.
14. Petition to Promulgate Regulations Pursuant to Government Code Section 11340.6 Concerning a Requirement for a Physician on Probation to Provide Patient Notification
15. Discussion and Possible Action on Legislation/Regulations – Ms. Simoes
 - A. 2015 Legislation Update and Implementation

AB 159	ABX2 15	SB 337	SB 643
AB 637	ACR 29	SB 396	SB 738
AB 679	SB 19	SB 408	SJR 7
AB 684	SB 277	SB 464	
 - B. 2016 Legislative Proposals
 - C. Status of Regulatory Actions
 1. Discussion and Possible Action of the Regulations Relating to Continuing Medical Education
 2. Discussion Possible Action of Regulations to Amend Disclaimers and Explanatory Information Applicable to Internet Postings – Ms. Webb
16. Update from the Department of Consumer Affairs – Ms. Lally

17. Presentation and Discussion on the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* Decision and Attorney General's Opinion – Ms. Dobbs and Ms. Webb
18. Update on the BreZE System
 - A. Medical Board of California Update – Mr. Eichelkraut and Ms. Lowe
 - B. Department of Consumer Affairs Update – Mr. Piccone
19. Discussion and Possible Action on Universidad Iberoamericana (UNIBE) Medical School Application for Recognition – Mr. Worden
20. Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting – Ms. Sparrevohn
21. Update, Discussion and Possible Action of Recommendations from the Enforcement Committee – Dr. Yip
22. Update and Discussion Regarding the Interim Suspension Order (ISO) Study - Ms. Kirchmeyer, Ms. Delp, Ms. Castro, and Mr. Gomez
23. Investigation and 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
24. Update from the Attorney General's Office – Ms. Castro
25. Agenda Items for the January 2016 Meeting in the Sacramento Area
26. Adjournment

Meeting Information

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

The call-in number for teleconference comments is:

Thursday October 29, 2015 - (888) 220-8450

Friday October 30, 2015 - (888) 221-3915

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 **3** and **13** – 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.

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.*

CHRISTINA MASLACH

Bio

Christina Maslach is Professor of Psychology at the University of California at Berkeley. She received her A.B., magna cum laude, in Social Relations from Harvard-Radcliffe College in 1967, and her Ph.D. in Psychology from Stanford University in 1971. She has conducted research in a number of areas within social and health psychology. However, she is best known as one of the pioneering researchers on job burnout, and the author of the *Maslach Burnout Inventory* (MBI), the most widely used research measure in the burnout field. She has written several books and numerous articles about burnout. In 2009, she received two awards from the Journal of Organizational Behavior, for co-authoring two (of the eight) most influential articles in its 30-year history, both of which dealt with burnout. In 2012, she and colleague Michael Leiter were honored as authors of one of the 50 most outstanding articles published by the top 300 management journals in the world, for their longitudinal research on early burnout predictors. In 2013, she received a lifetime career achievement award from the Tenth International Conference on Work, Stress, and Health. In 2014, she and Leiter launched a new e-journal, Burnout Research. Her record of both outstanding research and teaching led to Professor Maslach receiving a national award as “Professor of the Year.”

At the University of California at Berkeley, Professor Maslach has served as Vice Provost for Undergraduate Education, and twice as the Chair of the Faculty Senate. Her Berkeley awards include the Distinguished Teaching Award, the Berkeley Faculty Service Award, and the Berkeley Citation (the University’s highest honor). Among Professor Maslach’s other honors are the presidency of the Western Psychological Association, and her selection as a Fellow of the American Association for the Advancement of Science (that cited her "For groundbreaking work on the applications of social psychology to contemporary problems").

<http://maslach.socialpsychology.org/>

NEW INSIGHTS INTO BURNOUT AND HEALTH CARE

**CHRISTINA MASLACH, PH.D
UNIVERSITY OF CALIFORNIA, BERKELEY**



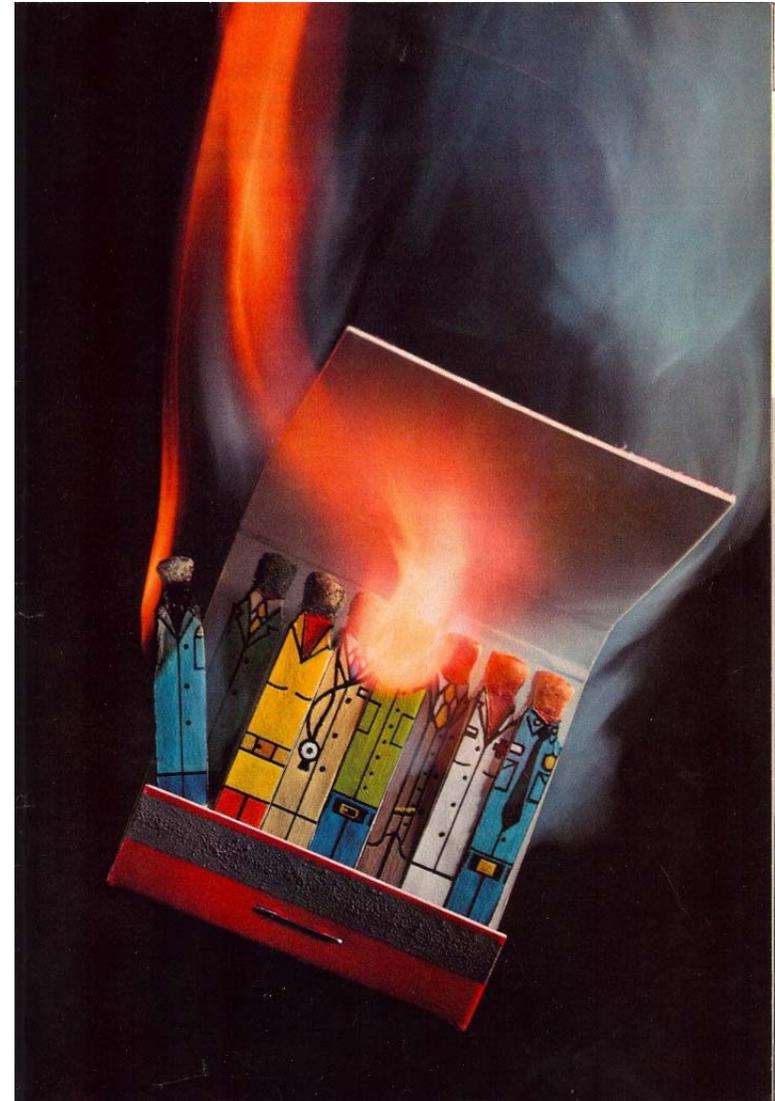
THE PROBLEM OF BURNOUT

EXHAUSTION

CYNICISM

PROFESSIONAL
INEFFICACY

*Workers are overwhelmed,
unable to cope, unmotivated,
and display negative attitudes
and poor performance*



OUTCOMES OF BURNOUT

- ◆ *Absenteeism*
- ◆ *Poor quality of care*
- ◆ *Incivility*
- ◆ *Turnover*
- ◆ *Health problems*
- ◆ *Depression*
- ◆ *Higher costs for organization*

Burnout among Health Care Professionals

- ◆ Health care has been the primary occupation for work on burnout, for several decades
- ◆ Burnout is linked to:
 - ◆ Poor quality of patient care
 - ◆ More medical errors
 - ◆ Dysfunctional relationships with colleagues
 - ◆ Greater risk of substance abuse
 - ◆ Greater risk of depression and suicidal ideation
 - ◆ Stronger intention to leave the medical profession

Recent Findings for Physicians

- ◆ In online survey, almost half of the 7000 physicians reported at least one symptom of burnout
- ◆ A 2014 study of medical students, residents, and early career physicians found burnout rates between 50 and 60 percent, which were significantly higher than matched controls
- ◆ A 2012 Commonwealth Fund study found that just over half of the primary care physicians surveyed age 50 years or older planned to leave practice within five years, as did 30 percent of the primary care physicians age 35 to 39.
- ◆ A 2012 national survey found that only 1 of 10 physicians would recommend medicine as a career

Is Burnout a Problem of the Person or the Situation?

- ◆ **Burnout is often mistakenly labeled a problem of individual physicians, leaving the underlying systemic and cultural problems unaddressed.**
- ◆ **“The fact that almost one in two US physicians has symptoms of burnout implies that the origins of this problem are rooted in the environment and care delivery system rather than in the personal characteristics of a few susceptible individuals.” [Mayo Clinic, 2012]**
- ◆ **“For physicians, burnout is the inevitable consequence of the way that medical education is organized and the subsequent maladaptive behaviors that are reinforced in healthcare organizations via the hidden curriculum. Thus, burnout is an important indicator of how the organization itself is functioning.” [Burnout Research, 2014]**

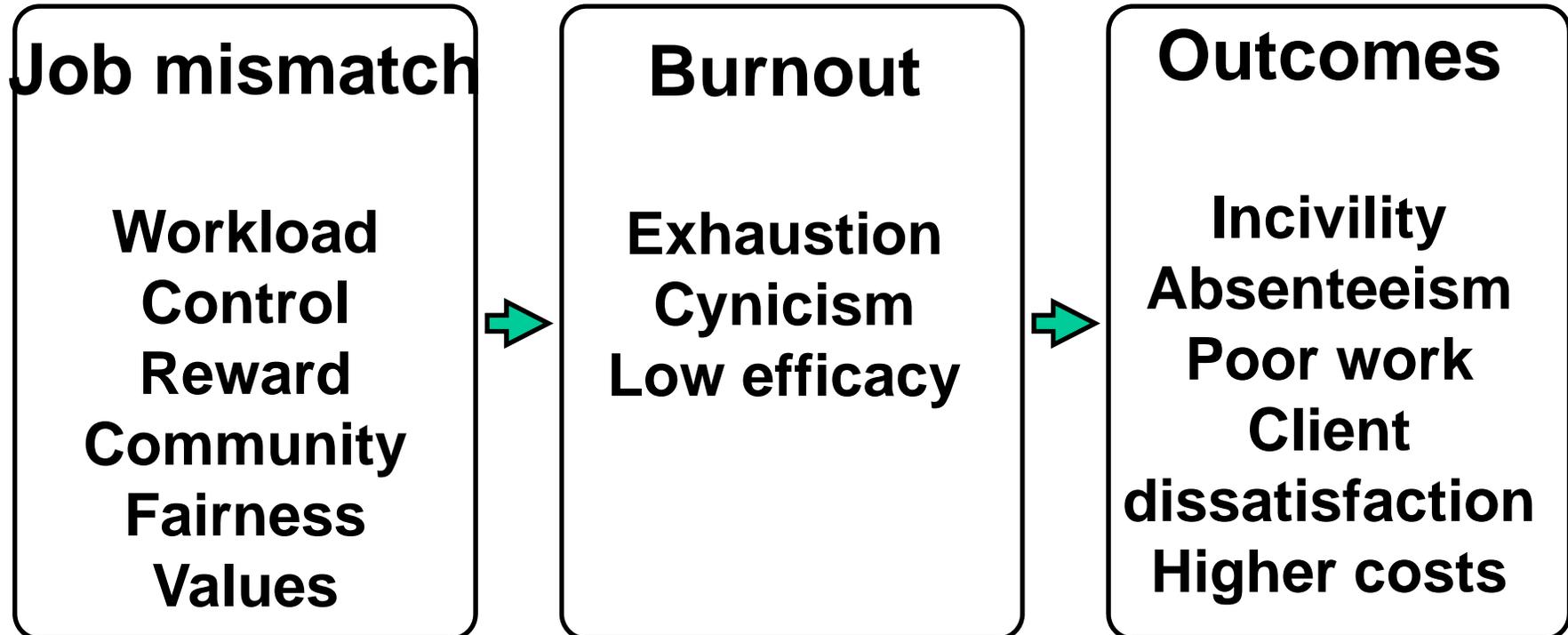
SIX STRATEGIC AREAS OF JOB-PERSON FIT

- WORKLOAD
- CONTROL
- REWARD
- COMMUNITY
- FAIRNESS
- VALUES

Mismatch of Job and Person

- **Demand Overload**
- **Lack of Control**
- **Insufficient Rewards**
- **Breakdown of Community**
- **Absence of Fairness**
- **Value Conflicts**

The Mediation Role of Burnout



BUILDING ENGAGEMENT

- **Work engagement is the positive opposite of burnout**
 - **Energy vs. exhaustion**
 - **Involvement vs. cynicism**
 - **Efficacy vs. inefficacy**
- **Efforts to achieve a positive goal may be better than trying to reduce a negative problem**

ONE TYPE OF STRATEGY TO BUILD ENGAGEMENT

- **Civility, Respect, and Engagement at Work (CREW)**
 - **Developed and tested in hospital settings**
 - **Six-month team process to build a supportive work community**
 - **Results show improved engagement, reduced burnout, less absenteeism**
 - **www.workengagement.com/crew**



CREW in Canadian Hospitals

- Design
 - Wave 1: Eight CREW Groups (N=252)
 - Wave 2: Seven CREW Groups (N=226)
 - Control: 26 Units No CREW (N=874)
- Significant CREW Impact on:
 - Civility
 - Incivility
 - Job Satisfaction/Commitment
 - Burnout/Absences
- Improvement Evidence One Year Later



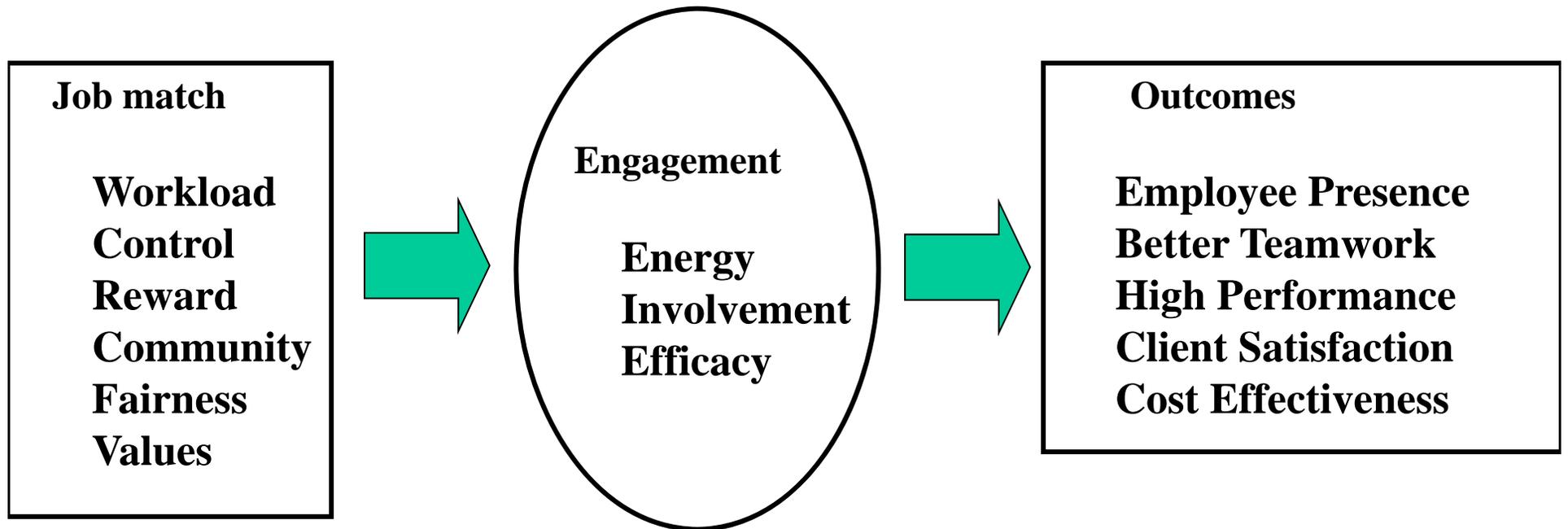
Leiter, M. P., Laschinger, H. K. S., Day, A., & Gilin-Oore, D. (2011).
The impact of civility interventions on workplace social behavior, distress, and attitudes.
Journal of Applied Psychology.

Appropriate Job and Person Match

- **Sustainable workload**
- **Choice and control**
- **Recognition and reward**
- **Supportive work community**
- **Fairness, respect, and social justice**
- **Clear values and meaningful work**



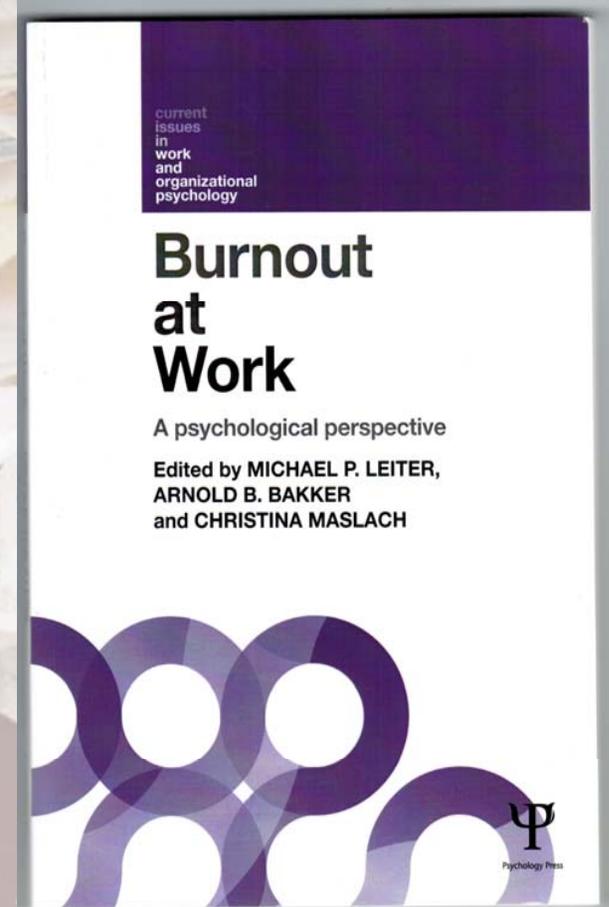
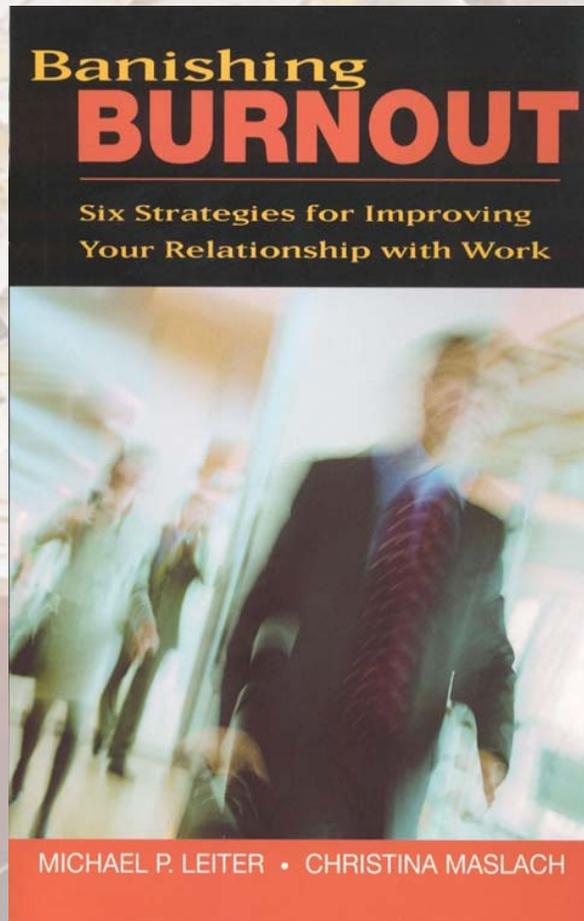
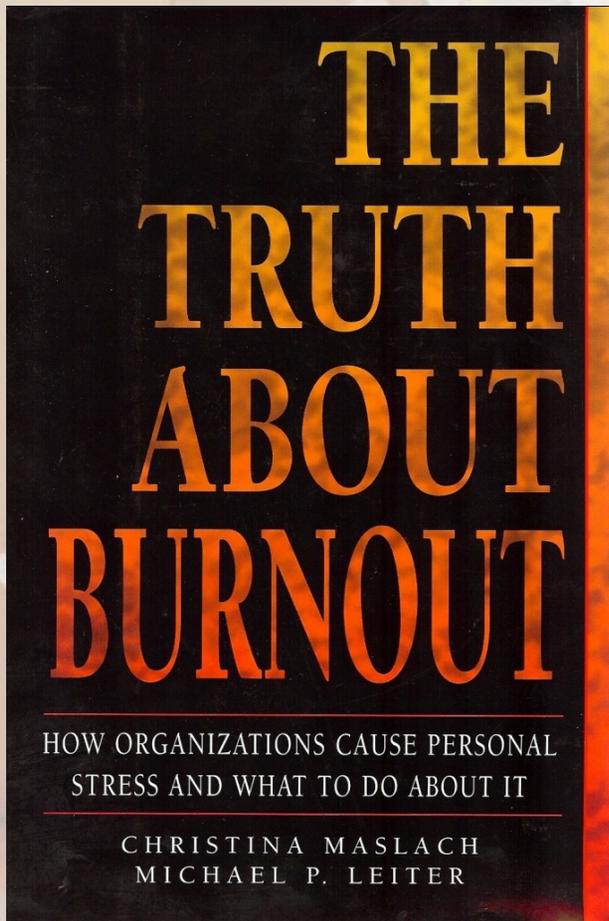
THE MEDIATION ROLE OF ENGAGEMENT



SHOULD WE FIX THE PERSON OR THE JOB?

- **BIAS TOWARD FIXING THE PERSON, BUT THAT ALONE DOES NOT ALWAYS WORK**
- **FIXING THE JOB SITUATION IS MORE RARE, BUT IS MORE LIKELY TO BE EFFECTIVE**
- **EVEN BETTER IS TO FIX PERSON AND JOB**

Want to find out more?





MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING



San Francisco Airport Marriott Waterfront
1800 Old Bayshore Hwy
Burlingame, CA 94010

Thursday July 30, 2015
Friday July 31, 2015

MEETING MINUTES

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

Members Present:

David Serrano Sewell, President
Dev GnanaDev, M.D., Vice President
Denise Pines, Secretary
Michelle Bholat, M.D.
Michael Bishop, M.D.
Randy Hawkins, M.D.
Howard Krauss, M.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:

Gerrie Schipske, R.N.P., J.D.

Staff Present:

Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs, Legal Counsel
Dennis Frankenstein, Business Services Officer
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Government Program Analyst
Letitia Robinson, Research Specialist
Elizabeth Rojas, Business Services Officer
Paulette Romero, Staff Services Manager II
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:

Jeremy Adler, Physician Assistant, California Academy of Physician Assistants
 Teresa Anderson, California Academy of Physician Assistants
 Carmen Balber, Consumer Watchdog
 Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
 Yvonne Choong, California Medical Association
 Zennie Coughlin, Kaiser Permanente
 Julie D'Angelo Fellmeth, Center for Public Interest Law
 Karen Ehrlich, L.M., Midwifery Advisory Council
 Lou Galiano, Videographer, Department of Consumer Affairs
 Bridget Gramme, Center for Public Interest Law
 Doug Grant, Investigator, Health Quality Investigation Unit
 Dr. Greenberg, Monitored Aftercare Program
 Honorable Jerry Hill, Senator
 Marian Hollingsworth, Consumers Union
 Sarah Huchel, Senate Business and Professions Committee
 Todd Iriyama, Investigator, Health Quality Investigation Unit
 Gail Jara, California Public Protection and Physician Health
 Lisa McGiffert, Consumers Union
 Karen Miato, Physicians Well Being, University of California Los Angeles
 Michelle Monseratt-Ramos, Consumers Union
 Carolyn Navarro
 James O'Donnell, Pacific Assistance Group
 Kerry Parker, California Society of Addiction Medication
 Adam Quinonez, Department of Consumer Affairs
 Susan Shinazy
 Michel Sucher, M.D., Monitored Aftercare Program
 Ashby Wolfe, M.D., Centers for Medicare and Medicaid Services
 Dr. Zemansky, Pacific Assistance Group

Mr. Serrano Sewell began by introducing special guest, State Senator Hill.

Senator Hill thanked the Medical Board of California (Board) for the great work they do and stated that Ms. Kirchmeyer and Ms. Simoes are extraordinary to work with. He also commented on how things have changed for the better in the past couple of years with the change of leadership, and feels that the Sunset Review that would be coming up in 2017 would go smoothly.

Senator Hill noted he is honored to Chair the Senate Business and Professions Committee. He explained a couple of situations that got him started on the path of politics and things that happened that encouraged him to want to make a difference in California.

Senator Hill stated one thing that had him truly concerned is a story he read in the paper about a physician in Orange County who killed some people by placing counterfeit, foreign materials in their bodies and for that, the physician got five years' probation. He noted, after reading that, he got rather angry and realized something is wrong. He then read some other cases, and stated he felt similarly concerned.

Senator Hill noted he knows that the Board is as concerned as he is about consumer protection around the state and he, as someone who looks at the Department of Consumer Affairs, reminded the Board that the main responsibility is to be sure that consumers are protected. He hoped that the Board would continue to look at that in the future knowing that consumers feel the same.

Dr. Krauss stated that he appreciates that Senator Hill took the time to come speak to the Board, and also that he knows the Senator appreciates what a difficult job the Board has. He also noted that with all the decisions the Board makes in collaboration with the Attorney General's (AG's) Office, it is often the Board that pushes for more, but with respect to due process in the law, sometimes the "onion had to be peeled" in the physicians discipline and licensure as well. He reminded the Senator that the Board is here to protect the people, not the physicians.

Mr. Serrano Sewell thanked Senator Hill for taking time out of his busy schedule to come and speak at the Board Meeting.

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Board to order on July 30, 2015, at 3:43 pm. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

Lisa McGiffert, Director of Consumers Union Safe Patient Project, submitted a petition with over 5100 signatures of Californians that urges the Board to require physicians who are on probation to disclose their probationary status to their patients. The signatures were recently gathered online beginning in June by Consumers Union. She stated there are over 400 physicians that are on probation currently in California, many for very serious violations. Most of these physicians are actively practicing. Consumers Union is asking the Board to add a requirement to probationary orders that would directly affect a fraction of California physicians; only 400 of the 102,000 practicing physicians. She stated that it seems small, but is a paramount issue for patients who are being treated by these physicians. They feel it is unreasonable for consumers to rely on posting on the Board's website as a primary way to inform patients of physicians who have been disciplined. She noted that many consumers do not even know that the Board exists, let alone those who do not have access to the internet, such as the elderly, low income, etc. Consumers Union is recommending the Board amend the guidelines to make this requirement a standard condition and urged the Board to take this action.

Marian Hollingsworth stated she feels that the importance of physician disclosure of probation is a very important part of the informed consent process. She hopes the Board takes it seriously when the issue is discussed at the Board's October Board meeting. She noted that Mr. Serrano Sewell promised to have that item on the agenda for that meeting. She also stated that the media is following this story and feels it is important from the consumer safety standpoint. The ABC affiliate in San Diego did a report on the Consumers Union petition in June and the Sacramento Bee newspaper recently ran an

article written by Ms. Hollingsworth about the importance of physician disclosure for probation. She asked the Members to read the article to see this important issue from a consumer perspective.

Michelle Monserrat-Ramos noted the Consumers Union offers the opportunity to write guest blogs for their Safe Patient Project website. She recently contributed a post discussing a physician on probation and a comparison between the Department of Motor Vehicles (DMV) and the Board, asking readers to determine who did a better job of protecting the public. The example given was a licensee with a long arrest record, including eight months in jail. The DMV took swift action, before the Board did. The licensee surrendered his license, then reapplied, got his license back only for the physician to violate probation, six to seven months later.

Agenda Item 3 **Approval of Minutes from the May 7-8, 2015 Meeting**

Ms. Yaroslavsky made a motion to approve the meeting minutes as written; s/Dr. Lewis. Motion carried unanimously.

Agenda Item 4 **Board Member Communications with Interested Parties**

Ms. Yaroslavsky noted she had a conversation with several members of the Consumers Union Safe Patient Project regarding many of the same issues that have been brought up during the recent public comment period.

Dr. Bishop stated he had a discussion with the past president of CAPA regarding Senate Bill (SB) 337.

Ms. Wright noted she also had a conversation with several members of the Consumers Union Safe Patient Project and hopes there is a way for their passion to be used as way to assist with consumer safety.

Mr. Serrano Sewell stated he also had a phone conversation with the Consumers Union Safe Patient Project in regard to physician disclosure of probation. He also had a conversation with the Director of the Department of Consumer Affairs (DCA), which he would provide more details on in his President's Report.

Agenda Item 5 **Presentations of Physician Health Programs and Discussion/Consideration**

Ms. Robinson provided the Members with information on physician health programs. She stated the Board's Diversion Program was originally established to provide public protection by monitoring impaired physicians to prevent them from working while under the influence. However, since the elimination of the Board's Diversion Program in 2008, an impaired physician must independently seek out additional sobriety activities, such as AA meetings, treatment programs, and group therapy sessions to assist in a successful recovery.

At the request of Board Members, staff invited two speakers to present information on other states physician health programs. Board staff also reviewed the laws and policies for two other California healing arts boards health programs and other states' physician health programs to gain knowledge on how their programs operated. Ms. Robinson noted that excerpts from a few states' program laws can be found in the Board packets on pages BRD 5-3 through BRD 5-12.

Mr. Serrano Sewell introduced Dr. Sucher who provided a presentation on the Arizona Medical Board Physician Health Program (PHP). Dr. Sucher thanked the Board for the invitation and introduced his colleague Dr. Greenberg. Their presentation included a PHP overview consisting of several areas of the program such as the purpose, history, oversight and operations, Monitored Aftercare Program (MAP) entry pathways, MAP elements and terms, and compliance and non-compliance tracks. It also included PHP tracks, accomplishments, MAP and PHP statistics, enhancements and future plans.

Dr. Suchers biography and power point presentation can be viewed on the Board's website:

http://www.mbc.ca.gov/About_Us/Meetings/2015/Materials/materials_20150730_brd-5b.pdf.

Ms. D'Angelo Fellmeth, Center for Public Interest Law, stated she was the Board's former Enforcement Monitor. She stated that California had approximately six times as many physicians as Arizona and is three times the geographical size of Arizona, which is a huge consideration. She noted that the California program, even at its worst, had double the number of participants than Arizona has currently. Ms. Fellmeth then gave a background history of her experiences of California's monitoring program as the Board's former Enforcement Monitor.

She stated that as the Board's Enforcement Monitor, she did not recommend abolishment of the program, but did recommend the Board consider several fundamental issues if the program was to continue. The first issue the Board should consider is if the diversion concept is diverting into a secret program of the most dangerous physicians, and if the program is using confidential mechanisms that are demonstrably failing. If that is the case, consider whether the program should be located within the Board, as she found it was a deterrent to the physicians entering the program. The third consideration she recommended is if the Board decided to continue the program, it needed to completely restructure the program in order to be sure it is effectively monitoring substance abusing physicians and protecting patients from those physicians.

James O'Donnell, an independent contractor with the Pacific Assistance Group (PAG), stated this group is a facilitative group in the San Francisco Bay Area. As a facilitator, he watches physicians very carefully, in terms of their attitude, how they are doing in recovery, and requires physicians to meet with him at least once or twice a week for five years. His job is to assess and report any mental or physical relapses. He stated that physicians come into their program decimated as human beings, because of their chemical dependency. He has seen hundreds of doctors and he finds that he sees a difference in these physicians daily and stated most of them leave the program as high functioning individuals. He noted that the original diversion program did a survey and found that physicians in diversion at that time had less complaints.

Michelle Monserrat-Ramos stated a diversion program is a threat to patient safety and urged the Board to continue with the progress of the Uniform Standards, and say “no” to diversion and “yes” to patient safety.

Karen Miato, Chair of the Physicians Well-Being Committee at UCLA, stated she wants to advocate strongly for a program to assist physicians with dependencies in the state of California.

Dr. Zemansky, a clinical psychologist and current President of PAG, noted the PAG does private monitoring under structured guidelines primarily set mainly by the Federation of State Physician Health Programs. She strongly believes that having options for physicians that have dependencies would best protect the public, as opposed to having only enforcement, which can only come after something happens.

Susan Shinazy stated that as physicians are the most highly educated in health care, she thinks they should stand up and lead the way for our culture in making it acceptable to admit to addiction and to get help. There should be no secrecy since they deal with human lives.

Mr. Serrano Sewell stated this agenda item would be continued to the next day to hear from Dr. Gundersen who had travel problems.

Agenda Item 6 **Discussion and Possible Action on Legislation/Regulations**

Ms. Simoes began by stating she contacted all Legislative district offices in the Bay area and invited them to the Board Meeting.

Agenda Item 6A **2015 Legislation**

Ms. Simoes then referred the Members to the tracker list in the Legislative Board packet. She noted the bills in blue are either two-year bills or bills where the Board had already taken a position. The bills in pink are Board-sponsored bills and would be discussed first and then those in green. She brought to the Members’ attention that several of the scope bills have turned into two-year bills. Ms. Simoes presented on the following bills.

SB 396 (Hill) would make consumer protection enhancements that the Board already voted to sponsor/support for accredited outpatient settings. She stated this bill would require peer review evaluations for physician and surgeons working in accredited outpatient settings; and it would allow accredited outpatient setting facility inspections performed by Accreditation Agencies (AAs) be unannounced after the initial inspection. For unannounced inspections, AAs must provide at least a 60-day window to the outpatient setting. Ms. Simoes noted this bill would also delay the report from the Board on the vertical enforcement and prosecution model from March 1, 2015 to March 1, 2016.

Ms. Simoes stated the bill would allow an accredited outpatient setting to access 805 reports from the Board when credentialing, granting or renewing staff privileges for providers at that facility. Ms. Simoes noted this bill had been significantly amended to

address concerns raised by the opposition. A number of provisions were removed from this bill and now the only two provisions that remain related to peer review and unannounced inspections. Ms. Simoes noted this bill is moving forward and currently on the Assembly floor and there is no longer any opposition to the bill.

SB 408 (Morrell) would ensure that the midwife assistants meet minimum training requirements and sets forth the duties that a midwife assistant could perform. The duties would be at the same level as a medical assistant, basically technical support services only. Ms. Simoes stated this bill would allow the Board to adopt regulations and standards for any additional midwife technical support services. She noted this bill is currently on the Assembly floor, had not received any “no” votes, and is moving forward.

SB 800 (Committee on Business, Professions, and Economic Development) is the vehicle by which omnibus legislation had been carried by the Senate Business, Professions, and Economic Development Committee. The Board had already discussed this bill, and the only change to this bill is there was language that was included that would have clarified in statute that the Board, for allied health care professionals, can put them on probation and allow them to apply for reinstatement. However, it was thought by Legislative staff that these amendments were too substantial, so they were removed from the bill. Ms. Simoes stated that next year, she would find an author for a new bill that would include all technical clarifying changes or anything that needs to be made more clear. Ms. Simoes noted she would work with the different program staff to identify all of the changes that need to be made and to make sure the Board had the authority to do all that needs to be done.

AB 266 (Bonta, Cooley, Jones-Sawyer, and Lackey) would enact the Medical Cannabis Regulation and Control Act and would establish the Office of Marijuana Regulation within the Office of the Governor, the Division of Medical Cannabis Regulation within the State Board of Equalization (BOE), the Division of Medical Cannabis Manufacturing and Testing within the California Department of Public Health (CDPH), and the Division of Medical Cannabis Cultivation within the California Department of Food and Agriculture (CDFA). Ms. Simoes reminded the Members that AB 26 was merged with AB 34, in which the Board took a support if amended position. She noted that now AB 34 had merged into AB 266, which means the law enforcement supported bill and the industry supported bill have merged into this current bill, AB 266. She stated that AB 26 and AB 34 were supported by the Board, with the request to add the requirement of an in-person examination. Both bills were supported by the Board because they would have provided the Board with enforcement tools that would help ensure consumer protection and would ensure that physicians are not making marijuana recommendations for financial or employment reasons. Ms. Simoes noted that the bill had been significantly amended since the Board took a neutral position at the May 2015 Board Meeting. As such, Board staff is suggesting that the Board change its position on this bill from a neutral position to a support position.

Dr. Krauss asked Ms. Simoes if the substance of this bill is making it more restrictive for a physician to issue a marijuana recommendation or if most of it is a reiteration of current law.

Ms. Simoes responded stating it is a reiteration of current law with the exception that currently it is not clear that Business and Professions Code (BPC) Section 2242 applies to recommendations for marijuana. She noted there are some court cases that make it unclear, and in the past, it had been important to the Board to add language to BPC Section 2242 to make it clear that it applies to recommendations for marijuana. She stated this bill does add that recommendation to BPC 2242, which is important for enforcement reasons for the Board.

Dr. GnanaDev stated he is pleased to hear that this bill would prohibit a physician from recommending cannabis to a patient unless they are the patient's attending physician.

Dr. Lewis made a motion to take a support position on AB 266; s/Ms. Yaroslavsky. Motion carried with one abstention (Krauss).

AB 483 (Patterson) would require initial licensing fees for specified healing arts licenses to be prorated on a monthly basis. The Board had taken a neutral, if amended position, and asked that the Board be removed from this bill. The Board's requested amendments were taken. The Board now has a neutral position on this bill. Ms. Simoes noted the Board had been added to AB 773 (Baker), which would change the initial license time period from birth date renewal, to a two-year license.

AB 684 (Alejo and Bonilla) would place a moratorium on discipline for registered opticians (RDOs) and optometrists by the Board or the Board of Optometry (CBO) for engaging in any business relationship prohibited by BPC Sections 655 and 2556. Ms. Simoes noted that this bill contains an urgency clause, so it would take effect immediately. She stated that at this time, putting a moratorium on disciplinary action for RDOs and optometrists makes sense. The Board took a neutral if amended position on this bill previously, and requested an amendment to ensure that the safe harbor only applies to RDOs and optometrists registered and licensed before the safe harbor takes effect. This requested amendment was taken, so the Board is now neutral on this bill. Ms. Simoes then noted that she, Ms. Kirchmeyer and Ms. Webb have participated in several meetings with the Governor's Office regarding the proposed language for this bill. The language was still in draft form, but she wanted to let the Members know that if this bill were to come to bill form, there may have to be an emergency Executive Committee meeting because it would be a bill that the Board would need to take a position on, but at this point, it is still just the moratorium with a neutral position.

Dr. Krauss stated this bill would give an advantage to big businesses and be a disadvantage to small businesses, which concerns him, but noted this may not be a battle the Board needs to fight.

Ms. Simoes stated this bill is not sponsored by any of the parties that support this bill. She noted that Senator Bonilla's office had made it clear that the purpose of this moratorium is to get interest parties together to decide if there can be a solution and, if not, to give the Boards and CBO, the time to get prepared to actively enforce the existing law.

AB 773 (Baker) would require licenses issued by the California Board of Psychology and the Board to be valid for two years from issuance. Ms. Simoes stated that Board staff believes that a two-year license would be a better way to resolve the issue of license fee overpayment. Board staff had discussed adding the Board to this bill with the author and her staff, and they were willing to add the Board to this bill. Ms. Simoes stated this bill was amended to add licenses issued by the Board. As such, the Board now had a support position on this bill.

SB 337 (Pavley) would establish alternative means for a supervising physician to ensure adequate supervision of a physician assistant (PA) for routine care and the administration, provision, or issuance of a Schedule II drug. Existing law requires all medical charts for Schedule II drug orders to be countersigned within seven days by the supervising physician. Ms. Simoes noted this bill would add two additional mechanisms, in addition to the existing five percent medical record countersign requirement, for a supervising physician to choose from to ensure adequate PA supervision. For all mechanisms, the supervising physician shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, pose the most significant risk to the patient. Ms. Simoes stated the two additional mechanisms have been significantly amended to address the Board's concerns, and are as follows:

- The supervising physician and the PA shall conduct a medical records review meeting, at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and PA shall review an aggregate of at least 10 medical records of patients treated by the PA functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and the PA.
- The supervising physician shall supervise the care provided by the PA through a review of cases involving treatment by the PA functioning under protocols adopted by the supervising physician. The review methods used shall be identified in the delegation of services agreement and shall include no less than an aggregate of 10 cases per month for at least 10 months of the year. Documentation of the cases reviewed during the month shall be jointly signed and dated by the supervising physician and the PA.

Ms. Simoes noted that existing law requires all medical charts for Schedule II drug orders to be countersigned with seven days by the supervising physician. This bill would create an additional mechanism for a supervising physician to ensure adequate supervision of the administration, provision, or issuance by a PA of a Schedule II drug order.

She stated the additional mechanism is only allowed if the PA had documentation evidencing the successful completion of an education course that covers controlled substances and meets specified standards. Ms. Simoes noted this bill had been amended to ensure that there are minimum requirements in the mechanism allowed to ensure adequate physician supervision. This bill still reduces the physician review of medical records for Schedule II drug orders from 100 percent to 20 percent. The supervising physician would be responsible for choosing the 20 percent of the drug orders that get signed. Ms. Simoes stated this bill would also require the PA to receive controlled substances training. With the amendments that have been taken to address the Board's concerns, Board staff is

recommending that the Board change its position from oppose unless amended to a neutral position.

Dr. Lewis stated he feels that since the Board's amendments were made, the Board should take a support position on this bill.

Dr. Lewis made a motion to take a support position on SB 337; s/Dr. Bishop.

Theresa Anderson, California Academy of Physician Assistants, thanked the Board for the opportunity to work with staff to address the Board's concerns and offered to answer any questions Members may have, as they are the sponsor of this bill.

Motion carried unanimously.

SB 464 (Hernandez) would authorize specified health care practitioners to use a self-screening tool that would identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and after an appropriate exam, prescribe, furnish or dispense self-administered hormonal contraceptives to the patient. Ms. Simoes noted that the sponsors of this bill believe it would help to improve preventative health services by increasing access to services in rural communities through the utilization of telemedicine by allowing patients to provide information to a health provider through self-screening tools. If telehealth is used, the existing telehealth laws would apply. Ms. Simoes stated the other health care practitioners named in this bill would also have to comply with their existing laws related to prescribing and can only provide services that are within their scope of practice. Board staff would have concerns if an appropriate prior exam was not required, but since it is, Board staff recommended that the Board take a neutral position on this bill.

*Ms. Yaroslavsky made a motion to take a neutral position on SB 464; s/Dr. Lewis.
Motion carried with one abstention (Krauss).*

SB 467 (Hill) is a sunset bill for several boards and includes pro rata requirements for DCA and reporting requirements for the AG's Office. Ms. Simoes noted that this bill would also require the Director of the DCA, through its Division of Investigation (DOI), to implement "Complaint Prioritization Guidelines" for boards to utilize in prioritizing their respective complaint and investigation workloads. She stated the Guidelines shall be used to determine the referral of complaints to DOI and those that are retained by the health care boards for investigation. Since the Board already had priorities set in law, these prioritization requirements should not apply to the Board. Senate Business and Professions Committee agreed and submitted language to exempt the Board from the Complaint Prioritization Guidelines in this bill. With that exemption, Board staff is suggesting the Board only watch this bill at this time.

SB 538 (Block) would expand the scope of practice for a naturopathic doctor (ND) and would allow an ND to prescribe certain drugs without physician supervision. Ms. Simoes noted that current law allows an ND to furnish or order legend drugs and Schedule III-V drugs in accordance with standardized procedures or protocols developed by the ND and

their supervising physician. She also stated that currently law authorizes an ND to provide repair and care incidental to superficial lacerations and abrasions, except suturing, and permits an ND to remove foreign bodies located in the superficial tissues. A physician may supervise up to four NDs at a time. Ms. Simoes stated this bill had been amended and significantly narrowed, however, it still allows NDs to prescribe Schedule V and legend drugs without physician supervision. For this reason, Board staff is recommending the Board continue to oppose this bill.

Dr. GnanaDev made a motion to continue with an oppose position on SB 538; s/Ms. Wright. Motion carried unanimously.

Agenda Item 6B **Status of Regulatory Actions**

Ms. Simoes referred the Members to page BRD 6B-1 in their packets, status of regulatory actions. Ms. Simoes pointed out the regulations related to Continuing Medical Education (CME) requirement and stated they are still being reviewed as the Board had received additional information from American Board of Medical Specialties (ABMS) related to the necessity of these regulations. She noted these regulations would be brought back to the Board at the October Board meeting.

Agenda Item 6C **Federal Legislation**

Ms. Simoes stated that both S1778 and HR3081 refer to the Telemedicine for Medicare Act of 2015. She noted in both bills Medicare participating physicians or practitioners who are licensed, or otherwise legally authorized to provide a health care service in a State, may provide such a service as a telemedicine service to a Medicare beneficiary who is in a different State. These bills would specify that any requirement that a physician or practitioner obtain a comparable license or other comparable legal authorization from such different State shall not apply. The Board had previously opposed this legislation and written letters to Congress expressing the Board's opposition. Board staff is requesting approval from the Board to again write letters expressing the Board's opposition and concerns for both of these Congressional bills.

Ms. Yaroslavsky made a motion to approve Board staff to write letters to Congress expressing the Board's opposition of these bills; s/Dr. GnanaDev. Motion carried unanimously.

Agenda Item 7 **President's Report**

Mr. Serrano Sewell gave an update on a meeting he had with the DCA Director, Mr. Kidane and his senior staff. Their discussion included the transition of the investigators and the importance of the Board's investigation and disciplinary process as it relates to consumer protection. They also discussed DCA's presentation of the vertical enforcement process, with the exchange of ideas, protocol and how everyone can work together. Mr. Serrano Sewell noted that Mr. Kidane and staff complimented the Board on how the Board fulfills their duty.

Ms. Serrano Sewell then gave a few brief highlights of the past year. The first being the legislative day that some of the Members participated in in October which he believes encouraged Senator Hill to come and speak at this meeting. He then noted that Ms. Kirchmeyer did an outstanding job in hiring the Board's new Deputy Director and Chief of Enforcement, and in successfully transferring the investigators to DCA. The Board had also approved and released updated Guidelines for Prescribing Controlled Substances for Pain. Mr. Serrano Sewell thanked staff for assisting in the process of the release of those guidelines. He also stated that the Board successfully sponsored legislation to ensure that documents on serious discipline remain posted on the Board's website in an effort to increase transparency.

Mr. Serrano Sewell wrapped up his President's report stating the Board had several interested parties meetings this past year where Members have heard ideas on what the Board should be doing to continue with consumer protection.

Ms. Kirchmeyer added that the Board had also passed the Regulations on SB 1441, Uniform Standards for Substance Abusing Licensees, and congratulated the Board on all the work that had been done and their accomplishments over the past year.

Agenda Item 8 **Update from the Executive Committee**

Mr. Serrano Sewell stated that the Executive Committee had met earlier in the day and discussed several issues. Ms. Kirchmeyer and Ms. Amaral gave a presentation and update on the Board's 15/16 budget. Ms. Kirchmeyer and Ms. Robinson gave a presentation on the Board's satisfaction survey as well as an update of the Board's strategic plan. Mr. Serrano Sewell noted the Committee Members also suggested some future agenda items for the next Executive Committee meeting, such as the Board's public outreach efforts as well as public education efforts and how to best utilize Members as ambassadors for the Board in promoting consumer protection.

Agenda Item 9 **Update from the Licensing Committee**

Dr. Bishop stated the Licensing Committee had met earlier in the day and approved the minutes from the July 24, 2014 meeting. He stated Mr. Worden provided an update on the licensing program for the past fiscal year. Mr. Worden also thanked the licensing managers and staff for their hard work. The Committee was advised that 5,873 physicians were licensed in fiscal year 14/15, which is an increase of 351 licenses from the previous year. Licensing staff were required to work overtime to process all of the applications for the residents and fellows who needed licensure by July 1, 2015. Dr. Bishop noted that the Board's call center had received 155,092 calls this past year, which is an increase of 6,624 more calls than in the prior year. Mr. Worden stated in his update that he believes the increase was due to the new licensing system in BreZE.

Dr. Bishop noted there are 107 medical schools pending recognition by the Board, with seven pending self-assessment reports. He stated that Mr. Worden provided an update on the June 30, 2015 interested parties meeting that was held in Sacramento regarding minimum requirements for accredited postgraduate training for licensure and physician

re-entry. Dr. Bishop noted that staff plans to hold another interested parties meeting in Southern California within the next few months and encouraged all interested parties to attend as it is critical to have public input at these meetings.

Agenda Item 10 **Update from the Education and Wellness Committee**

Ms. Yaroslavsky stated the Education and Wellness Committee had met earlier in the day and meeting minutes from the January 29, 2015 meeting were considered and approved. She noted the Committee was treated to a presentation by Dr. Ashby Wolfe, the Chief Medical Officer for Region IX, Centers for Medicare and Medicaid Services. Dr. Wolfe provided an update on the Affordable Care Act (ACA), as well as information on the ACA's compliance mandate for physicians.

Ms. Yaroslavsky stated the Committee also had a presentation from Dr. Andres Sciolla, Associate Professor of Clinical Psychiatry, Medical Director, Northgate Point Regional Support Team with the University of California, Davis. Dr. Sciolla pointed out how childhood trauma in adverse childhood experiences could affect one's health including increased morbidity and premature mortality.

Ms. Yaroslavsky noted that if any Members have anything they would like added to the next Education and Wellness Committee meeting agenda to please let staff know.

Dr. Bishop recommended having an expert give a presentation on physician burnout added to the next agenda. He stated it is becoming a bigger issue than some realize and he thinks it should be reviewed and discussed.

Mr. Serrano Sewell adjourned the meeting at 5:57 pm.

Friday, July 31, 2015

Members Present:

David Serrano Sewell, President
 Dev GnanaDev, M.D., Vice President
 Denise Pines, Secretary
 Michelle Bholat, M.D.
 Michael Bishop, M.D.
 Randy Hawkins, M.D.
 Howard Krauss, M.D.
 Sharon Levine, M.D.
 Ronald Lewis, M.D.
 Jamie Wright, Esq.
 Barbara Yaroslavsky
 Felix Yip, M.D.

Members Absent:

Gerrie Schipske, R.N.P., J.D,

Staff Present:

Liz Amaral, Deputy Director
 Christina Delp, Chief of Enforcement
 Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
 Dennis Frankenstein, Business Services Officer
 Cassandra Hockenson, Public Affairs Manager
 Kimberly Kirchmeyer, Executive Director
 Regina Rao, Associate Governmental Program Analyst
 Letitia Robinson, Research Specialist
 Elizabeth Rojas, Business Services Officer
 Paulette Romero, Staff Services Manager II
 Jennifer Simoes, Chief of Legislation
 Lisa Toof, Administrative Assistant II
 Kerrie Webb, Legal Counsel
 Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
 Carmen Balber, Consumer Watchdog
 Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
 Yvonne Choong, California Medical Association
 Janet Coffman, University of California, San Francisco
 Zennie Coughlin, Kaiser Permanente
 Julie D'Angelo Fellmeth, Center for Public Interest Law
 Rosanna Davis, President, California Association of Midwives
 Long Do, California Medical Association
 Michael Dugan, Federation of State Medical Boards
 Karen Ehrlich, L.M., Midwifery Advisory Council
 Lou Galiano, Videographer, Department of Consumer Affairs
 Mike Gomez, Deputy Director, Department of Consumer Affairs
 Bridget Gramme, Center for Public Interest Law
 Faith Gibson, Licensed Midwife
 Kenwood Gill, M.D.
 Doris C. Gundersen, M.D., Colorado Physician Health Program
 Mariam Hollingsworth, Consumers Union
 Gail Jara, CPPPH
 Christine Lally, Deputy Director, Department of Consumer Affairs
 Craig Leader, Investigator, Health Quality Investigation Unit
 Lisa McGiffert, Consumers Union
 Karen Miato, Physicians Well Being, University of California, Los Angeles
 Michelle Monseratt-Ramos, Consumers Union
 Susan Shinazy
 Robert Sumner, Department of Justice
 Laura Sweet, Deputy Chief, Health Quality Investigation Unit
 Sandra Thuston, Department of Justice
 Cynthia Verdis, Investigator, Health Quality Investigation Unit
 Jacqueline A. Watson, Federation of State Medical Boards

Agenda Item 11 **Call to Order/Roll Call**

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on July 31, 2015 at 9:06 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 12 **Public Comments on Items not on the Agenda**

Faith Gibson, licensed midwife, suggested the Board create a way to allow patients and/or colleagues to report an incident that took place with a physician without having to place an official complaint with the Board, so there is a record of an incident on file, but not an actual complaint.

Rosanna Davis, Licensed Midwife and President of the California Association of Midwives (CAM), thanked the Board for sponsoring midwife assistant legislation that would contribute to the safety of licensed midwife care in the out of hospital settings. She then thanked the Board staff for assisting with letters to drug suppliers so that licensed midwives can secure appropriate emergency medications. Ms. Davis then thanked Ms. Yaroslavsky for her many years of service on the Midwifery Advisory Council (MAC).

Ms. Davis announced plans that CAM had to implement a comprehensive quality of care program for licensed midwives. One aspect of this plan would include survey mechanisms for licensed midwives to receive feedback from the patients they assist as well as from physicians and nurses, hospital staff and the emergency medical services staff, after a transfer of care from home to hospital.

Kenwood Gill, M.D., commended the Board for assisting in making the CURES registration easy. He noted that he feels the Board's participation in the annual FSMB meetings is a conflict of interest and believes the interstate compact would adversely affect the state of California for a number of reasons.

Susan Shinazy commented on the Board's decision to make physicians tell their patients directly when they are on probation. She stated that not all patients have access to the internet to be able to check on each physician they see, so she encouraged the Board to make it mandatory that the physician notify their patients directly.

Agenda Item 13 **9:00 a.m. REGULATIONS – PUBLIC HEARING - Physician's and Surgeon's Licensing Examinations Minimum Passing Scores. Amendment to Section 1328.1 of Title 16, California Code of Regulations. This proposal would further define the law pertaining to passing scores on licensing examinations and eliminate the need for the Medical Board of California to pass a yearly resolution for the minimum passing examination score.**

Mr. Serrano Sewell stated this is the time and place set by the Board to conduct a public hearing on proposed regulations to amend the three separate sections of Title 16 of the California Code of

Regulation (CCR) as described in the notice published in the California Regulatory Notice Register and were sent by mail to those on the Board's mailing list.

This proposal would be seeking an amendment to Section 1328.1 of Title 16 of the California Code of Regulations. The proposal would further define BBC section 2177 pertaining to passing scores on licensing exams and eliminate the need for the Board to pass a yearly resolution for the minimum passing exam score. Mr. Serrano Sewell stated the written comment had to have been submitted by the deadline of July 20, 2015. He noted that no written public comment was received by the deadline.

Mr. Serrano Sewell noted the date as Friday, July 31, 2015 and the time as 9:30 a.m. Both Ms. Webb and Mr. Worden stated there had been no written comments received and the Board can move forward with the hearing.

No public comments were provided.

Mr. Serrano Sewell stated since there were no comments from the public or from Members of the Board, he asked for a motion to approve the regulation and ask staff to submit the regulatory package to the Office of Administrative Law (OAL) for finalization.

Dr. Lewis made a motion to approve the amendments to section 1328.1 of Title 16 and ask staff to submit the regulatory package to OAL for finalization; s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 14

9:05 a.m. REGULATIONS – PUBLIC HEARING - Outpatient Surgery Setting Accreditation Agency Standards. Amendment to Section 1313.4 of Title 16, California Code of Regulations. This proposal would make these regulations consistent with Health and Safety Code Section 1248.15 and 1248.35. The amendment will require all outpatient setting locations to be inspected and require an accreditation agency to report actions to the Board.

Mr. Serrano Sewell stated this is the time and place set by the Board to conduct a public hearing on proposed regulations to amend Section 1313.4 of Title 16 of the CCR as described in the notice published in the California Regulatory Notice Register and were sent by mail to those on the Board's mailing list. This proposal would make these regulations consistent with Health and Safety Code Section 1248.15 and 1248.35. The amendment would require all outpatient setting locations to be inspected and require an accreditation agency to report any actions to the Board within 24 hours.

Mr. Serrano Sewell stated written comment had to have been submitted by the deadline of July 20, 2015. He noted that no written public comment was received by the deadline.

Mr. Serrano Sewell noted the date as Friday, July 31, 2015 and the time as 9:34 a.m. Both Ms. Webb and Ms. Romero stated there had been no written comments received and the Board can move forward with the hearing.

Lisa McGiffert, Consumer's Union, supported the amendments and looks forward to seeing the change on the Board's website. She thanked Board staff for working with Consumer's Union over the years in getting the website improved in regards to the Outpatient Surgery Settings section.

Dr. Yip recommended staff check on each Accreditation Agency to see what criteria they use for reprimands.

Mr. Serrano Sewell stated with no additional comments from the public or from Members of the Board, he asked for a motion to approve the regulation and ask staff to submit the regulatory package to the Office of Administrative Law (OAL) for finalization.

Dr. Lewis made a motion to approve the amendments to section 1313.4 of Title 16 and ask staff to submit the regulatory package to the OAL for finalization; s/Dr. Yip. Motion carried unanimously.

Agenda Item 15 **9:10 a.m. REGULATIONS – PUBLIC HEARING - Disclaimers and Explanatory Information Applicable to Internet Postings. Amendment to Section 1355.35 of Title 16, California Code of Regulations. This proposal will update the list of disclaimers and explanatory information provided with public disclosure information released on the internet. The amendment will also add public disclosure screen types for court orders related to family support issues.**

Mr. Serrano Sewell stated this is the time and place set by the Board to conduct a public hearing on proposed regulations to amend Section 1355.35 of Title 16 of the CCR as described in the notice published in the California Regulatory Notice Register and were sent by mail to those on the Board's mailing list. This proposal would update the list of disclaimers and explanatory information provided with public disclosure information released on the internet. The amendment would also add public disclosure screen types for court orders related to family support issues.

Mr. Serrano Sewell stated the written comment had to have been submitted by the deadline of July 20, 2015. He noted that no written public comment was received by the deadline.

Mr. Serrano Sewell noted the date as Friday, July 31, 2015 and the time as 9:40 a.m. Both Ms. Webb and Mr. Romero stated there had been no written comments received and the Board can move forward with the hearing.

No public comments were provided.

Mr. Serrano Sewell stated since there were no comments from the public or from Members of the Board, he asked for a motion to approve the regulation and ask staff to submit the regulatory package to the Office of Administrative Law (OAL) for finalization.

Dr. Levine made a motion to approve the amendments to section 1355.35 of Title 16 and ask staff to submit the regulatory package to the OAL for finalization; s/Dr. Lewis. Motion carried unanimously.

Agenda Item 5 **Presentations on Physician Health Programs and Discussion/Consideration (cont'd from Thursday 7/30/15)**

Dr. Doris Gundersen gave a presentation on the Colorado Physician Health Program (CPHP). Dr. Gundersen is board certified in both general adult and forensic psychiatry. She is an Assistant Clinical Professor in the department of Psychiatry at the University of Colorado where she teaches medical students, residents, and fellows. Dr. Gundersen is currently the President of the Federation of State Physician Health Programs. Her presentation included CPHP's mission statement, and their program development. She described their funding history, and the CPHP's relationship with the Colorado Medical Board. She then reviewed their executive and clinical structure, and services as well as a review of their research activities and future endeavors.

Dr. Gundersen's presentation can be viewed in full on the Board's website at the following link: http://www.mbc.ca.gov/About_Us/Meetings/2015/Materials/materials_20150730_brd-5a.pdf

Dr. Lewis made a motion to direct staff to explore setting up meetings with interested parties on the topic of a physician health program. Motion passed unanimously.

Julie D'Angelo Fellmeth, Center for Public Interest Law, noted that the statement that "no participant in a physician health program had ever injured a patient while in the program" is heard often, but cannot be proven because participation in a diversion program is confidential. She stated that no program had ever been tracked to prove that anyone had graduated successfully after completing the program. She stated that there is no way to know if any program had ever been effective in assisting physicians in recovering from substance abuse or whether it had adequately protected patients. Ms. Fellmeth noted that any diversion program must stringently adhere to the SB 1441 uniform standards and any non-compliance with the program contract must be reported to the Board immediately and the participant must be removed from practice. She stated that there must be a two-strike policy as the first strike is having to enter the program. Any non-compliance is considered strike two and the physician is out of the program. She stated any new program created in California must not be controlled by the same organization or individuals of the former Diversion Program that were in control at the time of its abolishment in 2008, and the program must be audited every two years.

Miriam Hollingsworth, Consumers Union Safe Patient Project, stated they are against the possibility of a new diversion program, as the original program was discontinued for a number of reasons. She stated that these secret diversion programs do not work, and that all they do is keep dangerous, addicted physicians in practice while putting the unsuspected patient at risk of injury or death. She asked the Board that if a diversion program is reestablished, to be sure and have full disclosure to patients before being treated.

Michelle Monserat-Ramos, Consumers Union, asked the members to please remember that they were not appointed to their positions to rehabilitate physicians, but to protect California consumers.

Lisa McGiffert, Consumers Union, stated she is in full support of physicians getting rehabilitated, however, there are several programs out there for that purpose. She believes there is no need for the Board to create a special program that would interfere with the Board's oversight responsibilities.

Carmen Balber, Consumer Watchdog, stated she was troubled by the presentation that was given by Dr. Gundersen, as it stated they are advocates for physicians, which is the wrong approach for the Board to take. The Board's mission is to advocate for patient safety, and the past California program failures would preclude patient protection. Ms. Balber also noted that Dr. Gundersen's presentation stated that punishment for physicians is not the right tactic because it does not cure substance abuse, which is correct; however, there is no longer a diversion program because confidentially treating substance abusing physicians instead of disciplining them created a revolving door sending physicians back and forth from treatment to practice. She stated that if the Board decides to consider another diversion type program, confidentiality cannot be primary, treatment cannot take the place of discipline, and those responsible for running the program would have to be addressed.

Susan Shinazy stated Dr. Gundersen had mentioned in her presentation that more physicians would come forward for treatment if it were kept confidential; however, she did not show any statistics with that fact. She noted that helping anyone to hide addiction is enabling them, which is a huge disservice to patient safety.

Mr. Serrano Sewell stated he had no interest in replicating the Board's previous diversion program.

Motion carried unanimously.

Agenda Item 16 **Discussion and Possible Action on Proposed Regulations Updating the Model Disciplinary Orders and Disciplinary Guidelines**

Ms. Kirchmeyer reminded the Board that at the July 2014 Board meeting, Enforcement staff proposed several edits to the Board's Disciplinary Guidelines. Staff had intended to schedule a regulatory hearing for these edits, however, with the SB 1441 guidelines going through the process at that time, staff had to wait until those guidelines were finalized. With those now having been finalized, staff is now able to schedule the hearing for the disciplinary guidelines. However, since July 2014, staff have identified additional changes and edits that would either clarify the guidelines or make necessary changes.

Ms. Kirchmeyer referred the members to pages BRD 16-1 through 16-19 in their Board packets. She noted that the edits in red had already been approved and the edits in blue are the ones that need approval at this meeting. Ms. Kirchmeyer stated some of the edits are technical, such as changing the name of the agency, and the version number. The large strikeout area is a change in the manner in which these guidelines are provided. Previously the document would identify what changes have been made, however, those changes are now identified in the regulatory document, so staff is asking to eliminate that section.

Ms. Romero stated one significant change is in aligning the sections of cease practice orders to meet interim suspension orders, moving the need to file an accusation from 15 days to 30 days, as stated in the Government Code Section for interim suspension orders. In addition, staff realized that clarification was needed in the section of the final decision by a Board as compared to an administrative law judge. In the prior version, it appeared that both the Judge and the Board had a total of fifteen days to issue a decision, however it was the intention that each party had fifteen

days, and this amendment is recommended. Those conditions can be found in 9, 10 and 11. The changes in conditions 14, 15, 17, 18, and 23 remove the specific reference to the University of California San Diego Physician Assessment and Clinical Education (PACE) program. The Board should not identify one specific program, but instead, say a program approved, in advance, by the Board. On condition 28, at the July 2014 Board meeting, the Board approved the condition to include nurse practitioners (NPs), but the title had not been updated. Ms. Romero noted all other amendments are technical.

Ms. Kirchmeyer stated at this time staff is asking for a motion to approve the language as proposed and to notice the language for a public comment period. In addition, staff is seeking a motion to set this regulatory hearing for the October Board meeting.

Ms. Yaroslavsky made a motion to approve the language as proposed, as well as to set the regulatory hearing for the October Board meeting; s/Dr. Lewis. Motion carried unanimously.

Agenda Item 19 Executive Management Reports

Ms. Kirchmeyer began by asking for a motion to approve the orders following completion of probation and orders for license surrender during probation.

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

Ms. Kirchmeyer introduced the Board's new Chief of Enforcement, Christina Delp, stating she came from the Contractors State Licensing Board where she was the Deputy Chief of Enforcement and is pleased that she had joined the Board's team.

Ms. Kirchmeyer then noted she would not be going over the summaries in detail unless Members had any questions. She then stated the Memorandum of Understanding (MOU) with the California Research Bureau (CRB) to perform the ethnicity disciplinary demographic study had been signed, and work on the project would begin soon. Ms. Kirchmeyer noted there had been a delay in the signing of the MOU due to a leadership change at the CRB. The new leadership needed to review the MOU before signing. She stated that Board staff would provide requested data to the CRB so the study can begin.

Ms. Kirchmeyer stated that pursuant to a request at the last Board meeting, she met with the AG's Office and the DCA investigative unit to look into the interim suspension orders (ISOs) and ways to strengthen that process. She noted at their next meeting, discussion would include criteria for which cases may warrant an ISO. Once that criteria is identified, training would be provided to the investigators and deputies. She noted several more meetings would be held and a final report would be provided at the Board's October meeting.

Ms. Kirchmeyer stated she does not have a Board of Pharmacy (BOP) update, but did announce that the BOP conducted the final review of the comments on the hormonal contraception and Naloxone protocols at their meeting earlier in the week. She stated there would be a BOP update at the Board's October meeting.

In regards to the coordinated effort with other state agencies on prescribing psychotropic medications to foster children, the data use agreement with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) had been finalized and signed. Board staff had received the requested de-identified information, and staff is currently looking for a pediatric psychiatrist that can review this information to determine if physicians who may be inappropriately prescribing can be identified. Once that occurs, staff would work with DSS to obtain patient release forms for medical records to begin an investigation. This project had been delayed due to the search for the pediatric psychiatrist. In the meantime, staff met with a pediatrician to review the records and are now unsure how useful the information obtained is going to be at this point. However, after review from a pediatric psychiatrist, it may be found that a different type of data would be more useful and if so, would be requested at that time.

Ms. Kirchmeyer noted that staff would be attending a webinar hosted by DHCS and DSS, to discuss psychotropic medication data sharing efforts and staff was hopeful that it would assist in identifying further information that can be used for this project. Ms. Kirchmeyer stated that staff continues to encourage those who have foster children in their care to notify the Board of any physician they believe may be inappropriately prescribing these drugs.

Ms. Kirchmeyer stated the Board staff had been involved in the CURES program for quite some time, but she had asked Robert Sumner and Sandra Thuston from Department of Justice (DOJ) to come and give the Board a brief update on its current status.

Mr. Sumner, Deputy Attorney General working in the Office of Legislative Affairs, and Ms. Thuston, a manager in the AG's justice information services specific to law enforcement services, gave a brief update on the CURES program. Mr. Sumner stated that as of June 30th, it was announced that the CURES 2.0 went live and contains several features that are very useful to both the regulators as well as the users of the system. Their first priority is user acceptance. Issues that were identified during the user acceptance phase were worked out to be sure adoption could be done smoothly from the 1.0 system. They have done a "soft launch", rather than forcing everyone onto the new system all at once. They are transitioning people in to the system in phases. They currently have transitioned in regulators and would gradually be transitioning groups from the prescribing side.

Agenda Item 20 **Update from the Department of Consumer Affairs**

Ms. Lally reported that the Department of Consumer Affairs (DCA) had released many reports and data extracts that release one boards can now use to track their workloads. She stated of particular interest on the enforcement side, is the recent availability of a report providing the best data on cases referred to and pending at the AG's office. The report also provides information on outcomes of the disciplinary and administrative processes. Reports supplying similar levels of detailed information on intake in investigations are currently being tracked for late August or early September delivery, as testing of these reports are still in progress. She stated the DCA is committed to not releasing these reports if critical issues are not resolved during the testing phase. Ms. Lally thanked the Board staff who assisted in the design and critical input in the testing of the reports. She then noted that on the licensing side, data extracts of licensing applications received, both pending and completed are also provided on a regular basis to the boards by the DCA. In the future, these reports would be made available to be run on demand.

Ms. Lally then stated the final maintenance update for release one boards is scheduled in September. The DCA is grateful to staff for their continuing to communicate the maintenance priorities, as it results in requests being completed timely. Ms. Lally noted that release two of BreEZe is scheduled to launch in December. This release would include fixes and enhancements for release one boards. The maintenance release schedule for release two has not been finalized. She stated that DCA would be working with the vendor to get a maintenance schedule released as soon as possible.

Ms. Lally provided an update on the North Carolina Supreme Court decision. She noted the DCA legal office would continue to meet and work closely with Agency, the Governor's Office and the AG's Office on the decision. The DCA legal office is developing training for the Executive Officers, Board Presidents and Board Counsels on its impact. The training is scheduled for August, 2015. No specific date has been set yet. The DCA Legal Counsel is also following other legal cases that are taking place in other states that may possibly effect California.

Ms. Lally noted that Senator Hill had requested a legal opinion from the AG's office on the impact the Supreme Court Decision would have on the DCA's boards and bureaus and if the current Board structure provides sufficient active State supervision. She noted the DCA had been notified that Senator Hill and the Legislature would hold an informational hearing in the fall. Ms. Lally stated the DCA's legal counsel would be providing specific direction to all boards.

Ms. Lally then gave an update on the DCA's pro-rata study. She noted that enacted into law in January 2015, Senate Bill 1243 required the DCA to prepare a one-time study of their pro-rata system and the way expenses are distributed to DCA's boards and bureaus. In December 2014, the DCA commissioned CPS HR Consulting to conduct the study. The first part of the study was a survey of the boards and bureaus; the second was an analysis of how the pro-rata costs are distributed. She stated that nearly all of the Boards and Bureaus participated in the survey. The survey helped the DCA to determine that there are changes that can and must be made. She stated two of the most important areas are in customer service and timeliness. The results of this survey are being taken very seriously by the DCA and they are using this survey as a starting point to initiate improvements at the executive level.

Carolyn Navarro recommended the Board look at Yelp's website to see the reviews that people are giving in regard to their experiences with the Board.

Agenda Item 17 **Presentation and Update from the Federation of State Medical Boards – Jacqueline A. Watson, D.O. and Mike Dugan**

Ms. Watson and Mr. Dugan from the Federation of State Medical Boards (FSMB) gave a presentation and update on current issues at the FSMB. Those topics included the FSMBs vision and mission, the services and educational opportunities that the FSMB provides, and an update on their new five-year strategic plan. They also gave an advocacy update, which included discussion on the FSMB's 2015 policy initiatives, their scope of practice, the Interstate Medical Licensure Compact and opioid prescribing.

The FSMBs presentation can be viewed in full on the Board's website at the following link:
http://www.mbc.ca.gov/About_Us/Meetings/2015/Materials/materials_20150730_brd-17.pdf

Lisa McGiffert, Consumers Union, stated they work around the country and are pleased to see the FSMB information would be updated soon. She hoped that since the FSMB site is one of the few places that anyone in the country can look up their physicians, the FSMB would consider making disciplinary action information available to the public at no cost.

Dr. Gill thanked Ms. Watson and Mr. Dugan for attending and presenting at the meeting. He stated he believes there is no reason for California to consider the Interstate Compact at the current time as the needs of other states are very different from the needs of California. He then discussed the legislation being considered where Medicare beneficiaries can get telemedicine across state lines and the physician would be disciplined by the parent state and not where the beneficiary is located. He said if this Legislation should pass, it would impose a significant hardship on the state board that is responsible for disciplining the physician.

Agenda Item 18 **Presentation on Findings from the 2013 Supplemental Survey on Electronic Health Record Availability and Medi-Cal Participation – Janet Coffman, M.A., M.P.P., Ph.D., Associate Professor, University of California, San Francisco**

Dr. Coffman, University of California, San Francisco (UCSF), gave a presentation on the findings from the 2013 Supplements Survey done on Electronic Health Record availability and the participation of Med-Cal. Her presentation included information on the methods used in the survey to obtain the information, as well as the questionnaire which included voluntary questions as well as mandatory questions. She also presented many of the results of the survey, which included the 2011 – 2013 EHR availability, which was also broken down by practice type, by majority specialty, the five most frequently used features and the five least used features. Her presentation also provided facts and statistics about Medi-Cal participation.

Dr. Coffman's presentation can be viewed in full on the Board's website at the following link: http://www.mbc.ca.gov/About_Us/Meetings/2015/Materials/materials_20150730_brd-17.pdf

Carolyn Navarro stated she is angered that she had to contact Washington DC and have them contact Medi-Cal in California before anyone from Medi-Cal would respond to her complaints.

Agenda Item 21 **Investigation and Vertical Enforcement Program Report**

Mr. Gomez announced that they began the implementation of the new Vertical Enforcement (VE) Prosecution Manual. He stated he had met with all of the team members of the AG's office and investigators in the HQIU to go through the manual. He stated the primary goal was to create a new era of teamwork and collaboration to reduce delays in the enforcement process and increase the accountability to enhance consumer protection in California.

Mr. Gomez thanked Ms. Kirchmeyer and Ms. Castro for their valuable input into the creation of the manual and he felt that it is a product that would hold each individual accountable for their duties.

Ms. Sweet gave a presentation on the accomplishments that have taken place since the transition of the investigators from the Board to the DCA. Her presentation included accomplishments in their recruitment and retention efforts, improved efficiencies, improved staff morale, improved professionalism, and statistics of pending cases.

Ms. Sweet then announced that three of their investigators had been recognized by the Federal Department of Justice for their outstanding work on criminal cases during the past year; Supervising Investigator, Laura Gardhouse, Investigator Larry Bennett, and Supervising Investigator Carmen Aguilar-Marquez were awarded at a ceremony. She stated their investigators had won five like awards in the past five years, which is a testament of their passion and dedication for fulfilling the mission of public safety.

Ms. Castro gave an update on the VE Manual stating the negotiation team had been very motivated to get it completed, and she stated she is proud of the outcome. Ms. Castro noted now that the VE Manual is in place, their office would be starting to work on training staff as well as getting the Cloud concept finalized to assist in giving both attorneys and investigators access to the same files simultaneously. Her office would be working closely with DOJ to discuss collaboration software options to help determine which application would meet the needed requirements for all involved.

Ms. Yaroslavsky requested Ms. Sweet forward a copy of her presentation to the Board Members.

Dr. Lewis requested Ms. Sweet to provide a more detailed statistics chart to include a shorter time frame of improvements on enforcement case statuses.

Dr. Bholat asked Ms. Sweet what the percentage is of cases that go out to an expert reviewer and also what is being done to assist those reviewers to respond to these cases, in terms of the new manual.

Ms. Sweet responded that about 80% of cases go to expert reviewers once they have been processed by the Board staff protocol and then sent to the field offices.

Since the Board kept the Expert Reviewer Program, Ms. Kirchmeyer responded, noting that now that a new Chief of Enforcement had been hired, the training program would continue in the near future, on an annual or bi-annual basis, with the assistance of the HQUIU.

Dr. Bishop noted his concerns to Ms. Castro about the security of the Cloud that is being developed.

Ms. Castro stated that California had the Criminal Justice Information System Bureau that runs a system called the California Law Enforcement Tracking System (CLETS), which DOJ felt is very secure and encrypted. The security concerns is one of the reasons this project is taking longer than they had hoped since they are having more challenges since the BreEZe system had gone into place. They are taking these concerns seriously and would not release the Cloud until everything can work safely together.

Agenda Item 22 **Discussion and Possible Action on the Midwifery Challenge Program Offered by Maternidad La Luz**

Mr. Worden stated that previously, this school had approved a midwifery challenge program, but the law had since changed. With that change, staff requested that schools that already had challenge programs prove that they meet the new requirements. Mr. Worden noted this school

had met those requirement by submitting the necessary documents, which had been reviewed by he and Ms. Webb, who both agree that this school meets the necessary requirements of the new law, based on BPC Section 2513.

Mr. Worden asked the Board to approve this school, as it met the challenge requirements, based on BPC Section 2513.

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

Agenda Item 23 **Update from the Attorney General's Office**

Ms. Castro noted two new Deputy Attorney Generals had recently been hired. The first being Michael Yun from the Tulare District Attorney's office, and Leanna Shields from the San Diego District Attorney's office. She stated they are both very dedicated to this type of important work and would be a compliment to her current staff.

Ms. Castro then stated the DOJ had filed their responsive brief in the Lewis vs. Medical Board supreme court case in California. The case involved the CURES system and whether or not the Board should continue to use it. She noted this is just a legal challenge based on a privacy issue to determine if the Board would still be able to use the CURES system to assist in protecting the public during investigations. Ms. Castro stated she would hopefully have an update soon with a hearing schedule on that case.

Agenda Item 24 **Update on the Physician Assistant Board**

Dr. Bishop stated the Physician Assistant Board (PAB) went live with their BreEZe online renewal system in May and the website was updated to reflect the new service and staff had not experienced any issues with the system. PAB staff stated they were receiving fewer paper renewals and were able to quickly resolve last minute renewal issues by directing licensees to renew online with the BreEZe system.

Dr. Bishop then noted the PAB's website had been updated to provide licensees with information on the CURES 2.0 rollout and registration requirements.

Dr. Bishop announced that a regulatory hearing on the proposed guidelines for imposing the SB 1441 uniform standards regarding substance using licensees had been held on February 9, 2015. The PAB had voted to approve additional amendments in a 15-day public comment period. No public comments were received. Thus, the rulemaking file was finalized and submitted to the DCA for their review. Upon their approval, the file would then be forwarded to the OAL.

Dr. Bishop stated SB 2102 was effective January 1, 2015, and required the PAB to collect at time of the initial licensure renewal, specific demographic data for the Office of Statewide Health Planning and Development (OSHPD). PAB staff worked with the DCA and other boards to develop an electronic online survey. The initial license letter inserted with the wall certificate and pocket identification card would be updated with the link to the survey and the insert would be included with the renewal notice as well. He stated the PAB's website had also been updated

with information and links to the survey. The rollout of the survey took place in July, 2015. The PAB encouraged their licensees to complete the survey, as the data would provide helpful information to assist the State in determining health care shortages and the need for additional PA training programs. The data received would also be useful to the PAB with regard to public and policy goals of consumer protection.

Dr. Bishop noted that at the May 2015 PAB meeting, members discussed SB 337, which is currently pending before the legislature. Members voted to take an oppose unless amended position on the bill. The Members had concerns with the provisions of the bill regarding one of the two additional mechanisms. Specifically the method of concern would permit the supervising physician and PA to conduct medical record review meetings at least ten times annually. The PAB believed that ten times annually was too open ended and believed the time frame should be more precisely defined. In addition, the PAB noted there was no documentation provisions for these meetings. Finally, the PAB believed there should be a baseline of the number of cases reviewed at these meetings.

Dr. Bishop stated that at the July 2015 teleconference Board Meeting, the California Academy of Physician Assistants, sponsors of SB 337, provided amendments to the bill, which addressed the Board's concerns. The PAB then took a support if amended position on the bill.

Dr. Bishop then thanked the Medical Board for their continued support, stating the Executive Director, Ms. Kirchmeyer, and staff always make themselves available to the PAB whenever assistance is needed. He then stated the next PAB meeting is scheduled for August 3, 2015.

Agenda Item 25 Update on the Health Professions Education Foundation

Ms. Yaroslavsky stated a special application cycle had been opened from new money received from the California Endowment. It started May 18, 2015, and closed June 26, 2015. There were 53 applications received that are pending review at the end of July 2015. She thanked the California Endowment for their support and engagement in this program.

She stated the HPEF had also been doing outreach in trying to get the message of what they do out to the community. With that, she announced the engagement of their newest Executive Director, Linda Onsted Atkins, who had done an amazing job in her role as Acting Executive Director. Ms. Atkins had also taken on the role as the Assistant Executive Director for OSHPD.

Agenda Item 26 Agenda Items for the October 2015 Meeting in the San Diego Area

Mr. Serrano Sewell asked Members if there were any agenda items they would like added to the October Board Meeting agenda. He requested they contact Ms. Kirchmeyer if there is anything they would like added between now and then.

Mr. Serrano Sewell noted that if an administrative petition requesting the Board require physician notification to patients when they are on probation is received, it would be calendared for the October meeting.

Agenda Item 27 Election of Officers

Mr. Serrano Sewell stated that the Election of Board officers is done annually at the July Board Meeting. The Officer positions that would be voted on are Secretary, Vice President and President for the Board.

Mr. Serrano Sewell asked the Members for nominees for Secretary of the Board.

Dr. Lewis nominated Ms. Pines to continue as secretary of the Board; s/Ms. Yaroslavsky. No other nominations were made. Ms. Pines accepted the role to continue as Secretary. Vote passed unanimously.

Mr. Serrano Sewell asked the Members for nominees for Vice President of the Board.

Dr. Levine nominated Dr. GnanaDev to continue as Vice President of the Board; s/Dr. Yip. No other nominations were made. Dr. GnanaDev accepted the role to continue as Vice President. Vote passed unanimously.

Dr. GnanaDev asked the Members for nominees for President of the Board.

Ms. Yaroslavsky nominated Mr. Serrano Sewell to continue as President of the Board; s/Dr. Bishop. No other nominations were made. Mr. Serrano Sewell accepted the role to continue as President of the Board. Vote passed unanimously.

