State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Board, Committee and Task Force Meetings

January 21-22, 2016

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

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

January 21 - 22, 2016

Thursday, January 21, 2016

- **10:00 a.m. – 12:30 p.m.** **Panel A (Room: C&D)**
  (*Members: Wright (Chair), Lewis, Bishop, Hawkins, Serrano Sewell, Yaroslavsky, Yip)*

- **10:00 a.m. – 12:30 p.m.** **Panel B (Room: A&B)**
  (Members: GnanaDev (Chair), Bholat, Krauss, Lawson, Levine, Pines, Schipske)

- **12:30 p.m. – 12:45 p.m.** **Break**

- **12:45 p.m. – 1:45 pm** **Enforcement Committee (Room: A&B)**
  (Members: Yip (Chair), Bholat, Krauss, Yaroslavsky)

- **2:00 p.m. – 3:00 p.m.** **Public Outreach, Education and Wellness Committee (Room: A&B)**
  (Members: Lewis (Chair), Hawkins, Krauss, Levine, Pines, Serrano Sewell, Yaroslavsky)

- **3:15 p.m. – 5:30 p.m.** **Patient Notification Task Force (Room: A&B)**
  (Members: Serrano Sewell, (Chair), Lawson, Levine, Lewis,

Friday, January 22, 2016

- **8:30 a.m. – 3:00 p.m.** **Full Board Meeting (Room: A&B)**
  (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.

Cal Expo Courtyard by Marriott
1782 Tribute Road
Sacramento, CA 95815
(916) 929-7900

Thursday, January 21, 2016
Conference Room C&D
10:00 a.m. to 12:30 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

10:00 a.m. OPEN SESSION

1. Call to order/Roll Call

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

   COSGROVE, Zachary King

10:45 a.m. *CLOSED SESSION – Nonadopted Proposed Decision

COSGROVE, Zachary King

3. ***CLOSED SESSION**

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

4. **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

PANEL B MEETING AGENDA

MEMBERS OF PANEL B
Chair
Howard Krauss, M.D.
Vice Chair
Michelle Bholat, M.D.

Dev GnanaDev, M.D.
Kristina Lawson, J.D.
Sharon Levine, M.D.
Denise Pines
Gerrie Schipske, R.N.P., J.D.

Cal Expo Courtyard by Marriott
1782 Tribute Road
Sacramento, CA 95815
(916) 929-7900

Thursday, January 21, 2016
Conference Room A&B
10:00 a.m. to 12:30 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

10:00 a.m. OPEN SESSION

1. Call to Order/Roll Call

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

   RODRIGUEZ, Leonel Lamon, M.D.

10:45 a.m.*CLOSED SESSION – Nonadopted Proposed Decision

RODRIGUEZ, Leonel Lamon, M.D.

3. ***CLOSED SESSION**

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

4. **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.
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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

Courtyard by Marriott – Cal Expo
1782 Tribute Road
Sacramento, CA 95815
916-929-7900 (Directions Only)

January 21, 2016
12:45 – 1:45 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 October 29, 2015 Meeting

4. Enforcement Program Update – Ms. Delp

5. Update on Demographic Study – Ms. Robinson

6. Update on the Vertical Enforcement Report – Ms. Robinson/Ms. Scuri

7. Investigation and Vertical Enforcement Program Report
   A. Program Update from Health Quality Investigation Unit – Mr. Chriss and Ms. Nicholls
   B. Program Update from Health Quality Enforcement Section – Ms. Castro

8. Presentation on the Probation Unit's Roles and Functions – Ms. Delp

9. Future Agenda Items

10. Adjournment

Meeting Information

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

The call-in number for teleconference comments is: (844) 248-8038

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.

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MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE MEETING

The Westin San Diego
400 W. Broadway
San Diego, CA 92101

Thursday, October 29, 2015
3:00 pm – 4:00 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. Yip, Chair. With due notice having been mailed to all interested parties, the meeting was called to order at 3:40 p.m.

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

Members Absent:
None

Other Board Members Present:
Michael Bishop, M.D.
Dev GnanaDev, M.D.
Randy Hawkins, M.D.
Ronald Lewis, M.D.
Gerrie Schipske, J.D., R.N.P.

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

Curt Worden, Chief of Licensing
Members of the Audience:
Gloria Castro, Department of Justice, Deputy Attorney General
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Hamid Delavar, Midwestern University
Veverly Edwards, Consumers Union Safe Patient Project
Bridget Gramme, Center for Public Interest Law
Abraham Harn, Midwestern University
Marian Hollingsworth, Consumers Union Safe Patient Project
Anthony Jackson, M.D., NAACP, Black American Political Association of California
Karen Miotto, M.D., University of California, Los Angeles
Michelle Monserrat-Ramos, Consumers Union Safe Patient Project
Kerry Parker, California Society of Addiction Medicine
Dwayne Rogers, Physician Assistant Group
Arnold Savage, M.D., Black American Political Association of California
Danielle Sullivan, Center for Public Interest Law
Tracy Zemansky, Physician Assistance Group

Agenda Item 2 Public Comments on Items not on the Agenda

Dr. Gill stated he would like to see the Board look further into how hospital executives and administrators are trying to push the non-medical agendas to drive medical policies and practices by creating ill relationships between the professional ambitions and the absence of modern ambitions and linking the economic comparatives to the professional sense of trust.

Agenda Item 3 Approval of Minutes from January 29, 2015 Meeting

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

Agenda Item 4 Presentation and Discussion on Utilization Review and Possible Action on Recommendations

Ms. Webb gave a brief overview of Utilization Review (UR) in the context of workers compensation and managed care. This overview included discussion on 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 to the law and outreach.

Dr. Krauss agreed with Ms. Webb's suggestions for legislation on this issue. He also asked if statistics were available on how many complaints the Board has received regarding UR in past years, what the findings were, and how many of those complaints could not be adequately investigated because the UR reviewers were not licensed in California.

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Ms. Webb stated that she does not have the exact number, but the number is very small. Ms. Webb also stated, that there are a number of complaint cases that cannot move forward since staff do not know who the reviewing physician is or whether the physician is within California.

Ms. Yaroslavsky suggested finding a way to do better outreach to those entities that need to know about this issue. She recommended putting the PowerPoint information into a newsletter article.

Ms. Clavreul stated she is appalled by the Workers Compensation system. She stated that most of the Workers Compensation doctors are incompetent in regard to long term treatment and that their denial rate is high.

Ms. Choong stated the California Medical Association (CMA) appreciates the Board's attention to what they feel is an under-enforced area in the practice of medicine. She agreed that more transparency is needed with regard to physicians who are actually conducting the reviews and that the Medical Directors should be made aware that the Board can take action against them.

Dr. Gill noted that unless the UR people are asked to get a California license, he does not see much happening in this area.

Dr. Krauss made a motion to recommend to the full Board, that the Board support legislative changes to require utilization review and independent medical review physicians be licensed in California, have similar Board Certification and/or training as the treating physician and identify himself/herself in the report; s/Ms. Yaroslavsky. Motion carried unanimously.

Ms. Webb stated this is not legislation the Board would sponsor, however, there are efforts periodically to do this, and with that, the Board would take a support position on those bills.

Agenda Item 5 Update on Demographic Study

Ms. Robinson reminded the Committee that she had provided information on ethnic background data for complaints, investigations, and discipline at the October 2014 meeting. At that meeting, Members requested that staff analyze the data and provide a more detailed, in-depth review. Ms. Robinson stated that in January 2015, staff met with the California Research Bureau (CRB), to discuss a study on disciplinary action demographics. At the January meeting the Board approved a motion to enter into a Memorandum of Understanding (MOU) with the CRB. She noted that in July, staff met with the CRB to solicit input on the MOU, which was executed on July 29, 2015. In early August, staff again met with the CRB to discuss the data needed to conduct the study. Board staff provided CRB with the data needed, which included disciplinary action records from fiscal year 2003/2004 through 2012/2013.

Ms. Robinson noted that she followed up with the CRB on October 1, 2015, to get a status of the study. CRB stated they were doing a thorough review of the data provided and that once the review was completed, they would develop a research plan, outline a work schedule, and then begin conducting interviews with outside stakeholders. CRB recently requested additional data and the Board's Information Technology staff is working on providing this data to them. Ms. Robinson stated

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she will continue to monitor CRB's progress on this study and will provide additional updates at future committee meetings.

Ms. Yaroslavsky requested another update at the next Enforcement Committee meeting.

Agenda Item 6 Enforcement Program Update

Ms. Delp stated that the Enforcement Program continues to fill vacant positions within the various units of the program. In the July 2015 Enforcement Summary, it was reported that the Central Complaint Unit had five vacancies. She noted that four of those vacancies had been filled and those employees have begun working. In regard to the fifth vacancy, the top candidate is progressing through the hiring process and should begin working shortly. Ms. Delp stated the Central Investigation Office (CIO) filled its remaining Special Investigator, non-sworn position, and that person is scheduled to report to work on November 2, 2015. She stated that in the Probation Unit, the Northern California Inspector I position was filled and the employee reported to work in September. Ms. Delp then noted that interviews had been completed to fill one Inspector I position in the LA Metro area and one Associate Governmental Program Analyst in northern California. She noted that the Discipline Coordination Unit (DCU) is fully staffed.

Ms. Delp stated that currently, the Central Complaint Unit (CCU) is taking 15 days to initiate a complaint, however, staff is working together to reduce the time frame to 10 days in ensure compliance with Business and Profession Code section 129. In addition, analysts are continuing their efforts to reduce the number of days to process a complaint, which is a difficult goal to achieve, however, with the recently hired staff, significant strides are being made to achieve the goal. Management is confident this goal will be met, once training of new staff is completed.

Ms. Delp stated that effective August 31, 2015, the Board received authority to, once again, issue citations containing orders of abatement and fines to physicians for violating the statutes mentioned in California Code of Regulations section 1364.11.

Ms. Delp noted that the Special Investigators in CIO are each carrying a case load of approximately 35-40 cases, however, this will decrease with the addition of the new staff person that will begin working in November. Since the last summary report in July 2015, the unit has closed 58 cases and transmitted six cases to the Attorney General's (AG) Office. Three of those cases were for convictions, two were for petitions for reinstatement and one was a medical malpractice case. She stated staff in the DCU continue to focus their efforts on restoring public disciplinary documents to the Board's website to ensure compliance with Assembly Bill (AB) 1886. She noted that staff has been offered overtime to finish this project and management has developed a daily schedule for all staff to work on this project in hopes of completing it by December 31, 2015. Board staff will also be looking to hire temporary help to finalize the project.

In the Probation Unit, inspectors in each office have begun to see Orders that contain the new disciplinary guideline language contained in the recently implemented Uniform Standards for Substance Abusing Licensees, which took effect July 1, 2015. Ms. Delp stated that the inspector, supervisors and managers will meet on November 4, 2015 to discuss and develop a comprehensive training plan for the Inspectors focusing on subjects that will enhance their skills in monitoring

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probationers. She stated that she has been reviewing the Probation Operations Manual, conducting case reviews, and reviewing current policies and procedures to see where improvements can be made in the Enforcement Program.

Ms. Delp then noted that an issue had been raised by the AG's Office regarding the use of the same investigator who works a complaint both criminally and administratively. The AG's Office has asked the Division of Investigation (DOI) to develop a parallel policy for these types of investigations. During the month of November, the Board will reach out to the Health Quality Investigation Unit (HQIU) and the AG's Office to address this concern with the goal of reaching an agreement that works best for all agencies. In addition, a process will need to be established with HQIU where the Board is able to monitor the complaints deemed to be criminal investigations, as this oversight will ensure these complaints are being processed timely. These discussions have already begun with the HQIU's new Deputy Chief.

Ms. Delp stated in regard to the Vertical Enforcement (VE) Legislative report, on October 7, 2015, she and staff met with Deputy Director Gomez, Senior Assistant Attorney General Castro, Supervising Deputy Attorney General Terry Jones, and retired Department of Consumer Affairs (DCA) Attorney Anita Scuri to discuss the highlights and challenges of the VE process. Ms. Delp announced that Ms. Scuri will be assisting Board staff in writing the mandated report that is due to the legislature in March 2016. This report will communicate the effectiveness of the process and areas where improvement is needed to enhance the usefulness of VE in investigating Board complaints. The intent is to have two Board Members work with staff once the report is drafted to provide feedback regarding the content. A draft report is expected to be completed the first part of January 2016. The goal is to provide the draft report to the Board at the January 2016 meeting; however, this is dependent on the ability to run the necessary reports to be able to complete the draft. If needed, a special meeting may be held in February for the Board to review the report.

Ms. Delp then noted a "cloud" had been developed to share case information electronically via a secured system and the system will be utilized by staff within the Enforcement's DCU, CIO and the Probation Units, as well as HQIU and the AG's Office. This system will permit the timely receipt of case information and will reduce operating costs for all three agencies. A meeting is scheduled for November 3, 2015, with the AG's Office and HQIU to discuss the implementation of this process.

Agenda Item 7 Update Regarding Meeting with the Office of Administrative Hearings

Ms. Kirchmeyer spoke about the October 16, 2015 meeting she and Ms. Delp had with Director and Chief Administrative Law Judge (ALJ) Zachary Morazzini, Deputy Director Melissa Crowell, and Presiding ALJ Alan Alvord from the Office of Administrative Hearings (OAH). She stated that the topics of discussion were the Board's new regulations pertaining to the Uniform Standards for Substance Abusing Licensees, how the language and each condition cannot be deviated from with regard to Administrative orders it makes pursuant to the regulations, the length of time to set hearings, and lastly the establishment of training for the ALJs.

Ms. Delp stated that beginning next month, she will be working with Judge Alvord to schedule training with the ALJs. Trainings will be held on the last Friday of the month or during a lunch time period. Training topics will be, but are not limited to, impairment and how it impacts the practice of

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medicine, medical record keeping standards and expectations, emergency room procedures, prescribing practices and expectations, systems of the body, treating comorbid patients, medical terminology and medical errors, fitness for duty evaluations for physicians alleged to have a mental illness or physical disability, and substance abuse laws.

Ms. Kirchmeyer added that there have been problems finding individuals that can provide the training to OAH and that members of the Board may be asked for assistance with identifying speakers in the future.

Dr. Yip asked if the OAH training will be held at different sites in California.

Ms. Kirchmeyer commented that OAH has video conference capabilities to provide training throughout the state.

Agenda Item 8 Update Regarding Expert Reviewer Training

Ms. Delp stated that staff is reviewing and updating the expert reviewer guidelines in preparation of the upcoming expert reviewer training class, which is scheduled for March 2016 in Southern California. Ms. Delp said that she has contacted previous presenters to determine their interest in being a presenter again and she is in the process of securing a location and continuing education credits for taking the class. In addition to setting up the training, a recruitment plan to expand the number of experts with specific specialty fields of medicine has been developed. The recruitment plan will include inserting an article in the Board's Newsletter that stresses the purpose and importance of utilizing experts; a revision of the Board's recruitment letter to encourage participation in the program; and creating a brochure to accompany the recruitment letter that will highlight the benefits, expectations and compensation for services regarding the program. Also, testimonial videos from existing experts are being considered to enhance the Board's expert reviewer webpage, so prospective expert reviewers can hear firsthand from those currently participating in the program. Staff will also be reaching out to physician groups and organizations to do a presentation on the expert reviewer program. The specific fields of medicine where the recruitment efforts will be focused are provided in the Utilization Quarterly Expert Reviewer Report, which was included in the Board packet. Lastly, Ms. Delp stated the expert reviewer database called MEDEX is expected to get a new overhaul. Program staff will be recording elements needed to enhance the antiquated database and will be working with staff from the Information Systems Branch (ISB) to make the system user friendly for staff, investigators, and medical consultants to search for qualified experts to assist with complaint investigations.

Agenda Item 9 Update Regarding Psychotropic Medications being Prescribed to Children in Foster Care

Ms. Delp said the Board will be meeting with another pediatric psychiatrist to determine if the psychiatrist is interested in reviewing the data the Board received from the Department of Health Care Services (DHCS) and Department of Social Services (DSS). Ms. Delp also stated that it has been challenging to find an expert who is able to opine on the data that has been provided, mainly because the data seems to lack the substance needed to determine if there is

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inappropriate prescribing of psychotropic medications to children in foster care. The Board will meet with the potential consultant on November 9, 2015. This physician currently works for the UC Davis Health Care System and specializes in child and adolescent psychiatry, forensic psychiatry, and psychiatry. On October 12, 2015, Ms. Kirchmeyer, Ms. Simoes, and Ms. Delp met with executives from the DHCS and DSS to give them an update regarding the Board's analysis of the data they provided per the data use agreement. The Board's staff explained that the data may not be sufficient to make a decision as to appropriate prescribing and that the Board is still seeking a physician to review the data. In addition, it was explained that the Board may need to obtain additional information and it might be identified as necessary by the medical consultant in order to make a finding. Also at the meeting, the agencies and the Board developed a notification process whereby individuals in the healthcare delivery system for foster care children can directly contact Ms. Delp or Ms. Romero if they believe a physician is inappropriately prescribing medication to children in foster care. In turn, Ms. Romero or Ms. Delp will contact the DSS to obtain all de-identified patient information for the foster child for that prescriber. The de-identified patient information will be sent to a Board medical consultant who will determine which patients the Board will need to obtain patient records for, if any. Board staff will then work with DSS to obtain the patient records through a court order, so the Board can proceed with an investigation.

Agenda Item 10 Future Agenda Items

No items provided.

Agenda Item 11 Adjournment

There being no further business, the meeting was adjourned at 4:30 p.m.

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

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PROBATION UNIT

Medical Board of California
January 21, 2016

Christina Delp
Chief of Enforcement

Presentation Overview

- Highlight the organizational structure of the Probation Unit.
- Identify various positions within the Unit.
- Briefly explain the roles for each position.
- Discuss the possible probation terms and conditions imposed.
- Discuss how probation staff monitors compliance with the terms and conditions.
- Share concepts - focusing efforts to improve the effectiveness of Unit.

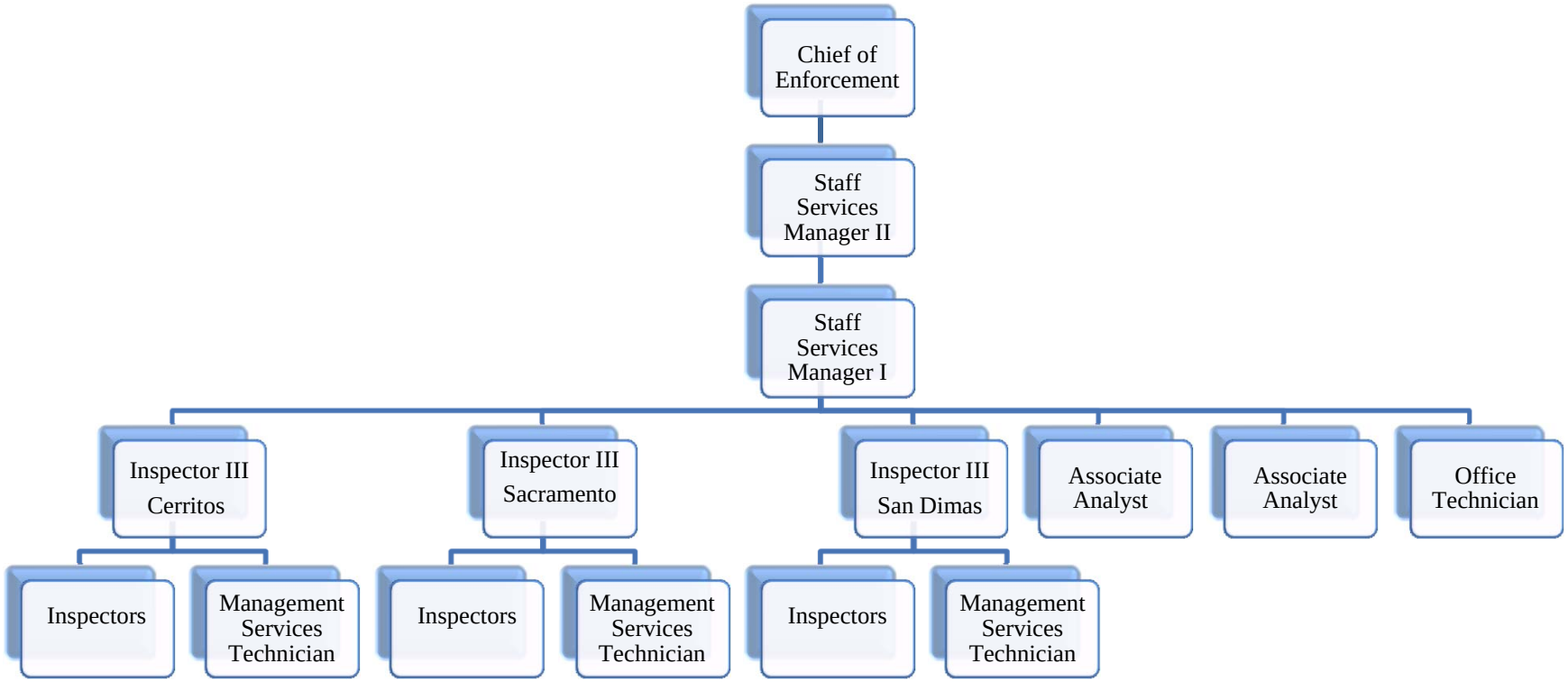
Learning Objectives

- Awareness of how the Unit monitors licensees on probation.
- Understand actions taken when licensees violate a term or condition.
- Appreciate that optimal success is a continual process.

Who's Who

- Probation Unit created in 2008
- Three Probation Offices
  1) Probation North - Sacramento
  2) Probation LA Central - Cerritos
  3) Probation South - San Dimas
- Total of 25 non-sworn staff
  - Manager, Supervisors, Inspectors, Analysts and Technicians

Organizational Chart



Statutory Authorities

- Disciplinary Guidelines were created to implement the mandates of Business and Professions (B&P) Code sections 2227 and 2229.
- B&P Code section 2227 defines the disciplinary actions to be imposed by administrative law judges (ALJ) or via stipulated agreements against licensees found guilty of violating the Medical Practice Act. Those actions are:
    1) Revocation of license;
    2) License suspension not to exceed one year;
    3) Probation;
    4) Publicly reprimanded, which may require licensee to complete relevant educational courses; or
    5) Any other action taken in relation to discipline as part of an order of probation, as the Board or ALJ deems proper.

Statutory Authorities

- B&P Code section 2229 expresses that:
  1) Public protection shall be the highest priority when the Board or an ALJ exercises its disciplinary authority;
  2) When exercising disciplinary authority, action shall be calculated to aid in the rehabilitation of licensee, or where, due to lack of continuing education or other reasons, restrict the scope of practice, or order restrictions, as indicated by the evidence; and
  3) The intent of the California Legislature is for the Board to seek out licensees who have demonstrated deficiencies in competency and then take actions as indicated to include further education, restrictions from practice, or other means, that will remove those deficiencies. Where rehabilitation and protection are inconsistent, protection shall be paramount.

Manual Model of Disciplinary Orders and Guidelines

(11th Edition 2011)

- Optional Conditions
  - Deviation is appropriate when case warrants deviation

Controlled Substances	Conditions 4 - 9
Biological Fluid Test	Conditions 10 and 11
Courses and Programs	Conditions 13 – 18
Psychiatric Evaluations	Condition 20
Monitoring	Condition 23
Third Party Chaperone	Condition 25
Prohibited Practice	Condition 26

Uniform Standards for Substance-Abusing Licensees
(2015)

The Board shall use these standards <u>without deviation</u> for individuals determined to be substance-abusing licensee:

- Clinical diagnostic evaluation and reports
- Notice of employer or supervisor information
- Biological fluid testing
- Substance abuse support group meeting
- Worksite monitor

Uniform Standards for Substance-Abusing Licensees
(2015)

- Violation of Probation - Substance-Abusing Licensee
  - Major violation
    1) Cease practice order
    2) Increase frequency of biological fluid testing
    3) Refer for further disciplinary action
  - Minor violation
    1) Cease practice order
    2) Practice limitations
    3) Increase supervision
    4) Increase documentation
    5) Cite and fine or warning letter
    6) Undergo clinical diagnostic evaluation
    7) Take other action determined by Board or designee

Enhancements

- Approval to hire an additional Staff Services Manager II.
- Implementation of random quality assurance case reviews.
- Restructured duties performed by analysts to provide oversight of licensees subjected to biological fluid testing and requirements for specific training or education levied with issuance of public reprimands.
- Inspector IIIs are responsible for monitoring the PC 23 and ISO restrictions/conditions imposed.

Enhancements (cont'd)

- Review of all form letters, templates and checklists to ensure they are up to date with current policies and procedures.
- Improve the way the transmittal packets are written to include the gathering of evidence to support a violation of probation.
- Added language to the Board's public letter of reprimand to include timeframes for completion of courses and added language that non-compliance may result in further disciplinary action for unprofessional conduct.
- Examining the biological ETG/ETS threshold that alerts or demonstrates that someone has significant consumption of alcohol.

Questions

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

Cal Expo Courtyard Marriott
1782 Tribute Road
Sacramento, CA 95815
(916) 929-7900
(directions only)

Thursday, January 21, 2016
2:00 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 October 29, 2015 Public Outreach, Education and Wellness Committee Meeting

4. Presentation, Discussion and Possible Action on the Public Outreach Campaign and Plan – Dr. Lewis

5. Presentation, Discussion and Possible Action on the Public Outreach Brochure – Dr. Lewis

6. Presentation, Discussion and Possible Action on Enhancements to the Website – Ms. Clark, Ms. Hockenson and Ms. Kirchmeyer

7. Future Agenda Items

8. Adjournment

Meeting Information

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

The call-in number for teleconference comments is: (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.

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.