Dr. Levine recommended the Board to consider in the future having these roles be voted on every two years instead of annually.

Mr. Serrano Sewell thanked the Members for his re-election and stated he is honored and looking forward to the upcoming year.

Agenda Item 28 Adjournment

Mr. Serrano Sewell adjourned the meeting at 12:33 p.m.

 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/2015/

Standing Committees, Task Forces & Councils Agenda Item 7A
of the Medical Board of California
September 2015

<i>Committee</i>	<i>Members</i>
Executive Committee	<p>David Serrano Sewell, J.D., President Dev GnanaDev, M.D., Vice President Michael Bishop, M.D., Licensing Committee Chair Sharon Levine, M.D., Immediate Past President Ronald Lewis, M.D., Public Outreach, Education and Wellness Committee Chair Denise Pines, Secretary Felix Yip, M.D., Enforcement Committee Chair</p>
Licensing Committee	<p>Michael Bishop, M.D., Chair Dev GnanaDev, M.D. Randy Hawkins, M.D. Denise Pines Gerrie Schipske, R.N.P., J.D. Jamie Wright, Esq.</p>
Enforcement Committee	<p>Felix Yip, M.D., Chair Michelle Bholat, M.D. Howard Krauss, M.D. Barbara Yaroslavsky</p>
Application Review & Special Programs Committee	<p>Gerrie Schipske, R.N.P., J.D., Chair Ronald Lewis, M.D. Felix Yip, M.D.</p>
Special Faculty Permit Review Committee	<p>Michelle Bholat, M.D., Chair Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) John A. Heydt, M.D. (UCR) Jonathan Hiatt, M.D. (UCLA) Laurence Katznelson, M.D. (Stanford) James Nuovo, M.D. (UCD) Andrew Ries, M.D. (UCSD) Frank Sinatra, M.D. (USC) Julianne Toohey, M.D. (UCI) Barbara Yaroslavsky</p>
Public Outreach, Education, and Wellness Committee	<p>Ronald Lewis, M.D., Chair Randy Hawkins, M.D. Howard Krauss, M.D. Sharon Levine, M.D. Denise Pines David Serrano Sewell Barbara Yaroslavsky</p>
Midwifery Advisory Council	<p>Carrie Sparrevohn, L.M., Chair James Byrne, M.D. Karen Ehrlich, L.M. Tosi Marceline, L.M. Monique Webster Barbara Yaroslavsky</p>

Panel A	Jamie Wright, Esq., Chair Ronald Lewis, M.D., Vice Chair Michael Bishop, M.D. Randy Hawkins, M.D. David Serrano Sewell, J.D. Barbara Yaroslavsky Felix Yip, M.D.	Agenda Item 7A
Panel B	Dev GnanaDev, M.D., Chair Howard Krauss, M.D., Vice Chair Michelle Bholat, M.D. Sharon Levine, M.D. Denise Pines Gerrie Schipske, R.N.P., J.D.	
Prescribing Task Force	Michael Bishop, M.D. Barbara Yaroslavsky	
Editorial Committee	Sharon Levine, M.D. Denise Pines	

Members of Executive Committee include: President, Vice President, Secretary, Immediate Past President, and the Chairs of the Licensing Committee, the Enforcement Committee, and the Public Outreach, Education and Wellness Committee.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 13, 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.

- 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 have been meeting with the DCA and the Department of Justice (DOJ) to discuss requirements for the new Controlled Substance Utilization Review and Evaluation System (CURES) database.
- Board staff have met with the California Medical Association (CMA) on issues of interest to both parties.
- Board staff attend webinars and teleconferences with staff from the Federation of State Medical Boards and the International Association of Medical Regulatory Authorities.
- Board staff have been meeting with Legislative staff providing updates on the Board, its actions, and issues of interest.
- Board staff met several times with the Governor's Office staff and interested parties regarding Assembly Bill 684, providing technical assistance and discussing its implementation.
- Board staff have had meetings with staff from the Health Quality Investigative Unit (HQIU) and the Attorney General's (AG) Office on Interim Suspension Orders and the vertical enforcement report.
- Board staff attended a Prescription Drug Abuse and Safe Prescribing webinar where best practices were discussed.
- Board staff attended a briefing from the California Health Policy Forum on *Enabling Information Sharing among California Health Providers: What's Next?*
- Board staff met with interested parties to discuss the elements of physician health program.
- Board staff attended a webinar by the Center for Disease Control and Prevention (CDC) that presented the CDC Opioid Prescribing Guidelines and provided an avenue for comment.
- Board staff attended a training by the DCA regarding the *North Carolina Dental Examiners v. Federal Trade Commission* decision.
- Board staff attended meetings held by the CMA on the corporate practice of medicine.
- Board staff met with CompUSA to discuss the licensing and renewal process.
- Board staff met with the Office of Administrative Hearings to provide a Board update.
- Board staff met with the Graduate Medical Education deans to discuss the application and licensure process.
- 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 met with staff from 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 6% vacancy rate which equates to 9 vacant positions. This is lower than the vacancy rate that was provided in the last Administrative Summary, which was 8%. Of those 9 vacant positions, the Board has 3 individuals pending a start date or verification of eligibility. Therefore, the Board only has 6 positions that do not have an individual identified for the position, which equates to a 4% vacancy rate for the Board.

Budget Update:

The Board's budget documents are attached, beginning on page BRD 8B-4 and continuing to page BRD 8B-16. The Board's fund condition on page BRD 8B-4 identifies the Board's fund reserve was at 5.4 months at the end of FY 14-15. As stated in the previous updates, it is important to note 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. The Board is continuing to work with DCA to resolve the issues with the Board's revenue. Once the overstated amount is known, the fund condition will be updated accordingly. The fund condition also includes repayment of the \$15 million loans to the general fund. The partial repayment of the general fund loans will occur in FY 15-16 (\$10 million) as identified in the Governor's Budget. This fund condition also shows the remaining \$5 million being repaid in FYs 16-17 and 17-18. With the repayment of the outstanding loans and taking into consideration future anticipated costs, the Board's fund reserve will be below its mandated level in FY 17-18. However, depending upon the actual revenue for FY 13-14, this could occur in FY 16-17. The Board staff will be closely monitoring the Board's budget to determine whether future changes are needed. The second fund condition on page BRD 8B-5 does not include the repayment of the general fund loans. As indicated by both fund conditions, it would not be prudent at this time to consider any reduction in licensing fees as previously recommended by the Bureau of State Audits because the Board anticipates to be within its mandatory level in FY 16-17, even with the loan repayments and below its mandated level in FY 18-19. In addition, the Board has future costs that could impact the Board's budget should they be approved.

The Board's overall actual expenditures for FY 14-15 can be found on BRD 8B-6 and for FY 15-16 through August 31, 2015 can be found on page BRD 8B-7. Pages BRD 8B-8 to 8B-12 show the budget report specifically for licensing, enforcement, the HQIU, and the AG expenditures. Page BRD 8B-16 provides the Board Members' expenditure report as of September 29, 2015.

BreEZe Update:

A report will be provided at the October Board Meeting by both Board staff and DCA staff on specific updates and the status of pending requests. The Board continues to not have the reports necessary to identify the Board's workload and processing timeframes. Although the Board's and DCA's staff are working on these reports, there are still no reports that identify the enforcement statistics previously reported to the Board by using the legacy databases.

Board staff continues to submit requests for changes/fixes to DCA for the BreEZe system. As previously stated, the Board has been notified that there will be no maintenance releases, unless there is an emergency release needed, from now until Release 2. Release 2 is scheduled to occur in January 2016 and therefore no maintenance releases for Release 1 boards will be performed during the testing and roll out of Release 2. The Board will be performing regression testing on all of its processes and functions during the Release 2 board user acceptance testing. This testing is intended to ensure that the Release 2 roll out will not impact the Board or its functions.

Controlled Substance Utilization Review and Evaluation System (CURES) Update

With the passage of AB 679 (Allen, Chapter 778), the deadline for CURES registration has been moved from January 1, 2016 to July 1, 2016. This will allow prescribers and dispensers an additional six months to become registered. In addition, the Board has been notified that the streamlined application and approval process should be available on October 30, 2015. All physicians will have to use a compliant browser to register for CURES using the streamlined process. However, after they are registered into the system, they will not need to use a compliant browser to access CURES. If the physician uses an older browser to access CURES, they will be redirected to CURES 1.0 for querying purposes and will not benefit from the improvements of CURES 2.0. The DOJ has stated that CURES 1.0 will be phased out in mid-2016, thereby requiring all physicians to have a compliant browser to access CURES 2.0 at this time. DOJ will be providing an updated notice within the next two weeks.

As part of its outreach efforts to physicians, the Board highlighted the CURES system, and the need for prescribers to register, in the Summer Newsletter. Once the streamlined application process has been implemented, the Board will send notifications to licensees via email, social media, and the Fall Newsletter. The material will include information on who needs to register, the new registration deadline date, the registration process, how to look up patient information, how to enter information for licensees who direct dispense, and other important information.

Federation of State Medical Board

Board staff continue to participate in webinars held by the FSMB and communicate on common issues. Board staff and Members also attend Committee and Task Force Meetings when possible.

The Board was notified that the inaugural meeting of the Interstate Medical Licensure Compact (Compact) Commission will be held October 27 and 28, 2015 in Chicago, Illinois. To date, 11 states have formally adopted the Compact and will become part of the Commission. The Commission, as outlined in the Compact will begin writing rules for the full implementation of the Compact. Nine states have legislation pending. At this time, the Board has not been notified that there is a Legislative member interested in introducing the Compact in California.

0758 - Medical Board
Analysis of Fund Condition

(Dollars in Thousands)

Fund Condition with General Fund Loan Repayments

	ACTUAL 2014-15	CY 2015-16	BY 2016-17	BY+1 2017-18	BY+2 2018-19
BEGINNING BALANCE	\$ 28,151	\$ 27,572	\$ 29,787	\$ 22,495	\$ 13,039
Prior Year Adjustment	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,151	\$ 27,572	\$ 29,787	\$ 22,495	\$ 13,039
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	\$ 345	\$ 195	\$ 205	\$ 205	\$ 205
125700 Other regulatory licenses and permits	\$ 6,727	\$ 6,369	\$ 6,370	\$ 6,370	\$ 6,370
125800 Renewal fees	\$ 47,253	\$ 46,477	\$ 46,516	\$ 46,516	\$ 45,727
125900 Delinquent fees	\$ 130	\$ 116	\$ 126	\$ 126	\$ 126
141200 Sales of documents	\$ 7	\$ 10	\$ 10	\$ 10	\$ 10
142500 Miscellaneous services to the public	\$ -	\$ -	\$ 30	\$ 30	\$ 30
150300 Income from surplus money investments	\$ 76	\$ 69	\$ 52	\$ 22	\$ 8
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 14	\$ 14	\$ 14	\$ 14	\$ 14
161400 Miscellaneous revenues	\$ 11	\$ 10	\$ 10	\$ 10	\$ 10
Totals, Revenues	\$ 54,563	\$ 53,260	\$ 53,333	\$ 53,303	\$ 52,500
Transfers:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ 3,000	\$ 3,000	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ 7,000	\$ -	\$ 2,000	\$ -
TOTALS, REVENUES AND TRANSFERS	\$ 54,563	\$ 63,260	\$ 56,333	\$ 55,303	\$ 52,500
TOTAL RESOURCES	\$ 82,714	\$ 90,832	\$ 86,120	\$ 77,798	\$ 65,539
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	\$ 48	\$ -	\$ -	\$ -	\$ -
8880 FSCU (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
FISCAL	\$ 4	\$ 107	\$ -	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 55,090	\$ 58,535	\$ 59,654	\$ 60,847	\$ 61,946
<u>2015-16 and ongoing Approved Costs</u>					
BreEZe Costs	\$ -	\$ 2,403	\$ 2,494	\$ -	\$ -
<u>Anticipated Future Costs</u>					
BreEZe Costs	\$ -	\$ -	\$ -	\$ 2,499	\$ 2,499
Change in Business Process	\$ -	\$ -	\$ 742	\$ 678	\$ 678
Expert Reviewer	\$ -	\$ -	\$ 735	\$ 735	\$ 735
Total Disbursements	\$ 55,142	\$ 61,045	\$ 63,625	\$ 64,759	\$ 65,858
1110 Reimbursement/Cost Recovery		\$ 1,817	\$ 1,817	\$ 1,817	\$ 1,817
FUND BALANCE					
Reserve for economic uncertainties	\$ 27,572	\$ 29,787	\$ 22,495	\$ 13,039	\$ (319)
Months in Reserve	5.4	5.6	4.2	2.4	-0.1

NOTES:

- A. Assumes workload and revenue projections are realized for FY 15/16 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$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.
- D. FY 14/15 miscellaneous revenues included the Unclaimed Property and the Attorney General Settlements and Judgements revenues.
- E. FY 15/16 Year-to-Date reimbursement/cost recovery is a net reduction in expenditures and is reflected for display purposes only.

10/5/2015

**0758 - Medical Board
Analysis of Fund Condition**

(Dollars in Thousands)

Fund Condition without General Fund Loan Repayments

	ACTUAL 2014-15	CY 2015-16	BY 2016-17	BY+1 2017-18	BY+2 2018-19
BEGINNING BALANCE	\$ 28,151	\$ 27,572	\$ 19,787	\$ 9,495	\$ (1,961)
Prior Year Adjustment	\$ -	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,151	\$ 27,572	\$ 19,787	\$ 9,495	\$ (1,961)
REVENUES AND TRANSFERS					
Revenues:					
125600 Other regulatory fees	\$ 345	\$ 195	\$ 205	\$ 205	\$ 205
125700 Other regulatory licenses and permits	\$ 6,727	\$ 6,369	\$ 6,370	\$ 6,370	\$ 6,370
125800 Renewal fees	\$ 47,253	\$ 46,477	\$ 46,516	\$ 46,516	\$ 45,727
125900 Delinquent fees	\$ 130	\$ 116	\$ 126	\$ 126	\$ 126
141200 Sales of documents	\$ 7	\$ 10	\$ 10	\$ 10	\$ 10
142500 Miscellaneous services to the public	\$ -	\$ -	\$ 30	\$ 30	\$ 30
150300 Income from surplus money investments	\$ 76	\$ 69	\$ 52	\$ 22	\$ 8
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 14	\$ 14	\$ 14	\$ 14	\$ 14
161400 Miscellaneous revenues	\$ 11	\$ 10	\$ 10	\$ 10	\$ 10
Totals, Revenues	\$ 54,563	\$ 53,260	\$ 53,333	\$ 53,303	\$ 52,500
Transfers:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ -	\$ -	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ -	\$ -	\$ -	\$ -
TOTALS, REVENUES AND TRANSFERS	\$ 54,563	\$ 53,260	\$ 53,333	\$ 53,303	\$ 52,500
TOTAL RESOURCES	\$ 82,714	\$ 80,832	\$ 73,120	\$ 62,798	\$ 50,539
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	\$ 48	\$ -	\$ -	\$ -	\$ -
8880 FSCU (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
FISCAL	\$ 4	\$ 107	\$ -	\$ -	\$ -
1110 Program Expenditures (State Operations)	\$ 55,090	\$ 58,535	\$ 59,654	\$ 60,847	\$ 61,946
<u>2015-16 and ongoing Approved Costs</u>					
BreEZe Costs	\$ -	\$ 2,403	\$ 2,494	\$ -	\$ -
<u>Anticipated Future Costs</u>					
BreEZe Costs	\$ -	\$ -	\$ -	\$ 2,499	\$ 2,499
Change in Business Process	\$ -	\$ -	\$ 742	\$ 678	\$ 678
Expert Reviewer	\$ -	\$ -	\$ 735	\$ 735	\$ 735
Total Disbursements	\$ 55,142	\$ 61,045	\$ 63,625	\$ 64,759	\$ 65,858
1110 Reimbursement/Cost Recovery		\$ 1,817	\$ 1,817	\$ 1,817	\$ 1,817
FUND BALANCE					
Reserve for economic uncertainties	\$ 27,572	\$ 19,787	\$ 9,495	\$ (1,961)	\$ (15,319)
Months in Reserve	5.4	3.7	1.8	-0.4	-2.9

NOTES:

- A. Assumes workload and revenue projections are realized for FY 15/16 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$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.
- D. FY 14/15 miscellaneous revenues included the Unclaimed Property and the Attorney General Settlements and Judgements revenues.
- E. FY 15/16 Year-to-Date reimbursement/cost recovery is a net reduction in expenditures and is reflected for display purposes only.

10/5/2015

Medical Board of California
Fiscal Year 2014-15
Budget Expenditure Report
(FM13 - June 30, 2015)
(100% 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	8,122,493	87.6	1,150,133
Board Members	31,500	91,297	289.8	(59,797)
Temp Help	755,888	176,532	23.4	579,356
Overtime	44,433	44,714	100.6	(281)
Staff Benefits	5,084,579	4,481,552	88.1	603,027
BL 12-03 Blanket	0	526,697	0.0	0
TOTALS, PERS SERVICES	15,189,026	13,443,285	88.5	2,272,438
OPERATING EXP & EQUIP				
General Expense	72,874	291,954	400.6	(219,080)
Fingerprint Reports	333,448	339,774	101.9	(6,326)
Minor Equipment	28,949	105,681	365.1	(76,732)
Printing	194,755	228,223	117.2	(33,468)
Communications	106,190	136,327	128.4	(30,137)
Postage	149,511	117,074	78.3	32,437
Insurance	2,053	3,080	150.0	(1,027)
Travel In-State	130,298	146,912	112.8	(16,614)
Travel Out-of-State	0	2,641	0.0	(2,641)
Training	54,894	5,902	10.8	48,992
Facilities Operation (Rent)	928,140	1,128,809	121.6	(200,669)
Consult/Prof Services	2,301,088	1,986,868	86.3	314,220
- Attorney General Services	13,347,280	12,024,173	90.1	1,323,107
- Office of Administrative Hearings	1,525,080	1,279,144	83.9	245,936
- Evidence/Witness	1,893,439	1,701,653	89.9	191,786
- Court Reporter Services	225,000	96,912	43.1	128,088
Departmental Prorata	5,059,555	5,085,746	100.5	(26,192)
HQIU	16,320,487	16,313,540	100.0	6,947
Consolidated Data Center	650,230	148,553	22.8	501,677
Data Processing	117,492	327,524	278.8	(210,032)
Central Admin Svcs (Statewide Prorata)	2,883,789	2,866,649	99.4	17,139
Major Equipment	57,180	95,132	166.4	(37,952)
Vehicle Operations	31,925	57,722	180.8	(25,797)
Other Items of Expense	0	0	0.0	0
Special Items of Expense	0	435	0.0	(435)
TOTALS, OE&E	46,413,657	44,490,428	95.9	1,923,228
TOTALS, EXPENDITURES	61,602,683	57,933,713	94.0	3,668,969
Scheduled Reimbursements	(384,000)	(353,373)	92.0	(30,627)
Distributed Costs	(780,000)	(672,846)	86.3	(107,154)
NET TOTAL, EXPENDITURES	60,438,683	56,907,495	94.2	3,531,188
Unscheduled Reimbursements*		(1,817,320)		
		55,090,175		

* no authority to spend

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report
(As of August 31, 2015)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	9,221,564	1,404,121	15.2	7,817,443
Board Members	31,500	5,900	18.7	25,600
Temp Help	755,880	33,809	4.5	722,071
BL 12-03 Blanket	0	83,749	0.0	(83,749)
Overtime	44,441	5,584	12.6	38,857
Staff Benefits	5,003,036	749,390	15.0	5,003,036
TOTALS, PERS SERVICES	15,056,421	2,282,553	15.2	13,523,259
OPERATING EXP & EQUIP				
General Expense	204,206	86,800	42.5	117,406
Fingerprint Reports	333,448	29,577	8.9	303,871
Printing	194,755	93,820	48.2	100,935
Communications	106,190	2,318	2.2	103,872
Postage	149,511	9,318	6.2	140,193
Insurance	2,053	0	0.0	2,053
Travel In-State	130,298	10,912	8.4	119,386
Travel Out-of-State	0	0	0.0	0
Training	54,895	2,104	3.8	52,791
Facilities Operation (Rent)	928,140	1,019,272	109.8	(91,132)
Consult/Prof Services	1,317,088	1,066,284	81.0	250,804
Departmental Prorata	6,419,849	1,603,754	25.0	5,691,778
HQIU	16,341,000	3,576,511	21.9	12,764,489
Consolidated Data Center	650,230	11,350	1.7	638,880
Data Processing	117,492	39,147	33.3	78,345
Central Admin Svcs (Statewide Prorata)	2,912,000	728,071	25.0	2,183,929
Major Equipment	8,500	0	0.0	8,500
Other Items of Expense	0	0	0.0	0
Vehicle Operations	31,925	6,360	19.9	25,565
Attorney General Services	13,347,280	2,171,029	16.3	11,176,251
Office of Administrative Hearings	1,750,080	0	0.0	1,750,080
Evidence/Witness	1,893,439	60,964	3.2	1,832,475
Court Reporter Services	225,000	110,832	49.3	114,168
Minor Equipment	35,200	34,945	99.3	255
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	47,152,579	10,663,368	22.6	37,364,895
TOTALS, EXPENDITURES	62,209,000	12,945,920	20.8	49,263,080
Scheduled Reimbursements	(384,000)	(69,148)	18.0	(314,852)
Distributed Costs	(780,000)	0	0.0	(780,000)
NET TOTAL, EXPENDITURES	61,045,000	12,876,772	21.1	48,168,228
Unscheduled Reimbursements*		(97,104)		
		12,779,668		

* no authority to spend

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Licensing
(As of August 31, 2015)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	2,633,146	409,728	15.6	2,223,418
Board Members	0	0	0.0	0
Temp Help	48,396	5,573	11.5	42,823
BL 12-03 Blanket	0	2,834	0.0	(2,834)
Overtime	21,716	99	0.5	21,617
Staff Benefits	1,345,267	228,072	17.0	1,345,267
TOTALS, PERS SERVICES	4,048,525	646,306	16.0	3,630,291
OPERATING EXP & EQUIP				
General Expense	22,382	3,406	15.2	18,976
Fingerprint Reports	333,448	29,449	8.8	303,999
Printing	92,626	8,703	9.4	83,923
Communications	19,646	60	0.3	19,586
Postage	72,495	3,469	4.8	69,026
Insurance	0	0	0.0	0
Travel In-State	17,178	1,202	7.0	15,976
Travel Out-of-State	0	0	0.0	0
Training	18,207	0	0.0	18,207
Facilities Operation (Rent)	269,758	322,113	119.4	(52,355)
Consult/Prof Services	794,091	1,024,521	129.0	(230,430)
Departmental Prorata	2,129,256	191,329	9.0	1,937,927
HQIU	0	0	0.0	0
Consolidated Data Center	0	0	0.0	0
Data Processing	8,664	2,130	24.6	6,534
Central Admin Svcs (Statewide Prorata)	965,816	728,071	75.4	237,745
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	29,189	4,110	14.1	25,079
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	0	0.0	0
Court Reporter Services	250	0	0.0	250
Minor Equipment	2,964	0	0.0	2,964
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	4,775,970	2,318,563	48.5	2,457,407
TOTALS, EXPENDITURES	8,824,495	2,964,868	33.6	5,859,627
Scheduled Reimbursements	(384,000)	(69,148)	18.0	(314,852)
Distributed Costs	(31,131)	0	0.0	(31,131)
NET TOTAL, EXPENDITURES	8,409,364	2,895,720	34.4	5,513,644
Unscheduled Reimbursements*		0		
		2,895,720		

* no authority to spend

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Enforcement
(As of August 31, 2015)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	2,512,068	378,626	15.1	2,133,442
Board Members	0	0	0.0	0
Temp Help	608,589	0	0.0	608,589
BL 12-03 Blanket	0	76,697	0.0	(76,697)
Overtime	10,281	3,224	31.4	7,057
Staff Benefits	1,558,101	215,815	13.9	1,558,101
TOTALS, PERS SERVICES	4,689,039	674,362	14.4	4,230,492
OPERATING EXP & EQUIP				
General Expense	69,469	47,657	68.6	21,812
Fingerprint Reports	0	128	0.0	(128)
Printing	43,898	74,946	170.7	(31,048)
Communications	40,015	145	0.4	39,870
Postage	74,371	5,462	7.3	68,909
Insurance	0	0	0.0	0
Travel In-State	39,017	2,110	5.4	36,907
Travel Out-of-State	0	0	0.0	0
Training	15,087	2,104	13.9	12,983
Facilities Operation (Rent)	294,072	346,070	117.7	(51,998)
Consult/Prof Services	479,560	30,776	6.4	448,784
Departmental Prorata	1,764,356	1,176,992	66.7	587,364
HQIU	16,341,000	3,576,511	21.9	12,764,489
Consolidated Data Center	0	0	0.0	0
Data Processing	15,045	18,912	125.7	(3,867)
Central Admin Svcs (Statewide Prorata)	800,300	0	0.0	800,300
Major Equipment	0	0	0.0	0
Other Items of Expense	0	0	0.0	0
Vehicle Operations	0	4,398	0.0	(4,398)
Attorney General Services	13,318,091	2,166,919	16.3	11,151,172
Office of Administrative Hearings	1,750,080	0	0.0	1,750,080
Evidence/Witness	1,736,958	60,814	3.5	1,676,144
Court Reporter Services	224,750	110,832	49.3	113,918
Minor Equipment	4,863	471	9.7	4,392
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	37,010,932	7,625,248	20.6	29,385,685
TOTALS, EXPENDITURES	41,699,971	8,299,610	19.9	33,400,361
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	(744,054)	0	0.0	(744,054)
NET TOTAL, EXPENDITURES	40,955,917	8,299,610	20.3	32,656,307
Unscheduled Reimbursements*		(26,290)		
		8,273,320		

* no authority to spend

**MEDICAL BOARD OF CALIFORNIA
 ATTORNEY GENERAL EXPENDITURES - FY 2015-16
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)**

page 1 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
July	Attorney Services	6188.50	\$170.00	\$1,052,045.00
	Paralegal Services	338.25	\$120.00	\$40,590.00
	Auditor/Analyst Services	279.50	\$99.00	\$27,670.50
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$1,120,305.50
August	Attorney Services	5743.50	\$170.00	\$976,395.00
	Paralegal Services	351.25	\$120.00	\$42,150.00
	Auditor/Analyst Services	255.50	\$99.00	\$25,294.50
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$2,773.85
				<hr/>
				\$1,046,613.35
September	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
October	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
November	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
December	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00

Total July-Dec = \$2,166,918.85
FY 2015-16 Budget = \$13,318,091.00
 BRD 8B - 10

**MEDICAL BOARD OF CALIFORNIA
 ATTORNEY GENERAL EXPENDITURES - FY 2015-16
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)**

page 2 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
January	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
February	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
March	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
April	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
May	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
June	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00

FYTD Total = \$2,166,918.85
FY 2015-16 Budget = \$1,318,091.00
 BRD 8B - 11

Health Quality Investigation Unit (HQIU)
Fiscal Year 2015-16
Budget Expenditure Report
(As of August 31, 2015)
 (17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,275,240	1,215,187	14.7	7,060,053
Temp Help	1,073,743	139,485	13.0	934,258
Overtime	5,559	480	8.6	5,079
Staff Benefits	4,351,289	669,985	15.4	3,681,304
BL 12-03 Blanket	0	7,397	0.0	(7,397)
TOTALS, PERS SERVICES				
	13,705,831	2,032,534	14.8	11,673,297
OPERATING EXP & EQUIP				
General Expense	108,734	101,953	93.8	6,781
Printing	59,000	50,108	84.9	8,892
Communications	100,000	8,305	8.3	91,695
Postage	21,000	8	0.0	20,992
Insurance	14,000	0	0.0	14,000
Travel In-State	222,000	8,787	4.0	213,213
Travel Out-of-State	7,000	0	0.0	7,000
Training	22,000	0	0.0	22,000
Facilities Operation (Rent)	1,574,000	1,219,344	77.5	354,656
Consult/Prof Services	91,000	26,628	29.3	64,372
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	0	0.0	15,000
Data Processing	0	28,610	0.0	(28,610)
Central Admin Svcs (Statewide Prorata)	0	0	0.0	0
Major Equipment	199,085	0	0.0	199,085
Other Items of Expense	28,000	22,978	82.1	10,741
Vehicle Operations	166,000	17,259	10.4	166,000
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	0	0.0	0
Court Reporter Services	0	59,999	0.0	(59,999)
Minor Equipment	8,350	0	0.0	8,350
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E				
	2,635,169	1,543,978	58.6	1,114,169
TOTALS, EXPENDITURES	16,341,000	3,576,511	21.9	12,764,489
Scheduled Reimbursements				0
Distributed Costs				0
NET TOTAL, EXPENDITURES				
Unscheduled Reimbursements*	16,341,000	3,576,511	21.9	12,764,489
		0		
		3,576,511		

* no authority to spend

**ENFORCEMENT/PROBATION RECEIPTS
MONTHLY PROFILE: JULY 2013 - JUNE 2016**

	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	850	800	500	100	50	1,963	600	5,813
Criminal Cost Recovery	844	29,175	4,060	13,683	15,041	1,185	1,133	6,184	1,499	7,009	1,194	3,284	84,291
Probation Monitoring	64,316	41,643	52,840	73,499	56,938	146,603	414,557	227,809	117,226	60,897	46,859	47,974	1,351,161
Exam	9,061	3,048	7,438	13,718	26,715	8,551	13,313	7,060	6,755	8,796	3,273	600	108,328
Cite/Fine	3,000	3,000	1,000	5,000	0	0	0	0	2,500	0	0	2,500	17,000
MONTHLY TOTAL	77,221	76,916	65,388	106,750	98,694	157,189	429,803	241,553	128,080	76,752	53,289	54,958	1,566,593
FYTD TOTAL	77,221	154,137	219,525	326,275	424,969	582,158	1,011,961	1,253,514	1,381,594	1,458,346	1,511,635	1,566,593	

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	FYTD Total
Invest Cost Recovery	50	50											100
Criminal Cost Recovery	451	4,851											5,302
Probation Monitoring	74,221	54,139											128,360
Exam	9,593	5,778											15,371
Cite/Fine	0	0											0
MONTHLY TOTAL	84,315	64,818	0	149,133									
FYTD TOTAL	84,315	149,133											

excel:enfreceiptsmoonthlyprofile.xls.revised 9/23/2015

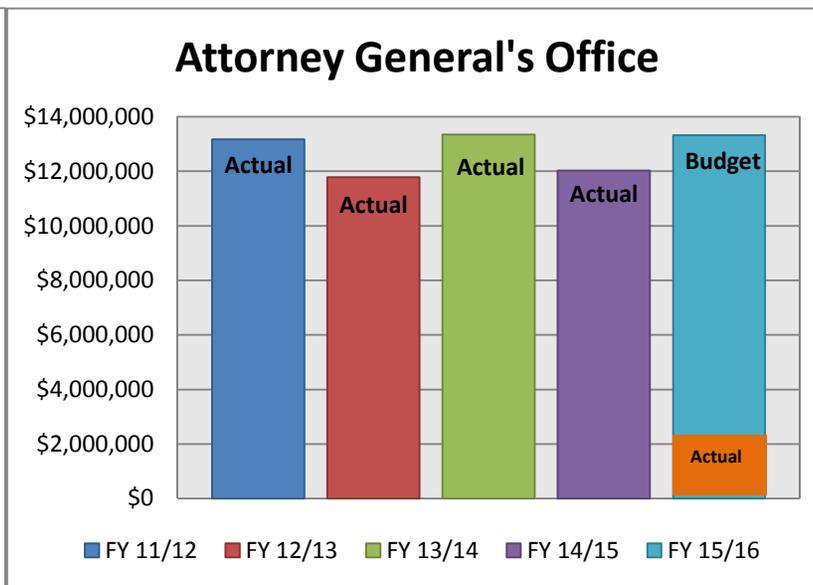
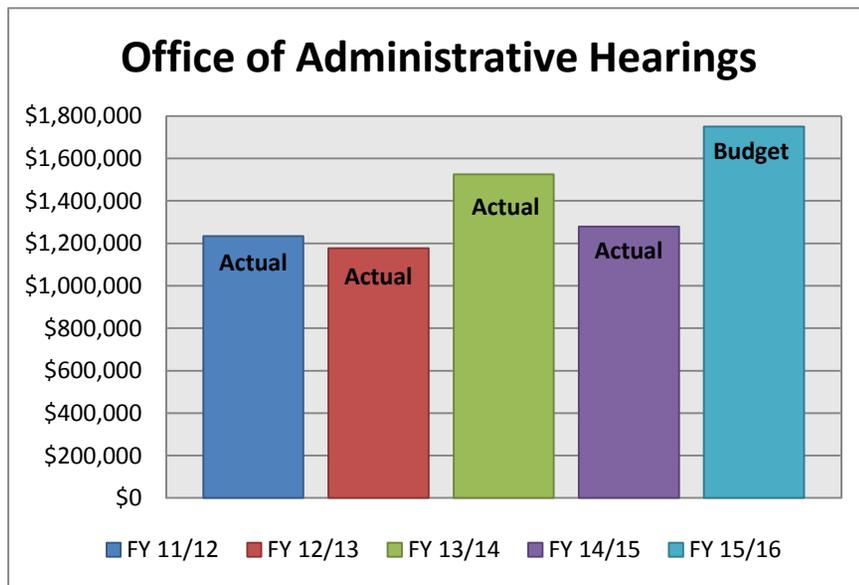
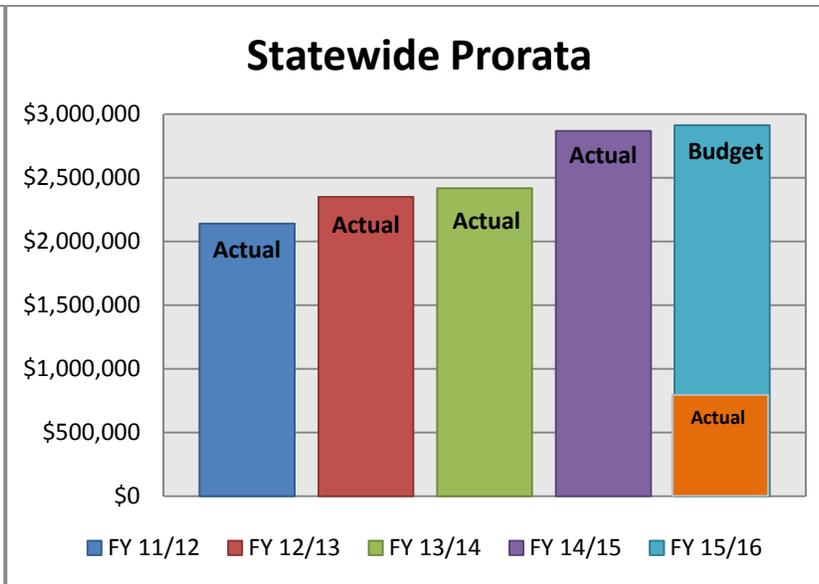
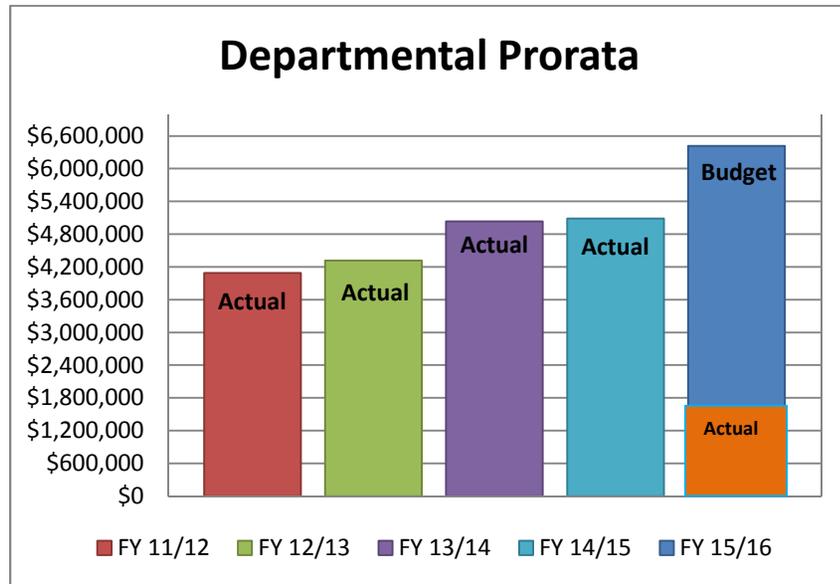
NOTE: Beginning with October 2013, payment amounts reflect payments made directly to MBC; they do not include payments made through BreZE online system. Online payment information is unavailable. BRD 8B - 13

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
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	1,909,018	45,230,270		6,502,878	1,576,586	3,154,922	2,065,009	60,438,683
\$ Spent*	1,517,922	40,108,425		8,845,645	1,413,056	2,745,722	2,276,725	56,907,495 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1
FY 15/16								
\$ Budgeted **	1,964,540	40,955,917		8,409,364	2,267,880	3,903,652	3,543,647	61,045,000
\$ Spent thru 08/31*	391,461	8,299,610		2,895,720	371,461	538,871	379,649	12,876,772 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

* net expenditures (excludes unscheduled reimbursements)
 ** Budgeted does not include pending current year budget adjustments.

External Agencies' Spending



NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR BHOLAT - Per diem													\$ -
Travel													\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. BISHOP - Per diem	\$ 800.00	\$ 600.00											\$ 1,400.00
Travel	\$ 880.03												\$ 880.03
	\$ 1,680.03	\$ 600.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,280.03
DR GNANADEV - Per diem	\$ 1,000.00	\$ 1,000.00											\$ 2,000.00
Travel	\$ 961.79												\$ 961.79
	\$ 1,961.79	\$ 1,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,961.79
DR HAWKINS - Per diem													\$ -
Travel													\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. KRAUSS - Per diem	\$ 500.00												\$ 500.00
Travel													\$ -
	\$ 500.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 500.00
DR. LEVINE - Per diem													\$ -
Travel	\$ 479.05												\$ 479.05
	\$ 479.05	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 479.05
DR. LEWIS - Per diem	\$ 1,000.00	\$ 700.00											\$ 1,700.00
Travel	\$ 750.90												\$ 750.90
	\$ 1,750.90	\$ 700.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,450.90
MR. LUI - Per diem													\$ -
Travel													\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MS. PINES - Per diem	\$ 1,300.00	\$ 1,100.00											\$ 2,400.00
Travel	\$ 728.51												\$ 728.51
	\$ 2,028.51	\$ 1,100.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,128.51
MS.SCHIPSKE - Per diem	\$ 1,000.00												\$ 1,000.00
Travel													\$ -
	\$ 1,000.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,000.00
MR. SERRANO SWELL- Per diem	\$ 600.00												\$ 600.00
Travel													\$ -
	\$ 600.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 600.00
MS.WRIGHT - Per diem	\$ 1,500.00	\$ 1,300.00											\$ 2,800.00
Travel	\$ 921.54												\$ 921.54
	\$ 2,421.54	\$ 1,300.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,721.54
MS. YAROSLAVSKY - Per diem		\$ 1,300.00											\$ 1,300.00
Travel	\$ 924.49												\$ 924.49
	\$ 924.49	\$ 1,300.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,224.49
DR. YIP - Per diem													\$ -
Travel													\$ -
	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

As of: 9/29/15

TOTAL PER DIEM \$ 13,700.00
 TOTAL PER DIEM BUDGETED \$ 31,500.00
 TOTAL TRAVEL \$ 5,646.31

TOTAL \$ 19,346.31

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 14, 2015
 ATTENTION: Members, Medical Board of California
 SUBJECT: Enforcement Program Summary
 STAFF CONTACT: Christina Delp, Chief of Enforcement

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 1048 experts in the Board's expert database. 239 experts were utilized to review 418 cases between January and September 2015. **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, or Psychiatry
- Dermatology
- Family Medicine
- Midwife Reviewer
- Neurological Surgery
- Neurology
- OB/Gyn
- Pathology
- Pain Medicine
- Plastic Surgery
- Psychiatry
- Surgery *(although the numbers show that we have more experts than total cases in this field, we still need to expand our list because it is difficult to find actively practicing surgeons readily available to perform reviews at time of request)*
- Urology

Staff has begun efforts to develop a recruitment plan to expand the number of experts within the aforementioned specialty fields of medicine. In addition, Staff have been reviewing and updating the Expert Reviewer Guidelines which are expected to be completed by December 31, 2015, in time for the Expert Reviewer training that is tentatively scheduled to be held in Southern California during March 2016. The Expert Reviewer database, called Med-X, is expected to get a new overhaul. Staff have been recording elements needed to enhance the antiquated database and will be working with staff from the Information Systems Branch (ISB) to make the system is user friendly for staff, investigators, and medical consultants to search for qualified Experts to assist with complaint investigations.

Staffing Update:

Enforcement Program management continues to fill vacant positions within the various units of the Enforcement Division. In the July 2015 Enforcement Summary, it was reported that the Central Complaint Unit had five vacancies. As of October 12, 2015, four of those vacancies have been filled and the new employees have reported to work and have begun training. Applicants for the final vacant position have been interviewed and the top candidate is progressing through the hiring process. The Complaint Investigation Office filled its remaining Special Investigator (non-sworn) position and the new employee is scheduled to report to work on November 2, 2015. In the Probation Unit, the Northern California

Inspector I position was filled and this employee reported to work in September. Interviews have been completed to fill one Inspector I position in the LA Metro area and one Associate Governmental Program Analyst position in Northern California. The Discipline Coordination Unit is fully staffed.

Central Complaint Unit (CCU):

The number of days it takes to initiation a complaint has increased to an average of fifteen (15) days, however staff continues to work together to reduce this timeframe to ten (10) days to ensure compliance with Business and Professions Code Section 129. Additionally, CCU analysts are continuing their efforts to reduce the number of days needed to complete the processing of complaints. This has been a difficult goal to achieve due to the vacancies in CCU, but the recently hired staff are making significant strides in learning their new functions. Management is confident they will contribute greatly once they have completed their training. Lastly, effective August 31, 2015, the Board received authority to once again issue citations containing orders of abatement and fines for violations of the statutes referred to in Title 16 of the California Code of Regulations, section 1364.11.

Complaint Investigation Office (CIO):

The Special Investigators (non-sworn) in CIO are each currently carrying a caseload of, approximately, 35-40 cases, however, this will decrease with the addition of the new investigator in November. Since the last summary report in July 2015, the unit has transmitted six (6) cases to the AG's Office; three (3) convictions, two (2) Petitions for Reinstatement and one (1) medical malpractice case. Staff have also completed ten (10) face-to-face subject interviews and closed fifty-eight (58) cases.

Discipline Coordination Unit (DCU):

DCU staff continues to focus their efforts on restoring public disciplinary documents on the Board website to ensure compliance with AB 1886. As indicated in the last Enforcement Summary, staff encountered a delay in the restoration when another component related to Breeze was identified. Management is currently offering overtime and has devised a daily schedule for all DCU staff to work on this project with the hopes of completing this project by December 31, 2015.

Probation Unit:

Management recently completed case reviews for all three of the Board's probation offices. Inspectors in each office are beginning to see Orders that include the new disciplinary guideline language contained in the recently implemented Uniform Standards for Substance-Abusing Licensees that took effect on March 25, 2015. On November 4, 2015, the Inspector Supervisors and management will meet to develop a comprehensive training plan for the unit's inspectors, focusing on subjects that will enhance their skills in monitoring probationers.

Vertical Enforcement Legislative Report:

On October 7, 2015, Board staff met with Department of Consumer Affairs (DCA) Chief Deputy Director Tracy Rhine, Deputy Director Michael Gomez, Senior Assistant Attorney General Gloria Castro, Supervising Deputy Attorney General Terry Jones and retired DCA Attorney Anita Scuri to discuss the upcoming report on the Vertical Enforcement (VE) process that is due to the Legislature on March 1, 2016. The group discussed the highlights and challenges of the VE process and discussed what items need to be included in the report. Ms. Scuri will be assisting Board staff in writing the report. The report will communicate the any efficiencies from the process and areas needing improvement to enhance the usefulness of VE in investigating Board complaints.

Technology Improvement – Cloud System:

The development of a “cloud” to share case information electronically via a secured system has been developed and will be utilized by staff within Enforcement’s DCU, CIO, and Probation Units; Health Quality Investigative Unit Investigators; and the Deputies at the Attorney General’s Office. This system will permit the timely receipt and sharing of case information and will reduce operating costs for the three agencies. A schedule to provide training to staff is under-development and it is anticipated staff from all agencies will be trained and proficient in using the cloud by the end of the first quarter in 2016.

**Medical Board of California
Expert Reviewer Program Report**

September 30, 2015

SPECIALTY	Number of cases reviewed by Experts from January 1 through September 30, 2015	Number of Experts and how often utilized from January 1 through September 30, 2015	Active List of Experts 1,048 ↓
<i>ADDICTION</i>	1	1 EXPERT 1 LIST EXPERT	11 ↓
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes) *INVOLVED 1 PREP W/ DAG and 2 COMPANION CASES (SAME SUBJECT, DIFFERENT COMPLAINTS). *FLAGGED AS UNAVAILALE TO REVIEW NEW CASES (LAST QUARTER OF CAL. YEAR 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.	10	6 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 6 CASES *	71 ↑
COLON & RECTAL SURGERY (CRS)			3
<i>COMPLEMENTARY/ALTERNATIVE MEDICINE</i>	5	2 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 4 CASES	17 ↓
DERMATOLOGY (D)	5	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 3 CASES	12 ↑
EMERGENCY (EM) *INVOLVED 5 COMPANION CASES and FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES (THE LAST QUARTER OF 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.	12	6 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 6 CASES*	44 ↓
FAMILY (FM) *FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES (THE LAST QUARTER OF CAL. YEAR 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.	66	29 EXPERTS 15 LIST EXPERTS REVIEWED 1 CASE EA 6 LIST EXPERTS REVIEWED 2 CASES EA 3 LIST EXPERTS REVIEWED 3 CASES EA 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES * 2 LIST EXPERTS REVIEWED 6 CASES EA* 1 LIST EXPERT REVIEWED 13 CASES*	65
<i>HAND SURGERY</i>	1	1 EXPERT 1 LIST EXPERT	13
<i>HOSPICE & PALLIATIVE MEDICINE</i>	1	1 EXPERT 1 LIST EXPERT	15
INTERNAL (General Internal Med)	49	34 EXPERTS 24 LIST EXPERTS REVIEWED 1 CASE EA 3 LIST EXPERTS REVIEWED 2 CASES EA 4 LIST EXPERTS REVIEWED 3 CASES EA 3 LIST EXPERTS REVIEWED 4 CASES EA	152 ↓

**Medical Board of California
Expert Reviewer Program Report**

September 30, 2015

SPECIALTY	Number of cases reviewed by Experts from January 1 through September 30, 2015	Number of Experts and how often utilized from January 1 through September 30, 2015	Active List of Experts 1,048 ↓
Cardiovascular Disease (Cv)	6	5 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA	32 ↓
Endocrinology (EDM)	1	1 EXPERT 1 LIST EXPERT	4
Gastroenterology (Ge)	7	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 3 CASES	21 ↑
Nephrology (Nep)			12 ↓
Pulmonary Disease (Pul)	1	1 EXPERT 1 LIST EXPERT	16
Rheumatology (Rhu)			5 ↓
MIDWIFE REVIEWER	2	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES	5
NEUROLOGICAL SURGERY (NS)	5	4 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES	8
NEUROLOGY (N) *INVOLVED 3COMPANION CASES AND ALSO FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES (THE LAST QUARTER OF 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.	18	8 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES*	22 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3
NUCLEAR MEDICINE (NuM)			4
OBSTETRICS & GYNECOLOGY (ObG) *FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES THE LAST QUARTER OF CAL. YEAR 2015	25	17 EXPERTS 11 LIST EXPERTS REVIEWED 1 CASE EA 3 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 6 CASES*	62 ↓

**Medical Board of California
Expert Reviewer Program Report**

September 30, 2015

SPECIALTY	Number of cases reviewed by Experts from January 1 through September 30, 2015	Number of Experts and how often utilized from January 1 through September 30, 2015	Active List of Experts 1,048 ↓
OPHTHALMOLOGY (Oph)	11	8 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES EA	26
ORTHOPAEDIC SURGERY (OrS)	6	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES	30 ↓
OTOLARYNGOLOGY (Oto)	1	1 EXPERT 1 LIST EXPERT	16 ↓
PAIN MEDICINE (PM) *FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES (THE LAST QUARTER OF CAL. YEAR 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.	25	14 EXPERTS 9 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 3 CASES 2 LIST EXPERTS REVIEWED 5 CASES EA*	29 ↓
PATHOLOGY (Path)	2	2 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 1 CASE	10 ↑
PEDIATRICS (Ped)	5	5 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA	48 ↓
Pediatric Cardiology (Cd)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE	5
PHYSICAL MEDICINE & REHABILITATION			11 ↑
PLASTIC SURGERY (PIS) *FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES THE LAST QUARTER OF CAL. YEAR 2015	38	14 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 2 LIST EXPERT REVIEWED 3 CASES EA 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES* 3 LIST EXPERTS REVIEWED 6 CASES EA*	38 ↓
OCCUPATIONAL MEDICINE	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA	6 ↓

**Medical Board of California
Expert Reviewer Program Report**

September 30, 2015

SPECIALTY	Number of cases reviewed by Experts from January 1 through September 30, 2015	Number of Experts and how often utilized from January 1 through September 30, 2015	Active List of Experts 1,048 ↓
<p>PSYCHIATRY (Psyc)</p> <p>*ALL 4 EXPERTS PERFORMED MOSTLY PSYCH EVALUATIONS, NOT CASE REVIEWS.</p> <p>**PERFORMED 4 CASE REVIEWS, 1 SUPPLEMENTAL WORK AND 6 PSYCH EVALUATIONS (FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF).</p> <p>***PERFORMED 6 CASE REVIEWS, 1 PREP, 9 PSYCH EVALUATIONS (FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF).</p>	104	<p>43 EXPERTS</p> <p>20 LIST EXPERTS REVIEWED 1 CASE EA 8 LIST EXPERTS REVIEWED 2 CASES EA 6 LIST EXPERTS REVIEWED 3 CASES EA 3 LIST EXPERTS REVIEWED 4 CASES EA 1 LIST EXPERT REVIEWED 1 CASE and PERFORMED 4 EVALUATIONS* 1 LIST EXPERT PERFORMED 5 EVALUATIONS* 1 LIST EXPERT REVIEWED 2 CASES and PERFORMED 4 EVALUATIONS* 1 LIST EXPERT PERFORMED 6 EVALUATIONS* 1 LIST EXPERT REVIEWED 5 CASES and PERFORMED 6 EVALUATIONS ** 1 LIST EXPERT REVIEWED 7 CASES and PERFORMED 9 EVALUATIONS and ADMINISTERED 1 ORAL COMP EXAM ***</p>	72 ↑
<p>RADIOLOGY (Rad)</p> <p>*INVOLVED 4 COMPANION CASES (FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES (THE LAST QUARTER OF 2015) WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.</p>	8	<p>4 EXPERTS</p> <p>3 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 5 CASES*</p>	28 ↓
<p>Radiation Oncology (Rad RO)</p>			4
<p>SLEEP MEDICINE (S)</p>	1	<p>1 EXPERT</p> <p>1 LIST EXPERT</p>	7
<p>SURGERY (S)</p>	12	<p>9 EXPERTS</p> <p>5 LIST EXPERTS REVIEWED 1 CASE EA 1 OFF LIST EXPERT REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 2 CASES EA</p>	29 ↓
<p>Pediatric Surgery (PdS)</p>			3
<p>VASCULAR SURGERY (VASCS)</p>	1	<p>2 EXPERTS</p> <p>2 LIST EXPERTS REVIEWED 1 CASE EA</p>	7
<p>THORACIC SURGERY (TS)</p>			11
<p>TOXICOLOGY</p>	1	<p>1 EXPERT</p> <p>1 LIST EXPERT</p>	7

**Medical Board of California
Expert Reviewer Program Report**

September 30, 2015

SPECIALTY	Number of cases reviewed by Experts from January 1 through September 30, 2015	Number of Experts and how often utilized from January 1 through September 30, 2015	Active List of Experts 1,048 ↓
------------------	--	---	---

UROLOGY (U) * INVOLVED 4 COMPANION CASES (FLAGGED AS UNAVAILABLE TO REVIEW NEW CASES THE LAST QUARTER OF CAL. YEAR 2015 WITHOUT PRIOR APPROVAL FROM MBC CHIEF OF ENF.)	10	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 6 CASES *	14
---	----	--	----

TOTAL CASES REVISED (Jan-Sep 30, 2015)	418
TOTAL EXPERTS UTILIZED (Jan-Sep 30, 2015)	239
TOTAL LIST OF ACTIVE EXPERTS	1,048

↓↑ Numbers fluctuate based on availability of experts and removal from the Program.

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 14, 2015
 ATTENTION: Members, Medical Board of California
 SUBJECT: Licensing Program Summary
 STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:

The Licensing Program experienced staff being out of the office due to vacations and other unplanned leaves, in addition to several vacant positions. However, staff continued to work hard in the first quarter of fiscal year (FY) 2015-16 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 – Cashiering
- 3 Management Services Technician - US/CAN P&S Application Reviewer

Staff Currently Training:

- 1 Management Services Technician – US/CAN P&S Application Reviewer
- 1 Staff Services Analyst – IMG P&S Application Review

STATISTICS:

The statistics are on pages BRD 8D - 3 through BRD 8D - 10. Please note that a few 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 have been obtained from the call center phone system, tracked manually, or from the BreEZe system.

Notable statistics include:

- Consumer Information Unit telephone calls answered: 19,692
 - 265 less calls answered than the previous quarter
- Consumer Information Unit telephone calls abandoned: 8,913
 - 1,293 more abandon calls than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 12,788
 - 2,875 more call back requests than the previous quarter
- P&S applications initial review completed: 1,341 (hand count)
- P&S licenses issued: 1,237
 - This is a decrease of 780 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 10 weeks out of the 13 weeks in the first quarter of FY 2015-16. The highest number of days the initial goal was exceeded was 19 days. Licensing had several staff out of the office during this time frame. Staff have been working overtime to reduce these numbers.

INTERNATIONAL MEDICAL SCHOOLS:

The statistics for the International Medical School Reviews are on page BRD 8D – 5. The review of International Medical Schools continues to be a demanding workload for the Board. The Board did not receive any new Self-Assessment Reports and there are currently seven Self-Assessment Reports that are pending. The Board will review one medical school for a possible site visit at the October 30, 2015 Board meeting.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:

The Board has one pending application from a physician specialty board requesting approval by the Board.

OUTREACH:

The Licensing Outreach Manager has attended the following licensing workshops and when appropriate, residents from affiliated hospitals are invited to attend, and CURES signups were also offered:

Orientation for upperclass residents and fellows:

- Loma Linda: about 75 residents
- UCI: about 60 residents
- UCLA: about 75 residents

License Fairs:

- August 5: License Fair (Day 1) at UCSF; approximately 95 residents
- September 9: UCSF for those residents rotating through SF General and Mission Bay hospitals; approximately 35 residents
- Sept 10: California Pacific Medical Center (SF); approximately 35 residents
- Sept 17-18: UCSD (including San Diego Veterans Administration, Rady Children's Hospital, and the UCSD Medical Center); approximately 100 residents

On September 24, 2015, Curtis Worden, Chief of Licensing and Anthony Salgado, Licensing Manager attended a Licensing Fair at UCSF; approximately 65 residents participated.

On September 29, 2015, Curtis Worden, Chief of Licensing, gave a presentation to the ACGME Coordinators at the UCI Medical Center in Orange, California; approximately 20 coordinators attended.

On September, 30, 2015, Curtis Worden, Chief of Licensing, attended a Licensing Fair at the UCI Medical Center in Orange, California; approximately 75 residents attended.

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

**WORKLOAD REPORT
as of September 30, 2015**

CONSUMER INFORMATION UNIT FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Total Calls Answered	19,692	19,692			
Calls Requesting Call Back	12,788	12,788			
Calls Abandoned	8,913	8,913			
Address Changes Completed	1,438	1,438			

CONSUMER INFORMATION UNIT FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Total Calls Answered	78,260	22,092	17,177	19,034	19,957
Calls Requesting Call Back	42,728	11,376	9,081	12,358	9,913
Calls Abandoned	34,104	9,204	7,193	10,087	7,620
Address Changes Completed	12,063	5,231	3,369	2,235	1,228

PHYSICIAN & SURGEON DATA FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	2,494	2,494			
Initial Reviews Completed	1,341	1,341			
Total Pending	0	N/A			
Reviewed	0	N/A			
Not Reviewed	0	N/A			
(SR2s Pending)	35	35			
Licenses Issued	1,237	1,237			
Renewals Issued	17,123	17,123			

PHYSICIAN & SURGEON DATA FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Applications Received	6,850			1,967	1,516
Initial Reviews Completed	N/A				
Total Pending	N/A				
Reviewed	N/A				
Not Reviewed	N/A				
(SR2s Pending)	N/A			16	21
Licenses Issued	5,873	1,222	1,243	1,391	2,017
Renewals Issued	33,341			16,675	16,666

**WORKLOAD REPORT
as of September 30, 2015**

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Beginning	N/A	7			
Received	4	4			
Reviewed	4	4			
Not Eligible	0	0			
Licensed	2	2			

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Received	6	3	0	2	1
Reviewed	8	2	1	2	3
Not Eligible	0	0	0	0	0
Licensed	0	0	0	0	0

SR 2 - CATEGORIES FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Alcohol/Drugs	7	7			
PG/Medical Knowledge	16	16			
Convictions	17	17			
Other	31	31			

SR 2 - CATEGORIES FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Alcohol/Drugs	33	10	4	14	5
PG/Medical Knowledge	105	42	19	25	19
Convictions	39	14	10	7	8
Other	112	34	29	24	25

**WORKLOAD REPORT
as of September 30, 2015**

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	N/A	107			
Pending Self-Assessment Reports (included above)	N/A	7			
New Self-Assessment Reports Received	0	0			
New Unrecognized Schools Received	13	13			
School Recognized Pursuant to CCR 1314(a)(1)	6	6			
School Recognized Pursuant to CCR 1314(a)(2)	0	0			
TOTAL Schools Pending Recognition at End of Quarter	N/A	114			

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	102	111
Pending Self-Assessment Reports (included above)	N/A	6	7	7	7
New Self-Assessment Reports Received	1	1	0	0	0
New Unrecognized Schools Received	59	22	12	16	9
School Recognized Pursuant to CCR 1314(a)(1)	54	18	16	7	13
School Recognized Pursuant to CCR 1314(a)(2)	0	0	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	N/A	106	102	111	107

*Three CCR 1314.1(a)(2) school files were closed due to lack of response to the Board's requests for information.

SPECIALTY BOARD APPLICATIONS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	0	0			
Applications Pending	1	1			

SPECIALTY BOARD APPLICATIONS FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Applications Received	0	0	0	0	0
Applications Pending	N/A	1	1	1	1

RESEARCH PSYCHOANALYST FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
RP Applications Received	1	1			
RP Licenses Issued	3	3			

RESEARCH PSYCHOANALYST FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
RP Applications Received	12	4	2	2	4
RP Licenses Issued	3	1	0	2	0

Licensing Program Report

**WORKLOAD REPORT
as of September 30, 2015**

Fiscal Year 2015-2016

LICENSED MIDWIVES FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	4	4			
Applications Pending	1	1			
Applications Withdrawn	0	0			
Licenses Issued	9	9			
Licenses Renewed	37	37			

LICENSED MIDWIVES FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
Applications Received	45	3	20	16	6
Applications Pending	N/A	2	7	10	6
Applications Withdrawn	1	0	1	0	0
Licenses Issued	42	5	14	13	10
Licenses Renewed	153	43	39	29	42

FICTITIOUS NAME PERMITS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
P&S - FNP Received	375	375			
P&S - FNP Issued	324	324			
P&S - FNP Pending	0	N/A			
P&S - FNP Renewed	1,337	1,337			
Podiatric FNP Received	6	6			
Podiatric FNP Issued	6	6			
Podiatric FNP Pending	0	N/A			
Podiatric FNP Renewed	36	36			

FICTITIOUS NAME PERMITS FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
P&S - FNP Received	N/A			322	364
P&S - FNP Issued	N/A			255	339
P&S - FNP Pending	N/A			N/A	N/A
P&S - FNP Renewed	N/A			1,371	1,319
Podiatric FNP Received	N/A			5	9
Podiatric FNP Issued	N/A			7	4
Podiatric FNP Pending	N/A			N/A	N/A
Podiatric FNP Renewed	N/A			30	37

**WORKLOAD REPORT
as of September 30, 2015**

OPTICAL REGISTRATIONS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
RDO - Business Registrations Issued	18	18			
RDO - Pending Applications Business	15	15			
CLS - Out-of-State - Business Registrations Issued	0	0			
CLS - Pending Out of State Applications -Business	1	1			
Spectacle Lens Registrations Issued	62	62			
Spectacle Lens - Pending Applications	26	26			
Contact Lens Registrations Issued	15	15			
Contact Lens - Pending Applications	5	5			
Spectacle Lens Registrations Renewed	214	214			
Contact Lens Registrations Renewed	93	93			

OPTICAL REGISTRATIONS FY 14/15					
	FY 14/15	Q1	Q2	Q3	Q4
RDO - Business Registrations Issued	N/A			17	13
RDO - Pending Applications Business	N/A			14	26
CLS - Out-of-State - Business Registrations Issued	N/A			0	0
CLS - Pending Out of State Applications -Business	N/A			1	1
Spectacle Lens Registrations Issued	N/A			62	62
Spectacle Lens - Pending Applications	N/A			45	35
Contact Lens Registrations Issued	N/A			18	26
Contact Lens - Pending Applications	N/A			13	5
Spectacle Lens Registrations Renewed	N/A			239	287
Contact Lens Registrations Renewed	N/A			111	130

TITLE 16. MEDICAL BOARD OF CALIFORNIA

NOTICE IS HEREBY GIVEN that the Medical Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at The Westin San Diego, 400 West Broadway, San Diego, CA 92101, 619-239-4500, at 9:00 a.m., on October 30, 2015.

Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office not later than 5:00 p.m. on October 19, 2015, or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as the contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018 of the Business and Professions Code (BPC) and Section 11400.20 of the Government Code (GC), and to implement, interpret or make specific Sections 2227, 2228, and 2229 of the BPC, as well as Sections 11400.20, 11425.50(e), and 11529 of the GC, the Board is considering changes to Section 1361 of Division 13 of Title 16 of the California Code of Regulations (CCR) as follows:

INFORMATIVE DIGEST/POLICY STATEMENT OVERVIEW

A. Informative Digest

In reaching its disciplinary decisions, the Board uses the Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) incorporated by reference into 16 CCR section 1361. Currently, the Board uses the 11th Edition of the Disciplinary Guidelines, which were adopted by regulation in 2011.

Proposed Amendment to 16 CCR section 1361:

This rulemaking proposes to amend 16 CCR section 1361 to incorporate by reference the 12th Edition/2015 of the Disciplinary Guidelines, instead of the 11th Edition/2011. It is necessary to incorporate the Disciplinary Guidelines by reference due to the size of the document.

Proposed Amendments to the Disciplinary Guidelines

The Disciplinary Guidelines will be amended to identify it as the 12th Edition, amended in 2015, instead of the 11th Edition, amended in 2011. Further, the Disciplinary Guidelines will be updated to reflect the new agency name of "Business, Consumer Services, and Housing Agency," from the prior name of "State and Consumer Services Agency."

The instructions for writing or calling the Board for additional copies of the Disciplinary Guidelines will be deleted, and interested parties will be advised that the document is accessible on the Board's website.

In the past, the Board has provided a summary of changes for each new addition at the beginning of the document. This summary will be deleted as it is unnecessary, since the rulemaking file is the official record for the justification and summary of all changes.

The Table of Contents will be changed to reflect the title changes to conditions 18, 19, and 28. Page number changes will be made, if necessary.

Conditions 9 (Controlled Substances – Abstain from Use), 10 (Alcohol – Abstain from Use), and 11 (Biological Fluid Testing) of the Disciplinary Guidelines currently authorize the issuance of a cease practice order for non-compliance, but require that an accusation be filed within 15 days, or the cease practice order will be dissolved. They also provide that a decision shall be received from the Administrative Law Judge (ALJ) or the Board within 15 days unless good cause can be shown for the delay.

The proposed amendments to **Conditions 9, 10, and 11** will reflect a change in GC 11529, effective January 1, 2014, which extended the timeframe for filing an accusation following the issuance of a suspension order from 15 days to 30 days. The proposed amendments to these conditions will also clarify that the ALJ and the Board would each have 15 days to issue a decision, and will define good cause for a delay in issuing such decision. Additionally, under **Condition 11**, the option to use a breathalyzer will be specifically included in the definition of "biological fluid testing."

Conditions 14 (Prescribing Practices Course), 15 (Medical Records Keeping Course), 17 (Professional Boundaries Program), 18 (Clinical Training Program), and 23 (Monitoring – Practice/Billing) currently specify that the courses are to be equivalent to the courses at the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego School of Medicine.

The proposed amendments to these conditions will remove reference to PACE to eliminate the appearance of endorsing one program's courses over others.

Condition 18 (Clinical Training Program) describes the Board's requirements for a clinical training program. Current law requires a two-day comprehensive assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment related to the respondent's area of practice in which he or she was alleged to be deficient, and required a minimum 40-hour program of clinical education in that area.

Current law further provides that the program will advise the Board of its recommendations for any additional education, training, or treatment for any medical or psychological condition, or anything else affecting respondent's practice of medicine.

Current law also requires respondent to pass an examination at the end of any additional education or clinical training.

Under Option #1: Condition Precedent of Condition 18, current law allows a respondent to practice medicine in a clinical training program approved by the Board, and indicates that respondent's practice shall be restricted to that which is required by the approved training program.

Under the proposed amendments, Condition 18 will be renamed "Clinical Competence Assessment Program." Moreover, the specific time-frame requirements of a two-day assessment and a 40-hour program will be deleted to permit the program to design an assessment and program particular to each respondent's circumstance. The proposed amendments will require a comprehensive assessment of respondent's physical and mental health; and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and the American Board of Medical Specialties pertaining to respondent's current or intended area of practice. The proposed amendments identify what the program shall consider during its assessment of the respondent, and specifies that the program shall require the respondent's on-site participation for a minimum of three to five days as determined by the program.

The proposed amendments require the program to submit a comprehensive assessment to the Board that unequivocally states whether the respondent has demonstrated the ability to practice safely and independently, and provide its recommendations for any further education, clinical training, or evaluation or treatment for any medical or psychological condition, or anything else affecting respondent's practice of medicine.

The proposed amendments will eliminate the requirement that the respondent pass an examination at the completion of additional education or clinical training.

Under Option #1: Condition Precedent of Condition 18, the proposed amendment eliminates the exception allowing respondent to practice medicine in a clinical training program.

Condition 19 (Oral and/or Written Examination) currently provides for the option of requiring the respondent to submit to an oral or written examination when appropriate.

The proposed amendments will strike the option of an oral examination as a condition that could be ordered.

It also strikes the language indicating that the respondent shall be allowed to take a second exam if he or she fails the first one.

Condition 25 (Third Party Chaperone) currently allows a respondent to nominate a replacement chaperone within 60 days after a chaperone leaves the respondent's employ.

The proposed amendment will reduce the time allowed to replace a chaperone from 60 days to 30 days.

Condition 28 (Supervision of Physician Assistants) currently prohibits a respondent from supervising physician assistants while on probation.

The proposed amendment will prohibit a respondent from supervising physician assistants and advanced practice nurses, and will change the title of the condition from “Supervision of Physician Assistants” to “Supervision of Physician Assistants and Advanced Practice Nurses.”

Condition 31 (General Probation Requirements) currently provides that the respondent shall comply with the Board’s probation unit and all terms and conditions of the Decision.

The proposed amendment will eliminate the phrase “and all terms and conditions of this Decision,” to reflect different requirements for respondents residing within California, and those residing in other states, during periods of non-practice, as further described under Condition 33, below.

Condition 33 (Non-practice While on Probation) currently does not well-differentiate what is expected from a respondent who is not practicing medicine during probation while residing in California versus while residing in another state. Additionally, current law requires the completion of a clinical training program following a period of non-practice exceeding 18 months.

The proposed amendments clarify that a respondent residing in California during periods of non-practice shall comply with all terms and conditions of probation. A respondent residing outside of California will be relieved of the responsibility to comply with the probationary terms and conditions with the exception of this condition (Condition 33), and the following terms and conditions of probation: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

Additionally, the proposed amendments allow the respondent to complete the Special Purpose Examination (SPEX) before returning to practice in lieu of requiring a comprehensive assessment program after 18 months of non-practice.

The Titles of Probation Conditions in the Section on Recommended Range of Penalties for Violations currently references “Clinical Training Program” for Condition 18, and “Oral or Written Examination” for Condition 19. The proposed amendments will change the titles of these conditions to “Clinical Competence Assessment Program,” for each reference to Condition 18, and to “Written Examination” for the reference to Condition 19 to reflect the proposed changes to the titles of these conditions.

B. Anticipated Benefits of Proposal

This regulatory action will update the Board’s Disciplinary Guidelines used in its enforcement decisions, and will amend 16 CCR section 1361 to incorporate

these updated Disciplinary Guidelines by reference as the 12th Edition/2015. The proposed amendments make the Disciplinary Guidelines consistent with current law and the current educational and probationary environment, clarify the terms and conditions of probation to reduce the likelihood of misinterpretation, and strengthen consumer protection.

C. Consistency and Compatibility with Existing State Regulations

During the process of developing these regulations and amendments, the Board conducted a search of any similar regulations on this topic and has concluded that these regulations are neither inconsistent nor incompatible with existing state regulations.

D. Incorporated by Reference Document

Manual of Model Disciplinary Orders and Disciplinary Guidelines, 12th Edition, 2015.

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None.

Local Mandate: None.

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

Business Impact:

The board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action. The representative private persons or directly affected businesses are physicians and surgeons, advanced practice nurses, and clinical competence assessment programs.

Effect on Housing Costs: None.

EFFECT ON SMALL BUSINESS

The Board has made an initial determination that the proposed regulatory action will have no effect on small businesses. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

RESULTS OF ECONOMIC IMPACT ASSESSMENT/ANALYSIS:

The Board has made the initial determination that this regulatory proposal will have the following impact:

- It is not likely to create or eliminate jobs within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It is not likely to create new businesses or eliminate existing businesses within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It will not likely affect the expansion of businesses currently doing business within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It will benefit the health and welfare of California residents because it updates and clarifies the terms and conditions of probation for physicians and surgeons subject to discipline, makes the Disciplinary Guidelines consistent with current law, and strengthens consumer protection.
- It will not have a significant impact on worker safety because these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

- It will not have an impact on the state's environment because these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

CONSIDERATION OF ALTERNATIVES

In accordance with GC section 11346.5(a)(13), the Board must determine that no reasonable alternative considered or brought to the attention of the Board would be more effective in carrying out the purpose for which this regulatory action is proposed or would be as effective and less burdensome to affected private persons than the proposed action or would be more cost-effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

The Board invites interested persons to present statements or arguments with respect to alternatives to the proposed regulations at the scheduled hearing or during the written comment period.

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations, and any document incorporated by reference, and of the initial statement of reasons, and all of the information upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the person designated in the Notice under Contact Person, below, or by accessing the Board's website at http://www.mbc.ca.gov/About_Us/Laws/Proposed_Regulations.

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

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

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

CONTACT PERSON

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

Name: Paulette Romero, Enforcement Program Manager
Address: 2005 Evergreen St, Ste. 1200
Sacramento, CA 95815
Telephone No.: (916) 263-2437
Fax No.: (916) 263-2435
E-Mail Address: paulette.romero@mbc.ca.gov

The backup contact person is:

Name: Kevin A Schunke, Regulations Manager
Address: Medical Board of California
2005 Evergreen St, Ste. 1200
Sacramento, CA 95815
Telephone No.: (916) 263-2368
Fax No.: (916) 263-8936
E-Mail Address: regulations@mbc.ca.gov

Website Access Materials regarding this proposal can be found at [http://www.mbc.ca.gov/About Us/Laws/Proposed Regulations](http://www.mbc.ca.gov/About_Us/Laws/Proposed_Regulations).

MEDICAL BOARD OF BOARD
INITIAL STATEMENT OF REASONS

Hearing Date: October 30, 2015

Subject Matter of Proposed Regulations: Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines)

Section(s) Affected: California Code of Regulations, Title 16, Division 13, Chapter 2, Article 4, Section 1361 (section 1361)

Specific Purpose of Each Adoption, Amendment, or Repeal:

1. Problem being addressed:

The current Disciplinary Guidelines (11th Edition/2011), incorporated by reference in section 1361, must be amended to be made consistent with current law. Additionally, the Disciplinary Guidelines must be amended to reflect changes that have occurred in the educational and probationary environments since the last update to clarify some conditions of probation, and to strengthen consumer protection. Accordingly, section 1361 must be amended to incorporate by reference the 12th Edition of the Disciplinary Guidelines as amended in 2015.

The Disciplinary Guidelines must be incorporated by reference because of the length of the document.

2. Anticipated benefits from this regulatory action:

This regulatory action will amend section 1361 to incorporate by reference the 12th Edition of the Disciplinary Guidelines. This 12th Edition makes the Disciplinary Guidelines consistent with current law, updates and clarifies the terms and conditions of probation for physicians and surgeons (physicians) subject to discipline, and strengthens consumer protection.

3. Specific Purpose of Each Amendment:

The purpose of this regulatory amendment is to incorporate by reference the 12th Edition of the Disciplinary Guidelines as amended in 2015. This 12th Edition makes the Disciplinary Guidelines consistent with current law, updates and clarifies the terms and conditions of probation for physicians subject to discipline, and strengthens consumer protection.

Factual Basis/Rationale

Currently, section 1316 incorporates by reference the 11th Edition of the Disciplinary Guidelines, as amended in 2011. In the last four years since the last amendment, there have been statutory changes that must be reflected in the Disciplinary Guidelines. Additionally, the Board has identified areas in need of technical changes to improve clarity in the conditions of probation, and to reflect the changing probationary environment. The Board has also identified changes necessary to improve consumer protection. Finally, the Board is proposing some additional non-substantive changes to the Disciplinary Guidelines.

The summary of changes to the Disciplinary Guidelines and the reasons therefore are as follows:

The Board seeks to amend the Disciplinary Guidelines to reflect the new agency name of “Business, Consumer Services, and Housing Agency,” and to identify the Disciplinary Guidelines as the 12th Edition, amended in 2015.

These amendments are necessary to reflect the current agency name, which has changed from “State and Consumer Services Agency,” to “Business, Consumer Services, and Housing Agency,” and to identify the new edition of the Disciplinary Guidelines being incorporated by reference in section 1361.

The Board seeks to add a statement advising interested parties that the Disciplinary Guidelines are available on the Board’s website, and to strike the section advising interested parties to write or call the Board for additional copies of the document.

This amendment is necessary to reflect the more efficient practice of obtaining Board documents online. This facilitates access to public documents, and improves efficiency for staff.

The Board seeks to strike the summary of changes that appears at the beginning of the Disciplinary Guidelines.

The rulemaking file is the official record for the justification and summary of all changes. There does not need to be a summary of changes included in the Disciplinary Guidelines.

The Board seeks to amend the Table of Contents as follows: Condition 18 will be amended to read “Clinical Competence Assessment Program;” Condition 19 will be amended to read “Written Examination;” and Condition 28 will be amended to read “Supervision of Physician Assistants and Advanced Practice Nurses.” Additionally, the page numbers in the Table of Contents will be changed, if necessary.

These changes to the Table of Contents are necessary because of the proposed amendments to the titles to Conditions 18, 19, and 28.

Further, it is likely that the page numbers of the conditions may change due to proposed additions and deletions to the Disciplinary Guidelines. If so, the Table of Contents will need to be amended for correctness.

Condition 9. Controlled Substances - Abstain from Use

The Board seeks to amend Condition 9 to make it consistent with a change in Government Code (GC) section 11529, effective January 1, 2014, which extended the timeframe for filing an accusation following the issuance of a suspension order from 15 days to 30 days. The proposed amendments to this condition will also clarify that the Administrative Law Judge (ALJ) and the Board each have 15 days to issue a decision, and will define good cause for the Board's delay in issuing such decision. The Board is proposing additional minor changes to add "the" and "is effective" to the following sentence: "The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective."

The amendments are necessary to make Condition 9 consistent with the changes in GC section 11529, and to clarify that the ALJ and Board each have a separate 15 days to issue a decision before a cease practice order dissolves. The Board's deadline may be extended for good cause, and the amendments are necessary to define good cause. Minor changes are also proposed for clarity and ease of reading.

Condition 10. Alcohol - Abstain from Use

The Board seeks to amend Condition 10 to make it consistent with a change in GC section 11529, effective January 1, 2014, which extended the timeframe for filing an accusation following the issuance of a suspension order from 15 days to 30 days. The proposed amendments to this condition will also clarify that the ALJ and the Board would each have 15 days to issue a decision, and will define good cause for the Board's delay in issuing such decision. The Board is proposing additional minor changes to add "the" and "is effective" to the following sentence: "The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective."

The amendments are necessary to make Condition 10 consistent with the changes in GC section 11529, and to clarify that the ALJ and Board each have a separate 15 days to issue a decision before a cease practice order dissolves. The Board's deadline may be extended for good cause, and the amendments are necessary to define good cause. Minor changes are also proposed for clarity and ease of reading.

Condition 11. Biological Fluid Testing

The Board seeks to amend Condition 11 to make it consistent with a change in GC section 11529, effective January 1, 2014, which extended the timeframe for

filing an accusation following the issuance of a suspension order from 15 days to 30 days. The proposed amendments to this condition will also clarify that the ALJ and the Board would each have 15 days to issue a decision, and will define good cause for the Board's delay in issuing such decision. The Board is proposing additional minor changes to add "the" and "is effective" to the following sentence: "The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective."

The amendments are necessary to make Condition 11 consistent with the changes in GC section 11529, and to clarify that the ALJ and Board each have a separate 15 days to issue a decision before a cease practice order dissolves. The Board's deadline may be extended for good cause, and the amendments are necessary to define good cause. Minor changes are also proposed for clarity and ease of reading.

Condition 14. Prescribing Practice Course

The Board seeks to amend Condition 14 to remove the reference to the Physician Assessment and Clinical Education Program (PACE) at the University of California, San Diego School of Medicine.

The amendments are necessary to eliminate the appearance of endorsing one program's courses over others. The amendments will clarify that the respondent shall enroll in a prescribing practices course approved in advance by the Board or its designee.

Condition 15. Medical Record Keeping Course

The Board seeks to amend Condition 15 to remove the reference to PACE at the University of California, San Diego School of Medicine.

The amendments are necessary to eliminate the appearance of endorsing one program's courses over others. The amendments will clarify that the respondent shall enroll in a medical record keeping course approved in advance by the Board or its designee.

Condition 17. Professional Boundaries Program

The Board seeks to amend Condition 17 to remove the reference to PACE at the University of California, San Diego School of Medicine.

The amendments are necessary to eliminate the appearance of endorsing one program's courses over others. The amendments will clarify that the respondent shall enroll in a professional boundaries program approved in advance by the Board or its designee.

Condition 18. Clinical Training Program

The Board seeks to amend Condition 18 to remove the reference to PACE at the University of California, San Diego School of Medicine, and to modify the components of an approved clinical training program. It further proposes non-substantive, grammatical changes.

The amendment to remove reference to PACE is necessary to eliminate the appearance of endorsing one entity's clinical competence assessment program over others. This amendment will clarify that the respondent shall enroll in an assessment program approved in advance by the Board or its designee.

The current Disciplinary Guidelines describe the clinical training program as a comprehensive assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40-hour program of clinical education in the area of practice in which respondent was alleged to be deficient.

Amendments are needed to this condition to reflect changes to the educational and probationary environments. Under the proposed amendments, Condition 18 will be renamed "Clinical Competence Assessment Program." Moreover, the specific time-frame requirements of a two-day assessment and a 40-hour program will be deleted. The proposed amendments will require a comprehensive assessment of respondent's physical and mental health; and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and the American Board of Medical Specialties pertaining to the respondent's current or intended area of practice. The proposed amendments identify what the program shall consider during its assessment of the respondent, and specifies that the program shall require the respondent's on-site participation for a minimum of three to five days as determined by the program. These changes are necessary to better permit the program to design an assessment program particular to each respondent's circumstance to improve consumer protection and rehabilitation of the respondent.

The proposed amendments require the program to submit a comprehensive assessment to the Board that unequivocally states whether the respondent has demonstrated the ability to practice safely and independently, and provide its recommendations for any further education, clinical training, or evaluation or treatment for any medical or psychological condition, or anything else affecting respondent's practice of medicine. These changes are necessary to clarify expectations of the Board for approved clinical competence assessment programs.

The proposed amendments will eliminate the requirement that the respondent pass an examination at the completion of additional education or clinical training. The current language has been interpreted to require an exit examination. This language does not accurately reflect the process, and needs to be corrected.

Testing is done throughout the clinical competence assessment program at various steps in order for the program to draw its conclusions and to make recommendations for further evaluations and training.