MEDICAL BOARD OF CALIFORNIA
Executive Office

Public Outreach, Education, and Wellness Committee Meeting
The Westin San Diego
400 W. Broadway
San Diego, CA 92101

Thursday, October 29, 2015
1:30 pm – 3:00 pm

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Public Outreach, Education, and Wellness Committee (committee) of the Medical Board of California (Board) was called to order by Chair Ronald Lewis, M.D., at 1:30 p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:
Ronald Lewis, M.D., Chair
Randy Hawkins, M.D.
Howard Krauss, M.D.
Sharon Levine, M.D.
Denise Pines
Barbara Yaroslavsky

Members of the Committee Not Present:
David Serrano Sewell

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

Members of the Audience:
Teresa Anderson, California Academy of Physician Assistants
Edward Barrera, Consumer Watchdog
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul
William Coltrin, M.D.
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Lou Galiano, Videographer, Department of Consumer Affairs
Dr. Gill
Bridgette Gramme, Center for Public Interest Law
Rae Greulich, Consumers Union Safe Patient Project
Dr. Jim Haye, California Medical Association
Robert Herbst, M.D.
Marian Hollingsworth, Consumers Union Safe Patient Project
Bruce Koltun, M.D.
Lisa McGiffert, Director, Consumers Union Safe Patient Project
Tina Minassian, Consumers Union Safe Patient Project
Karen Miotto, M.D.
Michelle Monserrat-Ramos, Consumers Union Safe Patient Project
Carol Moss, Consumers Union Safe Patient Project
Dr. Bruce Olmscheid, M.D.
Osteo Students
Kerry Parker, California Society of Addiction Medicine
Duane Rogers, Pacific Assistance Group
Dr. Greg Skipper, M.D., Board Certified Internist, Board Certified Addiction Medicine
Michael Sucher, M.D., Director of the Arizona Medical Board Physician Health Program
Danielle Sullivan, Center for Public Interest Law
Tracy Zemansky, Pacific Assistance Group

Agenda Item 2 Public Comment on Items Not on the Agenda

Ms. Clavreul stated that she was concerned about the speech that was given just before the meeting because at lunch there was a program on civility and that is a big issue. She continued with when there is a lack of civility it may impact the quality of a diagnosis, and that it concerned her that at many of the meetings, people are admonished, and that the speech before the meeting does not help.

Agenda Item 3 Approval of Minutes from the July 30, 2015, Education and Wellness Committee Meeting

Ms. Yaroslavsky made a motion to approve the minutes from the July 30, 2015 meeting; s/Dr. Krauss. Motion carried unanimously.

Agenda Item 4 Presentation, Discussion and Possible Action of Elements of a Successful Physician Health Program

Ms. Robinson stated the purpose of the presentation was to provide information and 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. Ms. Robinson stated that any physician health program would need to comply with the Uniform Standards for Substance-Abusing Licensees and would require regulatory changes. She stated that Senate Bill (SB) 1441 (Ridley-Thomas Chapter 548, Statutes of 2008) created the Substance Abuse Coordination Committee (SACC), that was charged with formulating 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.

Ms. Robinson stated there are 16 uniform standards that are covered and went over standards 2, 4, 6, 8, 9, 10, 13, 14, 15, and 16 in detail. She continued by describing elements of standard 16, saying that the Board must use the following criteria to determine if its program protects 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, and
- 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.

Ms. Kirchmeyer commented that the reason the previous standards were covered was because the Committee Members need to understand that any physician health program that is supported must adhere to each one of the uniform standards.

Dr. Levine asked a question regarding the purpose of the program, saying she thought the sole purpose was to assist physicians with substance abuse problems.

Ms. Kirchmeyer stated that Dr. Levine was correct regarding the thought behind a physician health program, but that it should also enable the Board to meet its mission of consumer protection.

Dr. Levine commented that when the term physician health is used it would encompass physicians with substance abuse problems, but it would also be open and available to assist physicians with other issues that were not addressed, but would have the potential to impair their function as physicians. The selection of the term *health* suggests something broader. She said she was just questioning if that is all that a physician health program will do.

Ms. Kirchmeyer said that one of the Board staff recommendations is that it be only for substance abuse issues and that staff is looking to the Board for recommendations. If the Board wants to add other items, they will be added at the end.

Dr. Krauss agreed with some of the concerns expressed by Dr. Levine and stated that there are things about the practice of medicine that causes some physicians to hide their problems for fear of having their business or practice infringed upon, and a physician who is suffering from depression will also hide. He stated that he also believes that substance abuse programs and physician health programs should not be used synonymously. He said he would encourage the staff to find some way of separating those terms so that they are not confused in the future, but that there is a need for both terms.

Ms. Kirchmeyer said Dr. Krauss' ideas will be listed in the staff recommendations.

Ms. Robinson stated that Board staff recommends the program should not reside within the Board, but that it should be run by a private/contracted non-profit entity. It should have adequate protocols for the program's communication with the Board and have regularly scheduled meetings. It should allow for both self-referrals and probationers to participate. It should report to the Board any physician who is terminated from the program, for any reason. Ms. Robinson added that the program will not be diversion, and if a complaint/report is received, the enforcement process will be followed. There should be clear and regular communication to the Board on the status of probationers in the program, and participants should share in the cost of administering the program. If the required audit finds the program is not in compliance, there must be repercussions. There must be sufficient resources to perform clinical roles and case management roles, with sufficient expertise and experience, and a case manager's case load should not to exceed 50 physicians. Ms. Robinson continued with recommendations and concerns from the consumers group, which asked if there is a need for a program, and recommended an analysis be completed to determine if there is a need for a program.

Ms. Kirchmeyer stated she wanted to explain the process of putting these suggestions together. Board staff met with each group, and the information being delivered is what came of all the information gathered from those groups. Items that were in the slides in this part of the presentation were things that staff did not believe should be elements of a physician health program. What staff is asking of the Committee is to look at these elements requested by stakeholders, and make a determination as to whether these items should be recommended. She stated that at the end of the presentation, staff is looking for a motion that any legislation moving forward would have the elements of what the Board has approved.

Ms. Robinson explained that some of the physician group recommendations included 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, plus what to expect from the program, how to contact it, how to enter it, how to refer to it, and how to use it. They also felt the program should have adequate and stable funding primarily from license fees, with additional funds from other sources such as fees from participants. Also providers working for the program should have immunity from liability.

Ms. Yaroslavsky wanted to know if there is any room to ask those providers of such programs if there are any weaknesses or strengths that they see that may be addressed within the Board's recommendations that might be helpful.

Ms. Kirchmeyer said that had been done and there was a lot of good input.

Ms. Yaroslavsky asked if when a licensee enters and finishes a program, will records need to be maintained, for how long and is that part of a process?
Ms. Kirchmeyer explained that record retention will be set up in the administration of the vendor, and, other state agencies will be looked at to see how long they keep their records at the facility for those individuals. Ms. Kirchmeyer clarified, that if there is a successful completion and it was a self-referral the Board would never have access to those records.

Dr. Levine questioned if this information would establish a baseline of what would need to be in a piece of legislation for a program that addresses the issue of substance-abusing licensees. She stated that the Board is focusing on the specific issues that need to be in place to meet the requirements of the uniform standards and to meet the requirements of consumer protection in regard to substance-abusing licensees.
Her only hope is that the word "health" is not attached to it because the Board has an interest in and a concern for a broader set of issues to maintain a high quality healthy practitioner inventory in California and would hope any legislative effort to create such a program would go beyond the substance-abusing physician licensees.

Ms. Kirchmeyer said that if the Committee feels strongly that the program needs to cover health issues beyond substance-abuse, then staff would put that in as an element. Ms. Kirchmeyer continued with an example that in the physician group recommendations there was a recommendation that it follow the National Physicians Health Program recommendations and the reason it was put in this slide was because they do take mental health individuals into the statewide physician health program. So, if that is something that the Committee wants to do, staff is not opposed to it if the Committee feels strongly about it.

Ms. Yaroslavsky stated that her sense is that there are many physicians for whom knowing that there is a place they can go to, call or a contact to get help would be a useful thing.

Ms. Kirchmeyer stated that she remembers a lot of the individuals that were in the prior program with mental health issues also had substance abuse issues.

Ms. Kirchmeyer asked that the Committee look at the Board staff recommendations on this subject, stating that it is similar to what Dr. Krauss brought up as a policy compendium. Staff would look at these elements and any future legislation seeking any type of a physician health program would have to include these elements in order to be supported by the Board.

Dr. Krauss said that he commends the Board staff for their work product and work effort and asked if staff could help him figure out where the firm lines in the sand are, because not everyone will be satisfied.

Ms. Kirchmeyer explained that the firm line would be with any legislation that goes forward and what Board supported elements get included.

Dr. Hawkins stated that the Board would like for physicians who want to step forward for help to do so and the Board must develop a program that invites them in, but, at the same time, does not put them in a position that would make them less likely to come forward.

Ms. Kirchmeyer said that is one of the consumer groups' concerns, that if you attach the program to the

Board you might not get individuals that actually want to enter the program.

Dr. Miotto commended the efforts of the Committee, and as the chair of the Medical Staff Wellbeing Committee, stated that she cannot stress enough the importance of addressing the mental health issues and finding an avenue where these issues can be dealt with, because as Dr. Krauss said, physicians feel very stigmatized by these issues.

Dr. Skipper, Board Certified Internist and Board Certified in Addiction Medicine, who runs the Promises Professional Evaluation and Treatment Program in Santa Monica, wanted to point out that the presentation's purpose implies that helping physicians is in conflict with protecting consumers. It says "While still meeting the Board's mission of consumer protection," and he believes that helping physicians in itself can help protect patients. He stated that he does not think that the program needs to be seen as either/or, and that early intervention for these physicians will help patients. Dr. Skipper stated there was a recommendation that the program have adequate medical leadership by a physician and/or physicians. Physicians should be part of the program and leadership to better communicate with the Board and committees of the Board. Also, emphasis should be put on education, early detection, and intervention rather than just on monitoring and probation because anybody can monitor people. Dr. Skipper also stated that what would be most helpful for public protection is providing ways for hospitals to get help for physicians and to help them decide if there should there be an intervention, how it should be done, and what should happen after that. A program is needed that really educates and helps with intervention rather than just monitoring, which seems to be the gist of the previous programs.

Mr. Barrera, Consumer Watchdog, stated that the guiding principles for any program should be transparency, accountability, and independence and that programs that confidentially treat substance-abusing doctors over protecting patients become a revolving door for drunk and high physicians. The Board should not sanction any program that lets doctors keep their addiction problems secret and avoids consequences when they fail. Patient safety should always trump physician confidentiality, and any complaint of possible substance abuse problems should be made a priority. Any enforcement should be handled expediently. It should not ever be connected to the California Medical Association or anyone connected to previous diversion programs and it also needs to be independent of the Board.

Ms. D'Angelo Fellmeth, Center for Public Interest Law, stated that the Board had a diversion program for 27 years that failed five performance audits, and that the Board unanimously voted to terminate it.
Ms. D'Angelo Fellmeth continued by saying that since then physician organizations have attempted on many occasions to create a new program for substance-abusing doctors, funded primarily by license fees collected by the Board. Each of those attempts were different, and each of them failed. She stated history should tell the Board that there is no need for a new program. There are literally thousands of treatment and monitoring programs in California and all over the United States, and nothing prevents any doctor from self-referring into one of them. Also, the effectiveness of these programs has never been proven, no program tracks participants after they leave the program. The Center for Public Interest Law has come up with some elements: first, the program must strictly comply with the uniform standards; secondly, doctors should not be able to participate in a Board funded program secretly, which is completely contrary to the Board's mission, only doctors who are on probation should be able to participate in any new program; third, all program noncompliance should be reported to the enforcement program immediately; fourth, a detailed program description and fiscal analysis must be prepared by the proponents; fifth, any new program must be

audited by the Bureau of State Audits every three years and if it is not performing well it should be ended; and finally, under no circumstances should a new program be directed or controlled by the same organizations or individuals who were part of the liaison committee that oversaw this Board's prior program. She suggested that the Board try tasking themselves to come up with standards and criteria for treatment and monitoring programs and evaluate programs based on those criteria and post a list of the good programs. If the Board thinks physicians do not go to treatment or monitoring programs because they cannot afford them, then create some kind of scholarship fund perhaps with voluntary contributions to help physicians who are truly intent on recovery to go to a program. Ms. D'Angelo Fellmeth encouraged the Committee to explore other options, as there is no need to create a new program.

Dr. Zemansky, President of Pacific Assistance Group (PAG), stated that individuals at the meeting held with Board staff had worked with physicians in recovery before the Boards program was sunset and she strongly supports the Board's effort to encourage physician wellness on every level. Any program that will be effective in preventing patient harm must have an early intervention and a self-referral option that is confidential and viable. Early intervention allows physicians who already find it difficult and challenging to ask for help to seek care before problems develop, which is the best way to ensure patient safety. As the lunch time speaker said, it is more effective to support positive values and action and be proactive, than to correct a negative problem and be reactive. She continued by stating that she strongly believes that patient safety equals physician early intervention and confidentiality and PAG supports the Board in developing and supporting a program.

Dr. William Coltrin, a diversion graduate, stated that wants to advocate for the redevelopment of diversion, which at a person level was very active in helping him direct his own life towards getting into recovery and staying in recovery successfully. He said that the one point he wanted to make was that there are differences in programs and that there are programs that can and do have special programs for health care providers. These programs can work with physicians during that recovery period. It is because of diversion in 1999 that he was directed to programs that were aligned with impaired physicians and believes that it contributed to his recovery then and continued recovery.

Dr. Herbst stated that he is in favor of and happy to hear that the Board is considering a Board supported health maintenance program for physicians. He continued saying that the uniform standards are fairly rigorous, and that he found that the previous health program helped him do things that he would not do by himself. He added that the program introduced him to the means of handling his problems and they provided the monitoring, which was a necessity. He also noted that other parts that are helpful were the education at the hospital level for the wellbeing committees and the Board should send out an action letter every month with information regarding what the programs are and where the programs are so physicians know where to go.
Ms. Monserrat-Ramos, Consumers Union Safe Patient Project, stated that she would not support any kind of program that used confidentiality, which prevents patients from being informed. The Board cannot support any confidential programs of any kind. Rehabilitating the physician cannot come before Californian's lives. She believes the Board must make the implementation of uniform standards its top priority, and give them time to work before putting in place any new system that might interfere with the standards.

Ms. Choong, California Medical Association (CMA), stated that her organization appreciates the Board's efforts to study this important issue, and that they support the development of a statewide physician health

program. She continued saying CMA believes that the establishment of a physician health program is consistent with the Board's mission of public protection and will increase patient safety by ensuring that impacted physicians are receiving coordinated treatment and monitoring services and that their recovery is appropriately supervised. She believes that such a program should also encourage education and early intervention. A program should encourage physicians to address issues before they rise to the level of impacting patient care. She further stated that the physician health program principles developed by Board staff provide an excellent starting point for the development of a robust and comprehensive program that will enhance the Board's ability to protect patients and rehabilitate physicians to return them to a safe and active practice. CMA urged the Committee's adoption of these recommendations and looks forward to continuing to work with the Board on this issue.

Dr. Olmscheid, stated he fully supports the Board's efforts to put a formal physician health program in place and hopes that it is a program where physicians feel safe enough to access. He respectfully asked the Board to give additional consideration to the ramifications of requiring public disclosure of all physicians who are receiving services and are doing well through a monitoring program. A program that does have confidentiality where appropriate, with public disclosure where appropriate, will foster self-referral and, at the same time, provide protection to consumers. A program that allows for confidential reporting to the Board, will allow the Board to administer a program that effectively monitors physicians who are receiving treatments for substance abuse and doing well, at the same time providing protection for consumers.

Dr. Rogers, stated that he fully supports the Board's efforts in developing a strong and accountable physician health program and that licensed physicians in California deserve this program. He believes that a confidential physician health program can achieve high levels of self-referral rates and thus early intervention before serious problems occur.

Dr. Sucher, Director of the Arizona Medical Board Physician Health Program (AMBPHP), stated that AMBPHP started out covering substance abuse as the primary focus and co-occurring mental illness, but lately have been covering every area of physician health. AMBPHP is actively involved in physician health activities in California. They run a private evaluation and monitoring program called the California Physicians Health Program. In addition to working with and advising the Board and staff, they have also worked with many medical groups, hospitals, and individual physicians. In Arizona, every single physician in the program is known to the Board, and are monitored and overseen by the Board's agreements. They are also required to notify hospitals, surgery centers and all employers and any other party who has the need to know, so there is no one in the program unknown to the Medical Board. Regarding self-referrals, almost everybody gets a shove from someone to get help. It is not realistic to think that people just go get help on their own. The Board and a physician health program play a key role in doing that. Strong medical leadership is needed. Regarding what happens after five years and record retention, records are never thrown away. There are some returns, and it is nice to have those records, because memories differ. The doctors who wrote the original blue print study that verifies the quality outcomes of a well-run physician health program, which was proceeded by good treatment, are doing a research study nationally, which AMBPHP is also participating. The preliminary data for outcomes after five years is extremely good. Dr. Sucher stated that he strongly supports the effort the Board is undertaking and he agrees with the staff recommendations. He stated that it has to be well run, regardless of the business structure. He believes it would vastly help the status of consumer and public protection and the Board in fulfilling its role by starting a program. Dr. Sucher closed stating that he believes that the state of California has been left short since diversion closed.

DRAFT

Ms. McGiffert, Director, Consumers Union Safe Patient Project, believes that this program is not needed and Consumers Union strongly supports the staff recommendation that if this program were to be set up, that there would be public information about physicians that were referred to this program because of probation. Consumers Union does believe that physicians are probably among the people who have the most resources for getting treatment, and Consumers Union supports them to get treatment. But, she stated that if they come to the attention of the Board because of some problem, especially for harming patients, then that should be public knowledge, especially if the Board decides to act on it. The Board just heard somebody recommend that the hospitals should know, the insurers should know, the employers should know, but the very people who need to know, the patients, are not on that list and Consumers Union thinks that patients should be able to see this information. She stated her recommendations who be to report to the Board any physician who is terminated from the program for any reason. The Board, should also receive notice about any physician who has violated the terms of the program. With regard to the audits, Consumers Union also thinks that if the program fails the audit there should be repercussions and they should be serious, such as termination. She closed by saying five bad audits should never happen again.

Ms. Minassian, Consumers Union Safe Patient Project, discussed her experience with a doctor that was in the diversion program with an alcohol problem. She stated the monitoring mechanisms did not work, random drug tests were not random, and the worksite monitor was the doctor's employee.

Ms. Moss, Consumers Union Safe Patient Project, stated the Board has been unable to monitor and protect the public from harm. She also stated that her company would not support the Board managing confidential programs.

Ms. Shinazy, Consumers Union Safe Patient Project, asked that the Board remove themselves from the vote for a diversion program of any type with any title, stating that she did not believe that the Members could be impartial, and it should be a public only vote.

Dr. Krauss moved that the Committee accept and endorse the Board staff recommendations for the elements of a Physician Health Program and the matter be forwarded to the full Board for approval; s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 5 Presentation, Discussion and Possible Action of "Verify a License" Campaign

Ms. Kirchmeyer stated the Board has a number of outreach plans, and, it will also be driving a broader agenda with an end result of making March "Verify a License" month. Board staff will continue with its outreach from now through March, including attending events, such as health fairs, health-related walks, and outreach at malls. The mall events in San Diego and Sacramento were very successful. Due to the Governor's restriction on travel, these events are running with the Board meetings in order to use the staff that are attending the meetings to host those events. Staff in probation around the state and Board Members will be used to assist with future events, as time permits.

Ms. Hockenson spoke about a number of avenues that will be used for advertising including Pandora radio, mass transit bill boards, utility bills, store receipts, jumbo trons, and radio and television public service announcements (PSAs).

Ms. Kirchmeyer spoke about the funding for these ads stating that all funds do have to be approved through the Department of Consumer Affairs (DCA).

Ms. Simoes spoke about free advertising that can be done without DCA approval. Posters have been developed that are similar to the brochures that can be placed where consumers receive healthcare, such as at schools, at other government agencies, libraries and other agencies where patients go. Also, the Board can work with other agencies to put information on the state pay stubs, and in the electronic newsletter to parents through various school districts.

Ms. Hockenson spoke about media distribution such as; Heart Radio, National Public Radio, Capitol Public Radio, and other media outlets. An article already came out in the San Francisco Chronicle regarding the campaign. The Board is trying to create activities that can draw media coverage.

Ms. Kirchmeyer spoke about Board staff working on products that will be used to promote the Board. A brochure has been developed and approved by the Editorial Committee and printed by DCA. DCA also assisted in the development of posters based upon the brochure that the Board can use. Board staff will be creating a PSA video that emphasizes the importance of checking the Board's website to verify that a physician is licensed and in good standing with the Board, and a tutorial that walks individuals through verifying a physician's license and education on the Board's documents and posting requirements. Ms. Kirchmeyer asked if the Board had any suggestions or questions for the plan.

Ms. Yaroslavsky stated that reaching 100 people at a time is not an effective use of time and suggested using the Newsletters sent out by the elected officials and have a targeted date for completion. She suggested that Board staff look at the large employers in the state of CA, such as the Universities, school districts, and libraries. She stated that this needs to be more targeted and unified.

Ms. Kirchmeyer said that everything Ms. Yaroslavsky stated is already in the current plan, including Twitter.

Ms. Simoes stated that she brings these items up at every legislative meeting she attends and that legislative staff seem eager to participate.
Dr. Levine stated that based on the comments, there probably needs to be a prioritized list of the most important and impactful tactics. Dr. Levine asked if the "Verify a License" brochure will be available in Spanish.

Ms. Kirchmeyer stated that other languages are currently being worked on, Spanish will be the easiest and that the term verify comes from the button on the webpage where consumers would go to verify a license.

Dr. Levine asked if that was the best language to have on the button and that there is no information as to what to do with the information that consumers find on the website.

Ms. Kirchmeyer stated that PSAs and tutorials will be available to help with information found on the website.

Dr. Levine asked how do you find your physician among the multiples, and that even adding a simple statement like, if you have questions about the information that you find, be sure to ask your physician at

your next visit, will give the public a place to go. Using simple English language terms for the people that are not as familiar with the process would be the best process.

Ms. Kirchmeyer said as far as the "verify" license staff has put this forward, and are amenable to change, input is needed as to what would be a better word than verify or maybe us a focus group.

Dr. Krauss commended the outreach effort and stated that this is viewed as an introduction to the website and people need to be driven to the website and once they get there they will explore it and learn more about the Board, and this is the best outreach. He concluded that this is a great start.

Ms. Kirchmeyer suggested marrying the two comments together such as check your doctor now or find out more information on the verify and then the website can be explained.

Ms. Yaroslavsky commented that something is needed that communicates clearly what information is on the website about the physician and what information is not there.

Ms. Kirchmeyer stated that the information is there but maybe it needs to be put in one spot, altogether and that most information is there regarding certification, they just need to be driven to the ABMS website.

Dr. Lewis asked if staffing is in place to handle this huge list and wondered how this was going to be handled. He added the Board Members are a willing group.

Ms. Kirchmeyer stated that this is a team effort and it would take staff and Board Members to get it done.

Dr. Barrera, Consumer Watchdog, stated that "Verify Your License" is an unclear button. He had several suggestions, one, that it be in several languages, and clear up the search button on Verify. Also regarding probation outreach, this plan should not replace doctors notifying their patients that they are on probation.

Ms. McGiffert, Director, Consumers Union Safe Patient Project, commended the Board regarding its outreach plan to educate the public and looks forward to helping the Board get the word out. She suggested "check out your doctor's background" or "look up your doctor" instead of "verify" and it should be on the website and in the written materials. Also, she recommended changing the language for the link to public documents to be clearer to patients like "Disciplinary actions taken by the Board," which is a quick way to look up whether your doctor is under some kind of order. She encouraged the Board to check website hits and maybe do a survey to see how many people know about the Medical Board. She suggested trying to get a question into surveys that are already being done so the Board can see the progress over time. Also, the sign that is in every doctor's office is inefficient and needs to be changed.

Ms. Greulich, Consumers Union Safe Patient Project, recommended that the Board create a brief summary in plain language, 6th grade level, for each disciplined physician on the website, describing the history of the violations, the license restrictions, a time line for the probation and update them on a monthly basis. She also suggested targeting the minority senior population because less than 40% of them use the internet, possibly by using some community based organizations to reach them.

Ms. Hollingsworth, Consumers Union Safe Patient Project, commented that the 800 number is unreliable, the non 800 number works better. Further, she stated it seemed that the employees would not find the doctors she asked about, because some doctors use different names on the website than they use in their practice. Bottom line is the call in system is not more effective than the Breeze website, the only reliable way for the public to be informed is for doctors to tell their own patients what their license status is.

Ms. Choong, CMA, also has concerns regarding understanding terms on the website as to whether their problems stem from not paying their taxes or problems with patient care. Also, if this campaign is sponsored by DCA, the Board might want to add other professions as well, such as doctors of osteopathy or nurse practitioners. CMA encourages patients to have a dialogue with their physician if they have concerns. CMA is looking forward to participating in the Board's stakeholder group meeting.

Dr. Gill spoke about the need for physicians to use their full legal names to avoid confusion and also the Breeze system does not cross populate information to fictitious name permits. He said the system needs to be fixed to show accurate information.

Ms. Shinazy, Consumers Union Safe Patient Project, questioned recordings that do not cover one of the over 200 languages spoken in California.

Dr. Levine said to make sure that the website address is displayed prominently on the front of the brochure.

Dr. Lewis commented that this is a very busy brochure. Dr. Lewis also asked if the physician is a DO does the website tell the consumer where to find their information.
Ms. Kirchmeyer commented that on the first page it states that if the public cannot find the physician they may be a doctor of osteopathy (DO). In addition if the public goes in from the Breeze webpage rather than through the Board's webpage, using the last name will pull up all physicians, including DOS.