Under Option #1: Condition Precedent of Condition 18, the proposed amendment eliminates the exception allowing respondent to practice medicine in a clinical training program. This change is necessary, because this language was deemed superfluous and confusing.

Condition 19. Oral and/or Written Examination

The Board seeks to amend Condition 19 to remove the oral examination as an evaluation tool that could be ordered. It also seeks to strike the language indicating that the respondent shall be allowed to take a second exam if he or she fails the first one.

Condition 19 provides an alternative method of evaluating a physician's medical knowledge when a clinical training program is not considered to be an appropriate condition to order for physicians charged with gross negligence or repeated negligent acts. This condition requires that an oral clinical examination be administered pursuant to the requirements outlined in Business and Professions Code section 2293. This evaluation component requires the Board to convene a panel of 3 experts to develop and administer an oral examination to the respondent. This evaluation tool has been the subject of frequent legal challenges and has been considered a less objective method of determining clinical competency.

In addition, the Board utilized the medical consultants located in each district office to facilitate and coordinate the administration of the oral clinical examination, if ordered. On July 1, 2014, pursuant to Senate Bill 304, the Board's sworn staff and their support staff, including the district medical consultants, were transferred to the Department of Consumer Affairs. The district medical consultants are no longer available to the Board's Probation Unit to provide the coordination of the oral clinical examination should it be ordered as a condition of probation.

As this evaluation tool has been considered a less objective method to test a physician's clinical competence and the Board no longer has the necessary resources to develop and administer the oral clinical examination, an amendment to this condition is required to eliminate the oral clinical examination as a condition that could be ordered.

The proposed amendment will also strike the language indicating that the respondent shall be allowed to take a second exam if he or she fails the first one. This deletion is necessary because it results in an inconsistency with subsequent language in the regulation that indicates that the failure to pass the examination within 180 calendar days after the effective date of the Decision is a probation violation. Accordingly, this change will not limit the number of times that the

respondent can take the written exam, but it will maintain the time limitation for completing this condition of probation.

Condition 23. Monitoring – Practice/Billing

The Board seeks to amend Condition 23 to remove the reference to PACE at the University of California, San Diego School of Medicine.

The amendments are necessary to eliminate the appearance of endorsing one program’s courses over others. The amendments will clarify that, in lieu of a monitor, the respondent may participate in a professional enhancement program approved in advance by the Board or its designee.

Condition 25. Third Party Chaperone

The Board seeks to amend Condition 25 to reduce the time allowed to replace a chaperone from 60 days to 30 days.

Condition 25 is ordered in cases where a physician’s conduct with a patient has been found to be inappropriate. In order to ensure adequate patient protection measures are in place, a third-party chaperone must be present when patients are being examined. Routinely, the third-party chaperone function is performed by one of the physician’s employees such as a medical assistant or another health care professional. The proposed amendment requires the replacement of a chaperone within 30 days. Amending the language in this condition to require that the physician replace the third-party chaperone within 30 days, rather than within 60 days, is appropriate in order to provide increased patient protection from a licensee already disciplined for inappropriate conduct with a patient.

Condition 28. Supervision of Physician Assistants

The Board seeks to amend the title and the terms of this condition to prohibit the supervision of advanced practice nurses in addition to physician assistants.

It has been a well-established requirement that physicians on probation are prohibited from supervising physician assistants. Similar to physician assistants, advanced practice nurses work under the general supervision of a physician, pursuant to established standardized procedures. An amendment to this condition is necessary to add the prohibition to supervise advanced practice nurses.

Condition 31. General Probation Requirements

The Board seeks to amend the language that requires the respondent to comply with all terms and conditions of probation.

This amendment is necessary because Condition 31, which outlines general probation requirements, was found to contain confusing language when read

together with Condition 33, Non-Practice While on Probation. Condition 33 states, in part, that periods of non-practice will relieve the respondent of the responsibility to comply with some of their probationary terms. However, Condition 31 states, in part, that “the respondent shall comply with the Board’s Probation Unit and all terms and conditions of this Decision.” An amendment is required to eliminate the phrase “and all terms and conditions of this Decision.”

Condition 33, as described below, will address the difference between respondents residing in California, who must comply with all terms and conditions of probation, even during periods of non-practice, and respondents residing in another state, who are relieved of the responsibility of complying with certain probationary terms during periods of non-practice.

Condition 33. Non-practice While on Probation

The Board seeks to amend the language to clarify that physicians residing in California are required to comply with all terms and conditions of probation, even during periods of non-practice. Physicians residing outside of California are relieved of complying with the terms and conditions of probation except for this condition (Condition 33), and the following terms and conditions: Obey All Laws; General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing. Additionally, the Board seeks to amend the requirement that physicians complete a clinical training program if their period of non-practice exceeds 18 months, and instead requires the respondent to successfully complete the Federation of State Medical Board’s (FSMB) Special Purpose Examination (SPEX).

When the Disciplinary Guidelines were revised in 2011, two conditions that described what was expected from a physician who was not practicing medicine during probation, either in California or out-of-state, were consolidated into one condition, Non-practice While on Probation. The new language stated that periods of non-practice relieved the respondent of the responsibility to comply with the terms of probation except for this condition (Condition 33), and the conditions entitled “Obey All Laws” and “General Probation Requirements.” After implementation, it was discovered that the new language inadvertently conflicted with the existing policy on what was required of non-practicing physicians residing in California. The 10th Edition of the Disciplinary Guidelines (Condition 34) stated that physicians residing in California but not practicing were expected to comply with all terms and condition of probation. Under these same guidelines, physicians residing out of state were only expected to comply with general conditions such as “obey all laws” and “probation unit compliance.” An amendment to the language is required to address this inconsistency and clarify the requirements for compliance with terms and conditions of probation during periods of non-practice for respondents residing in California and those residing in other states.

The Board is also proposing that, in lieu of requiring the respondent to enroll in a comprehensive assessment program after 18 months of non-practice, the

respondent be allowed to complete the SPEX, instead. When the Disciplinary Guidelines were revised in 2011, the Board added the requirement that if the period of non-practice exceeded 18 months, an assessment and clinical training program must be completed before the physician could resume practice. This requirement was added to address the Board's concern that a lengthy absence from the practice of medicine could impact the physician's clinical knowledge and skill set. Any disciplinary action taken against a physician for concerns about the quality of care provided, however, will have already included the requirement that the physician complete the clinical assessment program, where appropriate. Condition 33, however, applies to all cases, whether a quality of care concern was involved or not in the underlying discipline. The Board has concluded that any concerns about the physician's current clinical knowledge or skills can be addressed by requiring the physician to successfully complete the SPEX. This test is developed and administered through the FSMB and is used as a component in the testing performed by all approved clinical training programs currently accepted by the Board. This change will provide for consumer protection, and rehabilitation of the physician.

Changes to the Titles of Probation Conditions in the Section on Recommended Range of Penalties for Violations

The Board seeks to change the titles for probation conditions in the section on Recommended Range of Penalties for Violations to correspond with the proposed title changes to these conditions for consistency. The Board is seeking to change "Clinical Training Program" to Clinical Competence Assessment Program," for each reference to Condition 18, and "Oral or Written Examination" to "Written Examination" for the reference to Condition 19.

These amendments are necessary for the document's internal consistency with condition titles in the body, as well as in the Table of Contents.

Technical, Theoretical, and/or Empirical Study Reports, or Documents

- Senate Bill 304, which made statutory changes to GC section 11529.
- Staff report for the July 24-25, 2014 Board Meeting (agenda item 18).
- The relevant section of the approved minutes of the July 24-25, 2014 Board Meeting.
- Staff report for the July 30-31, 2015 Board Meeting (agenda item 16).
- The relevant section of the draft minutes of the July 31, 2015 Board Meeting is included in this rulemaking file, and will be replaced with the approved minutes following Board approval.
- Proposed changes to Condition 18 are based, in part, upon the

recommendations of representatives from PACE, including William Norcross, M.D., Peter Boal, and Kate Seippel, M.P.H. These recommendations were presented at the October 23, 2014 Enforcement Committee Meeting. A copy of the presentation is included in this rulemaking file.

- The relevant section of the approved minutes of the October 23, 2014 Enforcement Committee Meeting.

Business Impact

The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

Economic Impact Assessment

The Board has made the initial determination that this regulatory proposal will have the following impact:

- It is not likely to create or eliminate jobs within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It is not likely to create new businesses or eliminate existing businesses within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It will not likely affect the expansion of businesses currently doing business within the State of California. This initial determination is based on the fact that these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

- It will benefit the health and welfare of California residents because it updates and clarifies the terms and conditions of probation for physicians subject to discipline, makes the Disciplinary Guidelines consistent with current law, and strengthens consumer protection.
- It will not have a significant impact on worker safety because these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.
- It will not have an impact on the state's environment because these proposed amendments to the Disciplinary Guidelines will simply make this document consistent with current law, amend the document to reflect the changes that have occurred in the educational and probationary environment since the last update, clarify terms and conditions of probation, and improve consumer protection.

Specific Technologies or Equipment

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

Consideration of Alternatives

No reasonable alternative to the regulatory proposal would be either more effective in carrying out the purpose for which the action is proposed or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific. The public is invited to submit such alternatives during the public comment period.

Set forth below are the alternatives which were considered and the reasons each alternative was rejected:

1. Do not seek a change. This alternative was rejected because it would result in the Disciplinary Guidelines being inconsistent with current law, outdated, and containing language that has been deemed confusing and inconsistent with public protection.
2. Adopt the proposed regulatory amendments. This alternative was determined to be the most appropriate because it provides the public with Disciplinary Guidelines which reflect recent changes in law, changes in educational and probationary environments, and which is amended for clarity and consistency, and improvement in public protection.

**MEDICAL BOARD OF CALIFORNIA
DISCIPLINARY GUIDELINES**

PROPOSED TEXT

Legend

Underlined Indicates proposed amendments or additions to the existing regulation.
~~Strikeout~~ Indicates proposed deletions to the existing regulation.

1. Amend section 1361 in Article 4 of Chapter 2, Division 13, Title 16 of the California Code of Regulations to read as follows:

1361. Disciplinary Guidelines and Exceptions for Uniform Standards Related to Substance-Abusing Licensees

(a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled “Manual of Model Disciplinary Orders and Disciplinary Guidelines” (~~11th Edition/2014~~, 12th Edition/2015) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

(b) Notwithstanding subsection (a), the Board shall use the Uniform Standards for Substance-Abusing Licensees as provided in section 1361.5, without deviation, for each individual determined to be a substance-abusing licensee.

(c) Nothing in this section or section 1361.5 shall be construed as a limitation on the Board's authority to seek an interim suspension order against a licensee pursuant to section 11529 of the Government Code.

Note: Authority cited: Sections 315, 315.2, 315.4 and 2018, Business and Professions Code; and Section 11400.20, Government Code. Reference: Sections 315, 315.2, 315.4, 2227, 2228, 2229 and 2234, Business and Professions Code; and Sections 11400.20, ~~and 11425.50(e)~~, and 11529, Government Code.

2. Amend the “Manual of Model Disciplinary Orders and Disciplinary Guidelines” incorporated by reference into section 1361 in Article 4 of Chapter 2, Division 13, Title 16 of the California Code of Regulations to read as follows:

State of California

~~State and Consumer Services Agency~~
Business, Consumer Services, and Housing Agency

MEDICAL BOARD OF CALIFORNIA

**MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES**



44th 12th Edition
2014 2015

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

State of California
~~State and Consumer Services Agency~~
~~Business, Consumer Services, and Housing Agency~~
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
11th 12th Edition
~~2011-2015~~
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th 12th Edition for the intended use of those involved in the physician disciplinary process: Administrative Law Judges, defense attorneys, physicians-respondents, trial attorneys from the Office of the Attorney General, and the Board's disciplinary panel members who review proposed decisions and stipulations and make final decisions. These guidelines are not binding standards.

The Federation of State Medical Boards and other state medical boards have requested and received this manual. All are welcome to use and copy any part of this material for their own work.

To view this document visit http://www.mbc.ca.gov/Enforcement/disciplinary_guide.pdf
For additional copies of this manual, please write to the address below or visit
http://www.medbd.ca.gov/publications/disciplinary_guide.pdf:

Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
Phone (916) 263-2466

Revisions to the Manual of Model Disciplinary Orders and Disciplinary Guidelines are made periodically. Listed below are the most recent changes included in the 11th 12th edition approved by the Board following open discussion at a public meeting.

Summary of Changes

The former "Disciplinary Guidelines – Index" printed after the last "Standard Conditions" has been moved to the Table of Contents (a formatting change only) and has been renamed the "Recommended Range of Penalties for Violations" for clarity.

Model Condition Number:

~~5. Controlled Substances – Total Restriction~~

Eliminated the term "good faith" prior examination to reflect amendments made to statute that now requires an "appropriate prior examination and a medical indication" and adds "furnish" to the list of prohibited activities.

7. ~~Controlled Substances – Partial Restriction~~

~~Eliminated the term “good faith” prior examination to reflect amendments made to statute that now requires an “appropriate prior examination and a medical indication” and adds “furnish” to the list of prohibited activities.~~

8. ~~Controlled Substances – Maintain Records and Access To Records and Inventories~~

~~Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.~~

9. ~~Controlled Substances – Abstain From Use~~

~~Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet time requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.~~

10. ~~Alcohol – Abstain From Use~~

~~Added language that respondent shall cease the practice of medicine based upon a positive biological fluid test and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.~~

11. ~~Biological Fluid Testing –~~

~~Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Expands the parameters of biological fluid testing to include various testing mechanisms. Added language that respondent shall cease the practice of medicine for failing to cooperate with biological fluid testing and that the Board must meet requirements for filing an Accusation and/or Petition to Revoke and hold a hearing.~~

12. ~~Community Service – Free Services~~

~~Reworded the language regarding non-medical community service.~~

13. ~~Education Course~~

~~Deleted language limiting the education program or course to classroom, conference or seminar settings.~~

14. ~~Prescribing Practices Course~~

~~Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.~~

15. ~~Medical Record Keeping Course~~

~~Added language to require the course be equivalent to the course offered at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine. Also added language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.~~

16. ~~Professionalism Program (Ethics Course)~~

~~Amended the name and language to comport with subsequent regulations setting requirements for a professionalism program (previously referred to as an ethics course). Also added~~

language requiring the respondent to provide pertinent documents to the program and amended the language regarding completion of the course.

17. Professional Boundaries Program

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language permitting discretionary acceptance of a course taken prior to the effective date of the decision.

18. Clinical Training Program

Amended the language regarding completion of program and replaced the terms specialty and sub-specialty with area of practice in which respondent was deficient.

Added language that respondent shall cease the practice of medicine for failing to successfully complete the clinical training program. Also eliminated the subsequent optional term and made it a requirement.

19. Oral or Written Examination

Added that if the examination is an oral examination, it is to be administered in accordance with Business and Professions Code section 2293(a) and (b). Also eliminated the subsequent optional term and made it a requirement. Made technical changes.

20. Psychiatric Evaluation

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

21. Psychotherapy

Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

22. Medical Evaluation and Treatment

Added language requiring the respondent to provide pertinent documents/information to the evaluating physician. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

23. Monitoring - Practice/Billing

Restructured the formatting to clarify the type of monitor required. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. Added language that respondents shall cease the practice of medicine until they obtain a monitor if they do not meet the required timeline for obtaining a monitor.

24. Solo Practice Prohibition

Clarified the title to show it was a prohibition and clarified what constitutes solo practice. Added language that respondent shall cease the practice of medicine for failing to secure an approved practice setting within 60 days.

~~25. Third Party Chaperone~~

~~Restructured the formatting to clarify the type of patient in which respondent is required to have a chaperone. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation. In addition, language was added prohibiting employment termination of a chaperone for reporting to the Board. Added language that respondent shall cease the practice of medicine for failing to have an approved third-party chaperone.~~

~~26. Prohibited Practice~~

~~Restructured the formatting of the condition to clarify the type of practice prohibition and to require that all patients be notified of prohibition. Deleted language that required a written notification in addition to oral. Deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.~~

~~27. Notification~~

~~Required notification to be within seven days of the effective date of the decision rather than prior to practicing medicine.~~

~~28. Supervision of Physician Assistants~~

~~No change.~~

~~29. Obey All Laws~~

~~No change.~~

~~30. Quarterly Declarations~~

~~No change.~~

~~31. General Probation Requirements~~

~~Reformatted the conditions and added clarification regarding notification of residence or practice out-of-state and of email and telephone number.~~

~~32. Interview with the Board or its designee~~

~~Reworded for clarity.~~

~~Formerly 33. Residing or Practicing Out-of-State~~

~~Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.~~

~~Formerly 34. Failure to Practice Medicine- California Resident~~

~~Deleted condition due to combining conditions 33 and 34 to clarify non-practice regardless of physician location.~~

~~New 33. Non-Practice While on Probation~~

~~Combined former conditions #33 and #34. Clarified non-practice regardless of physician location. Added clinical training for non-practice of more than 18 calendar months, defined non-practice, and required physician to practice in two years.~~

34. Completion of Probation

Formerly # 35, it is re-numbered to reflect the combination of conditions #33 and #34. Reference to “cost recovery” is deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).

35. Violation of Probation

Formerly # 36, it is re-numbered to reflect the combination of conditions #33 and #34.

~~Formerly 37. Cost Recovery~~

~~Deleted condition due to elimination of authority to order cost recovery. See Business and Professions Code section 125.3(k).~~

36. License Surrender

Formerly 38, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, reworded for clarity.

37. Probation Monitoring Costs

Formerly 39, it is re-numbered to reflect the combination of conditions #33 and #34 and the deletion of condition #37. Also, deleted language that failure to comply is a violation of probation because the language is unnecessary as any failure to comply with the terms or conditions of probation is a violation of probation.

**STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS AND
DISCIPLINARY GUIDELINES**

Business and Professions Code section 2229 mandates protection of the public shall be the highest priority for the Medical Board and for the Administrative Law Judges of the Medical Quality Hearing Panel. Section 2229 further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the Manual of Model Disciplinary Orders and Disciplinary Guidelines (guidelines), 11-12th Edition. Consistent with the mandates of section 2229, these guidelines set forth the discipline the Board finds appropriate and necessary for the identified violations. In addition to protecting the public and, where not inconsistent, rehabilitating the licensee, the Board finds that imposition of the discipline set forth in the guidelines will promote uniformity, certainty and fairness, and deterrence, and, in turn, further public protection.

The Board expects that, absent mitigating or other appropriate circumstances such as early acceptance of responsibility, demonstrated willingness to undertake Board- ordered rehabilitation, the age of the case, and evidentiary problems, Administrative Law Judges hearing cases on behalf of the Board and proposed settlements submitted to the Board will follow the guidelines, including those imposing suspensions. Any proposed decision or settlement that departs from the disciplinary guidelines shall identify the departures and the facts supporting the departure.

The Model Disciplinary Orders contain three sections: three (3) Disciplinary Orders; twenty-three (23) Optional Conditions whose use depends on the nature and circumstances of the particular case; and eleven (11) Standard Conditions that generally appear in all probation cases. All orders should place the Disciplinary Order(s) first, Optional Condition(s) second, and Standard Condition(s) third.

**MODEL DISCIPLINARY ORDERS
TABLE OF CONTENTS**

Order No.		Page No.
DISCIPLINARY ORDERS		
1.	Revocation - Single Cause	9
2.	Revocation - Multiple Causes	9
3.	Standard Stay Order	9
OPTIONAL CONDITIONS		
4.	Actual Suspension	9
5.	Controlled Substances - Total Restriction	9
6.	Controlled Substances - Surrender of DEA Permit	10
7.	Controlled Substances - Partial Restriction	10
8.	Controlled Substances - Maintain Records and Access To Records and Inventories	10
9.	Controlled Substances - Abstain From Use	11
10.	Alcohol - Abstain From Use	11
11.	Biological Fluid Testing	12
12.	Community Service - Free Services	12
13.	Education Course	13
14.	Prescribing Practices Course	13
15.	Medical Record Keeping Course	13
16.	Professionalism Program (Ethics Course)	14
17.	Professional Boundaries Program	14
18.	Clinical <u>Competence Assessment</u> Training Program	15
19.	Oral or Written Examination	16
20.	Psychiatric Evaluation	17
21.	Psychotherapy	17
22.	Medical Evaluation and Treatment	18
23.	Monitoring - Practice/Billing	19
24.	Solo Practice Prohibition	20
25.	Third Party Chaperone	20
26.	Prohibited Practice	21
STANDARD CONDITIONS		
27.	Notification	22
28.	Supervision of Physician Assistants <u>and Advanced Practice Nurses</u>	22
29.	Obey All Laws	22
30.	Quarterly Declarations	22
31.	General Probation Requirements	22
32.	Interview with the Board or its designee	23
33.	Non-Practice While on Probation	23
34.	Completion of Probation	23
35.	Violation of Probation	24
36.	License Surrender	24
37.	Probation Monitoring Costs	24

RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

<u>B&P Sec.</u>		<u>Page No.</u>
141(a)	Disciplinary Action Taken By Others	25
651	Advertising: Fraudulent, Misleading, Deceptive	25
725	Excessive Prescribing	25
725	Excessive Treatments	25
726	Sexual Misconduct	26
729	Sexual Exploitation	26
820	Mental or Physical Illness	26
2232	Registration as a Sex Offender	26
2234	Unprofessional Conduct	27
2234(b)	Gross Negligence	27
2234(c)	Repeated Negligent Acts	27
2234(d)	Incompetence	27
2234(e)	Dishonesty Related to Patient Care, Treatment, Management, or Billing	27
2234(e)	Dishonesty Not Related to Patient Care, Treatment, Management, or Billing	27
2235	Procuring License by Fraud	27
2236	Conviction of Crime Related to Patient Care, Treatment, Management or Billing	28
2236	Conviction of Crime - Felony Conviction Not Related to Patient Care, Treatment, Management or Billing	28
2236	Conviction of Crime - Misdemeanor Conviction Not Related To Patient Care, Treatment, Management or Billing	28
2237	Conviction of Drugs Violations	28
2238	Violation of Drug Statutes	28
2238	Illegal Sales of Controlled Substance	29
2239	Excessive Use of Controlled Substances	28
2239	Excessive Use of Alcohol	29
2241	Prescribing to Addicts	29
2242	Prescribing Without an Appropriate Prior Examination	25
2252	Illegal Cancer Treatment	30
2258	Illegal Cancer Treatment	30
2261	Making False Statements	30
2262	Alteration of Medical Records	30
2264	Aiding and Abetting Unlicensed Practice	30
2266	Failure to Maintain Adequate Records	27
2271	False or Misleading Advertising	25
2280	Practice Under the Influence of Narcotic	28
2280	Practice Under the Influence of Alcohol	29
2285	Fictitious Name Violation	30
2288	Impersonation of Applicant in Exam	30
2305	Disciplinary Action Taken by Others	25
2306	Practice During Suspension	30
2417	Business Organization in Violation of Chapter Violation of Probation	31 31

MODEL DISCIPLINARY ORDERS

1. Revocation - Single Cause

Certificate No. _____ issued to respondent _____ is revoked.

2. Revocation - Multiple Causes

Certificate No. _____ issued to respondent _____ is revoked pursuant to determination of Issues (e.g. I, II, and III), separately and for all of them.

3. Standard Stay Order

However, revocation stayed and respondent is placed on probation for (e.g., ten) years upon the following terms and conditions.

OPTIONAL CONDITIONS

4. Actual Suspension

As part of probation, respondent is suspended from the practice of medicine for (e.g., 90 days) beginning the sixteenth (16th) day after the effective date of this decision.

5. Controlled Substances - Total Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined in the California Uniform Controlled Substances Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5.

If respondent forms the medical opinion, after an appropriate prior examination and a medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and a medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

6. Controlled Substances - Surrender of DEA Permit

Respondent is prohibited from practicing medicine until respondent provides documentary proof to the Board or its designee that respondent's DEA permit has been surrendered to the Drug Enforcement Administration for cancellation, together with any state prescription forms and all controlled substances order forms. Thereafter, respondent shall not reapply for a new DEA permit without the prior written consent of the Board or its designee.

7. Controlled Substances - Partial Restriction

Respondent shall not order, prescribe, dispense, administer, furnish, or possess any controlled substances as defined by the California Uniform Controlled Substances Act, except for those drugs listed in Schedule(s) _____ (e.g., IV and V) of the Act.

Respondent shall not issue an oral or written recommendation or approval to a patient or a patient's primary caregiver for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. If respondent forms the medical opinion, after an appropriate prior examination and medical indication, that a patient's medical condition may benefit from the use of marijuana, respondent shall so inform the patient and shall refer the patient to another physician who, following an appropriate prior examination and medical indication, may independently issue a medically appropriate recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5. In addition, respondent shall inform the patient or the patient's primary caregiver that respondent is prohibited from issuing a recommendation or approval for the possession or cultivation of marijuana for the personal medical purposes of the patient and that the patient or the patient's primary caregiver may not rely on respondent's statements to legally possess or cultivate marijuana for the personal medical purposes of the patient. Respondent shall fully document in the patient's chart that the patient or the patient's primary caregiver was so informed. Nothing in this condition prohibits respondent from providing the patient or the patient's primary caregiver information about the possible medical benefits resulting from the use of marijuana.

Note: Also use Condition 8, which requires that separate records be maintained for all controlled substances prescribed.

(Option)

Respondent shall immediately surrender respondent's current DEA permit to the Drug Enforcement Administration for cancellation and reapply for a new DEA permit limited to those Schedules authorized by this order. Within 15 calendar days after the effective date of this Decision, respondent shall submit proof that respondent has surrendered respondent's DEA permit to the Drug Enforcement Administration for cancellation and re-issuance. Within 15 calendar days after the effective date of issuance of a new DEA permit, respondent shall submit a true copy of the permit to the Board or its designee.

8. Controlled Substances- Maintain Records and Access to Records and Inventories

Respondent shall maintain a record of all controlled substances ordered, prescribed, dispensed, administered, or possessed by respondent, and any recommendation or approval which enables a patient or patient's primary caregiver to possess or cultivate marijuana for the

personal medical purposes of the patient within the meaning of Health and Safety Code section 11362.5, during probation, showing all the following: 1) the name and address of patient; 2) the date; 3) the character and quantity of controlled substances involved; and 4) the indications and diagnosis for which the controlled substances were furnished.

Respondent shall keep these records in a separate file or ledger, in chronological order. All records and any inventories of controlled substances shall be available for immediate inspection and copying on the premises by the Board or its designee at all times during business hours and shall be retained for the entire term of probation.

9. Controlled Substances - Abstain From Use

Respondent shall abstain completely from the personal use or possession of controlled substances as defined in the California Uniform Controlled Substances Act, dangerous drugs as defined by Business and Professions Code section 4022, and any drugs requiring a prescription. This prohibition does not apply to medications lawfully prescribed to respondent by another practitioner for a bona fide illness or condition.

Within 15 calendar days of receiving any lawfully prescribed medications, respondent shall notify the Board or its designee of the: issuing practitioner's name, address, and telephone number; medication name, strength, and quantity; and issuing pharmacy name, address, and telephone number.

If respondent has a confirmed positive biological fluid test for any substance (whether or not legally prescribed) and has not reported the use to the Board or its designee, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board within ~~45~~ 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within ~~45~~ 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

10. Alcohol - Abstain From Use

Respondent shall abstain completely from the use of products or beverages containing alcohol.

If respondent has a confirmed positive biological fluid test for alcohol, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board ~~within 45~~ 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. ~~A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay.~~ Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within ~~45~~ 30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

11. Biological Fluid Testing

Respondent shall immediately submit to biological fluid testing, at respondent's expense, upon request of the Board or its designee. "Biological fluid testing" may include, but is not limited to, urine, blood, breathalyzer, hair follicle testing, or similar drug screening approved by the Board or its designee. Prior to practicing medicine, respondent shall contract with a laboratory or service approved in advance by the Board or its designee that will conduct random, unannounced, observed, biological fluid testing. The contract shall require results of the tests to be transmitted by the laboratory or service directly to the Board or its designee within four hours of the results becoming available. Respondent shall maintain this laboratory or service contract during the period of probation.

A certified copy of any laboratory test result may be received in evidence in any proceedings between the Board and respondent.

If respondent fails to cooperate in a random biological fluid testing program within the specified time frame, respondent shall receive a notification from the Board or its designee to immediately cease the practice of medicine. The respondent shall not resume the practice of medicine until the final decision on an accusation and/or a petition to revoke probation is effective. An accusation and/or petition to revoke probation shall be filed by the Board ~~within 45~~ 30 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. If the case is heard by an Administrative Law Judge alone, he or she shall forward a Proposed Decision to the Board within 15 days of submission of the matter. Within 15 days of receipt by the Board of the Administrative Law Judge's proposed decision, the Board shall issue its Decision, unless good cause can be shown for the delay. If the case is heard by the Board, the Board shall issue its decision within 15 days of submission of the case, unless good cause can be shown for the delay. ~~A decision shall be received from the Administrative Law Judge or the Board within 15~~

~~days unless good cause can be shown for the delay. Good cause includes, but is not limited to, non-adoption of the proposed decision, request for reconsideration, remands and other interlocutory orders issued by the Board.~~ The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within ~~45~~30 days of the issuance of the notification to cease practice or does not provide respondent with a hearing within 30 days of a such a request, the notification of cease practice shall be dissolved.

12. Community Service - Free Services

[Medical community service shall only be authorized in cases not involving quality of care.]

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval a community service plan in which respondent shall within the first 2 years of probation, provide _____ hours of free services (e.g., medical or nonmedical) to a community or non-profit organization. If the term of probation is designated for 2 years or less, the community service hours must be completed not later than 6 months prior to the completion of probation.

Prior to engaging in any community service respondent shall provide a true copy of the Decision(s) to the chief of staff, director, office manager, program manager, officer, or the chief executive officer at every community or non-profit organization where respondent provides community service and shall submit proof of compliance to the Board or its designee within 15 calendar days. This condition shall also apply to any change(s) in community service.

Community service performed prior to the effective date of the Decision shall not be accepted in fulfillment of this condition.

13. Education Course

Within 60 calendar days of the effective date of this Decision, and on an annual basis thereafter, respondent shall submit to the Board or its designee for its prior approval educational program(s) or course(s) which shall not be less than 40 hours per year, for each year of probation. The educational program(s) or course(s) shall be aimed at correcting any areas of deficient practice or knowledge and shall be Category I certified. The educational program(s) or course(s) shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure. Following the completion of each course, the Board or its designee may administer an examination to test respondent's knowledge of the course. Respondent shall provide proof of attendance for 65 hours of CME of which 40 hours were in satisfaction of this condition.

14. Prescribing Practices Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in prescribing practices ~~equivalent to the Prescribing Practices Course at the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program),~~ approved in advance by the Board or its designee. Respondent shall provide the ~~program~~ approved course provider with any information and documents that the ~~Program~~ approved course provider may deem pertinent. Respondent shall participate in and

successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The prescribing practices course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A prescribing practices course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

15. Medical Record Keeping Course

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a course in medical record keeping ~~equivalent to the Medical Record Keeping Course offered by the Physician Assessment and Clinical Education Program, University of California, San Diego School of Medicine (Program)~~, approved in advance by the Board or its designee. Respondent shall provide the ~~program~~ approved course provider with any information and documents that the ~~Program~~ approved course provider may deem pertinent. Respondent shall participate in and successfully complete the classroom component of the course not later than six (6) months after respondent's initial enrollment. Respondent shall successfully complete any other component of the course within one (1) year of enrollment. The medical record keeping course shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A medical record keeping course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the course, or not later than 15 calendar days after the effective date of the Decision, whichever is later.

16. Professionalism Program (Ethics Course)

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a professionalism program, that meets the requirements of Title 16, California Code of Regulations (CCR) section 1358. Respondent shall participate in and successfully complete that program. Respondent shall provide any information and documents that the program may deem pertinent. Respondent shall successfully complete the classroom component of the program not later than six (6) months after respondent's initial enrollment, and the longitudinal component of the program not later than the time specified by the program, but no later than one (1) year after attending the classroom component. The professionalism program shall be at

respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

A professionalism program taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the program would have been approved by the Board or its designee had the program been taken after the effective date of this Decision.

Respondent shall submit a certification of successful completion to the Board or its designee not later than 15 calendar days after successfully completing the program or not later than 15 calendar days after the effective date of the Decision, whichever is later.

17. Professional Boundaries Program

Within 60 calendar days from the effective date of this Decision, respondent shall enroll in a professional boundaries program equivalent to the Professional Boundaries Program offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine ("Program") approved in advance by the Board or its designee. Respondent, at the Pprogram's discretion, shall undergo and complete the Pprogram's assessment of respondent's competency, mental health and/or neuropsychological performance, and at minimum, a 24 hour program of interactive education and training in the area of boundaries, which takes into account data obtained from the assessment and from the Decision(s), Accusation(s) and any other information that the Board or its designee deems relevant. The Pprogram shall evaluate respondent at the end of the training and the Pprogram shall provide any data from the assessment and training as well as the results of the evaluation to the Board or its designee.

Failure to complete the entire Pprogram not later than six (6) months after respondent's initial enrollment shall constitute a violation of probation unless the Board or its designee agrees in writing to a later time for completion. Based on respondent's performance in and evaluations from the assessment, education, and training, the Pprogram shall advise the Board or its designee of its recommendation(s) for additional education, training, psychotherapy and other measures necessary to ensure that respondent can practice medicine safely. Respondent shall comply with Pprogram recommendations. At the completion of the Pprogram, respondent shall submit to a final evaluation. The Pprogram shall provide the results of the evaluation to the Board or its designee. The professional boundaries program shall be at respondent's expense and shall be in addition to the Continuing Medical Education (CME) requirements for renewal of licensure.

The Pprogram has the authority to determine whether or not respondent successfully completed the Pprogram.

A professional boundaries course taken after the acts that gave rise to the charges in the Accusation, but prior to the effective date of the Decision may, in the sole discretion of the Board or its designee, be accepted towards the fulfillment of this condition if the course would have been approved by the Board or its designee had the course been taken after the effective date of this Decision.

(Option # 1: Condition Precedent)

Respondent shall not practice medicine until respondent has successfully completed the Pprogram and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)

If respondent fails to complete the Pprogram within the designated time period, respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the Pprogram.

18. Clinical Competence Assessment Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical competence assessment training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program") approved in advance by the Board or its designee. Respondent shall successfully complete the Pprogram not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Pprogram shall consist of a Comprehensive Assessment program comprised of an two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice in which respondent was alleged to be deficient, and at minimum, a 40-hour a program of clinical education in the respondent's area of practice in which respondent was alleged to be deficient and. The program shall which takes into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 to 5 days as determined by the program for the assessment and clinical education evaluation.

At the end of the evaluation, the program will submit a report to Based on respondent's performance and test results in the assessment and clinical education, the Program will advise the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the Clinical Competence Assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition, treatment for any or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the Pprogram's recommendations.

At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination. Determination as to whether respondent successfully completed the examination or successfully completed the clinical competence assessment program is solely within the program's jurisdiction.

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical competence assessment training program within the designated time period, respondent shall receive a

notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment training program have been completed. If the respondent did not successfully complete the clinical competence assessment training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

(Option #1: Condition Precedent)

Respondent shall not practice medicine until respondent has successfully completed the Pprogram and has been so notified by the Board or its designee in writing, ~~except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.~~

(Option #2)

Within 60 days after respondent has successfully completed the clinical competence assessment training program, respondent shall participate in a professional enhancement program ~~equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine~~ approved in advance by the Board or its designee, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

19. ~~Oral and/or~~ Written Examination

[NOTE: This condition should **only** be used where a clinical training program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or a written examination, ~~administered by the Board or its designee. The Board or its designee shall designate a subject matter and administer the oral and/or written.~~

~~If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.~~

~~If respondent is required to take and pass a written exam, that examination shall be either the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.~~

~~If respondent fails the first examination, respondent shall be allowed to take and pass a second examination.~~

Failure to pass the required oral and/or written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations.

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the first written examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days

after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

(Option 1: Condition Precedent)

Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from practicing in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

(Option: Condition Precedent)

Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

21. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Respondent shall have the treating psychotherapist submit quarterly status reports to the Board or its designee. The Board or its designee may require respondent to undergo psychiatric

evaluations by a Board-appointed board certified psychiatrist. If, prior to the completion of probation, respondent is found to be mentally unfit to resume the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is mentally fit to resume the practice of medicine without restrictions.

Respondent shall pay the cost of all psychotherapy and psychiatric evaluations.

Note: This condition is for those cases where the evidence demonstrates that the respondent has had impairment (impairment by mental illness, alcohol abuse and/or drug self-abuse) related to the violations but is not at present a danger to respondent's patients.

22. Medical Evaluation and Treatment

Within 30 calendar days of the effective date of this Decision, and on a periodic basis thereafter as may be required by the Board or its designee, respondent shall undergo a medical evaluation by a Board-appointed physician who shall consider any information provided by the Board or designee and any other information the evaluating physician deems relevant and shall furnish a medical report to the Board or its designee. Respondent shall provide the evaluating physician any information and documentation that the evaluating physician may deem pertinent.

Following the evaluation, respondent shall comply with all restrictions or conditions recommended by the evaluating physician within 15 calendar days after being notified by the Board or its designee. If respondent is required by the Board or its designee to undergo medical treatment, respondent shall within 30 calendar days of the requirement notice, submit to the Board or its designee for prior approval the name and qualifications of a California licensed treating physician of respondent's choice. Upon approval of the treating physician, respondent shall within 15 calendar days undertake medical treatment and shall continue such treatment until further notice from the Board or its designee.

The treating physician shall consider any information provided by the Board or its designee or any other information the treating physician may deem pertinent prior to commencement of treatment. Respondent shall have the treating physician submit quarterly reports to the Board or its designee indicating whether or not the respondent is capable of practicing medicine safely. Respondent shall provide the Board or its designee with any and all medical records pertaining to treatment, the Board or its designee deems necessary.

If, prior to the completion of probation, respondent is found to be physically incapable of resuming the practice of medicine without restrictions, the Board shall retain continuing jurisdiction over respondent's license and the period of probation shall be extended until the Board determines that respondent is physically capable of resuming the practice of medicine without restrictions. Respondent shall pay the cost of the medical evaluation(s) and treatment.

(Option- Condition Precedent)

Respondent shall not engage in the practice of medicine until notified in writing by the Board or its designee of its determination that respondent is medically fit to practice safely.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23. Monitoring - Practice/Billing

Within 30 calendar days of the effective date of this Decision, if the respondent is providing direct patient care, the respondent shall submit to the Board or its designee for prior approval as a _____ [insert: practice, billing, or practice and billing] 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(s) and Accusation(s), and a proposed monitoring plan. Within 15 calendar days of receipt of the Decision(s), Accusation(s), and proposed monitoring plan, the monitor shall submit a signed statement that the monitor has read the Decision(s) and Accusation(s), 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 _____ [insert: practice, billing, or practice and billing] 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 _____ [insert: medicine or billing, or both], and whether respondent is practicing medicine safely, billing appropriately or both. 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 (3) 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~~ approved in advance by the Board or

its designee, 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.

24. Solo Practice Prohibition

Respondent is prohibited from engaging in the solo practice of medicine. Prohibited solo practice includes, but is not limited to, a practice where: 1) respondent merely shares office space with another physician but is not affiliated for purposes of providing patient care, or 2) respondent is the sole physician practitioner at that location.

If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting 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. The respondent shall not resume practice until an appropriate practice setting is established.

If, during the course of the probation, the respondent's practice setting changes and the respondent is no longer practicing in a setting in compliance with this Decision, the respondent shall notify the Board or its designee within 5 calendar days of the practice setting change. If respondent fails to establish a practice with another physician or secure employment in an appropriate practice setting within 60 calendar days of the practice setting change, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume practice until an appropriate practice setting is established.

25. Third Party Chaperone

During probation, respondent shall have a third party chaperone present while consulting, examining or treating _____ [insert: male, female, or minor] patients. Respondent shall, within 30 calendar days of the effective date of the Decision, submit to the Board or its designee for prior approval name(s) of persons who will act as the third party chaperone.

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

Each third party chaperone shall sign (in ink or electronically) and date each patient medical record at the time the chaperone's services are provided. Each third party chaperone shall read the Decision(s) and the Accusation(s), and fully understand the role of the third party chaperone.

Respondent shall maintain a log of all patients seen for whom a third party chaperone is required. The log shall contain the: 1) patient initials, address and telephone number; 2) medical record number; and 3) date of service. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

Respondent is prohibited from terminating employment of a Board-approved third party chaperone solely because that person provided information as required to the Board or its designee.

If the third party chaperone resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name of the person(s) who will act as the third party chaperone. If respondent fails to obtain approval of a replacement chaperone within ~~30~~ 60-calendar days of the resignation or unavailability of the chaperone, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall cease the practice of medicine until a replacement chaperone is approved and assumes monitoring responsibility.

(Option)

Respondent shall provide written notification to respondent's patients that a third party chaperone shall be present during all consultations, examination, or treatment with **[insert: male, female or minor]** patients. Respondent shall maintain in the patient's file a copy of the written notification, shall make the notification available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the notification for the entire term of probation.

26. Prohibited Practice

During probation, respondent is prohibited from _____ **[insert: practicing, performing, or treating]** _____ **[insert: a specific medical procedure; surgery; on a specific patient population]**. After the effective date of this Decision, all patients being treated by the respondent shall be notified that the respondent is prohibited from _____ **[insert: practicing, performing or treating]** _____ **[insert: a specific medical procedure; surgery; on a specific patient population]**. Any new patients must be provided this notification at the time of their initial appointment.

Respondent shall maintain a log of all patients to whom the required oral notification was made. The log shall contain the: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date the notification was made; and 5) a description of the notification given. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

STANDARD CONDITIONS

27. Notification

Within seven (7) days of the effective date of this Decision, the respondent shall provide a true copy of this Decision and 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 Board or its designee within 15 calendar days.

This condition shall apply to any change(s) in hospitals, other facilities or insurance carrier.

28. Supervision of Physician Assistants and Advanced Practice Nurses

During probation, respondent is prohibited from supervising physician assistants and advanced practice nurses.

29. 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.

30. 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.

31. General Probation Requirements

Compliance with Probation Unit

Respondent shall comply with the Board's probation unit ~~and all terms and conditions of this Decision.~~

Address Changes

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

Place of Practice

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

License Renewal

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

Travel or Residence Outside California

Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32. 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.

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine in California as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination ~~a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines"~~ prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

34. 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.

35. 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.

36. 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 or her 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.

37. 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.

RECOMMENDED RANGE OF PENALTIES FOR VIOLATIONS

DISCIPLINARY ACTION TAKEN BY OTHERS [B&P 141(a) & 2305]

Minimum penalty: Same for similar offense in California

Maximum penalty: Revocation

MISLEADING ADVERTISING (B&P 651 & 2271)

Minimum penalty: Stayed revocation, 1 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

EXCESSIVE PRESCRIBING (B&P 725), or PRESCRIBING WITHOUT AN APPROPRIATE PRIOR EXAMINATION (B&P 2242)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances-Total DEA restriction [5],
Surrender DEA permit [6] or
Partial DEA restriction [7]
3. Maintain Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Competence Assessment ~~Training~~-Program [18]
9. Monitoring-Practice/Billing [23]

EXCESSIVE TREATMENTS (B&P 725)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment ~~Training~~-Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

SEXUAL MISCONDUCT (B&P 726)

Minimum penalty: Stayed revocation, 7 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Professional Boundaries Program [17]
5. Psychiatric Evaluation [20]
6. Psychotherapy [21]
7. Monitoring-Practice/Billing [23]
8. Third Party Chaperone [25]
9. Prohibited Practice [26]

SEXUAL EXPLOITATION (B&P 729)

Minimum penalty: Revocation

Effective January 1, 2003, Business and Professions Code 2246 was added to read, "Any proposed decision or decision issued under this article that contains any finding of fact that the licensee engaged in any act of sexual exploitation, as described in paragraphs (3) to (5), inclusive, of subdivision (b) of Section 729, with a patient shall contain an order of revocation. The revocation shall not be stayed by the administrative law judge."

MENTAL OR PHYSICAL ILLNESS (B&P 820)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. ~~Oral~~ Written Examination [19]
2. Psychiatric Evaluation [20]
3. Psychotherapy [21]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]

REGISTRATION AS A SEX OFFENDER (B&P 2232)

Minimum penalty: Revocation

Section 2232(a) of the Business and Professions Code provides that "Except as provided in subdivisions (b), (c), and (d), the board shall promptly revoke the license of any person who, at any time after January 1, 1947, has been required to register as a sex offender pursuant to the provisions of section 290 of the Penal Code."

**GENERAL UNPROFESSIONAL CONDUCT (B&P 2234), or
GROSS NEGLIGENCE [B&P 2234 (b)], or
REPEATED NEGLIGENT ACTS [B&P 2234(c)], or
INCOMPETENCE [B&P 2234(d)], or
FAILURE TO MAINTAIN ADEQUATE RECORDS (B&P 2266)**

Minimum penalty: Stayed revocation, 5 years probation

NOTE: In cases charging repeated negligent acts with one patient, a public reprimand may, in appropriate circumstances, be ordered.

Maximum penalty: Revocation

1. Education course [13]
2. Prescribing Practices Course [14]
3. Medical Record Keeping Course [15]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment ~~Training~~-Program [18]
6. Monitoring-Practice/Billing [23]
7. Solo Practice Prohibition [24]
8. Prohibited Practice [26]

DISHONESTY - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing [B&P 2234(e)]

Minimum penalty: Stayed revocation, one year suspension at least 7 years probation

Maximum penalty: Revocation

1. Professionalism Program (Ethics Course) [16]
2. Psychiatric Evaluation [20]
3. Medical Evaluation [22]
4. Monitoring-Practice/Billing [23]
5. Solo Practice Prohibition [24]
6. Prohibited Practice [26]
7. Victim Restitution

DISHONESTY - Substantially related to the qualifications, function or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing [BP 2234 (e)]

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation [22]
6. Monitoring-Practice/Billing (if financial dishonesty or conviction of financial crime) [23]
7. Victim Restitution

PROCURING LICENSE BY FRAUD (B&P 2235)

1. Revocation [1] [2]

CONVICTION OF CRIME - Substantially related to the qualifications, functions or duties of a physician and surgeon and *arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, one year suspension, at least 7 years probation

Maximum penalty: Revocation

1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Monitoring-Practice/Billing [23]
6. Solo Practice Prohibition [24]
7. Prohibited Practice [26]
8. Victim Restitution

CONVICTION OF CRIME - Felony conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 7 years probation

Maximum penalty: Revocation

1. Suspension of 30 days or more [4]
2. Community Service [12]
3. Professionalism Program (Ethics Course) [16]
4. Psychiatric Evaluation [20]
5. Medical Evaluation and Treatment [22]
6. Monitoring-Practice/Billing (if dishonesty or conviction of a financial crime) [23]
7. Victim Restitution

CONVICTION OF CRIME - Misdemeanor conviction substantially related to the qualifications, functions or duties of a physician and surgeon but *not arising from* or occurring during patient care, treatment, management or billing (B&P 2236)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Community Service [12]
2. Professionalism Program (Ethics Course) [16]
3. Psychiatric Evaluation [20]
4. Medical Evaluation and Treatment [22]
5. Victim Restitution

**CONVICTION OF DRUG VIOLATIONS (B&P 2237), or
VIOLATION OF DRUG STATUTES (B&P 2238), or
EXCESSIVE USE OF CONTROLLED SUBSTANCES (B&P 2239), or
PRACTICE UNDER THE INFLUENCE OF NARCOTIC (B&P 2280)**

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances - Total DEA restriction [5],
Surrender DEA permit [6], or
Partial DEA restriction [7]

3. Maintain Drug Records and Access to Records and Inventories [8]
4. Controlled Substances - Abstain From Use [9]
5. Alcohol-Abstain from Use [10]
6. Biological Fluid Testing [11]
7. Education Course [13]
8. Prescribing Practices Course [14]
9. Medical Record Keeping Course [15]
10. Professionalism Program (Ethics Course) [16]
11. Psychiatric Evaluation [20]
12. Psychotherapy [21]
13. Medical Evaluation and Treatment [22]
14. Monitoring-Practice/Billing [23]
15. Prohibited Practice [26]

ILLEGAL SALES OF CONTROLLED SUBSTANCES (B&P 2238)

Revocation [1] [2]

**EXCESSIVE USE OF ALCOHOL (B&P 2239) or
PRACTICE UNDER THE INFLUENCE OF ALCOHOL (B&P 2280)**

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances-Abstain From Use [9]
3. Alcohol-Abstain from Use [10]
4. Biological Fluid Testing [11]
5. Professionalism Program (Ethics Course) [16]
6. Psychiatric Evaluation [20]
7. Psychotherapy [21]
8. Medical Evaluation and Treatment [22]
9. Monitoring-Practice/Billing [23]

PRESCRIBING TO ADDICTS (B&P 2241)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Controlled Substances- Total DEA restriction [5],
Surrender DEA permit [6], or
Partial restriction [7]
3. Maintain Drug Records and Access to Records and Inventories [8]
4. Education Course [13]
5. Prescribing Practices Course [14]
6. Medical Record Keeping Course [15]
7. Professionalism Program (Ethics Course) [16]
8. Clinical Competence Assessment Training Program [18]
9. Monitoring-Practice/Billing [23]
10. Prohibited Practice [26]

ILLEGAL CANCER TREATMENT (B&P 2252 and 2258)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education course [13]
3. Prescribing Practices Course [14]
4. Professionalism Program (Ethics Course) [16]
5. Clinical Competence Assessment Training Program [18]
6. Monitoring-Practice/Billing [23]
7. Prohibited Practice [26]

**MAKING FALSE STATEMENTS (B&P 2261), or
ALTERATION OF MEDICAL RECORDS (B&P 2262)**

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Medical Record Keeping Course [15]
3. Professionalism Program (Ethics Course) [16]
4. If fraud involved, see “Dishonesty” guidelines

AIDING AND ABETTING UNLICENSED PRACTICE (B&P 2264)

Minimum penalty: Stayed revocation, 5 years probation

Maximum penalty: Revocation

1. Suspension of 60 days or more [4]
2. Education Course [13]
3. Professionalism Program (Ethics Course) [16]
4. Monitoring-Practice/Billing [23]
5. Prohibited Practice [26]

FICTITIOUS NAME VIOLATION (B&P 2285)

Minimum penalty: Stayed revocation, one year probation

Maximum penalty: Revocation

IMPERSONATION OF APPLICANT IN EXAM (B&P 2288)

1. Revocation [1] [2]

PRACTICE DURING SUSPENSION (B&P 2306)

1. Revocation [1] [2]

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)

Minimum penalty: Revocation

Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION

Minimum penalty: 30 day suspension

Maximum penalty: Revocation

The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Psychiatric Evaluation [20]
5. Psychotherapy [21]
6. Medical Evaluation and Treatment [22]
7. Third Party Chaperone [25]

It is the expectation of the Medical Board of California that the appropriate penalty for a physician who did not successfully complete a clinical training program ordered as part of his or her probation is revocation.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 14, 2015
ATTENTION: Members, Medical Board of California
SUBJECT: Consideration of Administrative Petition from Consumers Union
Safe Patient Project
FROM: Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the petition filed by the Consumers Union Safe Patient Project (CUSPP) pursuant to Government (Gov.) Code section 11340.6, grant or deny the petition.

If the Members vote to deny the petition, instruct staff to work with the Board President to draft a letter indicating why the Medical Board of California (Board) has reached its decision on the merits of the petition, and to transmit the letter to the Office of Administrative Law pursuant to Gov. Code section 11340.7. If the Members vote to grant the petition, instruct staff to proceed with the regular rulemaking process to make the requested amendments to the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines).

BACKGROUND:

Under Gov. Code section 11340.6, interested parties may petition state agencies to promulgate regulations. CUSPP has petitioned the Board for regulations to require that physicians on probation disclose their probationary status to their patients (See Attachment A). Specifically, CUSPP petitions the Board to amend its Disciplinary Guidelines to require as a standard condition of probation:

1. that physicians who continue to see patients be required to inform their patients of their probationary status;
2. that patients be notified of the physician's probationary status when the patient contacts the physician's office to make an appointment;
3. that this disclosure be required to be in writing and signed at the time of the patient's appointment by each patient the physician sees while on probation to acknowledge the notice;
4. that this disclosure be posted in the physician's office in a place readily apparent to patients;
5. that the written disclosures described in 3 and 4 above include at least a one-paragraph description of the offenses that led the Board to place the physician on probation;
6. that the written disclosures include a description of any practice restrictions placed on the physician;
7. that the patient be referred for more details to Board online documents related to the physician's probation;
8. that the physician maintain a log of all patients to whom the required oral notification was made. The log should contain the following: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date notification was made; 5) a copy of the notification given; and 6) a signed attestation by the patient that notification was received. Respondent shall keep this log

Consideration of Administrative Petition from CUSPP

October 14, 2015

Page 2

in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the Board or its designee, and shall retain the log for the entire term of probation.

If the Board grants the petition, then the matter will proceed through the regular rulemaking process in accordance with Gov. Code section 11346, et seq.

If the Board denies the petition, then the Board is required to notify CUSSP in writing within 30 days of receipt of the petition indicating why the agency has reached its decision on the merits of the petition. Pursuant to discussions, CUSSP understands that the Board may require additional time to respond.

CURRENT LAW

Standard Condition number 27 in the Board's Disciplinary Guidelines requires the licensee to provide a copy of his or her disciplinary decision and accusation to the Chief of Staff or Chief Executive Officer at every hospital where privileges or membership are extended to the licensee. A copy must also be provided at any facility where the licensee engages in the practice of medicine, including all physicians and locum tenens registries, and to the Chief Executive Officer at every malpractice insurance carrier which extends malpractice insurance coverage to the licensee.

Additionally, under Optional Condition number 25, the Board currently may require a licensee to provide written notification to patients in circumstances where the licensee is required to have a third-party chaperone present during the consultation, examination, or treatment by the licensee. Notification to patients may also be required if Optional Condition number 26, regarding Prohibited Practice, is included in the licensee's probationary order.

Pursuant to reports by Executive Officers in California, no other health care Board or Bureau mandates all of its licensees on probation to report their probationary status to patients. Moreover, no medical board in the country, that responded to staff's inquiry on the subject, mandates all of its licensees on probation to report their probationary status to patients.

PREVIOUS BOARD ACTION

At its October 2012 Board Meeting, the Members considered adding Notification to Patients of Physician's Discipline as an issue to present to the Legislature as part of the Sunset Review process. The Board rejected this proposal, and instead wanted the focus to be on educating the public to obtain information about physicians from the Board and its website.

**Administrative Petition
from Consumers Union Safe Patient Project and Activists
Calling on the Medical Board of California to
Require that Physicians on Probation Inform their Patients of the Physicians' Probation**

I. Introduction

California state statute requires that protection of the public is the Medical Board of California's (MBC) paramount responsibility and gives the MBC authority to discipline physicians, including placing them on probation. State law gives the MBC broad discretion to impose restrictions on physicians on probation. The MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines already requires that physicians on probation disclose to hospitals and malpractice insurers when they are on probation, but has no such requirement for notifying physicians' patients. A policy passed by the MBC in October 2014 stated it was MBC policy that all California consumers should know the history of disciplinary actions of any healthcare provider they may consider seeing. This petition is brought by the Consumers Union Safe Patient Project California Network (CUSPP) and its activists who believe the MBC should exercise its authority and fulfill its responsibility by requiring that physicians on probation disclose their probation status to their patients. Many California patients unknowingly receive health services from physicians who have been placed on probation for a range of offenses including offenses related to substance abuse, sexual misconduct, violence, patient deaths, incompetence, gross negligence, repeated negligent acts and other miscellaneous violations.

Generally, patients are unaware when their physician is on probation, but the public has concerns about physicians on probation continuing to practice as usual. In a Consumer Reports National Research Center telephone survey of a nationally representative sample, 79% of respondents agreed that when a physician's license is limited, suspended or revoked, the physician should be restricted to work that does not require patient care or treatment until their licenses are in good standing again.

Physicians on probation are much more likely to require further discipline than physicians who were never disciplined. When the MBC allows physicians to continue practicing medicine while on probation, those physicians should notify their patients so they are aware of any probationary limitations and can decide for themselves whether or not they want to entrust their care to a physician on probation. Patients have a right to know when their physician has been sanctioned by the MBC.

II. Parties

A. Petitioners

Consumers Union Safe Patient Project (CUSPP), a nationwide campaign, has organized a California Network of patient safety advocates. CUSPP has been working in California on issues relating to hospital safety (hospital-acquired infections and medical errors) since 2003. Members of the CUSPP monitor agency meetings, testify at legislative hearings and participate as members of various health-related state committees. For several years, CUSPP has been monitoring the work of the Medical Board of California. We share with the MBC a similar mission of protecting health care consumers.

B. Respondent

Kimberly Kirchmeyer is the Executive Director of the Medical Board of California, the mission of which is to protect healthcare consumers through proper licensing and regulation of physicians and surgeons.

III. Statement of Facts

California physicians on probation

Physicians are routinely placed on probation by the MBC for multiple years. Generally, while on probation these physicians are allowed to continue practicing medicine, often with limitations and requirements, but most commonly they are not required to provide any information to their patients regarding their MBC discipline. As of September 29, 2015, nearly 500 California physicians – among 102,000 California physicians in active practice – were on probation. (Spreadsheet obtained upon request from the MBC Executive Director, October 5, 2015)

According to the MBC, during fiscal years 2011-2012 and 2012-2013, 444 of 561 physicians on probation were *actively practicing* in California. (Probation Monitoring, MBC documents distributed at the October 23, 2013, Enforcement Committee Meeting, agenda item # 9.)

Physicians are placed on probation following the Attorney General making an accusation for a variety of reasons, for example, gross negligence/incompetence (the most common reason for probation), substance abuse, inappropriate prescribing, sexual misconduct, conviction of a felony and other miscellaneous violations. Typically, the MBC does not take action on a finding of guilt; instead, the Attorney General provides the accusation to the MBC and the MBC takes action based on the physician agreeing to the action without a finding of guilt.

Significant rates of recidivism

The California Research Bureau (CRB) in its November 2008 report, *Physician Misconduct and Public Disclosure Practices at the Medical Board of California*, reported that physicians who have received serious sanctions are far more likely to receive additional sanctions in the future. According to the CRB report, "*These findings strongly imply that disciplinary histories provide patients with important information about the likely qualities of different physicians.*"

The CRB cited research that examined physician discipline data from the Federation of State Medical Boards. The researchers split their sample into two periods, Period A 1994 – 98 and Period B 1999 – 2002. They classified physicians by whether they had no sanctions in the period, or had been assessed with one or more mild, medium or severe sanctions. Severe sanctions encompassed disciplinary actions that resulted in the revocation, suspension, surrender, or mandatory retirement of a license or the loss of privileges afforded by that license. The medium sanctions included actions that resulted in *probation*, limitation, or conditions on the medical license or a restriction of license privileges.

The study found that less than 1% of physicians who were unsanctioned during Period A were assessed a disciplinary action during Period B. However, physicians sanctioned during the earlier period were *much more likely* to be assessed additional sanctions in the second period, for example:

- 15.7% of those who received a medium sanction in Period A went on to receive either a medium or a severe sanction in Period B;
- physicians who received a medium sanction in Period A were 28% more likely to receive a *severe* sanction in Period B than someone who received no sanction in period A; and,
- physicians who received a medium sanction in Period A were 32% more likely to receive *another medium* sanction in Period B than someone who received no sanction in Period A.

(*An Evaluation of Physician Discipline by State Medical Boards.*" By Darren Grant, and Kelly C Alfred, Journal of Health Politics, Policy and Law, Vol.32, No. 5, October 2007, Duke University Press)

MBC's own data tells a similar story. In FY 2011-2012 and FY 2012-2013, 17% of 444 actively-practicing California physicians on probation (77 doctors total) either required subsequent discipline or surrendered their licenses while on probation. (Probation Monitoring, MBC documents distributed at the October 23, 2013, Enforcement Committee Meeting, agenda item # 9.)

Patients uninformed of their physician's probation

When the MBC places physicians on probation, generally they continue to practice medicine and see patients. The MBC posts information regarding probation on its website and distributes the information to its email list which includes media and interested persons who have signed up to receive it. Sometimes local media outlets cover stories about local physicians being disciplined

by the MBC. While the MBC makes some effort to disclose the actions they take, it is unreasonable to rely on emails, postings on the MBC website and occasional media articles to inform patients when their physician has been disciplined. We suspect that most patients do not even know that the MBC exists, let alone check the MBC website regularly for information about their physicians. A related 2011 Consumer Reports National Research Center telephone survey of a nationally representative sample revealed that only one-quarter of respondents (26%) said they would know where to file a complaint about a medical error they experienced at a hospital. This lack of awareness may also extend to where to file complaints against physicians. *Most patients are unaware of the regulatory agencies entrusted with the mission of protecting patient safety.*

According to a recent Pew Research Center U.S. analysis, seniors, i.e., those most likely to seek healthcare, are also the group most likely to say they never go online. About four-in-ten adults ages 65 and older (39%) do not use the internet, compared with only 3% of 18- to 29-year-olds. One-in-five African Americans, 18% of Hispanics and 5% of English-speaking Asian-Americans do not use the internet, compared with 14% of whites.

Even in cases where a patient is aware of the Medical Board, it is unlikely that it would occur to a patient, who has been in a particular physician's care for many years, to check whether the physician has recently been disciplined. Under its current guidelines, it is the MBC's general practice to keep patients in the dark regarding physician discipline. In some cases this leaves patients vulnerable to dangerous care.

Occasionally, the MBC includes a requirement that a disciplined physician notify patients regarding the discipline. For example, the following requirement to notify patients was placed on Dr. J.V.G. when he was placed on seven-years probation by the MBC in 2015.

"During probation, respondent is prohibited from performing any of the following procedures on any patient: diaphragmatic herniorrhaphies, gastrectomy, small and large bowel incision and resection, common duct incisions, diverting biliary procedures, splenectomy, adrenalectomy, radical lymphadenectomy, thyroid resection, parathyroid resection, salivary gland resection, thyroglossal duct cyst resection, broncoscopy, upper extremity-minor, laparoscopic (lysis of adhesions, vagotomy, herniorrhaphy), lymphadenectomy, cystoscopy, pancreas incision and resection, hepatic surgery, liver resection and esophageal diverticula resection. In addition, during probation, respondent is also prohibited from providing emergency room (ER) on call coverage. This prohibited practice condition shall remain in full force and effect until and unless respondent provides satisfactory proof of his successful completion of the Clinical Training Program (PACE)... all patients being treated by the respondent shall be notified in writing that he is subject to the aforementioned prohibited practice condition which shall list each of the prohibited procedures and activities listed above. All new patients must also be provided with this written notification at the time of their appointment... Respondent shall maintain a log of all patients to whom the required written notification was made." (emphasis added) (May 11, 2015 Stipulated Settlement and Disciplinary Order in the

case of Dr. J.V.G., page 8;
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?lastName=&firstName=&licenseType=C&licenseNumber=42883>)

And in another example, the following requirement to notify certain patients, i.e. family members, was required of Dr. C.C.A. when she was placed on probation by the MBC in in 2012 and in 2015:

"During the probationary term, Respondent shall continue to be prohibited from prescribing, furnishing, and/or providing samples of narcotics, dangerous drugs, and/or controlled substances to any family member. Respondent shall further be prohibited from treating, diagnosing, or counseling any family member during probation. After the effective date of this Decision, the first time that a family member seeking the prohibited services contacts Respondent, Respondent shall orally notify the family member that Respondent is prohibited from prescribing, furnishing, and/or providing samples of narcotics, dangerous drugs, and/or controlled substances to any family member and is further prohibited from treating, diagnosing, or counseling any family member during the probationary period." (emphasis added) (January 20, 2015 Stipulated Settlement and Disciplinary Order in the case of Dr. C.C.A., page 5;
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?lastName=&firstName=&licenseType=A&licenseNumber=105195>)

At a March 2015 Joint Oversight Hearing, legislators expressed dismay that patients are not informed when health practitioners are on probation. Senator Marty Block, member, Senate Business, Professions and Economic Development committee said:

"But my question is 'how do we protect patients, prospective patients, when a dentist is on probation. Is there a sign that tells them the dentist is on probation? If I go into a dentist's office, how do I know my dentist is on probation?' I know, by the way, that there is now a requirement that people are told there's a website they can go to. My guess is that virtually no people go to that website. My guess is that if we took a survey of a hundred people coming out of Ralph's 98 would say they have never gone to that website but they all go to the dentist... If a dentist is a known meth user, if a dentist has burned, disfigured, and killed a patient, why not have them put up a sign that says that in their office?... it's not just dentists...there are probably the same problems with many other health practitioners..."

Jerry Hill, chair, Senate Business, Professions and Economic Development Committee:

"...when you go into a restaurant in many counties... there's a sign that says you didn't get an A, you got a C. It lets people know that there's a difference in that restaurant. Is there any other notification provision for dentists who are on suspension or have particular problems other than going to a website?"

(March 23, 2015. Joint Oversight Hearing, Senate Business, Professions and Economic Development Committee and Assembly Business and Professions Committee

7:31:21 to 7:38:10: http://calchannel.granicus.com/MediaPlayer.php?view_id=7&clip_id=2664)

MBC staff proposal for an effective consumer notification

In October, 2012 MBC staff made a proposal to the MBC to require physicians to inform their patients when the physician is on probation and required to have a monitor. In its recommendation staff said, *"This would insure the public has the ability to make informed decisions regarding their healthcare provider."* (Draft MBC Sunset Review Report presented at the MBC Quarterly Board Meeting in October 2012). During the board meeting discussion, then-MBC-board member, Sylvia Diego, M.D. said:

"I think the big governing bodies have no trouble finding out. It's the patient who, at the end of the day, is the consumer protection who we're after. They're the ones who are going to have the hardest time finding out. Because the hospitals and everyone else, they are all going to find out."

Unfortunately, the Board rejected the proposal. (MBC Quarterly Board meeting webcast October 12, 2013, 4:40 to 4:51)

IV. Right to Petition

This petition is filed pursuant to the California Constitution, which guarantees the public the right to petition the government for redress of grievances. Cal. Const. Art. 1 Section 3. Additionally, this petition is filed pursuant to the Government Code. Cal. Gov. Code section 11340.6. This provision mandates a speedy response or a public hearing. (Cal. Gov. Code Section 11340.7)

V. Legal Claim

The MBC's paramount responsibility is patient safety and the MBC has the authority and responsibility to require disclosure to patients when their physician is on probation.

MBC-related statutes and policies – patient safety and right to know

Business and professions code 2229 requires that "Protection of the public shall be the highest priority" for the MBC.

MBC Policy Compendium, Policy and Principles 3) states that "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.*" (emphasis added) (approved by the MBC October 24, 2014)

MBC-related statutes – MBC authority to require disclosure

The MBC is empowered to discipline physicians in ways it deems proper. Business and Professions code section 2227 (a) sets forth what the MBC may do in disciplining a physician

(e.g., revoke or suspend a license, place a physician on probation, etc); Business and Professions code section 2227 (a) (5) further states that a licensee can "Have any other action taken in relation to discipline as part of an order as the board or administrative law judge may deem proper."

MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines

The MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines (MBC Manual) states that, "Consistent with the mandates of section 2229, these guidelines set forth discipline the Board finds appropriate and necessary for the identified violations." The MBC Manual includes standard conditions that generally appear in all probation orders as well as optional conditions the use of which depends on the nature and circumstances of the particular case. The MBC Manual states that any proposed decision or settlement that departs from the disciplinary guidelines is required to identify the departure, and the facts supporting the departure. (MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th edition, 2011, page 6)

Currently, Standard Condition 27 in the (MBC) Manual of Model Disciplinary Orders and Disciplinary Guidelines requires that physicians disclose their probationary status:

- at every hospital where the physician has privileges;
- at any facility where the physician engages in the practice of medicine;
- to every malpractice insurance carrier that provides coverage to the physician.

(MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th edition, 2011, page 2)

Currently, Optional Condition 26 allows for direct notification of patients of physicians who are on probation and have restrictions on their practice. However, this is *optional*, not standard and is not routinely used. Optional Condition 26 describes a process for notifying patients. (MBC Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th edition, 2011, page 21)

VI. Relief

Physicians' probationary status is already public information, posted on the MBC website, disclosed in agency newsletters and sent in emails by the MBC to interested parties who have signed up to receive them. Physicians on probation are already required by standard MBC guidelines to report their probationary status to hospitals, malpractice insurers and others. However, patients of physicians on probation, i.e., those with the most at stake, are, for all practical purposes, kept in the dark.

Published research and practical California experience tell us that physicians on probation are much more likely to harm their patients than physicians who have not been disciplined. Petitioners believe that, in the interest of fostering patient safety, and in the interest of government transparency, the MBC should timely exercise its authority and fulfill its responsibility by amending its guidelines to require that physicians on probation disclose their probationary status to their patients.

WHEREFORE, Petitioners pray:

That MBC amend its Manual of Model Disciplinary Orders and Disciplinary Guidelines to require as a standard condition of probation:

1. that physicians who continue to see patients be required to inform their patients of their probationary status;
2. that patients be notified of the physician's probationary status when the patient contacts the physician's office to make an appointment;
3. that this disclosure be required to be in writing and signed at the time of the patient's appointment by each patient the physician sees while on probation to acknowledge the notice;
4. that this disclosure be posted in the physician's office in a place readily apparent to patients;
5. that the written disclosures described in #3 and #4 above include at least a one-paragraph description of the offenses that led the MBC to place the physician on probation;
6. that the written disclosures include a description of any practice restrictions placed on the physician;
7. that the patient be referred for more details to MBC online documents related to the physician's probation;
8. that the physician maintain a log of all patients to whom the required oral notification was made. The log should contain the following: 1) patient's name, address and phone number; patient's medical record number, if available; 3) the full name of the person making the notification; 4) the date notification was made; 5) a copy of the notification given; and 6) a signed attestation by the patient that notification was received. Respondent shall keep this log in a separate file or ledger, in chronological order, shall make the log available for immediate inspection and copying on the premises at all times during business hours by the board or its designee, and shall retain the log for the entire term of probation.

Please address follow-up to Maryann O'Sullivan, project consultant,
maryannosullivan 1@gmail.com; 415-457-1417; (o) 510-757-7942 (c)

Dated: October 8, 2015

Respectfully submitted by the following co-petitioners:

Lisa McGiffert

Director

Consumers Union Safe Patient Project

www.SafePatientProject.org

lmcgiffert@consumer.org

512-477-4431 ext 7509

Consumers Union Safe Patient Project California Network Activists:

Alicia Cole, Sherman Oaks

Veverly Edwards, Orange County

Jack French, Escondido
Sarah Hitchcock-Glover RN, Los Gatos
Marian Hollingsworth, La Mesa
Rae Greulich, Simi Valley
Suzan Shinazy, Bakersfield
Tina Minasian, Sacramento
Michele Monserratt-Ramos, Los Angeles
Carole Moss, Perris
Ty Moss, Perris

MEDICAL BOARD OF CALIFORNIA - 2015 TRACKER LIST
October 13, 2015

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 159	Calderon	Investigational Drugs, Biological Products, and Devices	VETOED	No Position	7/6/15
AB 611	Dahle	Controlled Substances: Prescriptions: Reporting	2-year Bill		4/15/15
AB 637	Campos	Physician Orders for Life Sustaining Treatment Forms	Chaptered, #217	Support	
AB 679	Allen	Controlled Substances	Chaptered, #778		9/10/15
AB 684	Bonilla	Healing Arts: Licensees: Disciplinary Actions	Chaptered, #405		9/4/15
AB 890	Ridley-Thomas	Anesthesiologist Assistants	2-year Bill	Support if Amended	5/5/15
AB 1306	Burke	Healing Arts: Certified Nurse-Midwives: Scope of Practice	2-year Bill		7/1/15
ABX2 15	Eggman	End of Life	Chaptered, #1		9/3/15
ACR 29	Frazier	Donate Life California Day: Driver's License	Chaptered, #42	Support	4/20/15
SB 19	Wolk	Physician Orders for Life Sustaining Treatment Form: Electronic Registry Pilot	Chaptered, #504		9/4/15
SB 22	Roth	Residency Training	2-year Bill	Support	6/4/15
SB 277	Pan	Public Health: Vaccinations	Chaptered, #35	Support	6/18/15
SB 323	Hernandez	Nurse Practitioners	2-year Bill	Oppose	7/9/15
SB 337	Pavley	Physician Assistants	Chaptered, #536	Support	9/1/15
SB 396	Hill	Outpatient Settings and Surgical Clinics	Chaptered, #287	Strong Support	6/29/15

Pink – Sponsored Bill, Green – Chaptered, Orange - Vetoed, Blue – 2-year Bill

MEDICAL BOARD OF CALIFORNIA - 2015 TRACKER LIST
October 13, 2015

SB 408	Morrell	Midwife Assistants	Chaptered, #280	Sponsor/Support	5/6/15
SB 464	Hernandez	Healing Arts: Self-Reporting Tools	Chaptered, #387	Neutral	5/22/15
SB 482	Lara	Controlled Substances: CURES Database	2-year Bill	Support	4/30/15
SB 538	Block	Naturopathic Doctors	2-year Bill	Oppose	7/7/15
SB 622	Hernandez	Optometry	2-year Bill	Oppose Unless Amended	5/4/15
SB 643	McGuire	Medical Marijuana	Chaptered, #719		9/11/15
SB 738	Huff	Pupil Health: Epinephrine Auto-Injectors: Liability Limitation	Chaptered, #132	Support	5/13/15
SB 800	Sen. B&P	Health Omnibus	Chaptered, #426	Sponsor/Support MBC Provisions	9/3/15
SJR 7	Pan	Medical Residency Programs	Chaptered, #90	Support	4/6/15

Pink – Sponsored Bill, Green – Chaptered, Orange - Vetoed, Blue – 2-year Bill



OFFICE OF THE GOVERNOR

OCT 11 2015

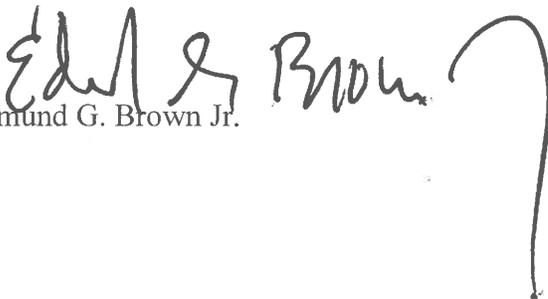
To the Members of the California State Assembly:

I am returning Assembly Bill 159 without my signature.

This bill would permit a pharmaceutical manufacturer to make an investigational drug available to a patient with an immediately life-threatening disease on the recommendation of two physicians.

Patients with life threatening conditions should be able to try experimental drugs, and the United States Food and Drug Administration's compassionate use program allows this to happen. The proposed changes to this program will streamline access to these drugs. Before authorizing an alternative state pathway, we should give this federal expedited process a chance to work.

Sincerely,

A handwritten signature in black ink that reads "Edmund G. Brown Jr." with a large, sweeping flourish at the end.

Edmund G. Brown Jr.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 637
Author: Campos
Chapter: 217
Bill Date: February 24, 2015, Introduced
Subject: Physician Orders for Life Sustaining Treatment Forms
Sponsor: California Medical Association (CMA) and
Coalition for Compassionate Care of California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow nurse practitioners (NPs) and physician assistants (PAs), under physician supervision, to sign Physician Orders for Life Sustaining Treatment (POLST) forms.

BACKGROUND

In the early 1990s, 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 patients' 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 and must be signed by both the patient and their physician to become actionable.

ANALYSIS

According to the author's office, there have been reported difficulties by some nursing homes in obtaining a physician's signature on a POLST form in a timely manner. Currently, patients discuss their end-of-life care wishes with all members of their health care team, including NPs and PAs. The author's office believes that expanding the number and type of healthcare providers who can assist patients in establishing their end-of-life care orders will help to ensure that patients' end-of-life care wishes are followed.

Allowing NPs and PAs, who are under the supervision of a physician, seems to be a reasonable expansion and one that will help to improve patient care. NPs and PAs are involved in providing end-of-life care to patients in California, so it makes sense to allow them to sign off on POLST forms to ensure that patients have better access to providers who can assist in establishing end-of-life care orders. This bill will further the Medical Board of California's (Board) mission of promoting access to care and the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: California Medical Association (co-sponsor); Coalition for Compassionate Care of California (co-sponsor); AARP; Association of Northern California Oncologists; Blue Shield of California; California Assisted Living Association; California Association for Health Services at Home; California Association for Nurse Practitioners; California Chapter of the American College of Emergency Physicians; California Long-Term Care Ombudsman Association; Contra Costa County Advisory Council on Aging; Contra Costa County Board of Supervisors; LeadingAge California; Medical Board of California; Medical Oncology Association of Southern California, Inc.; and Physician Assistant Board

OPPOSITION: California Right to Life Committee

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Assembly Bill No. 637

CHAPTER 217

An act to amend Section 4780 of the Probate Code, relating to resuscitative measures.

[Approved by Governor August 17, 2015. Filed with
Secretary of State August 17, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 637, Campos. Physician Orders for Life Sustaining Treatment forms.

Existing law defines a request regarding resuscitative measures to mean a written document, signed by an individual, as specified, and the physician, that directs a health care provider regarding resuscitative measures, and includes a Physician Orders for Life Sustaining Treatment form (POLST form). Existing law requires a physician to treat a patient in accordance with the POLST form and specifies the criteria for creation of a POLST form, including that the form be completed by a health care provider based on patient preferences and medical indications, and signed by a physician and the patient or his or her legally recognized health care decisionmaker.

This bill would authorize the signature of a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law to create a valid POLST form.

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

SECTION 1. Section 4780 of the Probate Code is amended to read:
4780. (a) As used in this part:

(1) "Request regarding resuscitative measures" means a written document, signed by (A) an individual with capacity, or a legally recognized health care decisionmaker, and (B) the individual's physician, that directs a health care provider regarding resuscitative measures. A request regarding resuscitative measures is not an advance health care directive.

(2) "Request regarding resuscitative measures" includes one, or both of, the following:

(A) A prehospital "do not resuscitate" form as developed by the Emergency Medical Services Authority or other substantially similar form.

(B) A Physician Orders for Life Sustaining Treatment form, as approved by the Emergency Medical Services Authority.

(3) "Physician Orders for Life Sustaining Treatment form" means a request regarding resuscitative measures that directs a health care provider regarding resuscitative and life-sustaining measures.

(b) A legally recognized health care decisionmaker may execute the Physician Orders for Life Sustaining Treatment form only if the individual lacks capacity, or the individual has designated that the decisionmaker's authority is effective pursuant to Section 4682.

(c) The Physician Orders for Life Sustaining Treatment form and medical intervention and procedures offered by the form shall be explained by a health care provider, as defined in Section 4621. The form shall be completed by a health care provider based on patient preferences and medical indications, and signed by a physician, or a nurse practitioner or a physician assistant acting under the supervision of the physician and within the scope of practice authorized by law, and the patient or his or her legally recognized health care decisionmaker. The health care provider, during the process of completing the Physician Orders for Life Sustaining Treatment form, should inform the patient about the difference between an advance health care directive and the Physician Orders for Life Sustaining Treatment form.

(d) An individual having capacity may revoke a Physician Orders for Life Sustaining Treatment form at any time and in any manner that communicates an intent to revoke, consistent with Section 4695.

(e) A request regarding resuscitative measures may also be evidenced by a medallion engraved with the words "do not resuscitate" or the letters "DNR," a patient identification number, and a 24-hour toll-free telephone number, issued by a person pursuant to an agreement with the Emergency Medical Services Authority.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 679
Author: Allen
Chapter: 778
Bill Date: September 10, 2015, Amended
Subject: Controlled Substances
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill amends existing law that requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances and pharmacists to be registered with CURES by extending the date from January 1, 2016, to July 1, 2016. This bill contains an urgency clause, so it becomes effective immediately.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. Since 2009, more than 8,000 doctors and pharmacists have signed up to use CURES, which has more than 100 million prescriptions. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license prescribers and dispensers, for purposes of funding and upgrading the CURES system. In addition, this bill requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances to be registered with CURES by January 1, 2016. DOJ is currently in the process of modernizing CURES to more efficiently serve prescribers, pharmacists and entities that may utilize the data contained within the system and allow health care practitioners and pharmacists to apply for registration online. It is estimated that the new CURES 2.0 system will not be fully operational until at least October 2015.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

ANALYSIS

This bill amends existing law that requires all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedule II, III, or IV controlled substances to be registered with CURES by extending the date from January 1, 2016, to July 1, 2016. This bill contains an urgency clause, so it becomes effective immediately.

DOJ is currently in the process of modernizing CURES pursuant to SB 800. This modernization and streamlined application for CURES registration was originally expected to be completed in July 2015, and the requirement for health care practitioners and pharmacists to register was not until January 1, 2016. However, the CURES 2.0 system is not yet fully functional to allow for registration online, and this is not anticipated to be ready until at least October 2015. This bill was introduced to allow time for the new online registration process to be implemented and allow for a smooth transition to the online registration process for health care practitioners.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent “doctor shopping”. Delaying the registration requirement until the new CURES 2.0 is up and running and available to physicians to register online makes sense. The Board did not take a position on this bill as the language was put in the bill at the very end of session.