Dr. Levine stated that there are so many organizations that support ethnic minorities and community health groups, they are non-profit and are there to bridge roads between the community and the providers, and she suggested that staff engage some of them as community stakeholder, because they can also help with translation and putting out information.

Dr. Levine stated that it would be helpful for the Committee at the next meeting to see a refined set of next steps and have them prioritized.

Dr. Lewis reiterated Dr. Levine's comments.

Agenda Item 6 Future Agenda Items

Dr. Hawkins suggested a follow up on the demographics study.

Dr. Gill asked the Board to consider using a foundation model of practicing medicine and that it would be good to have a conversation on the non-profit foundation and the lines that are being crossed regarding the corporate practice of medicine.

Agenda Item 7 Adjournment

Dr. Lewis adjourned the meeting at 3:35 p.m.

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

DRAFT

"Check Up on Your Doctor's 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 their ability to verify a physician's license on the Board's website. This will allow patients to ensure a physician is licensed and is in good standing with the Board.

Situational Analysis: The assumption is that most Californians are not aware of the Board's function and the tools available to them to obtain information about their current and/or potential physician.

Target Audience: Every patient in California. Target groups are seniors, ethnic groups/communities, parents, Legislators, California consumers, using a prioritized approach.

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 and Board Members in those areas provide outreach or attend the events around other approved Board events, such as a Board Meeting. In addition, California is a diverse state where many different languages are used, the Board will need to use the census information to identify the top three languages used in California and translate brochures and information into those three languages.

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 a particular month as "Check Up on Your Doctor's License" month.

Proposed outreach includes:
These two items will need to be completed before outreach priorities can begin:

- ✓ 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

Priority 1

- ✓ Information about the Board on utility bills throughout the state
- ✓ Information about the Board on city, county, and state employee paystubs
- ✓ Work with the AARP to provide Board information at their conferences, in their publications, and on their website
- ✓ Board reach out to unions so they can provide their members information about the Board and a link to the Board's website on union materials.
- ✓ Provide an interview and PSA to iHeart Radio, this could be with the Board staff and/or with Board Members
- ✓ Interview/PSA on NPR and Capitol Public Radio

- ✓ Encourage Legislative Members, Congressional Members, and local government to include information and a link to the Board's website in their newsletters and to Tweet the Board's link and post the Board's link on their websites
- ✓ Hold a Legislative Day (possibly two) at the Capitol where Board staff passes out brochures and Members meet with key Legislators

Priority 2

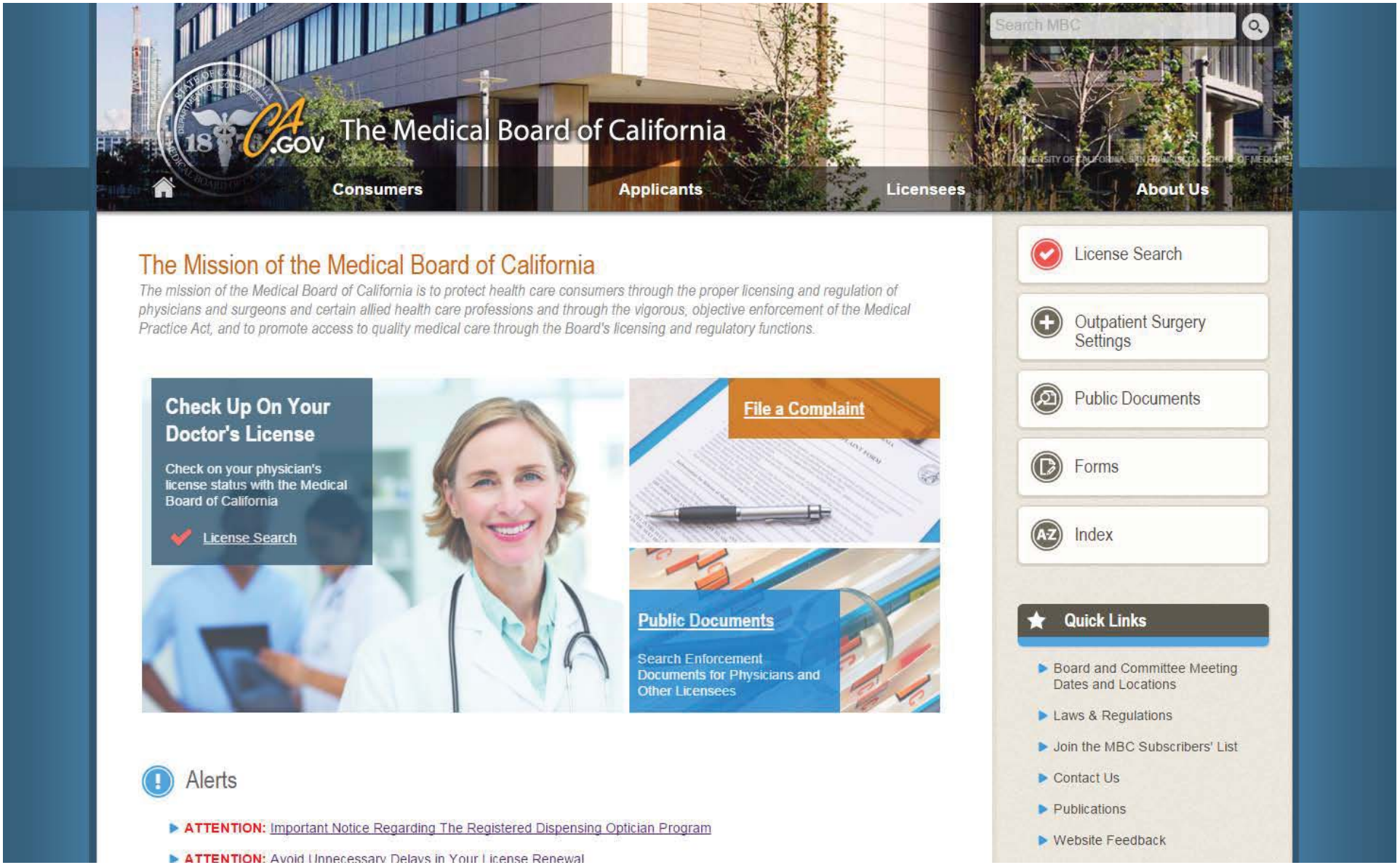
- ✓ Work with other DCA regulatory boards to explore ways to leverage community health workers to assist in the outreach campaign
- ✓ Ads in community newspapers and school publications
- ✓ Air PSA on three television markets
- ✓ Invite media to all events held during the focus month and provide them with information on the campaign

Other Outreach Items

- ✓ Board staff and Board Members will attend health fair events throughout California
- ✓ Ads on mass transit (in English and Spanish) throughout the state
- ✓ Information about the Board on store coupons and receipts throughout the state
- ✓ Provide information to Teachers Associations
- ✓ Commercials on Facebook, Google, Pandora, YouTube, Twitter
- ✓ PSA to run on Sirius XM radio
- ✓ Contact the Governor's Office to seek interest/support with a quote and a link on the Board's home page in the focus month
- ✓ Seek a Legislative Resolution to proclaim focus month as "Check Up on Your Doctor's License" month
- ✓ Issue a Press Release at the beginning of the focus month

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

PROPOSED HOMEPAGE DESIGN CHANGES:



MEDICAL BOARD OF CALIFORNIA

PATIENT NOTIFICATION TASK FORCE AGENDA

MEMBERS

David Serrano Sewell, Chair
Kristina Lawson, J.D.
Sharon Levine, M.D.
Ron Lewis, M.D.

Cal Expo Courtyard Marriott
1782 Tribute Road
Sacramento, CA 95815
(916) 929-7900 (directions only)

Thursday January 21, 2016
3:15 p.m. – 5:30 p.m.
(or until the conclusion of business)

Teleconference – See Attached Meeting Information

ORDER OF ITEMS IS SUBJECT TO CHANGE

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

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

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

Thursday, January 21, 2016

3:15 pm

1. Call to Order/Roll Call

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

3. Discussion, Consideration, and Possible Action on the Mission of the Task Force

4. Discussion on Outreach to the Public Regarding Physicians on Probation

5. Discussion on Information Available on the Website Regarding Physician Discipline

6. Discussion on the Signage Required Pursuant to Business and Professions Code Section 138

7. Discussion on Revisions to the Disciplinary Guidelines

8. Future Steps

9. Adjournment

Meeting Information

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

The call-in number for teleconference comments is: (844) 248-8038

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 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.

Patient Notification Task Force Mission

Mission Statement: The mission of the Patient Notification Task Force is to explore methods to address concerns regarding patients being unaware that a physician is on probation.

Objectives: The objectives of the Task Force are to explore possible additions and/or improvements to existing methods of informing patients when physicians are on probation.

Items for the Task Force to explore and consider may include:

- the current distribution method of information regarding a physician on probation;
- the information that is currently available to members of the public for its review and consideration;
- the sign that is required to be posted regarding the physician being regulated by the Board;
- the disciplinary guidelines; and
- any other changes that can assist patients to be aware of the information available to them regarding their physician or potential physician.

At the conclusion, the Task Force will provide a report, with possible recommendations, to the Board for its consideration and/or approval.

Business and Professions Code section 138

Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations pursuant to this section if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state.

California Code of Regulations, Title 16, Division 13, Chapter 2, Article 1, section 1355.4 – Notice to Consumers

(a) A licensee engaged in the practice of medicine shall provide notice to each patient of the fact that the licensee is licensed and regulated by the board. The notice shall include the following statement and information:

NOTICE
Medical doctors are licensed and regulated
by the Medical Board of California
(800) 633-2322
www.mbc.ca.gov

(b) The notice required by this section shall be provided by one of the following methods:

(1) Prominently posting the notice in an area visible to patients on the premises where the licensee provides the licensed services, in which case the notice shall be in at least 48-point type in Arial font.

(2) Including the notice in a written statement, signed and dated by the patient or the patient's representative and retained in that patient's medical records, stating the patient understands the physician is licensed and regulated by the board.

(3) Including the notice in a statement on letterhead, discharge instructions, or other document given to a patient or the patient's representative, where the notice is placed immediately above the signature line for the patient in at least 14-point type.

NOTICE TO CONSUMERS

Medical doctors are licensed and regulated by the Medical Board of California

(800) 633-2322

www.mbc.ca.gov

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

11TH Edition
2011

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

State of California
State and Consumer Services Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
11th Edition
2011
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

The Board produced this Manual of Model Disciplinary Orders and Disciplinary Guidelines, 11th 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.

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 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), 11th 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.

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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 final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 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 final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board

within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 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 final decision on an accusation and/or a petition to revoke probation. An accusation and/or petition to revoke probation shall be filed by the Board within 15 days of the notification to cease practice. If the respondent requests a hearing on the accusation and/or petition to revoke probation, the Board shall provide the respondent with a hearing within 30 days of the request, unless the respondent stipulates to a later hearing. A decision shall be received from the Administrative Law Judge or the Board within 15 days unless good cause can be shown for the delay. The cessation of practice shall not apply to the reduction of the probationary time period.

If the Board does not file an accusation or petition to revoke probation within 15 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 with any information and documents that the Program 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 with any information and documents that the Program 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"). Respondent, at the Program's discretion, shall undergo and complete the Program'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 Program shall evaluate respondent at the end of the training and the Program 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 Program 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 Program 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 Program recommendations. At the completion of the Program, respondent shall submit to a final evaluation. The Program 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 Program has the authority to determine whether or not respondent successfully completed the Program.

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 Program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the Program 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 Program.

18. Clinical Training Program

Within 60 calendar days of the effective date of this Decision, respondent shall enroll in a clinical training or educational program equivalent to the Physician Assessment and Clinical Education Program (PACE) offered at the University of California - San Diego School of Medicine ("Program"). Respondent shall successfully complete the Program not later than six (6) months after respondent's initial enrollment unless the Board or its designee agrees in writing to an extension of that time.

The Program shall consist of a Comprehensive Assessment program comprised of a two-day assessment of respondent's physical and mental health; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment pertaining to respondent's area of practice in which respondent was alleged to be deficient, and at minimum, a 40 hour program of clinical education in the area of practice in which respondent was alleged to be deficient and which takes into account data obtained from the assessment, Decision(s),

Accusation(s), and any other information that the Board or its designee deems relevant. Respondent shall pay all expenses associated with the clinical training program.

Based on respondent's performance and test results in the assessment and clinical education, 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, treatment for any medical condition, treatment for any psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with Program 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 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 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 training program have been completed. If the respondent did not successfully complete the clinical training program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

(Option #1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the Program and has been so notified by the Board or its designee in writing, except that respondent may practice in a clinical training program approved by the Board or its designee. Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.

(Option #2)
Within 60 days after respondent has successfully completed the clinical training program, respondent shall participate in a professional enhancement program equivalent to the one offered by the Physician Assessment and Clinical Education Program at the University of California, San Diego School of Medicine, which shall include quarterly chart review, semi-annual practice assessment, and semi-annual review of professional growth and education. Respondent shall participate in the professional enhancement program at respondent's expense during the term of probation, or until the Board or its designee determines that further participation is no longer necessary.