FISCAL: None to the Board

SUPPORT: California Medical Association

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) and a boxed article to inform physicians of the delayed registration date for CURES
- Notify/train Board staff
- Send an email blast to all physicians to provide notification that the CURES registration date has been extended until July 1, 2016
- Update the Board’s website to reflect the new July 1, 2016 date for required CURES registration

Assembly Bill No. 679

CHAPTER 778

An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances, and declaring the urgency thereof, to take effect immediately.

[Approved by Governor October 11, 2015. Filed with
Secretary of State October 11, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 679, Travis Allen. Controlled substances.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law authorizes the Department of Justice to provide the history of controlled substances dispensed to an individual to a licensed health care practitioner, pharmacist, or both, providing care or services to the individual. By January 1, 2016, or upon licensure in the case of a pharmacist, or upon receipt of a federal Drug Enforcement Administration registration in the case of another health care practitioner authorized to prescribe, order, administer, furnish, or dispense controlled substances, whichever respective event occurs later, existing law requires those persons to apply to the Department of Justice to obtain approval to access information contained in the CURES database regarding the controlled substance history of a patient under his or her care.

This bill would extend those January 1, 2016, deadlines to July 1, 2016.

This bill would declare that it is to take effect immediately as an urgency statute.

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

SECTION 1. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the

Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of

Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

SEC. 2. This act is an urgency statute necessary for the immediate preservation of the public peace, health, or safety within the meaning of Article IV of the Constitution and shall go into immediate effect. The facts constituting the necessity are:

In order to ensure that health care practitioners and pharmacists are not out of compliance with the requirement to apply to access data contained in the Controlled Substance Utilization Review and Evaluation System Prescription Drug Monitoring Program on January 1, 2016, it is necessary that this act take effect immediately.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 684
Author: Alejo
Chapter: 405
Bill Date: September 4, 2015, Amended
Subject: State Board of Optometry: Optometrists: Nonresident Contact Lens
Sellers: Registered Dispensing Opticians
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes the establishment of landlord-tenant leasing relationships between a Registered Dispensing Optician (RDO), optometrist, and an optical company, as specified. This bill transfers the RDO Program from the Medical Board of California (Board) to the California State Board of Optometry (CBO). This bill replaces one optometrist Board Member on the CBO with an RDO Board Member and establishes an RDO Advisory Committee in the CBO. Lastly, this bill establishes a three-year transition period for companies that directly employ optometrists to transition to leasing arrangements.

BACKGROUND

The Board currently is the regulatory agency charged with overseeing the RDO Program. The RDO Program is comprised of four sections, RDOs (business location), Spectacle Lens Dispensers (SLDs), Contact Lens Dispensers (CLDs), and Non-Resident Contact Lens Dispensers (NCLDs). RDO registration is required for individuals, corporations, and firms engaged in the business of filling prescriptions of physicians licensed by the Board or optometrists licensed by CBO for prescription lenses. A registered SLD is authorized to fit and adjust spectacle lenses at any place of business holding an RDO registration, provided that the RDO certificate of registration is displayed in a conspicuous place at the place of business where the SLD is fitting and adjusting. A registered CLD is authorized to fit and adjust contact lenses at any place of business holding an RDO registration, provided that the RDO certificate of registration is displayed in a conspicuous place at the place of business where the CLD is fitting and adjusting. NCLD registration is required for individuals, partnerships, and corporations located outside of California that ship, mail, or deliver in any manner, contact lenses at retail to a patient at a California address. According to the Board's 13/14 Annual Report, there are 1,047 RDO registrants, 2,110 SLD registrants, 921 CLD registrants, and 6 NCLD registrants.

In California, there are currently two eye care service models, an optometrist's private office and a co-location office. A co-location office is where an optical retail store is co-located with a Knox-Keene plan (regulated by the Department of Managed Health Care) that provides optometry care. At co-location sites, patients receive an eye exam and can fill their

prescription for corrective eyewear during the same visit at the co-located optical retail store, some examples are Walmart and Lenscrafters. At private optometrist's offices, patients receive an eye exam and can then take their prescription elsewhere to have it filled, or have the optometrist send it out for them. California law specifies that the patient is not required to have the prescription filled on site.

Existing law, Business and Professions Code (BPC) Sections 655 and 2556, prohibits optometrists and RDOs from having any membership, proprietary interest, co-ownership, landlord-tenant relationship or any profit-sharing agreement with each other. Optometrists are also prohibited from having any membership, proprietary interest, co-ownership, landlord-tenant relationship or any profit-sharing arrangement in any form with those who manufacture, sell, or distribute lenses, frames, optical supplies, optometric appliances or devices or kindred products to physicians and surgeons, optometrists or RDOs. Existing law prohibits RDOs from advertising the furnishing of, or furnishing the services of a refractionist, an optometrist or a physician and surgeon. RDOs are also prohibited from directly or indirectly employing or maintaining on or near the premises used for optical dispensing, a refractionist, optometrist, physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes. RDOs are prohibited from duplicating or changing lenses without a prescription or order from a person duly licensed to issue the prescription.

There have been many lawsuits related to the Optometry Practice Act and BPC Sections 655 and 2556. However, existing law has been found to be constitutional by the courts. There are 14 United States jurisdictions that allow direct employment of optometrists by optical companies and direct landlord-tenant relationships are permitted in 47 states. In addition, 49 states allow optical companies to franchise to optometrists.

ANALYSIS

This bill will allow an optometrist, an RDO, an optical company, or a health plan to enter into a direct or indirect landlord-tenant relationship if the practice is owned by the optometrist and in every phase is under the optometrist's exclusive control, as specified. This bill allows the landlord to terminate the lease for specified reasons. This bill prohibits the RDO or optical company from interfering with the professional judgment of the optometrist.

This bill moves the RDO Program, consisting of RDO registrants, SLD registrants, CLD registrants and NCLD registrants, to the CBO effective January 1, 2016. This bill authorizes the CBO to inspect any premises where the RDO is co-located with an optometrist practice and would authorize the CBO to inspect lease agreements. This bill would replace a CBO optometrist Board Member position with an RDO Board Member to address concerns regarding conflict of interest. This bill establishes an RDO Committee to advise and make recommendations to the CBO regarding the regulation of the RDO Program. The Committee will be made up of five members, two RDOs, two public members, and one member of the CBO.

This bill is sponsored by the author, and according to the author, “Co-located vision models have existed in California for nearly three decades. They serve millions of patients annually and employ thousands of optometrists and opticians. With the conclusion of legal suits over the last few years, the state is compelled to enforce a decades old law that has found this business model to be unlawful. AB 684 is seeking a legislative solution that allows multiple models to continue to operate, while also leveling the playing field for both large and small operators, ensuring that consumers’ interests are protected, and optometrists’ clinical judgment is preserved. This legislation would clarify and modernize the law.” This bill allows for a three year transition period for businesses to transition from the unlawful direct employment model to the leasing arrangement model.

This bill is a result of numerous stakeholder meetings convened by the Governor’s office, and attended by all stakeholders, including the Board, CBO and the Department of Consumer Affairs (DCA). Board staff have attended these meetings and offered feedback and technical input. Most of the Board’s staff suggestions have been taken and amended into the bill. However, there are some technical fixes and changes still needed, as this bill was being worked on until the very end of session. The Governor’s Office, DCA, and CBO are all aware that further changes are needed and the Governor’s Office has committed to making needed changes as the RDO Program transitions to CBO. The Board will continue to work with all interested parties, including CBO, DCA, and the Governor’s Office, to provide any assistance needed during the transition of the RDO Program to CBO.

FISCAL: None to the Board

SUPPORT: None on File

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General’s Office, Health Quality Enforcement Section
- Transfer all applications and case files (including pending cases) to CBO, this includes hard copies and electronic files
- Allow CBO to access RDO Program files in BreZE
- Update the Board’s RDO Program webpage, forms, and certificates
- Train CBO staff on the RDO Program, including the new staff position that will be hired to support the RDO Program
- Post a transition webpage to inform consumers and RDO Program registrants that the RDO program is moving to CBO
- Ensure that all interested parties are notified of the RDO Program moving to CBO effective January 1, 2016

Assembly Bill No. 684

CHAPTER 405

An act to amend Sections 2546.2, 2546.9, 2550.1, 2554, 2556, 2567, 3010.5, 3011, 3013 of, to add Sections 2556.1, 2556.2, 3020, 3021, 3023.1 to, and to repeal and add Section 655 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 1, 2015. Filed with
Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 684, Alejo. State Board of Optometry: optometrists: nonresident contact lens sellers: registered dispensing opticians.

Existing law prohibits a licensed optometrist and a registered dispensing optician from having any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, with each other. Existing law prohibits a licensed optometrist from having any membership, proprietary interest, coownership, landlord-tenant relationship, or any profit-sharing arrangement in any form, directly or indirectly, either by stock ownership, interlocking directors, trusteeship, mortgage, trust deed, or otherwise with any person who is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, or dispensing opticians of lenses, frames, optical supplies, optometric appliances or devices or kindred products. Existing law makes a violation of these provisions by a licensed optometrist and any other persons, whether or not a healing arts licensee, who participates with a licensed optometrist, subject to a crime.

Under existing law, the Medical Board of California is responsible for the registration and regulation of nonresident contact lens sellers and dispensing opticians. Existing law requires fees collected from nonresident contact lens sellers to be deposited in the Dispensing Opticians Fund, and to be available, upon appropriation, to the Medical Board of California. Existing law requires fees collected from registered dispensing optician to be paid into the Contingent Fund of the Medical Board of California. Existing law makes a violation of the registered dispensing optician provisions a crime. Existing law, the Optometry Practice Act, makes the State Board of Optometry responsible for the licensure and regulation of optometrists. A violation of the Optometry Practice Act is a crime. Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime.

This bill would repeal those prohibitions. The bill would prohibit a licensed optometrist from having any membership, proprietary interest,

coownership, or any profit-sharing arrangement, either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with any registered dispensing optician or any optical company, as defined, except as otherwise authorized. The bill would authorize a registered dispensing optician or optical company to operate, own, or have an ownership interest in a health plan, defined as a licensed health care service plan, if the health plan does not directly employ optometrists to provide optometric services directly to enrollees of the health plan, and would also provide for the direct or indirect provision of products and services to the health plan or its contracted providers or enrollees or to other optometrists, as specified. The bill would authorize an optometrist, a registered dispensing optician, an optical company, or a health plan to execute a lease or other written agreement giving rise to a direct or indirect landlord-tenant relationship with an optometrist if specified conditions are contained in a written agreement, as provided. The bill would authorize the State Board of Optometry, to inspect, upon request, an individual lease agreement, and the bill would require the landlord or tenant to comply. Because the failure to comply with that request would be a crime under specified acts, the bill would impose a state-mandated local program. The bill would prohibit a registered dispensing optician from having any membership, proprietary interest, coownership, or profit sharing arrangement either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with an optometrist, except as authorized. The bill would make a violation of these provisions a crime. By creating a new crime, the bill would impose a state-mandated local program.

This bill would instead make the State Board of Optometry responsible for the registration and regulation of nonresident contact lens sellers and dispensing opticians. The bill would direct fees collected from registered dispensing opticians and persons seeking registration as a dispensing optician to be paid into the Dispensing Opticians Fund, and to be available, upon appropriation, to the State Board of Optometry. The bill would make various conforming changes in that regard.

Existing law requires each registered dispensing optician to conspicuously and prominently display at each registered location the name of the registrant's employee who is currently designated to handle customer inquiries and complaints and the telephone number where he or she may be reached during business hours.

This bill would instead require specified consumer information to be displayed. Because a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program.

Existing law makes it unlawful to, among other things, advertise the furnishing of, or to furnish, the services of a refractionist, an optometrist, or a physician and surgeon, or to directly or indirectly employ or maintain on or near the premises used for optical dispensing, a refractionist, an optometrist, a physician and surgeon, or a practitioner of any other profession for the purpose of any examination or treatment of the eyes.

This bill, except as specified, would make it unlawful for a registered dispensing optician to, among other things, advertise the furnishing of, or to furnish, the services of an optometrist or a physician and surgeon or to directly employ an optometrist or physician and surgeon for the purpose of any examination or treatment of the eyes. The bill would authorize the State Board of Optometry, by regulation, to impose and issue administrative fines and citations for a violation of these provisions, as specified. The bill would require all licensed optometrists in a setting with a registered dispensing optician to report the business relationship to the State Board of Optometry. The bill would authorize the State Board of Optometry to inspect any premises at which the business of a registered dispensing optician is co-located with the practice of an optometrist for the purposes of determining compliance with the aforementioned written lease agreement provisions. The bill would also authorize the State Board of Optometry to take disciplinary action against a party who fails to comply with the inspection and would require the State Board of Optometry to provide specified copies of the inspection results. Because would be a crime a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program

This bill, until January 1, 2019, would prohibit an individual, corporation, or firm operating as a registered dispensing optician before the effective date of the bill, or an employee of such an entity, from being subject to any action for engaging in that aforementioned unlawful conduct. Because a violation of the registered dispensing provisions would be a crime, the bill would impose a state-mandated local program. The bill would require any health plan subject to these provisions to report to the State Board of Optometry in writing that certain percentages of its locations no longer employ an optometrist by specified dates. The bill would require the State Board of Optometry to provide those reports to the Director of Consumer Affairs and the Legislature.

Under existing law, the State Board of Optometry consists of 11 members, 6 licensee members and 5 public members.

This bill would require one of the nonpublic members to be a registered dispensing optician and would require the Governor to make that appointment. The bill would establish a dispensing optician committee to advise and make recommendations to the board regarding the regulation of dispensing opticians, as provided. The bill would require the advisory committee to consist of 5 members, including 2 registered dispensing opticians, 2 public members, and a member of the State Board of Optometry.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 655 of the Business and Professions Code is repealed.

SEC. 2. Section 655 is added to the Business and Professions Code, to read:

655. (a) For the purposes of this section, the following terms have the following meanings:

(1) "Health plan" means a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(2) "Optical company" means a person or entity that is engaged in the manufacture, sale, or distribution to physicians and surgeons, optometrists, health plans, or dispensing opticians of lenses, frames, optical supplies, or optometric appliances or devices or kindred products.

(3) "Optometrist" means a person licensed pursuant to Chapter 7 (commencing with Section 3000) or an optometric corporation, as described in Section 3160.

(4) "Registered dispensing optician" means a person licensed pursuant to Chapter 5.5 (commencing with Section 2550).

(5) "Therapeutic ophthalmic product" means lenses or other products that provide direct treatment of eye disease or visual rehabilitation for diseased eyes.

(b) No optometrist may have any membership, proprietary interest, coownership, or any profit-sharing arrangement, either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with any registered dispensing optician or any optical company, except as otherwise permitted under this section.

(c) (1) A registered dispensing optician or an optical company may operate, own, or have an ownership interest in a health plan so long as the health plan does not directly employ optometrists to provide optometric services directly to enrollees of the health plan, and may directly or indirectly provide products and services to the health plan or its contracted providers or enrollees or to other optometrists. For purposes of this section, an optometrist may be employed by a health plan as a clinical director for the health plan pursuant to Section 1367.01 of the Health and Safety Code or to perform services related to utilization management or quality assurance or other similar related services that do not require the optometrist to directly provide health care services to enrollees. In addition, an optometrist serving as a clinical director may not employ optometrists to provide health care services to enrollees of the health plan for which the optometrist is serving as clinical director. For the purposes of this section, the health plan's

utilization management and quality assurance programs that are consistent with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code) do not constitute providing health care services to enrollees.

(2) The registered dispensing optician or optical company shall not interfere with the professional judgment of the optometrist.

(3) The Department of Managed Health Care shall forward to the State Board of Optometry any complaints received from consumers that allege that an optometrist violated the Optometry Practice Act (Chapter 7 (commencing with Section 3000)). The Department of Managed Health Care and the State Board of Optometry shall enter into an Inter-Agency Agreement regarding the sharing of information related to the services provided by an optometrist that may be in violation of the Optometry Practice Act that the Department of Managed Health Care encounters in the course of the administration of the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with section 1340) of Division 2 of the Health and Safety Code).

(d) An optometrist, a registered dispensing optician, an optical company, or a health plan may execute a lease or other written agreement giving rise to a direct or indirect landlord-tenant relationship with an optometrist, if all of the following conditions are contained in a written agreement establishing the landlord-tenant relationship:

(1) (A) The practice shall be owned by the optometrist and in every phase be under the optometrist's exclusive control, including the selection and supervision of optometric staff, the scheduling of patients, the amount of time the optometrist spends with patients, fees charged for optometric products and services, the examination procedures and treatment provided to patients and the optometrist's contracting with managed care organizations.

(B) Subparagraph A shall not preclude a lease from including commercially reasonable terms that: (i) require the provision of optometric services at the leased space during certain days and hours, (ii) restrict the leased space from being used for the sale or offer for sale of spectacles, frames, lenses, contact lenses, or other ophthalmic products, except that the optometrist shall be permitted to sell therapeutic ophthalmic products if the registered dispensing optician, health plan, or optical company located on or adjacent to the optometrist's leased space does not offer any substantially similar therapeutic ophthalmic products for sale, (iii) require the optometrist to contract with a health plan network, health plan, or health insurer, or (iv) permit the landlord to directly or indirectly provide furnishings and equipment in the leased space.

(2) The optometrist's records shall be the sole property of the optometrist. Only the optometrist and those persons with written authorization from the optometrist shall have access to the patient records and the examination room, except as otherwise provided by law.

(3) The optometrist's leased space shall be definite and distinct from space occupied by other occupants of the premises, have a sign designating

that the leased space is occupied by an independent optometrist or optometrists and be accessible to the optometrist after hours or in the case of an emergency, subject to the facility's general accessibility. This paragraph shall not require a separate entrance to the optometrist's leased space.

(4) All signs and displays shall be separate and distinct from that of the other occupants and shall have the optometrist's name and the word "optometrist" prominently displayed in connection therewith. This paragraph shall not prohibit the optometrist from advertising the optometrist's practice location with reference to other occupants or prohibit the optometrist or registered dispensing optician from advertising their participation in any health plan's network or the health plan's products in which the optometrist or registered dispensing optician participates.

(5) There shall be no signs displayed on any part of the premises or in any advertising indicating that the optometrist is employed or controlled by the registered dispensing optician, health plan or optical company.

(6) Except for a statement that an independent doctor of optometry is located in the leased space, in-store pricing signs and as otherwise permitted by this subdivision, the registered dispensing optician or optical company shall not link its advertising with the optometrist's name, practice, or fees.

(7) Notwithstanding paragraphs (4) and (6), this subdivision shall not preclude a health plan from advertising its health plan products and associated premium costs and any copayments, coinsurance, deductibles, or other forms of cost-sharing, or the names and locations of the health plan's providers, including any optometrists or registered dispensing opticians that provide professional services, in compliance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(8) A health plan that advertises its products and services in accordance with paragraph (7) shall not advertise the optometrist's fees for products and services that are not included in the health plan's contract with the optometrist.

(9) The optometrist shall not be precluded from collecting fees for services that are not included in a health plan's products and services, subject to any patient disclosure requirements contained in the health plan's provider agreement with the optometrist or that are not otherwise prohibited by the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(10) The term of the lease shall be no less than one year and shall not require the optometrist to contract exclusively with a health plan. The optometrist may terminate the lease according to the terms of the lease. The landlord may terminate the lease for the following reasons:

(A) The optometrist's failure to maintain a license to practice optometry or the imposition of restrictions, suspension or revocation of the optometrist's

license or if the optometrist or the optometrist's employee is or becomes ineligible to participate in state or federal government-funded programs.

(B) Termination of any underlying lease where the optometrist has subleased space, or the optometrist's failure to comply with the underlying lease provisions that are made applicable to the optometrist.

(C) If the health plan is the landlord, the termination of the provider agreement between the health plan and the optometrist, in accordance with the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(D) Other reasons pursuant to the terms of the lease or permitted under the Civil Code.

(11) The landlord shall act in good faith in terminating the lease and in no case shall the landlord terminate the lease for reasons that constitute interference with the practice of optometry.

(12) Lease or rent terms and payments shall not be based on number of eye exams performed, prescriptions written, patient referrals or the sale or promotion of the products of a registered dispensing optician or an optical company.

(13) The landlord shall not terminate the lease solely because of a report, complaint, or allegation filed by the optometrist against the landlord, a registered dispensing optician or a health plan, to the State Board of Optometry or the Department of Managed Health Care or any law enforcement or regulatory agency.

(14) The landlord shall provide the optometrist with written notice of the scheduled expiration date of a lease at least 60 days prior to the scheduled expiration date. This notice obligation shall not affect the ability of either party to terminate the lease pursuant to this section. The landlord may not interfere with an outgoing optometrist's efforts to inform the optometrist's patients, in accordance with customary practice and professional obligations, of the relocation of the optometrist's practice.

(15) The State Board of Optometry may inspect, upon request, an individual lease agreement pursuant to its investigational authority, and if such a request is made, the landlord or tenant, as applicable, shall promptly comply with the request. Failure or refusal to comply with the request for lease agreements within 30 days of receiving the request constitutes unprofessional conduct and is grounds for disciplinary action by the appropriate regulatory agency. Only personal information as defined in Section 1798.3 of the Civil Code may be redacted prior to submission of the lease or agreement. This section shall not affect the Department of Managed Health Care's authority to inspect all books and records of a health plan pursuant to Section 1381 of the Health and Safety Code.

Any financial information contained in the lease submitted to a regulatory entity, pursuant to this paragraph, shall be considered confidential trade secret information that is exempt from disclosure under the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code).

(16) This subdivision shall not be applicable to the relationship between any optometrist employee and the employer medical group, or the relationship between a medical group exclusively contracted with a health plan regulated by the Department of Managed Health Care and that health plan.

(e) No registered dispensing optician may have any membership, proprietary interest, coownership, or profit sharing arrangement either by stock ownership, interlocking directors, trusteeship, mortgage, or trust deed, with an optometrist, except as permitted under this section.

(f) Nothing in this section shall prohibit a person licensed under Chapter 5 (commencing with Section 2000) or its professional corporation from contracting with or employing optometrists, ophthalmologists, or optometric assistants and entering into a contract or landlord tenant relationship with a health plan, an optical company, or a registered dispensing optician, in accordance with Sections 650 and 654 of this code.

(g) Any violation of this section constitutes a misdemeanor as to such person licensed under Chapter 7 (commencing with Section 3000) of this division and as to any and all persons, whether or not so licensed under this division, who participate with such licensed person in a violation of any provision of this section.

SEC. 3. Section 2546.2 of the Business and Professions Code is amended to read:

2546.2. All references in this chapter to the division shall mean the State Board of Optometry.

SEC. 4. Section 2546.9 of the Business and Professions Code is amended to read:

2546.9. The amount of fees prescribed in connection with the registration of nonresident contact lens sellers is that established by the following schedule:

(a) The initial registration fee shall be one hundred dollars (\$100).

(b) The renewal fee shall be one hundred dollars (\$100).

(c) The delinquency fee shall be twenty-five dollars (\$25).

(d) The fee for replacement of a lost, stolen, or destroyed registration shall be twenty-five dollars (\$25).

(e) The fees collected pursuant to this chapter shall be deposited in the Dispensing Opticians Fund, and shall be available, upon appropriation, to the State Board of Optometry for the purposes of this chapter.

SEC. 5. Section 2550.1 of the Business and Professions Code is amended to read:

2550.1. All references in this chapter to the board or the Board of Medical Examiners or division shall mean the State Board of Optometry.

SEC. 6. Section 2554 of the Business and Professions Code is amended to read:

2554. Each registrant shall conspicuously and prominently display at each registered location the following consumer information:

“Eye doctors are required to provide patients with a copy of their ophthalmic lens prescriptions as follows:

Spectacle prescriptions: Release upon completion of exam.

Contact lens prescriptions: Release upon completion of exam or upon completion of the fitting process.

Patients may take their prescription to any eye doctor or registered dispensing optician to be filled.

Optometrists and registered dispensing opticians are regulated by the State Board of Optometry. The State Board of Optometry receives and investigates all consumer complaints involving the practice of optometry and registered dispensing opticians. Complaints involving a California-licensed optometrist or a registered dispensing optician should be directed to:

California State Board of Optometry
Department of Consumer Affairs
2450 Del Paso Road, Suite 105
Sacramento, CA 95834
Phone: 1-866-585-2666 or (916) 575-7170
Email: optometry@dca.ca.gov
Website: www.optometry.ca.gov

SEC. 7. Section 2556 of the Business and Professions Code is amended to read:

2556. (a) Except as authorized by Section 655, it is unlawful for a registered dispensing optician to do any of the following: to advertise the furnishing of, or to furnish, the services of an optometrist or a physician and surgeon, to directly employ an optometrist or physician and surgeon for the purpose of any examination or treatment of the eyes, or to duplicate or change lenses without a prescription or order from a person duly licensed to issue the same. For the purposes of this section, “furnish” does not mean to enter into a landlord-tenant relationship of any kind.

(b) Notwithstanding Section 125.9, the board may, by regulation, impose and issue administrative fines and citations for a violation of this section or Section 655, which may be assessed in addition to any other applicable fines, citations, or administrative or criminal actions.

SEC. 8. Section 2556.1 is added to the Business and Professions Code, to read:

2556.1. All licensed optometrists in a setting with a registered dispensing optician shall report the business relationship to the State Board of Optometry, as determined by the board. The State Board of Optometry shall have the authority to inspect any premises at which the business of a registered dispensing optician is co-located with the practice of an optometrist, for the purposes of determining compliance with Section 655. The inspection may include the review of any written lease agreement between the registered dispensing optician and the optometrist or between the optometrist and the health plan. Failure to comply with the inspection or any request for information by the board may subject the party to disciplinary action. The board shall provide a copy of its inspection results, if applicable, to the Department of Managed Health Care.

SEC. 9. Section 2556.2 is added to the Business and Professions Code, to read:

2556.2. (a) Notwithstanding any other law, subsequent to the effective date of this section and until January 1, 2019, any individual, corporation, or firm operating as a registered dispensing optician under this chapter before the effective date of this section, or an employee of such an entity, shall not be subject to any action for engaging in conduct prohibited by Section 2556 or Section 655 as those sections existed prior to the effective date of this bill, except that a registrant shall be subject to discipline for duplicating or changing lenses without a prescription or order from a person duly licensed to issue the same.

(b) Nothing in this section shall be construed to imply or suggest that a person registered under this chapter is in violation of or in compliance with the law.

(c) This section shall not apply to any business relationships prohibited by Section 2556 commencing registration or operations on or after the effective date of this section.

(d) Subsequent to the effective date of this section and until January 1, 2019, nothing in this section shall prohibit an individual, corporation, or firm operating as a registered dispensing optician from engaging in a business relationship with an optometrist licensed pursuant to Chapter 7 (commencing with Section 3000) before the effective date of this section at locations registered with the Medical Board of California before the effective date of this section.

(e) This section does not apply to any administrative action pending, litigation pending, cause for discipline, or cause of action accruing prior to September 1, 2015.

(f) Any health plan, as defined in Section 655, subject to this section shall report to the State Board of Optometry in writing that (1) 15 percent of its locations no longer employ an optometrist by January 1, 2017, (2) 45 percent of its locations no longer employ an optometrist by August 1, 2017, and (3) 100 percent of its locations no longer employ an optometrist by January 1, 2019. The board shall provide those reports as soon as it receives them to the director and the Legislature. The report to the Legislature shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 10. Section 2567 of the Business and Professions Code is amended to read:

2567. (a) The provisions of Article 19 (commencing with Section 2420) and Article 20 (commencing with Section 2435) of Chapter 5 which are not inconsistent or in conflict with this chapter apply to the issuance and govern the expiration and renewal of certificates issued under this chapter. All fees collected from persons registered or seeking registration under this chapter shall be paid into the Dispensing Opticians Fund, and shall be available, upon appropriation, to the State Board of Optometry for the purposes of this chapter. Any moneys within the Contingent Fund of the Medical Board of California collected pursuant to this chapter shall be deposited in the Dispensing Opticians Fund.

(b) The board may employ, subject to civil service regulations, whatever additional clerical assistance is necessary for the administration of this chapter.

SEC. 11. Section 3010.5 of the Business and Professions Code is amended to read:

3010.5. (a) There is in the Department of Consumer Affairs a State Board of Optometry in which the enforcement of this chapter is vested. The board consists of 11 members, five of whom shall be public members and one of the nonpublic members shall be an individual registered as a dispensing optician. The registered dispensing optician member shall be registered pursuant to Chapter 5.5. (commencing with Section 2550) and in good standing with the board.

Six members of the board shall constitute a quorum.

(b) The board shall, with respect to conducting investigations, inquiries, and disciplinary actions and proceedings, have the authority previously vested in the board as created pursuant to former Section 3010. The board may enforce any disciplinary actions undertaken by that board.

(c) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date. Notwithstanding any other law, the repeal of this section renders the board subject to review by the appropriate policy committees of the Legislature.

SEC. 12. Section 3011 of the Business and Professions Code is amended to read:

3011. Members of the board, except the public members and the registered dispensing optician member, shall be appointed only from persons who are registered optometrists of the State of California and actually engaged in the practice of optometry at the time of appointment or who are members of the faculty of a school of optometry. The public members shall not be a licentiate of the board or of any other board under this division or of any board referred to in Sections 1000 and 3600.

No person except the registered dispensing optician member, including the public members, shall be eligible to membership in the board who is a stockholder in or owner of or a member of the board of trustees of any school of optometry or who shall be financially interested, directly or indirectly, in any concern manufacturing or dealing in optical supplies at wholesale.

No person shall serve as a member of the board for more than two consecutive terms.

A member of the faculty of a school of optometry may be appointed to the board; however, no more than two faculty members of schools of optometry may be on the board at any one time. Faculty members of the board shall not serve as public members.

SEC. 13. Section 3013 of the Business and Professions Code is amended to read:

3013. (a) Each member of the board shall hold office for a term of four years, and shall serve until the appointment and qualification of his or her

successor or until one year shall have elapsed since the expiration of the term for which he or she was appointed, whichever first occurs.

(b) Vacancies occurring shall be filled by appointment for the unexpired term.

(c) The Governor shall appoint three of the public members, five members qualified as provided in Section 3011, and the registered dispensing optician member as provided in Section 3010.5. The Senate Committee on Rules and the Speaker of the Assembly shall each appoint a public member.

(d) No board member serving between January 1, 2000, and June 1, 2002, inclusive, shall be eligible for reappointment.

(e) For initial appointments made on or after January 1, 2003, one of the public members appointed by the Governor and two of the professional members shall serve terms of one year. One of the public members appointed by the Governor and two of the professional members shall serve terms of three years. The remaining public member appointed by the Governor and the remaining two professional members shall serve terms of four years. The public members appointed by the Senate Committee on Rules and the Speaker of the Assembly shall each serve for a term of four years.

(f) The initial appointment of a registered dispensing optician member shall replace the optometrist member whose term expired on June 1, 2015.

SEC. 14. Section 3020 is added to the Business and Professions Code, to read:

3020. (a) There shall be established under the State Board of Optometry a dispensing optician committee to advise and make recommendations to the board regarding the regulation of a dispensing opticians pursuant to Chapter 5.5 (commencing with Section 2550). The committee shall consist of five members, two of whom shall be registered dispensing opticians, two of whom shall be public members, and one of whom shall be a member of the board. Initial appointments to the committee shall be made by the board. The board shall stagger the terms of the initial members appointed. The filling of vacancies on the committee shall be made by the board upon recommendations by the committee.

(b) The committee shall be responsible for:

(1) Recommending registration standards and criteria for the registration of dispensing opticians.

(2) Reviewing of the disciplinary guidelines relating to registered dispensing opticians.

(3) Recommending to the board changes or additions to regulations adopted pursuant to Chapter 5.5 (commencing with Section 2550).

(4) Carrying out and implementing all responsibilities and duties imposed upon it pursuant to this chapter or as delegated to it by the board.

(c) The committee shall meet at least twice a year and as needed in order to conduct its business.

(d) Recommendations by the committee regarding scope of practice or regulatory changes or additions shall be approved, modified, or rejected by the board within 90 days of submission of the recommendation to the board. If the board rejects or significantly modifies the intent or scope of the

recommendation, the committee may request that the board provide its reasons in writing for rejecting or significantly modifying the recommendation, which shall be provided by the board within 30 days of the request.

(e) After the initial appointments by the board pursuant to subdivision (a), the Governor shall appoint the registered dispensing optician members and the public members. The committee shall submit a recommendation to the board regarding which board member should be appointed to serve on the committee, and the board shall appoint the member to serve. Committee members shall serve a term of four years except for the initial staggered terms. A member may be reappointed, but no person shall serve as a member of the committee for more than two consecutive terms.

SEC. 15. Section 3021 is added to the Business and Professions Code, to read:

3021. The board shall have rulemaking authority with respect to Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) in accordance with Section 3025. Regulations adopted pursuant to Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) by the Medical Board of California prior to the effective date of this section shall continue to be valid, except that any reference to the board or division contained therein shall be construed to mean the State Board of Optometry, unless the context determines otherwise.

SEC. 16. Section 3023.1 is added to the Business and Professions Code, to read:

3023.1. (a) The nonresident contact lens seller program established under Chapter 5.45 (commencing with Section 2546) and the registered dispensing optician, spectacle lens dispensing, and contact lens dispensing programs established under Chapter 5.5 (commencing with Section 2550) are hereby transferred from the jurisdiction of the Medical Board of California and placed under the jurisdiction of the State Board of Optometry.

(b) All the duties, powers, purposes, responsibilities, and jurisdictions of the Medical Board of California under Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550) shall be transferred to the State Board of Optometry.

(c) For the performance of the duties and the exercise of the powers vested in the board under Chapter 5.45 (commencing with Section 2546) and Chapter 5.5 (commencing with Section 2550), the State Board of Optometry shall have possession and control of all records, papers, offices, equipment, supplies, or other property, real or personal, held for the benefit or use by the Medical Board of California.

SEC. 17. The Legislature finds and declares that Section 1 of this act imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to

demonstrate the interest protected by this limitation and the need for protecting that interest:

In order to allow the State Board of Optometry and the Department of Managed Health Care to fully accomplish its goals, it is imperative to protect the interests of those persons submitting information to those departments to ensure that any personal or sensitive business information that this act requires those persons to submit is protected as confidential information.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ABX2 15
Author: Eggman
Chapter: 1
Bill Date: September 3, 2015, Amended
Subject: End of Life
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill establishes the End of Life Option Act (Act) in California, which will remain in effect until January 1, 2026. This Act gives a mentally competent, adult California resident who has a terminal disease the legal right to ask for and receive a prescription from his or her physician to hasten death, as long as required criteria is met.

BACKGROUND

The End of Life Option Act is modeled after Oregon law that was enacted in 1997. This medical practice is also recognized in Washington, Vermont, and Montana under the State Supreme Court's 2010 decision in the *Baxter* case. The data collected in Oregon shows that the end of life option is used in fewer than 1 in 500 deaths (60 to 70 a year out of a total of over 30,000 deaths). Comparable numbers are seen in the State of Washington.

ANALYSIS

This bill allows a competent, qualified individual, who is an adult with a terminal disease, to make a request to receive a prescription for aid-in-dying drug, if all of the following conditions are satisfied:

- The individual's attending physician has diagnosed the individual with a terminal disease. Terminal disease is defined as an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.
- The individual has voluntarily expressed the wish to receive a prescription for aid-in-dying drug.
- The individual is a resident of California and is able to establish residency through either possession of a California driver's license or other identification issued by the State of California, being registered to vote in California, evidence that the person owns or leases property in California, or the filing of a California tax return for the most recent tax year.
- The individual documents his or her request.
- The individual has the physical and mental ability to self-administer the aid-in-dying drug.

This bill would specify that a person may not be considered a qualified individual solely because of age or disability. This bill would specify that a request for a prescription for aid-in-dying drug can only be made solely and directly by the individual diagnose with the terminal disease and shall not be made on behalf of the patient, through a power of attorney, advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decision maker.

This bill would require an individual seeking to obtain a prescription for an aid-in-dying drug to submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician must receive all three requests required directly. A valid written request must meet all of the following conditions:

- Shall be in the form specified in this bill;
- Shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug; and
- Shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief, the individual is personally known to them or has provided proof of identity, is acting voluntarily and signed the request in their presence, and is of sound mind and not under duress, fraud, or undue influence. This bill would specify that only one of the two witnesses may be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual's estate upon death; or may own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides. The attending physician, consulting physician, or mental health specialist of the individual cannot be one of the witnesses.

This bill would specify that an individual may rescind his or her request for aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual's mental state. The attending physician is required to offer the qualified individual an opportunity to withdraw or rescind the request.

This bill defines an attending physician as the physician who has primary responsibility for the health care of an individual and treatment of the individual's terminal disease. Before prescribing an aid-in-dying drug, the attending physician must do all of the following:

- Make the initial determination whether the requesting adult has the capacity to make medical decisions, and if there are indications of a mental disorder, refer the individual for a mental health specialist assessment. If a mental health specialist assessment referral is made, no aid-in-dying drugs can be prescribed until the specialist determines the individual has the capacity to make medical decisions and is not suffering from impaired judgment. The attending physician must determine whether the requesting adult has a terminal disease, determine if the requesting adult has voluntarily made the request for an aid-in-dying drug, and determine if the requesting adult meets the requirements of a qualified individual.

- Confirm the individual is making an informed decision by discussing his or her medical diagnosis and prognosis; the potential risks and probable result associated with ingesting the aid-in-dying drug; the possibility that he or she may choose to obtain the aid-in-dying drug but not take it; and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.
- Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the requirements of this bill. The consulting physician is independent from the attending physician and must be qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual's terminal disease. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician must examine the individual and his or her relevant medical records, confirm in writing the attending physician's diagnosis and prognosis, determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision. The consulting physician must fulfill the record documentation required by this bill and submit the compliance form to the attending physician.
- Confirm the individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, whether or not the qualified individual is feeling coerced or unduly influenced by another person.
- Counsel the qualified individual about the importance of having another person present when he or she ingests the aid-in-dying drug, the importance of not taking the aid-in-dying drug in a public place, the importance of notifying the next of kin of his or her request for the aid-in-dying drug, the importance of participating in a hospice program, and the importance of maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.
- Inform the individual that he or she may withdraw or rescind the request for aid-in-dying drug at any time and in any manner.
- Offer the qualified individual the opportunity to withdraw or rescind the request for aid-in-dying drug before prescribing the aid-in-dying drug.
- Verify, immediately prior to writing the prescription for aid-in-dying drug, that the qualified individual is making an informed decision.
- Confirm that all requirements are met and all appropriate steps are carried out in accordance with this bill before writing a prescription.
- Fulfill the required record documentation pursuant to this bill.
- Complete the attending physician checklist and compliance form included in this bill and collect the consulting physician compliance form also included in this bill and include both forms in the individual's medical record and also submit both forms to the California Department of Public Health (CDPH).
- Give the qualified individual the final attestation form, included in this bill, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the individual choosing to self-administer the aid-in-dying drug.

If an individual is referred to a mental health specialist by the attending or consulting physician, the mental health specialist must examine the individual and his or her relevant medical records; determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision; determine that the individual is not suffering from impaired judgment due to a mental disorder; and fulfill the record documentation requirements of this bill.

This bill would require the following to be documented in the individual's medical record:

- All oral requests for aid-in-dying drugs.
- All written requests for aid-in-dying drugs.
- The attending physician's diagnosis and prognosis, determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.
- The consulting physician's diagnosis and prognosis, verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.
- A report of the outcome and determinations made during a mental health specialist's assessment, if performed.
- The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.
- A note by the attending physician indicating that the requirements in this bill have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

If the requirements are met, the attending physician may deliver the aid-in-dying drug in any of the following ways:

- Dispense the aid-in-dying drug directly if the physician is authorized to dispense medicine under California law, has a current United States Drug Enforcement Administration certificate, and has complied with any applicable administrative rule or regulation.
- With the qualified individual's written consent, the attending physician may contact a pharmacist and deliver the prescription to the pharmacist, who shall dispense the medications to the qualified individual, the attending physician, or a person expressly designated by the qualified individual.

Within 30 days of writing a prescription for an aid-in-dying drug, the attending physician must submit to CDPH, a copy of the qualifying patient's written request, the attending checklist and compliance form, and the consulting physician compliance form. Within 30 calendar days following the individual's death from ingesting the aid-in-dying drug, or any other cause, the attending physician must submit the attending physician follow up form to CDPH. Upon receiving the final attestation form from the qualified individual, the attending

physician shall add this form to the medical records of the individual.

CDPH must collect and review the information submitted by the attending physician, which shall be confidential. Beginning on July 1, 2017, and each year thereafter, based on the information collected in the previous year, CDPH is required to create a report with the information collected. The report must include the number of people for whom the aid-in-dying prescription was written; the number of known individuals who died each year that received aid-in-dying prescriptions and the cause of death; the total cumulative number of aid-in-dying prescriptions written; the total cumulative number of people who died due to use of aid-in-dying drugs; the number of people who died who were enrolled in hospice or other palliative care programs; the number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California; the number of physicians who wrote prescriptions for aid-in-dying drugs; and demographic percentages of people who died due to using an aid-in-dying drug, for age at death, education level, race, sex, type of insurance, and underlying illness.

CDPH must post on its website the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow up form. This bill allows the Medical Board of California (Board) to update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow up form. However, this bill already includes the actual forms to be used, until and unless they are updated by the Board.

This bill states that a death resulting from the self-administering of an aid-in-dying drug is not suicide, preventing health and insurance coverage from being exempt on that basis. This bill also provides that an individual's act of self-administering aid-in-dying drug may not have an effect upon a life, health, or accident insurance or annuity policy other than that of a natural death from the underlying illness. This bill prohibits an insurance carrier from providing any information in communications made about the availability of an aid-in-dying drug, unless it is requested by the individual or the individual's attending physician. This bill also prohibits any communication from including both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill prohibits a person from being subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. This bill permits a person who is present to prepare the aid-in-dying drug (but not assist in the ingesting of the drug) without civil or criminal liability.

This bill prohibits a health care provider or professional organization or association from censoring, disciplining, suspending, or revoking licensure, privileges, membership, or administering other penalty to an individual for participating or refusing to participate in good faith compliance with this bill.

This bill specifies that a request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this bill shall not be the sole basis for the appointment of a guardian or conservator.

This bill provides liability protections for providers and specifies that health care providers are not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for participating in this bill, as specified. This bill prohibits a health care provider from being sanctioned for making an initial determination that an individual has a terminal illness and informing him or her of the medical prognosis; providing information about the End of Life Option Act to a patient upon the request of the individual; providing an individual, upon request, with a referral to another physician; or, contracting with an individual to act outside the course and scope of the provider's capacity as an employee or independent contractor of a health care provider that prohibits activities under this bill.

This bill permits a health care provider to prohibit its employees, independent contractors, or other persons from participating in activities under this bill while on premises owned or under the management or direct control of that prohibiting health care provider, as specified. This bill indicates that nothing shall be construed to prevent, or to allow a prohibiting health care provider to prohibit its employees or contractor from participating in activities under this bill, as specified.

This bill specifies that notwithstanding any contrary provision in this bill, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this bill. Additionally, health care providers may be sanctioned by their licensing board or agency for conduct and acts of unprofessional conduct, including failure to comply in good faith with this bill. This bill provides that nothing in this bill may be construed to authorize a physician or any other person to end an individual's life by lethal injection, mercy killing, or active euthanasia. This bill specifies that actions taken in accordance with this bill shall not, for any purpose, constitute suicide, assisted suicide, mercy killing, homicide, or elder abuse under the law.

This bill makes it a felony to knowingly alter or forge a request for an aid-in-dying drug to end an individual's life without his or her authorization, or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug if the act is done with the intent or effect of causing the individual's death, or to knowingly coerce or exert undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent.

The Board, as a regulatory agency, historically has not taken positions on policy bills that affect an individual's rights in end-of-life health care choices. As such, the Board did not take a policy position on SB 128 (Wolk), which is very similar to this bill.

FISCAL: None to the Board

SUPPORT: Advisory Council of the Central Coast Commission for Senior Citizens; AIDS Healthcare Foundation; AIDS Project Los Angeles; American Nurses Association\California; California Association for Nurse Practitioners; California Association of Marriage and Family Therapists; California Chapter of the National Association of Social Workers; California Church IMPACT; California Commission on Aging; California Democratic Party; California Primary Care Association; California Psychological Association; California Senior Legislature; Cardinal Point at Mariner Square Residents' Association; Church Council of West Hollywood United Church of Christ; City of Cathedral City; City of Santa Barbara; Coast side Democrats; Compassion and Choices California; Conference of California Bar Associations; Democratic Party of Orange County; Democratic Party of Santa Barbara County; Democratic Service Club of Santa Barbara County; Desert Ministries United Church of Christ; Desert Stonewall Democrats; Ethical Culture Society of Silicon Valley; Five Counties Central Labor Council; Full Circle Living and Dying Collective; GLMA: Health Professionals Advancing LGBT Equality; Gray Panthers of Long Beach; Humanist Society of Santa Barbara; Humboldt and Del Norte Counties Central Labor Council; Laguna Woods Democratic Club; Lompoc Valley Democratic Club; Los Angeles LGBT Center; Mar Vista Community Council; Potrero Hill Democratic Club; Progressive Christians Uniting; Sacramento Central Labor Council, AFL-CIO; San Benito County Democratic Central Committee; San Francisco AIDS Foundation; San Mateo County Democracy for America; San Mateo County Democratic Party; San Mateo County Medical Association; Santa Barbara County Board of Supervisors; Santa Cruz City Council; Sierra County Democratic Central Committee; South Orange County Democratic Club; Tehachapi Mountain Democratic Club; Unitarian Universalist Church of the Verdugo Hills; Ventura County Board of Supervisors; and Visalia Democratic Club

OPPOSITION: Agudath Israel of California; Alliance of Catholic Health Care; Association of Northern California Oncologists; California Catholic Conference; California Disability Alliance; California Foundation for Independent Living Centers; Coalition of Concerned Medical Professionals; Communities Actively Living Independent and Free; Communities United in Defense of Olmstead; Dignity Health; Disability Action Center; Disability Rights California; Disability Rights Education and Defense Fund; FREED Center for Independent Living; Independent Living Center of Southern California; Independent Living Resource Center of San Francisco; Medical Oncology Association of Southern

California; Patients' Rights Action Fund; Placer Independent Resource Services; Rabbinical Council of California; Silicon Valley Independent Living Center; and The Arc of California

IMPLEMENTATION:

- Newsletter article(s), including one stand-alone article for physicians
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website to include information on the End of Life Option Act and links to CDPH's webpage that includes links to the forms required for attending and consulting physicians

Assembly Bill No. 15

CHAPTER 1

An act to add and repeal Part 1.85 (commencing with Section 443) of Division 1 of the Health and Safety Code, relating to end of life.

[Approved by Governor October 5, 2015. Filed with
Secretary of State October 5, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

AB 15, Eggman. End of life.

Existing law authorizes an adult to give an individual health care instruction and to appoint an attorney to make health care decisions for that individual in the event of his or her incapacity pursuant to a power of attorney for health care.

This bill, until January 1, 2026, would enact the End of Life Option Act authorizing an adult who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease, as defined, to make a request for a drug prescribed pursuant to these provisions for the purpose of ending his or her life. The bill would establish the procedures for making these requests. The bill would also establish specified forms to request an aid-in-dying drug, under specified circumstances, an interpreter declaration to be signed subject to penalty of perjury, thereby creating a crime and imposing a state-mandated local program, and a final attestation for an aid-in-dying drug. This bill would require specified information to be documented in the individual's medical record, including, among other things, all oral and written requests for an aid-in-dying drug.

This bill would prohibit a provision in a contract, will, or other agreement from being conditioned upon, or affected by, a person making or rescinding a request for the above-described drug. The bill would prohibit the sale, procurement, or issuance of any life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for any policy or plan contract, from being conditioned upon or affected by the request. The bill would prohibit an insurance carrier from providing any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. The bill would also prohibit any communication from containing both the denial of treatment and information as to the availability of aid-in-dying drug coverage.

This bill would provide a person, except as provided, immunity from civil or criminal liability solely because the person was present when the qualified individual self-administered the drug, or the person assisted the qualified individual by preparing the aid-in-dying drug so long as the person did not

assist with the ingestion of the drug, and would specify that the immunities and prohibitions on sanctions of a health care provider are solely reserved for conduct of a health care provider provided for by the bill. The bill would make participation in activities authorized pursuant to its provisions voluntary, and would make health care providers immune from liability for refusing to engage in activities authorized pursuant to its provisions. The bill would also authorize a health care provider to prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under the act while on the premises owned or under the management or direct control of that prohibiting health care provider, or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

This bill would make it a felony to knowingly alter or forge a request for drugs to end an individual's life without his or her authorization or to conceal or destroy a withdrawal or rescission of a request for a drug, if it is done with the intent or effect of causing the individual's death. The bill would make it a felony to knowingly coerce or exert undue influence on an individual to request a drug for the purpose of ending his or her life, to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without their knowledge or consent. By creating a new crime, the bill would impose a state-mandated local program. The bill would provide that nothing in its provisions is to be construed to authorize ending a patient's life by lethal injection, mercy killing, or active euthanasia, and would provide that action taken in accordance with the act shall not constitute, among other things, suicide or homicide.

This bill would require physicians to submit specified forms and information to the State Department of Public Health after writing a prescription for an aid-in-dying drug and after the death of an individual who requested an aid-in-dying drug. The bill would authorize the Medical Board of California to update those forms and would require the State Department of Public Health to publish the forms on its Internet Web site. The bill would require the department to annually review a sample of certain information and records, make a statistical report of the information collected, and post that report to its Internet Web site.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Part 1.85 (commencing with Section 443) is added to Division 1 of the Health and Safety Code, to read:

PART 1.85. END OF LIFE OPTION ACT

443. This part shall be known and may be cited as the End of Life Option Act.

443.1. As used in this part, the following definitions shall apply:

(a) “Adult” means an individual 18 years of age or older.

(b) “Aid-in-dying drug” means a drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to a terminal disease.

(c) “Attending physician” means the physician who has primary responsibility for the health care of an individual and treatment of the individual’s terminal disease.

(d) “Attending physician checklist and compliance form” means a form, as described in Section 443.22, identifying each and every requirement that must be fulfilled by an attending physician to be in good faith compliance with this part should the attending physician choose to participate.

(e) “Capacity to make medical decisions” means that, in the opinion of an individual’s attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make and communicate an informed decision to health care providers.

(f) “Consulting physician” means a physician who is independent from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.

(g) “Department” means the State Department of Public Health.

(h) “Health care provider” or “provider of health care” means any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code; any person licensed pursuant to the Osteopathic Initiative Act or the Chiropractic Initiative Act; any person certified pursuant to Division 2.5 (commencing with Section 1797) of this code; and any clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of this code.

(i) “Informed decision” means a decision by an individual with a terminal disease to request and obtain a prescription for a drug that the individual may self-administer to end the individual’s life, that is based on an understanding and acknowledgment of the relevant facts, and that is made after being fully informed by the attending physician of all of the following:

- (1) The individual's medical diagnosis and prognosis.
- (2) The potential risks associated with taking the drug to be prescribed.
- (3) The probable result of taking the drug to be prescribed.
- (4) The possibility that the individual may choose not to obtain the drug or may obtain the drug but may decide not to ingest it.

(5) The feasible alternatives or additional treatment opportunities, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(j) "Medically confirmed" means the medical diagnosis and prognosis of the attending physician has been confirmed by a consulting physician who has examined the individual and the individual's relevant medical records.

(k) "Mental health specialist assessment" means one or more consultations between an individual and a mental health specialist for the purpose of determining that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(l) "Mental health specialist" means a psychiatrist or a licensed psychologist.

(m) "Physician" means a doctor of medicine or osteopathy currently licensed to practice medicine in this state.

(n) "Public place" means any street, alley, park, public building, any place of business or assembly open to or frequented by the public, and any other place that is open to the public view, or to which the public has access.

(o) "Qualified individual" means an adult who has the capacity to make medical decisions, is a resident of California, and has satisfied the requirements of this part in order to obtain a prescription for a drug to end his or her life.

(p) "Self-administer" means a qualified individual's affirmative, conscious, and physical act of administering and ingesting the aid-in-dying drug to bring about his or her own death.

(q) "Terminal disease" means an incurable and irreversible disease that has been medically confirmed and will, within reasonable medical judgment, result in death within six months.

443.2. (a) An individual who is an adult with the capacity to make medical decisions and with a terminal disease may make a request to receive a prescription for an aid-in-dying drug if all of the following conditions are satisfied:

(1) The individual's attending physician has diagnosed the individual with a terminal disease.

(2) The individual has voluntarily expressed the wish to receive a prescription for an aid-in-dying drug.

(3) The individual is a resident of California and is able to establish residency through any of the following means:

(A) Possession of a California driver license or other identification issued by the State of California.

(B) Registration to vote in California.

(C) Evidence that the person owns or leases property in California.

(D) Filing of a California tax return for the most recent tax year.

(4) The individual documents his or her request pursuant to the requirements set forth in Section 443.3.

(5) The individual has the physical and mental ability to self-administer the aid-in-dying drug.

(b) A person shall not be considered a “qualified individual” under the provisions of this part solely because of age or disability.

(c) A request for a prescription for an aid-in-dying drug under this part shall be made solely and directly by the individual diagnosed with the terminal disease and shall not be made on behalf of the patient, including, but not limited to, through a power of attorney, an advance health care directive, a conservator, health care agent, surrogate, or any other legally recognized health care decisionmaker.

443.3. (a) An individual seeking to obtain a prescription for an aid-in-dying drug pursuant to this part shall submit two oral requests, a minimum of 15 days apart, and a written request to his or her attending physician. The attending physician shall directly, and not through a designee, receive all three requests required pursuant to this section.

(b) A valid written request for an aid-in-dying drug under subdivision (a) shall meet all of the following conditions:

(1) The request shall be in the form described in Section 443.11.

(2) The request shall be signed and dated, in the presence of two witnesses, by the individual seeking the aid-in-dying drug.

(3) The request shall be witnessed by at least two other adult persons who, in the presence of the individual, shall attest that to the best of their knowledge and belief the individual is all of the following:

(A) An individual who is personally known to them or has provided proof of identity.

(B) An individual who voluntarily signed this request in their presence.

(C) An individual whom they believe to be of sound mind and not under duress, fraud, or undue influence.

(D) Not an individual for whom either of them is the attending physician, consulting physician, or mental health specialist.

(c) Only one of the two witnesses at the time the written request is signed may:

(1) Be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the individual’s estate upon death.

(2) Own, operate, or be employed at a health care facility where the individual is receiving medical treatment or resides.

(d) The attending physician, consulting physician, or mental health specialist of the individual shall not be one of the witnesses required pursuant to paragraph (3) of subdivision (b).

443.4. (a) An individual may at any time withdraw or rescind his or her request for an aid-in-dying drug, or decide not to ingest an aid-in-dying drug, without regard to the individual’s mental state.

(b) A prescription for an aid-in-dying drug provided under this part may not be written without the attending physician directly, and not through a designee, offering the individual an opportunity to withdraw or rescind the request.

443.5. (a) Before prescribing an aid-in-dying drug, the attending physician shall do all of the following:

(1) Make the initial determination of all of the following:

(A) (i) Whether the requesting adult has the capacity to make medical decisions.

(ii) If there are indications of a mental disorder, the physician shall refer the individual for a mental health specialist assessment.

(iii) If a mental health specialist assessment referral is made, no aid-in-dying drugs shall be prescribed until the mental health specialist determines that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder.

(B) Whether the requesting adult has a terminal disease.

(C) Whether the requesting adult has voluntarily made the request for an aid-in-dying drug pursuant to Sections 443.2 and 443.3.

(D) Whether the requesting adult is a qualified individual pursuant to subdivision (o) of Section 443.1.

(2) Confirm that the individual is making an informed decision by discussing with him or her all of the following:

(A) His or her medical diagnosis and prognosis.

(B) The potential risks associated with ingesting the requested aid-in-dying drug.

(C) The probable result of ingesting the aid-in-dying drug.

(D) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it.

(E) The feasible alternatives or additional treatment options, including, but not limited to, comfort care, hospice care, palliative care, and pain control.

(3) Refer the individual to a consulting physician for medical confirmation of the diagnosis and prognosis, and for a determination that the individual has the capacity to make medical decisions and has complied with the provisions of this part.

(4) Confirm that the qualified individual's request does not arise from coercion or undue influence by another person by discussing with the qualified individual, outside of the presence of any other persons, except for an interpreter as required pursuant to this part, whether or not the qualified individual is feeling coerced or unduly influenced by another person.

(5) Counsel the qualified individual about the importance of all of the following:

(A) Having another person present when he or she ingests the aid-in-dying drug prescribed pursuant to this part.

(B) Not ingesting the aid-in-dying drug in a public place.

(C) Notifying the next of kin of his or her request for an aid-in-dying drug. A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason.

(D) Participating in a hospice program.

(E) Maintaining the aid-in-dying drug in a safe and secure location until the time that the qualified individual will ingest it.

(6) Inform the individual that he or she may withdraw or rescind the request for an aid-in-dying drug at any time and in any manner.

(7) Offer the individual an opportunity to withdraw or rescind the request for an aid-in-dying drug before prescribing the aid-in-dying drug.

(8) Verify, immediately before writing the prescription for an aid-in-dying drug, that the qualified individual is making an informed decision.

(9) Confirm that all requirements are met and all appropriate steps are carried out in accordance with this part before writing a prescription for an aid-in-dying drug.

(10) Fulfill the record documentation required under Sections 443.8 and 443.19.

(11) Complete the attending physician checklist and compliance form, as described in Section 443.22, include it and the consulting physician compliance form in the individual's medical record, and submit both forms to the State Department of Public Health.

(12) Give the qualified individual the final attestation form, with the instruction that the form be filled out and executed by the qualified individual within 48 hours prior to the qualified individual choosing to self-administer the aid-in-dying drug.

(b) If the conditions set forth in subdivision (a) are satisfied, the attending physician may deliver the aid-in-dying drug in any of the following ways:

(1) Dispensing the aid-in-dying drug directly, including ancillary medication intended to minimize the qualified individual's discomfort, if the attending physician meets all of the following criteria:

(A) Is authorized to dispense medicine under California law.

(B) Has a current United States Drug Enforcement Administration (USDEA) certificate.

(C) Complies with any applicable administrative rule or regulation.

(2) With the qualified individual's written consent, contacting a pharmacist, informing the pharmacist of the prescriptions, and delivering the written prescriptions personally, by mail, or electronically to the pharmacist, who may dispense the drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual and with the designation delivered to the pharmacist in writing or verbally.

(c) Delivery of the dispensed drug to the qualified individual, the attending physician, or a person expressly designated by the qualified individual may be made by personal delivery, or, with a signature required on delivery, by United Parcel Service, United States Postal Service, Federal Express, or by messenger service.

443.6. Before a qualified individual obtains an aid-in-dying drug from the attending physician, the consulting physician shall perform all of the following:

- (a) Examine the individual and his or her relevant medical records.
- (b) Confirm in writing the attending physician's diagnosis and prognosis.
- (c) Determine that the individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision.
- (d) If there are indications of a mental disorder, refer the individual for a mental health specialist assessment.
- (e) Fulfill the record documentation required under this part.
- (f) Submit the compliance form to the attending physician.

443.7. Upon referral from the attending or consulting physician pursuant to this part, the mental health specialist shall:

- (a) Examine the qualified individual and his or her relevant medical records.
- (b) Determine that the individual has the mental capacity to make medical decisions, act voluntarily, and make an informed decision.
- (c) Determine that the individual is not suffering from impaired judgment due to a mental disorder.
- (d) Fulfill the record documentation requirements of this part.

443.8. All of the following shall be documented in the individual's medical record:

- (a) All oral requests for aid-in-dying drugs.
- (b) All written requests for aid-in-dying drugs.
- (c) The attending physician's diagnosis and prognosis, and the determination that a qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the attending physician has determined that the individual is not a qualified individual.
- (d) The consulting physician's diagnosis and prognosis, and verification that the qualified individual has the capacity to make medical decisions, is acting voluntarily, and has made an informed decision, or that the consulting physician has determined that the individual is not a qualified individual.
- (e) A report of the outcome and determinations made during a mental health specialist's assessment, if performed.
- (f) The attending physician's offer to the qualified individual to withdraw or rescind his or her request at the time of the individual's second oral request.
- (g) A note by the attending physician indicating that all requirements under Sections 443.5 and 443.6 have been met and indicating the steps taken to carry out the request, including a notation of the aid-in-dying drug prescribed.

443.9. (a) Within 30 calendar days of writing a prescription for an aid-in-dying drug, the attending physician shall submit to the State Department of Public Health a copy of the qualifying patient's written request, the attending physician checklist and compliance form, and the consulting physician compliance form.

(b) Within 30 calendar days following the qualified individual’s death from ingesting the aid-in-dying drug, or any other cause, the attending physician shall submit the attending physician followup form to the State Department of Public Health.

443.10. A qualified individual may not receive a prescription for an aid-in-dying drug pursuant to this part unless he or she has made an informed decision. Immediately before writing a prescription for an aid-in-dying drug under this part, the attending physician shall verify that the individual is making an informed decision.

443.11. (a) A request for an aid-in-dying drug as authorized by this part shall be in the following form:

REQUEST FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I,, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I request that my attending physician prescribe an aid-in-dying drug that will end my life in a humane and dignified manner if I choose to take it, and I authorize my attending physician to contact any pharmacist about my request.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

I understand that I have the right to withdraw or rescind this request at any time.

I understand the full import of this request and I expect to die if I take the aid-in-dying drug to be prescribed. My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this request voluntarily, without reservation, and without being coerced.

Signed:.....

Dated:.....

DECLARATION OF WITNESSES

We declare that the person signing this request:

- (a) is personally known to us or has provided proof of identity;
- (b) voluntarily signed this request in our presence;
- (c) is an individual whom we believe to be of sound mind and not under duress, fraud, or undue influence; and

(d) is not an individual for whom either of us is the attending physician, consulting physician, or mental health specialist.

.....Witness 1/Date

.....Witness 2/Date

NOTE: Only one of the two witnesses may be a relative (by blood, marriage, registered domestic partnership, or adoption) of the person signing this request or be entitled to a portion of the person’s estate upon death. Only one of the two witnesses may own, operate, or be employed at a health care facility where the person is a patient or resident.

(b) (1) The written language of the request shall be written in the same translated language as any conversations, consultations, or interpreted conversations or consultations between a patient and his or her attending or consulting physicians.

(2) Notwithstanding paragraph (1), the written request may be prepared in English even when the conversations or consultations or interpreted conversations or consultations were conducted in a language other than English if the English language form includes an attached interpreter’s declaration that is signed under penalty of perjury. The interpreter’s declaration shall state words to the effect that:

I, (INSERT NAME OF INTERPRETER), am fluent in English and (INSERT TARGET LANGUAGE).

On (insert date) at approximately (insert time), I read the “Request for an Aid-In-Dying Drug to End My Life” to (insert name of individual/patient) in (insert target language).

Mr./Ms. (insert name of patient/qualified individual) affirmed to me that he/she understood the content of this form and affirmed his/her desire to sign this form under his/her own power and volition and that the request to sign the form followed consultations with an attending and consulting physician.

I declare that I am fluent in English and (insert target language) and further declare under penalty of perjury that the foregoing is true and correct.

Executed at (insert city, county, and state) on this (insert day of month) of (insert month), (insert year).

X _____ Interpreter signature

X _____ Interpreter printed name

X _____ Interpreter address

(3) An interpreter whose services are provided pursuant to paragraph (2) shall not be related to the qualified individual by blood, marriage, registered domestic partnership, or adoption or be entitled to a portion of the person’s estate upon death. An interpreter whose services are provided pursuant to paragraph (2) shall meet the standards promulgated by the California Healthcare Interpreting Association or the National Council on Interpreting in Health Care or other standards deemed acceptable by the department for health care providers in California.

(c) The final attestation form given by the attending physician to the qualified individual at the time the attending physician writes the prescription shall appear in the following form:

FINAL ATTESTATION FOR AN AID-IN-DYING DRUG TO END MY LIFE IN A HUMANE AND DIGNIFIED MANNER I,, am an adult of sound mind and a resident of the State of California.

I am suffering from, which my attending physician has determined is in its terminal phase and which has been medically confirmed.

I have been fully informed of my diagnosis and prognosis, the nature of the aid-in-dying drug to be prescribed and potential associated risks, the expected result, and the feasible alternatives or additional treatment options, including comfort care, hospice care, palliative care, and pain control.

I have received the aid-in-dying drug and am fully aware that this aid-in-dying drug will end my life in a humane and dignified manner.

INITIAL ONE:

..... I have informed one or more members of my family of my decision and taken their opinions into consideration.

..... I have decided not to inform my family of my decision.

..... I have no family to inform of my decision.

My attending physician has counseled me about the possibility that my death may not be immediately upon the consumption of the drug.

I make this decision to ingest the aid-in-dying drug to end my life in a humane and dignified manner. I understand I still may choose not to ingest the drug and by signing this form I am under no obligation to ingest the drug. I understand I may rescind this request at any time.

Signed:.....

Dated:.....

Time:.....

(1) Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. If aid-in-dying medication is not returned or relinquished upon the patient's death as required in Section 443.20, the completed form shall be delivered

by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.

(2) Upon receiving the final attestation form the attending physician shall add this form to the medical records of the qualified individual.

443.12. (a) A provision in a contract, will, or other agreement executed on or after January 1, 2016, whether written or oral, to the extent the provision would affect whether a person may make, withdraw, or rescind a request for an aid-in-dying drug is not valid.

(b) An obligation owing under any contract executed on or after January 1, 2016, may not be conditioned or affected by a qualified individual making, withdrawing, or rescinding a request for an aid-in-dying drug.

443.13. (a) (1) The sale, procurement, or issuance of a life, health, or annuity policy, health care service plan contract, or health benefit plan, or the rate charged for a policy or plan contract may not be conditioned upon or affected by a person making or rescinding a request for an aid-in-dying drug.

(2) Pursuant to Section 443.18, death resulting from the self-administration of an aid-in-dying drug is not suicide, and therefore health and insurance coverage shall not be exempted on that basis.

(b) Notwithstanding any other law, a qualified individual's act of self-administering an aid-in-dying drug shall not have an effect upon a life, health, or annuity policy other than that of a natural death from the underlying disease.

(c) An insurance carrier shall not provide any information in communications made to an individual about the availability of an aid-in-dying drug absent a request by the individual or his or her attending physician at the behest of the individual. Any communication shall not include both the denial of treatment and information as to the availability of aid-in-dying drug coverage. For the purposes of this subdivision, "insurance carrier" means a health care service plan as defined in Section 1345 of this code or a carrier of health insurance as defined in Section 106 of the Insurance Code.

443.14. (a) Notwithstanding any other law, a person shall not be subject to civil or criminal liability solely because the person was present when the qualified individual self-administers the prescribed aid-in-dying drug. A person who is present may, without civil or criminal liability, assist the qualified individual by preparing the aid-in-dying drug so long as the person does not assist the qualified person in ingesting the aid-in-dying drug.

(b) A health care provider or professional organization or association shall not subject an individual to censure, discipline, suspension, loss of license, loss of privileges, loss of membership, or other penalty for participating in good faith compliance with this part or for refusing to participate in accordance with subdivision (e).

(c) Notwithstanding any other law, a health care provider shall not be subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff

action, sanction, or penalty or other liability for participating in this part, including, but not limited to, determining the diagnosis or prognosis of an individual, determining the capacity of an individual for purposes of qualifying for the act, providing information to an individual regarding this part, and providing a referral to a physician who participates in this part. Nothing in this subdivision shall be construed to limit the application of, or provide immunity from, Section 443.16 or 443.17.

(d) (1) A request by a qualified individual to an attending physician to provide an aid-in-dying drug in good faith compliance with the provisions of this part shall not provide the sole basis for the appointment of a guardian or conservator.

(2) No actions taken in compliance with the provisions of this part shall constitute or provide the basis for any claim of neglect or elder abuse for any purpose of law.

(e) (1) Participation in activities authorized pursuant to this part shall be voluntary. Notwithstanding Sections 442 to 442.7, inclusive, a person or entity that elects, for reasons of conscience, morality, or ethics, not to engage in activities authorized pursuant to this part is not required to take any action in support of an individual's decision under this part.

(2) Notwithstanding any other law, a health care provider is not subject to civil, criminal, administrative, disciplinary, employment, credentialing, professional discipline, contractual liability, or medical staff action, sanction, or penalty or other liability for refusing to participate in activities authorized under this part, including, but not limited to, refusing to inform a patient regarding his or her rights under this part, and not referring an individual to a physician who participates in activities authorized under this part.

(3) If a health care provider is unable or unwilling to carry out a qualified individual's request under this part and the qualified individual transfers care to a new health care provider, the individual may request a copy of his or her medical records pursuant to law.

443.15. (a) Subject to subdivision (b), notwithstanding any other law, a health care provider may prohibit its employees, independent contractors, or other persons or entities, including other health care providers, from participating in activities under this part while on premises owned or under the management or direct control of that prohibiting health care provider or while acting within the course and scope of any employment by, or contract with, the prohibiting health care provider.

(b) A health care provider that elects to prohibit its employees, independent contractors, or other persons or entities, including health care providers, from participating in activities under this part, as described in subdivision (a), shall first give notice of the policy prohibiting participation under this part to the individual or entity. A health care provider that fails to provide notice to an individual or entity in compliance with this subdivision shall not be entitled to enforce such a policy against that individual or entity.

(c) Subject to compliance with subdivision (b), the prohibiting health care provider may take action, including, but not limited to, the following, as applicable, against any individual or entity that violates this policy:

(1) Loss of privileges, loss of membership, or other action authorized by the bylaws or rules and regulations of the medical staff.

(2) Suspension, loss of employment, or other action authorized by the policies and practices of the prohibiting health care provider.

(3) Termination of any lease or other contract between the prohibiting health care provider and the individual or entity that violates the policy.

(4) Imposition of any other nonmonetary remedy provided for in any lease or contract between the prohibiting health care provider and the individual or entity in violation of the policy.

(d) Nothing in this section shall be construed to prevent, or to allow a prohibiting health care provider to prohibit, any other health care provider, employee, independent contractor, or other person or entity from any of the following:

(1) Participating, or entering into an agreement to participate, in activities under this part, while on premises that are not owned or under the management or direct control of the prohibiting provider or while acting outside the course and scope of the participant's duties as an employee of, or an independent contractor for, the prohibiting health care provider.

(2) Participating, or entering into an agreement to participate, in activities under this part as an attending physician or consulting physician while on premises that are not owned or under the management or direct control of the prohibiting provider.

(e) In taking actions pursuant to subdivision (c), a health care provider shall comply with all procedures required by law, its own policies or procedures, and any contract with the individual or entity in violation of the policy, as applicable.

(f) For purposes of this section:

(1) "Notice" means a separate statement in writing advising of the prohibiting health care provider policy with respect to participating in activities under this part.

(2) "Participating, or entering into an agreement to participate, in activities under this part" means doing or entering into an agreement to do any one or more of the following:

(A) Performing the duties of an attending physician as specified in Section 443.5.

(B) Performing the duties of a consulting physician as specified in Section 443.6.

(C) Performing the duties of a mental health specialist, in the circumstance that a referral to one is made.

(D) Delivering the prescription for, dispensing, or delivering the dispensed aid-in-dying drug pursuant to paragraph (2) of subdivision (b) of, and subdivision (c) of, Section 443.5.

(E) Being present when the qualified individual takes the aid-in-dying drug prescribed pursuant to this part.

(3) “Participating, or entering into an agreement to participate, in activities under this part” does not include doing, or entering into an agreement to do, any of the following:

(A) Diagnosing whether a patient has a terminal disease, informing the patient of the medical prognosis, or determining whether a patient has the capacity to make decisions.

(B) Providing information to a patient about this part.

(C) Providing a patient, upon the patient’s request, with a referral to another health care provider for the purposes of participating in the activities authorized by this part.

(g) Any action taken by a prohibiting provider pursuant to this section shall not be reportable under Sections 800 to 809.9, inclusive, of the Business and Professions Code. The fact that a health care provider participates in activities under this part shall not be the sole basis for a complaint or report by another health care provider of unprofessional or dishonorable conduct under Sections 800 to 809.9, inclusive, of the Business and Professions Code.

(h) Nothing in this part shall prevent a health care provider from providing an individual with health care services that do not constitute participation in this part.

443.16. (a) A health care provider may not be sanctioned for any of the following:

(1) Making an initial determination pursuant to the standard of care that an individual has a terminal disease and informing him or her of the medical prognosis.

(2) Providing information about the End of Life Option Act to a patient upon the request of the individual.

(3) Providing an individual, upon request, with a referral to another physician.

(b) A health care provider that prohibits activities under this part in accordance with Section 443.15 shall not sanction an individual health care provider for contracting with a qualified individual to engage in activities authorized by this part if the individual health care provider is acting outside of the course and scope of his or her capacity as an employee or independent contractor of the prohibiting health care provider.

(c) Notwithstanding any contrary provision in this section, the immunities and prohibitions on sanctions of a health care provider are solely reserved for actions of a health care provider taken pursuant to this part. Notwithstanding any contrary provision in this part, health care providers may be sanctioned by their licensing board or agency for conduct and actions constituting unprofessional conduct, including failure to comply in good faith with this part.

443.17. (a) Knowingly altering or forging a request for an aid-in-dying drug to end an individual’s life without his or her authorization or concealing or destroying a withdrawal or rescission of a request for an aid-in-dying drug is punishable as a felony if the act is done with the intent or effect of causing the individual’s death.

(b) Knowingly coercing or exerting undue influence on an individual to request or ingest an aid-in-dying drug for the purpose of ending his or her life or to destroy a withdrawal or rescission of a request, or to administer an aid-in-dying drug to an individual without his or her knowledge or consent, is punishable as a felony.

(c) For purposes of this section, “knowingly” has the meaning provided in Section 7 of the Penal Code.

(d) The attending physician, consulting physician, or mental health specialist shall not be related to the individual by blood, marriage, registered domestic partnership, or adoption, or be entitled to a portion of the individual’s estate upon death.

(e) Nothing in this section shall be construed to limit civil liability.

(f) The penalties in this section do not preclude criminal penalties applicable under any law for conduct inconsistent with the provisions of this section.

443.18. Nothing in this part may be construed to authorize a physician or any other person to end an individual’s life by lethal injection, mercy killing, or active euthanasia. Actions taken in accordance with this part shall not, for any purposes, constitute suicide, assisted suicide, homicide, or elder abuse under the law.

443.19. (a) The State Department of Public Health shall collect and review the information submitted pursuant to Section 443.9. The information collected shall be confidential and shall be collected in a manner that protects the privacy of the patient, the patient’s family, and any medical provider or pharmacist involved with the patient under the provisions of this part. The information shall not be disclosed, discoverable, or compelled to be produced in any civil, criminal, administrative, or other proceeding.

(b) On or before July 1, 2017, and each year thereafter, based on the information collected in the previous year, the department shall create a report with the information collected from the attending physician followup form and post that report to its Internet Web site. The report shall include, but not be limited to, all of the following based on the information that is provided to the department and on the department’s access to vital statistics:

(1) The number of people for whom an aid-in-dying prescription was written.

(2) The number of known individuals who died each year for whom aid-in-dying prescriptions were written, and the cause of death of those individuals.

(3) For the period commencing January 1, 2016, to and including the previous year, cumulatively, the total number of aid-in-dying prescriptions written, the number of people who died due to use of aid-in-dying drugs, and the number of those people who died who were enrolled in hospice or other palliative care programs at the time of death.

(4) The number of known deaths in California from using aid-in-dying drugs per 10,000 deaths in California.

(5) The number of physicians who wrote prescriptions for aid-in-dying drugs.

(6) Of people who died due to using an aid-in-dying drug, demographic percentages organized by the following characteristics:

- (A) Age at death.
- (B) Education level.
- (C) Race.
- (D) Sex.
- (E) Type of insurance, including whether or not they had insurance.
- (F) Underlying illness.

(c) The State Department of Public Health shall make available the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, as described in Section 443.22, by posting them on its Internet Web site.

443.20. A person who has custody or control of any unused aid-in-dying drugs prescribed pursuant to this part after the death of the patient shall personally deliver the unused aid-in-dying drugs for disposal by delivering it to the nearest qualified facility that properly disposes of controlled substances, or if none is available, shall dispose of it by lawful means in accordance with guidelines promulgated by the California State Board of Pharmacy or a federal Drug Enforcement Administration approved take-back program.

443.21. Any governmental entity that incurs costs resulting from a qualified individual terminating his or her life pursuant to the provisions of this part in a public place shall have a claim against the estate of the qualified individual to recover those costs and reasonable attorney fees related to enforcing the claim.

443.215. This part shall remain in effect only until January 1, 2026, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2026, deletes or extends that date.

443.22. (a) The Medical Board of California may update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form, based on those provided in subdivision (b). Upon completion, the State Department of Public Health shall publish the updated forms on its Internet Web site.

(b) Unless and until updated by the Medical Board of California pursuant to this section, the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician followup form shall be in the following form:

**ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM**

A		PATIENT INFORMATION
PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH	
PATIENT RESIDENTIAL ADDRESS (STREET, CITY, ZIP CODE)		

B		ATTENDING PHYSICIAN INFORMATION
PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () —	
MAILING ADDRESS (STREET, CITY, ZIP CODE)		
PHYSICIAN'S LICENSE NUMBER		

C		CONSULTING PHYSICIAN INFORMATION
PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () —	
MAILING ADDRESS (STREET, CITY, ZIP CODE)		
PHYSICIAN'S LICENSE NUMBER		

D		ELIGIBILITY DETERMINATION
1. TERMINAL DISEASE		
2. CHECK BOXES FOR COMPLIANCE:		
<input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination that patient is a resident of California. <input type="checkbox"/> 3. Determination that patient has the capacity to make medical decisions** <input type="checkbox"/> 4. Determination that patient is acting voluntarily. <input type="checkbox"/> 5. Determination of capacity by mental health specialist, if necessary. <input type="checkbox"/> 6. Determination that patient has made his/her decision after being fully informed of: <ul style="list-style-type: none"> <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with ingesting the requested aid-in-dying drug; <input type="checkbox"/> d) The probable result of ingesting the aid-in-dying drug; <input type="checkbox"/> e) The possibility that he or she may choose to obtain the aid-in-dying drug but not take it 		

ATTENDING PHYSICIAN CHECKLIST & COMPLIANCE FORM

E	ADDITIONAL COMPLIANCE REQUIREMENTS
	<input type="checkbox"/> 1. Counseled patient about the importance of all of the following: <input type="checkbox"/> a) Maintaining the aid-in-dying drug in a safe and secure location until the time the qualified individual will ingest it; <input type="checkbox"/> b) Having another person present when he or she ingests the aid-in-dying drug; <input type="checkbox"/> c) Not ingesting the aid-in-dying drug in a public place; <input type="checkbox"/> d) Notifying the next of kin of his or her request for an aid-in-dying drug. (an individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason); and <input type="checkbox"/> e) Participating in a hospice program or palliative care program. <input type="checkbox"/> 2. Informed patient of right to rescind request (1 st time) <input type="checkbox"/> 3. Discussed the feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control. <input type="checkbox"/> 4. Met with patient one-on-one, except in the presence of an interpreter, to confirm the request is not coming from coercion <input type="checkbox"/> 5. First oral request for aid-in-dying: _____ / _____ / _____ Attending physician initials: _____ <input type="checkbox"/> 6. Second oral request for aid-in-dying: _____ / _____ / _____ Attending physician initials: _____ <input type="checkbox"/> 7. Written request submitted: _____ / _____ / _____ Attending physician initials: _____ <input type="checkbox"/> 8. Offered patient right to rescind (2 nd time)

F	PATIENT'S MENTAL STATUS
	<p>Check one of the following (required):</p> <input type="checkbox"/> I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder
	Mental health specialist's information, if applicable:
	MENTAL HEALTH SPECIALIST NAME
	MENTAL HEALTH SPECIALIST TITLE & LICENSE NUMBER
	MENTAL HEALTH SPECIALIST ADDRESS (STREET, CITY, ZIP CODE)

ATTENDING PHYSICIAN CHECKLIST &
COMPLIANCE FORM

G MEDICATION PRESCRIBED	
PHARMACIST NAME	TELEPHONE NUMBER () -
1. Aid-in-dying medication prescribed: <input type="checkbox"/> a. Name: _____ <input type="checkbox"/> b. Dosage: _____ 2. Antiemetic medication prescribed: <input type="checkbox"/> a. Name: _____ <input type="checkbox"/> b. Dosage: _____ 3. Method prescription was delivered: <input type="checkbox"/> a. In person <input type="checkbox"/> b. By mail <input type="checkbox"/> c. Electronically 4. Date medication was prescribed: ____/____/____	

X	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make
 *****Mental Health Specialist" means a psychiatrist or a licensed psychologist.

CONSULTING PHYSICIAN COMPLIANCE FORM

A PATIENT INFORMATION	
PATIENT'S NAME (LAST, FIRST, M.I.)	DATE OF BIRTH

B ATTENDING PHYSICIAN	
ATTENDING PHYSICIAN'S NAME (LAST, FIRST, M.I.)	TELEPHONE NUMBER () . —

C CONSULTING PHYSICIAN'S REPORT	
1. TERMINAL DISEASE	DATE OF EXAMINATION(S)
2. Check boxes for compliance. <i>(Both the attending and consulting physicians must make these determinations.)</i> <input type="checkbox"/> 1. Determination that the patient has a terminal disease. <input type="checkbox"/> 2. Determination that patient has the mental capacity to make medical decisions.** <input type="checkbox"/> 3. Determination that patient is acting voluntarily. <input type="checkbox"/> 4. Determination that patient has made his/her decision after being fully informed of: <input type="checkbox"/> a) His or her medical diagnosis; and <input type="checkbox"/> b) His or her prognosis; and <input type="checkbox"/> c) The potential risks associated with taking the drug to be prescribed; and <input type="checkbox"/> d) The potential result of taking the drug to be prescribed; and <input type="checkbox"/> e) The feasible alternatives, including, but not limited to, comfort care, hospice care, palliative care and pain control.	

D PATIENT'S MENTAL STATUS		
Check one of the following (required): <input type="checkbox"/> I have determined that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> I have referred the patient to the mental health specialist**** listed below for one or more consultations to determine that the individual has the capacity to make medical decisions and is not suffering from impaired judgment due to a mental disorder. <input type="checkbox"/> If a referral was made to a mental health specialist, the mental health specialist has determined that the patient is not suffering from impaired judgment due to a mental disorder		
MENTAL HEALTH SPECIALIST'S NAME	TELEPHONE NUMBER () —	DATE

E CONSULTANT'S INFORMATION		
X	PHYSICIAN'S SIGNATURE	DATE
	NAME (PLEASE PRINT)	
MAILING ADDRESS		
CITY, STATE AND ZIP CODE		TELEPHONE NUMBER () —

** "Capacity to make medical decisions" means that, in the opinion of an individual's attending physician, consulting physician, psychiatrist, or psychologist, pursuant to Section 4609 of the Probate Code, the individual has the ability to understand the nature and consequences of a health care decision, the ability to understand its significant benefits, risks, and alternatives, and the ability to make
 ****"Mental Health Specialist" means a psychiatrist or a licensed psychologist.

ATTENDING PHYSICIAN FOLLOW-UP FORM

The End of Life Option Act requires physicians who write a prescription for an aid-in-dying drug to complete this follow-up form within **30 calendar days** of a patient's death, whether from ingestion of the aid-in-dying drug obtained under the Act or from any other cause.

For the State Department of Public Health to accept this form, it **must** be signed by the attending physician, whether or not he or she was present at the patient's time of death.

This form should be mailed or sent electronically to the State Department of Public Health. All information is kept strictly confidential.

Date: ____/____/____

Patient name: _____

Attending physician name: _____

Did the patient die from ingesting the aid-in-dying drug, from their underlying illness, or from another cause such as terminal sedation or ceasing to eat or drink?

- Aid-in-dying drug** (lethal dose) → Please sign below and go to page 2.
Attending physician signature: _____
- Underlying illness** → There is no need to complete the rest of the form. Please sign below.
Attending physician signature: _____
- Other** → There is no need to complete the rest of the form. Please specify the circumstances surrounding the patient's death and sign.
Please specify:

Attending physician signature: _____

PART A and PART B should only be completed if the patient died from ingesting the lethal dose of the aid-in-dying drug.

Please read carefully the following to determine which situation applies. Check the box that indicates the scenario and complete the remainder of the form accordingly.

- The attending physician was present at the time of death.
→ The attending physician must complete this form in its entirety and sign Part A and Part B.
- The attending physician was not present at the time of death, but another licensed health care provider was present.
→ The licensed health care provider must complete and sign Part A of this form. The attending physician must complete and sign Part B of the form.
- Neither the attending physician nor another licensed health care provider was present at the time of death.
→ Part A may be left blank. The attending physician must complete and sign Part B of the form.

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART A: To be completed and signed by the attending physician or another licensed health care provider present at death:

1. Was the attending physician at the patient's bedside when the patient took the aid-in-dying drug?

- Yes
- No

If no: Was another physician or trained health care provider present when the patient ingested the aid-in-dying drug?

- Yes, another physician
- Yes, a trained health-care provider/volunteer
- No
- Unknown

2. Was the attending physician at the patient's bedside at the time of death?

- Yes
- No

If no: Was another physician or a licensed health care provider present at the patient's time of death?

- Yes, another physician or licensed health care provider
- No
- Unknown

3. On what day did the patient consume the lethal dose of the aid-in-dying?

____/____/____ (month/day/year) Unknown

4. On what day did the patient die after consuming the lethal dose of the aid-in-dying drug?

____/____/____ (month/day/year) Unknown

5. Where did the patient ingest the lethal dose of the aid-in-dying drug?

- Private home
- Assisted-living residence
- Nursing home
- Acute care hospital in-patient
- In-patient hospice resident
- Other (specify) _____
- Unknown

6. What was the time between the ingestion of the lethal dose of aid-in-dying drug and unconsciousness?

Minutes _____ and/or Hours _____ Unknown

7. What was the time between lethal medication ingestion and death?

Minutes _____ and/or Hours _____ Unknown

ATTENDING PHYSICIAN FOLLOW-UP FORM

8. Were there any complications that occurred after the patient took the lethal dose of the aid-in-dying drug?

- Yes- vomiting, emesis
- Yes-regained consciousness
- No Complications
- Other- Please describe: _____
- Unknown

9. Was the Emergency Medical System activated for any reason after ingesting the lethal dose of the aid-in-dying drug?

- Yes- Please describe: _____
- No
- Unknown

10. At the time of ingesting the lethal dose of the aid-in-dying drug, was the patient receiving hospice care?

- Yes
- No, refused care
- No, other (specify) _____

Signature of attending physician present at time of death: _____

Name of Licensed Health Care Provider present at time of death if not attending physician: _____

Signature of Licensed Health Care Provider: _____

ATTENDING PHYSICIAN FOLLOW-UP FORM

PART B: To be completed and signed by the attending physician

12. On what date was the prescription written for the aid-in-dying drug? ____/____/____

13. When the patient initially requested a prescription for the aid-in-dying drug, was the patient receiving hospice care?

- Yes
- No, refused care
- No, other (specify) _____

14. What type of health-care coverage did the patient have for their underlying illness? (Check all that apply.)

- Medicare
- Medi-cal
- Covered California
- V.A.
- Private Insurance
- No insurance
- Had insurance, don't know type

15. Possible concerns that may have contributed to the patient's decision to request a prescription for aid-in-dying drug. Please check "yes," "no," or "Don't know," depending on whether or not you believe that concern contributed to their request (Please check as many boxes as you think may apply)

A concern about...

- His or her terminal condition representing a steady loss of autonomy

- Yes
- No
- Don't Know

- The decreasing ability to participate in activities that made life enjoyable

- Yes
- No
- Don't Know

- The loss of control of bodily functions

- Yes
- No
- Don't Know

- Persistent and uncontrollable pain and suffering

- Yes
- No
- Don't Know

- A loss of Dignity

- Yes
- No
- Don't Know

- Other concerns (specify): _____

Signature of attending physician: _____

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Section 443.19 to the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

(a) Any limitation to public access to personally identifiable patient data collected pursuant to Section 443.19 of the Health and Safety Code as proposed to be added by this act is necessary to protect the privacy rights of the patient and his or her family.

(b) The interests in protecting the privacy rights of the patient and his or her family in this situation strongly outweigh the public interest in having access to personally identifiable data relating to services.

(c) The statistical report to be made available to the public pursuant to subdivision (b) of Section 443.19 of the Health and Safety Code is sufficient to satisfy the public's right to access.

SEC. 3. The provisions of this part are severable. If any provision of this part 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. 4. 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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: ACR 29
Author: Frazier
Chapter: Resolution Chapter 42
Bill Date: April 20, 2015, Amended
Subject: Donate Life California Day: Driver's License
Sponsor: Donate Life California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This resolution would make findings and declarations regarding the importance of organ donation. This resolution would proclaim April 20, 2015, as Department of Motor Vehicles (DMV)/Donate Life California Day and the month of April 2015 as DMV/Donate Life California Month in California. This resolution would encourage all Californians to register with the Donate Life California Registry when applying for or renewing a driver's license or identification card.

ANALYSIS:

- This resolution makes the following findings and declarations:
- Organ, tissue, eye, and blood donation are compassionate and life-giving acts looked upon and recognized in the highest regard. A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives, the donation of tissue can save and enhance lives of up to 50 others, and a single blood donation can help save three people in need.
 - There are currently more than 123,000 individuals nationwide and over 22,000 Californians currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs.
 - A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the DMV, which is on its tenth year as the official partner of Donate Life California.
 - Nearly 12 million Californians have joined together to save lives by signing up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure their wishes of donating their organs are recognized and honored.
 - Minorities are more likely to need a life-saving transplant due to higher incidences of hypertension, diabetes, and hepatitis, which are conditions that can potentially lead to organ failure. In California, Latinos make up 39% of those waiting for life-saving transplants, Pacific Islanders make up 20%, and African Americans another 12%.

This resolution proclaims April 20, 2015, as DMV/Donate Life California Day and April 2015 as DMV/Donate Life California Month in California. This resolution

encourages all Californian to register with the Donate Life California Registry when applying for or renewing a driver's license or identification card.

The Medical Board of California (Board) voted to be the honorary state sponsor of Donate Life California's specialized license plate in 2013, because the license plate helped to increase awareness and raise money for organ and tissue donation, education and outreach. The Board has also supported similar resolutions in the past for the same reasons. This resolution will also help to raise awareness by proclaiming April 20, 2015 as DMV/Donate Life California Day and April 2015 as DMV/Donate Life California Month. For this reason, the Board voted to support this resolution.

FISCAL: None

SUPPORT: Donate Life California (Sponsor)
 Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter Article(s)

Assembly Concurrent Resolution No. 29

RESOLUTION CHAPTER 42

Assembly Concurrent Resolution No. 29—Relative to organ donation.

[Filed with Secretary of State May 26, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

ACR 29, Frazier. Donate Life California Day: driver's license.

This measure would designate April 20, 2015, as DMV/Donate Life California Day in the State of California and the month of April 2015, as DMV/Donate Life California Month in the State of California, and would encourage all Californians to sign up with the Donate Life California Organ and Tissue Donor Registry.

WHEREAS, Organ, tissue, eye, and blood donation are compassionate and life-giving acts looked upon and recognized in the highest regard; and

WHEREAS, More than 123,000 individuals nationwide and over 22,000 Californians are currently on the national organ transplant wait list. While about one-third of these patients receive a transplant each year, another one-third die while waiting due to a shortage of donated organs; and

WHEREAS, A single individual's donation of heart, lungs, liver, kidneys, pancreas, and small intestine can save up to eight lives, the donation of tissue can save and enhance the lives of up to 50 others, and a single blood donation can help three people in need; and

WHEREAS, Millions of lives each year are saved and enhanced by donors of organs, tissue, eyes, and blood; and

WHEREAS, The California Department of Motor Vehicles is celebrating 100 years of service to the State of California and ten years as the official partner of Donate Life California; and

WHEREAS, A California resident can register with the Donate Life California Registry when applying for or renewing his or her driver's license or identification card at the Department of Motor Vehicles; and

WHEREAS, Nearly twelve million Californians have joined together to save lives by signing up with the state-authorized Donate Life California Organ and Tissue Donor Registry to ensure that their wishes to be an organ, eye, and tissue donor are recognized and honored; and

WHEREAS, Minorities are more likely to need a life-saving transplant due to higher incidences of hypertension, diabetes, and hepatitis, conditions that can potentially lead to organ failure and placement on the national organ transplant waiting list; and

WHEREAS, Nationwide, minorities make up 58 percent of organ transplant candidates and 64 percent of those awaiting kidney transplants. In California, Latinos make up 39 percent of those waiting for life-saving

transplants, Asians and Pacific Islanders 20 percent, and African Americans another 12 percent; and

WHEREAS, Minorities make up more than one-half of the population of high school students in California, according to the State Department of Education. These high school students will have the opportunity to make a decision about saving lives and joining the state-authorized Donate Life California Registry to ensure that their wishes to be organ, eye, and tissue donors are recognized and honored; and

WHEREAS, Donate Life California has developed a comprehensive Educator Resource Guide that includes many of the health education content standards for California public schools. This Educator Resource Guide includes lesson plans and educational DVDs about organ, eye, and tissue donation, and the Donate Life California Registry created specifically for the youth population; now, therefore, be it

Resolved by the Assembly of the State of California, the Senate thereof concurring, That in recognition of April as National Donate Life Month, the Legislature proclaims April 20, 2015, as DMV/Donate Life California Day in the State of California, and April 2015 as DMV/Donate Life California Month in the State of California. In doing so, the Legislature encourages all Californians to check “YES” when applying for or renewing a driver’s license or identification card, or by signing up at www.donatelifecalifornia.org or www.donevidacalifornia.org; and be it further

Resolved, that the Chief Clerk of the Assembly transmit copies of this resolution to the author for appropriate distribution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 19
Author: Wolk
Chapter: 504
Bill Date: September 4, 2015, Amended
Subject: Physician Orders for Life Sustaining Treatment Form: Electronic Registry Pilot
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the California Physician Orders for Life Sustaining Treatment (POLST) eRegistry Pilot.

BACKGROUND

In the early 1990s, 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 patients' 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 eRegistry Pilot Act. This bill was significantly amended since the Medical Board of California (Board) took a support in concept position on this bill. This bill was amended to make the POLST Registry a pilot project. This bill would require the Emergency Medical Services Authority (EMSA) to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, for the purpose of collecting a patient's POLST information received from a physician or physician's designee and disseminating the information to an authorized user. This bill would define an authorized user as a person authorized by EMSA to submit information to, or receive information from, the POLST eRegistry Pilot, including health care providers and their designees. This bill would only allow EMSA to implement this bill if it determines that sufficient non-state funds are available to allow for the development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot.

This bill requires EMSA to coordinate the pilot, which could be operated by, and as part of, health exchange networks, or by an independent contractor, or a combination of both. This bill permits the pilot to operate in a single geographic area or multiple geographic areas

and may test various methods of making POLST information available electronically. This bill requires EMSA to adopt guidelines necessary for the pilot, as specified. EMSA must seek input from interested parties before adopting the guidelines. The guidelines must include the means to submit initial or subsequent POLST information, or withdraw POLST information, and must include a method for electronic delivery and the use of legally sufficient electronic signatures. The pilot must comply with state and federal privacy and security laws and regulations. This bill requires EMSA to submit a detailed plan to the Legislature that explains how the pilot will operate.

This bill provides protections for health care providers who honor a patient's request regarding resuscitative measures obtained from the POLST eRegistry and states that providers are not subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the health care provider believes in good faith that the action or decision is consistent with the patient's health care decisions included in their POSLT form.

This bill requires an independent contractor approved by EMSA to perform an evaluation of the POLST eRegistry Pilot. This bill would sunset on January 1, 2020.

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. The idea of making the POLST form available electronically is a good one, but many of the specific details on how this will happen are not included in this bill and it is contingent on receiving non-state funding. The Board does not have a position on the amended version of this bill.

FISCAL: None to the Board

SUPPORT: Coalition for Compassionate Care of California (Sponsor); AARP; Arc and United Cerebral Palsy California Collaboration; Alliance of Catholic Health Care; Blue Shield of California; California Accountable Physician Groups; California Assisted Living Association; California Association of Physician Groups; California American College of Emergency Physicians; California Commission on Aging; California Hospital Association; Care Like a Daughter, LLC; Long Term Ombudsman Services of San Luis Obispo County; Mission Hospital, Laguna Beach; Mission Hospital, Mission Viejo; Petaluma Valley Hospital; Providence Health and Services Southern California; Queen of the Valley Medical Center, Napa; Redwood Memorial Hospital, Fortuna; Riverside Family Physicians; Santa Rosa Memorial; St. Mary Medical Center, Apple Valley; St. Joseph Hospital, Orange; St. Jude Medical Center, Fullerton; and Vynca

OPPOSITION: California Advocates for Nursing Home Reform
California Right to Life Committee

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff

Senate Bill No. 19

CHAPTER 504

An act to add and repeal Section 4788 of the Probate Code, relating to resuscitative measures.

[Approved by Governor October 5, 2015. Filed with
Secretary of State October 5, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 19, Wolk. Physician Orders for Life Sustaining Treatment form: electronic registry pilot.

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 eRegistry Pilot Act. The bill would require the Emergency Medical Services Authority to establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting POLST information received from a physician or physician's designee. The bill would require the authority to coordinate the POLST eRegistry Pilot, which would be operated by health information exchange networks, by an independent contractor, or by a combination thereof. The bill would require the authority to implement these provisions only after it determines that sufficient nonstate funds are available for development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot. When the POLST eRegistry Pilot is operable in the geographic area in which he or she operates or practices, a physician or physician's designee who completes POLST information would be required to include the POLST information in the patient's official medical record and would be required to submit a copy of the form to, or to enter the information into, the POLST eRegistry Pilot, unless a patient or his or her health care decisionmaker chooses not to participate in the POLST eRegistry Pilot. The bill would require the authority to adopt guidelines for, among other things, the operation of the POLST eRegistry Pilot, including the means by which POLST information would

be submitted electronically, modified, or withdrawn, 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 POLST information received by the POLST eRegistry Pilot. The bill would require that any disclosure of POLST information in the POLST eRegistry Pilot be made in accordance with applicable state and federal privacy and security laws and regulations. The bill would provide immunity from criminal prosecution, civil liability, discipline for unprofessional conduct, and any other sanction for a health care provider who honors a patient's request regarding resuscitative measures obtained from the POLST eRegistry Pilot, as specified. The bill would require an independent contractor approved by the authority to conduct an evaluation of the POLST eRegistry Pilot. The provisions of the bill would be operative until January 1, 2020.

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 eRegistry Pilot Act.

SEC. 2. Section 4788 is added to the Probate Code, to read:

4788. (a) For purposes of this section:

(1) "Authority" means the Emergency Medical Services Authority.

(2) "Authorized user" means a person authorized by the authority to submit information to, or to receive information from, the POLST eRegistry Pilot, including health care providers, as defined in Section 4781, and their designees.

(3) "POLST" means a Physician Orders for Life Sustaining Treatment that fulfills the requirements, in any format, of Section 4780.

(4) "POLST eRegistry Pilot" means the California POLST eRegistry Pilot Act established pursuant to this section to make electronic, in addition to other modes of submission and transmission, POLST information available to authorized users.

(b) (1) The authority shall establish a pilot project, in consultation with stakeholders, to operate an electronic registry system on a pilot basis, to be known as the California POLST eRegistry Pilot, for the purpose of collecting a patient's POLST information received from a physician or physician's designee and disseminating the information to an authorized user.

(2) The authority shall implement this section only after determining that sufficient nonstate funds are available to allow for the development of the POLST eRegistry Pilot, any related startup costs, and an evaluation of the POLST eRegistry Pilot.

(3) The authority shall coordinate the POLST eRegistry Pilot, which shall be operated by, and as a part of, the health information exchange networks, or by an independent contractor, or by a combination thereof. The POLST eRegistry Pilot may operate in a single geographic area or multiple geographic areas and may test various methods of making POLST

information available electronically. The design of the POLST eRegistry Pilot shall be sufficiently robust, based on the success of the pilot, to inform the permanent, statewide operation of a POLST eRegistry.

(4) The authority shall adopt guidelines necessary for the operation of the POLST eRegistry Pilot. In developing these guidelines, the authority shall seek input from interested parties and hold at least one public meeting. The adoption, amendment, or repeal of the guidelines authorized by this paragraph is hereby exempted from the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The guidelines shall include, but not be limited to, the following:

(A) The means by which initial or subsequent POLST information may be submitted to, or withdrawn from, the POLST eRegistry Pilot, which shall include a method for electronic delivery of this information and the use of legally sufficient electronic signatures.

(B) Appropriate and timely methods by which the information in the POLST eRegistry Pilot may be disseminated to an authorized user.

(C) Procedures for verifying the identity of an authorized user.

(D) Procedures to ensure the accuracy of, and to appropriately protect the confidentiality of, POLST information submitted to the POLST eRegistry Pilot.

(E) The requirement that a patient, or, when appropriate, his or her legally recognized health care decisionmaker, receive a confirmation or a receipt that the patient's POLST information has been received by the POLST eRegistry Pilot.

(F) The ability of a patient, or, when appropriate, his or her legally recognized health care decisionmaker, with his or her health care provider, as defined in Section 4621, to modify or withdraw POLST information on the POLST eRegistry Pilot.

(6) (A) Prior to implementation of the POLST eRegistry Pilot, the authority shall submit a detailed plan to the Legislature that explains how the POLST eRegistry Pilot will operate.

(B) The plan to be submitted pursuant to subparagraph (A) shall be submitted in compliance with Section 9795 of the Government Code.

(c) The operation of the POLST eRegistry Pilot, for all users, shall comply with state and federal privacy and security laws and regulations, including, but not limited to, compliance with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the regulations promulgated pursuant to the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), found at Parts 160 and 164 of Title 45 of the Code of Federal Regulations.

(d) When the POLST eRegistry Pilot is operable in the geographic area in which he or she practices or operates, a physician or physician's designee who completes POLST information with a patient or his or her legally recognized health care decisionmaker shall include the POLST information in the patient's official medical record and shall submit a copy of the POLST

form to, or enter the POLST information into, the POLST eRegistry Pilot, unless the patient or the legally recognized health care decisionmaker chooses not to participate in the POLST eRegistry Pilot.

(e) When the POLST eRegistry Pilot is operable in the geographic area in which they practice or operate, physicians, hospitals, and health information exchange networks shall make electronic POLST information available, for use during emergencies, through the POLST eRegistry Pilot to health care providers, as defined in Section 4781, that also practice or operate in a geographic area where the POLST eRegistry Pilot is operable, but that are outside of their health information exchange networks.

(f) In accordance with Section 4782, a health care provider, as defined in Section 4781, who honors a patient's request regarding resuscitative measures obtained from the POLST eRegistry Pilot shall not be subject to criminal prosecution, civil liability, discipline for unprofessional conduct, administrative sanction, or any other sanction, if the health care provider (1) believes in good faith that the action or decision is consistent with this part, and (2) has no knowledge that the action or decision would be inconsistent with a health care decision that the individual signing the request would have made on his or her own behalf under like circumstances.

(g) An independent contractor approved by the authority shall perform an evaluation of the POLST eRegistry Pilot.

(h) This section shall remain in effect only until January 1, 2020, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2020, deletes or extends that date.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 277
Author: Pan
Chapter: 35
Bill Date: June 18, 2015, Amended
Subject: Pupil Health: Vaccinations
Sponsor: Vaccinate California
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill eliminates the personal belief exemption from the requirement that children receive specified vaccines for certain infectious diseases prior to being admitted to any private or public elementary or secondary school, or day care center.

BACKGROUND

According to the authors, in early 2015, California became the epicenter of a measles outbreak that was the result of unvaccinated individuals infecting vulnerable individuals, including children who are unable to receive vaccinations due to health conditions or age requirements. According to the Centers for Disease Control and Prevention, there were more cases of measles in January 2015 in the United States than in any one month in the past 20 years. Measles has spread through California and the United States, in large part, because of communities with large numbers of unvaccinated people. Between 2000 and 2012, the number of Personal Belief Exemptions (PBE) from vaccinations required for school entry that were filed rose by 337%. In 2000, the PBE rate for Kindergartners entering California schools was under 1%. However, as of 2012, that number rose to 2.6%. From 2012 to 2014, the number of children entering Kindergarten without receiving some or all of their required vaccinations due to their parent's personal beliefs increased to 3.15%. In certain pockets of California, exemption rates are as high as 21% which places California communities at risk for preventable diseases. Given the highly contagious nature of diseases such as measles, vaccination rates of up to 95% are necessary to preserve herd immunity and prevent future outbreaks.

According to the United States Department of Health and Human Services, when a critical portion of a community is immunized against a contagious disease, most members of the community are protected against that disease because there is little opportunity for an outbreak. Even those who are not eligible for certain vaccines, such as infants, pregnant women, or immunocompromised individuals, get some protection because the spread of contagious disease is contained. This is known as community immunity.

Existing law provides that each child between the ages of 6 and 18 years is subject to compulsory full-time education, and requires attendance at the public full-time day school or continuation school or classes for the full school day. Existing law requires parents and guardians to send the student to school for the full school day. Currently, the admission of a student to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center is prohibited, unless, prior to the child's first admission to that institution, the child has been fully immunized. Immunizations are currently required for Diphtheria, Haemophilus influenzae type b, Measles, Mumps, Pertussis (whooping cough), Poliomyelitis, Rubella, Tetanus, Hepatitis B, Varicella (chickenpox), and any other disease deemed appropriate by the California Department of Public Health (CDPH), taking into consideration the recommendations of the Advisory Committee on Immunization Practices (ACIP) of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

Existing law provides that immunization is not required for admission to a school or other institution if the parent or guardian files with the school a letter or affidavit that documents which immunizations have been given and which immunizations have not been given on the basis that they are contrary to his or her beliefs (personal belief exemption). The personal belief exemption letter or affidavit must be accompanied by a form prescribed by CDPH that must include specified information, including a signed attestation from the health care practitioner that indicates that the health care practitioner provided the parent or guardian with information regarding the benefits and risks of the immunization and the health risks of the communicable diseases to the child and the community, and a written statement signed by the parent or guardian that indicates that the signer has received the information provided by the health care practitioner.

Existing law also provides that a child is exempt from immunization requirements if the parent or guardian files with the school or other institution a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances that contraindicate immunization (medical exemption).

ANALYSIS

This bill deletes the personal belief exemption from the existing immunization requirements. This bill specifies that if CDPH adds an immunization to the list in the future, that personal belief exemptions would be allowed for that additional immunization. This bill exempts a child in a home-based private school or a pupil who is enrolled in independent study from the immunization requirements. This bill allows a child who has submitted a personal belief exemption prior to January 1, 2016 to continue to attend school or daycare under the personal belief exemption until enrollment in the next grade span. This bill defines grade span as birth to preschool, kindergarten to grade 6, or grades 7 to 12. Lastly, this bill specifies that

when issuing a medical exemption a physician must consider the family medical history of the child.

Vaccines have been scientifically proven to be effective in preventing illnesses. Ensuring that children receive the ACIP recommended vaccination schedule is the standard of care, unless there is a medical reason that the child should not receive the vaccine; this bill would still allow for a medical exemption to address these circumstances. For these reasons, the Medical Board of California (Board) took a support position on this bill.

FISCAL: None to the Board

SUPPORT: Vaccinate California (Sponsor); Insurance Commissioner Dave Jones; AIDS Healthcare Foundation; American Academy of Pediatrics; American Federation of State, County and Municipal Employees; American Lung Association; American Nurses Association; Association of Northern California Oncologists; California Academy of Family Physicians; California Academy of Physician Assistants; California Association of Nurse Practitioners; California Association of Physician Groups; California Chapter of the American College of Emergency Physicians; California Children's Hospital Association; California Coverage & Health Initiatives; California Hepatitis Alliance; California Hospital Association; California Immunization Coalition; California Medical Association; California Optometric Association; California Pharmacists Association; California Primary Care Association; California Public Health Association – North; California School Boards Association; California School Employees Association; California School Nurses Organization; California State Association of Counties; California State Parent-Teacher Association; Carlsbad High School Parent-Teacher-Student Association; Child Care Law Center; Children Now; Children's Defense Fund-California; Children's Healthcare Is a Legal Duty, Inc.; Children's Hospital Oakland; Children's Specialty Care Coalition; City of Berkeley; City of Beverly Hills; City of Pasadena; County Health Executives Association of California; County of Alameda; County of Los Angeles; County of Marin; County of Santa Clara; County of Santa Cruz; County of Santa Cruz Democratic Party; County of Yolo; Democratic Women's Club of Santa Cruz County; First 5 California; Foundation for Pediatric Health; Health Officers Association of California; Junior Leagues of California; Kaiser Permanente; Los Angeles Community College District; Los Angeles County Supervisor Sheila Kuehl; Los Angeles Unified School District; March of Dimes California Chapter; Medical Board of California; Memorial Care Health System Physician Society; National Coalition of 100 Black Women Sacramento Chapter; Osteopathic Physicians and Surgeons of California; Project Inform; Providence Health and Services

Southern California; San Diego Union High School District; San Francisco Unified School District; Santa Monica Malibu Union Unified School District; Secular Coalition for California; Silicon Valley Leadership Group; Solano Beach School District; The Children's Partnership; UAW Local 5810, Postdoctoral Researchers at the University of California; and hundreds of individuals

OPPOSITION:

AWAKE California; Association of American Physicians and Surgeons; California Chiropractic Association; California Naturopathic Doctors Association; California Nurses for Ethical Standards; California ProLife Council; California Right to Life Committee, Inc.; Canary Party; Capitol Resource Institute; Educate. Advocate.; Families for Early Autism Treatment; Homeschool Association of California; National Vaccine Information Center; Pacific Justice Institute Center for Public Policy; ParentalRights.Org; Safe Minds; and hundreds of individuals

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Update website to include information on new vaccine requirements and medical exemptions, including what a physician should consider before issuing a medical exemption (this is a possible enforcement issue)
- Update citation and fine regulations to include improper medical exemptions or non-compliance with the provisions of this bill

Senate Bill No. 277

CHAPTER 35

An act to amend Sections 120325, 120335, 120370, and 120375 of, to add Section 120338 to, and to repeal Section 120365 of, the Health and Safety Code, relating to public health.

[Approved by Governor June 30, 2015. Filed with
Secretary of State June 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 277, Pan. Public health: vaccinations.

Existing law prohibits the governing authority of a school or other institution from unconditionally admitting any person as a pupil of any public or private elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless prior to his or her admission to that institution he or she has been fully immunized against various diseases, including measles, mumps, and pertussis, subject to any specific age criteria. Existing law authorizes an exemption from those provisions for medical reasons or because of personal beliefs, if specified forms are submitted to the governing authority. Existing law requires the governing authority of a school or other institution to require documentary proof of each entrant's immunization status. Existing law authorizes the governing authority of a school or other institution to temporarily exclude a child from the school or institution if the authority has good cause to believe that the child has been exposed to one of those diseases, as specified.

This bill would eliminate the exemption from existing specified immunization requirements based upon personal beliefs, but would allow exemption from future immunization requirements deemed appropriate by the State Department of Public Health for either medical reasons or personal beliefs. The bill would exempt pupils in a home-based private school and students enrolled in an independent study program and who do not receive classroom-based instruction, pursuant to specified law from the prohibition described above. The bill would allow pupils who, prior to January 1, 2016, have a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization, to be enrolled in any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span, as defined. Except as under the circumstances described above, on and after July 1, 2016, the bill would prohibit a governing authority from unconditionally admitting to any of those institutions for the first time or

admitting or advancing any pupil to the 7th grade level, unless the pupil has been immunized as required by the bill. The bill would specify that its provisions do not prohibit a pupil who qualifies for an individualized education program, pursuant to specified laws, from accessing any special education and related services required by his or her individualized education program. The bill would narrow the authorization for temporary exclusion from a school or other institution to make it applicable only to a child who has been exposed to a specified disease and whose documentary proof of immunization status does not show proof of immunization against one of the diseases described above. The bill would make conforming changes to related provisions.

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

SECTION 1. Section 120325 of the Health and Safety Code is amended to read:

120325. In enacting this chapter, but excluding Section 120380, and in enacting Sections 120400, 120405, 120410, and 120415, it is the intent of the Legislature to provide:

(a) A means for the eventual achievement of total immunization of appropriate age groups against the following childhood diseases:

- (1) Diphtheria.
- (2) Hepatitis B.
- (3) Haemophilus influenzae type b.
- (4) Measles.
- (5) Mumps.
- (6) Pertussis (whooping cough).
- (7) Poliomyelitis.
- (8) Rubella.
- (9) Tetanus.
- (10) Varicella (chickenpox).

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(b) That the persons required to be immunized be allowed to obtain immunizations from whatever medical source they so desire, subject only to the condition that the immunization be performed in accordance with the regulations of the department and that a record of the immunization is made in accordance with the regulations.

(c) Exemptions from immunization for medical reasons.

(d) For the keeping of adequate records of immunization so that health departments, schools, and other institutions, parents or guardians, and the persons immunized will be able to ascertain that a child is fully or only partially immunized, and so that appropriate public agencies will be able

to ascertain the immunization needs of groups of children in schools or other institutions.

(e) Incentives to public health authorities to design innovative and creative programs that will promote and achieve full and timely immunization of children.

SEC. 2. Section 120335 of the Health and Safety Code is amended to read:

120335. (a) As used in this chapter, “governing authority” means the governing board of each school district or the authority of each other private or public institution responsible for the operation and control of the institution or the principal or administrator of each school or institution.

(b) The governing authority shall not unconditionally admit any person as a pupil of any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, unless, prior to his or her first admission to that institution, he or she has been fully immunized. The following are the diseases for which immunizations shall be documented:

- (1) Diphtheria.
- (2) Haemophilus influenzae type b.
- (3) Measles.
- (4) Mumps.
- (5) Pertussis (whooping cough).
- (6) Poliomyelitis.
- (7) Rubella.
- (8) Tetanus.
- (9) Hepatitis B.
- (10) Varicella (chickenpox).

(11) Any other disease deemed appropriate by the department, taking into consideration the recommendations of the Advisory Committee on Immunization Practices of the United States Department of Health and Human Services, the American Academy of Pediatrics, and the American Academy of Family Physicians.

(c) Notwithstanding subdivision (b), full immunization against hepatitis B shall not be a condition by which the governing authority shall admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school.

(d) The governing authority shall not unconditionally admit or advance any pupil to the 7th grade level of any private or public elementary or secondary school unless the pupil has been fully immunized against pertussis, including all pertussis boosters appropriate for the pupil’s age.

(e) The department may specify the immunizing agents that may be utilized and the manner in which immunizations are administered.

(f) This section does not apply to a pupil in a home-based private school or a pupil who is enrolled in an independent study program pursuant to Article 5.5 (commencing with Section 51745) of Chapter 5 of Part 28 of the Education Code and does not receive classroom-based instruction.

(g) (1) A pupil who, prior to January 1, 2016, submitted a letter or affidavit on file at a private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center stating beliefs opposed to immunization shall be allowed enrollment to any private or public elementary or secondary school, child day care center, day nursery, nursery school, family day care home, or development center within the state until the pupil enrolls in the next grade span.

(2) For purposes of this subdivision, “grade span” means each of the following:

(A) Birth to preschool.

(B) Kindergarten and grades 1 to 6, inclusive, including transitional kindergarten.

(C) Grades 7 to 12, inclusive.

(3) Except as provided in this subdivision, on and after July 1, 2016, the governing authority shall not unconditionally admit to any of those institutions specified in this subdivision for the first time, or admit or advance any pupil to 7th grade level, unless the pupil has been immunized for his or her age as required by this section.

(h) This section does not prohibit a pupil who qualifies for an individualized education program, pursuant to federal law and Section 56026 of the Education Code, from accessing any special education and related services required by his or her individualized education program.

SEC. 3. Section 120338 is added to the Health and Safety Code, to read:

120338. Notwithstanding Sections 120325 and 120335, any immunizations deemed appropriate by the department pursuant to paragraph (11) of subdivision (a) of Section 120325 or paragraph (11) of subdivision (b) of Section 120335, may be mandated before a pupil’s first admission to any private or public elementary or secondary school, child care center, day nursery, nursery school, family day care home, or development center, only if exemptions are allowed for both medical reasons and personal beliefs.

SEC. 4. Section 120365 of the Health and Safety Code is repealed.

SEC. 5. Section 120370 of the Health and Safety Code is amended to read:

120370. (a) If the parent or guardian files with the governing authority a written statement by a licensed physician to the effect that the physical condition of the child is such, or medical circumstances relating to the child are such, that immunization is not considered safe, indicating the specific nature and probable duration of the medical condition or circumstances, including, but not limited to, family medical history, for which the physician does not recommend immunization, that child shall be exempt from the requirements of Chapter 1 (commencing with Section 120325, but excluding Section 120380) and Sections 120400, 120405, 120410, and 120415 to the extent indicated by the physician’s statement.

(b) If there is good cause to believe that a child has been exposed to a disease listed in subdivision (b) of Section 120335 and his or her documentary proof of immunization status does not show proof of

immunization against that disease, that child may be temporarily excluded from the school or institution until the local health officer is satisfied that the child is no longer at risk of developing or transmitting the disease.

SEC. 6. Section 120375 of the Health and Safety Code is amended to read:

120375. (a) The governing authority of each school or institution included in Section 120335 shall require documentary proof of each entrant's immunization status. The governing authority shall record the immunizations of each new entrant in the entrant's permanent enrollment and scholarship record on a form provided by the department. The immunization record of each new entrant admitted conditionally shall be reviewed periodically by the governing authority to ensure that within the time periods designated by regulation of the department he or she has been fully immunized against all of the diseases listed in Section 120335, and immunizations received subsequent to entry shall be added to the pupil's immunization record.

(b) The governing authority of each school or institution included in Section 120335 shall prohibit from further attendance any pupil admitted conditionally who failed to obtain the required immunizations within the time limits allowed in the regulations of the department, unless the pupil is exempted under Section 120370, until that pupil has been fully immunized against all of the diseases listed in Section 120335.

(c) The governing authority shall file a written report on the immunization status of new entrants to the school or institution under their jurisdiction with the department and the local health department at times and on forms prescribed by the department. As provided in paragraph (4) of subdivision (a) of Section 49076 of the Education Code, the local health department shall have access to the complete health information as it relates to immunization of each student in the schools or other institutions listed in Section 120335 in order to determine immunization deficiencies.

(d) The governing authority shall cooperate with the county health officer in carrying out programs for the immunization of persons applying for admission to any school or institution under its jurisdiction. The governing board of any school district may use funds, property, and personnel of the district for that purpose. The governing authority of any school or other institution may permit any licensed physician or any qualified registered nurse as provided in Section 2727.3 of the Business and Professions Code to administer immunizing agents to any person seeking admission to any school or institution under its jurisdiction.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 337
Author: Pavley
Chapter: 536
Bill Date: September 1, 2015, Amended
Subject: Physician Assistants
Sponsor: California Academy of Physician Assistants (CAPA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish alternative means for a supervising physician to ensure adequate supervision of a physician assistant (PA) for routine care and the administration, provision, or issuance of a Schedule II drug.

BACKGROUND:

The Physician Assistant Practice Act (Act) was established to encourage the utilization of PAs by physicians, and by physicians and podiatrists practicing in the same medical group, and to provide that existing legal constraints should not be an unnecessary hindrance to the more effective provision of health care services. It is also the purpose of the Act to allow for innovative development of programs for the education, training, and utilization of PAs. There are approximately 10,000 PAs practicing in California.

Existing law requires a supervising physician to review, countersign, and date a sample consisting of, at a minimum, five percent of the medical records of patients treated by a PA within 30 days of the date of treatment. Existing law requires the supervising physician to select for review those cases that by diagnosis, problem, treatment, or procedure represent the most significant risk to the patient.

Existing law requires a supervising physician who delegates the authority to issue a drug order to a PA to prepare and adopt a formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. Existing law requires a supervising physician to review and countersign, within seven days, the record of any patient cared for by a PA for whom the PA's Schedule II drug order has been issued or carried out.

In October 2014, hydrocodone combination products (HCPs) were re-scheduled from a Schedule III medication to a Schedule II medication, which, according to the sponsor, significantly increased administrative responsibilities related to documentation in various practice types.

According to the sponsor, this bill recognizes the need to streamline patient care performed by PAs under the supervision of physician and surgeons. The sponsor believes this bill provides greater flexibility to medical practices by offering physicians several options to ensure adequate supervision of PA medical visits.

ANALYSIS:

This bill would add an additional mechanism, in addition to the existing five percent medical record countersignature requirement, for a supervising physician to use to ensure adequate PA supervision. This bill would define a medical records review meeting as a meeting between the supervising physician and the PA during which medical records are reviewed to ensure adequate supervision of the PA. These meetings may occur in person or by electronic communication. This bill would require the supervising physician to review a sample of at least 10 medical records per month, for at least 10 months during the year, using a combination of the existing countersignature mechanism and the new medical records review mechanism.

Existing law requires all medical charts for Schedule II drug orders to be countersigned within seven days by the supervising physician. This bill would create an additional mechanism for a supervising physician to ensure adequate supervision of the administration, provision, or issuance by a PA of a Schedule II drug order. The additional mechanism is only allowed if the PA has documentation evidencing the successful completion of an education course that covers controlled substances and meets specified standards. The mechanism would require the supervising physician to review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the PA for whom the PA's Schedule II drug order has been issued or carried out.

The intent of this bill is to provide flexibility and allow for a more team-based approach in PA supervision, which the Medical Board of California (Board) believes is a laudable goal. This bill has been amended to ensure that there are minimum requirements in the mechanisms allowed to ensure adequate physician supervision, and these minimum requirements will ensure consumer protection and provide for a more team-based approach. Although this bill reduces the physician review of medical records for Schedule II drug orders, the supervising physician will be responsible for choosing the 20 percent of Schedule II drug orders that get signed, and these records could potentially be discussed at medical records review meetings with the supervising physician and the PA. For these reasons, the Board took a support position on SB 337.

FISCAL: None

SUPPORT: CAPA (sponsor)
CAPG
Medical Board of California
Pacific Pain Medicine Consultants
Pacific Southwest Pain Center
Physician Assistant Board
Planned Parenthood Affiliates of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Update the Board's website
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 337

CHAPTER 536

An act to amend Sections 3501, 3502, and 3502.1 of the Business and Professions Code, relating to healing arts.

[Approved by Governor October 6, 2015. Filed with
Secretary of State October 6, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 337, Pavley. Physician assistants.

Existing law, the Physician Assistant Practice Act, provides for regulation of physician assistants and authorizes a physician assistant to perform medical services as set forth by regulations when those services are rendered under the supervision of a licensed physician and surgeon, as specified. The act requires the supervising physician and surgeon to review, countersign, and date a sample consisting of, at a minimum, 5% of the medical records of patients treated by the physician assistant functioning under adopted protocols within 30 days of the date of treatment by the physician assistant. The act requires the supervising physician and surgeon to select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient. A violation of those supervision requirements is a misdemeanor.

This bill would require that the medical record for each episode of care for a patient identify the physician and surgeon who is responsible for the supervision of the physician assistant. The bill would delete those medical record review provisions, and, instead, require the supervising physician and surgeon to use one or more of described review mechanisms. By adding these new requirements, the violation of which would be a crime, this bill would impose a state-mandated local program by changing the definition of a crime.

The act authorizes a physician assistant, while under prescribed supervision of a physician and surgeon, to administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device. The act prohibits a physician assistant from administering, providing, or issuing a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets approved standards. The act requires that the medical record of any patient cared for by a physician assistant for whom a physician assistant's Schedule II drug order has been issued or carried out to be

reviewed, countersigned, and dated by a supervising physician and surgeon within 7 days.

This bill would establish an alternative medical records review mechanism, and would authorize the supervising physician and surgeon to use the alternative mechanism, or a sample review mechanism using a combination of the 2 described mechanisms, as specified, to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 3501 of the Business and Professions Code is amended to read:

3501. (a) As used in this chapter:

- (1) "Board" means the Physician Assistant Board.
- (2) "Approved program" means a program for the education of physician assistants that has been formally approved by the board.
- (3) "Trainee" means a person who is currently enrolled in an approved program.
- (4) "Physician assistant" means a person who meets the requirements of this chapter and is licensed by the board.
- (5) "Supervising physician" or "supervising physician and surgeon" means a physician and surgeon licensed by the Medical Board of California or by the Osteopathic Medical Board of California who supervises one or more physician assistants, who possesses a current valid license to practice medicine, and who is not currently on disciplinary probation for improper use of a physician assistant.
- (6) "Supervision" means that a licensed physician and surgeon oversees the activities of, and accepts responsibility for, the medical services rendered by a physician assistant.
- (7) "Regulations" means the rules and regulations as set forth in Chapter 13.8 (commencing with Section 1399.500) of Title 16 of the California Code of Regulations.
- (8) "Routine visual screening" means uninvasive nonpharmacological simple testing for visual acuity, visual field defects, color blindness, and depth perception.
- (9) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.
- (10) "Delegation of services agreement" means the writing that delegates to a physician assistant from a supervising physician the medical services

the physician assistant is authorized to perform consistent with subdivision (a) of Section 1399.540 of Title 16 of the California Code of Regulations.

(11) “Other specified medical services” means tests or examinations performed or ordered by a physician assistant practicing in compliance with this chapter or regulations of the Medical Board of California promulgated under this chapter.

(12) “Medical records review meeting” means a meeting between the supervising physician and surgeon and the physician assistant during which medical records are reviewed to ensure adequate supervision of the physician assistant functioning under protocols. Medical records review meetings may occur in person or by electronic communication.

(b) A physician assistant acts as an agent of the supervising physician when performing any activity authorized by this chapter or regulations adopted under this chapter.

SEC. 2. Section 3502 of the Business and Professions Code is amended to read:

3502. (a) Notwithstanding any other law, a physician assistant may perform those medical services as set forth by the regulations adopted under this chapter when the services are rendered under the supervision of a licensed physician and surgeon who is not subject to a disciplinary condition imposed by the Medical Board of California prohibiting that supervision or prohibiting the employment of a physician assistant. The medical record, for each episode of care for a patient, shall identify the physician and surgeon who is responsible for the supervision of the physician assistant.

(b) (1) Notwithstanding any other law, a physician assistant performing medical services under the supervision of a physician and surgeon may assist a doctor of podiatric medicine who is a partner, shareholder, or employee in the same medical group as the supervising physician and surgeon. A physician assistant who assists a doctor of podiatric medicine pursuant to this subdivision shall do so only according to patient-specific orders from the supervising physician and surgeon.

(2) The supervising physician and surgeon shall be physically available to the physician assistant for consultation when that assistance is rendered. A physician assistant assisting a doctor of podiatric medicine shall be limited to performing those duties included within the scope of practice of a doctor of podiatric medicine.

(c) (1) A physician assistant and his or her supervising physician and surgeon shall establish written guidelines for the adequate supervision of the physician assistant. This requirement may be satisfied by the supervising physician and surgeon adopting protocols for some or all of the tasks performed by the physician assistant. The protocols adopted pursuant to this subdivision shall comply with the following requirements:

(A) A protocol governing diagnosis and management shall, at a minimum, include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be provided to the patient.

(B) A protocol governing procedures shall set forth the information to be provided to the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the followup care.

(C) Protocols shall be developed by the supervising physician and surgeon or adopted from, or referenced to, texts or other sources.

(D) Protocols shall be signed and dated by the supervising physician and surgeon and the physician assistant.

(2) (A) The supervising physician and surgeon shall use one or more of the following mechanisms to ensure adequate supervision of the physician assistant functioning under the protocols:

(i) The supervising physician and surgeon shall review, countersign, and date a sample consisting of, at a minimum, 5 percent of the medical records of patients treated by the physician assistant functioning under the protocols within 30 days of the date of treatment by the physician assistant.

(ii) The supervising physician and surgeon and physician assistant shall conduct a medical records review meeting at least once a month during at least 10 months of the year. During any month in which a medical records review meeting occurs, the supervising physician and surgeon and physician assistant shall review an aggregate of at least 10 medical records of patients treated by the physician assistant functioning under protocols. Documentation of medical records reviewed during the month shall be jointly signed and dated by the supervising physician and surgeon and the physician assistant.

(iii) The supervising physician and surgeon shall review a sample of at least 10 medical records per month, at least 10 months during the year, using a combination of the countersignature mechanism described in clause (i) and the medical records review meeting mechanism described in clause (ii). During each month for which a sample is reviewed, at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (i) and at least one of the medical records in the sample shall be reviewed using the mechanism described in clause (ii).

(B) In complying with subparagraph (A), the supervising physician and surgeon shall select for review those cases that by diagnosis, problem, treatment, or procedure represent, in his or her judgment, the most significant risk to the patient.

(3) Notwithstanding any other law, the Medical Board of California or the board may establish other alternative mechanisms for the adequate supervision of the physician assistant.

(d) No medical services may be performed under this chapter in any of the following areas:

(1) The determination of the refractive states of the human eye, or the fitting or adaptation of lenses or frames for the aid thereof.

(2) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, or orthoptics.

(3) The prescribing of contact lenses for, or the fitting or adaptation of contact lenses to, the human eye.

(4) The practice of dentistry or dental hygiene or the work of a dental auxiliary as defined in Chapter 4 (commencing with Section 1600).

(e) This section shall not be construed in a manner that shall preclude the performance of routine visual screening as defined in Section 3501.

(f) Compliance by a physician assistant and supervising physician and surgeon with this section shall be deemed compliance with Section 1399.546 of Title 16 of the California Code of Regulations.

SEC. 3. Section 3502.1 of the Business and Professions Code is amended to read:

3502.1. (a) In addition to the services authorized in the regulations adopted by the Medical Board of California, and except as prohibited by Section 3502, while under the supervision of a licensed physician and surgeon or physicians and surgeons authorized by law to supervise a physician assistant, a physician assistant may administer or provide medication to a patient, or transmit orally, or in writing on a patient's record or in a drug order, an order to a person who may lawfully furnish the medication or medical device pursuant to subdivisions (c) and (d).

(1) A supervising physician and surgeon who delegates authority to issue a drug order to a physician assistant may limit this authority by specifying the manner in which the physician assistant may issue delegated prescriptions.

(2) Each supervising physician and surgeon who delegates the authority to issue a drug order to a physician assistant shall first prepare and adopt, or adopt, a written, practice specific, formulary and protocols that specify all criteria for the use of a particular drug or device, and any contraindications for the selection. Protocols for Schedule II controlled substances shall address the diagnosis of illness, injury, or condition for which the Schedule II controlled substance is being administered, provided, or issued. The drugs listed in the protocols shall constitute the formulary and shall include only drugs that are appropriate for use in the type of practice engaged in by the supervising physician and surgeon. When issuing a drug order, the physician assistant is acting on behalf of and as an agent for a supervising physician and surgeon.

(b) "Drug order," for purposes of this section, means an order for medication that is dispensed to or for a patient, issued and signed by a physician assistant acting as an individual practitioner within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations. Notwithstanding any other provision of law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription or order of the supervising physician, (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by physician assistants pursuant to authority granted by their supervising physicians and surgeons, and (3) the signature of a physician assistant on a drug order shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(c) A drug order for any patient cared for by the physician assistant that is issued by the physician assistant shall either be based on the protocols

described in subdivision (a) or shall be approved by the supervising physician and surgeon before it is filled or carried out.

(1) A physician assistant shall not administer or provide a drug or issue a drug order for a drug other than for a drug listed in the formulary without advance approval from a supervising physician and surgeon for the particular patient. At the direction and under the supervision of a physician and surgeon, a physician assistant may hand to a patient of the supervising physician and surgeon a properly labeled prescription drug prepackaged by a physician and surgeon, manufacturer as defined in the Pharmacy Law, or a pharmacist.

(2) A physician assistant shall not administer, provide, or issue a drug order to a patient for Schedule II through Schedule V controlled substances without advance approval by a supervising physician and surgeon for that particular patient unless the physician assistant has completed an education course that covers controlled substances and that meets standards, including pharmacological content, approved by the board. The education course shall be provided either by an accredited continuing education provider or by an approved physician assistant training program. If the physician assistant will administer, provide, or issue a drug order for Schedule II controlled substances, the course shall contain a minimum of three hours exclusively on Schedule II controlled substances. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established by the board prior to the physician assistant's use of a registration number issued by the United States Drug Enforcement Administration to the physician assistant to administer, provide, or issue a drug order to a patient for a controlled substance without advance approval by a supervising physician and surgeon for that particular patient.

(3) Any drug order issued by a physician assistant shall be subject to a reasonable quantitative limitation consistent with customary medical practice in the supervising physician and surgeon's practice.

(d) A written drug order issued pursuant to subdivision (a), except a written drug order in a patient's medical record in a health facility or medical practice, shall contain the printed name, address, and telephone number of the supervising physician and surgeon, the printed or stamped name and license number of the physician assistant, and the signature of the physician assistant. Further, a written drug order for a controlled substance, except a written drug order in a patient's medical record in a health facility or a medical practice, shall include the federal controlled substances registration number of the physician assistant and shall otherwise comply with Section 11162.1 of the Health and Safety Code. Except as otherwise required for written drug orders for controlled substances under Section 11162.1 of the Health and Safety Code, the requirements of this subdivision may be met through stamping or otherwise imprinting on the supervising physician and surgeon's prescription blank to show the name, license number, and if applicable, the federal controlled substances registration number of the physician assistant, and shall be signed by the physician assistant. When

using a drug order, the physician assistant is acting on behalf of and as the agent of a supervising physician and surgeon.

(e) The supervising physician and surgeon shall use either of the following mechanisms to ensure adequate supervision of the administration, provision, or issuance by a physician assistant of a drug order to a patient for Schedule II controlled substances:

(1) The medical record of any patient cared for by a physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out shall be reviewed, countersigned, and dated by a supervising physician and surgeon within seven days.

(2) If the physician assistant has documentation evidencing the successful completion of an education course that covers controlled substances, and that controlled substance education course (A) meets the standards, including pharmacological content, established in Sections 1399.610 and 1399.612 of Title 16 of the California Code of Regulations, and (B) is provided either by an accredited continuing education provider or by an approved physician assistant training program, the supervising physician and surgeon shall review, countersign, and date, within seven days, a sample consisting of the medical records of at least 20 percent of the patients cared for by the physician assistant for whom the physician assistant's Schedule II drug order has been issued or carried out. Completion of the requirements set forth in this paragraph shall be verified and documented in the manner established in Section 1399.612 of Title 16 of the California Code of Regulations. Physician assistants who have a certificate of completion of the course described in paragraph (2) of subdivision (c) shall be deemed to have met the education course requirement of this subdivision.

(f) All physician assistants who are authorized by their supervising physicians to issue drug orders for controlled substances shall register with the United States Drug Enforcement Administration (DEA).

(g) The board shall consult with the Medical Board of California and report during its sunset review required by Article 7.5 (commencing with Section 9147.7) of Chapter 1.5 of Part 1 of Division 2 of Title 2 of the Government Code the impacts of exempting Schedule III and Schedule IV drug orders from the requirement for a physician and surgeon to review and countersign the affected medical record of a patient.

SEC. 4. 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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 396
Author: Hill
Chapter: 287
Bill Date: June 29, 2015, Amended
Subject: Outpatient Settings
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

SB 396 makes consumer protection enhancements that the Medical Board of California (Board) already voted to sponsor/support for accredited outpatient settings. This bill requires peer review evaluations for physicians and surgeons working in accredited outpatient settings; and it allows accredited outpatient setting facility inspections performed by Accreditation Agencies (AAs) be unannounced (after the initial inspection). For unannounced inspections, AAs must provide at least a 60-day window to the outpatient setting.

This bill also delays the report from the Board on the vertical enforcement and prosecution model from March 1, 2015, to March 1, 2016.

The bill allows an accredited outpatient setting and a “Medicare certified ambulatory surgical center” (i.e. ASC) to access 805 reports from the Board when credentialing, granting or renewing staff privileges for providers at that facility.

BACKGROUND

AB 595 (Chapter 1276) of 1994 required that certain outpatient settings (including ASCs) either be licensed by the state, Medicare certified, or accredited by an agency approved by the Division of Licensing within the Board. The intent was to “ensure that health care services are safely and effectively performed in these settings.” In 2007, a September court ruling (Capen v. Shewry: 155 Cal.App.4th 378) prohibited the California Department of Public Health from issuing state licenses to physician-owned outpatient settings. As a result, the vast majority of outpatient settings are now accredited by AAs approved by the Board.

Accredited outpatient settings and Medicare certified ASCs are currently not on the list of eligible facilities that can obtain 805 reports from the Board, so these facilities are unable to ensure that physician and surgeons and others providing care in those facilities have not been denied staff privileges, been removed from a medical staff, or have had his or her staff privileges restricted.

In addition, existing law allows a physician who owns his or her own outpatient setting to choose not to have peer review of his or her practice, which means that procedures performed in outpatient settings are not subject to peer review. Lastly, routine inspections currently performed by AAs for outpatient setting accreditation are announced.

ANALYSIS

The Board believes that peer review is important to ensure consumer protection, and that procedures that are being done in outpatient settings should be subject to peer review evaluations. This bill requires physicians working in accredited outpatient settings to be subjected to the peer review process at least every two years. The findings would be given to the governing body of the outpatient setting and the findings and peer review process would be reviewed by the AAs at the next inspection of the outpatient setting.

Inspections currently performed by AAs for outpatient setting accreditation are announced. This bill allows subsequent routine inspections to be unannounced, however AAs must give a 60-day window to accredited outpatient settings for unannounced routine inspections. Allowing for unannounced inspections will help to ensure that facilities do not have time to prepare for an inspection and will be in line with inspections performed by other oversight agencies.

This bill allows an accredited outpatient setting and a “Medicare certified ambulatory surgical center” to access 805 reports from the Board to ensure patient protection when credentialing, granting or renewing staff privileges for providers at that facility. The Board already voted to support and/or sponsor these provisions.

Unrelated to outpatient settings, this bill extends the deadline for the Board’s legislative report on the vertical enforcement (VE) and prosecution model by one year, to March 1, 2016. This will give the Board adequate time to assess how the VE model is working with the transfer of the investigators to the Department of Consumer Affairs, Division of Investigation. This change is needed as the report due date has passed and the Board currently has insufficient information to complete the VE report.

FISCAL: None

SUPPORT: California Ambulatory Surgery Association
Medical Board of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) - a separate article may be needed geared towards physicians that work in outpatient settings

- Notify/train Board staff
- Meet with AAs to explain the bill's provisions and ensure that they understand the new outpatient setting requirements. Provide any needed guidance to the AAs.
- Update Board's website
- Work with staff on processes to allow accredited and certified outpatient settings to access 805 reports from the Board
- Draft letter for all accredited outpatient settings on the new requirements of this bill, including any guidance from the Board. Send letter to AAs for dissemination to all accredited outpatient settings.
- Work with DCA to complete the VE report by March 1, 2016

Senate Bill No. 396

CHAPTER 287

An act to amend Section 805.5 of the Business and Professions Code, to amend Section 12529.7 of the Government Code, and to amend Sections 1248.15 and 1248.35 of the Health and Safety Code, relating to health care.

[Approved by Governor September 9, 2015. Filed with
Secretary of State September 9, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 396, Hill. Health care: outpatient settings and surgical clinics: facilities: licensure and enforcement.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law provides that it is unprofessional conduct for a physician and surgeon to perform procedures in any outpatient setting except in compliance with specified provisions. Existing law prohibits an association, corporation, firm, partnership, or person from operating, managing, conducting, or maintaining an outpatient setting in the state unless the setting is one of the specified settings, which include, among others, an ambulatory surgical clinic that is certified to participate in the Medicare Program, a surgical clinic licensed by the State Department of Public Health, or an outpatient setting accredited by an accreditation agency approved by the Division of Licensing of the Medical Board of California.

Existing law provides that an outpatient setting that is accredited shall be inspected by the accreditation agency and may be inspected by the Medical Board of California. Existing law requires that the inspections be conducted no less often than once every 3 years by the accreditation agency and as often as necessary by the Medical Board of California to ensure quality of care provided.

This bill would authorize the accrediting agency to conduct unannounced inspections subsequent to the initial inspection for accreditation, if the accreditation agency provides specified notice of the unannounced routine inspection to the outpatient setting.

Existing law requires members of the medical staff and other practitioners who are granted clinical privileges in an outpatient setting to be professionally qualified and appropriately credentialed for the performance of privileges granted and requires the outpatient setting to grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting. A willful violation of these provisions is a crime.

This bill would additionally require that each licensee who performs procedures in an outpatient setting that requires the outpatient setting to be

accredited be peer reviewed, as specified, at least every 2 years, by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The bill would require the findings of the peer review to be reported to the governing body, which shall determine if the licensee continues to be professionally qualified and appropriately credentialed for the performance of privileges granted. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Existing law requires specified entities, including any health care service plan or medical care foundation, to request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California, prior to granting or renewing staff privileges, to determine if a certain report has been made indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted.

This bill would also require an outpatient setting and a facility certified to participate in the federal Medicare Program as an ambulatory surgical center to request that report. By expanding the scope of a crime, this bill would impose a state-mandated local program.

Existing law establishes a vertical enforcement and prosecution model for cases before the Medical Board of California, and requires the board to report to the Governor and the Legislature on that model by March 1, 2015.

This bill would extend the date that report is due to March 1, 2016.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 805.5 of the Business and Professions Code is amended to read:

805.5. (a) Prior to granting or renewing staff privileges for any physician and surgeon, psychologist, podiatrist, or dentist, any health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code, any health care service plan or medical care foundation, the medical staff of the institution, a facility certified to participate in the federal Medicare Program as an ambulatory surgical center, or an outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code shall request a report from the Medical Board of California, the Board of Psychology, the Osteopathic Medical Board of California, or the Dental Board of California to determine if any report has been made pursuant to Section 805 indicating that the applying physician and surgeon, psychologist, podiatrist, or dentist has been denied staff privileges, been removed from a medical staff, or had his or her staff privileges restricted as provided in

Section 805. The request shall include the name and California license number of the physician and surgeon, psychologist, podiatrist, or dentist. Furnishing of a copy of the 805 report shall not cause the 805 report to be a public record.

(b) Upon a request made by, or on behalf of, an institution described in subdivision (a) or its medical staff the board shall furnish a copy of any report made pursuant to Section 805 as well as any additional exculpatory or explanatory information submitted electronically to the board by the licensee pursuant to subdivision (f) of that section. However, the board shall not send a copy of a report (1) if the denial, removal, or restriction was imposed solely because of the failure to complete medical records, (2) if the board has found the information reported is without merit, (3) if a court finds, in a final judgment, that the peer review, as defined in Section 805, resulting in the report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, or (4) if a period of three years has elapsed since the report was submitted. This three-year period shall be tolled during any period the licensee has obtained a judicial order precluding disclosure of the report, unless the board is finally and permanently precluded by judicial order from disclosing the report. If a request is received by the board while the board is subject to a judicial order limiting or precluding disclosure, the board shall provide a disclosure to any qualified requesting party as soon as practicable after the judicial order is no longer in force.

If the board fails to advise the institution within 30 working days following its request for a report required by this section, the institution may grant or renew staff privileges for the physician and surgeon, psychologist, podiatrist, or dentist.

(c) Any institution described in subdivision (a) or its medical staff that violates subdivision (a) is guilty of a misdemeanor and shall be punished by a fine of not less than two hundred dollars (\$200) nor more than one thousand two hundred dollars (\$1,200).

SEC. 2. Section 12529.7 of the Government Code is amended to read:

12529.7. By March 1, 2016, the Medical Board of California, in consultation with the Department of Justice and the Department of Consumer Affairs, shall report and make recommendations to the Governor and the Legislature on the vertical enforcement and prosecution model created under Section 12529.6.

SEC. 3. Section 1248.15 of the Health and Safety Code is amended to read:

1248.15. (a) The board shall adopt standards for accreditation and, in approving accreditation agencies to perform accreditation of outpatient settings, shall ensure that the certification program shall, at a minimum, include standards for the following aspects of the settings' operations:

(1) Outpatient setting allied health staff shall be licensed or certified to the extent required by state or federal law.

(2) (A) Outpatient settings shall have a system for facility safety and emergency training requirements.

(B) There shall be onsite equipment, medication, and trained personnel to facilitate handling of services sought or provided and to facilitate handling of any medical emergency that may arise in connection with services sought or provided.

(C) In order for procedures to be performed in an outpatient setting as defined in Section 1248, the outpatient setting shall do one of the following:

(i) Have a written transfer agreement with a local accredited or licensed acute care hospital, approved by the facility's medical staff.

(ii) Permit surgery only by a licensee who has admitting privileges at a local accredited or licensed acute care hospital, with the exception that licensees who may be precluded from having admitting privileges by their professional classification or other administrative limitations, shall have a written transfer agreement with licensees who have admitting privileges at local accredited or licensed acute care hospitals.

(iii) Submit for approval by an accrediting agency a detailed procedural plan for handling medical emergencies that shall be reviewed at the time of accreditation. No reasonable plan shall be disapproved by the accrediting agency.

(D) The outpatient setting shall submit for approval by an accreditation agency at the time of accreditation a detailed plan, standardized procedures, and protocols to be followed in the event of serious complications or side effects from surgery that would place a patient at high risk for injury or harm or to govern emergency and urgent care situations. The plan shall include, at a minimum, that if a patient is being transferred to a local accredited or licensed acute care hospital, the outpatient setting shall do all of the following:

(i) Notify the individual designated by the patient to be notified in case of an emergency.

(ii) Ensure that the mode of transfer is consistent with the patient's medical condition.

(iii) Ensure that all relevant clinical information is documented and accompanies the patient at the time of transfer.

(iv) Continue to provide appropriate care to the patient until the transfer is effectuated.

(E) All physicians and surgeons transferring patients from an outpatient setting shall agree to cooperate with the medical staff peer review process on the transferred case, the results of which shall be referred back to the outpatient setting, if deemed appropriate by the medical staff peer review committee. If the medical staff of the acute care facility determines that inappropriate care was delivered at the outpatient setting, the acute care facility's peer review outcome shall be reported, as appropriate, to the accrediting body or in accordance with existing law.

(3) The outpatient setting shall permit surgery by a dentist acting within his or her scope of practice under Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code or physician and surgeon, osteopathic physician and surgeon, or podiatrist acting within his or her scope of practice under Chapter 5 (commencing with Section 2000)

of Division 2 of the Business and Professions Code or the Osteopathic Initiative Act. The outpatient setting may, in its discretion, permit anesthesia service by a certified registered nurse anesthetist acting within his or her scope of practice under Article 7 (commencing with Section 2825) of Chapter 6 of Division 2 of the Business and Professions Code.

(4) Outpatient settings shall have a system for maintaining clinical records.

(5) Outpatient settings shall have a system for patient care and monitoring procedures.

(6) (A) Outpatient settings shall have a system for quality assessment and improvement.

(B) (i) Members of the medical staff and other practitioners who are granted clinical privileges shall be professionally qualified and appropriately credentialed for the performance of privileges granted. The outpatient setting shall grant privileges in accordance with recommendations from qualified health professionals, and credentialing standards established by the outpatient setting.

(ii) Each licensee who performs procedures in an outpatient setting that requires the outpatient setting to be accredited shall be, at least every two years, peer reviewed, which shall be a process in which the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of a licensee is reviewed to make recommendations for quality improvement and education, if necessary, including when the outpatient setting has only one licensee. The peer review shall be performed by licensees who are qualified by education and experience to perform the same types of, or similar, procedures. The findings of the peer review shall be reported to the governing body, which shall determine if the licensee continues to meet the requirements described in clause (i). The process that resulted in the findings of the peer review shall be reviewed by the accrediting agency at the next survey to determine if the outpatient setting meets applicable accreditation standards pursuant to this section.

(C) Clinical privileges shall be periodically reappraised by the outpatient setting. The scope of procedures performed in the outpatient setting shall be periodically reviewed and amended as appropriate.

(7) Outpatient settings regulated by this chapter that have multiple service locations shall have all of the sites inspected.

(8) Outpatient settings shall post the certificate of accreditation in a location readily visible to patients and staff.

(9) Outpatient settings shall post the name and telephone number of the accrediting agency with instructions on the submission of complaints in a location readily visible to patients and staff.

(10) Outpatient settings shall have a written discharge criteria.

(b) Outpatient settings shall have a minimum of two staff persons on the premises, one of whom shall either be a licensed physician and surgeon or a licensed health care professional with current certification in advanced cardiac life support (ACLS), as long as a patient is present who has not been discharged from supervised care. Transfer to an unlicensed setting of a

patient who does not meet the discharge criteria adopted pursuant to paragraph (10) of subdivision (a) shall constitute unprofessional conduct.

(c) An accreditation agency may include additional standards in its determination to accredit outpatient settings if these are approved by the board to protect the public health and safety.

(d) No accreditation standard adopted or approved by the board, and no standard included in any certification program of any accreditation agency approved by the board, shall serve to limit the ability of any allied health care practitioner to provide services within his or her full scope of practice. Notwithstanding this or any other provision of law, each outpatient setting may limit the privileges, or determine the privileges, within the appropriate scope of practice, that will be afforded to physicians and allied health care practitioners who practice at the facility, in accordance with credentialing standards established by the outpatient setting in compliance with this chapter. Privileges may not be arbitrarily restricted based on category of licensure.

(e) The board shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

(f) The board may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting as specified in Section 1248.

(g) As part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, “conducting a reasonable investigation” means querying the Medical Board of California and the Osteopathic Medical Board of California to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision.

SEC. 4. Section 1248.35 of the Health and Safety Code is amended to read:

1248.35. (a) Every outpatient setting that is accredited shall be inspected by the accreditation agency and may also be inspected by the Medical Board of California. The Medical Board of California shall ensure that accreditation agencies inspect outpatient settings.

(b) Unless otherwise specified, the following requirements apply to inspections described in subdivision (a).

(1) The frequency of inspection shall depend upon the type and complexity of the outpatient setting to be inspected.

(2) Inspections shall be conducted no less often than once every three years by the accreditation agency and as often as necessary by the Medical Board of California to ensure the quality of care provided. After the initial inspection for accreditation, subsequent inspections may be unannounced.

For unannounced routine inspections, the accreditation agency shall notify the outpatient setting that the inspection will occur within 60 days.

(3) The Medical Board of California or the accreditation agency may enter and inspect any outpatient setting that is accredited by an accreditation agency at any reasonable time to ensure compliance with, or investigate an alleged violation of, any standard of the accreditation agency or any provision of this chapter.

(c) If an accreditation agency determines, as a result of its inspection, that an outpatient setting is not in compliance with the standards under which it was approved, the accreditation agency may do any of the following:

(1) Require correction of any identified deficiencies within a set timeframe. Failure to comply shall result in the accrediting agency issuing a reprimand or suspending or revoking the outpatient setting's accreditation.

(2) Issue a reprimand.

(3) Place the outpatient setting on probation, during which time the setting shall successfully institute and complete a plan of correction, approved by the board or the accreditation agency, to correct the deficiencies.

(4) Suspend or revoke the outpatient setting's certification of accreditation.

(d) (1) Except as is otherwise provided in this subdivision, before suspending or revoking a certificate of accreditation under this chapter, the accreditation agency shall provide the outpatient setting with notice of any deficiencies and the outpatient setting shall agree with the accreditation agency on a plan of correction that shall give the outpatient setting reasonable time to supply information demonstrating compliance with the standards of the accreditation agency in compliance with this chapter, as well as the opportunity for a hearing on the matter upon the request of the outpatient setting. During the allotted time to correct the deficiencies, the plan of correction, which includes the deficiencies, shall be conspicuously posted by the outpatient setting in a location accessible to public view. Within 10 days after the adoption of the plan of correction, the accrediting agency shall send a list of deficiencies and the corrective action to be taken to the board and to the California State Board of Pharmacy if an outpatient setting is licensed pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code. The accreditation agency may immediately suspend the certificate of accreditation before providing notice and an opportunity to be heard, but only when failure to take the action may result in imminent danger to the health of an individual. In such cases, the accreditation agency shall provide subsequent notice and an opportunity to be heard.

(2) If an outpatient setting does not comply with a corrective action within a timeframe specified by the accrediting agency, the accrediting agency shall issue a reprimand, and may either place the outpatient setting on probation or suspend or revoke the accreditation of the outpatient setting, and shall notify the board of its action. This section shall not be deemed to prohibit an outpatient setting that is unable to correct the deficiencies, as specified in the plan of correction, for reasons beyond its control, from

voluntarily surrendering its accreditation prior to initiation of any suspension or revocation proceeding.

(e) The accreditation agency shall, within 24 hours, report to the board if the outpatient setting has been issued a reprimand or if the outpatient setting's certification of accreditation has been suspended or revoked or if the outpatient setting has been placed on probation. If an outpatient setting has been issued a license by the California State Board of Pharmacy pursuant to Article 14 (commencing with Section 4190) of Chapter 9 of Division 2 of the Business and Professions Code, the accreditation agency shall also send this report to the California State Board of Pharmacy within 24 hours.

(f) The accreditation agency, upon receipt of a complaint from the board that an outpatient setting poses an immediate risk to public safety, shall inspect the outpatient setting and report its findings of inspection to the board within five business days. If an accreditation agency receives any other complaint from the board, it shall investigate the outpatient setting and report its findings of investigation to the board within 30 days.

(g) Reports on the results of any inspection shall be kept on file with the board and the accreditation agency along with the plan of correction and the comments of the outpatient setting. The inspection report may include a recommendation for reinspection. All final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, shall be public records open to public inspection.

(h) If one accrediting agency denies accreditation, or revokes or suspends the accreditation of an outpatient setting, this action shall apply to all other accrediting agencies. An outpatient setting that is denied accreditation is permitted to reapply for accreditation with the same accrediting agency. The outpatient setting also may apply for accreditation from another accrediting agency, but only if it discloses the full accreditation report of the accrediting agency that denied accreditation. Any outpatient setting that has been denied accreditation shall disclose the accreditation report to any other accrediting agency to which it submits an application. The new accrediting agency shall ensure that all deficiencies have been corrected and conduct a new onsite inspection consistent with the standards specified in this chapter.

(i) If an outpatient setting's certification of accreditation has been suspended or revoked, or if the accreditation has been denied, the accreditation agency shall do all of the following:

- (1) Notify the board of the action.
- (2) Send a notification letter to the outpatient setting of the action. The notification letter shall state that the setting is no longer allowed to perform procedures that require outpatient setting accreditation.
- (3) Require the outpatient setting to remove its accreditation certification and to post the notification letter in a conspicuous location, accessible to public view.

(j) The board may take any appropriate action it deems necessary pursuant to Section 1248.7 if an outpatient setting's certification of accreditation has been suspended or revoked, or if accreditation has been denied.

SEC. 5. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 408
Author: Morrell
Chapter: 280
Bill Date: May 6, 2015, Amended
Subject: Midwife Assistants
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

SB 408 ensures that midwife assistants meet minimum training requirements and sets forth the duties that a midwife assistant could perform, which should be at the same level as duties that a medical assistant can perform, technical support services only. This bill allows the Board to adopt regulations and standards for any additional midwife technical support services.

BACKGROUND

The Board licenses Licensed Midwives (LMs). It has been brought to the attention of the Board that LMs need to use assistants. As such, this issue was raised in the Board's 2012 Sunset Review Report. Currently, there is no definition for a midwife assistant in statute, nor are there specific training requirements or duties that a midwife assistant may perform. Some LMs use other LMs as assistants, while some use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student and midwifery school to provide clinical training to the student midwife. Other LMs use someone who may or may not have formal midwifery training and/or someone that the LM has trained. The duties that a midwife assistant performs also varies greatly from LM to LM. This unregulated practice is a serious consumer protection issue and this bill would define midwife assistants and define the services they can provide. This bill is modeled after existing law related to medical assistants, which are under the supervision of a physician and surgeon (Business and Professions Code Section 2069 - 2071).

ANALYSIS

SB 408 defines a "midwife assistant" as a person, who may be unlicensed, who performs basic administrative, clerical, and midwife technical support services in accordance with existing law for a LM, is at least 18 years of age, and has had at least the minimum amount of hours of appropriate training pursuant to standards established by the Board for a medical assistant. This bill defines "midwife technical support services" as simple routine medical tasks and procedures that may be safely performed by a midwife assistant who has

limited training and who functions under the supervision of a LM or a certified nurse midwife (CNM).

This bill allows a midwife assistant to do the following:

- Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a LM or CNM.
- Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under supervision of a LM or CNM if the educational and training requirements have been met.
- Perform the following midwife technical support services:
 - Administer medications orally, sublingually, topically, or rectally, or by providing a single dose to a patient for immediate self-administration, and administer oxygen at the direction of a supervising LM or CNM. The LM or CNM must verify the correct medication and dosage before the midwife assistant administers the medication.
 - Assist in immediate newborn care when a LM or CNM is engaged in a concurrent activity that precludes the LM or CNM from doing so.
 - Assist in placement of the device used for auscultation of fetal heart tones when a LM or CNM is engaged in concurrent activity that precludes the LM or CNM from doing so.
 - Collect, by noninvasive techniques, and preserve specimens for testing, including, but not limited to, urine.
 - Assist patients to and from a patient examination room, bed, or bathroom.
 - Assist patient in activities of daily living, such as assisting with bathing or clothing.
 - As authorized by the LM or CNM, provide patient information and instructions.
 - Collect and record patient data, including height, weight, temperature, pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.
 - Perform simple laboratory and screening tests customarily performed in a medical or midwife office.
 - Perform additional midwife technical support services under regulations established by the Board.

This bill establishes training requirements in statute for midwife assistants and parameters on what services can be provided by midwife assistants, which furthers the Board's mission of consumer protection. For this reason, the Board voted to sponsor this important legislation. Amendments were taken in committee to address concerns raised by the California Medical Association and the American College of Obstetricians and Gynecologists and to add CNMs as supervisors, as requested by the CNM Association.

FISCAL: Minimal and absorbable to update regulations related to training requirements

SUPPORT: Medical Board of California (Sponsor)
American Nurses Association of California
County of Santa Cruz Board of Supervisors
Monterey County Board of Supervisors
Planned Parenthood

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General's Office, Health Quality Enforcement Section
- Hold Interested Parties Meeting regarding training requirements for midwife assistants
- Update/develop regulations to set forth the training requirements for midwife assistants, similar to what is required for medical assistants
- Update website to include information on what is required to be a midwife assistant, what duties a midwife assistant can perform and frequently asked questions. Use the medical assistant information on the Board's website as a guide for the midwife assistant information.

Senate Bill No. 408

CHAPTER 280

An act to add Section 2516.5 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 8, 2015. Filed with
Secretary of State September 8, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 408, Morrell. Midwife assistants.

The Licensed Midwifery Practice Act of 1993 provides for the licensing and regulation of midwives by the Medical Board of California. The license to practice midwifery authorizes the holder to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family planning care, for the mother, and immediate care for the newborn. The Licensed Midwifery Practice Act of 1993 requires a midwife to refer to a physician and surgeon under prescribed circumstances. A violation of the Licensed Midwifery Practice Act of 1993 is a crime.

The Nursing Practice Act provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The Nursing Practice Act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal.

This bill would authorize a midwife assistant to perform certain assistive activities under the supervision of a licensed midwife or certified nurse-midwife, including the administration of medicine, the withdrawing of blood, and midwife technical support services. The bill would define terms for these purposes. The bill would prohibit a midwife assistant from being employed for inpatient care in a licensed general acute care hospital. By adding new requirements and prohibitions to the Licensed Midwifery Practice Act of 1993, the violation of which would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 2516.5 is added to the Business and Professions Code, to read:

2516.5. (a) As used in this section, the following definitions apply:

(1) "Midwife assistant" means a person, who may be unlicensed, who performs basic administrative, clerical, and midwife technical supportive services in accordance with this chapter for a licensed midwife or certified nurse-midwife, is at least 18 years of age, and has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board for a medical assistant pursuant to Section 2069. The midwife assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. Each employer of the midwife assistant or the midwife assistant shall retain a copy of the certificate as a record.

(2) "Midwife technical supportive services" means simple routine medical tasks and procedures that may be safely performed by a midwife assistant who has limited training and who functions under the supervision of a licensed midwife or certified nurse-midwife.

(3) "Specific authorization" means a specific written order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed on a patient, which shall be placed in the patient's medical record, or a standing order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed. A notation of the standing order shall be placed in the patient's medical record.

(4) "Supervision" means the supervision of procedures authorized by this section by a licensed midwife or certified nurse-midwife, within his or her scope of practice, who is physically present on the premises during the performance of those procedures.

(b) Notwithstanding any other provision of law, a midwife assistant may do all of the following:

(1) Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a licensed midwife or certified nurse-midwife. A midwife assistant may also perform all these tasks and services in a clinic licensed in accordance with subdivision (a) of Section 1204 of the Health and Safety Code upon the specific authorization of a licensed midwife or certified nurse-midwife.

(2) Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under the supervision of a licensed midwife or certified nurse-midwife, if the midwife assistant has met the educational and training requirements for medical assistants as

established in Section 2070. Each employer of the assistant shall retain a copy of any related certificates as a record.

(3) Perform the following midwife technical support services:

(A) Administer medications orally, sublingually, topically, or rectally, or by providing a single dose to a patient for immediate self-administration, and administer oxygen at the direction of the supervising licensed midwife or certified nurse-midwife. The licensed midwife or certified nurse-midwife shall verify the correct medication and dosage before the midwife assistant administers medication.

(B) Assist in immediate newborn care when the licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(C) Assist in placement of the device used for auscultation of fetal heart tones when a licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(D) Collect by noninvasive techniques and preserve specimens for testing, including, but not limited to, urine.

(E) Assist patients to and from a patient examination room, bed, or bathroom.

(F) Assist patients in activities of daily living, such as assisting with bathing or clothing.

(G) As authorized by the licensed midwife or certified nurse-midwife, provide patient information and instructions.

(H) Collect and record patient data, including height, weight, temperature, pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.

(I) Perform simple laboratory and screening tests customarily performed in a medical or midwife office.

(4) Perform additional midwife technical support services under regulations and standards established by the board.

(c) (1) Nothing in this section shall be construed as authorizing the licensure of midwife assistants. Nothing in this section shall be construed as authorizing the administration of local anesthetic agents by a midwife assistant. Nothing in this section shall be construed as authorizing the board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(2) Nothing in this section shall be construed as authorizing a midwife assistant to perform any clinical laboratory test or examination for which he or she is not authorized under Chapter 3 (commencing with Section 1200).