19. Oral and/or Written Examination

[**NOTE:** This condition should **only** be used where a clinical training program is not appropriate.]

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass an oral and/or 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 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, 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 standard~~s~~ 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, 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 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

During probation, respondent is prohibited from supervising physician assistants.

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. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice. Practicing medicine in another state of the United States or Federal jurisdiction while on probation with the medical licensing authority of that state or jurisdiction shall not be considered non-practice. A Board-ordered suspension of practice shall not be considered as a period of non-practice.

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

Respondent's period of non-practice while on probation shall not exceed two (2) years.

Periods of non-practice will not apply to the reduction of the probationary term.

Periods of non-practice will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; and General Probation Requirements.

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 year~~s~~ 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 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 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 or 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 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 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 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 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.
Kristina Lawson, J.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.

Cal Expo Courtyard Marriott
1782 Tribute Road
Sacramento, CA 95815
(916) 929-7900 (Directions Only)
Room A&B

Friday, January 22, 2016
8:30 a.m. – 3:00 p.m.
(or until the conclusion of business)

Teleconference – See Attached Meeting Information

ORDER OF ITEMS IS SUBJECT TO CHANGE

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

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

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

Friday January 22, 2016

8:30 a.m.

1. Call to Order/Roll Call

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

3. Approval of Minutes from the October 29-30, 2015 Meeting

4. President's Report – Mr. Serrano Sewell
   A. Swearing In of New Board Member – Ms. Lawson
   B. Committee Roster Updates

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

6. Executive Management Reports – Ms. Kirchmeyer
   A. Administrative Summary
   B. Enforcement Program Summary
   C. Licensing Program Summary

D. Update on the CURES Program
E. Update on the Federation of State Medical Boards
F. BreEZe Update
G. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children

7. Update from the Department of Consumer Affairs, which may include Updates pertaining to the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory and Policy Matters – Ms. Lally

8. Discussion and Possible Action on Legislation/Regulations – Ms. Simoes
   A. 2016 Legislation

AB 611	SB 323
AB 890	SB 482
AB 1306	SB 538
SB 22	SB 622

   B. Other Recently Introduced Bills within Board Purview
   C. Status of Regulatory Actions

9. Update, Discussion and Possible Action on Recommendations from the Public Outreach, Education, and Wellness Committee – Dr. Lewis

10. Update, Discussion and Possible Action on Recommendations from the Patient Notification Task Force – Mr. Serrano Sewell

11. Update, Discussion and Possible Action of Recommendations from the Enforcement Committee – Dr. Yip

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

13. Special Faculty Permit Review Committee Recommendations: Approval of Applicants – Dr. Bholat

14. Discussion and Possible Action on Universidad Autonoma de Guadalajara Application for Recognition – Dr. Nuovo and Mr. Worden

15. Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting – Ms. Sparrevohn

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

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

18. Agenda Items for the May 2016 Meeting in the Los Angeles Area

19. 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:

Friday January 22, 2016 – (844) 248-8038

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 Board, but the President may apportion available time among those who wish to speak.

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

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

MEDICAL BOARD OF CALIFORNIA
QUARTERLY BOARD MEETING

The Westin San Diego
400 W. Broadway
San Diego, CA 92101

Thursday October 29, 2015
Friday October 30, 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:
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.
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:
David Serrano Sewell, President

Staff Present:
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dennis Frankenstein, Staff Services Analyst
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Staff Services Manager I
Regina Rao, Associate Government Program Analyst
Letitia Robinson, Research Specialist II
Elizabeth Rojas, Staff Services Analyst
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:
Steve Alexander
Teresa Anderson, California Academy of Physician Assistants
Edward Barrera, Consumer Watchdog
Steven Brewer, Investigator, Health Quality Investigation Unit
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Alex Chin, Arizona College of Osteopathic Medicine
Rosa Ching, Arizona College of Osteopathic Medicine
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Veverly Edwards, Consumer's Union
Julie D'Angelo Fellmeth, Center for Public Interest Law
Lou Galiano, Videographer, Department of Consumer Affairs
Amanda Gittelman, Arizona College of Osteopathic Medicine
Bridget Gramme, Center for Public Interest Law
James Hay, M.D., California MedicalAssociation
Marian Hollingsworth, Consumer's Union
Christina Maslach, Ph.P, University of California, Berkeley
Nicole McAllister, Arizona College of Osteopathic Medicine
Lisa McGiffert, Consumer's Union
Karen Miotto, M.D., University of California, Los Angeles
Michelle Monseratt-Ramos, Consumer's Union
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit
Tri Nguyen, Arizona College of Osteopathic Medicine
Kerry Parker, California Society of Addiction Medicine
Michaelray Paulino, Investigator, Health Quality Investigation Unit
Jasjit Saini, Arizona College of Osteopathic Medicine
Susan Shinazy, Consumer's Union
Alexandria Styke, Arizona College of Osteopathic Medicine
Kai En Tang, Arizona College of Osteopathic Medicine
Chau Vu, Arizona College of Osteopathic Medicine
Christina Vu, Arizona College of Osteopathic Medicine
Matthew Wostak, Arizona College of Osteopathic Medicine
Tracy Zemansky, Physician Assistance Group

Agenda Item 1 Luncheon Presentation – Physician Burnout – Christina Maslach, Ph.D.

Dr. Maslach with the University of California, Berkeley, gave a presentation on New Insights into Burnout and Health Care. The presentation included the problems and outcome of burnout among Health Care Professionals.

Agenda Item 2 Call to Order/Roll Call

Dr. GnanaDev called the meeting of the Board to order on October 29, 2015, at 4:50 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 3 Public Comments on Items not on the Agenda

Mr. Barrera, Consumer Watchdog stated that his organization strongly supports the requirement that physicians notify their patients when the physician is on probation.

Agenda Item 4 Approval of Minutes from the July 29-30, 2015 Meeting

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

Agenda Item 5 Board Member Communications with Interested Parties

Dr. Levine, Ms. Schipske, Ms. Pines, Ms. Yaroslavsky and Dr. Hawkins had individual conversations with Consumer's Union regarding the administrative petition that was on the agenda.

Dr. Krauss stated he had email correspondence with Consumer's Union.

Dr. GnanaDev stated he has regular meetings with the California Medical Association and American Medical Association, but Board items/issues are never discussed.

Agenda Item 6 Update, Discussion and Possible Action on Recommendations from the Public Outreach, Education, and Wellness Committee

Dr. Lewis provided an update from the Public Outreach, Education, and Wellness Committee meeting. He stated he has taken over the roll as Chair of this Committee and that the name of the Committee has changed. The Committee's mission will now include overseeing the Board's public outreach, in addition to the physician education and wellness. The first item the Committee discussed was the elements of a successful physician health program. The Committee reviewed the uniform standards for substance-abusing physicians. He stated the Board staff had met with consumer groups and all licensee groups in September to obtain each group's recommendations on the elements a successful physician health program should include. He noted Board staff took recommendations from each group as well as staff recommendations and presented those recommendations in a power point presentation at the Committee meeting. After Committee discussion and public comment, the Committee approved the staff recommended elements. Dr. Lewis noted it is important to mention that the Committee does not believe the Board should sponsor legislation to create a physician health program, but if legislation is introduced, the Board would want the legislation to include the Board approved elements. The Committee is asking the Board to approve its recommendations for elements of a successful physician health program. Dr. Lewis then asked for a motion to approve the recommendations.

Ms. Wright made a motion to approve the Committee's recommendations for the elements of a successful physician health program; s/Ms. Yaroslavsky.

Ms. Hollingsworth, Consumer's Union, stated the BreEZe system needs some adjustments made, as some physicians go by a different name to their patients then they do on their actual licenses. When that happens, physicians often cannot be located in the system.

Ms. Fellmeth, Center for Public Interest Law (CPIL), stated she understands that the Committee is recommending to the Board that it set some parameters for a physician health program, if legislation should create such a program. Ms. Fellmeth stated that several key elements are missing from the public documentation handed out at the meeting. She noted several of the staff recommendations refer to the Uniform Standards, but are not shown on the public document handouts and requests that they be added. She added that in respect to the recommendation that this program be run by a private, non-contracted entity, she would like two additions added. The first being the Board require that entity be contracted through a competitive bidding process. The second request is that no organization or entity that was connected to the prior diversion program be involved in any way.

Ms. Fellmeth then stated that recommendation number six in the handouts states, "Report to the Board, any physician who is terminated from the program, for any reason." That recommendation is inconsistent with the Uniform Standard number 16. Ms. Fellmeth stated she had a couple of other recommended changes to be made, but will talk with staff about those recommended changes at a later time.

Mr. Barrera, Consumer Watchdog, stated if this program does get established at some point, he strongly urges the Board to not support any program that would let physicians keep their addiction problems secret and avoid consequences when they fail.

Mr. Alexander, prior Board Member, stated he has training in both alcohol and drug related issues and has trained hundreds of physicians and surgeons on how to speak publicly, work with boards and develop good public policy. He strongly urged the Board to follow the Board's prior decision to defund the physician diversion program that was in place at the time and end the secrecy that transpired prior to that. He noted that anyone could have a family member that could lose their life as a result of an error while the physician is under the influence.

Ms. Monseratt-Ramos, Consumer's Union Safe Patient Project, stated she first became familiar with substance abusing physicians in 2007 when the now terminated diversion program was up for sunset review. She lost her fiancé to a physician who was addicted to drugs because the physician was in a secret program, which did not allow the public to know the truth about him before becoming his patient. She noted there is nothing that prevents a physician from seeking treatment with complete confidentiality, and there is no need to create a special program that may interfere with oversight responsibility of the Board.

Dr. Miotto, Chair of the Well Being Program at UCLA, stated she is concerned with the question that has been raised that if the Board does not address or endorse a program that somehow the public will be safer. As a treatment provider, she does not understand the thought process behind that question, because treatment is what makes people safer. She stated she appreciated the Board's looking into this very important issue.

Motion carried unanimously.

Dr. Lewis continued his update stating the Committee also heard a presentation from the Board staff on the current "Verify a License" campaign and the Board's outreach plan. Staff presented a list of proposed outreach programs including mall outreach that has already begun, public service announcements, including television air time, radio interviews, billboard advertising,

advertising on rapid transit, and working with various organizations on getting the Board's website information printed on various items. The Board staff has proposed the campaign be focused on getting the month of March declared as the "verify a physician's license" month. Staff would also have the Board's Legislative Day in the month of March, to get legislators involved. The outreach plan also includes a timeline of activity events to implement, starting in October, focusing many of the outreach efforts in March. Dr. Lewis noted Members recommended staff work on a process to prioritize outreach items and deliverables and that the plan include this information in future Committee meetings and that staff develop a webpage to explain the various license statuses and what information is and is not available on the physician's profile. In addition, staff will consider revisions to the "Verify a License" brochure.

Ms. McGiffert, Consumer's Union, stated they support this outreach plan and would like to see it incorporated in the daily activities of staff and not just a one-time campaign. She noted much of the work would be lost if it is not put in plain language. She also recommended doing outreach on disciplinary orders.

Agenda Item 7 President's Report

Dr. GnanaDev read a statement on behalf of President Serrano Sewell. The statement read that Mr. Serrano Sewell wanted to thank the Board and the Committee for the work done on the outreach program. He has seen a lot of positive and educational press over the past two weeks on how a consumer can look up their physician. He feels this campaign will make an impact on patients of California. It reaches to the heart of the Board's mission of public protection. He stated he hopes that all Members make education a top priority when talking with friends, co-workers and associates. He hopes this campaign will lead to another Legislative Day at the State Capitol. He noted there is a lot of work to do within the upcoming months and he looks forward to working with staff and Members on this outreach.

In Mr. Serrano Sewell's statement, he also thanked Ms. Yaroslavsky for her service on the Education and Wellness Committee. She was chair of the Committee for several years, and has led the Board in numerous activities while on the Committee.

Dr. GnanaDev noted there have been some changes made to the Committee memberships as well as renaming the Education and Wellness Committee to the Public Outreach, Education, and Wellness Committee.

Dr. GnanaDev also announced that Panel B had elected a new chair for the panel. Dr. Krauss is now the new Chair of Panel B and Dr. Bholat is now the Vice Chair.

Ms. Edwards, Consumer's Union, stated they have reviewed the standing Committee Roster are they are concerned about the representation of the Board's public members on a few of the committees, for example, the Executive Committee and the Enforcement Committee. The legislature requires the Board be composed of eight physicians and seven public members. An approximate 50-50 ratio. She urged the Board to revisit the Board's Committee composition with the aim of having it reflect the 50-50 ratio as required by the legislature.

Agenda Item 8 **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. Yip made a motion to approve the orders; s/Ms. Yaroslavsky. Motion carried unanimously.

Ms. Kirchmeyer announced the appointment of the Board's newest Member, Kristina Lawson. Ms. Lawson was appointed by the Governor on October 28, 2015, but due to the brief time frame between her appointment and the meeting date, she was unable to attend the meeting. Ms. Kirchmeyer stated she looks forward to working with Ms. Lawson and that everyone is pleased to have her on the Board.