(d) Notwithstanding any other law, a midwife assistant shall not be employed for inpatient care in a licensed general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because

this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 464
Author: Hernandez
Chapter: 387
Bill Date: May 22, 2015, Amended
Subject: Healing Arts: Self Reporting Tools
Sponsor: Planned Parenthood Affiliates of California
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes specified health care practitioners to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and after an appropriate examination, prescribe, furnish, or dispense self-administered hormonal contraceptives to the patient.

ANALYSIS

This bill allows a physician and surgeon, registered nurse, a certified nurse-midwife, a nurse practitioner, a physician assistant, and a pharmacist, acting within the scope of each respective license type, to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient. This bill requires an appropriate prior examination, and after that examination, the practitioner can prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. This bill allows blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool that identifies patient risk factors.

The sponsors believe that the bill will help to improve preventive health services by increasing access to services in rural communities through the utilization of telemedicine by allowing patients to provide information to a health provider through self-screening tools.

A physician can already use a self-screening tool for the purposes provided for in this bill, as long as an appropriate prior exam is performed, which this bill also requires. If telehealth is used, the existing telehealth laws would also apply. The other health care practitioners named in this bill would also have to comply with their existing laws related to prescribing and can only provide services that are within their current scope. The Board would have concerns if an appropriate prior exam was not required, but since it is, the Board took a neutral position on this bill.

FISCAL: None

SUPPORT: Planned Parenthood Affiliates of California (Sponsor); California Medical Association; California Primary Care Association; Community Action Fund of Planned Parenthood of Orange and San Bernardino Counties; Icebreaker Health; NARAL Pro-Choice California; Planned Parenthood – Los Angeles, Mar Monte, Northern California, Pacific Southwest, Pasadena, San Gabriel Valley, Santa Barbara, Ventura, and San Luis Obispo Counties; and Numerous Individuals

OPPOSITION: California Catholic Conference; California Nurses Association; and California Right to Life Committee, Inc.

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General’s Office, Health Quality Enforcement Section

Senate Bill No. 464

CHAPTER 387

An act to add Section 2242.2 to the Business and Professions Code, relating to healing arts.

[Approved by Governor September 30, 2015. Filed with
Secretary of State September 30, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 464, Hernandez. Healing arts: self-reporting tools.

The Medical Practice Act provides for licensure and regulation of physicians and surgeons by the Medical Board of California, and authorizes a physician and surgeon to, among other things, use drugs or devices in or upon human beings. The Medical Practice Act makes it unprofessional conduct for a physician and surgeon to prescribe, dispense, or furnish dangerous drugs without an appropriate prior examination and medical indication. The act prohibits, with specified exceptions, a person or entity from prescribing, dispensing, or furnishing, or causing to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices on the Internet for delivery to a person in California without an appropriate prior examination and medical indication.

The Nursing Practice Act provides for the licensure and regulation of registered nurses, including nurse practitioners and certified nurse-midwives, by the Board of Registered Nursing within the Department of Consumer Affairs. The Nursing Practice Act authorizes a registered nurse to dispense self-administered hormonal contraceptives, as specified, in accordance with standardized procedures, including demonstration of competency in providing the appropriate prior examination comprised of checking blood pressure, weight, and patient and family health history, including medications taken by the patient. The Nursing Practice Act also authorizes certified nurse-midwives and nurse practitioners to furnish or order drugs or devices, as specified.

The Physician Assistant Practice Act provides for the licensure and regulation of physician assistants by the Physician Assistant Board within the jurisdiction of the Medical Board of California, and authorizes a physician assistant to administer or provide medication to a patient or to transmit a drug order, as specified.

The Pharmacy Law provides for the licensing and regulation of pharmacists by the California State Board of Pharmacy within the Department of Consumer Affairs, and authorizes a pharmacist to furnish self-administered hormonal contraceptives in accordance with standardized procedures and protocols. The Pharmacy Law requires the standardized procedures and protocols to require a patient to use a self-screening tool

that will identify patient risk factors for the use of self-administered hormonal contraceptives, as specified.

This bill, notwithstanding any other law, would authorize a physician and surgeon, a registered nurse acting in accordance with the authority of the Nursing Practice Act, a certified nurse-midwife acting within the scope of specified existing law relating to nurse-midwives, a nurse practitioner acting within the scope of specified existing law relating to nurse practitioners, a physician assistant acting within the scope of specified existing law relating to physician assistants, or a pharmacist acting within the scope of a specified existing law relating to pharmacists to use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, to prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. The bill would authorize blood pressure, weight, height, and patient health history to be self-reported using the self-screening tool.

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

SECTION 1. Section 2242.2 is added to the Business and Professions Code, to read:

2242.2. Notwithstanding any other law, a physician and surgeon, a registered nurse acting in accordance with Section 2725.2, a certified nurse-midwife acting within the scope of Section 2746.51, a nurse practitioner acting within the scope of Section 2836.1, a physician assistant acting within the scope of Section 3502.1, and a pharmacist acting within the scope of Section 4052.3 may use a self-screening tool that will identify patient risk factors for the use of self-administered hormonal contraceptives by a patient, and, after an appropriate prior examination, prescribe, furnish, or dispense, as applicable, self-administered hormonal contraceptives to the patient. Blood pressure, weight, height, and patient health history may be self-reported using the self-screening tool that identifies patient risk factors.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 643
Author: McGuire
Chapter: 719
Bill Date: July 13, 2015, Amended
Subject: Medical Marijuana
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill is part of a package of three bills that establish a regulatory framework for the cultivation, sale, and transport of medical cannabis by the Bureau of Medical Marijuana Regulation in the Department of Consumer Affairs, the Department of Food and Agriculture, and other state entities. However, this analysis will only cover the portion of the bill related to the requirements on physicians recommending medical cannabis and the Medical Board of California (Board).

BACKGROUND:

In 1996, California voters approved the Compassionate Use Act (Proposition 215), which allowed Californians access to marijuana for medical purposes, and prohibited punitive action against physicians for making 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:

The portions of this bill that impact the Board are very similar to the provisions in AB 26 (Jones-Sawyer), AB 34 (Bonta and Jones-Sawyer), and the previous version of AB 266 (Bonta, Cooley, Jones-Sawyer, and Lackey). The three bills related to medical cannabis were re-written and now SB 643 contains the provisions related to physicians recommending medical cannabis.

This bill includes in the Board's priorities cases that allege a physician has recommended cannabis to patients for medical purposes without a good faith prior examination and medical reason therefor.

This bill now creates a new section in law related to recommending medical cannabis, which states that physicians recommending cannabis to a patient for a medical

purpose without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. This bill prohibits a physician from recommending cannabis to a patient unless that physician is the patient’s attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code (HSC). The HSC defines an “attending physician” as an individual who possesses a license in good standing to practice medicine or osteopathy issued by the Board 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. The physician also must have conducted a medical examination of that patient before recording in the patient's medical record the physician's assessment of whether the patient has a serious medical condition and whether the medical use of marijuana is appropriate.

This bill also subjects physicians recommending cannabis to the definition of “financial interest” in Business and Professions Code Section (BPC) 650.01 and does not allow a physician to accept, solicit, or offer any form of remuneration from or to a licensed dispenser, producer, or processor of cannabis products in which the licensee or his or her immediate family has a financial interest. This bill does not allow a cannabis clinic or dispensary to directly or indirectly employ physicians to provide marijuana recommendations, a violation would constitute unprofessional conduct. This bill does not allow a person to distribute any form of advertising for physician recommendations for medical cannabis unless the advertisement contains a notice to consumers, as specified.

This bill requires the Board to consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research (CMCR) on developing and adopting medical guidelines for the appropriate administration and use of cannabis.

Lastly, this bill specifies that a violation of the new section of law regulating medical cannabis recommendations is a misdemeanor and punishable by up to one year and county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars and shall constitute unprofessional conduct.

This bill gives 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. This is an important amendment because the prescribing requirements in existing law do not necessarily apply to marijuana recommendations. This bill also makes marijuana recommendation cases a priority of the Board, which will help to ensure consumer protection. Lastly, this bill prohibits physicians from being employed by cannabis clinics or dispensaries, which will help to ensure that physicians are not making marijuana recommendations for financial or employment reasons.

FISCAL: Minimal and absorbable fiscal impact to the Board

SUPPORT: California Association of Code Enforcement Officers;
California College & University Police Chiefs Association;

California League of Conservation Voters; California Native Plant Society; California Police Chiefs Association; California State Association of Counties; California State Parks Foundation; California Teamsters Public Affairs Council; California Trout; California Urban Streams Partnership; Clean Water Action; Defenders of Wildlife; League of California Cities; Pacific Forest Trust; Rural County Representatives of California; Trout Unlimited; The Nature Conservancy; The Trust for Public Land; UFCW Western States Council; and Urban Counties Caucus

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s) and a stand-alone article on the new requirements for recommending medical cannabis
- Notify/train Board staff and Department of Consumer Affairs, Division of Investigation staff and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's current statement on recommending marijuana and consult and solicit input from the CMCR on needed revisions
- Update the Board's website with the revised statement and the new requirements for recommending medical cannabis

Senate Bill No. 643

CHAPTER 719

An act to amend Sections 144, 2220.05, 2241.5, and 2242.1 of, to add Sections 19302.1, 19319, 19320, 19322, 19323, 19324, and 19325 to, to add Article 25 (commencing with Section 2525) to Chapter 5 of Division 2 of, and to add Article 6 (commencing with Section 19331), Article 7.5 (commencing with Section 19335), Article 8 (commencing with Section 19337), and Article 11 (commencing with Section 19348) to Chapter 3.5 of Division 8 of, the Business and Professions Code, relating to medical marijuana.

[Approved by Governor October 9, 2015. Filed with
Secretary of State October 9, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 643, McGuire. Medical marijuana.

(1) Existing law, the Compassionate Use Act of 1996, an initiative measure enacted by the approval of Proposition 215 at the November 6, 1996, statewide general election, authorizes the use of marijuana for medical purposes. Existing law enacted by the Legislature requires the establishment of a program for the issuance of identification cards to qualified patients so that they may lawfully use marijuana for medical purposes, and requires the establishment of guidelines for the lawful cultivation of marijuana grown for medical use. Existing law provides for the licensure of various professions by the Department of Consumer Affairs. Existing law, the Sherman Food, Drug, and Cosmetic Law, provides for the regulation of food, drugs, devices, and cosmetics, as specified. A violation of that law is a crime.

This bill would, among other things, set forth standards for a physician and surgeon prescribing medical cannabis and require the Medical Board of California to prioritize its investigative and prosecutorial resources to identify and discipline physicians and surgeons that have repeatedly recommended excessive cannabis to patients for medical purposes or repeatedly recommended cannabis to patients for medical purposes without a good faith examination, as specified. The bill would require the Bureau of Medical Marijuana to require an applicant to furnish a full set of fingerprints for the purposes of conducting criminal history record checks. The bill would prohibit a physician and surgeon who recommends cannabis to a patient for a medical purpose from accepting, soliciting, or offering any form of remuneration from a facility licensed under the Medical Marijuana Regulation and Safety Act. The bill would make a violation of this prohibition a misdemeanor, and by creating a new crime, this bill would impose a state-mandated local program.

This bill would require the Governor, under the Medical Marijuana Regulation and Safety Act, to appoint, subject to confirmation by the Senate, a chief of the Bureau of Medical Marijuana Regulation. The act would require the Department of Consumer Affairs to have the sole authority to create, issue, renew, discipline, suspend, or revoke licenses for the transportation and storage, unrelated to manufacturing, of medical marijuana, and would authorize the department to collect fees for its regulatory activities and impose specified duties on this department in this regard. The act would require the Department of Food and Agriculture to administer the provisions of the act related to, and associated with, the cultivation, and transportation of, medical cannabis and would impose specified duties on this department in this regard. The act would require the State Department of Public Health to administer the provisions of the act related to, and associated with, the manufacturing and testing of medical cannabis and would impose specified duties on this department in this regard.

This bill would authorize counties to impose a tax upon specified cannabis-related activity.

This bill would require an applicant for a state license pursuant to the act to provide a statement signed by the applicant under penalty of perjury, thereby changing the scope of a crime and imposing a state-mandated local program.

This bill would set forth standards for the licensed cultivation of medical cannabis, including, but not limited to, establishing duties relating to the environmental impact of cannabis and cannabis products. The bill would also establish state cultivator license types, as specified.

(2) This bill would provide that its provisions are severable.

(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 with regard to certain mandates no reimbursement is required by this act for a specified reason.

With regard to any other mandates, this bill would provide that, if the Commission on State Mandates determines that the bill contains costs so mandated by the state, reimbursement for those costs shall be made pursuant to the statutory provisions noted above.

(4) Existing constitutional provisions require that a statute that limits the right of access to the meeting of public bodies or the writings of public bodies or the writings of public officials and agencies be adopted with finding demonstrating the interest protected by the limitation and the need for protecting that interest. The bill would make legislative findings to that effect.

(5) The bill would become operative only if AB 266 and AB 243 of the 2015–16 Regular Session are enacted and take effect on or before January 1, 2016.

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

SECTION 1. Section 144 of the Business and Professions Code is amended to read:

144. (a) Notwithstanding any other provision of law, an agency designated in subdivision (b) shall require an applicant to furnish to the agency a full set of fingerprints for purposes of conducting criminal history record checks. Any agency designated in subdivision (b) may obtain and receive, at its discretion, criminal history information from the Department of Justice and the United States Federal Bureau of Investigation.

(b) Subdivision (a) applies to the following:

- (1) California Board of Accountancy.
- (2) State Athletic Commission.
- (3) Board of Behavioral Sciences.
- (4) Court Reporters Board of California.
- (5) State Board of Guide Dogs for the Blind.
- (6) California State Board of Pharmacy.
- (7) Board of Registered Nursing.
- (8) Veterinary Medical Board.
- (9) Board of Vocational Nursing and Psychiatric Technicians.
- (10) Respiratory Care Board of California.
- (11) Physical Therapy Board of California.
- (12) Physician Assistant Committee of the Medical Board of California.
- (13) Speech-Language Pathology and Audiology and Hearing Aid Dispenser Board.
- (14) Medical Board of California.
- (15) State Board of Optometry.
- (16) Acupuncture Board.
- (17) Cemetery and Funeral Bureau.
- (18) Bureau of Security and Investigative Services.
- (19) Division of Investigation.
- (20) Board of Psychology.
- (21) California Board of Occupational Therapy.
- (22) Structural Pest Control Board.
- (23) Contractors' State License Board.
- (24) Naturopathic Medicine Committee.
- (25) Professional Fiduciaries Bureau.
- (26) Board for Professional Engineers, Land Surveyors, and Geologists.
- (27) Bureau of Medical Marijuana Regulation.

(c) For purposes of paragraph (26) of subdivision (b), the term "applicant" shall be limited to an initial applicant who has never been registered or licensed by the board or to an applicant for a new licensure or registration category.

SEC. 2. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its

investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances 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) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 3. Section 2241.5 of the Business and Professions Code is amended to read:

2241.5. (a) A physician and surgeon may prescribe for, or dispense or administer to, a person under his or her treatment for a medical condition dangerous drugs or prescription controlled substances for the treatment of pain or a condition causing pain, including, but not limited to, intractable pain.

(b) No physician and surgeon shall be subject to disciplinary action for prescribing, dispensing, or administering dangerous drugs or prescription controlled substances in accordance with this section.

(c) This section shall not affect the power of the board to take any action described in Section 2227 against a physician and surgeon who does any of the following:

(1) Violates subdivision (b), (c), or (d) of Section 2234 regarding gross negligence, repeated negligent acts, or incompetence.

(2) Violates Section 2241 regarding treatment of an addict.

(3) Violates Section 2242 or 2525.3 regarding performing an appropriate prior examination and the existence of a medical indication for prescribing, dispensing, or furnishing dangerous drugs or recommending medical cannabis.

(4) Violates Section 2242.1 regarding prescribing on the Internet.

(5) Fails to keep complete and accurate records of purchases and disposals of substances listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) or controlled substances scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970 (21 U.S.C. Sec. 801 et seq.), or pursuant to the federal Comprehensive Drug Abuse Prevention and Control Act of 1970. A physician and surgeon shall keep records of his or her purchases and disposals of these controlled substances or dangerous drugs, including the date of purchase, the date and records of the sale or disposal of the drugs by the physician and surgeon, the name and address of the person receiving the drugs, and the reason for the disposal or the dispensing of the drugs to the person, and shall otherwise comply with all state recordkeeping requirements for controlled substances.

(6) Writes false or fictitious prescriptions for controlled substances listed in the California Uniform Controlled Substances Act or scheduled in the federal Comprehensive Drug Abuse Prevention and Control Act of 1970.

(7) Prescribes, administers, or dispenses in violation of this chapter, or in violation of Chapter 4 (commencing with Section 11150) or Chapter 5 (commencing with Section 11210) of Division 10 of the Health and Safety Code.

(d) A physician and surgeon shall exercise reasonable care in determining whether a particular patient or condition, or the complexity of a patient's treatment, including, but not limited to, a current or recent pattern of drug abuse, requires consultation with, or referral to, a more qualified specialist.

(e) Nothing in this section shall prohibit the governing body of a hospital from taking disciplinary actions against a physician and surgeon pursuant to Sections 809.05, 809.4, and 809.5.

SEC. 4. Section 2242.1 of the Business and Professions Code is amended to read:

2242.1. (a) No person or entity may prescribe, dispense, or furnish, or cause to be prescribed, dispensed, or furnished, dangerous drugs or dangerous devices, as defined in Section 4022, on the Internet for delivery to any person in this state, without an appropriate prior examination and medical indication, except as authorized by Section 2242.

(b) Notwithstanding any other provision of law, a violation of this section may subject the person or entity that has committed the violation to either

a fine of up to twenty-five thousand dollars (\$25,000) per occurrence pursuant to a citation issued by the board or a civil penalty of twenty-five thousand dollars (\$25,000) per occurrence.

(c) The Attorney General may bring an action to enforce this section and to collect the fines or civil penalties authorized by subdivision (b).

(d) For notifications made on and after January 1, 2002, the Franchise Tax Board, upon notification by the Attorney General or the board of a final judgment in an action brought under this section, shall subtract the amount of the fine or awarded civil penalties from any tax refunds or lottery winnings due to the person who is a defendant in the action using the offset authority under Section 12419.5 of the Government Code, as delegated by the Controller, and the processes as established by the Franchise Tax Board for this purpose. That amount shall be forwarded to the board for deposit in the Contingent Fund of the Medical Board of California.

(e) If the person or entity that is the subject of an action brought pursuant to this section is not a resident of this state, a violation of this section shall, if applicable, be reported to the person's or entity's appropriate professional licensing authority.

(f) Nothing in this section shall prohibit the board from commencing a disciplinary action against a physician and surgeon pursuant to Section 2242 or 2525.3.

SEC. 5. Article 25 (commencing with Section 2525) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 25. Recommending Medical Cannabis

2525. (a) It is unlawful for a physician and surgeon who recommends cannabis to a patient for a medical purpose to accept, solicit, or offer any form of remuneration from or to a facility issued a state license pursuant to Chapter 3.5 (commencing with Section 19300) of Division 8, if the physician and surgeon or his or her immediate family have a financial interest in that facility.

(b) For the purposes of this section, "financial interest" shall have the same meaning as in Section 650.01.

(c) A violation of this section shall be a misdemeanor punishable by up to one year in county jail and a fine of up to five thousand dollars (\$5,000) or by civil penalties of up to five thousand dollars (\$5,000) and shall constitute unprofessional conduct.

2525.1. The Medical Board of California shall consult with the California Marijuana Research Program, known as the Center for Medicinal Cannabis Research, authorized pursuant to Section 11362.9 of the Health and Safety Code, on developing and adopting medical guidelines for the appropriate administration and use of medical cannabis.

2525.2. 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 shall not recommend medical

cannabis to a patient, unless that person is the patient’s attending physician, as defined by subdivision (a) of Section 11362.7 of the Health and Safety Code.

2525.3. Recommending medical cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication constitutes unprofessional conduct.

2525.4. It is unprofessional conduct for any attending physician recommending medical cannabis to be employed by, or enter into any other agreement with, any person or entity dispensing medical cannabis.

2525.5. (a) A person shall not distribute any form of advertising for physician recommendations for medical cannabis in California unless the advertisement bears the following notice to consumers:

NOTICE TO CONSUMERS: The Compassionate Use Act of 1996 ensures that seriously ill Californians have the right to obtain and use cannabis for medical purposes where medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of medical cannabis. Recommendations must come from an attending physician as defined in Section 11362.7 of the Health and Safety Code. Cannabis is a Schedule I drug according to the federal Controlled Substances Act. Activity related to cannabis use is subject to federal prosecution, regardless of the protections provided by state law.

(b) Advertising for attending physician recommendations for medical cannabis shall meet all of the requirements in Section 651. Price advertising shall not be fraudulent, deceitful, or misleading, including statements or advertisements of bait, discounts, premiums, gifts, or statements of a similar nature.

SEC. 6. Section 19302.1 is added to the Business and Professions Code, to read:

19302.1. (a) The Governor shall appoint a chief of the bureau, subject to confirmation by the Senate, at a salary to be fixed and determined by the director with the approval of the Director of Finance. The chief shall serve under the direction and supervision of the director and at the pleasure of the Governor.

(b) Every power granted to or duty imposed upon the director under this chapter may be exercised or performed in the name of the director by a deputy or assistant director or by the chief, subject to conditions and limitations that the director may prescribe. In addition to every power granted or duty imposed with this chapter, the director shall have all other powers and duties generally applicable in relation to bureaus that are part of the Department of Consumer Affairs.

(c) The director may employ and appoint all employees necessary to properly administer the work of the bureau, in accordance with civil service laws and regulations.

(d) The Department of Consumer Affairs shall have the sole authority to create, issue, renew, discipline, suspend, or revoke licenses for the

transportation, storage unrelated to manufacturing activities, distribution, and sale of medical marijuana within the state and to collect fees in connection with activities the bureau regulates. The bureau may create licenses in addition to those identified in this chapter that the bureau deems necessary to effectuate its duties under this chapter.

(e) The Department of Food and Agriculture shall administer the provisions of this chapter related to and associated with the cultivation of medical cannabis. The Department of Food and Agriculture shall have the authority to create, issue, and suspend or revoke cultivation licenses for violations of this chapter. The State Department of Public Health shall administer the provisions of this chapter related to and associated with the manufacturing and testing of medical cannabis.

SEC. 7. Section 19319 is added to the Business and Professions Code, to read:

19319. (a) A qualified patient, as defined in Section 11362.7 of the Health and Safety Code, who cultivates, possesses, stores, manufactures, or transports cannabis exclusively for his or her personal medical use but who does not provide, donate, sell, or distribute cannabis to any other person is not thereby engaged in commercial cannabis activity and is therefore exempt from the licensure requirements of this chapter.

(b) A primary caregiver who cultivates, possesses, stores, manufactures, transports, donates, or provides cannabis exclusively for the personal medical purposes of no more than five specified qualified patients for whom he or she is the primary caregiver within the meaning of Section 11362.7 of the Health and Safety Code, but 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 exempt from the licensure requirements of this chapter.

SEC. 8. Section 19320 is added to the Business and Professions Code, to read:

19320. (a) Licensing authorities administering this chapter may issue state licenses only to qualified applicants engaging in commercial cannabis activity pursuant to this chapter. Upon the date of implementation of regulations by the licensing authority, no person shall engage in commercial cannabis activity without possessing both a state license and a local permit, license, or other authorization. A licensee shall not commence activity under the authority of a state license until the applicant has obtained, in addition to the state license, a license or permit from the local jurisdiction in which he or she proposes to operate, following the requirements of the applicable local ordinance.

(b) Revocation of a local license, permit, or other authorization shall terminate the ability of a medical cannabis business to operate within that local jurisdiction until the local jurisdiction reinstates or reissues the local license, permit, or other required authorization. Local authorities shall notify the bureau upon revocation of a local license. The bureau shall inform relevant licensing authorities.

(c) Revocation of a state license shall terminate the ability of a medical cannabis licensee to operate within California until the licensing authority reinstates or reissues the state license. Each licensee shall obtain a separate license for each location where it engages in commercial medical cannabis activity. However, transporters only need to obtain licenses for each physical location where the licensee conducts business while not in transport, or any equipment that is not currently transporting medical cannabis or medical cannabis products, permanently resides.

(d) In addition to the provisions of this chapter, local jurisdictions retain the power to assess fees and taxes, as applicable, on facilities that are licensed pursuant to this chapter and the business activities of those licensees.

(e) Nothing in this chapter shall be construed to supersede or limit state agencies, including the State Water Resources Control Board and Department of Fish and Wildlife, from establishing fees to support their medical cannabis regulatory programs.

SEC. 9. Section 19322 is added to the Business and Professions Code, to read:

19322. (a) A person or entity shall not submit an application for a state license issued by the department pursuant to this chapter unless that person or entity has received a license, permit, or authorization by a local jurisdiction. An applicant for any type of state license issued pursuant to this chapter shall do all of the following:

(1) Electronically submit to the Department of Justice fingerprint images and related information required by the Department of Justice for the purpose of obtaining information as to the existence and content of a record of state or federal convictions and arrests, and information as to the existence and content of a record of state or federal convictions and arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance, pending trial or appeal.

(A) The Department of Justice shall provide a response to the licensing authority pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(B) The licensing authority shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for applicants.

(C) The Department of Justice shall charge the applicant a fee sufficient to cover the reasonable cost of processing the requests described in this paragraph.

(2) Provide documentation issued by the local jurisdiction in which the proposed business is operating certifying that the applicant is or will be in compliance with all local ordinances and regulations.

(3) Provide evidence of the legal right to occupy and use the proposed location. For an applicant seeking a cultivator, distributor, manufacturing, or dispensary license, provide a statement from the owner of real property or their agent where the cultivation, distribution, manufacturing, or dispensing commercial medical cannabis activities will occur, as proof to demonstrate the landowner has acknowledged and consented to permit

cultivation, distribution, manufacturing, or dispensary activities to be conducted on the property by the tenant applicant.

(4) If the application is for a cultivator or a dispensary, provide evidence that the proposed location is located beyond at least a 600-foot radius from a school, as required by Section 11362.768 of the Health and Safety Code.

(5) Provide a statement, signed by the applicant under penalty of perjury, that the information provided is complete, true, and accurate.

(6) (A) For an applicant with 20 or more employees, provide a statement that the applicant will enter into, or demonstrate that it has already entered into, and abide by the terms of a labor peace agreement.

(B) For the purposes of this paragraph, “employee” does not include a supervisor.

(C) For purposes of this paragraph, “supervisor” means an individual having authority, in the interest of the licensee, to hire, transfer, suspend, lay off, recall, promote, discharge, assign, reward, or discipline other employees, or responsibility to direct them or to adjust their grievances, or effectively to recommend such action, if, in connection with the foregoing, the exercise of that authority is not of a merely routine or clerical nature, but requires the use of independent judgment.

(7) Provide the applicant’s seller’s permit number issued pursuant to Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code or indicate that the applicant is currently applying for a seller’s permit.

(8) Provide any other information required by the licensing authority.

(9) For an applicant seeking a cultivation license, provide a statement declaring the applicant is an “agricultural employer,” as defined in the Alatorre-Zenovich-Dunlap-Berman Agricultural Labor Relations Act of 1975 (Part 3.5 (commencing with Section 1140) of Division 2 of the Labor Code), to the extent not prohibited by law.

(10) For an applicant seeking licensure as a testing laboratory, register with the State Department of Public Health and provide any information required by the State Department of Public Health.

(11) Pay all applicable fees required for licensure by the licensing authority.

(b) For applicants seeking licensure to cultivate, distribute, or manufacture medical cannabis, the application shall also include a detailed description of the applicant’s operating procedures for all of the following, as required by the licensing authority:

(1) Cultivation.

(2) Extraction and infusion methods.

(3) The transportation process.

(4) Inventory procedures.

(5) Quality control procedures.

SEC. 10. Section 19323 is added to the Business and Professions Code, to read:

19323. (a) The licensing authority shall deny an application if either the applicant or the premises for which a state license is applied do not qualify for licensure under this chapter.

(b) The licensing authority may deny the application for licensure or renewal of a state license if any of the following conditions apply:

(1) Failure to comply with the provisions of this chapter or any rule or regulation adopted pursuant to this chapter, including but not limited to, any requirement imposed to protect natural resources, instream flow, and water quality pursuant to subdivision (a) of Section 19332.

(2) Conduct that constitutes grounds for denial of licensure pursuant to Chapter 2 (commencing with Section 480) of Division 1.5.

(3) A local agency has notified the licensing authority that a licensee or applicant within its jurisdiction is in violation of state rules and regulation relating to commercial cannabis activities, and the licensing authority, through an investigation, has determined that the violation is grounds for termination or revocation of the license. The licensing authority shall have the authority to collect reasonable costs, as determined by the licensing authority, for investigation from the licensee or applicant.

(4) The applicant has failed to provide information required by the licensing authority.

(5) The applicant or licensee has been convicted of an offense that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, except that if the licensing authority determines that the applicant or licensee is otherwise suitable to be issued a license and granting the license would not compromise public safety, the licensing authority shall conduct a thorough review of the nature of the crime, conviction, circumstances, and evidence of rehabilitation of the applicant, and shall evaluate the suitability of the applicant or licensee to be issued a license based on the evidence found through the review. In determining which offenses are substantially related to the qualifications, functions, or duties of the business or profession for which the application is made, the licensing authority shall include, but not be limited to, the following:

(A) A felony conviction for the illegal possession for sale, sale, manufacture, transportation, or cultivation of a controlled substance.

(B) A violent felony conviction, as specified in subdivision (c) of Section 667.5 of the Penal Code.

(C) A serious felony conviction, as specified in subdivision (c) of Section 1192.7 of the Penal Code.

(D) A felony conviction involving fraud, deceit, or embezzlement.

(6) The applicant, or any of its officers, directors, or owners, is a licensed physician making patient recommendations for medical cannabis pursuant to Section 11362.7 of the Health and Safety Code.

(7) The applicant or any of its officers, directors, or owners has been subject to fines or penalties for cultivation or production of a controlled substance on public or private lands pursuant to Section 12025 or 12025.1 of the Fish and Game Code.

(8) The applicant, or any of its officers, directors, or owners, has been sanctioned by a licensing authority or a city, county, or city and county for unlicensed commercial medical cannabis activities or has had a license revoked under this chapter in the three years immediately preceding the date the application is filed with the licensing authority.

(9) Failure to obtain and maintain a valid seller's permit required pursuant to Part 1 (commencing with Section 6001) of Division 2 of the Revenue and Taxation Code.

SEC. 11. Section 19324 is added to the Business and Professions Code, to read:

19324. Upon the denial of any application for a license, the licensing authority shall notify the applicant in writing. Within 30 days of service of the notice, the applicant may file a written petition for a license with the licensing authority. Upon receipt of a timely filed petition, the licensing authority shall set the petition for hearing. The hearing shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the director of each licensing authority shall have all the powers granted therein.

SEC. 12. Section 19325 is added to the Business and Professions Code, to read:

19325. An applicant shall not be denied a state license if the denial is based solely on any of the following:

(a) A conviction or act that is substantially related to the qualifications, functions, or duties of the business or profession for which the application is made for which the applicant or licensee has obtained a certificate of rehabilitation pursuant to Chapter 3.5 (commencing with Section 4852.01) of Title 6 of Part 3 of the Penal Code.

(b) A conviction that was subsequently dismissed pursuant to Section 1203.4, 1203.4a, or 1203.41 of the Penal Code.

SEC. 13. Article 6 (commencing with Section 19331) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 6. Licensed Cultivation Sites

19331. The Legislature finds and declares all of the following:

(a) The United States Environmental Protection Agency has not established appropriate pesticide tolerances for, or permitted the registration and lawful use of, pesticides on cannabis crops intended for human consumption pursuant to the Federal Insecticide, Fungicide, and Rodenticide Act (7 U.S.C. 136 et seq.).

(b) The use of pesticides is not adequately regulated due to the omissions in federal law, and cannabis cultivated in California for California patients can and often does contain pesticide residues.

(c) Lawful California medical cannabis growers and caregivers urge the Department of Pesticide Regulation to provide guidance, in absence of federal guidance, on whether the pesticides currently used at most cannabis

cultivation sites are actually safe for use on cannabis intended for human consumption.

19332. (a) The Department of Food and Agriculture shall promulgate regulations governing the licensing of indoor and outdoor cultivation sites.

(b) The Department of Pesticide Regulation, in consultation with the Department of Food and Agriculture, shall develop standards for the use of pesticides in cultivation, and maximum tolerances for pesticides and other foreign object residue in harvested cannabis.

(c) The State Department of Public Health shall develop standards for the production and labeling of all edible medical cannabis products.

(d) The Department of Food and Agriculture, in consultation with the Department of Fish and Wildlife and the State Water Resources Control Board, shall ensure that individual and cumulative effects of water diversion and discharge associated with cultivation do not affect the instream flows needed for fish spawning, migration, and rearing, and the flows needed to maintain natural flow variability.

(e) The Department of Food and Agriculture shall have the authority necessary for the implementation of the regulations it adopts pursuant to this chapter. The regulations shall do all of the following:

(1) Provide that weighing or measuring devices used in connection with the sale or distribution of medical cannabis are required to meet standards equivalent to Division 5 (commencing with Section 12001).

(2) Require that cannabis cultivation by licensees is conducted in accordance with state and local laws related to land conversion, grading, electricity usage, water usage, agricultural discharges, and similar matters. Nothing in this chapter, and no regulation adopted by the department, shall be construed to supersede or limit the authority of the State Water Resources Control Board, regional water quality control boards, or the Department of Fish and Wildlife to implement and enforce their statutory obligations or to adopt regulations to protect water quality, water supply, and natural resources.

(3) Establish procedures for the issuance and revocation of unique identifiers for activities associated with a cannabis cultivation license, pursuant to Article 8 (commencing with Section 19337). All cannabis shall be labeled with the unique identifier issued by the Department of Food and Agriculture.

(4) Prescribe standards, in consultation with the bureau, for the reporting of information as necessary related to unique identifiers, pursuant to Article 8 (commencing with Section 19337).

(f) The Department of Pesticide Regulation, in consultation with the State Water Resources Control Board, shall promulgate regulations that require that the application of pesticides or other pest control in connection with the indoor or outdoor cultivation of medical cannabis meets standards equivalent to Division 6 (commencing with Section 11401) of the Food and Agricultural Code and its implementing regulations.

(g) State cultivator license types issued by the Department of Food and Agriculture include:

(1) Type 1, or “specialty outdoor,” for outdoor cultivation using no artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises, or up to 50 mature plants on noncontiguous plots.

(2) Type 1A, or “specialty indoor,” for indoor cultivation using exclusively artificial lighting of less than or equal to 5,000 square feet of total canopy size on one premises.

(3) Type 1B, or “specialty mixed-light,” for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, of less than or equal to 5,000 square feet of total canopy size on one premises.

(4) Type 2, or “small outdoor,” for outdoor cultivation using no artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(5) Type 2A, or “small indoor,” for indoor cultivation using exclusively artificial lighting between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(6) Type 2B, or “small mixed-light,” for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 5,001 and 10,000 square feet, inclusive, of total canopy size on one premises.

(7) Type 3, or “outdoor,” for outdoor cultivation using no artificial lighting from 10,001 square feet to one acre, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(8) Type 3A, or “indoor,” for indoor cultivation using exclusively artificial lighting between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(9) Type 3B, or “mixed-light,” for cultivation using a combination of natural and supplemental artificial lighting at a maximum threshold to be determined by the licensing authority, between 10,001 and 22,000 square feet, inclusive, of total canopy size on one premises. The Department of Food and Agriculture shall limit the number of licenses allowed of this type.

(10) Type 4, or “nursery,” for cultivation of medical cannabis solely as a nursery. Type 4 licensees may transport live plants.

19332.5. (a) Not later than January 1, 2020, the Department of Food and Agriculture in conjunction with the bureau, shall make available a certified organic designation and organic certification program for medical marijuana, if permitted under federal law and the National Organic Program (Section 6517 of the federal Organic Foods Production Act of 1990 (7 U.S.C. Sec. 6501 et seq.)), and Article 7 (commencing with Section 110810) of Chapter 5 of Part 5 of Division 104 of the Health and Safety Code.

(b) The bureau may establish appellations of origin for marijuana grown in California.

(c) It is unlawful for medical marijuana to be marketed, labeled, or sold as grown in a California county when the medical marijuana was not grown in that county.

(d) It is unlawful to use the name of a California county in the labeling, marketing, or packaging of medical marijuana products unless the product was grown in that county.

19333. An employee engaged in commercial cannabis cultivation activity shall be subject to Wage Order 4-2001 of the Industrial Welfare Commission.

SEC. 14. Article 7.5 (commencing with Section 19335) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 7.5. Unique Identifier and Track and Trace Program

19335. (a) The Department of Food and Agriculture, in consultation with the bureau, shall establish a track and trace program for reporting the movement of medical marijuana items throughout the distribution chain that utilizes a unique identifier pursuant to Section 11362.777 of the Health and Safety Code and secure packaging and is capable of providing information that captures, at a minimum, all of the following:

(1) The licensee receiving the product.

(2) The transaction date.

(3) The cultivator from which the product originates, including the associated unique identifier, pursuant to Section 11362.777 of the Health and Safety Code.

(b) (1) The Department of Food and Agriculture shall create an electronic database containing the electronic shipping manifests which shall include, but not be limited to, the following information:

(A) The quantity, or weight, and variety of products shipped.

(B) The estimated times of departure and arrival.

(C) The quantity, or weight, and variety of products received.

(D) The actual time of departure and arrival.

(E) A categorization of the product.

(F) The license number and the unique identifier pursuant to Section 11362.777 of the Health and Safety Code issued by the licensing authority for all licensees involved in the shipping process, including cultivators, transporters, distributors, and dispensaries.

(2) (A) The database shall be designed to flag irregularities for all licensing authorities in this chapter to investigate. All licensing authorities pursuant to this chapter may access the database and share information related to licensees under this chapter, including social security and individual taxpayer identifications notwithstanding Section 30.

(B) The Department of Food and Agriculture shall immediately inform the bureau upon the finding of an irregularity or suspicious finding related to a licensee, applicant, or commercial cannabis activity for investigatory purposes.

(3) Licensing authorities and state and local agencies may, at any time, inspect shipments and request documentation for current inventory.

(4) The bureau shall have 24-hour access to the electronic database administered by the Department of Food and Agriculture.

(5) The Department of Food and Agriculture shall be authorized to enter into memoranda of understandings with licensing authorities for data sharing purposes, as deemed necessary by the Department of Food and Agriculture.

(6) Information received and contained in records kept by the Department of Food and Agriculture or licensing authorities for the purposes of administering this section are confidential and shall not be disclosed pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code), except as necessary for authorized employees of the State of California or any city, county, or city and county to perform official duties pursuant to this chapter or a local ordinance.

(7) Upon the request of a state or local law enforcement agency, licensing authorities shall allow access to or provide information contained within the database to assist law enforcement in their duties and responsibilities pursuant to this chapter.

19336. (a) Chapter 4 (commencing with Section 55121) of Part 30 of Division 2 of the Revenue and Taxation Code shall apply with respect to the bureau's collection of the fees, civil fines, and penalties imposed pursuant to this chapter.

(b) Chapter 8 (commencing with Section 55381) of Part 30 of Division 2 of the Revenue and Taxation Code shall apply with respect to the disclosure of information under this chapter.

SEC. 15. Article 8 (commencing with Section 19337) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 8. Licensed Transporters

19337. (a) A licensee authorized to transport medical cannabis and medical cannabis products between licenses shall do so only as set forth in this chapter.

(b) Prior to transporting medical cannabis or medical cannabis products, a licensed transporter of medical cannabis or medical cannabis products shall do both of the following:

(1) Complete an electronic shipping manifest as prescribed by the licensing authority. The shipping manifest must include the unique identifier, pursuant to Section 11362.777 of the Health and Safety Code, issued by the Department of Food and Agriculture for the original cannabis product.

(2) Securely transmit the manifest to the bureau and the licensee that will receive the medical cannabis product. The bureau shall inform the Department of Food and Agriculture of information pertaining to commercial cannabis activity for the purpose of the track and trace program identified in Section 19335.

(c) During transportation, the licensed transporter shall maintain a physical copy of the shipping manifest and make it available upon request to agents of the Department of Consumer Affairs and law enforcement officers.

(d) The licensee receiving the shipment shall maintain each electronic shipping manifest and shall make it available upon request to the Department of Consumer Affairs and any law enforcement officers.

(e) Upon receipt of the transported shipment, the licensee receiving the shipment shall submit to the licensing agency a record verifying receipt of the shipment and the details of the shipment.

(f) Transporting, or arranging for or facilitating the transport of, medical cannabis or medical cannabis products in violation of this chapter is grounds for disciplinary action against the license.

19338. (a) This chapter shall not be construed to authorize or permit a licensee to transport or cause to be transported cannabis or cannabis products outside the state, unless authorized by federal law.

(b) A local jurisdiction shall not prevent transportation of medical cannabis or medical cannabis products on public roads by a licensee transporting medical cannabis or medical cannabis products in compliance with this chapter.

SEC. 16. Article 11 (commencing with Section 19348) is added to Chapter 3.5 of Division 8 of the Business and Professions Code, to read:

Article 11. Taxation

19348. (a) (1) A county may impose a tax on the privilege of cultivating, dispensing, producing, processing, preparing, storing, providing, donating, selling, or distributing medical cannabis or medical cannabis products by a licensee operating pursuant to this chapter.

(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, if necessary, and the manner of collection of the tax. The tax may be imposed for general governmental purposes or for purposes specified in the ordinance by the board of supervisors.

(3) In addition to any other method of collection authorized by law, the board of supervisors may provide for the 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. A tax imposed pursuant to this section is a tax and not a fee or special assessment. The board of supervisors shall specify whether the tax applies throughout the entire county or within the unincorporated area of the county.

(4) The tax authorized by this section may be imposed upon any or all of the activities set forth in paragraph (1), as specified in the ordinance, regardless of whether the activity is undertaken individually, collectively, or cooperatively, and regardless of whether the activity is for compensation or gratuitous, as determined by the board of supervisors.

(b) A tax imposed pursuant to this section shall be subject to applicable voter approval requirements imposed by law.

(c) This section is declaratory of existing law and does not limit or prohibit the levy or collection of any other fee, charge, or tax, or a 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 a county as provided by law.

(d) This section shall not be construed to authorize a county to impose a sales or use tax in addition to the sales and use tax imposed under an ordinance conforming to the provisions of Sections 7202 and 7203 of the Revenue and Taxation Code.

SEC. 17. 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. 18. The Legislature finds and declares that Section 14 of this act, which adds Section 19335 to the Business and Professions Code, thereby imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitation imposed under this act is necessary for purposes of compliance with the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 1320d et seq.), the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code), and the Insurance Information and Privacy Protection Act (Article 6.6 (commencing with Section 791) of Part 2 of Division 1 of the Insurance Code).

SEC. 19. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution for certain costs that may be incurred by a local agency or school district because, in that regard, 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.

However, if the Commission on State Mandates determines that this act contains other costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

SEC. 20. This act shall become operative only if Assembly Bill 266 and Assembly Bill 243 of the 2015–16 Session are enacted and take effect on or before January 1, 2016.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 738
Author: Huff
Chapter: 132
Bill Date: May 13, 2015, Amended
Subject: Pupil Health: Epinephrine Auto-Injectors: Liability Limitation
Sponsor: California Society for Allergy, Asthma and Immunology (CSAAI)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill provides liability protection for physicians writing standing order prescriptions for epinephrine auto-injectors for school districts, county offices of education, and charter schools.

BACKGROUND

SB 1266 (Huff, Chapter 321, Statutes of 2014) was signed into law last year. This bill requires school districts, county offices of education (COE), and charter schools to provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered, as specified. This bill authorizes school nurses or trained personnel to use the epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. Epinephrine is the first line of treatment for someone who is experiencing anaphylaxis, a potential lethal allergic reaction. Epinephrine is easily administered and has very little side effect.

According to the author's office, once SB 1266 took effect, many physicians began raising questions about issuing the prescription due to liability concerns. Physicians have concerns with issuing standing orders to the school, and have requested liability coverage in law, similar to what is in place for Automated External Defibrillators (AEDs) and opioid antagonists (Naloxone). In addition, recent data from the California School Nurse Organization shows that many schools cannot implement SB 1266 because they cannot obtain the necessary prescription.

ANALYSIS

This bill states that an authorizing physician and surgeon shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the issuance of a prescription or order pursuant to existing law related to epinephrine auto injectors, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct.

The Board has supported bills in the past that provide this type of liability protection for physicians, including AB 635 (Ammiano) in 2013. The Board took a support position on this bill because it will help school districts obtain standing order prescriptions, so they can benefit from SB 1266 from last year.

FISCAL: None to the Board

SUPPORT: CSAAI (Sponsor); Advocacy Council – American College of Allergy, Asthma and Immunology; American Academy of Allergy, Asthma and Immunology; American College of Allergy, Asthma and Immunology; Association of Regional Centers Agencies; California Chapter of the American College of Emergency Physicians; California School Nurses Organization; Civil Justice Association of California; Los Angeles Unified School District; Medical Board of California; Rady Children’s Specialists of San Diego; Sanofi; Santa Clara Office of Education; Sutter Medical Foundation; and three individuals

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General’s Office, Health Quality Enforcement Section

Senate Bill No. 738

CHAPTER 132

An act to amend Section 49414 of the Education Code, relating to pupil health.

[Approved by Governor July 16, 2015. Filed with
Secretary of State July 16, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 738, Huff. Pupil health: epinephrine auto-injectors: liability limitation.

Existing law requires school districts, county offices of education, and charter schools to provide emergency epinephrine auto-injectors to school nurses and trained personnel who have volunteered, as specified, and authorizes school nurses and trained personnel to use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction. Existing law requires a qualified supervisor of health or administrator at a school district, county office of education, or charter school to obtain the prescription for epinephrine auto-injectors from an authorizing physician and surgeon, as defined, and authorizes the prescription to be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.

This bill would prohibit an authorizing physician and surgeon from being subject to professional review, being liable in a civil action, or being subject to criminal prosecution for the issuance of a prescription or order, pursuant to these provisions, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct. The bill would also update an entity reference.

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

SECTION 1. Section 49414 of the Education Code is amended to read:

49414. (a) School districts, county offices of education, and charter schools shall provide emergency epinephrine auto-injectors to school nurses or trained personnel who have volunteered pursuant to subdivision (d), and school nurses or trained personnel may use epinephrine auto-injectors to provide emergency medical aid to persons suffering, or reasonably believed to be suffering, from an anaphylactic reaction.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Anaphylaxis" means a potentially life-threatening hypersensitivity to a substance.

(A) Symptoms of anaphylaxis may include shortness of breath, wheezing, difficulty breathing, difficulty talking or swallowing, hives, itching, swelling, shock, or asthma.

(B) Causes of anaphylaxis may include, but are not limited to, an insect sting, food allergy, drug reaction, and exercise.

(2) “Authorizing physician and surgeon” may include, but is not limited to, a physician and surgeon employed by, or contracting with, a local educational agency, a medical director of the local health department, or a local emergency medical services director.

(3) “Epinephrine auto-injector” means a disposable drug delivery system with a spring-activated needle that is designed for emergency administration of epinephrine to provide rapid, convenient first aid for persons suffering a potentially fatal reaction to anaphylaxis.

(4) “Qualified supervisor of health” may include, but is not limited to, a school nurse.

(5) “Volunteer” or “trained personnel” means an employee who has volunteered to administer epinephrine auto-injectors to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, has been designated by a school, and has received training pursuant to subdivision (d).

(c) Each private elementary and secondary school in the state may voluntarily determine whether or not to make emergency epinephrine auto-injectors and trained personnel available at its school. In making this determination, a school shall evaluate the emergency medical response time to the school and determine whether initiating emergency medical services is an acceptable alternative to epinephrine auto-injectors and trained personnel. A private elementary or secondary school choosing to exercise the authority provided under this subdivision shall not receive state funds specifically for purposes of this subdivision.

(d) Each public and private elementary and secondary school in the state may designate one or more volunteers to receive initial and annual refresher training, based on the standards developed pursuant to subdivision (e), regarding the storage and emergency use of an epinephrine auto-injector from the school nurse or other qualified person designated by an authorizing physician and surgeon.

(e) (1) Every five years, or sooner as deemed necessary by the Superintendent, the Superintendent shall review minimum standards of training for the administration of epinephrine auto-injectors that satisfy the requirements of paragraph (2). For purposes of this subdivision, the Superintendent shall consult with organizations and providers with expertise in administering epinephrine auto-injectors and administering medication in a school environment, including, but not limited to, the State Department of Public Health, the Emergency Medical Services Authority, the American Academy of Allergy, Asthma and Immunology, the California School Nurses Organization, the California Medical Association, the American Academy of Pediatrics, Food Allergy Research and Education, the California Society of Allergy, Asthma and Immunology, the American College of Allergy,

Asthma and Immunology, the Sean N. Parker Center for Allergy Research, and others.

(2) Training established pursuant to this subdivision shall include all of the following:

(A) Techniques for recognizing symptoms of anaphylaxis.

(B) Standards and procedures for the storage, restocking, and emergency use of epinephrine auto-injectors.

(C) Emergency followup procedures, including calling the emergency 911 telephone number and contacting, if possible, the pupil's parent and physician.

(D) Recommendations on the necessity of instruction and certification in cardiopulmonary resuscitation.

(E) Instruction on how to determine whether to use an adult epinephrine auto-injector or a junior epinephrine auto-injector, which shall include consideration of a pupil's grade level or age as a guideline of equivalency for the appropriate pupil weight determination.

(F) Written materials covering the information required under this subdivision.

(3) Training established pursuant to this subdivision shall be consistent with the most recent Voluntary Guidelines for Managing Food Allergies In Schools and Early Care and Education Programs published by the federal Centers for Disease Control and Prevention and the most recent guidelines for medication administration issued by the department.

(4) A school shall retain for reference the written materials prepared under subparagraph (F) of paragraph (2).

(f) A school district, county office of education, or charter school shall distribute a notice at least once per school year to all staff that contains the following information:

(1) A description of the volunteer request stating that the request is for volunteers to be trained to administer an epinephrine auto-injector to a person if the person is suffering, or reasonably believed to be suffering, from anaphylaxis, as specified in subdivision (b).

(2) A description of the training that the volunteer will receive pursuant to subdivision (d).

(g) (1) A qualified supervisor of health at a school district, county office of education, or charter school shall obtain from an authorizing physician and surgeon a prescription for each school for epinephrine auto-injectors that, at a minimum, includes, for elementary schools, one regular epinephrine auto-injector and one junior epinephrine auto-injector, and for junior high schools, middle schools, and high schools, if there are no pupils who require a junior epinephrine auto-injector, one regular epinephrine auto-injector. A qualified supervisor of health at a school district, county office of education, or charter school shall be responsible for stocking the epinephrine auto-injector and restocking it if it is used.

(2) If a school district, county office of education, or charter school does not have a qualified supervisor of health, an administrator at the school

district, county office of education, or charter school shall carry out the duties specified in paragraph (1).

(3) A prescription pursuant to this subdivision may be filled by local or mail order pharmacies or epinephrine auto-injector manufacturers.

(4) An authorizing physician and surgeon shall not be subject to professional review, be liable in a civil action, or be subject to criminal prosecution for the issuance of a prescription or order pursuant to this section, unless the physician and surgeon's issuance of the prescription or order constitutes gross negligence or willful or malicious conduct.

(h) A school nurse or, if the school does not have a school nurse or the school nurse is not onsite or available, a volunteer may administer an epinephrine auto-injector to a person exhibiting potentially life-threatening symptoms of anaphylaxis at school or a school activity when a physician is not immediately available. If the epinephrine auto-injector is used it shall be restocked as soon as reasonably possible, but no later than two weeks after it is used. Epinephrine auto-injectors shall be restocked before their expiration date.

(i) A volunteer shall initiate emergency medical services or other appropriate medical followup in accordance with the training materials retained pursuant to paragraph (4) of subdivision (e).

(j) A school district, county office of education, or charter school shall ensure that each employee who volunteers under this section will be provided defense and indemnification by the school district, county office of education, or charter school for any and all civil liability, in accordance with, but not limited to, that provided in Division 3.6 (commencing with Section 810) of Title 1 of the Government Code. This information shall be reduced to writing, provided to the volunteer, and retained in the volunteer's personnel file.

(k) A state agency, the department, or a public school may accept gifts, grants, and donations from any source for the support of the public school carrying out the provisions of this section, including, but not limited to, the acceptance of epinephrine auto-injectors from a manufacturer or wholesaler.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 800
Author: Committee on Business, Professions, and Economic Development
Chapter 426
Bill Date: July 16, 2015, Amended
Subject: Omnibus
Sponsor: Committee, Medical Board of California and other affected regulatory health boards
Position: Support provisions related to the Board

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). The omnibus language clarifies that registration is required to practice as a polysomnographic technologist, technician, or trainee in California. This bill also makes other technical, clarifying changes to fix an incorrect code section reference in existing law, delete an outdated section of statute related to a pilot project that no longer exists, and clarify that a licensee cannot call themselves “doctor”, “physician”, “Dr.”, or “M.D.”, if their license to practice medicine has been suspended or revoked.

ANALYSIS:

BPC Section 146 – Polysomnography

Existing statute does not specifically state that registration is required to practice as a polysomnographic technologist, technician, or trainee in California. Due to this ambiguity, the Board has encountered issues with pursuing action against individuals who are practicing polysomnography without being registered with the Board. This bill adds the code section related to polysomnographic technologists, technicians, and trainees to Business and Professions Code Section 146, which requires registration to engage in businesses and professions that are regulated by the code sections listed.

This bill ensures that individuals practicing as polysomnographic technologists in California are registered and subject to appropriate regulation by the Board if not. This will further the Board’s mission of consumer protection.

BPC Section 2054 – Jurisdiction Language

This bill makes a technical, clarifying change in the section of law that regulates when individuals can use the words “doctor”, “physician”, “Dr”, or the initials “M.D.” Current law does not allow use if an individual has been issued a license to practice medicine in another jurisdiction and has had that license suspended or revoked. The word “another jurisdiction” in existing law leads to the interpretation that this provision

may not apply to California licensees who have had their licenses suspended or revoked, although it should. It does not protect consumers to allow licensees in California that have had their license suspended or revoked to be able to use “doctor”, “physician”, “Dr.”, or “M.D.”.

This bill clarifies that any licensee (including those licensed in California), cannot call themselves “doctor”, “physician”, “Dr.”, or use the initials “M.D.”, if their license to practice medicine has been suspended or revoked. This will help to further the Board’s mission of consumer protection.

BPC 2401 – Sunsetted Pilot Program

BPC Section 2401 specifies exemptions to the ban on the corporate practice of medicine. One of these exemptions included a pilot program in 2401.1, that has since been sunsetted and repealed. This change simply cleans up the code section.

BPC 2529 – Incorrect Code Section Reference

A registered Research Psychoanalyst is an individual who has graduated from an approved psychoanalytic institution and is registered with the Board. Research Psychoanalysts may engage in psychoanalysis as an adjunct to teaching, training or research. Additionally, students who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a Student Research Psychoanalyst, may engage in psychoanalysis under supervision. B&P Code Section 2529 references code sections that define unprofessional conduct for Research Psychoanalysts. One of the code sections referenced is 725, which is the wrong code section, as Research Psychoanalysts cannot prescribe.

This bill corrects an incorrect code reference, as excessive prescribing does not apply to Research Psychoanalysts, however sexual misconduct could apply and is the correct code section that should be referred to in this section, BPC Section 726, not 725.

These statute changes were already approved by the Board to be included in the omnibus bill.

FISCAL: None to the Board

SUPPORT: Medical Board of California

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff, Department of Consumer Affairs, Division of Investigation staff, and the Attorney General’s Office, Health Quality Enforcement Section

Senate Bill No. 800

CHAPTER 426

An act to amend Sections 28, 146, 500, 650.2, 800, 1603a, 1618.5, 1640.1, 1648.10, 1650, 1695, 1695.1, 1905.1, 1944, 2054, 2401, 2428, 2529, 2650, 2770, 2770.1, 2770.2, 2770.7, 2770.8, 2770.10, 2770.11, 2770.12, 2770.13, 2835.5, 3057, 3509.5, 4836.2, 4887, 4938, 4939, 4980.399, 4980.43, 4980.54, 4984.01, 4989.34, 4992.09, 4996.2, 4996.22, 4996.28, 4999.1, 4999.2, 4999.3, 4999.4, 4999.5, 4999.7, 4999.45, 4999.46, 4999.55, 4999.76, and 4999.100 of, to amend the heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of, and to repeal Section 1917.2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor October 1, 2015. Filed with
Secretary of State October 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SB 800, Committee on Business, Professions and Economic Development.
Healing arts.

Under existing law, the Department of Consumer Affairs is comprised of various boards that license and regulate the practice of various professions and vocations, including those relating to the healing arts:

(1) Existing law requires persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist to have completed prescribed coursework or training in child abuse assessment and reporting. Existing law requires the training to have been obtained from an accredited or approved educational institution, a continuing education provider approved by the responsible board, or a course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved by the responsible board.

This bill would require the responsible board to specify a continuing education provider for child abuse assessment and reporting coursework by regulation, and would permit the responsible board to approve or accept a sponsored or offered course.

(2) Existing law relating to unlicensed activity enforcement lists specified provisions that require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions and, notwithstanding any other law, makes a violation of a listed provision punishable as an infraction under specified circumstances.

This bill would include in those listed provisions an existing requirement for the registration of individuals as certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees.

The bill would also include in those listed provisions a provision of the Educational Psychologist Practice Act that makes it unlawful for any person to practice educational psychology or use any title or letters that imply that he or she is a licensed educational psychologist unless, at the time of so doing, he or she holds a valid, unexpired, and unrevoked license under that act, the violation of which is a misdemeanor. The bill would further include in those listed provisions existing requirements of the Licensed Professional Clinical Counselor Act that a person not practice or advertise the performance of professional clinical counseling services without a license and pay the license fee, as required by that act, the violation of which is a misdemeanor.

By creating new infractions, this bill would impose a state-mandated local program.

(3) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. For purposes of the act, any reference to the Board of Dental Examiners is deemed a reference to the Dental Board of California.

This bill would delete certain existing references to the Board of Dental Examiners and, instead, refer to the Dental Board of California.

(4) Existing law provides for the regulation of dental hygienists by the Dental Hygiene Committee of California, within the jurisdiction of the Dental Board of California. Existing law authorizes the committee, until January 1, 2010, to contract with the dental board to carry out any of specified provisions relating to the regulation of dental hygienists, and, on and after January 1, 2010, to contract with the dental board to perform investigations of applicants and licensees. Existing law requires a new educational program for registered dental hygienists to submit a specified feasibility study. Existing law limits the fee for each curriculum review and site evaluation for these programs to a specified amount.

This bill would require the Dental Hygiene Committee of California to create and maintain a central file of the names of licensees, to provide an individual historical record with information on acts of licensee misconduct and discipline. The bill would remove the limiting dates from the contracting provisions, thereby authorizing the committee to contract with the dental board indefinitely to carry out any of specified provisions relating to the regulation of dental hygienists, including performing investigations of applicants and licensees. The bill would additionally limit the fee for each feasibility study review to that same specified amount.

(5) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board issues a physician and surgeon's certificate to a licensed physician surgeon. The act prohibits a person who fails to renew his or her license within 5 years after its expiration from renewing it, and prohibits the license from being reissued, reinstated, or restored thereafter, although the act authorizes a person to apply for and obtain a new license under specified circumstances.

This bill would recast that renewal provision to prohibit renewal by a person who voluntarily cancels his or her license or who fails to renew it as described, and would authorize that person to apply for and obtain a license under those specified circumstances, without regard to reissuance, reinstatement, or restoration.

(6) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct for, among other things, repeated acts of clearly excessive prescribing, furnishing, dispensing, or administering of drugs or treatment, use of diagnostic procedures, or use of diagnostic or treatment facilities.

This bill would substitute, for those described bases for suspension or revocation of the exemption, the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer.

(7) The Physical Therapy Practice Act provides for the licensure and regulation of physical therapists and physical therapist assistants by the Physical Therapy Board of California. The act establishes education requirements for a physical therapist assistant, including subject matter instruction through a combination of didactic and clinical experiences, and requires the clinical experience to include at least 18 weeks of full-time experience with a variety of patients.

This bill would delete that 18-week full-time experience requirement for physical therapist assistant education.

(8) The Nursing Practice Act provides for the licensure and regulation of registered nurses and nurse practitioners by the Board of Registered Nursing. The act, on and after January 1, 2008, requires an applicant for initial qualification or certification as a nurse practitioner who has not been qualified or certified as a nurse practitioner to meet specified requirements. Certain provisions allow the board to find registered nurses qualified to use the title of “nurse practitioner.”

This bill would delete those title provisions.

The Nursing Practice Act provides for a diversion program to identify and rehabilitate registered nurses whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness.

This bill would instead refer to the program as an intervention program.

(9) The Optometry Practice Act provides for the licensure and regulation of optometrists by the State Board of Optometry. The act prescribes license eligibility requirements, including, but not limited to, submitting proof that the person is licensed in good standing as of the date of application in every state where he or she holds a license, including compliance with continuing education requirements, submitting proof that the person has been in active practice in a state in which he or she is licensed for a total of at least 5,000 hours in 5 of the 7 consecutive years immediately preceding the date of his or her application, and has never had his or her license to practice optometry

revoked or suspended. For purposes of those provisions, “in good standing” includes the requirement that the person has not been found mentally incompetent by a physician so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

This bill would delete that active practice requirement and would require that the license have never been revoked or suspended in any state where the person holds a license. The bill, with regard to making such a finding of mental incompetence, would replace a finding by a physician with a finding by a licensed psychologist or licensed psychiatrist.

(10) The Physician Assistant Practice Act requires the Physician Assistant Board to annually elect a chairperson and vice chairperson from among its members.

This bill would require the annual election of a president and vice president.

(11) Existing law relating to veterinary medicine requires a veterinary assistant to obtain a controlled substance permit from the Veterinary Medical Board in order to administer a controlled substance, and authorizes the board to deny, revoke, or suspend the permit, after notice and hearing, for any of specified causes. Existing law authorizes the board to revoke or suspend a permit for the same.

This bill would, instead, authorize the board to suspend or revoke the controlled substance permit of a veterinary assistant, after notice and hearing, for any of specified causes, and to deny, revoke, or suspend a permit for the same.

(12) The Acupuncture Licensure Act provides for the licensure and regulation of the practice of acupuncture by the Acupuncture Board. The act requires the board to issue a license to practice acupuncture to a person who meets prescribed requirements. The act requires, in the case of an applicant who has completed education and training outside the United States and Canada, documented educational training and clinical experience that meets certain standards established by the board. Existing law, commencing January 1, 2017, specifically requires the board to establish standards for the approval of educational training and clinical experience received outside the United States and Canada.

This bill would remove Canada from those provisions, thereby applying the same standards to all training and clinical experience completed outside the United States.

(13) The Board of Behavioral Sciences is responsible for administering the Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

The Licensed Marriage and Family Therapist Act provides for the licensure and regulation of marriage and family therapists by the Board of Behavioral Sciences. The act sets forth the educational and training requirements for licensure as a marriage and family therapist, including certain supervised-experience requirements whereby a prospective licensee

is required to work a specified number of hours in a clinical setting under the supervision of experienced professionals. The act requires all persons to register with the board as an intern in order to be credited for postdegree hours of supervised experience gained toward licensure. The act, with regard to interns, requires all postdegree hours of experience to be credited toward licensure, except when employed in a private practice setting, if certain conditions are met. The act limits the number of hours applicants for a marriage and family therapist license may provide counseling services via telehealth.

The bill would require postdegree hours of experience to be credited toward licensure if certain conditions are met. The bill would prohibit an applicant for licensure as a marriage and family therapist from being employed or volunteering in a private practice until registered as an intern by the board. The bill would similarly prohibit an applicant for professional clinical counselor under the Licensed Professional Clinical Counselor Act from being employed or volunteering in a private practice until registered as an intern by the board.

The bill would authorize a marriage and family therapist intern and trainee to provide services via telehealth if he or she is supervised as required by the act, and is acting within the scope authorized by the act and in accordance with any regulations governing the use of telehealth promulgated by the Board of Behavioral Sciences.

The Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act require applicants for licensure under those acts to comply with specified educational and experience requirements, including, but not limited to, hours of supervised experience, and sets forth terms, conditions, and limitations for those hours of experience, as specified.

The bill would revise those experience requirements and provide that individuals who submit applications for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the current requirements.

The Licensed Marriage and Family Therapist Act, the Educational Psychologist Practice Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act require the Board of Behavioral Sciences to approve continuing education providers for specified educational courses relating to licensure for marriage and family therapists, educational psychologists, clinical social workers, and professional clinical counselors.

This bill would modify those acts to require the Board of Behavioral Sciences to identify, by regulation, acceptable continuing education providers.

The Licensed Marriage and Family Therapist Act and the Licensed Professional Clinical Counselor Act provide for the registration of interns and allow a maximum of possible renewals after initial registration, after which a new registration number is required to be obtained. The Clinical Social Worker Practice Act provides similarly for the registration and renewal of registration of associate clinical social workers. An applicant

who is issued a subsequent number is barred from employment or volunteering in a private practice.

This bill would revise those provisions to refer throughout to subsequent registration numbers.

(14) Existing law provides for the registration of telephone medical advice services. Existing law imposes requirements for obtaining and maintaining registration, including a requirement that medical advice services be provided by specified licensed, registered, or certified health care professionals.

This bill would expand the specified health care professionals to include naturopathic doctors and licensed professional clinical counselors. The bill would require a service to notify the department of certain business changes, and to submit quarterly reports.

(15) This bill would additionally delete or update obsolete provisions and make conforming or nonsubstantive changes.

(16) This bill would incorporate additional changes to Section 1944 of the Business and Professions Code made by this bill and AB 483 to take effect if both bills are chaptered and this bill is chaptered last.

(17) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

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

SECTION 1. Section 28 of the Business and Professions Code is amended to read:

28. (a) The Legislature finds that there is a need to ensure that professionals of the healing arts who have demonstrable contact with victims and potential victims of child, elder, and dependent adult abuse, and abusers and potential abusers of children, elders, and dependent adults are provided with adequate and appropriate training regarding the assessment and reporting of child, elder, and dependent adult abuse that will ameliorate, reduce, and eliminate the trauma of abuse and neglect and ensure the reporting of abuse in a timely manner to prevent additional occurrences.

(b) The Board of Psychology and the Board of Behavioral Sciences shall establish required training in the area of child abuse assessment and reporting for all persons applying for initial licensure and renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist. This training shall be required one time only for all persons applying for initial licensure or for licensure renewal.

(c) All persons applying for initial licensure or renewal of a license as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist shall, in addition to all other requirements for licensure or renewal, have completed coursework or training in child abuse

assessment and reporting that meets the requirements of this section, including detailed knowledge of the Child Abuse and Neglect Reporting Act (Article 2.5 (commencing with Section 11164) of Chapter 2 of Title 1 of Part 4 of the Penal Code). The training shall meet all of the following requirements:

(1) Be obtained from one of the following sources:

(A) An accredited or approved educational institution, as defined in Sections 2902, 4980.36, 4980.37, 4996.18, and 4999.12, including extension courses offered by those institutions.

(B) A continuing education provider as specified by the responsible board by regulation.

(C) A course sponsored or offered by a professional association or a local, county, or state department of health or mental health for continuing education and approved or accepted by the responsible board.

(2) Have a minimum of seven contact hours.

(3) Include the study of the assessment and method of reporting of sexual assault, neglect, severe neglect, general neglect, willful cruelty or unjustifiable punishment, corporal punishment or injury, and abuse in out-of-home care. The training shall also include physical and behavioral indicators of abuse, crisis counseling techniques, community resources, rights and responsibilities of reporting, consequences of failure to report, caring for a child's needs after a report is made, sensitivity to previously abused children and adults, and implications and methods of treatment for children and adults.

(4) An applicant shall provide the appropriate board with documentation of completion of the required child abuse training.

(d) The Board of Psychology and the Board of Behavioral Sciences shall exempt an applicant who applies for an exemption from this section and who shows to the satisfaction of the board that there would be no need for the training in his or her practice because of the nature of that practice.

(e) It is the intent of the Legislature that a person licensed as a psychologist, clinical social worker, professional clinical counselor, or marriage and family therapist have minimal but appropriate training in the areas of child, elder, and dependent adult abuse assessment and reporting. It is not intended that, by solely complying with this section, a practitioner is fully trained in the subject of treatment of child, elder, and dependent adult abuse victims and abusers.

(f) The Board of Psychology and the Board of Behavioral Sciences are encouraged to include coursework regarding the assessment and reporting of elder and dependent adult abuse in the required training on aging and long-term care issues prior to licensure or license renewal.

SEC. 2. Section 146 of the Business and Professions Code is amended to read:

146. (a) Notwithstanding any other provision of law, a violation of any code section listed in subdivision (c) is an infraction subject to the procedures described in Sections 19.6 and 19.7 of the Penal Code when either of the following applies:

(1) A complaint or a written notice to appear in court pursuant to Chapter 5c (commencing with Section 853.5) of Title 3 of Part 2 of the Penal Code is filed in court charging the offense as an infraction unless the defendant, at the time he or she is arraigned, after being advised of his or her rights, elects to have the case proceed as a misdemeanor.

(2) The court, with the consent of the defendant and the prosecution, determines that the offense is an infraction in which event the case shall proceed as if the defendant has been arraigned on an infraction complaint.

(b) Subdivision (a) does not apply to a violation of the code sections listed in subdivision (c) if the defendant has had his or her license, registration, or certificate previously revoked or suspended.

(c) The following sections require registration, licensure, certification, or other authorization in order to engage in certain businesses or professions regulated by this code:

- (1) Sections 2052 and 2054.
- (2) Section 2630.
- (3) Section 2903.
- (4) Section 3575.
- (5) Section 3660.
- (6) Sections 3760 and 3761.
- (7) Section 4080.
- (8) Section 4825.
- (9) Section 4935.
- (10) Section 4980.
- (11) Section 4989.50.
- (12) Section 4996.
- (13) Section 4999.30.
- (14) Section 5536.
- (15) Section 6704.
- (16) Section 6980.10.
- (17) Section 7317.
- (18) Section 7502 or 7592.
- (19) Section 7520.
- (20) Section 7617 or 7641.
- (21) Subdivision (a) of Section 7872.
- (22) Section 8016.
- (23) Section 8505.
- (24) Section 8725.
- (25) Section 9681.
- (26) Section 9840.
- (27) Subdivision (c) of Section 9891.24.
- (28) Section 19049.

(d) Notwithstanding any other law, a violation of any of the sections listed in subdivision (c), which is an infraction, is punishable by a fine of not less than two hundred fifty dollars (\$250) and not more than one thousand dollars (\$1,000). No portion of the minimum fine may be suspended by the court unless as a condition of that suspension the defendant is required to

submit proof of a current valid license, registration, or certificate for the profession or vocation that was the basis for his or her conviction.

SEC. 3. Section 500 of the Business and Professions Code is amended to read:

500. If the register or book of registration of the Medical Board of California, the Dental Board of California, or the California State Board of Pharmacy is destroyed by fire or other public calamity, the board, whose duty it is to keep the register or book, may reproduce it so that there may be shown as nearly as possible the record existing in the original at the time of destruction.

SEC. 4. Section 650.2 of the Business and Professions Code is amended to read:

650.2. (a) Notwithstanding Section 650 or any other provision of law, it shall not be unlawful for a person licensed pursuant to Chapter 4 (commencing with Section 1600) of Division 2 or any other person, to participate in or operate a group advertising and referral service for dentists if all of the following conditions are met:

(1) The patient referrals by the service result from patient-initiated responses to service advertising.

(2) The service advertises, if at all, in conformity with Section 651 and subdivisions (i) and (l) of Section 1680.

(3) The service does not employ a solicitor within the meaning of subdivision (j) of Section 1680.

(4) The service does not impose a fee on the member dentists dependent upon the number of referrals or amount of professional fees paid by the patient to the dentist.

(5) Participating dentists charge no more than their usual and customary fees to any patient referred.

(6) The service registers with the Dental Board of California, providing its name and address.

(7) The service files with the Dental Board of California a copy of the standard form contract that regulates its relationship with member dentists, which contract shall be confidential and not open to public inspection.

(8) If more than 50 percent of its referrals are made to one individual, association, partnership, corporation, or group of three or more dentists, the service discloses that fact in all public communications, including, but not limited to, communication by means of television, radio, motion picture, newspaper, book, or list or directory of healing arts practitioners.

(9) When member dentists pay any fee to the service, any advertisement by the service shall clearly and conspicuously disclose that fact by including a statement as follows: "Paid for by participating dentists." In print advertisements, the required statement shall be in at least 9-point type. In radio advertisements, the required statement shall be articulated so as to be clearly audible and understandable by the radio audience. In television advertisements, the required statement shall be either clearly audible and understandable to the television audience, or displayed in a written form

that remains clearly visible for at least five seconds to the television audience. This subdivision shall be operative on and after July 1, 1994.

(b) The Dental Board of California may adopt regulations necessary to enforce and administer this section.

(c) The Dental Board of California may suspend or revoke the registration of any service that fails to comply with paragraph (9) of subdivision (a). No service may reregister with the board if it has a registration that is currently under suspension for a violation of paragraph (9) of subdivision (a), nor may a service reregister with the board if it had a registration revoked by the board for a violation of paragraph (9) of subdivision (a) less than one year after that revocation.

(d) The Dental Board of California may petition the superior court of any county for the issuance of an injunction restraining any conduct that constitutes a violation of this section.

(e) It is unlawful and shall constitute a misdemeanor for a person to operate a group advertising and referral service for dentists without providing its name and address to the Dental Board of California.

(f) It is the intent of the Legislature in enacting this section not to otherwise affect the prohibitions provided in Section 650. The Legislature intends to allow the pooling of resources by dentists for the purposes of advertising.

(g) This section shall not be construed to authorize a referral service to engage in the practice of dentistry.

SEC. 5. Section 800 of the Business and Professions Code is amended to read:

800. (a) The Medical Board of California, the Board of Psychology, the Dental Board of California, the Dental Hygiene Committee of California, the Osteopathic Medical Board of California, the State Board of Chiropractic Examiners, the Board of Registered Nursing, the Board of Vocational Nursing and Psychiatric Technicians of the State of California, the State Board of Optometry, the Veterinary Medical Board, the Board of Behavioral Sciences, the Physical Therapy Board of California, the California State Board of Pharmacy, the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board, the California Board of Occupational Therapy, the Acupuncture Board, and the Physician Assistant Board shall each separately create and maintain a central file of the names of all persons who hold a license, certificate, or similar authority from that board. Each central file shall be created and maintained to provide an individual historical record for each licensee with respect to the following information:

(1) Any conviction of a crime in this or any other state that constitutes unprofessional conduct pursuant to the reporting requirements of Section 803.

(2) Any judgment or settlement requiring the licensee or his or her insurer to pay any amount of damages in excess of three thousand dollars (\$3,000) for any claim that injury or death was proximately caused by the licensee's negligence, error or omission in practice, or by rendering unauthorized

professional services, pursuant to the reporting requirements of Section 801 or 802.

(3) Any public complaints for which provision is made pursuant to subdivision (b).

(4) Disciplinary information reported pursuant to Section 805, including any additional exculpatory or explanatory statements submitted by the licensee pursuant to subdivision (f) of Section 805. If a court finds, in a final judgment, that the peer review resulting in the 805 report was conducted in bad faith and the licensee who is the subject of the report notifies the board of that finding, the board shall include that finding in the central file. For purposes of this paragraph, “peer review” has the same meaning as defined in Section 805.

(5) Information reported pursuant to Section 805.01, including any explanatory or exculpatory information submitted by the licensee pursuant to subdivision (b) of that section.

(b) (1) Each board shall prescribe and promulgate forms on which members of the public and other licensees or certificate holders may file written complaints to the board alleging any act of misconduct in, or connected with, the performance of professional services by the licensee.

(2) If a board, or division thereof, a committee, or a panel has failed to act upon a complaint or report within five years, or has found that the complaint or report is without merit, the central file shall be purged of information relating to the complaint or report.

(3) Notwithstanding this subdivision, the Board of Psychology, the Board of Behavioral Sciences, and the Respiratory Care Board of California shall maintain complaints or reports as long as each board deems necessary.

(c) (1) The contents of any central file that are not public records under any other provision of law shall be confidential except that the licensee involved, or his or her counsel or representative, shall have the right to inspect and have copies made of his or her complete file except for the provision that may disclose the identity of an information source. For the purposes of this section, a board may protect an information source by providing a copy of the material with only those deletions necessary to protect the identity of the source or by providing a comprehensive summary of the substance of the material. Whichever method is used, the board shall ensure that full disclosure is made to the subject of any personal information that could reasonably in any way reflect or convey anything detrimental, disparaging, or threatening to a licensee’s reputation, rights, benefits, privileges, or qualifications, or be used by a board to make a determination that would affect a licensee’s rights, benefits, privileges, or qualifications. The information required to be disclosed pursuant to Section 803.1 shall not be considered among the contents of a central file for the purposes of this subdivision.

(2) The licensee may, but is not required to, submit any additional exculpatory or explanatory statement or other information that the board shall include in the central file.

(3) Each board may permit any law enforcement or regulatory agency when required for an investigation of unlawful activity or for licensing, certification, or regulatory purposes to inspect and have copies made of that licensee's file, unless the disclosure is otherwise prohibited by law.

(4) These disclosures shall effect no change in the confidential status of these records.

SEC. 6. Section 1603a of the Business and Professions Code is amended to read:

1603a. A member of the Dental Board of California who has served two terms shall not be eligible for reappointment to the board. In computing two terms hereunder, that portion of an unexpired term that a member fills as a result of a vacancy shall be excluded.

SEC. 7. Section 1618.5 of the Business and Professions Code is amended to read:

1618.5. (a) The board shall provide to the Director of the Department of Managed Health Care a copy of any accusation filed with the Office of Administrative Hearings pursuant to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, when the accusation is filed, for a violation of this chapter relating to the quality of care of any dental provider of a health care service plan, as defined in Section 1345 of the Health and Safety Code. There shall be no liability on the part of, and no cause of action shall arise against, the State of California, the Dental Board of California, the Department of Managed Health Care, the director of that department, or any officer, agent, employee, consultant, or contractor of the state or the board or the department for the release of any false or unauthorized information pursuant to this section, unless the release is made with knowledge and malice.

(b) The board and its executive officer and staff shall maintain the confidentiality of any nonpublic reports provided by the Director of the Department of Managed Health Care pursuant to subdivision (i) of Section 1380 of the Health and Safety Code.

SEC. 8. Section 1640.1 of the Business and Professions Code is amended to read:

1640.1. As used in this article, the following definitions shall apply:

(a) "Specialty" means an area of dental practice approved by the American Dental Association and recognized by the board.

(b) "Discipline" means an advanced dental educational program in an area of dental practice not approved as a specialty by the American Dental Association; but offered from a dental college approved by the board.

(c) "Dental college approved by the board" means a dental school or college that is approved by the Commission on Dental Accreditation of the American Dental Association, that is accredited by a body that has a reciprocal accreditation agreement with that commission, or that has been approved by the Dental Board of California through its own approval process.

SEC. 9. Section 1648.10 of the Business and Professions Code is amended to read:

1648.10. (a) The Dental Board of California shall develop and distribute a fact sheet describing and comparing the risks and efficacy of the various types of dental restorative materials that may be used to repair a dental patient's oral condition or defect. The fact sheet shall include:

(1) A description of the groups of materials that are available to the profession for restoration of an oral condition or defect.

(2) A comparison of the relative benefits and detriments of each group of materials.

(3) A comparison of the cost considerations associated with each group of materials.

(4) A reference to encourage discussion between patient and dentist regarding materials and to inform the patient of his or her options.

(b) The fact sheet shall be made available by the Dental Board of California to all licensed dentists.

(c) The Dental Board of California shall update the fact sheet described in subdivision (a) as determined necessary by the board.

SEC. 10. Section 1650 of the Business and Professions Code is amended to read:

1650. Every person who is now or hereafter licensed to practice dentistry in this state shall register on forms prescribed by the board, his or her place of practice with the executive officer of the Dental Board of California, or, if he or she has more than one place of practice, all of the places of practice, or, if he or she has no place of practice, to so notify the executive officer of the board. A person licensed by the board shall register with the executive officer within 30 days after the date of his or her license.

SEC. 11. Section 1695 of the Business and Professions Code is amended to read:

1695. It is the intent of the Legislature that the Dental Board of California seek ways and means to identify and rehabilitate licentiates whose competency may be impaired due to abuse of dangerous drugs or alcohol, so that licentiates so afflicted may be treated and returned to the practice of dentistry in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Dental Board of California shall implement this legislation in part by establishing a diversion program as a voluntary alternative approach to traditional disciplinary actions.

SEC. 12. Section 1695.1 of the Business and Professions Code is amended to read:

1695.1. As used in this article:

(a) "Board" means the Dental Board of California.

(b) "Committee" means a diversion evaluation committee created by this article.

(c) "Program manager" means the staff manager of the diversion program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 13. Section 1905.1 of the Business and Professions Code is amended to read:

1905.1. The committee may contract with the dental board to carry out this article. The committee may contract with the dental board to perform investigations of applicants and licensees under this article.