Ms. Kirchmeyer then noted she would not be going over the summaries in detail unless Members had any questions, but stated she had some things to give updates on and some things to bring to the Members' attention.

She began by stating the Board's vacancy rate is at 4%, which is the lowest it has been in several years. She is glad to be filling positions in hopes that it will make a difference in the licensing and enforcement statistics.

Ms. Kirchmeyer then noted that staff is currently working on the required Vertical Enforcement report that is due to the legislature on March 1, 2016. The required date was moved from March 2015 to March 2016 due to the transition of the investigators to Department of Consumer Affairs (DCA). She is pleased to announce that Anita Scuri will be assisting Ms. Robinson on the completion of the report. A meeting with DCA and the Attorney General's (AG's) office has already been held to discuss the report. The report has to be completed in consultation with these two entities, so it was believed that an early meeting to start receiving input would be valuable. The biggest issue at this point will be the ability to obtain the reports needed. Staff is looking into this issue currently and the Board is looking into hiring limited term positions to assist in BreEZe report writing. Ms. Kirchmeyer stated she will be working with Mr. Serrano Sewell to identify two Members to work with staff on this project. The report will be looking at the effectiveness of the Vertical Enforcement program and identifying any recommendations for improvement.

Ms. Kirchmeyer announced that the prior week the Board received the AG's opinion on medical assistants. In October 2013, the Board approved staff to request an AG's opinion on whether a medical assistant could perform basic pulmonary function testing. The Board had been contacted by the Respiratory Care Board (RCB) stating that they were of the opinion that a medical assistant could not perform such duties. Therefore, in collaboration with the RCB, an opinion was requested. The AG's opinion states that a medical assistant may lawfully perform spirometric pulmonary function testing if the test is a usual and customary part of the medical practice where the medical assistant is employed and the requirements for training, competency, authorization, and supervision are satisfied. She stated Board staff will be completing an analysis of the opinion and will update the Board's website as appropriate based upon the information. A copy of the opinion will also be provided to the Members.

Ms. Kirchmeyer noted that on October 23, 2015, the Board received a letter from the Bureau of State Audits (BSA). The letter stated they were conducting an audit pertaining to the oversight and monitoring of children in foster care who have been prescribed psychotropic medications. Therefore, the BSA will be auditing the responsibilities of the Board in this area. A meeting has been scheduled

with a pediatric psychiatrist to discuss information the Board has received. The goal of this meeting is that the psychiatrist can either assist in the identification of physicians who may be inappropriately prescribing or can assist in identifying additional information needed to obtain from the Department of Health Care Services (DHCS) or the Department of Social Services (DSS).

Ms. Kirchmeyer announced that the recently passed Assembly Bill (AB) 679 extended the CURES registration requirement date to July 1, 2016, instead of the previous requirement date of January 1, 2016. She then noted that the information in the Board packets under BRD 8B-3 is no longer current. At the time of writing the report, the understanding was that the streamlined application process would be available October 30, 2015 for all users. The original intent was to redirect users into an updated version of CURES depending on the user's browser. While Department of Justice (DOJ) is working on this redirect, it will not be ready until late November or early December. Until that time, users will need to continue to register by using a notary. All physicians will be notified once this redirect has been completed. The Board, the DCA, and the DOJ recommend that users implement an update to their systems in order to use a compliant browser for the updated version of CURES. This will allow physicians to take advantage of the improvement and alerts that will be available in the new upgraded version.

Ms. Kirchmeyer stated the inaugural meeting of the Interstate Medical Licensure Compact Commission took place in Chicago on October 27-28, 2015. Eleven states are now part of the Commission and more are in the process of approving the legislation. The meeting was held to begin the process of establishing the roles and duties of the Commission, Commissioners, and States. She noted that in addition, they established working groups on planning, finance and rules.

Ms. Kirchmeyer stated currently, the Board has not been approached by any Legislative offices inquiring about legislation on the compact.

The Federation of State Medical Boards (Federation) had also sent out a notice stating they are seeking resolutions by February 26, 2016 for their annual meeting. Ms. Kirchmeyer requested if any Member has an type of resolution idea that they would like submitted, to please contact her directly, so that it can be developed and presented at the January 2016 Board meeting. The Federation is seeking nominations for elected offices and that request had been sent to the Board members; however, no Board Member had shown interest to date.

Dr. GnanaDev thanked Ms. Kirchmeyer for handling the psychotropic drugs and foster children issue. He stated it is not just a Medical Board issue, it also is an issue where the DSS and DHCS are involved.

Ms. Clavreul stated her concerns for the current CURES system and the way the release dates keeps changing and getting wrong information.

Agenda Item 9 Update on the Physician Assistant Board

Dr. Bishop stated Board staff was informed that the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions will begin their Sunset Oversight Review in the Fall of 2015.

He noted that the Physician Assistant Board (PAB), is scheduled to be reviewed. The Board was last reviewed in 2012. Staff has begun preparation of the report, which is due to the Legislature December 1, 2015.

Dr. Bishop announced that the Governor signed SB 800, which is the DCA Omnibus bill. This bill made non-controversial or technical changes to various provisions pertaining to the healing licensing programs of the DCA. Among other things, the bill deleted the terms "board chair and vice chair" and replaced them with "president and vice president."

He noted the Governor also signed SB 337 (Pavley). This bill requires medical records to reflect the supervising physician for each episode of care; requires a physician assistant who transmits an oral order to identify the supervising physician; recasts medical record review provisions to require the supervising physician to utilize one of more mechanisms; and recasts prescribing provisions for a physician assistant when prescribing Schedule II controlled substances.

Dr. Bishop also noted that the revised physician assistant application for licensure was placed on the PAB's website. The application recently was updated to reflect recent changes in law and reporting requirements. Additionally, the new application is much more professional in appearance.

Dr. Bishop then announced that on September 21, 2015, Board Member Jed Grant and the PAB's Executive Officer attended a training session sponsored by the DCA regarding the North Carolina Dental Examiners v. Federal Trade Commission case.

He noted that this case could have potential impact on the DCA, including the PAB. The case established a new standard for determining whether a state licensing board is entitled to immunity from antitrust actions. The PAB will discuss this case and potential impact to the PAB at its November meeting.

Dr. Bishop thanked the Board, Ms. Kirchmeyer, and her staff for their continued support as it is always appreciated.

He then stated the next scheduled PAB meeting is November 2, 2015.

Agenda Item 10 Update on the Health Professions Education Foundation

Dr. Yip stated the Health Professions Education Foundation had done a very good job in the area of outreach and has received over 5000 applications. He then noted he and Ms. Yaroslavsky are assisting and are pleased with the outreach being done.

Dr. GnanaDev adjourned the meeting at 5:50 pm.

Friday, October 30, 2015

Members Present:
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.
Gerrie Schipske, R.N.P., J.D,
Jamie Wright, Esq.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:
David Serrano Sewell, President

Staff Present:
Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dennis Frankenstein, Staff Services Analyst
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Natalie Lowe, Staff Services Manager I
Regina Rao, Associate Governmental Program Analyst
Letitia Robinson, Research Specialist II
Elizabeth Rojas, Staff Services Analyst
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
Hari Avedissian, Arizona College of Osteopathic Medicine
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul
Zennie Coughlin, Kaiser Permanente
Sara Davis, California Association of Midwives
Julie D'Angelo Fellmeth, Center for Public Interest Law
Veverly Edwards, Consumer's Union
Karen Ehrlich, L.M., Midwifery Advisory Council
Duncan Fraser, Investigator, Health Quality Investigation Unit
Lou Galiano, Videographer, Department of Consumer Affairs
Mike Gomez, Deputy Director, Department of Consumer Affairs
Bridget Gramme, Center for Public Interest Law
Rae Greulich, Consumer's Union
Kshipra Joshi, Arizona College of Osteopathic Medicine
Grace Kang, Arizona College of Osteopathic Medicine

Naila Khan, Arizona College of Osteopathic Medicine
David Killoran
Mariam Hollingsworth, Consumer's Union
Christine Lally, Deputy Director, Department of Consumer Affairs
Dr. Lang, Golden State Medical Association
Michelle Lee, Arizona College of Osteopathic Medicine
Michelle Leong, Arizona College of Osteopathic Medicine
Lisa McGiffert, Consumer's Union
Michelle Monseratt-Ramos, Consumer's Union
Carol Moss, Consumer's Union.
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit
Jason Piccione, Department of Consumer Affairs
Eric Ryan, Supervising Investigator, Health Quality Investigation Unit
Albert Shin, Arizona College of Osteopathic Medicine
Susan Shinazy, Consumer's Union
Carrie Sparrevohn, Midwifery Advisory Council

Agenda Item 11 Call to Order/Roll Call

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on October 30, 2015 at 9:00 a.m. A quorum was present and due notice was provided to all interested parties.

Dr. GnanaDev thanked the students from Midwestern University for attending.

Agenda Item 12 Public Comments on Items not on the Agenda

Ms. Clavreul stated her concerns of the medical students taking a picture of the sign in sheet as proof that they attended the meeting.

Agenda Item 13 9:00 a.m. REGULATIONS – PUBLIC HEARING - Manual of Model Disciplinary Order and Guidelines (Disciplinary Guidelines). Amendment to Section 1361 of Title 16, Californian 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.

Dr. GnanaDev stated this is the time and place set by the Board to conduct a public hearing to consider changes to Section 1361 of Division 13 of Title 16 of the California Code of Regulations as described in the notice published in the California Regulatory Notice Register and sent by mail or electronic mail to those on the Board's mailing and subscribers' lists.

The current Disciplinary Guidelines (11th Edition, adopted in 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.

Dr. GnanaDev noted that the date was October 30, 2015, and the time was 9:08 a.m. He stated the purpose of the hearing was to receive oral testimony concerning the regulatory proposals described in the notice.

Dr. GnanaDev stated that after Ms. Webb's opening statement, he would call on those persons who wants to testify.

Ms. Webb stated there had been no public comment received, however, a comment was received at the meeting from Bridget Gramme from the CPIL, relating to Condition 33, where the Board has removed that after a period of non-practice that exceeds 18 months, a clinical training program would be required before reentering practice. Instead of the required training, the physician would be required to take the Federation of State Medical Board's Special Purpose Examination before reentering into practice.

Ms. Webb noted the purpose of staff's suggestion for the clinical program to be removed is because a quality of care issue that required a clinical training program would have already been part of the probationary order. CPIL suggested the Board leave the clinical training in the guidelines to state that, in the event the 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 or, at the Board's discretion, a clinical training program that meets the criteria of condition 18 of the current version on the Board's Disciplinary Guidelines prior to resuming the practice of medicine. Ms. Webb stated her concern with that change is that it may create challenges to how the Board uses its discretion. The expectation of these guidelines is that a quality of care issue would have already been addressed in the probationary order.

Ms. Gramme, CPIL, stated their biggest concern is that the Board would be giving up their discretion and rights in the appropriate circumstances to be able to order it. She stated they do not object to having the guidelines stay as they are written, they just do not want the Board to give up their discretion.

Dr. Levine stated the Board uses discretion when implementing the Disciplinary Guidelines as they are not rules, they are guidelines. Dr. Levine agreed with CPIL's suggestion of adding the Special Purpose Examination as an option, but maintaining under the appropriate circumstance the ability to decide on a case to case basis the appropriate option.

Dr. Bishop also agreed with the CPIL and Dr. Levine. He stated it makes sense to not give up an option that could be very helpful.

Dr. GnanaDev stated, he too, agrees that option should not be given up.

Dr. Lewis made a motion to adopt the language with the proposed amendment to Condition 33, and authorize the staff to prepare the modified language for a 15-day public comment period. If no negative comments are received, allow staff to finalize the rulemaking package to present to the Office of Administrative Law (OAL), making any non-substantive changes that are required; s/Ms. Yaroslavsky.

Dr. Bishop asked for clarification to Condition 18 in regards to the on-site participation for assessment and evaluation. Ms. Webb recommended the language be edited to state a minimum of 3 and no more than 5 days.

Dr. Lewis amended his motion to include Ms. Webb's amendments to condition 18; s/Ms. Yaroslavsky.

Dr. Lang, Golden State Medical Association, congratulated Ms. Kirchmeyer on her leadership on the demographics evaluation for medical board actions that were commented on and presented previously.

Dr. Lang then stated her concerns about the current discussion on Condition 33 of the guidelines. She noted that sometimes when people have this kind of discretionary control over the future of a physician, they do not have enough knowledge to know what is appropriate. She stated the majority of the Members on the Board, are not physicians and have never practiced medicine. She suggested the Board reconsider this being a mandatory inclusion in the disciplinary guidelines as it may hinder physicians returning to practice.

Motion carried unanimously.