SEC. 14. Section 1917.2 of the Business and Professions Code is repealed.

SEC. 15. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The committee shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for issuance of an original license shall not exceed two hundred fifty dollars (\$250).

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(5) The biennial renewal fee shall not exceed one hundred sixty dollars (\$160).

(6) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(7) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars (\$25) or one-half of the renewal fee, whichever is greater.

(8) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(9) The fee for each curriculum review, feasibility study review, and site evaluation for educational programs for dental hygienists who are not accredited by a committee-approved agency shall not exceed two thousand one hundred dollars (\$2,100).

(10) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars (\$750).

(11) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars (\$500).

(12) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars (\$5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars (\$250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars (\$150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars (\$250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars (\$250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars (\$250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(l) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

SEC. 15.5. Section 1944 of the Business and Professions Code is amended to read:

1944. (a) The committee shall establish by resolution the amount of the fees that relate to the licensing of a registered dental hygienist, a registered dental hygienist in alternative practice, and a registered dental hygienist in extended functions. The fees established by board resolution in effect on June 30, 2009, as they relate to the licensure of registered dental hygienists, registered dental hygienists in alternative practice, and registered dental hygienists in extended functions, shall remain in effect until modified by the committee. The fees are subject to the following limitations:

(1) The application fee for an original license and the fee for the issuance of an original license shall not exceed two hundred fifty dollars (\$250).

Commencing July 1, 2017, the fee for the issuance of an original license shall be prorated on the monthly basis.

(2) The fee for examination for licensure as a registered dental hygienist shall not exceed the actual cost of the examination.

(3) The fee for examination for licensure as a registered dental hygienist in extended functions shall not exceed the actual cost of the examination.

(4) The fee for examination for licensure as a registered dental hygienist in alternative practice shall not exceed the actual cost of administering the examination.

(5) The biennial renewal fee shall not exceed one hundred sixty dollars (\$160).

(6) The delinquency fee shall not exceed one-half of the renewal fee. Any delinquent license may be restored only upon payment of all fees, including the delinquency fee, and compliance with all other applicable requirements of this article.

(7) The fee for issuance of a duplicate license to replace one that is lost or destroyed, or in the event of a name change, shall not exceed twenty-five dollars (\$25) or one-half of the renewal fee, whichever is greater.

(8) The fee for certification of licensure shall not exceed one-half of the renewal fee.

(9) The fee for each curriculum review, feasibility study review, and site evaluation for educational programs for dental hygienists who are not accredited by a committee-approved agency shall not exceed two thousand one hundred dollars (\$2,100).

(10) The fee for each review or approval of course requirements for licensure or procedures that require additional training shall not exceed seven hundred fifty dollars (\$750).

(11) The initial application and biennial fee for a provider of continuing education shall not exceed five hundred dollars (\$500).

(12) The amount of fees payable in connection with permits issued under Section 1962 is as follows:

(A) The initial permit fee is an amount equal to the renewal fee for the applicant's license to practice dental hygiene in effect on the last regular renewal date before the date on which the permit is issued.

(B) If the permit will expire less than one year after its issuance, then the initial permit fee is an amount equal to 50 percent of the renewal fee in effect on the last regular renewal date before the date on which the permit is issued.

(b) The renewal and delinquency fees shall be fixed by the committee by resolution at not more than the current amount of the renewal fee for a license to practice under this article nor less than five dollars (\$5).

(c) Fees fixed by the committee by resolution pursuant to this section shall not be subject to the approval of the Office of Administrative Law.

(d) Fees collected pursuant to this section shall be collected by the committee and deposited into the State Dental Hygiene Fund, which is hereby created. All money in this fund shall, upon appropriation by the Legislature in the annual Budget Act, be used to implement this article.

(e) No fees or charges other than those listed in this section shall be levied by the committee in connection with the licensure of registered dental hygienists, registered dental hygienists in alternative practice, or registered dental hygienists in extended functions.

(f) The fee for registration of an extramural dental facility shall not exceed two hundred fifty dollars (\$250).

(g) The fee for registration of a mobile dental hygiene unit shall not exceed one hundred fifty dollars (\$150).

(h) The biennial renewal fee for a mobile dental hygiene unit shall not exceed two hundred fifty dollars (\$250).

(i) The fee for an additional office permit shall not exceed two hundred fifty dollars (\$250).

(j) The biennial renewal fee for an additional office as described in Section 1926.4 shall not exceed two hundred fifty dollars (\$250).

(k) The initial application and biennial special permit fee is an amount equal to the biennial renewal fee specified in paragraph (6) of subdivision (a).

(l) The fees in this section shall not exceed an amount sufficient to cover the reasonable regulatory cost of carrying out this article.

SEC. 16. Section 2054 of the Business and Professions Code is amended to read:

2054. (a) Any person who uses in any sign, business card, or letterhead, or, in an advertisement, the words “doctor” or “physician,” the letters or prefix “Dr.,” the initials “M.D.,” or any other terms or letters indicating or implying that he or she is a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, or that he or she is entitled to practice hereunder, or who represents or holds himself or herself out as a physician and surgeon, physician, surgeon, or practitioner under the terms of this or any other law, without having at the time of so doing a valid, unrevoked, and unsuspended certificate as a physician and surgeon under this chapter, is guilty of a misdemeanor.

(b) A holder of a valid, unrevoked, and unsuspended certificate to practice podiatric medicine may use the phrases “doctor of podiatric medicine,” “doctor of podiatry,” and “podiatric doctor,” or the initials “D.P.M.,” and shall not be in violation of subdivision (a).

(c) Notwithstanding subdivision (a), any of the following persons may use the words “doctor” or “physician,” the letters or prefix “Dr.,” or the initials “M.D.”:

(1) A graduate of a medical school approved or recognized by the board while enrolled in a postgraduate training program approved by the board.

(2) A graduate of a medical school who does not have a certificate as a physician and surgeon under this chapter if he or she meets all of the following requirements:

(A) If issued a license to practice medicine in any jurisdiction, has not had that license revoked or suspended by that jurisdiction.

(B) Does not otherwise hold himself or herself out as a physician and surgeon entitled to practice medicine in this state except to the extent authorized by this chapter.

(C) Does not engage in any of the acts prohibited by Section 2060.

(3) A person authorized to practice medicine under Section 2111 or 2113 subject to the limitations set forth in those sections.

SEC. 17. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other provision of law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other provision of law.

SEC. 18. Section 2428 of the Business and Professions Code is amended to read:

2428. (a) A person who voluntarily cancels his or her license or who fails to renew his or her license within five years after its expiration shall not renew it, but that person may apply for and obtain a new license if he or she:

(1) Has not committed any acts or crimes constituting grounds for denial of licensure under Division 1.5 (commencing with Section 475).

(2) Takes and passes the examination, if any, which would be required of him or her if application for licensure was being made for the first time, or otherwise establishes to the satisfaction of the licensing authority that passes on the qualifications of applicants for the license that, with due regard for the public interest, he or she is qualified to practice the profession or activity for which the applicant was originally licensed.

(3) Pays all of the fees that would be required if application for licensure was being made for the first time.

The licensing authority may provide for the waiver or refund of all or any part of an examination fee in those cases in which a license is issued without an examination pursuant to this section.

Nothing in this section shall be construed to authorize the issuance of a license for a professional activity or system or mode of healing for which licenses are no longer required.

(b) In addition to the requirements set forth in subdivision (a), an applicant shall establish that he or she meets one of the following requirements: (1) satisfactory completion of at least two years of approved postgraduate training; (2) certification by a specialty board approved by the American Board of Medical Specialties or approved by the board pursuant to subdivision (h) of Section 651; or (3) passing of the clinical competency written examination.

(c) Subdivision (a) shall apply to persons who held licenses to practice podiatric medicine except that those persons who failed to renew their licenses within three years after its expiration may not renew it, and it may not be reissued, reinstated, or restored, except in accordance with subdivision (a).

SEC. 19. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words “psychological,” “psychologist,” “psychology,”

“psychometrists,” “psychometrics,” or “psychometry,” or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, and 2235.

SEC. 20. Section 2650 of the Business and Professions Code is amended to read:

2650. (a) The physical therapist education requirements are as follows:

(1) Except as otherwise provided in this chapter, each applicant for a license as a physical therapist shall be a graduate of a professional degree program of an accredited postsecondary institution or institutions approved by the board and shall have completed a professional education program including academic course work and clinical internship in physical therapy.

(2) Unless otherwise specified by the board by regulation, the educational requirements shall include instruction in the subjects prescribed by the Commission on Accreditation in Physical Therapy Education (CAPTE) of the American Physical Therapy Association or Physiotherapy Education Accreditation Canada and shall include a combination of didactic and clinical experiences. The clinical experience shall include at least 18 weeks of full-time experience with a variety of patients.

(b) The physical therapist assistant educational requirements are as follows:

(1) Except as otherwise provided in this chapter, each applicant for a license as a physical therapist assistant shall be a graduate of a physical therapist assistant program of an accredited postsecondary institution or institutions approved by the board, and shall have completed both the academic and clinical experience required by the physical therapist assistant program, and have been awarded an associate degree.

(2) Unless otherwise specified by the board by regulation, the educational requirements shall include instruction in the subjects prescribed by the CAPTE of the American Physical Therapy Association or Physiotherapy Education Accreditation Canada or another body as may be approved by the board by regulation and shall include a combination of didactic and clinical experiences.

SEC. 21. The heading of Article 3.1 (commencing with Section 2770) of Chapter 6 of Division 2 of the Business and Professions Code is amended to read:

Article 3.1. Intervention Program

SEC. 22. Section 2770 of the Business and Professions Code is amended to read:

2770. It is the intent of the Legislature that the Board of Registered Nursing seek ways and means to identify and rehabilitate registered nurses

whose competency may be impaired due to abuse of alcohol and other drugs, or due to mental illness so that registered nurses so afflicted may be rehabilitated and returned to the practice of nursing in a manner that will not endanger the public health and safety. It is also the intent of the Legislature that the Board of Registered Nursing shall implement this legislation by establishing an intervention program as a voluntary alternative to traditional disciplinary actions.

SEC. 23. Section 2770.1 of the Business and Professions Code is amended to read:

2770.1. As used in this article:

(a) "Board" means the Board of Registered Nursing.

(b) "Committee" means an intervention evaluation committee created by this article.

(c) "Program manager" means the staff manager of the intervention program, as designated by the executive officer of the board. The program manager shall have background experience in dealing with substance abuse issues.

SEC. 24. Section 2770.2 of the Business and Professions Code is amended to read:

2770.2. (a) One or more intervention evaluation committees is hereby created in the state to be established by the board. Each committee shall be composed of five persons appointed by the board. No board member shall serve on any committee.

(b) Each committee shall have the following composition:

(1) Three registered nurses, holding active California licenses, who have demonstrated expertise in the field of chemical dependency or psychiatric nursing.

(2) One physician, holding an active California license, who specializes in the diagnosis and treatment of addictive diseases or mental illness.

(3) One public member who is knowledgeable in the field of chemical dependency or mental illness.

(c) It shall require a majority vote of the board to appoint a person to a committee. Each appointment shall be at the pleasure of the board for a term not to exceed four years. In its discretion the board may stagger the terms of the initial members appointed.

SEC. 25. Section 2770.7 of the Business and Professions Code is amended to read:

2770.7. (a) The board shall establish criteria for the acceptance, denial, or termination of registered nurses in the intervention program. Only those registered nurses who have voluntarily requested to participate in the intervention program shall participate in the program.

(b) A registered nurse under current investigation by the board may request entry into the intervention program by contacting the board. Prior to authorizing a registered nurse to enter into the intervention program, the board may require the registered nurse under current investigation for any violations of this chapter or any other provision of this code to execute a statement of understanding that states that the registered nurse understands

that his or her violations that would otherwise be the basis for discipline may still be investigated and may be the subject of disciplinary action.

(c) If the reasons for a current investigation of a registered nurse are based primarily on the self-administration of any controlled substance or dangerous drug or alcohol under Section 2762, or the illegal possession, prescription, or nonviolent procurement of any controlled substance or dangerous drug for self-administration that does not involve actual, direct harm to the public, the board shall close the investigation without further action if the registered nurse is accepted into the board's intervention program and successfully completes the program. If the registered nurse withdraws or is terminated from the program by an intervention evaluation committee, and the termination is approved by the program manager, the investigation shall be reopened and disciplinary action imposed, if warranted, as determined by the board.

(d) Neither acceptance nor participation in the intervention program shall preclude the board from investigating or continuing to investigate, or taking disciplinary action or continuing to take disciplinary action against, any registered nurse for any unprofessional conduct committed before, during, or after participation in the intervention program.

(e) All registered nurses shall sign an agreement of understanding that the withdrawal or termination from the intervention program at a time when the program manager or intervention evaluation committee determines the licensee presents a threat to the public's health and safety shall result in the utilization by the board of intervention program treatment records in disciplinary or criminal proceedings.

(f) Any registered nurse terminated from the intervention program for failure to comply with program requirements is subject to disciplinary action by the board for acts committed before, during, and after participation in the intervention program. A registered nurse who has been under investigation by the board and has been terminated from the intervention program by an intervention evaluation committee shall be reported by the intervention evaluation committee to the board.

SEC. 26. Section 2770.8 of the Business and Professions Code is amended to read:

2770.8. A committee created under this article operates under the direction of the intervention program manager. The program manager has the primary responsibility to review and evaluate recommendations of the committee. Each committee shall have the following duties and responsibilities:

(a) To evaluate those registered nurses who request participation in the program according to the guidelines prescribed by the board, and to make recommendations.

(b) To review and designate those treatment services to which registered nurses in an intervention program may be referred.

(c) To receive and review information concerning a registered nurse participating in the program.

(d) To consider in the case of each registered nurse participating in a program whether he or she may with safety continue or resume the practice of nursing.

(e) To call meetings as necessary to consider the requests of registered nurses to participate in an intervention program, and to consider reports regarding registered nurses participating in a program.

(f) To make recommendations to the program manager regarding the terms and conditions of the intervention agreement for each registered nurse participating in the program, including treatment, supervision, and monitoring requirements.

SEC. 27. Section 2770.10 of the Business and Professions Code is amended to read:

2770.10. Notwithstanding Article 9 (commencing with Section 11120) of Chapter 1 of Part 1 of Division 3 of Title 2 of the Government Code, relating to public meetings, a committee may convene in closed session to consider reports pertaining to any registered nurse requesting or participating in an intervention program. A committee shall only convene in closed session to the extent that it is necessary to protect the privacy of such a licensee.

SEC. 28. Section 2770.11 of the Business and Professions Code is amended to read:

2770.11. (a) Each registered nurse who requests participation in an intervention program shall agree to cooperate with the rehabilitation program designed by the committee and approved by the program manager. Any failure to comply with a rehabilitation program may result in termination of the registered nurse's participation in a program. The name and license number of a registered nurse who is terminated for any reason, other than successful completion, shall be reported to the board's enforcement program.

(b) If the program manager determines that a registered nurse, who is denied admission into the program or terminated from the program, presents a threat to the public or his or her own health and safety, the program manager shall report the name and license number, along with a copy of all intervention program records for that registered nurse, to the board's enforcement program. The board may use any of the records it receives under this subdivision in any disciplinary proceeding.

SEC. 29. Section 2770.12 of the Business and Professions Code is amended to read:

2770.12. (a) After the committee and the program manager in their discretion have determined that a registered nurse has successfully completed the intervention program, all records pertaining to the registered nurse's participation in the intervention program shall be purged.

(b) All board and committee records and records of a proceeding pertaining to the participation of a registered nurse in the intervention program shall be kept confidential and are not subject to discovery or subpoena, except as specified in subdivision (b) of Section 2770.11 and subdivision (c).

(c) A registered nurse shall be deemed to have waived any rights granted by any laws and regulations relating to confidentiality of the intervention program, if he or she does any of the following:

(1) Presents information relating to any aspect of the intervention program during any stage of the disciplinary process subsequent to the filing of an accusation, statement of issues, or petition to compel an examination pursuant to Article 12.5 (commencing with Section 820) of Chapter 1. The waiver shall be limited to information necessary to verify or refute any information disclosed by the registered nurse.

(2) Files a lawsuit against the board relating to any aspect of the intervention program.

(3) Claims in defense to a disciplinary action, based on a complaint that led to the registered nurse's participation in the intervention program, that he or she was prejudiced by the length of time that passed between the alleged violation and the filing of the accusation. The waiver shall be limited to information necessary to document the length of time the registered nurse participated in the intervention program.

SEC. 30. Section 2770.13 of the Business and Professions Code is amended to read:

2770.13. The board shall provide for the legal representation of any person making reports under this article to a committee or the board in any action for defamation directly resulting from those reports regarding a registered nurse's participation in an intervention program.

SEC. 31. Section 2835.5 of the Business and Professions Code is amended to read:

2835.5. On and after January 1, 2008, an applicant for initial qualification or certification as a nurse practitioner under this article who has not been qualified or certified as a nurse practitioner in California or any other state shall meet the following requirements:

(a) Hold a valid and active registered nursing license issued under this chapter.

(b) Possess a master's degree in nursing, a master's degree in a clinical field related to nursing, or a graduate degree in nursing.

(c) Satisfactorily complete a nurse practitioner program approved by the board.

SEC. 32. Section 3057 of the Business and Professions Code is amended to read:

3057. (a) The board may issue a license to practice optometry to a person who meets all of the following requirements:

(1) Has a degree as a doctor of optometry issued by an accredited school or college of optometry.

(2) Has successfully passed the licensing examination for an optometric license in another state.

(3) Submits proof that he or she is licensed in good standing as of the date of application in every state where he or she holds a license, including compliance with continuing education requirements.

(4) Is not subject to disciplinary action as set forth in subdivision (h) of Section 3110. If the person has been subject to disciplinary action, the board shall review that action to determine if it presents sufficient evidence of a violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(5) Has furnished a signed release allowing the disclosure of information from the National Practitioner Database and, if applicable, the verification of registration status with the federal Drug Enforcement Administration. The board shall review this information to determine if it presents sufficient evidence of a violation of this chapter to warrant the submission of additional information from the person or the denial of the application for licensure.

(6) Has never had his or her license to practice optometry revoked or suspended in any state where the person holds a license.

(7) (A) Is not subject to denial of an application for licensure based on any of the grounds listed in Section 480.

(B) Is not currently required to register as a sex offender pursuant to Section 290 of the Penal Code.

(8) Has met the minimum continuing education requirements set forth in Section 3059 for the current and preceding year.

(9) Has met the certification requirements of Section 3041.3 to use therapeutic pharmaceutical agents under subdivision (e) of Section 3041.

(10) Submits any other information as specified by the board to the extent it is required for licensure by examination under this chapter.

(11) Files an application on a form prescribed by the board, with an acknowledgment by the person executed under penalty of perjury and automatic forfeiture of license, of the following:

(A) That the information provided by the person to the board is true and correct, to the best of his or her knowledge and belief.

(B) That the person has not been convicted of an offense involving conduct that would violate Section 810.

(12) Pays an application fee in an amount equal to the application fee prescribed pursuant to subdivision (a) of Section 3152.

(13) Has successfully passed the board's jurisprudence examination.

(b) If the board finds that the competency of a candidate for licensure pursuant to this section is in question, the board may require the passage of a written, practical, or clinical examination or completion of additional continuing education or coursework.

(c) In cases where the person establishes, to the board's satisfaction, that he or she has been displaced by a federally declared emergency and cannot relocate to his or her state of practice within a reasonable time without economic hardship, the board may reduce or waive the fees required by paragraph (12) of subdivision (a).

(d) Any license issued pursuant to this section shall expire as provided in Section 3146, and may be renewed as provided in this chapter, subject to the same conditions as other licenses issued under this chapter.

(e) The term "in good standing," as used in this section, means that a person under this section:

(1) Is not currently under investigation nor has been charged with an offense for any act substantially related to the practice of optometry by any public agency, nor entered into any consent agreement or subject to an administrative decision that contains conditions placed by an agency upon a person's professional conduct or practice, including any voluntary surrender of license, nor been the subject of an adverse judgment resulting from the practice of optometry that the board determines constitutes evidence of a pattern of incompetence or negligence.

(2) Has no physical or mental impairment related to drugs or alcohol, and has not been found mentally incompetent by a licensed psychologist or licensed psychiatrist so that the person is unable to undertake the practice of optometry in a manner consistent with the safety of a patient or the public.

SEC. 33. Section 3509.5 of the Business and Professions Code is amended to read:

3509.5. The board shall elect annually a president and a vice president from among its members.

SEC. 34. Section 4836.2 of the Business and Professions Code is amended to read:

4836.2. (a) Applications for a veterinary assistant controlled substance permit shall be upon a form furnished by the board.

(b) The fee for filing an application for a veterinary assistant controlled substance permit shall be set by the board in an amount the board determines is reasonably necessary to provide sufficient funds to carry out the purposes of this section, not to exceed one hundred dollars (\$100).

(c) The board may suspend or revoke the controlled substance permit of a veterinary assistant after notice and hearing for any cause provided in this subdivision. The proceedings under this section shall be conducted in accordance with the provisions for administrative adjudication in Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all the powers granted therein. The board may deny, revoke, or suspend a veterinary assistant controlled substance permit for any of the following reasons:

(1) The employment of fraud, misrepresentation, or deception in obtaining a veterinary assistant controlled substance permit.

(2) Chronic inebriety or habitual use of controlled substances.

(3) The veterinary assistant to whom the permit is issued has been convicted of a state or federal felony controlled substance violation.

(4) Violating or attempts to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this chapter, or of the regulations adopted under this chapter.

(d) The board shall not issue a veterinary assistant controlled substance permit to any applicant with a state or federal felony controlled substance conviction.

(e) (1) As part of the application for a veterinary assistant controlled substance permit, the applicant shall submit to the Department of Justice fingerprint images and related information, as required by the Department of Justice for all veterinary assistant applicants, for the purposes of obtaining

information as to the existence and content of a record of state or federal convictions and state or federal arrests and information as to the existence and content of a record of state or federal arrests for which the Department of Justice establishes that the person is free on bail or on his or her own recognizance pending trial or appeal.

(2) When received, the Department of Justice shall forward to the Federal Bureau of Investigation requests for federal summary criminal history information that it receives pursuant to this section. The Department of Justice shall review any information returned to it from the Federal Bureau of Investigation and compile and disseminate a response to the board summarizing that information.

(3) The Department of Justice shall provide a state or federal level response to the board pursuant to paragraph (1) of subdivision (p) of Section 11105 of the Penal Code.

(4) The Department of Justice shall charge a reasonable fee sufficient to cover the cost of processing the request described in this subdivision.

(f) The board shall request from the Department of Justice subsequent notification service, as provided pursuant to Section 11105.2 of the Penal Code, for persons described in paragraph (1) of subdivision (e).

(g) This section shall become operative on July 1, 2015.

SEC. 35. Section 4887 of the Business and Professions Code is amended to read:

4887. (a) A person whose license or registration has been revoked or who has been placed on probation may petition the board for reinstatement or modification of penalty including modification or termination of probation after a period of not less than one year has elapsed from the effective date of the decision ordering the disciplinary action. The petition shall state such facts as may be required by the board.

(b) The petition shall be accompanied by at least two verified recommendations from veterinarians licensed by the board who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed. The petition shall be heard by the board. The board may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities since the license or registration was in good standing, and the petitioner's rehabilitation efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the board finds necessary.

(c) The board reinstating the license or registration or modifying a penalty may impose terms and conditions as it determines necessary. To reinstate a revoked license or registration or to otherwise reduce a penalty or modify probation shall require a vote of five of the members of the board.

(d) The petition shall not be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. The board may deny without a hearing or argument any petition filed pursuant to this section

within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 36. Section 4938 of the Business and Professions Code is amended to read:

4938. The board shall issue a license to practice acupuncture to any person who makes an application and meets the following requirements:

(a) Is at least 18 years of age.

(b) Furnishes satisfactory evidence of completion of one of the following:

(1) (A) An approved educational and training program.

(B) If an applicant began his or her educational and training program at a school or college that submitted a letter of intent to pursue accreditation to, or attained candidacy status from, the Accreditation Commission for Acupuncture and Oriental Medicine, but the commission subsequently denied the school or college candidacy status or accreditation, respectively, the board may review and evaluate the educational training and clinical experience to determine whether to waive the requirements set forth in this subdivision with respect to that applicant.

(2) Satisfactory completion of a tutorial program in the practice of an acupuncturist that is approved by the board.

(3) In the case of an applicant who has completed education and training outside the United States, documented educational training and clinical experience that meets the standards established pursuant to Sections 4939 and 4941.

(c) Passes a written examination administered by the board that tests the applicant's ability, competency, and knowledge in the practice of an acupuncturist. The written examination shall be developed by the Office of Professional Examination Services of the Department of Consumer Affairs.

(d) Is not subject to denial pursuant to Division 1.5 (commencing with Section 475).

(e) Completes a clinical internship training program approved by the board. The clinical internship training program shall not exceed nine months in duration and shall be located in a clinic in this state that is an approved educational and training program. The length of the clinical internship shall depend upon the grades received in the examination and the clinical training already satisfactorily completed by the individual prior to taking the examination. On and after January 1, 1987, individuals with 800 or more hours of documented clinical training shall be deemed to have met this requirement. The purpose of the clinical internship training program shall be to ensure a minimum level of clinical competence.

Each applicant who qualifies for a license shall pay, as a condition precedent to its issuance and in addition to other fees required, the initial licensure fee.

SEC. 37. Section 4939 of the Business and Professions Code, as added by Section 9 of Chapter 397 of the Statutes of 2014, is amended to read:

4939. (a) The board shall establish standards for the approval of educational training and clinical experience received outside the United States.

(b) This section shall become operative on January 1, 2017.

SEC. 38. Section 4980.399 of the Business and Professions Code is amended to read:

4980.399. (a) Except as provided in subdivision (a) of Section 4980.398, each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider as specified by the board by regulation, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

SEC. 39. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage

and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. Experience shall not be gained by an intern or trainee as an independent contractor.

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision

(c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars (\$500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(l) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 40. Section 4980.54 of the Business and Professions Code is amended to read:

4980.54. (a) The Legislature recognizes that the education and experience requirements in this chapter constitute only minimal requirements to ensure that an applicant is prepared and qualified to take the licensure examinations as specified in subdivision (d) of Section 4980.40 and, if he or she passes those examinations, to begin practice.

(b) In order to continuously improve the competence of licensed marriage and family therapists and as a model for all psychotherapeutic professions, the Legislature encourages all licensees to regularly engage in continuing education related to the profession or scope of practice as defined in this chapter.

(c) Except as provided in subdivision (e), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of marriage and family therapy in the preceding two years, as determined by the board.

(d) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education

coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as defined by the board.

(f) The continuing education shall be obtained from one of the following sources:

(1) An accredited school or state-approved school that meets the requirements set forth in Section 4980.36 or 4980.37. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

(g) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (f), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(h) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of marriage and family therapy.

(2) Aspects of the discipline of marriage and family therapy in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of marriage and family therapy.

(i) A system of continuing education for licensed marriage and family therapists shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(j) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (f) shall be deemed to be an approved provider.

(k) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 41. Section 4984.01 of the Business and Professions Code, as amended by Section 31 of Chapter 473 of the Statutes of 2013, is amended to read:

4984.01. (a) The marriage and family therapist intern registration shall expire one year from the last day of the month in which it was issued.

(b) To renew the registration, the registrant shall, on or before the expiration date of the registration, complete all of the following actions:

- (1) Apply for renewal on a form prescribed by the board.
 - (2) Pay a renewal fee prescribed by the board.
 - (3) Participate in the California law and ethics examination pursuant to Section 4980.399 each year until successful completion of this examination.
 - (4) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, and whether any disciplinary action has been taken against him or her by a regulatory or licensing board in this or any other state subsequent to the last renewal of the registration.
- (c) The registration may be renewed a maximum of five times. No registration shall be renewed or reinstated beyond six years from the last day of the month during which it was issued, regardless of whether it has been revoked. When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4980.399. An applicant who is issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.
- (d) This section shall become operative on January 1, 2016.

SEC. 42. Section 4989.34 of the Business and Professions Code is amended to read:

4989.34. (a) To renew his or her license, a licensee shall certify to the board, on a form prescribed by the board, completion in the preceding two years of not less than 36 hours of approved continuing education in, or relevant to, educational psychology.

(b) (1) The continuing education shall be obtained from either an accredited university or a continuing education provider as specified by the board by regulation.

(2) The board shall establish, by regulation, a procedure identifying acceptable providers of continuing education courses, and all providers of continuing education shall comply with procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(c) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of educational psychology.

(2) Aspects of the discipline of educational psychology in which significant recent developments have occurred.

(3) Aspects of other disciplines that enhance the understanding or the practice of educational psychology.

(d) The board may audit the records of a licensee to verify completion of the continuing education requirement. A licensee shall maintain records of the completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon its request.

(e) The board may establish exceptions from the continuing education requirements of this section for good cause, as determined by the board.

(f) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The amount of the fees shall be sufficient to meet, but shall not exceed, the costs of administering this section.

(g) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 43. Section 4992.09 of the Business and Professions Code is amended to read:

4992.09. (a) Except as provided in subdivision (a) of Section 4992.07, an applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application except for as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at a minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider, as specified by the board by regulation, a county, state or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics

examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative on January 1, 2016.

SEC. 44. Section 4996.2 of the Business and Professions Code is amended to read:

4996.2. Each applicant for a license shall furnish evidence satisfactory to the board that he or she complies with all of the following requirements:

(a) Is at least 21 years of age.

(b) Has received a master's degree from an accredited school of social work.

(c) Has had two years of supervised post-master's degree experience, as specified in Section 4996.23.

(d) Has not committed any crimes or acts constituting grounds for denial of licensure under Section 480. The board shall not issue a registration or license to any person who has been convicted of any crime in this or another state or in a territory of the United States that involves sexual abuse of children or who is required to register pursuant to Section 290 of the Penal Code or the equivalent in another state or territory.

(e) Has completed adequate instruction and training in the subject of alcoholism and other chemical substance dependency. This requirement applies only to applicants who matriculate on or after January 1, 1986.

(f) Has completed instruction and training in spousal or partner abuse assessment, detection, and intervention. This requirement applies to an applicant who began graduate training during the period commencing on January 1, 1995, and ending on December 31, 2003. An applicant who began graduate training on or after January 1, 2004, shall complete a minimum of 15 contact hours of coursework in spousal or partner abuse assessment, detection, and intervention strategies, including knowledge of community resources, cultural factors, and same gender abuse dynamics. Coursework required under this subdivision may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

(g) Has completed a minimum of 10 contact hours of training or coursework in human sexuality as specified in Section 1807 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

(h) Has completed a minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 1807.2 of Title 16 of the California Code of Regulations. This training or coursework may be satisfactory if taken either in fulfillment of other educational requirements for licensure or in a separate course.

SEC. 45. Section 4996.22 of the Business and Professions Code is amended to read:

4996.22. (a) (1) Except as provided in subdivision (c), the board shall not renew any license pursuant to this chapter unless the applicant certifies to the board, on a form prescribed by the board, that he or she has completed

not less than 36 hours of approved continuing education in or relevant to the field of social work in the preceding two years, as determined by the board.

(2) The board shall not renew any license of an applicant who began graduate study prior to January 1, 2004, pursuant to this chapter unless the applicant certifies to the board that during the applicant's first renewal period after the operative date of this section, he or she completed a continuing education course in spousal or partner abuse assessment, detection, and intervention strategies, including community resources, cultural factors, and same gender abuse dynamics. On and after January 1, 2005, the course shall consist of not less than seven hours of training. Equivalent courses in spousal or partner abuse assessment, detection, and intervention strategies taken prior to the operative date of this section or proof of equivalent teaching or practice experience may be submitted to the board and at its discretion, may be accepted in satisfaction of this requirement. Continuing education courses taken pursuant to this paragraph shall be applied to the 36 hours of approved continuing education required under paragraph (1).

(b) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completion of required continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(c) The board may establish exceptions from the continuing education requirement of this section for good cause as defined by the board.

(d) The continuing education shall be obtained from one of the following sources:

(1) An accredited school of social work, as defined in Section 4991.2, or a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers, as specified by the board by regulation.

(e) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (d), shall adhere to the procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(f) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding, or the practice, of social work.

(2) Aspects of the social work discipline in which significant recent developments have occurred.

(3) Aspects of other related disciplines that enhance the understanding, or the practice, of social work.

(g) A system of continuing education for licensed clinical social workers shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(h) The continuing education requirements of this section shall comply fully with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

(i) The board may adopt regulations as necessary to implement this section.

(j) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (d) shall be deemed to be an approved provider.

SEC. 46. Section 4996.28 of the Business and Professions Code is amended to read:

4996.28. (a) Registration as an associate clinical social worker shall expire one year from the last day of the month during which it was issued. To renew a registration, the registrant shall, on or before the expiration date of the registration, complete all of the following actions:

(1) Apply for renewal on a form prescribed by the board.

(2) Pay a renewal fee prescribed by the board.

(3) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, and whether any disciplinary action has been taken by a regulatory or licensing board in this or any other state, subsequent to the last renewal of the registration.

(4) On and after January 1, 2016, obtain a passing score on the California law and ethics examination pursuant to Section 4992.09.

(b) A registration as an associate clinical social worker may be renewed a maximum of five times. When no further renewals are possible, an applicant may apply for and obtain a subsequent associate clinical social worker registration number if the applicant meets all requirements for registration in effect at the time of his or her application for a subsequent associate clinical social worker registration number. An applicant issued a subsequent associate registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

SEC. 47. Section 4999.1 of the Business and Professions Code is amended to read:

4999.1. Application for registration as a telephone medical advice service shall be made on a form prescribed by the department, accompanied by the fee prescribed pursuant to Section 4999.5. The department shall make application forms available. Applications shall contain all of the following:

(a) The signature of the individual owner of the telephone medical advice service, or of all of the partners if the service is a partnership, or of the

president or secretary if the service is a corporation. The signature shall be accompanied by a resolution or other written communication identifying the individual whose signature is on the form as owner, partner, president, or secretary.

(b) The name under which the person applying for the telephone medical advice service proposes to do business.

(c) The physical address, mailing address, and telephone number of the business entity.

(d) The designation, including the name and physical address, of an agent for service of process in California.

(e) A list of all health care professionals providing medical advice services that are required to be licensed, registered, or certified pursuant to this chapter. This list shall be submitted to the department on a form to be prescribed by the department and shall include, but not be limited to, the name, state of licensure, type of license, and license number.

(f) The department shall be notified within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes.

SEC. 48. Section 4999.2 of the Business and Professions Code is amended to read:

4999.2. (a) In order to obtain and maintain a registration, a telephone medical advice service shall comply with the requirements established by the department. Those requirements shall include, but shall not be limited to, all of the following:

(1) (A) Ensuring that all health care professionals who provide medical advice services are appropriately licensed, certified, or registered as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as an occupational therapist pursuant to Chapter 5.6 (commencing with Section 2570), as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a naturopathic doctor pursuant to Chapter 8.2 (commencing with Section 3610), as a marriage and family therapist pursuant to Chapter 13 (commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991), as a licensed professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), or as a chiropractor pursuant to the Chiropractic Initiative Act, and operating consistent with the laws governing their respective scopes of practice in the state within which they provide telephone medical advice services, except as provided in paragraph (2).

(B) Ensuring that all health care professionals who provide telephone medical advice services from an out-of-state location, as identified in

subparagraph (A), are licensed, registered, or certified in the state within which they are providing the telephone medical advice services and are operating consistent with the laws governing their respective scopes of practice.

(2) Ensuring that the telephone medical advice provided is consistent with good professional practice.

(3) Maintaining records of telephone medical advice services, including records of complaints, provided to patients in California for a period of at least five years.

(4) Ensuring that no staff member uses a title or designation when speaking to an enrollee, subscriber, or consumer that may cause a reasonable person to believe that the staff member is a licensed, certified, or registered health care professional described in subparagraph (A) of paragraph (1), unless the staff member is a licensed, certified, or registered professional.

(5) Complying with all directions and requests for information made by the department.

(6) Notifying the department within 30 days of any change of name, physical location, mailing address, or telephone number of any business, owner, partner, corporate officer, or agent for service of process in California, together with copies of all resolutions or other written communications that substantiate these changes.

(7) Submitting quarterly reports, on a form prescribed by the department, to the department within 30 days of the end of each calendar quarter.

(b) To the extent permitted by Article VII of the California Constitution, the department may contract with a private nonprofit accrediting agency to evaluate the qualifications of applicants for registration pursuant to this chapter and to make recommendations to the department.

SEC. 49. Section 4999.3 of the Business and Professions Code is amended to read:

4999.3. (a) The department may suspend, revoke, or otherwise discipline a registrant or deny an application for registration as a telephone medical advice service based on any of the following:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant or any employee of the registrant.

(2) An act of dishonesty or fraud by the registrant or any employee of the registrant.

(3) The commission of any act, or being convicted of a crime, that constitutes grounds for denial or revocation of licensure pursuant to any provision of this division.

(b) The proceedings shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the department shall have all powers granted therein.

(c) Copies of any complaint against a telephone medical advice service shall be forwarded to the Department of Managed Health Care.

(d) The department shall forward a copy of any complaint submitted to the department pursuant to this chapter to the entity that issued the license to the licensee involved in the advice provided to the patient.

SEC. 50. Section 4999.4 of the Business and Professions Code is amended to read:

4999.4. (a) Every registration issued to a telephone medical advice service shall expire 24 months after the initial date of issuance.

(b) To renew an unexpired registration, the registrant shall, before the time at which the registration would otherwise expire, pay the renewal fee authorized by Section 4999.5.

(c) An expired registration may be renewed at any time within three years after its expiration upon the filing of an application for renewal on a form prescribed by the bureau and the payment of all fees authorized by Section 4999.5. A registration that is not renewed within three years following its expiration shall not be renewed, restored, or reinstated thereafter, and the delinquent registration shall be canceled immediately upon expiration of the three-year period.

SEC. 51. Section 4999.5 of the Business and Professions Code is amended to read:

4999.5. The department may set fees for registration and renewal as a telephone medical advice service sufficient to pay the costs of administration of this chapter.

SEC. 52. Section 4999.7 of the Business and Professions Code is amended to read:

4999.7. (a) This section does not limit, preclude, or otherwise interfere with the practices of other persons licensed or otherwise authorized to practice, under any other provision of this division, telephone medical advice services consistent with the laws governing their respective scopes of practice, or licensed under the Osteopathic Initiative Act or the Chiropractic Initiative Act and operating consistent with the laws governing their respective scopes of practice.

(b) For purposes of this chapter, “telephone medical advice” means a telephonic communication between a patient and a health care professional in which the health care professional’s primary function is to provide to the patient a telephonic response to the patient’s questions regarding his or her or a family member’s medical care or treatment. “Telephone medical advice” includes assessment, evaluation, or advice provided to patients or their family members.

(c) For purposes of this chapter, “health care professional” is an employee or independent contractor described in Section 4999.2 who provides medical advice services and is appropriately licensed, certified, or registered as a dentist, dental hygienist, dental hygienist in alternative practice, or dental hygienist in extended functions pursuant to Chapter 4 (commencing with Section 1600), as a physician and surgeon pursuant to Chapter 5 (commencing with Section 2000) or the Osteopathic Initiative Act, as a registered nurse pursuant to Chapter 6 (commencing with Section 2700), as a psychologist pursuant to Chapter 6.6 (commencing with Section 2900), as a naturopathic doctor pursuant to Chapter 8.2 (commencing with Section 3610), as an optometrist pursuant to Chapter 7 (commencing with Section 3000), as a marriage and family therapist pursuant to Chapter 13

(commencing with Section 4980), as a licensed clinical social worker pursuant to Chapter 14 (commencing with Section 4991), as a licensed professional clinical counselor pursuant to Chapter 16 (commencing with Section 4999.10), or as a chiropractor pursuant to the Chiropractic Initiative Act, and who is operating consistent with the laws governing his or her respective scopes of practice in the state in which he or she provides telephone medical advice services.

SEC. 53. Section 4999.45 of the Business and Professions Code, as amended by Section 54 of Chapter 473 of the Statutes of 2013, is amended to read:

4999.45. (a) An intern employed under this chapter shall:

(1) Not perform any duties, except for those services provided as a clinical counselor trainee, until registered as an intern.

(2) Not be employed or volunteer in a private practice until registered as an intern.

(3) Inform each client prior to performing any professional services that he or she is unlicensed and under supervision.

(4) Renew annually for a maximum of five years after initial registration with the board.

(b) When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4999.53. An applicant issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

(c) This section shall become operative on January 1, 2016.

SEC. 54. Section 4999.46 of the Business and Professions Code, as amended by Section 3 of Chapter 435 of the Statutes of 2014, is amended to read:

4999.46. (a) To qualify for licensure as specified in Section 4999.50, applicants shall complete experience related to the practice of professional clinical counseling under an approved supervisor. The experience shall comply with the following:

(1) A minimum of 3,000 postdegree hours of supervised experience performed over a period of not less than two years (104 weeks).

(2) Not more than 40 hours in any seven consecutive days.

(3) Not less than 1,750 hours of direct counseling with individuals, groups, couples, or families in a setting described in Section 4999.44 using a variety of psychotherapeutic techniques and recognized counseling interventions within the scope of practice of licensed professional clinical counselors.

(4) Not less than 150 hours of clinical experience in a hospital or community mental health setting, as defined in Section 1820 of Title 16 of the California Code of Regulations.

(5) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests,

writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to professional clinical counseling that have been approved by the applicant's supervisor.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) No hours of clinical mental health experience may be gained more than six years prior to the date the application for examination eligibility was filed.

(d) An applicant shall register with the board as an intern in order to be credited for postdegree hours of experience toward licensure. Postdegree hours of experience shall be credited toward licensure, provided that the applicant applies for intern registration within 90 days of the granting of the qualifying degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(e) All applicants and interns shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of professional clinical counseling.

(f) Experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Experience obtained under the supervision of a supervisor with whom the applicant has had or currently has a personal, professional, or business relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(g) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in paragraph (5) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting.

(1) No more than six hours of supervision, whether individual or group, shall be credited during any single week. This paragraph shall apply to supervision hours gained on or after January 1, 2009.

(2) An intern shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour of face-to-face contact on an individual basis or two hours of face-to-face contact in a group of not more than eight persons in segments lasting no less than one continuous hour.

(4) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable, may obtain the required weekly direct supervisor

contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(h) This section shall become operative on January 1, 2016.

SEC. 55. Section 4999.55 of the Business and Professions Code is amended to read:

4999.55. (a) Each applicant and registrant shall obtain a passing score on a board-administered California law and ethics examination in order to qualify for licensure.

(b) A registrant shall participate in a board-administered California law and ethics examination prior to his or her registration renewal.

(c) Notwithstanding subdivision (b), an applicant who holds a registration eligible for renewal, with an expiration date no later than June 30, 2016, and who applies for renewal of that registration between January 1, 2016, and June 30, 2016, shall, if eligible, be allowed to renew the registration without first participating in the California law and ethics examination. These applicants shall participate in the California law and ethics examination in the next renewal cycle, and shall pass the examination prior to licensure or issuance of a subsequent registration number, as specified in this section.

(d) If an applicant fails the California law and ethics examination, he or she may retake the examination, upon payment of the required fees, without further application, except as provided in subdivision (e).

(e) If a registrant fails to obtain a passing score on the California law and ethics examination described in subdivision (a) within his or her renewal period on or after the operative date of this section, he or she shall complete, at minimum, a 12-hour course in California law and ethics in order to be eligible to participate in the California law and ethics examination. Registrants shall only take the 12-hour California law and ethics course once during a renewal period. The 12-hour law and ethics course required by this section shall be taken through a continuing education provider as specified by the board by regulation, a county, state, or governmental entity, or a college or university.

(f) The board shall not issue a subsequent registration number unless the registrant has passed the California law and ethics examination.

(g) Notwithstanding subdivision (f), an applicant who holds or has held a registration, with an expiration date no later than January 1, 2017, and who applies for a subsequent registration number between January 1, 2016, and January 1, 2017, shall, if eligible, be allowed to obtain the subsequent registration number without first passing the California law and ethics examination. These applicants shall pass the California law and ethics examination during the next renewal period or prior to licensure, whichever occurs first.

(h) This section shall become operative January 1, 2016.

SEC. 56. Section 4999.76 of the Business and Professions Code is amended to read:

4999.76. (a) Except as provided in subdivision (c), the board shall not renew any license pursuant to this chapter unless the applicant certifies to

the board, on a form prescribed by the board, that he or she has completed not less than 36 hours of approved continuing education in or relevant to the field of professional clinical counseling in the preceding two years, as determined by the board.

(b) The board shall have the right to audit the records of any applicant to verify the completion of the continuing education requirement. Applicants shall maintain records of completed continuing education coursework for a minimum of two years and shall make these records available to the board for auditing purposes upon request.

(c) The board may establish exceptions from the continuing education requirement of this section for good cause, as defined by the board.

(d) The continuing education shall be obtained from one of the following sources:

(1) A school, college, or university that is accredited or approved, as defined in Section 4999.12. Nothing in this paragraph shall be construed as requiring coursework to be offered as part of a regular degree program.

(2) Other continuing education providers as specified by the board by regulation.

(e) The board shall establish, by regulation, a procedure for identifying acceptable providers of continuing education courses, and all providers of continuing education, as described in paragraphs (1) and (2) of subdivision (d), shall adhere to procedures established by the board. The board may revoke or deny the right of a provider to offer continuing education coursework pursuant to this section for failure to comply with this section or any regulation adopted pursuant to this section.

(f) Training, education, and coursework by approved providers shall incorporate one or more of the following:

(1) Aspects of the discipline that are fundamental to the understanding or the practice of professional clinical counseling.

(2) Significant recent developments in the discipline of professional clinical counseling.

(3) Aspects of other disciplines that enhance the understanding or the practice of professional clinical counseling.

(g) A system of continuing education for licensed professional clinical counselors shall include courses directly related to the diagnosis, assessment, and treatment of the client population being served.

(h) The board shall, by regulation, fund the administration of this section through continuing education provider fees to be deposited in the Behavioral Sciences Fund. The fees related to the administration of this section shall be sufficient to meet, but shall not exceed, the costs of administering the corresponding provisions of this section. For the purposes of this subdivision, a provider of continuing education as described in paragraph (1) of subdivision (d) shall be deemed to be an approved provider.

(i) The continuing education requirements of this section shall fully comply with the guidelines for mandatory continuing education established by the Department of Consumer Affairs pursuant to Section 166.

SEC. 57. Section 4999.100 of the Business and Professions Code, as amended by Section 66 of Chapter 473 of the Statutes of 2013, is amended to read:

4999.100. (a) An intern registration shall expire one year from the last day of the month in which it was issued.

(b) To renew a registration, the registrant on or before the expiration date of the registration, shall do the following:

(1) Apply for a renewal on a form prescribed by the board.

(2) Pay a renewal fee prescribed by the board.

(3) Notify the board whether he or she has been convicted, as defined in Section 490, of a misdemeanor or felony, or whether any disciplinary action has been taken by any regulatory or licensing board in this or any other state, subsequent to the registrant's last renewal.

(4) Participate in the California law and ethics examination pursuant to Section 4999.53 each year until successful completion of this examination.

(c) The intern registration may be renewed a maximum of five times. Registration shall not be renewed or reinstated beyond six years from the last day of the month during which it was issued, regardless of whether it has been revoked. When no further renewals are possible, an applicant may apply for and obtain a subsequent intern registration number if the applicant meets the educational requirements for registration in effect at the time of the application for a subsequent intern registration number and has passed the California law and ethics examination described in Section 4999.53. An applicant who is issued a subsequent intern registration number pursuant to this subdivision shall not be employed or volunteer in a private practice.

(d) This section shall become operative on January 1, 2016.

SEC. 58. Section 15.5 of this bill incorporates amendments to Section 1944 of the Business and Professions Code proposed by both this bill and Assembly Bill 483. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2016, (2) each bill amends Section 1944 of the Business and Professions Code, and (3) this bill is enacted after Assembly Bill 483, in which case Section 15 of this bill shall not become operative.

SEC. 59. 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.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SJR 7
Author: Pan
Chapter: Resolution Chapter 90
Bill Date: April 6, 2015, Amended
Subject: Medical Residency Training Programs
Sponsor: California Academy of Family Physicians
California Medical Association
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This resolution urges the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs, and to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care.

BACKGROUND

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 could apply for a residency slot, than there are residency positions available.

ANALYSIS

This resolution makes the following legislative findings:

- According to a 2014 report by the California Healthcare Foundation, although California has more than 105,000 licensed physicians, only 71,000 are actively involved in providing patient care.
- Federal funding levels for residency training programs have been frozen since 1997, while California's population has increased by more than 10% since that time.
- Medicare's rigid payment formulas for GME do not allow for the innovation needed to improve medical education to produce physicians with the appropriate training needed to meet the nation's current and future health care needs.

- Many primary care physicians, including those who have graduated from California medical schools, want to train in California, but are forced to leave the state because of the shortage in training slots at residency programs. California has been able to address only a minimal portion of primary care residency programs' funding shortfall with state funds.
- Increasing funding for primary care medical residency training programs is a critical step in addressing the physician shortage problem and improving access to medical care.

This resolution urges the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs that are set to expire this year; to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care; and to encourage the development of primary care physician training programs in ambulatory, community, and medically underserved sites through new funding methodologies and incentives.

This resolution encourages increased funding and residency programs in California and would promote more residency positions in California. This resolution may help more physicians to receive residency training and potentially end up practicing in California. For these reasons, the Board took a support position on this resolution.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)

Senate Joint Resolution No. 7

RESOLUTION CHAPTER 90

Senate Joint Resolution No. 7—Relative to physicians.

[Filed with Secretary of State July 1, 2015.]

LEGISLATIVE COUNSEL'S DIGEST

SJR 7, Pan. Medical residency programs.

This measure would urge the Congress and the President of the United States to renew funding for the Health Resources and Services Administration's Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs, and to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to health care.

WHEREAS, According to a 2014 report by the California Healthcare Foundation, although California has more than 105,000 licensed physicians, only 71,000 are actively involved in providing patient care; and

WHEREAS, Certain regions of the state, such as the San Joaquin Valley and the Inland Empire, lack the recommended supply of primary care and specialty physicians and, as a result, those areas have higher populations in poor health; and

WHEREAS, California's shortage and poor distribution of physicians is likely to be exacerbated by increased levels of insured patients and projected increases in the number of physicians planning to retire; and

WHEREAS, Federal funding levels for residency training programs have been frozen since 1997, while California's population has increased by more than 10 percent since that time; and

WHEREAS, Medicare's rigid payment formulas for graduate medical education do not allow for the innovation needed to improve medical education to produce physicians with the appropriate training needed to meet the nation's current and future health care needs; and

WHEREAS, California has been able to address only a minimal portion of primary care residency programs' funding shortfall with state funds; and

WHEREAS, Many primary care physicians, including those who have graduated from California medical schools, want to train in California, but are forced to leave the state because of the shortage in training slots at residency programs; and

WHEREAS, California has the highest retention rate of physicians who complete their residency training in-state; and

WHEREAS, Increasing funding for primary care medical residency training programs is a critical step in addressing the physician shortage problem and improving access to medical care; now, therefore, be it

Resolved by the Senate and the Assembly of the State of California, jointly, That the Legislature calls upon Congress and the President of the United States to renew funding for the Health Resources and Services Administration’s Teaching Health Center and Primary Care Residency Expansion Graduate Medical Education Programs that are set to expire this year; and be it further

Resolved, That the Legislature calls upon Congress and the President to lift the freeze on residency positions funded by Medicare to expand physician supply and improve access to care; and be it further

Resolved, That the Legislature calls upon Congress and the President to encourage the development of primary care physician training programs in ambulatory, community, and medically underserved sites through new funding methodologies and incentives; and be it further

Resolved, That the Secretary of the Senate transmit copies of this resolution to the President and the Vice President of the United States, to the Speaker of the House of Representatives, to the Majority Leader of the Senate, to each Senator and Representative from California in the Congress of the United States, and to the author for appropriate distribution.

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	Gonzalez	Employment: Paid Sick Days: In-Home Supportive Services	2-year Bill	03/11/15
AB 12	Cooley	State Government: Administrative Regulations: Review	2-year Bill	08/19/15
AB 19	Chang	GO BIZ: Small Business: Regulations	2-year Bill	05/06/15
AB 41	Chau	Health Care Coverage: Discrimination	2-year Bill	
AB 50	Mullin	Medi-Cal: Evidence-Based Home Visiting Program	Vetoed	09/04/15
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	2-year Bill	04/20/15
AB 68	Waldron	Medi-Cal	Vetoed	08/18/15
AB 70	Waldron	Emergency Medical Services: Reporting	2-year Bill	03/26/15
AB 73	Waldron	Prescriber Prevails Act	2-year Bill	05/04/15
AB 83	Gatto	Personal Data	2-year Bill	07/15/15
AB 85	Wilk	Open Meetings	Vetoed	04/15/15
AB 170	Gatto	Newborn Screening: Genetic Diseases: Blood Samples	2-year Bill	07/08/15
AB 174	Gray	UC: Medical Education	2-year Bill	06/01/15
AB 193	Maienschein	Mental Health: Conservatorship Hearings	Vetoed	09/02/15
AB 243	Wood	Medical Marijuana	Chaptered, #688	09/11/15
AB 258	Levine	Organ Transplants: Medical Marijuana: Qualified Patients	Chaptered, #51	03/25/15
AB 259	Dababneh	Personal Information: Privacy	2-year Bill	
AB 266	Bonta	Medical Marijuana	Chaptered, #689	09/11/15
AB 304	Gonzalez	Sick Leave: Accrual Limitations	Chaptered, #67	04/27/15
AB 322	Waldron	Privacy: Social Security Numbers	2-year Bill	03/26/15
AB 330	Chang	State Government	2-year Bill	
AB 333	Melendez	Healing Arts: Continuing Education	Chaptered, #360	06/24/15
AB 339	Gordon	Health Care Coverage: Outpatient Prescription Drugs	Chaptered, #619	09/04/15
AB 344	Chavez	Medi-Cal	2-year Bill	
AB 351	Jones-Sawyer	Public Contracts: Small Business Participation	2-year Bill	

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 366	Bonta	Medi-Cal: Annual Access Monitoring Report	2-year Bill	07/07/15
AB 374	Nazarian	Health Care Coverage: Prescription Drugs	Chaptered, #621	09/02/15
AB 383	Gipson	Public Health: Hepatitis C	2-year Bill	04/30/15
AB 389	Chau	Hospitals: Language Assistance Services	Chaptered, #327	09/01/15
AB 403	Stone, M	Public Social Services: Foster Care Placement	Chaptered, #773	07/07/15
AB 410	Obernolte	Reports Submitted to Legislative Committees	Vetoed	08/24/15
AB 411	Lackey	Public Contracts	2-year Bill	
AB 413	Chavez	California Disabled Veteran Business Enterprise Program	Chaptered, #513	06/30/15
AB 419	Kim	Go BIZ: Regulations	2-year Bill	05/04/15
AB 444	Gipson	Health Facilities: Epidural and Enteral Feeding Connecters	Chaptered, #198	06/01/15
AB 463	Chiu	Pharmaceutical Cost Transparency Act of 2015	2-year Bill	
AB 466	McCarty	State Civil Service: Employment Procedures	2-year Bill	07/06/15
AB 483	Patterson	Healing Arts: License Fees: Proration	Vetoed	09/02/15
AB 486	Bonilla	Centralized Hospital Packaging Pharmacies: Medication Labels	Chaptered, #241	
AB 503	Rodriguez	Emergency Medical Service	Chaptered, #362	07/07/15
AB 507	Olsen	DCA: BreEZe System: Annual Report	2-year Bill	07/09/15
AB 508	Garcia, C.	Public Health: Prenatal Care	2-year Bill	
AB 513	Jones-Sawyer	Professions and Vocations	2-year Bill	
AB 521	Nazarian	HIV Testing	Vetoed	09/04/15
AB 532	McCarty	State Agencies: Collection of Data: Race or Ethnic Origin	Chaptered, #433	09/03/15
AB 533	Bonta	Health Care Coverage: Out-of-Network Coverage	2-year Bill	09/04/15
AB 537	Allen, T.	Public Employees' Benefits	2-year Bill	
AB 546	Gonzalez	Peace Officers: Basic Training Requirements	Chaptered, #200	06/29/15
AB 570	Allen, T.	Cardiovascular Disease: High Blood Pressure	2-year Bill	
AB 572	Gaines	California Diabetes Program	2-year Bill	07/02/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 574	Patterson	General Acute Care Hospitals: Cardiovascular Surgical Teams	2-year Bill	03/26/15
AB 584	Cooley	Public Employee Retirement Systems	2-year Bill	04/06/15
AB 614	Brown	Health Care Standards of Practice	Chaptered, #435	06/02/15
AB 618	Maienschein	Parole: Primary Mental Health Clinicians	2-year Bill	
AB 623	Wood	Abuse-Deterrent Opioid Analgesic Drug Products	2-year Bill	05/04/15
AB 635	Atkins	Medical Interpretation Services	2-year Bill	
AB 649	Patterson	Medical Waste: Law Enforcement Drug Take back Programs	2-year Bill	06/24/15
AB 664	Dodd	Medi-Cal: Universal Assessment Tool Report	Chaptered, #367	06/25/15
AB 676	Calderon	Employment: Discrimination	Vetoed	08/31/15
AB 714	Melendez	State Employees: Health Benefits	2-year Bill	
AB 728	Hadley	State Government: Financial Reporting	Chaptered, #371	08/24/15
AB 741	Williams	Mental Health: Community Care Facilities	2-year Bill	05/04/15
AB 750	Low	Business and Professions: Retired License Category	2-year Bill	04/16/15
AB 757	Gomez	Healing Arts: Clinical Laboratories	Vetoed	06/22/15
AB 766	Ridley-Thomas	Public School Health Center Support Program	2-year Bill	04/27/15
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	2-year Bill	
AB 773	Baker	Board of Psychology: Licenses	Chaptered, #336	09/01/15
AB 775	Chiu	Reproductive FACT Act	Chaptered, #700	05/04/15
AB 788	Chu	Prescriptions	2-year Bill	03/26/15
AB 789	Calderon	Contact Lens Sellers: Prohibited Practices: Fines	2-year Bill	04/22/15
AB 791	Cooley	Electronic Health Records	2-year Bill	
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	2-year Bill	
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	2-year Bill	
AB 843	Hadley	Controller: Internet Web Site	2-year Bill	03/26/15
AB 845	Cooley	Health Care Coverage: Vision Care	2-year Bill	04/21/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 848	Stone, M	Alcoholism and Drug Abuse Treatment Facilities	Chaptered, #744	08/31/15
AB 859	Medina	Medi-Cal: Obesity Treatment Plans	2-year Bill	04/30/15
AB 868	Obernolte	PERS: Contracting Agencies: Transfer of Membership	Chaptered, #86	
AB 918	Stone, M	Health and Care Facilities: Seclusion and Behavior Restraints	Chaptered, #340	08/26/15
AB 972	Jones	Ken Maddy California Cancer Registry	2-year Bill	
AB 981	Mayes	Eyeglasses	2-year Bill	
AB 993	Comm. P.E.R.S	State Employees: MOU	2-year Bill	
AB 1001	Gatto	Child Abuse: Reporting	2-year Bill	
AB 1027	Gatto	Health Care Coverage: Contracted Rates	2-year Bill	03/26/15
AB 1046	Dababneh	Hospitals: Community Benefits	2-year Bill	04/07/15
AB 1060	Bonilla	Cancer Clinical Trials	Vetoed	08/31/15
AB 1067	Gipson	Foster Children: Psychotropic Medication	2-year Bill	03/26/15
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	2-year Bill	07/01/15
AB 1073	Ting	Pharmacy: Prescription Drug Labels	Chaptered, #784	09/04/15
AB 1092	Mullin	Magnetic Resonance Imaging Technologists	2-year Bill	05/04/15
AB 1102	Santiago	Health Care Coverage: Medi-Cal Access Program	Sen. Health	07/09/15
AB 1104	Rodriguez	Search Warrants	Chaptered, #124	06/23/15
AB 1117	Garcia, C.	Medi-Cal: Vaccination Rates	Sen. Approps	06/01/15
AB 1124	Perea	Workers Compensation: Medication Formulary	Chaptered, #525	09/04/15
AB 1125	Weber	State Agency Contracts: Small Business	2-year Bill	05/04/15
AB 1129	Burke	Emergency Medical Services: Data and Information System	Chaptered, #377	08/20/15
AB 1133	Achadjian	School-Based Early Mental Health Intervention and Prevention	2-year Bill	04/15/15
AB 1174	Bonilla	Health Research: Women's Health	2-year Bill	04/20/15
AB 1215	Ting	California Open Data Standard	2-year Bill	03/26/15
AB 1219	Baker	California Cancer Task Force	2-year Bill	

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1223	O'Donnell	Emergency Medical Services: Ambulance Transportation	Chaptered, #379	06/30/15
AB 1231	Wood	Medi-Cal: Non-Medical Transport	Vetoed	09/04/15
AB 1254	Grove	Health Care Service Plans: Abortion Coverage	2-year Bill	04/06/15
AB 1281	Wilk	Regulations: Legislative Review	2-year Bill	03/26/15
AB 1293	Holden	State Public Employment: Labor Negotiations	Vetoed	03/26/15
AB 1294	Holden	State Government: Prompt Payment of Claims	2-year Bill	03/26/15
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	2-year Bill	07/16/15
AB 1302	Brown	Public Contracts: Disabled Veterans	2-year Bill	
AB 1337	Linder	Medical Records: Electronic Delivery	Chaptered, #528	07/16/15
AB 1351	Eggman	Deferred Entry of Judgment: Pretrial Diversion	Vetoed	09/03/15
AB 1352	Eggman	Deferred Entry of Judgment: Withdrawal of Plea	Chaptered, #646	09/09/15
AB 1357	Bloom	Children and Family Health Promotion Program	2-year Bill	04/29/15
AB 1359	Nazarian	Optometry: Therapeutic Pharmaceutical Agents Certification	Chaptered, #443	06/16/15
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	2-year Bill	04/16/15
AB 1396	Bonta	Public Health Finance	2-year Bill	06/03/15
AB 1423	Stone, M	Prisoners: Medical Treatment	Chaptered, #381	04/20/15
AB 1434	McCarty	Health Insurance: Prohibition on Health Insurance Sales	2-year Bill	04/20/15
AB 1445	Brown	Public Contracts: Small Business Contracts	2-year Bill	
AB 1460	Thurmond	Hospitals: Community Benefit Plans	2-year Bill	
AB 1485	Patterson	Medi-Cal: Radiology	2-year Bill	05/05/15
ABX2 12	Patterson	Cadaveric Fetal Tissue	Assembly	
ABX2 13	Gipson	Medi-Cal: AIDS Medi-Cal Waiver Program	Assembly	
ACA 3	Gallagher	Public Employees' Retirement	2-year Bill	
ACR 38	Brown	California Task Force on Family Caregiving	Chaptered, #200	09/02/15
ACR 97	Bonilla	Medical Training: Osteopathic Students	Chaptered, #189	09/02/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 3	Leno	Minimum Wage: Adjustment	2-year Bill	03/11/15
SB 4	Lara	Health Care Coverage: Immigration Status	Chaptered, #709	09/10/15
SB 10	Lara	Health Care Coverage: Immigration Status	2-year Bill	09/09/15
SB 11	Beall	Peace Officer Training: Mental Health	Chaptered, #468	08/28/15
SB 24	Hill	Electronic Cigarettes: Licensing and Restrictions	2-year Bill	06/01/15
SB 26	Hernandez	California Health Care Cost and Quality Database	2-year Bill	05/05/15
SB 29	Beall	Peace Officer Training: Mental Health	Chaptered, #469	08/31/15
SB 36	Hernandez	Medi-Cal: Demonstration Project	Chaptered, #759	09/04/15
SB 43	Hernandez	Health Care Coverage: Essential Health Benefits	Chaptered, #648	08/17/15
SB 52	Walters	Regulatory Boards: Healing Arts	2-year Bill	
SB 58	Knight	Public Employees' Retirement System	2-year Bill	
SB 131	Cannella	UC: Medical Education	2-year Bill	05/12/15
SB 137	Hernandez	Health Care Coverage: Provider Directories	Chaptered, #649	09/04/15
SB 139	Galgiani	Controlled Substances	2-year Bill	08/18/15
SB 145	Pan	Robert F. Kennedy Farm Workers Medical Plan	Chaptered, #712	09/10/15
SB 190	Beall	Health Care Coverage: Acquired Brain Injury	2-year Bill	04/06/15
SB 201	Wieckowski	California Public Records Act	2-year Bill	
SB 202	Hernandez	Controlled Substances: Unfair or Deceptive Practice	2-year Bill	03/16/15
SB 214	Berryhill	Foster Care Services	2-year Bill	
SB 216	Pan	Public Employees' Retirement System	Chaptered, #244	06/03/15
SB 221	Jackson	State Public Employees: Sick Leave: Veterans	Chaptered, #794	07/09/15
SB 238	Mitchell	Foster Care: Psychotropic Medication	Chaptered, #534	09/04/15
SB 243	Hernandez	Medi-Cal: Reimbursement: Provider Rates	2-year Bill	05/12/15
SB 251	Roth	Disability Access: Civil Rights: Income Tax Credit	Vetoed	09/04/15
SB 253	Monning	Dependent Children: Psychotropic Medication	2-year Bill	08/31/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 275	Hernandez	Health Facility Data	2-year Bill	
SB 280	Stone, J	Public Employees: Compensation	2-year Bill	04/15/15
SB 282	Hernandez	Health Care Coverage: Prescription Drugs	Chaptered, #654	09/02/15
SB 289	Mitchell	Telephonic and Electronic Patient Management Services	2-year Bill	05/04/15
SB 291	Lara	Mental Health: Vulnerable Communities	Vetoed	09/04/15
SB 293	Pan	Public Employees: Retirement	2-year Bill	
SB 296	Cannella	Medi-Cal: Specialty Mental Health Services: Documentation	2-year Bill	08/28/15
SB 299	Monning	Medi-Cal: Provider Enrollment	Chaptered, #271	05/18/15
SB 315	Monning	Health Care Access Demonstration Project Grants	2-year Bill	08/31/15
SB 319	Beall	Child Welfare Services: Public Health Nursing	Chaptered, #535	09/03/15
SB 346	Wieckowski	Health Facilities: Community Benefits	2-year Bill	04/23/15
SB 349	Bates	Optometry: Mobile Optometric Facilities	2-year Bill	04/06/15
SB 354	Huff	California Public Employees Pension Reform Act	Chaptered, #158	04/06/15
SB 370	Wolk	Immunizations: Disclosure of Information: TB Screening	2-year Bill	
SB 375	Berryhill	Public Employees' Retirement	2-year Bill	
SB 376	Lara	Public Contracts: UC	Vetoed	08/18/15
SB 402	Mitchell	Pupil Health: Vision Examinations	2-year Bill	05/04/15
SB 407	Morrell	Comprehensive Perinatal Services Program: Licensed Midwives	Chaptered, #313	07/07/15
SB 435	Pan	Medical Home: Health Care Delivery Model	2-year Bill	07/07/15
SB 447	Allen	Medi-Cal: Clinics: Enrollment Applications	2-year Bill	06/01/15
SB 453	Pan	Prisons: Involuntary Medication	Chaptered, #260	07/08/15
SB 459	Liu	State Government: Data	2-year Bill	
SB 467	Hill	Professions and Vocations	Chaptered, #656	09/03/15
SB 484	Beall	Juveniles	Chaptered, #540	09/03/15
SB 492	Liu	Coordinate Care Initiative: Consumer Ed. & Info. Guide	2-year Bill	06/25/15

MBC TRACKER II BILLS
10/15/2015

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 525	Nielsen	Respiratory Care Practice	Chaptered, #247	06/16/15
SB 547	Liu	Long-Term Care	2-year Bill	
SB 560	Monning	Licensing Boards	Asm. Approps	07/09/15
SB 563	Pan	Workers' Compensation: Utilization Review	2-year Bill	04/30/15
SB 570	Jackson	Personal Information: Privacy: Breach	Chaptered, #543	09/01/15
SB 571	Liu	Long-Term Care: CalCareNet	2-year Bill	04/21/15
SB 573	Pan	Statewide Open Data Portal	2-year Bill	07/09/15
SB 579	Jackson	Employees: Time Off	Chaptered, #802	07/16/15
SB 587	Stone, J	Pharmacy: Drug Regimens: Hypertension and Hyperlipidemia	2-year Bill	04/09/15
SB 609	Stone, J	Controlled Substances: Narcotic Replacement Treatment	2-year Bill	04/21/15
SB 613	Allen	Public Health: Dementia Guidelines: Workgroup	Chaptered, #577	07/06/15
SB 614	Leno	Medi-Cal: Mental Health Services	2-year Bill	08/31/15
SB 644	Hancock	LEAP: Persons with Developmental Disabilities	Chaptered, #356	08/28/15
SB 658	Hill	Automated External Defibrillators	Chaptered, #264	06/15/15
SB 671	Hill	Pharmacy: Biological Product	Chaptered, #545	07/16/15
SB 729	Wieckowski	Consumer Complaints	2-year Bill	
SB 744	Huff	Pupil Health: Epinephrine Auto-Injectors	2-year Bill	
SB 779	Hall	Skilled Nursing Facilities: Certified Nurse Assistants	2-year Bill	05/04/15
SB 780	Mendoza	Psychiatric Technicians and Assistants	2-year Bill	
SB 792	Mendoza	Day Care Facilities: Immunizations: Exemptions	Chaptered, #807	09/04/15
SCR 4	Pan	Physician Anesthesiologist Week	Chaptered, #3	
SCR 13	Jackson	American Heart Month and Wear Red Day in California	Chaptered, #22	01/29/15
SR 17	Jackson	California Health Care Decisions Day	Adopted	03/16/15

LEGISLATIVE PROPOSALS 2016

Verify a Physician's License Campaign

Board staff is working on launching an outreach campaign to encourage all patients to verify their physician's license on the Medical Board's website. Part of the plan for this campaign is to focus outreach efforts in March. Board staff is suggesting that the Board pursue a legislative resolution to proclaim March of every year, "Verify a Physician's License Month". This is another tool to enhance the outreach campaign efforts to improve the Board's visibility, and increase awareness of the Board's website and the physician profile information it offers to consumers.

Resignation of License Option for Discipline

Board staff has become aware of a growing number of cases that result in discipline because a licensee has some type of disability that impairs his or her practice, but the licensee does not apply for a disabled license. Many times these cases result in a patient care incident and related discipline. Board staff is also seeing the same issue for older physicians who continue to practice although they may face some cognitive issues due to age. Many of these physicians have had long, distinguished careers, which unfortunately have to end in discipline. Both of these types of cases are difficult cases to settle. Many of these physicians have not had prior discipline, and do not want to surrender their licenses. For physicians in this situation who are facing an accusation that would result in more than a public letter of reprimand, but less than revocation, the Board is suggesting a new option for discipline, resignation of a license. The resignation option would allow a physician to voluntarily resign, but not allow the physician to reinstate his or her license. A resignation option might be more desirable for the disabled or older physician, and would ensure patient protection by taking that physician out of practice in California. It would merely be an option for the Board to consider for discipline, and it would be up to the Board to decide if that particular option is appropriate for each particular case.

Allied Health Licensee Clean up

Board staff is suggesting that law be amended to clarify the Board's authority in licensing and regulating allied health licensees (Licensed Midwives, Research Psychoanalysts and Polysomnographic Technologists and Trainees). There are many provisions that apply to physicians and surgeons that the Board also applies to allied health licensees, and the Board wishes to clarify its authority in law to do so. The Board tried to include some of these provisions in last year's omnibus bill, but they were removed because legislative staff thought they were too substantive for omnibus legislation. The Board would like clear authority to take disciplinary action against allied health licensees for excessive use of drugs or alcohol (Business and Professions Code (BPC) Section 2239), to revoke or deny a license for registered sex offenders (BPC Section 2232), to allow allied health licensees to petition for license reinstatement (BPC Section 2307), to allow the Board to use probation as a disciplinary option for allied health licensees (BPC Section 2228), and to obtain payment for the costs of probation monitoring.

Major Clean up Items

There are also several areas that need clean up where the changes may be too substantive for omnibus. Board staff would like to run a bill that would include the allied health clean up and the other major clean up items.

- Board staff would like to clean up the provisions in the Medical Practice Act that include the Board of Podiatric Medicine (BPM). As legislation was going through last session, it became clear that existing law does not accurately portray the Board's relationship with the BPM. In existing law it appears that the Board oversees and houses the BPM, when that is not the case. Board staff would like to clean up all sections that reference Board oversight over the BPM and move or amend the appropriate sections of the Medical Practice Act and the laws that regulate the BPM, in Article 22 of the BPC.
- Existing law (BPC Section 2221) lists the reasons a physician's license application can be denied. The Board also has the responsibility to deny or approve a postgraduate training authorization letter (PTAL) for international graduates. Although the Board currently uses the same reasons to deny a PTAL as it does for denying a license, this authority needs to be clarified in statute by including PTALs in BPC Section 2221.
- The Board currently has a limited practice license that applicants or disabled status licensees may apply for if they are otherwise eligible for licensure, but unable to practice all aspects of medicine safely due to a disability. The way the law is written now, only new licensees or disabled status licensees can apply for a limited practice license. Board staff believes that all licensees should be able to apply for a limited practice license at any time. Board staff would like to make it clear in law that the limited practice license is an option for all licensees.
- Currently when a physician is on probation, all related discipline documents are available on the Board's website for as long as those documents are public. However, if the Board issues a probationary license to an applicant (BPC Section 2221), it is not specified in law how long that information should be made available to the public. Board staff believes this information should follow the law related to physicians placed on probation, and that documents related to probationary licenses should be disclosed to an inquiring member of the public and posted on the Board's website.
- Existing law related to investigations that involve the death of a patient (BPC Section 2225(c)(1)) allows the Board to inspect and copy the medical records of the deceased patient without the authorization of the next of kin of the deceased patient or court order, solely for the purpose of determining the extent to which the death was result of the physician's conduct in violation of the Medical Practice Act. The Board must provide a written request to the physician that owns the records, which includes a declaration that the Board has been unsuccessful in locating or contacting the patient's next of kin after reasonable efforts. Sometimes the physician is no longer practicing at the facility where the care of the deceased patient occurred or where the records are located. Board staff would like to amend this section to allow the Board to send a written request to the facility where the care occurred or where the records are located, in an attempt to secure the patient records and allow the Board to move forward with its investigation.

Omnibus

- Delete BPC Section 852 related to the Task Force on Culturally and Linguistically Competent Physicians and Dentists, as this task force no longer exists.
- Delete BPC Sections 2380 – 2392, as the Bureau of Medical Statistics does not exist in the Board.
- Delete BPC Section 2029 related to retention of complaints, as this section is not relevant. The Board has its own records retention schedule and BPC Section 2227.5 also specifies how long the Board retains complaints. In addition, the Board’s statute of limitations (BPC Section 2230.5) already applies.
- BPC Section 2441 is related to limited practice licenses. This section requires the applicant/licensee to sign an agreement in which the applicant/licensee agrees to limit his or her practice in the manner prescribed to by the reviewing physician. This subdivision (b) needs to be amended to clarify that the Board must also agree to the practice limitation that the reviewing physician is suggesting for the applicant/licensee.

**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***
Issuance of Citations	Filed with Secretary of State; at request of Board, became effective immediately on 8/31/15	7/25/14	8/08/14	9/24/14; continued to 10/14/14	7/25/14	To DCA 5/6/15 To Agency 6/11/15 To DOF 6/19/15	7/30/15	8/31/15
CME Requirements	Public Hearing held 5/8/15	10/24/14	3/6/15	5/8/2015	5/8/15			
Physician & Surgeon Licensing Examinations Minimum Passing Scores	Staff working to finish the file	5/8/15	6/5/15	7/31/15	7/31/15			
Outpatient Surgery Setting Accreditation Agency Standards	Staff working to finish the file	5/8/15	6/5/15	7/31/15	7/31/15			
Disclaimers and Explanatory Information Applicable to Internet Postings	Will be discussed at meeting on 10/30/15 with a request for a 15-day notice for amended language	5/8/15	6/5/15	7/31/15	7/31/15			
Disciplinary Guidelines	Public hearing scheduled 10/30/15	7/25/14 7/31/15	9/4/15	10/30/15				

Prepared by Kevin A. Schunke
Updated on October 12, 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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 14, 2015
ATTENTION: Members, Medical Board of California
SUBJECT: Proposed Amendments to Title 16 of the California Code
of Regulations section 1355.35
FROM: Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the attached proposed language modifying Title 16 California Code of Regulations (CCR) section 1355.35 (Attachment A), make a motion to approve the modified language, and authorize staff to notice the modified language for a 15-day comment period. If no negative comments are received, authorize the Executive Director to make any non-substantive changes and complete the rulemaking process.

BACKGROUND:

At the May 2015 meeting of the Medical Board of California (Board) Board Members authorized staff to begin the regulatory process to amend 16 CCR section 1355.35. The proposed amendments to the regulations would allow the Board to provide disclaimers and explanatory information on the Internet, as appropriate, regarding court orders, misdemeanor convictions, licenses issued with a public letter of reprimand, and probationary licenses. The amended regulations would also update the Board's address, and update the chart defining the terms related to the status code of a license to include status codes regarding the issuance of a temporary license for noncompliance with a judgment or order for family support and a license suspension for noncompliance with a judgment or order for family support.

The proposed amendments to section 1355.35 were noticed for a 45-day comment period. No comments were received from the public. Upon further review, however, an error was identified in 1355.35(a)(10) due to a recent legislative amendment to the Code section referenced in the regulation. Accordingly, staff recommends the language be amended as indicated in Attachment A, and noticed for a 15-day comment period.

If the Members vote to support this modification, it will be noticed for a 15-day comment period. If no adverse comments are received, the Board could authorize the Executive Director to make any non-substantive changes required to complete the rulemaking process.

MEDICAL BOARD OF CALIFORNIA

**DISCLAIMERS AND EXPLANATORY INFORMATION
APPLICABLE TO INTERNET POSTINGS**

Specific Language of Proposed Changes

MODIFIED TEXT

Legend

Originally proposed amendments are shown by ~~strikethrough~~ for deleted text and underline for new text.

Changes to the originally proposed language are shown by ~~highlighted double strikethrough~~ for deleted text and by highlighted double underline for new text.

(1) Amend Section 1355.35 of Article 1, Chapter 2, Division 13, of Title 16 of the California Code of Regulations to read as follows:

Section 1355.35. Disclaimers and Explanatory Information Applicable to Internet Postings.

License Status Definitions.

(a) In addition to the disclaimer required by Section 803.1(c) of the code, the following disclaimers and explanatory information, as appropriate, shall be provided with information released on the Internet:

(1) Administrative Citation Issued:

A citation and/or fine has been issued for a minor violation of the law. This is not considered disciplinary action under California law but is an administrative action. Payment of the fine amount represents satisfactory resolution of this matter.

(2) Administrative Disciplinary Action:

The Medical Board's public disclosure screens are updated periodically as new information becomes available. Please contact the Central File Room at (916) 263-2525 or at ~~1426 Howe Avenue, Suite 54, Sacramento, CA 95825~~ 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of public documents at a minimal charge.

(3) Arbitration Award:

An arbitration award is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported arbitration awards and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by

law from releasing a copy of the arbitration award report or any other information concerning the award.

(4) Administrative Action Taken by Other State or Federal Government:

This information is provided by another state/federal government agency. The Medical Board of California may take administrative action based on the action imposed by another state/federal government agency. For more information or verification, contact the agency listed below that imposed the action.

(5) Felony Conviction:

The information provided only includes felony convictions that are known to the Board. All felony convictions known to the Board are reviewed and administrative action is taken only if it is determined that a violation of the Medical Practice Act occurred. For more information regarding felony convictions, contact the court of jurisdiction listed below.

(6) Hospital Disciplinary Action:

The action taken by this healthcare facility against this physician's staff privileges to provide healthcare services at this facility was for a medical disciplinary cause or reason. The Medical Board is authorized by law to disclose only revocations and terminations of staff privileges. The Medical Board is prohibited from releasing a copy of the actual report or any other information.

(7) Malpractice Judgment:

A malpractice judgment is a payment for damages and does not necessarily reflect that the physician's medical competence is below the standard of care. The Medical Board reviews all such reported judgments and action is taken only if it is determined that a violation of the Medical Practice Act occurred. The Medical Board is prohibited by law from releasing a copy of the judgment report or any other information concerning the judgment. For more information contact the court of jurisdiction listed below.

(8) Malpractice Settlements:

A settlement entered into by the licensee is a resolution of a claim for damages for death or personal injury caused by the licensee's negligence, error, or omission in practice, or by his or her rendering of unauthorized professional services. The Medical Board is required by law to disclose certain information related to the existence of multiple settlements made on or after January 1, 2003 in an amount of \$30,000 or more.

(9) Court Order:

This information would be provided if a physician's practice has been temporarily restricted or suspended pursuant to a court order. Please contact the Central File Room at (916) 263-2525 or at 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815, to obtain a copy of the public documents.

(10) Misdemeanor Conviction:

California Business and Professions Code section 2027(b)(5)(A)(7) states effective January 1, 2007, any all misdemeanor convictions that result in a disciplinary action or an accusation that is not subsequently withdrawn or dismissed shall be posted on the Internet. Upon receipt of a certified copy of an expungement order granted pursuant to Section 1203.4 of the Penal Code from a licensee, the Medical Board shall, within six months of receipt of the expungement order, post notification of the expungement order and the date thereof on its website.

(11) License Issued with Public Letter of Reprimand:

The Medical Board of California has concurrently issued the licensee a medical license and a Public Letter of Reprimand for a minor violation that does not require probationary status or warrant denial of licensure. The issuance of a Public Letter of Reprimand is not considered disciplinary action and is not reported to the National Practitioner Databank or the Federation of State Medical Boards.

(12) Probationary License:

License issued on a probationary basis subject to terms and conditions. Practice is permitted unless otherwise specified or license expires.

(b) Information released on the Internet shall be accompanied by a listing of the types of information available from the board on the Internet about physicians licensed by the board and a listing of the types of information that is confidential and not available from the board.

(c) The chart below defined the terms related to the status of a license for purposes of information released about a licensee.

Description Displayed on Web Site	Public Definition of Status Code
License Canceled	License has been voluntarily canceled, or the license has been expired for at least five years and has not been reviewed. No practice is permitted.
License Deceased	Licensee is deceased.
License Delinquent	License renewal fee has not been paid. No practice is permitted.
License Revoked	License has been revoked as a result of disciplinary action rendered by the Board. No practice is permitted.
License Suspended	Licensee has been suspended. No practice is permitted.
License Denied – Family Support	License denied for noncompliance with a judgment or order for support. No practice is permitted. Questions should be directed to the Department of Consumer Affairs’ Family Support Unit at (916) 574-8018.
<u>150 Day Temporary License-Family Support</u>	<u>Licensee issued a temporary 150-day license for noncompliance with a judgment or order for support. Practice is permitted until the license expiration date. Questions should be directed to the Department of Consumer Affairs’ Family Support Unit at (916) 574-8018.</u>
<u>License Suspended – Family Support</u>	<u>License suspended for noncompliance with a judgment or order for support. No practice is permitted. Questions should be directed to the Department of Consumer Affairs’ Family Support Unit at (916) 574-8018.</u>
Licensee in Military	Practice is limited to military service including

	military dependents.
License Inactive	Licensee is required to pay the full renewal fee but is exempt from complying with the continuing medical education requirements. No practice is permitted.
License Renewed & Current	Licensee meets requirements for the practice of medicine in California.
License Renewal Pending	Licensee failed to certify compliance with the continuing medical education requirements and/or failed to certify that he or she disclosed the names of those health-related facilities in which the licensee and/or family may have a financial interest. Practice is permitted unless license expires.
License Retired	License is in retired status and the licensee is exempt from payment of the renewal fee. No practice is permitted.
License Surrendered	Licensee has surrendered his or her license to resolve a disciplinary action. No practice is permitted.
License in Voluntary Service	License is in voluntary service status with no payment allowed for medical services.
License Disabled	Licensee is unable to practice due to a disability. No practice is permitted.
Voluntary Surrender of License	Licensee has voluntarily surrendered the license and the surrender has been accepted by the Board. No disciplinary action was involved. No practice is permitted.
Voluntary Limitations on Practice	Licensee has signed an agreement in which licensee will limit his or her practice in a manner prescribed by the reviewing physician.

Note: Authority cited: Sections 803.1, 2018 and 2027, Business and Professions Code.
Reference: Sections 803.1 and 2027, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 9, 2015
ATTENTION: Board Members
SUBJECT: North Carolina State Board of Dental Examiners v. FTC
FROM: Dianne Dobbs, Senior Staff Counsel
Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

Review the attached Attorney General's Opinion regarding the U.S. Supreme Court case of North Carolina State Board of Dental Examiners v. Federal Trade Commission, which provides an analysis of what constitutes "active state supervision" of licensing boards to preserve state action immunity, and discusses the measures to consider taking to protect against antitrust liability for board members.

BACKGROUND:

On February 25, 2015, the U.S. Supreme Court rendered a decision in North Carolina State Board of Dental Examiners v. Federal Trade Commission that is causing licensing boards across the nation and across disciplines to evaluate their structure and how they make policy decisions effecting market participants. This is an antitrust case about the scope of the "state-action" doctrine. The North Carolina Board of Dental Examiners is comprised of a majority of practicing dentists. The dental board aggressively pursued non-dentist teeth whiteners by sending them warning letters and cease-and-desist letters claiming that they were engaged in the unauthorized practice of dentistry. Ultimately, non-dentist teeth whiteners stopped offering these services in North Carolina.

The Federal Trade Commission (FTC) determined that the dental board's actions violated the federal antitrust law and sued the board. The dental board argued that its actions did not violate the law, because it is a state agency and is therefore immune from antitrust law. The case progressed all the way to the U.S. Supreme Court, which held that a state board on which a controlling number of decision makers are active market participants in the occupation the board regulates must satisfy "active supervision" requirements to get antitrust state-action immunity.

For boards consisting of a controlling number of market participants, the defensibility of their actions is going to turn on whether the state's review mechanisms provide "realistic assurance" that the boards' anticompetitive conduct promotes state policy, rather than merely the market participants' individual interests. The Court identified a few constant requirements of active supervision: 1) The supervisor must review the substance of the anticompetitive decision, not merely the procedures followed to produce it; 2) The supervisor must have the power to veto or modify particular decisions to ensure they accord with state policy; 3) The mere potential for state supervision is not an adequate substitute for a decision by the state; and 4) the state supervisor may not itself be an active market participant.

The Court further held that the inquiry regarding active supervision is flexible and is context-dependent; it is not meant to require daily involvement in a board's operations or micromanagement of its every decision. Thus, the result in this Supreme Court case is unlikely to impact the Medical Board's licensing or typical enforcement decisions. Nonetheless, it is expected that this decision will lead to future litigation against similarly-comprised boards across the country.

ATTORNEY GENERAL'S OPINION

This case prompted California Senator Jerry Hill to request an opinion from the Attorney General (AG) as to what constitutes “active state supervision” of state licensing boards, and how to guard against antitrust liability for board members.

Overview of Conclusions

In short, the AG’s opinion stated the following:

“Active state supervision” requires a state official to review the substance of a regulatory decision made by a state licensing board, in order to determine whether the decision actually furthers a clearly articulated state policy to displace competition with regulation in a particular market. The official reviewing the decision must not be an active member of the market being regulated, and must have and exercise the power to approve, modify, or disapprove the decision.

AG Opinion No. 15-402, at p. 1.

The AG’s opinion identified some broad areas of operation where board members can act with reasonable confidence of preserving their state action immunity:

1. Promulgation of regulations, in light of the public notice, written justification, Director review, and review by the Office of Administrative Law pursuant to the Administrative Procedure Act. Please note that market-sensitive regulations will require more active supervision than others.
2. Disciplinary decisions, in light of the due process procedures in place; participation of state actors, such as board executive directors, investigators, prosecutors, and administrative law judges; and the availability of administrative mandamus review.
3. Carrying out the actions required by a detailed anticompetitive statutory scheme, because, “detailed legislation leaves nothing for the state to supervise, and thus it may be said that the legislation itself satisfies the supervision requirement.”
4. The adoption of safety standards that are based on objective expert judgments, because they have been found by the courts to be pro-competitive, rather than anti-competitive.

Id., at pp. 8-9.

Board Composition

The AG found that changing the composition of the boards to decrease the number of market-participant board members would not necessarily shield board members from antitrust liability. The AG pointed out that the U.S. Supreme Court did not use the term “majority;” it used “controlling number.” There are several unresolved questions regarding how changing the board composition would impact antitrust liability. As long as these questions remain unresolved, radical changes to the board make up would likely create new challenges, with no promise of bolstering state-action immunity. Id., at pp. 10-11.

Increasing Active State Supervision

With regard to options for increasing state supervision of board actions, the AG suggested the powers of the Director of the Department of Consumer Affairs could be expanded to make review of anti-competitive board decisions mandatory, or to make the Director's review available upon the request of a board. Moreover, statutory changes would need to be considered to prevent the Director's disapproval from being overridden by the board pursuant to Business and Professions Code section 313.1(e)(3), because such an override would nullify the "active supervision" and the benefit of state-action immunity gained by the Director's review. Id., at p. 14.

Legislation Granting Immunity to Board Members

The AG pointed out that a state cannot grant blanket immunity for anticompetitive activity; there would probably still have to be active state supervision to give effect to the intended immunity. Id., at p. 15.

Indemnification of Board Members

Board members are generally entitled to have the state provide for the defense of any civil action stemming from an act or omission in the scope of employment. While the state does not have to provide a defense in cases where the board member acted due to actual fraud, corruption, or actual malice, there is no exception to the duty to defend for antitrust violations. Id., at p. 16.

In general, the government is liable for injuries caused by an act within the scope of employment, but is not liable for punitive damages. If an antitrust violation is proven, an award of treble damages is automatic. There is a question as to whether treble damages equates to punitive damages that would not be paid by the state, but by the individual or individuals who were found to have taken the anti-competitive action. The AG opined that treble damages are not the same as punitive damages, and should be paid by the state, if awarded. Id., at pp. 16-17.

The question about the legal status of treble damage awards could be resolved with a legislative change "to specify that treble damage antitrust awards are not punitive damages within the meaning of the Government Claims Act." This change would act as reassurance to board members that if an antitrust violation is proven, the state, and not the individual board members, will pay for the compensatory, general, and treble damages. Id., at p. 17.

Training

Finally, the AG advised that the potential for board member liability may be significantly reduced by providing training on antitrust concepts so that there is a shared awareness of the sensitivity of certain kinds of actions. Such training will prepare board members to be able to harness the evidence and articulate the reasons for their decisions in market-sensitive areas. Id., at p. 18.

TO BE PUBLISHED IN THE OFFICIAL REPORTS

OFFICE OF THE ATTORNEY GENERAL
State of California

KAMALA D. HARRIS
Attorney General

OPINION	:	No. 15-402
	:	
of	:	September 10, 2015
	:	
KAMALA D. HARRIS	:	
Attorney General	:	
	:	
SUSAN DUNCAN LEE	:	
Deputy Attorney General	:	
	:	

THE HONORABLE JERRY HILL, MEMBER OF THE STATE SENATE, has requested an opinion on the following question:

What constitutes “active state supervision” of a state licensing board for purposes of the state action immunity doctrine in antitrust actions, and what measures might be taken to guard against antitrust liability for board members?

CONCLUSIONS

“Active state supervision” requires a state official to review the substance of a regulatory decision made by a state licensing board, in order to determine whether the decision actually furthers a clearly articulated state policy to displace competition with regulation in a particular market. The official reviewing the decision must not be an active member of the market being regulated, and must have and exercise the power to approve, modify, or disapprove the decision.

Measures that might be taken to guard against antitrust liability for board members include changing the composition of boards, adding lines of supervision by state officials, and providing board members with legal indemnification and antitrust training.

ANALYSIS

In *North Carolina State Board of Dental Examiners v. Federal Trade Commission*,¹ the Supreme Court of the United States established a new standard for determining whether a state licensing board is entitled to immunity from antitrust actions.

Immunity is important to state actors not only because it shields them from adverse judgments, but because it shields them from having to go through litigation. When immunity is well established, most people are deterred from filing a suit at all. If a suit is filed, the state can move for summary disposition of the case, often before the discovery process begins. This saves the state a great deal of time and money, and it relieves employees (such as board members) of the stresses and burdens that inevitably go along with being sued. This freedom from suit clears a safe space for government officials and employees to perform their duties and to exercise their discretion without constant fear of litigation. Indeed, allowing government actors freedom to exercise discretion is one of the fundamental justifications underlying immunity doctrines.²

Before *North Carolina Dental* was decided, most state licensing boards operated under the assumption that they were protected from antitrust suits under the state action immunity doctrine. In light of the decision, many states—including California—are reassessing the structures and operations of their state licensing boards with a view to determining whether changes should be made to reduce the risk of antitrust claims. This opinion examines the legal requirements for state supervision under the *North Carolina Dental* decision, and identifies a variety of measures that the state Legislature might consider taking in response to the decision.

¹ *North Carolina State Bd. of Dental Examiners v. F. T. C.* (2015) ___ U.S. ___, 135 S. Ct. 1101 (*North Carolina Dental*).

² See *Mitchell v. Forsyth* (1985) 472 U.S. 511, 526; *Harlow v. Fitzgerald* (1982) 457 U.S. 800, 819.

I. *North Carolina Dental* Established a New Immunity Standard for State Licensing Boards

A. *The North Carolina Dental* Decision

The North Carolina Board of Dental Examiners was established under North Carolina law and charged with administering a licensing system for dentists. A majority of the members of the board are themselves practicing dentists. North Carolina statutes delegated authority to the dental board to regulate the practice of dentistry, but did not expressly provide that teeth-whitening was within the scope of the practice of dentistry.

Following complaints by dentists that non-dentists were performing teeth-whitening services for low prices, the dental board conducted an investigation. The board subsequently issued cease-and-desist letters to dozens of teeth-whitening outfits, as well as to some owners of shopping malls where teeth-whiteners operated. The effect on the teeth-whitening market in North Carolina was dramatic, and the Federal Trade Commission took action.

In defense to antitrust charges, the dental board argued that, as a state agency, it was immune from liability under the federal antitrust laws. The Supreme Court rejected that argument, holding that a state board on which a controlling number of decision makers are active market participants must show that it is subject to “active supervision” in order to claim immunity.³

B. State Action Immunity Doctrine Before *North Carolina Dental*

The Sherman Antitrust Act of 1890⁴ was enacted to prevent anticompetitive economic practices such as the creation of monopolies or restraints of trade. The terms of the Sherman Act are broad, and do not expressly exempt government entities, but the Supreme Court has long since ruled that federal principles of dual sovereignty imply that federal antitrust laws do not apply to the actions of states, even if those actions are anticompetitive.⁵

This immunity of states from federal antitrust lawsuits is known as the “state action doctrine.”⁶ The state action doctrine, which was developed by the Supreme Court

³ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1114.

⁴ 15 U.S.C. §§ 1, 2.

⁵ *Parker v. Brown* (1943) 317 U.S. 341, 350-351.

⁶ It is important to note that the phrase “state action” in this context means something

in *Parker v. Brown*,⁷ establishes three tiers of decision makers, with different thresholds for immunity in each tier.

In the top tier, with the greatest immunity, is the state itself: the sovereign acts of state governments are absolutely immune from antitrust challenge.⁸ Absolute immunity extends, at a minimum, to the state Legislature, the Governor, and the state's Supreme Court.

In the second tier are subordinate state agencies,⁹ such as executive departments and administrative agencies with statewide jurisdiction. State agencies are immune from antitrust challenge if their conduct is undertaken pursuant to a "clearly articulated" and "affirmatively expressed" state policy to displace competition.¹⁰ A state policy is sufficiently clear when displacement of competition is the "inherent, logical, or ordinary result" of the authority delegated by the state legislature.¹¹

The third tier includes private parties acting on behalf of a state, such as the members of a state-created professional licensing board. Private parties may enjoy state action immunity when two conditions are met: (1) their conduct is undertaken pursuant to a "clearly articulated" and "affirmatively expressed" state policy to displace competition, and (2) their conduct is "actively supervised" by the state.¹² The

very different from "state action" for purposes of analysis of a civil rights violation under section 1983 of title 42 of the United States Code. Under section 1983, *liability* attaches to "state action," which may cover even the inadvertent or unilateral act of a state official not acting pursuant to state policy. In the antitrust context, a conclusion that a policy or action amounts to "state action" results in *immunity* from suit.

⁷ *Parker v. Brown*, *supra*, 317 U.S. 341.

⁸ *Hoover v. Ronwin* (1984) 466 U.S. 558, 574, 579-580.

⁹ Distinguishing the state itself from subordinate state agencies has sometimes proven difficult. Compare the majority opinion in *Hoover v. Ronwin*, *supra*, 466 U.S. at p. 581 with dissenting opinion of Stevens, J., at pp. 588-589. (See *Costco v. Maleng* (9th Cir. 2008) 522 F.3d 874, 887, *subseq. hrg.* 538 F.3d 1128; *Charley's Taxi Radio Dispatch Corp. v. SIDA of Haw., Inc.* (9th Cir. 1987) 810 F.2d 869, 875.)

¹⁰ See *Town of Hallie v. City of Eau Claire* (1985) 471 U.S. 34, 39.

¹¹ *F.T.C. v. Phoebe Putney Health Systems, Inc.* (2013) ___ U.S. ___, 133 S.Ct. 1003, 1013; see also *Southern Motor Carriers Rate Conference, Inc. v. U.S.* (1985) 471 U.S. 48, 57 (state policy need not compel specific anticompetitive effect).

¹² *Cal. Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc.* (1980) 445 U.S. 97, 105 (*Midcal*).

fundamental purpose of the supervision requirement is to shelter only those private anticompetitive acts that the state approves as actually furthering its regulatory policies.¹³ To that end, the mere possibility of supervision—such as the existence of a regulatory structure that is not operative, or not resorted to—is not enough. “The active supervision prong . . . requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy.”¹⁴

C. State Action Immunity Doctrine After *North Carolina Dental*

Until the Supreme Court decided *North Carolina Dental*, it was widely believed that most professional licensing boards would fall within the second tier of state action immunity, requiring a clear and affirmative policy, but not active state supervision of every anticompetitive decision. In California in particular, there were good arguments that professional licensing boards¹⁵ were subordinate agencies of the state: they are formal, ongoing bodies created pursuant to state law; they are housed within the Department of Consumer Affairs and operate under the Consumer Affairs Director’s broad powers of investigation and control; they are subject to periodic sunset review by the Legislature, to rule-making review under the Administrative Procedure Act, and to administrative and judicial review of disciplinary decisions; their members are appointed by state officials, and include increasingly large numbers of public (non-professional) members; their meetings and records are subject to open-government laws and to strong prohibitions on conflicts of interest; and their enabling statutes generally provide well-guided discretion to make decisions affecting the professional markets that the boards regulate.¹⁶

Those arguments are now foreclosed, however, by *North Carolina Dental*. There, the Court squarely held, for the first time, that “a state board on which a controlling

¹³ *Patrick v. Burget* (1988) 486 U.S. 94, 100-101.

¹⁴ *Ibid.*

¹⁵ California’s Department of Consumer Affairs includes some 25 professional regulatory boards that establish minimum qualifications and levels of competency for licensure in various professions, including accountancy, acupuncture, architecture, medicine, nursing, structural pest control, and veterinary medicine—to name just a few. (See http://www.dca.gov/about_ca/entities.shtml.)

¹⁶ Cf. 1A Areeda & Hovenkamp, *supra*, ¶ 227, p. 208 (what matters is not what the body is called, but its structure, membership, authority, openness to the public, exposure to ongoing review, etc.).

number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity."¹⁷ The effect of *North Carolina Dental* is to put professional licensing boards "on which a controlling number of decision makers are active market participants" in the third tier of state-action immunity. That is, they are immune from antitrust actions as long as they act pursuant to clearly articulated state policy to replace competition with regulation of the profession, *and* their decisions are actively supervised by the state.

Thus arises the question presented here: What constitutes "active state supervision"?¹⁸

D. Legal Standards for Active State Supervision

The active supervision requirement arises from the concern that, when active market participants are involved in regulating their own field, "there is a real danger" that they will act to further their own interests, rather than those of consumers or of the state.¹⁹ The purpose of the requirement is to ensure that state action immunity is afforded to private parties only when their actions actually further the state's policies.²⁰

There is no bright-line test for determining what constitutes active supervision of a professional licensing board: the standard is "flexible and context-dependent."²¹ Sufficient supervision "need not entail day-to-day involvement" in the board's operations or "micromanagement of its every decision."²² Instead, the question is whether the review mechanisms that are in place "provide 'realistic assurance'" that the anticompetitive effects of a board's actions promote state policy, rather than the board members' private interests.²³

¹⁷ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1114; *Midcal*, *supra*, 445 U.S at p. 105.

¹⁸ Questions about whether the State's anticompetitive policies are adequately articulated are beyond the scope of this Opinion.

¹⁹ *Patrick v. Burget*, *supra*, 486 U.S. at p. 100, citing *Town of Hallie v. City of Eau Claire*, *supra*, 471 U.S. at p. 47; see *id.* at p. 45 ("A private party . . . may be presumed to be acting primarily on his or its own behalf").

²⁰ *Patrick v. Burget*, *supra*, 486 U.S. at pp. 100-101.

²¹ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1116.

²² *Ibid.*

²³ *Ibid.*

The *North Carolina Dental* opinion and pre-existing authorities allow us to identify “a few constant requirements of active supervision”:²⁴

- The state supervisor who reviews a decision must have the power to reverse or modify the decision.²⁵
- The “mere potential” for supervision is not an adequate substitute for supervision.²⁶
- When a state supervisor reviews a decision, he or she must review the substance of the decision, not just the procedures followed to reach it.²⁷
- The state supervisor must not be an active market participant.²⁸

Keeping these requirements in mind may help readers evaluate whether California law already provides adequate supervision for professional licensing boards, or whether new or stronger measures are desirable.

II. Threshold Considerations for Assessing Potential Responses to *North Carolina Dental*

There are a number of different measures that the Legislature might consider in response to the *North Carolina Dental* decision. We will describe a variety of these, along with some of their potential advantages or disadvantages. Before moving on to those options, however, we should put the question of immunity into proper perspective.

²⁴ *Id.* at pp. 1116-1117.

²⁵ *Ibid.*

²⁶ *Id.* at p. 1116, citing *F.T.C. v. Ticor Title Ins. Co.* (1992) 504 U.S. 621, 638. For example, a passive or negative-option review process, in which an action is considered approved as long as the state supervisor raises no objection to it, may be considered inadequate in some circumstances. (*Ibid.*)

²⁷ *Ibid.*, citing *Patrick v. Burget*, *supra*, 486 U.S. at pp. 102-103. In most cases, there should be some evidence that the state supervisor considered the particular circumstances of the action before making a decision. Ideally, there should be a factual record and a written decision showing that there has been an assessment of the action’s potential impact on the market, and whether the action furthers state policy. (See *In the Matter of Indiana Household Moves and Warehousemen, Inc.* (2008) 135 F.T.C. 535, 555-557; see also Federal Trade Commission, Report of the State Action Task Force (2003) at p. 54.)

²⁸ *North Carolina Dental*, *supra*, 135 S.Ct. at pp. 1116-1117.

There are two important things keep in mind: (1) the loss of immunity, if it is lost, does not mean that an antitrust violation has been committed, and (2) even when board members participate in regulating the markets they compete in, many—if not most—of their actions do not implicate the federal antitrust laws.

In the context of regulating professions, “market-sensitive” decisions (that is, the kinds of decisions that are most likely to be open to antitrust scrutiny) are those that create barriers to market participation, such as rules or enforcement actions regulating the scope of unlicensed practice; licensing requirements imposing heavy burdens on applicants; marketing programs; restrictions on advertising; restrictions on competitive bidding; restrictions on commercial dealings with suppliers and other third parties; and price regulation, including restrictions on discounts.

On the other hand, we believe that there are broad areas of operation where board members can act with reasonable confidence—especially once they and their state-official contacts have been taught to recognize actual antitrust issues, and to treat those issues specially. Broadly speaking, promulgation of regulations is a fairly safe area for board members, because of the public notice, written justification, Director review, and review by the Office of Administrative Law as required by the Administrative Procedure Act. Also, broadly speaking, disciplinary decisions are another fairly safe area because of due process procedures; participation of state actors such as board executive officers, investigators, prosecutors, and administrative law judges; and availability of administrative mandamus review.

We are not saying that the procedures that attend these quasi-legislative and quasi-judicial functions make the licensing boards altogether immune from antitrust claims. Nor are we saying that rule-making and disciplinary actions are per se immune from antitrust laws. What we are saying is that, assuming a board identifies its market-sensitive decisions and gets active state supervision for those, then ordinary rule-making and discipline (faithfully carried out under the applicable rules) may be regarded as relatively safe harbors for board members to operate in. It may require some education and experience for board members to understand the difference between market-sensitive and “ordinary” actions, but a few examples may bring in some light.

North Carolina Dental presents a perfect example of a market-sensitive action. There, the dental board decided to, and actually succeeded in, driving non-dentist teeth-whitening service providers out of the market, even though nothing in North Carolina’s laws specified that teeth-whitening constituted the illegal practice of dentistry. Counter-examples—instances where no antitrust violation occurs—are far more plentiful. For example, a regulatory board may legitimately make rules or impose discipline to prohibit license-holders from engaging in fraudulent business practices (such as untruthful or

deceptive advertising) without violating antitrust laws.²⁹ As well, suspending the license of an individual license-holder for violating the standards of the profession is a reasonable restraint and has virtually no effect on a large market, and therefore would not violate antitrust laws.³⁰

Another area where board members can feel safe is in carrying out the actions required by a detailed anticompetitive statutory scheme.³¹ For example, a state law prohibiting certain kinds of advertising or requiring certain fees may be enforced without need for substantial judgment or deliberation by the board. Such detailed legislation leaves nothing for the state to supervise, and thus it may be said that the legislation itself satisfies the supervision requirement.³²

Finally, some actions will not be antitrust violations because their effects are, in fact, pro-competitive rather than anti-competitive. For instance, the adoption of safety standards that are based on objective expert judgments have been found to be pro-competitive.³³ Efficiency measures taken for the benefit of consumers, such as making information available to the purchasers of competing products, or spreading development costs to reduce per-unit prices, have been held to be pro-competitive because they are pro-consumer.³⁴

III. Potential Measures for Preserving State Action Immunity

A. Changes to the Composition of Boards

The *North Carolina Dental* decision turns on the principle that a state board is a group of private actors, not a subordinate state agency, when “a controlling number of decisionmakers are active market participants in the occupation the board regulates.”³⁵

²⁹ See generally *California Dental Assn. v. F.T.C.* (1999) 526 U.S. 756.

³⁰ See *Oksanen v. Page Memorial Hospital* (4th Cir. 1999) 945 F.2d 696 (*en banc*).

³¹ See *324 Liquor Corp. v. Duffy* (1987) 479 U.S. 335, 344, fn. 6.

³² 1A Areeda & Hovenkamp, *Antitrust Law, supra*, ¶ 221, at p. 66; ¶ 222, at pp. 67, 76.

³³ See *Allied Tube & Conduit Corp. v. Indian Head, Inc.* (1988) 486 U.S. 492, 500-501.

³⁴ *Broadcom Corp. v. Qualcomm Inc.* (3rd Cir. 2007) 501 F.3d 297, 308-309; see generally *Bus. & Prof. Code*, § 301.

³⁵ 135 S.Ct. at p. 1114.

This ruling brings the composition of boards into the spotlight. While many boards in California currently require a majority of public members, it is still the norm for professional members to outnumber public members on boards that regulate healing-arts professions. In addition, delays in identifying suitable public-member candidates and in filling public seats can result in de facto market-participant majorities.

In the wake of *North Carolina Dental*, many observers' first impulse was to assume that reforming the composition of professional boards would be the best resolution, both for state actors and for consumer interests. Upon reflection, however, it is not obvious that sweeping changes to board composition would be the most effective solution.³⁶

Even if the Legislature were inclined to decrease the number of market-participant board members, the current state of the law does not allow us to project accurately how many market-participant members is too many. This is a question that was not resolved by the *North Carolina Dental* decision, as the dissenting opinion points out:

What is a “controlling number”? Is it a majority? And if so, why does the Court eschew that term? Or does the Court mean to leave open the possibility that something less than a majority might suffice in particular circumstances? Suppose that active market participants constitute a voting bloc that is generally able to get its way? How about an obstructionist minority or an agency chair empowered to set the agenda or veto regulations?³⁷

Some observers believe it is safe to assume that the *North Carolina Dental* standard would be satisfied if public members constituted a majority of a board. The

³⁶ Most observers believe that there are real advantages in staffing boards with professionals in the field. The combination of technical expertise, practiced judgment, and orientation to prevailing ethical norms is probably impossible to replicate on a board composed entirely of public members. Public confidence must also be considered. Many consumers would no doubt share the sentiments expressed by Justice Breyer during oral argument in the *North Carolina Dental* case: “[W]hat the State says is: We would like this group of brain surgeons to decide who can practice brain surgery in this State. I don’t want a group of bureaucrats deciding that. I would like brain surgeons to decide that.” (*North Carolina Dental*, *supra*, transcript of oral argument p. 31, available at http://www.supremecourt.gov/oral_arguments/argument_transcripts/13-534_16h1.pdf (hereafter, Transcript).)

³⁷ *North Carolina Dental*, *supra*, 135 S.Ct. at p. 1123 (dis. opn. of Alito, J).

obvious rejoinder to that argument is that the Court pointedly did not use the term “majority;” it used “controlling number.” More cautious observers have suggested that “controlling number” should be taken to mean the majority of a quorum, at least until the courts give more guidance on the matter.

North Carolina Dental leaves open other questions about board composition as well. One of these is: Who is an “active market participant”?³⁸ Would a retired member of the profession no longer be a participant of the market? Would withdrawal from practice during a board member’s term of service suffice? These questions were discussed at oral argument,³⁹ but were not resolved. Also left open is the scope of the market in which a member may not participate while serving on the board.⁴⁰

Over the past four decades, California has moved decisively to expand public membership on licensing boards.⁴¹ The change is generally agreed to be a salutary one for consumers, and for underserved communities in particular.⁴² There are many good reasons to consider continuing the trend to increase public membership on licensing boards—but we believe a desire to ensure immunity for board members should not be the decisive factor. As long as the legal questions raised by *North Carolina Dental* remain unresolved, radical changes to board composition are likely to create a whole new set of policy and practical challenges, with no guarantee of resolving the immunity problem.

B. Some Mechanisms for Increasing State Supervision

Observers have proposed a variety of mechanisms for building more state oversight into licensing boards’ decision-making processes. In considering these alternatives, it may be helpful to bear in mind that licensing boards perform a variety of

³⁸ *Ibid.*

³⁹ Transcript, *supra*, at p. 31.

⁴⁰ *North Carolina Dental, supra*, 135 S.Ct. at p. 1123 (dis. opn. of Alito, J). Some observers have suggested that professionals from one practice area might be appointed to serve on the board regulating another practice area, in order to bring their professional expertise to bear in markets where they are not actively competing.

⁴¹ See Center for Public Interest Law, *A Guide to California’s Health Care Licensing Boards* (July 2009) at pp. 1-2; Shimberg, *Occupational Licensing: A Public Perspective* (1982) at pp. 163-165.

⁴² See Center for Public Interest Law, *supra*, at pp. 15-17; Shimberg, *supra*, at pp. 175-179.

distinct functions, and that different supervisory structures may be appropriate for different functions.

For example, boards may develop and enforce standards for licensure; receive, track, and assess trends in consumer complaints; perform investigations and support administrative and criminal prosecutions; adjudicate complaints and enforce disciplinary measures; propose regulations and shepherd them through the regulatory process; perform consumer education; and more. Some of these functions are administrative in nature, some are quasi-judicial, and some are quasi-legislative. Boards' quasi-judicial and quasi-legislative functions, in particular, are already well supported by due process safeguards and other forms of state supervision (such as vertical prosecutions, administrative mandamus procedures, and public notice and scrutiny through the Administrative Procedure Act). Further, some functions are less likely to have antitrust implications than others: decisions affecting only a single license or licensee in a large market will rarely have an anticompetitive effect within the meaning of the Sherman Act. For these reasons, it is worth considering whether it is less urgent, or not necessary at all, to impose additional levels of supervision with respect to certain functions.

Ideas for providing state oversight include the concept of a superagency, such as a stand-alone office, or a committee within a larger agency, which has full responsibility for reviewing board actions *de novo*. Under such a system, the boards could be permitted to carry on with their business as usual, except that they would be required to refer each of their decisions (or some subset of decisions) to the superagency for its review. The superagency could review each action file submitted by the board, review the record and decision in light of the state's articulated regulatory policies, and then issue its own decision approving, modifying, or vetoing the board's action.

Another concept is to modify the powers of the boards themselves, so that all of their functions (or some subset of functions) would be advisory only. Under such a system, the boards would not take formal actions, but would produce a record and a recommendation for action, perhaps with proposed findings and conclusions. The recommendation file would then be submitted to a supervising state agency for its further consideration and formal action, if any.

Depending on the particular powers and procedures of each system, either could be tailored to encourage the development of written records to demonstrate executive discretion; access to administrative mandamus procedures for appeal of decisions; and the development of expertise and collaboration among reviewers, as well as between the reviewers and the boards that they review. Under any system, care should be taken to structure review functions so as to avoid unnecessary duplication or conflicts with other agencies and departments, and to minimize the development of super-policies not

adequately tailored to individual professions and markets. To prevent the development of “rubber-stamp” decisions, any acceptable system must be designed and sufficiently staffed to enable plenary review of board actions or recommendations at the individual transactional level.

As it stands, California is in a relatively advantageous position to create these kinds of mechanisms for active supervision of licensing boards. With the boards centrally housed within the Department of Consumer Affairs (an “umbrella agency”), there already exists an organization with good knowledge and experience of board operations, and with working lines of communication and accountability. It is worth exploring whether existing resources and minimal adjustments to procedures and outlooks might be converted to lines of active supervision, at least for the boards’ most market-sensitive actions.

Moreover, the Business and Professions Code already demonstrates an intention that the Department of Consumer Affairs will protect consumer interests as a means of promoting “the fair and efficient functioning of the free enterprise market economy” by educating consumers, suppressing deceptive and fraudulent practices, fostering competition, and representing consumer interests at all levels of government.⁴³ The free-market and consumer-oriented principles underlying *North Carolina Dental* are nothing new to California, and no bureaucratic paradigms need to be radically shifted as a result.

The Business and Professions Code also gives broad powers to the Director of Consumer Affairs (and his or her designees)⁴⁴ to protect the interests of consumers at every level.⁴⁵ The Director has power to investigate the work of the boards and to obtain their data and records;⁴⁶ to investigate alleged misconduct in licensing examinations and qualifications reviews;⁴⁷ to require reports;⁴⁸ to receive consumer complaints⁴⁹ and to initiate audits and reviews of disciplinary cases and complaints about licensees.⁵⁰

⁴³ Bus. & Prof. Code, § 301.

⁴⁴ Bus. & Prof. Code, §§ 10, 305.

⁴⁵ See Bus. & Prof. Code, § 310.

⁴⁶ Bus. & Prof. Code, § 153.

⁴⁷ Bus. & Prof. Code, § 109.

⁴⁸ Bus. & Prof. Code, § 127.

⁴⁹ Bus. & Prof. Code, § 325.

⁵⁰ Bus. & Prof. Code, § 116.

In addition, the Director must be provided a full opportunity to review all proposed rules and regulations (except those relating to examinations and licensure qualifications) before they are filed with the Office of Administrative Law, and the Director may disapprove any proposed regulation on the ground that it is injurious to the public.⁵¹ Whenever the Director (or his or her designee) actually exercises one of these powers to reach a substantive conclusion as to whether a board's action furthers an affirmative state policy, then it is safe to say that the active supervision requirement has been met.⁵²

It is worth considering whether the Director's powers should be amended to make review of certain board decisions mandatory as a matter of course, or to make the Director's review available upon the request of a board. It is also worth considering whether certain existing limitations on the Director's powers should be removed or modified. For example, the Director may investigate allegations of misconduct in examinations or qualification reviews, but the Director currently does not appear to have power to review board decisions in those areas, or to review proposed rules in those areas.⁵³ In addition, the Director's power to initiate audits and reviews appears to be limited to disciplinary cases and complaints about licensees.⁵⁴ If the Director's initiative is in fact so limited, it is worth considering whether that limitation continues to make sense. Finally, while the Director must be given a full opportunity to review most proposed regulations, the Director's disapproval may be overridden by a unanimous vote of the board.⁵⁵ It is worth considering whether the provision for an override maintains its utility, given that such an override would nullify any "active supervision" and concomitant immunity that would have been gained by the Director's review.⁵⁶

⁵¹ Bus. & Prof. Code, § 313.1.

⁵² Although a written statement of decision is not specifically required by existing legal standards, developing a practice of creating an evidentiary record and statement of decision would be valuable for many reasons, not the least of which would be the ability to proffer the documents to a court in support of a motion asserting state action immunity.

⁵³ Bus. & Prof. Code, §§ 109, 313.1.

⁵⁴ Bus. & Prof. Code, § 116.

⁵⁵ Bus. & Prof. Code, § 313.1.

⁵⁶ Even with an override, proposed regulations are still subject to review by the Office of Administrative Law.

C. Legislation Granting Immunity

From time to time, states have enacted laws expressly granting immunity from antitrust laws to political subdivisions, usually with respect to a specific market.⁵⁷ However, a statute purporting to grant immunity to private persons, such as licensing board members, would be of doubtful validity. Such a statute might be regarded as providing adequate authorization for anticompetitive activity, but active state supervision would probably still be required to give effect to the intended immunity. What is quite clear is that a state cannot grant blanket immunity by fiat. “[A] state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful”⁵⁸

IV. Indemnification of Board Members

So far we have focused entirely on the concept of immunity, and how to preserve it. But immunity is not the only way to protect state employees from the costs of suit, or to provide the reassurance necessary to secure their willingness and ability to perform their duties. Indemnification can also go a long way toward providing board members the protection they need to do their jobs. It is important for policy makers to keep this in mind in weighing the costs of creating supervision structures adequate to ensure blanket state action immunity for board members. If the costs of implementing a given supervisory structure are especially high, it makes sense to consider whether immunity is an absolute necessity, or whether indemnification (with or without additional risk-management measures such as training or reporting) is an adequate alternative.

As the law currently stands, the state has a duty to defend and indemnify members of licensing boards against antitrust litigation to the same extent, and subject to the same exceptions, that it defends and indemnifies state officers and employees in general civil litigation. The duty to defend and indemnify is governed by the Government Claims Act.⁵⁹ For purposes of the Act, the term “employee” includes officers and uncompensated servants.⁶⁰ We have repeatedly determined that members of a board,

⁵⁷ See 1A Areeda & Hovenkamp, *Antitrust Law*, *supra*, 225, at pp. 135-137; e.g. *AI Ambulance Service, Inc. v. County of Monterey* (9th Cir. 1996) 90 F.3d 333, 335 (discussing Health & Saf. Code, § 1797.6).

⁵⁸ *Parker v. Brown*, *supra*, 317 U.S. at 351.

⁵⁹ Gov. Code, §§ 810-996.6.

⁶⁰ See Gov. Code § 810.2.

commission, or similar body established by statute are employees entitled to defense and indemnification.⁶¹

A. Duty to Defend

Public employees are generally entitled to have their employer provide for the defense of any civil action “on account of an act or omission in the scope” of employment.⁶² A public entity may refuse to provide a defense in specified circumstances, including where the employee acted due to “actual fraud, corruption, or actual malice.”⁶³ The duty to defend contains no exception for antitrust violations.⁶⁴ Further, violations of antitrust laws do not inherently entail the sort of egregious behavior that would amount to fraud, corruption, or actual malice under state law. There would therefore be no basis to refuse to defend an employee on the bare allegation that he or she violated antitrust laws.

B. Duty to Indemnify

The Government Claims Act provides that when a public employee properly requests the employer to defend a claim, and reasonably cooperates in the defense, “the public entity shall pay any judgment based thereon or any compromise or settlement of the claim or action to which the public entity has agreed.”⁶⁵ In general, the government is liable for an injury proximately caused by an act within the scope of employment,⁶⁶ but is not liable for punitive damages.⁶⁷

One of the possible remedies for an antitrust violation is an award of treble damages to a person whose business or property has been injured by the violation.⁶⁸ This raises a question whether a treble damages award equates to an award of punitive damages within the meaning of the Government Claims Act. Although the answer is not

⁶¹ E.g., 81 Ops.Cal.Atty.Gen. 199, 200 (1998); 57 Ops.Cal.Atty.Gen. 358, 361 (1974).

⁶² Gov. Code, § 995.

⁶³ Gov. Code, § 995.2, subd. (a).

⁶⁴ Cf. *Mt. Hawley Insurance Co. v. Lopez* (2013) 215 Cal.App.4th 1385 (discussing Ins. Code, § 533.5).

⁶⁵ Gov. Code, § 825, subd. (a).

⁶⁶ Gov. Code, § 815.2.

⁶⁷ Gov. Code, § 818.

⁶⁸ 15 U.S.C. § 15(a).

entirely certain, we believe that antitrust treble damages do *not* equate to punitive damages.

The purposes of treble damage awards are to deter anticompetitive behavior and to encourage private enforcement of antitrust laws.⁶⁹ And, an award of treble damages is automatic once an antitrust violation is proved.⁷⁰ In contrast, punitive damages are “uniquely justified by and proportioned to the actor’s particular reprehensible conduct as well as that person or entity’s net worth . . . in order to adequately make the award ‘sting’”⁷¹ Also, punitive damages in California must be premised on a specific finding of malice, fraud, or oppression.⁷² In our view, the lack of a malice or fraud element in an antitrust claim, and the immateriality of a defendant’s particular conduct or net worth to the treble damage calculation, puts antitrust treble damages outside the Government Claims Act’s definition of punitive damages.⁷³

C. Possible Improvements to Indemnification Scheme

As set out above, state law provides for the defense and indemnification of board members to the same extent as other state employees. This should go a long way toward reassuring board members and potential board members that they will not be exposed to undue risk if they act reasonably and in good faith. This reassurance cannot be complete, however, as long as board members face significant uncertainty about how much litigation they may have to face, or about the status of treble damage awards.

Uncertainty about the legal status of treble damage awards could be reduced significantly by amending state law to specify that treble damage antitrust awards are not punitive damages within the meaning of the Government Claims Act. This would put them on the same footing as general damages awards, and thereby remove any uncertainty as to whether the state would provide indemnification for them.⁷⁴

⁶⁹ *Clayworth v. Pfizer, Inc.* (2010) 49 Cal.4th 758, 783-784 (individual right to treble damages is “incidental and subordinate” to purposes of deterrence and vigorous enforcement).

⁷⁰ 15 U.S.C. § 15(a).

⁷¹ *Piscitelli v. Friedenber*g (2001) 87 Cal.App.4th 953, 981-982.

⁷² Civ. Code, §§ 818, 3294.

⁷³ If treble damages awards were construed as constituting punitive damages, the state would still have the option of paying them under Government Code section 825.

⁷⁴ Ideally, treble damages should not be available at all against public entities and public officials. Since properly articulated and supervised anticompetitive behavior is

As a complement to indemnification, the potential for board member liability may be greatly reduced by introducing antitrust concepts to the required training and orientation programs that the Department of Consumer Affairs provides to new board members.⁷⁵ When board members share an awareness of the sensitivity of certain kinds of actions, they will be in a much better position to seek advice and review (that is, active supervision) from appropriate officials. They will also be far better prepared to assemble evidence and to articulate reasons for the decisions they make in market-sensitive areas. With training and practice, boards can be expected to become as proficient in making and demonstrating sound market decisions, and ensuring proper review of those decisions, as they are now in making and defending sound regulatory and disciplinary decisions.

V. Conclusions

North Carolina Dental has brought both the composition of licensing boards and the concept of active state supervision into the public spotlight, but the standard it imposes is flexible and context-specific. This leaves the state with many variables to consider in deciding how to respond.

Whatever the chosen response may be, the state can be assured that *North Carolina Dental*'s "active state supervision" requirement is satisfied when a non-market-

permitted to the state and its agents, the deterrent purpose of treble damages does not hold in the public arena. Further, when a state indemnifies board members, treble damages go not against the board members but against public coffers. "It is a grave act to make governmental units potentially liable for massive treble damages when, however 'proprietary' some of their activities may seem, they have fundamental responsibilities to their citizens for the provision of life-sustaining services such as police and fire protection." (*City of Lafayette, La. v. Louisiana Power & Light Co.* (1978) 435 U.S. 389, 442 (dis. opn. of Blackmun, J).)

In response to concerns about the possibility of treble damage awards against municipalities, Congress passed the Local Government Antitrust Act (15 U.S.C. §§ 34-36), which provides that local governments and their officers and employees cannot be held liable for treble damages, compensatory damages, or attorney's fees. (See H.R. Rep. No. 965, 2nd Sess., p. 11 (1984).) For an argument that punitive sanctions should never be levied against public bodies and officers under the Sherman Act, see 1A Areeda & Hovenkamp, *supra*, ¶ 228, at pp. 214-226. Unfortunately, because treble damages are a product of federal statute, this problem is not susceptible of a solution by state legislation.

⁷⁵ Bus. & Prof. Code, § 453.

participant state official has and exercises the power to substantively review a board's action and determines whether the action effectuates the state's regulatory policies.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 12, 2015
ATTENTION: Medical Board of California
SUBJECT: Recognition of International Medical School
Universidad Iberoamericana School of Medicine
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

After review and discussion of the initial evaluation of the Universidad Iberoamericana School of Medicine (UNIBE), Board staff is requesting a motion to authorize the following recommendations:

- 1) Authorize a site visit team to conduct a site inspection of UNIBE and the clinical teaching hospital(s) in the Dominican Republic where the majority of UNIBE students receive clinical training.
- 2) Approve the composition of the site team, which usually includes at least one Board executive staff member, one legal counsel, one Board Member and a medical consultant.
- 3) Delegate to staff the determination of the hospital training site or sites to be evaluated.
- 4) Approve staff to move forward with an out-of-country travel request to authorize travel to the medical school and teaching hospital sites in the Dominican Republic.

BACKGROUND AND ANALYSIS:

UNIBE is a private, non-profit institution that is fully accredited by the Dominican Republic Ministry of Higher Education. The School of Medicine was one of the first academic programs offered by the university and was founded in 1982. UNIBE also offers 15 undergraduate programs and 30 graduate programs, including but not limited to: law, engineering, education, arts, business and health sciences. This report is focusing on the School of Medicine.

The School of Medicine is a five year program. The first year is a pre-medical year and upon successful completion, the medical students start what UNIBE refers to as:

- First year of basic science
- Second year of basic science
- Third year clinical clerkships
- Fourth year clinical clerkships

Universidad Iberoamericana School of Medicine
Request for Recognition by the Medical Board of California
October 12, 2015

UNIBE has approximately 400 faculty who have appropriate credentials from US and European universities. UNIBE has two tracks: Regular Track (taught in Spanish); and International Track (taught in English). The majority of the students are in the Regular Track. In 2013, 253 students were enrolled in the Regular Track and 82 students in the International Track. UNIBE states both tracks require the same curriculum, the same courses, use the same labs and are required to participate in the same research and service learning programs.

UNIBE implemented a “New Educational Model” in 2007, and in 2009 UNIBE required all students to pass a basic science examination in order to progress to the clinical clerkship rotation years.

All third year clinical clerkships are conducted only in the Dominican Republic. Fourth year UNIBE students are eligible for clinical clerkship rotations in some cities in the US, Latin America, Asia and Europe. Based upon UNIBE’s July 14, 2015 response to the Board regarding where the students are doing clinical clerkship rotations, only 24 students completed clerkships in the US in the 2013-2014 academic year.

Many of the students in the International Track seek to obtain postgraduate training in Accreditation Council for Graduate Medical Education (ACGME) accredited residency programs. UNIBE requires International Track students to sit for and pass United States Medical Licensing Examinations (USMLE) Step 1, prior to starting clinical clerkships. In addition, International Track students are required to pass USMLE Steps 1, 2 CK and 2 CS in order to graduate.

The report prepared by Licensing Medical Consultant, James Nuovo , M.D., has been included for your review (pages BRD 19 - 3 through 8). Dr. Nuovo is recommending a site visit at UNIBE and the clinical clerkship teaching facilities in the Dominican Republic.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board’s recognition. These costs include all team members’ lodging, air and ground travel, costs within the guidelines allowed by the State, the medical consultant’s time and daily per diem expense, staff daily per diem expense and the Board Member’s daily per diem expense. Title 16 of the California Code of Regulations section 1314.1(e) requires the medical school to submit payment to the Board for the team’s estimated travel expenses in advance of the site visit.

Date: August 17, 2015

To: Curtis J. Worden
Chief of Licensing
Medical Board of California

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

RE: Evaluation of the Universidad Iberoamericana (UNIBE) School of Medicine

Background

The Medical Board of California (Board) requested a review of the materials provided by the Universidad Iberoamericana (UNIBE) School of Medicine. These were submitted in pursuit of a request for the recognition of UNIBE by the Board to enable their students and graduates to participate in clinical clerkships, to enter graduate medical education programs in California and to become eligible for a license to practice medicine in California.

This report is based on my review of the documents provided to the Board and from a response by the School to additional questions posed after my review of the Self-Assessment Report.

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

Recommendation

The documents that have been provided are insufficient to determine whether the Universidad Iberoamericana School of Medicine is in substantial compliance with the requirements of Business and Professions Code Sections 2089 and 2089.5 and the California Code of Regulations, Title 16, Section 1314.1.

In order to determine whether the UNIBE Program is in substantial compliance with the aforementioned statutes and regulations, I recommend that the Board consider a site visit.

Review

UNIBE has been in existence since 1982. It is described as a private, non-profit institution that is fully accredited by the government of the Dominican Republic Ministry of Higher Education.

The School's mission statement is: "To achieve the development of medical professionals who will be updated with knowledge and have the capacity required to respond to the health needs of society, and promote an integral, human, ethical and innovated approach, developing leadership skills, critical attitude, and a compromise with research and continuous education."

More specifically, they state that the School aims to educate physicians who will:

1. Be able to apply medical knowledge in the prevention, diagnosis and treatment of diseases.
2. Have the analytic tools, through knowledge and the understanding of the principles of health and disease that will allow for the holistic care and treatment of individuals.
3. Respond in an ethical and competent manner to the health and medical needs of the community.
4. Be sensitive, compassionate and socially responsible.
5. Perceive the medical career as a life-long learning experience and be able to understand, design and conduct relevant research.

As a demonstration of their commitment to high academic standards, the School indicates that they will:

1. Attract students of high scholastic performance, serious approach to learning and considerable potential to benefit from and contribute to the stimulating academic environment.
2. Have the Admissions Committee carefully evaluate each applicant's personal qualities such as maturity, responsibility, and leadership abilities as well as their capacity for empathy and judgment. Serious consideration is also given to effective communication and interpersonal skills, community service and a sincere motivation for pursuing a career in medicine.

There are approximately 400 faculty with appropriate credentials from US and European universities.

The UNIBE students are eligible for clinical rotations in some cities in the US, Latin America, Asia and Europe.

Students may be enrolled in either the "Spanish-Language Program" (also known as the Regular Track) or the "English-Language Program" (also known as the International Track). The majority of the students are in the Regular Track; e.g. in 2013 there were

253 students in the Regular Track and 82 students in the International Track. The School states there is no difference in the curriculum; “both tracks are required to take the same course, the contents and methodology are the same, they use the same labs and are required to participate in the same research and service learning programs.”

Many of the students in the International Track seek residency training positions in the US after graduation. Therefore, the School has required that the International Track students sit for the USMLE examinations before starting their clinical clerkships and must pass Step 2 (CK and CS) in order to graduate.

The following is a detailed assessment of the School based on the aforementioned regulations and on their responses to the Self-Assessment Report and the additional concerns brought by this reviewer.

Business and Professions Code Section 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. The curriculum at UNIBE is a 5-year program that is comprised on 3 semesters per year (each semester is 16 weeks duration). Therefore, the total amount of training exceeds the requirements of Section 2089; specifically, the number of hours of instruction exceeds the 4,000 hour minimum requirement in Section 2089 (total hours reported = 8,085 which includes 1,650 hours of premedical requirements).

UNIBE does require a minimum of 80% attendance; Professors obtain attendance information at the beginning of each class. At the end of the semester, an attendance report is submitted to the School by each Professor. Students with absences in excess of 20% are not able to sit for the final examination and are required to complete the course in its entirety.

The School’s curriculum includes all of the required coursework listed in Section 2089(b). The information provided in the Self-Assessment Report indicates that the goals, objectives and course content are appropriate.

The School provided information on their admissions standards. The Self-Study Report describes these admission requirements which include the following: a National Test Certificate, a High School Certificate, Health Certification and a Police Certification/Background Check. Applications are reviewed by the Admissions Committee which includes: the Academic Vice-Rector, Registrar Officer, the Dean of Students and the Admissions Director.

The School describes a policy on accepting transfer students. The policy is as follows:

“Since 2010, students can only transfer credits to the premedical component of the curriculum. The maximum number of credit hours allowed is 8.” Further, “students must start the medical component of their program at UNIBE. Therefore, no determination for placement is needed.”

Business and Professions Code Section 2089.5

The documents provided by UNIBE indicate that the program provides instruction to all of the base sciences and clinical sciences coursework required in Section 2089.5 at multiple facilities. Based on the information provided, it appears that students do this training at a variety of clinical sites.

The third year clerkships combine hospital rotations with lectures on campus. Therefore, all third year rotations are conducted only in the Dominican Republic.

Item #7 in the July 14, 2015 memo to the Board provides information on the number of sites used in the Dominican Republic for the clerkships in Psychiatry, Internal Medicine, Surgery, Family Medicine, Obstetrics and Gynecology and Pediatrics/Neonatology. This information includes the number of students at each site and whether they are in the Regular Track or the International Track.

In the fourth year, students may complete clinical clerkships at a number of international sites in the US, Puerto Rico, Spain and Portugal; however, the information provided in the July 14, 2015 response letter indicates that very few students (24) have completed clerkships in the US in the 2013-2014 academic year.

As stated, UNIBE is a private non-profit institution that is accredited by the government of the Dominican Republic (Ministry of Higher Education). It is “recognized by the World Health Organization, Tribunal Examinador de Medicasos de Puerto Rico, and Spain’s Ministry of Education.” The campus is located in Santa Domingo.

The organizational structure of the School includes a Board of Trustees, Rector, Academic Board, Academic Vice-Rector, Deans, School Directors, Academic Coordinators and Department Directors. Resumes of the members of the organizational structure of the School are presented and appear appropriate. There is also a list in the Self-Assessment Report with the names of the Director of the School of Medicine, the Associate Dean for Academic Affairs and Coordinators for the Basic and Clinical Sciences. Finally, there is a Supervisor of Hospital Rotations.

There is a description of the means by which the School engages in an ongoing review of the program including documentation of the level and extent of its supervision. This is described as the “New Educational Model” which was implemented in 2007. There is a description of the evaluation process of each student. The evaluations are done on a regular basis and document completion of all components of the curriculum.

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

The medical school is a private, non-profit institution that is accredited by the government of the Dominican Republic. Its mission is to: “Develop medical

professionals with the most current knowledge and skills required to respond to today's health care necessities in society.”

The Self-Assessment Report contains extensive and a clearly defined mission statement and educational/research and service objectives.

The report includes the exact language of “broad expectations” and lists goals and objectives. The report lists the integral role of research in its mission and includes statements of its importance, nature, objectives, processes and evaluation of research in the medical education and practice of the School. The School has developed opportunities for student research as well as funding to support these activities.

The structure and content of the education program provides an adequate foundation in the basic sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills and to use those principles and skills to provide competent medical care. However, as noted below, a site visit will be necessary to confirm that the training in the clinical sciences is sufficient.

As required in Section 1314.1, the administration and governance system allows the institution to accomplish its objective, i.e., its statements of the items of knowledge, skills, behavior and attitude that students are expected to learn. The institution's governance gives faculty a formal role in the institution's decision-making process. Students enrolled in the program are not permitted to serve as an instructor, administrator, officer, or director of the School.

UNIBE provided a detailed description of the faculty for each course; and these documents indicate that there are an adequate number for the size of the school. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content.

There is a clear description of the governing body of UNIBE and a description of the faculty evaluation and development programs.

UNIBE has standards governing the admission requirements. There is a description of the admissions criteria, student selection and promotion processes. This description is consistent with the institution's mission and objectives. The School's policy on transfer students has been described above.

The description of the policies for Admissions and Promotion are presented in the Self-Study Report. Regarding promotion standards the School states the following:

After 2009, in order to progress to the clinical years, all students must pass a basic science examination. International Track students must pass USMLE Step 1. In order to graduate, students must have completed all coursework and internship requirements and pass a clinical skills examination. International Track students must pass USMLE Step 2 (CK and CS).

The School provides a description of its Financial Resources in the Self-Assessment Report.

The facilities available to carry out the educational mission, both basic sciences and clinical rotations, are described in this report. They appear to be adequate to achieve the stated educational goals and objectives of the basic science component of the program. I was unable to determine if the clinical facilities including the major hospitals and ambulatory care facilities are adequate. This will be an important component of a site visit; to ensure that the clinical training opportunities are adequate.

The School indicates that it is compliant with the requirement to retain student transcripts. They are kept indefinitely.

Summary

Based on my review of the materials provided by the School, I feel that the Board should consider a site visit of the UNIBE Program in order to assess its compliance with the aforementioned statutes and regulations.

Thank you for the opportunity to review the materials from UNIBE.

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 12, 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 next MAC meeting:

- Task Force Update:
 - Licensed Midwife Annual Report (LMAR) Data Collection Tool and Interested Parties Meeting held October 13, 2015
 - Discussion, update and approval of changes to the LMAR
- Update on continuing regulatory efforts required by Assembly Bill (AB) 1308
- Update on legislation related to midwifery that was passed this year
- Update on Challenge Mechanism for National Midwifery Institute

BACKGROUND:

The last MAC meeting was held on August 13, 2015. At this meeting, the MAC heard a report from the LMAR task force. Staff made recommendations regarding action that would be needed to move forward on this proposal. A report on best practices for home to hospital transfers, given by Diane Holzer, was well received and appreciated. The MAC received an update on the midwife assistant bill and the bill to allow licensed midwives to provide and be reimbursed for the Comprehensive Perinatal Services Program (CPSP), which have both passed and been signed by the Governor.

The MAC heard updates on the continuing efforts to craft regulations required by AB 1308 (Bonilla, Chapter 665, Statutes of 2013). The interested parties continue to work on coming 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. The continuing point of disagreement continues to focus on care for women who have had a prior cesarean. With the passage of the CPSP bill there may be some movement on this issue as a part of that bill requires these regulations be in place before it can be implemented.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 13, 2015
 ATTENTION: Members, Enforcement Committee
 SUBJECT: Interim Suspension Orders
 STAFF CONTACT: Kimberly Kirchmeyer, Executive Director
 Gloria Castro, Senior Assistant Attorney General
 Michael Gomez, Deputy Director of the Division of Investigation
 and Enforcement Programs

REQUESTED ACTION:

This report is intended to provide the Members with strategies identified to expedite cases where an Interim Suspension Order (ISO) should be sought. No action is needed at this time.

BACKGROUND:

At the May 7, 2015 Medical Board of California (Board) Meeting, the Members directed the Executive Director to work with the Attorney General's (AG) Office and the Health Quality Investigation Unit (HQIU) to identify strategies to expedite cases where an ISO should be sought and to report these strategies to the Board at the October 2015 Meeting.

Board staff and staff from the HQIU and the AG's Office have met to conduct a policy review of the handling of ISOs. Part of the review was a review of what happened in ISO matters, including timelines and action taken along the complaint and investigation processes. In addition, the review included an analysis of what could have been done to improve the process and what can be done in the future to eliminate any obstacles that occurred. Based upon this review, the ISO policy workgroup identified several improvements that could be implemented to expedite the investigation and issuance of an ISO. The following is a list of improvements/policy changes that can be made:

- 1) Expert training – for cases alleging physical or mental impairment, training needs to be provided to the Board's subject matter experts on report writing and clarity of reports. The reports need to specifically indicate whether the individual is safe to practice without any restrictions.
- 2) If an expert report states that the individual needs to have restrictions in order to practice safely, an ISO should be considered to pursue an order instituting those restrictions.
- 3) Board monitoring of all investigation/prosecution cases – on a monthly basis, the Board needs to monitor cases that are at both at the AG's Office and at the HQIU to ensure all cases that could be an ISO are moving forward.
- 4) Close monitoring by the Board of the requirement in Business and Professions Code (BPC) section 2220(a) – BCP section 2220(a) specifically states that within 30 days of receipt of a BPC section 805 or 805.01 report the Board must investigate the circumstances to determine if an ISO should be issued. A process needs to be in place for follow up by the Board with HQIU and the AG's Office to see this determination is made in the required timeframe.
- 5) Central Complaint Unit's (CCU) immediate transfer of BPC 805 and 805.01 reports – the Board's CCU will immediately transfer these reports via email to both the HQIU and AG's Office upon receipt in order to expedite the process.
- 6) The Board, HQIU, and AG's Office report reconciliation – Board, HQIU, and AG's Office staff will, on a monthly basis, reconcile reports for cases that have been referred to the AG's Office to request an ISO. This will ensure that cases that have been identified as ISO cases are actually prioritized by the Board, HQIU, and the AG's Office.

- 7) Request that the Office of Administrative Hearings expedites ISO decisions and serves the Board, along with the AG's Office, to ensure timely receipt of decisions where ISOs are issued, as well as denied. In addition, the Office of Administrative Hearings should also be specifically requested, when granting an ISO on an ex parte basis, to issue the ISO immediately at the conclusion of the ex parte hearing, rather than taking the matter under submission, so that the physician can be immediately and personally served with the ISO before leaving the Office of Administrative Hearings. Taking such matters under submission, in order to prepare a detailed decision to be issued later is only appropriate at the conclusion of a noticed hearing on the ISO petition.
- 8) Recommend training to the Office of Administrative Hearings on impairment and how it impacts the practice of medicine. Such training could be provided by the Physician Assessment and Clinical Training Program Staff, if available.
- 9) Update the investigation report synopsis – HQIU will clearly identify in the case synopsis of a Report of Investigation that the case is being transmitted for an ISO and an Accusation.
- 10) The Lead Prosecutor (LP) and the Supervising Investigator I should review each case immediately upon receipt and throughout the course of the investigation to determine if the case should be identified and handled as an ISO. In addition, during quarterly case reviews, both the LP and the Supervising Investigator I shall review all the cases to identify if there is a need to seek an ISO. Throughout the course of any investigation, the Deputy Attorney General and the Investigator assigned shall alert their chain of command that the evidence has changed the matter to an ISO.
- 11) Add ISO cases to the Monthly Investigative Case Activity Report (MICAR) – adding these cases to the MICAR report will immediately inform the Senior Assistant Attorney General that a case is being transmitted for an ISO so that the case can be closely monitored.
- 12) Any disagreement on whether a case should be processed as an ISO should be immediately placed into the dispute resolution process and follow the chain of command.
- 13) As soon as possible, establish a parallel criminal/administrative investigation policy and process for cases where HQIU designates a Board investigation as criminal. Providing for a parallel policy will help protect the Board's integrity in its investigation process when these dual pathways arise. Additionally, staff anticipates this policy will eliminate the need to wait for a criminal case to proceed through the criminal process before seeking an ISO (or a Penal Code Section 23 Order). This may result in an investigator assigned to the criminal investigation and a separate investigator assigned to the administrative investigation. This would allow the investigations that have been designated as criminal by HQIU, which may also be ISO cases, to proceed in the administrative process if warranted by the evidence.
- 14) Create an activity code within the BreEZe system to identify a case as an ISO case for monitoring and statistics.

Several of these recommendations have already been implemented. Recommendations 1, 2, 4, 5, 9, and 11 have been either fully implemented or are in the process of completion. Board staff will continue to work with HQIU and the AG's Office to implement the remainder of these changes as soon as possible to assist in the timely identification and processing of cases warranting an ISO.

An update on the progress of these changes and their impact will be provided at a future Enforcement Committee meeting.

Health Quality Investigations Unit



HQIU Renewed Focus

- Consumer Protection
- Identifying and prioritizing ISO cases and those that present the biggest threat to the public
- Avoiding time gaps in investigations
- Providing high quality, thorough investigations
- Investigator Retention

HQIU UPCOMING EVENTS

- Replacement cell phones are being programmed and distributed to HQIU offices (November 2015)
- CNOA (California Narcotic Officers' Association) Training-San Francisco (November 2015)
- Medical Consultant Statewide Meeting (Target Date January 2016)
- 805 Joint Training with HQIU investigators and HQE DAGS (Target Date February 2016)

HQIU UPCOMING EVENTS

- Field Training Officer (FTO) pay differential has been approved by the Director and has been forwarded to CalHR for final processing.
- HQIU Retention Pay Proposal was submitted to the Director and it will be included in the collective bargaining process set for Spring 2016.
- Numerous hiring panels are taking place throughout the state to fill vacancies.

ELECTRONIC CASE BINDER



- Developed by Detective Dan Pearce of the San Diego Sheriff's Department.
- Adopted by San Diego Sheriff's Homicide Unit, San Diego P.D. Homicide Unit, and the San Diego District Attorney's Office.
- Recommended to HQIU by San Diego HQIU Investigator Steve Brewer.
- Given to HQIU free of charge.



- 133 pounds
- 14 binders
- 2.5 cases of paper
- **EQUALS ON AVERAGE:**
- **\$250**



- No Binders
- No Paper

- **EQUALS
ON
AVERAGE:**

- **\$7**

Current Vacancies

- There are currently 25 Investigator vacancies out of 76 Investigator positions (33%)
- 16 Investigator candidates have been identified and are in background
- There are 6 more anticipated Investigator vacancies (Investigators in background with other agencies)
- SROA hiring rules have resulted in an unprecedented exit of many Investigators who received job reinstatement offers from the agencies that previously laid them off

Current Vacancies

- Retention Pay Proposal is crucial to retaining investigators
- We currently have 25 vacancies, retention pay is worth the investment in investigators who are highly specialized
- The cost of continually re-hiring investigators is almost equal to the amount of the retention pay proposal.

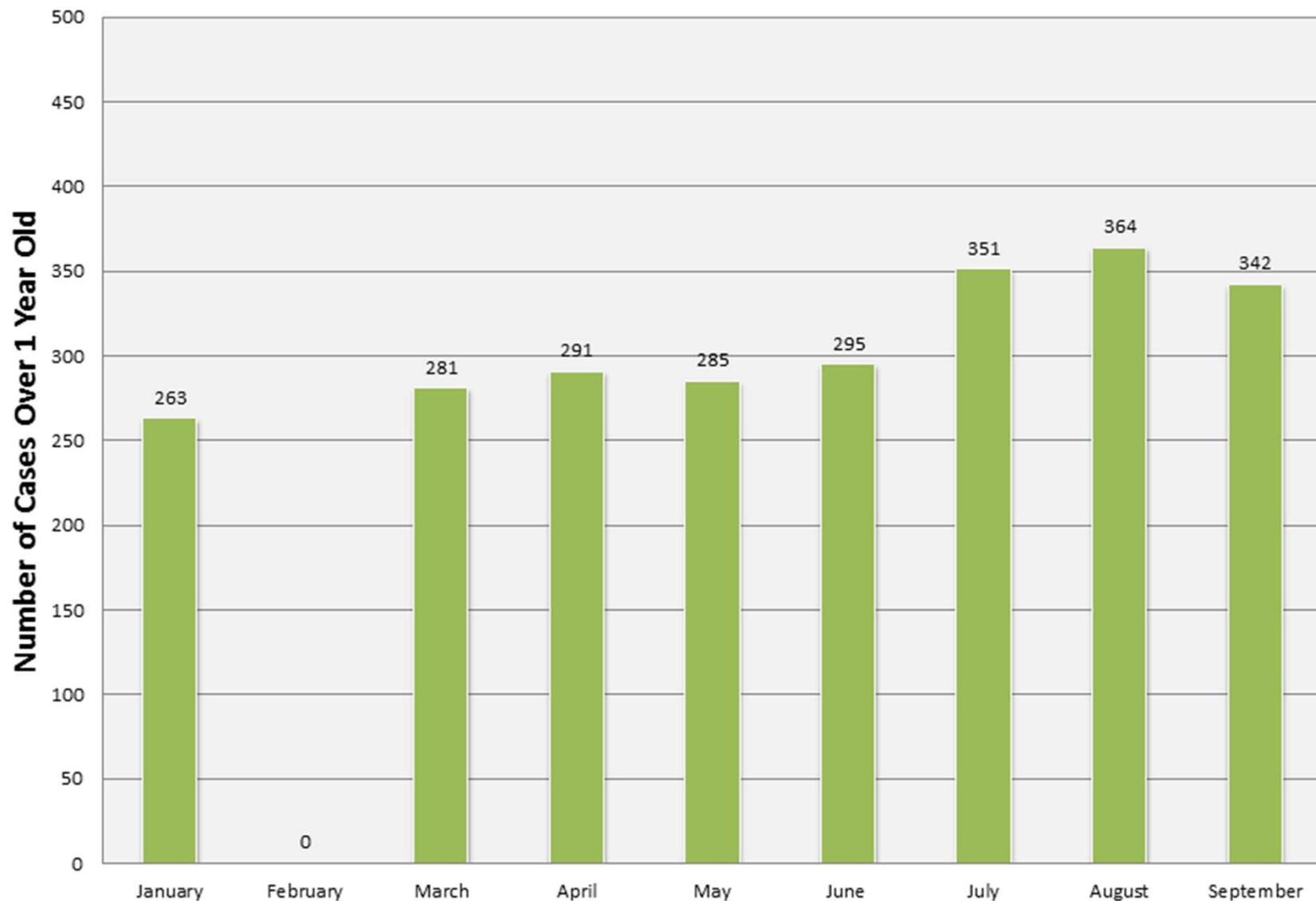
Current Vacancies

- Investigators who have stayed need our support
- Caseloads have doubled
- Ideal caseload is 15-18 complex cases per Investigator
- In many areas of the state Investigators are assigned 30+ complex cases
- We will focus on identifying/working priority cases and eliminating time gaps in non priority cases
- Offer overtime to keep up with the workload

Data Parameters

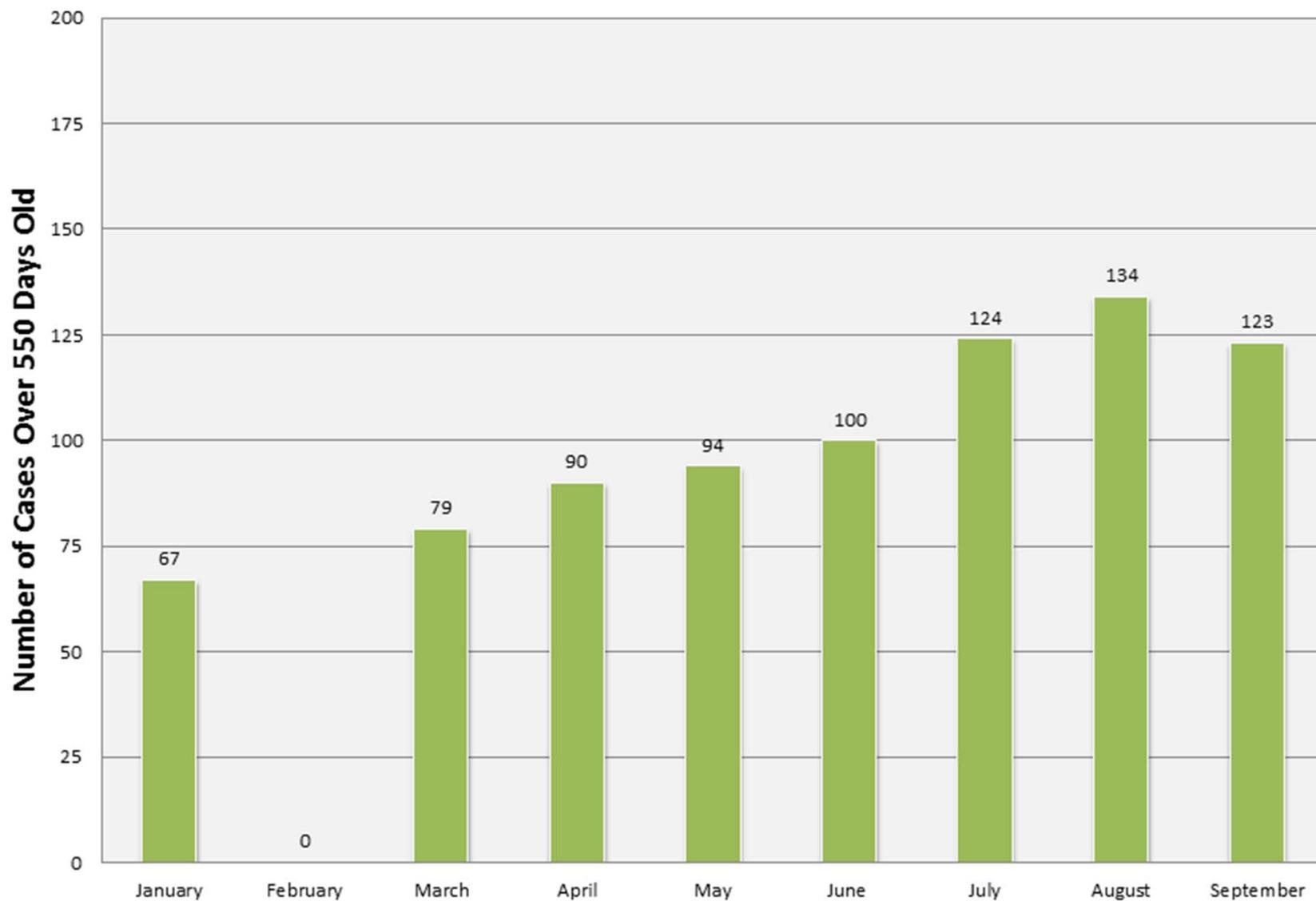
- Statistical figures comparing case age information cannot be obtained from Breeze Reports. These limitations necessitated staff manually compiling data.
- There is no retrievable data for February 2015, and also no retrievable data for July/August 2014.
- The following slides are monthly comparisons that were manually calculated based on month end statistics.

January-September 2015 HQUI Active Cases Stats



This data has been manually calculated and has not been verified by the MBC data integrity analyst.

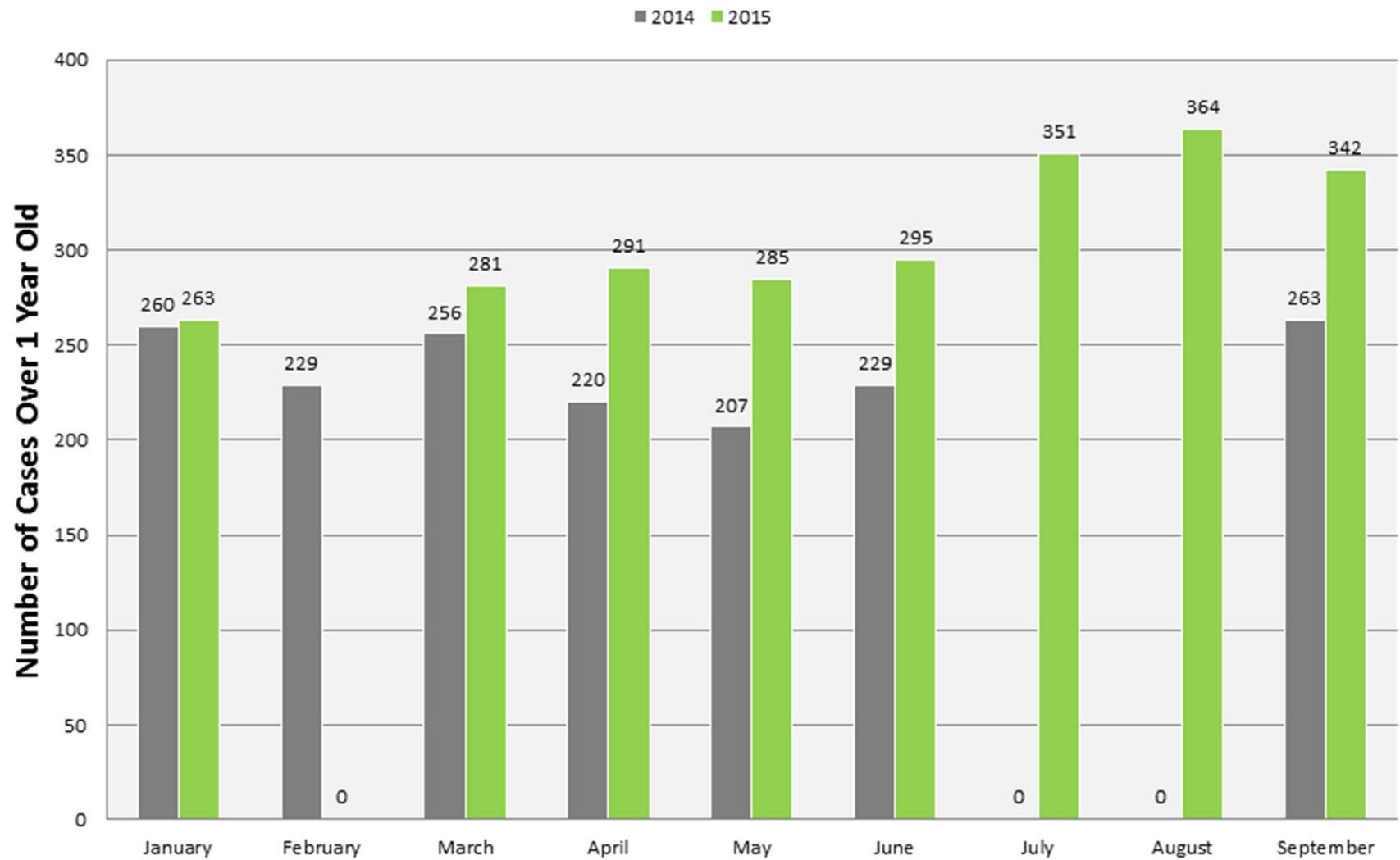
January-September 2015 HQUI Active Cases Stats



This data has been manually calculated and has not been verified by the MBC data integrity analyst.

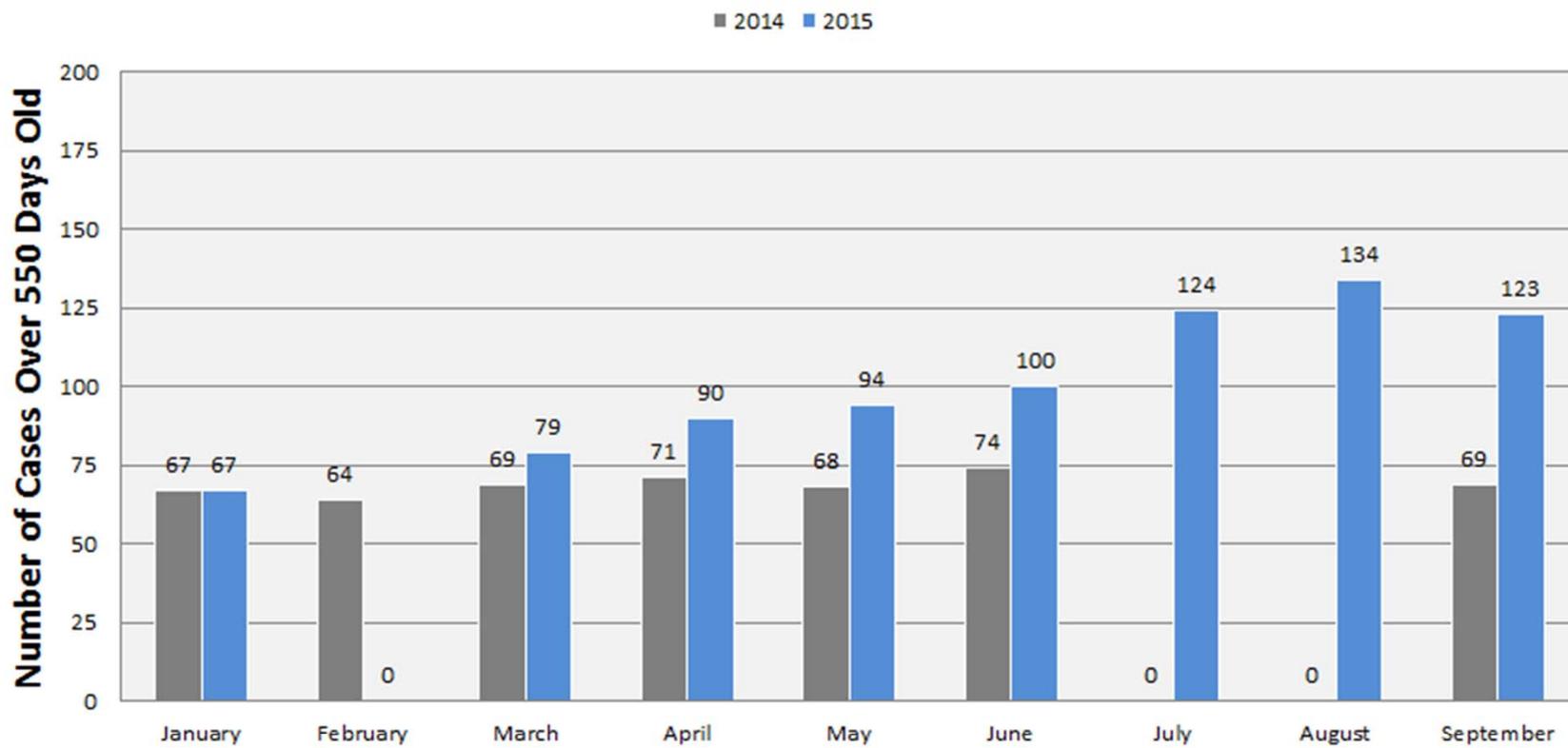
Chart Area

January-September 2014 & 2015 HQIU Active Cases Stats Comparison



This data has been manually calculated and has not been verified by the MBC data integrity analyst.

January-September 2014 & 2015 HQU Active Cases Stats Comparison



This data has been manually calculated and has not been verified by the MBC data integrity analyst.