Agenda Item 14 **Petition to Promulgate Regulations Pursuant to Government Code Section 11340.6 Concerning a Requirement for a Physician on Probation to Provide Patient Notification**

Ms. Webb referred the Members to tab 14 in their packets. She stated that Consumer's Union Safe Patient Project has filed a petition with the Board pursuant to Government Code section 11340.6 asking the Board to amend its disciplinary guidelines to require as a standard condition of probation the following: 1) physicians that continue to see patients be required to inform their patients of their probationary status; 2) 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 appointments by each patient the physician sees while on probation to acknowledge the notice; 4) that this disclosure be posted in the physician's office, 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 the Board's online documents related to the physician's probation; and 8) that the physician maintain a log of all patients to whom the required oral notification was made. The log should contain the following: patient's name, address and phone number; patient's medical record number if available; the full name of the person making the notification; the date notification was made; a copy of the notification given; and 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 at all times during business hours by the Board or designee; and shall retain the log for the entire term of probation.

Ms. Webb noted that after discussion and consideration, the Board must decide to grant or deny the petition. If the Board grants the petition, then the proposed regulatory change is subject to the regular rulemaking process. She stated if the Board denies the petition, then pursuant to Government Code section 11340.6, the Board must write a letter to the petitioners indicating why the Board has reached

its decision on the merits. This letter would also be submitted to the OAL for publication in the California Regulatory Notice Register.

Ms. Hollingsworth stated how important it is for patients to know about their physicians, especially those physicians on probation. She feels that a good foundation for a relationship between physician and patient is trust. Not only is trust important in this relationship, but it is important that patients can trust the Board to keep them from physicians who could pose a threat.

Ms. Greulich stated she loves physicians because her husband's life was extended by twelve years by brilliant, skilled physicians. Those are the types of physicians that the consumers of California should be seeing. Many of the physicians are put on probation for egregious offenses, which is why consumers have a right to know, since they are trusting their vulnerable loved ones to the care of a physician for treatment, whether he or she has a record that is questionable in any way.

Ms. Monseratt-Ramos noted many of the physicians are on probation due to substance abuse, sexually abusing their patients, and mental health issues. She stated the many consumers, such as the elderly and/or those already ill, often do not have access to the internet to check the physicians or time to check them when going from the emergency room into surgery, etc.

Ms. Clavreul stated the Board's duty is to protect the patient, not the physician. She hopes that there is a way that both can be done. She added there must be some kind of way to protect the patient but also assist the physician who is wanting to make a positive change and better themselves.

Ms. McGiffert, Director of Consumer's Union Safe Patient Project, noted that they have petitioned the Board to require as a condition of probation, that physicians inform their patients of their probationary status. She stated that currently physicians have to inform other entities of their probationary status, but not their patients, whom should be the first to be notified. She noted that opponents of the proposal see probation as a minor action in response to minor problems, which of course, is not the case. A probation order is a revocation of a license, and that revocation is set aside for a period of time in which the Board monitors the physicians and certain conditions have to be met. Often, these conditions are considered necessary to protect the public. She stated many of these physicians are on probation for serious offenses. She commented that though there are other reasons some are on probation, the orders they have reviewed have all had repeated problems. She urged the Board to not make protecting the physicians a higher priority than protecting the consumers.

Ms. Fellmeth, CPIL, stated they support Consumer's Union's petition in concept. She noted that they support the disclosure of probationary status in a meaningful way. Physicians on probation have been afforded full procedural due process and they have either agreed to probation or have been ordered to complete some terms of probation by the Board. Ms. Fellmeth stated CPIL has an additional reason for disclosing probationary status. That reason has to do with the Board's probation unit. She stated the probation unit is monitoring those physicians who have come extremely close to revocation and have been seriously disciplined. Any violation of probation should be detected promptly and should become the subject of a petition to revoke probation so as to remove a dangerous practitioner from practice. The probation unit positions has non-sworn investigators who are lacking the power of sworn peace officers and whom have double the caseloads of those who investigate the disciplinary matters. She stated they have to monitor compliance with all terms and conditions of approximately 520 probationers at any given time, including almost 3000 required drug tests per year. She noted that according to the Board's recent Sunset Report, 306 drug tests have come up as dirty taken by

probationers in 2011/2012, yet the probation unit reported only 33 probation violations to the AG's Office, and 34 petitions to revoke probation were filed. She stated, something does not compute with those numbers. She stated if probation violation detection is not working for whatever reason, patients are at risk, which would provide the Board a reason to grant Consumer's Union's petition.

Ms. Choong, CMA, stated CMA has serious concerns about this petition. Probationary status on physicians can already be found on the Board's website. They would argue that physicians can be disciplined for a wide variety of issues, many of which do not pertain to quality of care, such as record keeping errors, failure to pay their taxes or child support, etc. When a physician is placed on probation with restrictions, it means that the Board has deemed them safe to practice with those particular restrictions in place. Probation does not mean full, unrestricted practice. CMA feels that requiring physicians to notify their patients when placed on probation sends a mixed message regarding the physician's safety to practice. They believe if the physician is not safe to practice, the Board would revoke their license. Ms. Choong stated that this requirement could inhibit the Board's ability to settle cases, which would put more of a strain on the Board's investigative and hearing resources at a substantially higher cost to the Board. CMA strongly urged the Board to not go forward with this proposal at this time.

Dr. Gordon, previous Board Member, stated he is a family doctor, having a solo practice for 35 years. He stated he currently works part time at a clinic for the homeless and is a consultant in bioethics at a local hospital. He noted he had spent eight years as a Member of the Medical Quality Assurance starting in 1976. Dr. Gordon stated the Board has 2 important responsibilities and they are to protect the public and to supervise the profession. He noted during his tenure, it was the first time the Board had a non physician president of the Board. He stated the Board at that time was also the first in the nation to have a substantial number of non-licensees as Members. He noted that for several years while he was on the Board, the Members took their dues away from the Federation of State Medical Boards (Federation) because it was determined at the time that it was captured by the profession and had anti-consumerist attitudes. He stated this changed national health policy and professional medical licensing. He added they later rejoined the Federation. He noted that he is certain that the current Members are unaware of this history. He noted it is this history that brought him before the current Members to speak on the petition to approve and make patient notification a standard part of probationary orders. He knows that the investigation and discipline of physicians demands the greatest attention to the legal due process and the facts of the case. He stated in most cases the record of disciplinary actions over the years reflects physicians given probation with terms and conditions. He stated that he has provided a folder with information on disciplinary actions against licensed physicians in San Francisco for inadequate, inappropriate and unprofessional behavior as far back as medical school. He stated these are life long problems where probation is only a temporary rehabilitation.

Ms. Shinazy stated concerns about the consumers who do not have and/or cannot get internet service, or speak another language and cannot understand the website information, as well as the elderly or disabled who also cannot access the Board's website to check the status of their physician.

Ms. Moss, co-founder of Niles Project, stated she works very closely with Consumer's Union and they are asking the Board to approve the Consumer's Union request to provide the basic human right all consumers deserve. She urged the Board's approval on this request.

Dr. Lang noted that as a physician in private practice, putting another piece of paper in front of a patient is not necessarily going to have the safety effect that is expected, as many of today's patients do not

read in great detail all of the paperwork that is required to be filled out before seeing their physician. Dr. Lang also stated that the Board has discretion and does not put a physician in practice if they believe they are a significant safety risk to consumers, which is what the Board is already doing.

Ms. Kirchmeyer stated that she had done a survey with other boards under the DCA, and had heard back from approximately 26 of the 38 boards. She found that only one board has in its disciplinary guidelines, as an optional term and condition, a requirement that a sign must be posted during probation and also have it posted on the licensee's website. Although, this term and condition has been an option for a few years, it has never been used in a settlement and no Administrative Law Judge (ALJ) has ever added the condition into any order. Ms. Kirchmeyer found that there are approximately six boards that requires during suspension or revocation, a sign be posted in the offices of the licensee. There are also approximately three other boards that, like the Medical Board, require, under certain conditions, licensees to notify their clients/patients. Ms. Kirchmeyer noted that she had also sent the request out to the other State Medical Boards. She only received a response from six of them and none of them have the patient notification requirement.

Dr. Hawkins stated this request does have merit. He feels that Consumer's Union should be commended for coming forward and no matter the outcome, consumers will have a better understanding of what the Board does because of this request, and will be made aware of where they can get information about their physicians.

Dr. Hawkins then stated although fairly new to the Board, he truly believes the Board understands its primary function is to protect the public. He stated he was one of those physicians, who before being appointed to the Board wondered if there was bias within the Board. He stated that bias does not exist within this Board, and he has been convinced of that since becoming a Member of the Board. Dr. Hawkins stated he believes strongly that probation does protect the public and the Board takes the disciplinary guidelines very seriously. He feels that this requested requirement could get in the way of patient care.

Dr. Krauss stated he has reviewed several of the publications that Consumer's Union had forwarded to the Members. He noted he was intrigued to read many of the media publications referenced the Board's rejection of a similar proposal back in 2012, prior to his appointment to the Board. He noticed that in those articles, it stated the Board was comprised of a majority of physicians, by which he infers that some of the media and public may believe that a physician member is too conflicted to weigh these matters. He noted, that he, as well as several other physician members, are on other boards where they receive very little or no compensation as Members. Dr. Krauss then stated that one might conclude that his commitment to consumer protection in his volunteerism is a conflict to his own personal interest. He noted that no one from any of the other boards that he participates in have lobbied him on this matter. He stated that as a Member of this Board, he shares the same concerns as the Consumer's Union. Dr. Krauss noted that the public does need to be informed, however this is not just a Medical Board issue. He stated that the DCA has 42 boards and bureaus, where 20 of the boards and/or bureaus are health related and each board's websites varies in the ability to research the disciplinary actions taken against licensees.

Dr. Krauss noted that this petition may be excessive and may prevent successful conclusions in disciplinary proceedings. His recommendation is to have continued meetings with all stakeholders to achieve and improve public information regarding disciplinary actions against any and all licensees, not just those of the Medical Board.

Ms. Schipske requested that staff work on how to communicate to those without internet access and/or the elderly and disabled who have no way of finding out on their own about their physician's status. She stated she agrees with Dr. Krauss that disclosure should be system wide and not focused on one particular set of licensees.

Ms. Wright stated she supports the concept of this petition, however, there has to be a middle ground on how to reach all consumers, not just those with internet access.

Dr. Levine stated she has learned a lot throughout the process of the petition and thanked Consumer's Union for the many hours they have put into the preparation for this meeting. She noted she has some concern about this petition and the degree of detail and there are still several issues that need to be addressed before making a final decision on it. She feels that the Board needs to work on how to get information out to consumers by means other than the website.

Dr. Bishop stated that he would not be comfortable voting on this issue today because there is not enough information and/or answers at this point and to put something into regulation that is imperfect is something he could not abide by. He strongly recommended that the Board take the same very aggressive stance that the Prescription Task Force took by having several interested parties' meetings to get more input before making a final decision on this issue.

Dr. Lewis agreed there is not enough information at this point to make a final decision, but reminded everyone of the Public Outreach, Education and Wellness Committee, whose charge is to focus on public outreach and how to provide information to those hard to reach consumers. He recommended this Committee take the thoughts from the public and Members and work on a well-developed plan to deal with some of the issues brought forward in the petition, and bring it back to the Board before making a final decision today.

Dr. Yip stated he agrees with his colleagues and that there is certainly room for improvement and more discussions should take place.

Ms. Yaroslavsky noted she feels this has been an educational experience for all the Members to hear in such an organized and passionate, unified voice what they feel is important for consumers. She stated her concern is that what the intent of the petition is may not happen. She agreed there are licensees out there that have done egregious things; however, this request may not be appropriate in all situations. So, there needs to be a way to ensure that it is done in an appropriate non-punitive manner which is what is important to everyone. She would like to see it done in a way that will be effective and will make the best impact on the broadest amount of people.

Ms. Pines stated she empathizes with Consumer's Union and everyone who has come and spoken today; however, she believes that one thing that has not been considered is the unintended consequences of people who would receive a notice about their physician. Being a woman of color, she is concerned about what a notice like that would do to the consumers in communities of color. Many of these communities do not have a lot of physicians to choose from and often, do not go to a physician for whatever reason, whether it be cultural reasons, financial reasons, or other reasons.

Ms. Pines noted that when she was first appointed to the Board and was walked through the investigation process step by step, she realized how incredibly detailed that process is. She would like to have staff look more into what would happen if a such notice were received by every individual and

what the anticipated actions would be, so that those responses can be considered before moving forward and making a decision on this issue.

Dr. Bholat stated that also as a woman of color, she also believes there is much more to be considered and discussed before a decision is made.

Dr. Lewis made a motion to deny the petition and authorize staff work with the Board President and Vice President to send a letter to the petitioners and the Office of Administrative Law; s/Dr. Krauss.

Ms. McGiffert, Consumer's Union, thanked the Board for their comments and stated they look forward to working with the Board and staff as this issue moves forward. She noted she understands that some Members have concerns with the prescriptiveness of this, but urged Members to consider the substance of what it is trying to do.

Ms. Fellmeth, CPIL, suggested that the Board delegate to the Enforcement Committee an in-depth look at the probation program, including the method of detecting violations, and the method of bringing those violations to the attention of the AG's office. She noted if the Board's probation unit is not detecting or forwarding violations, then patients are not being protected.

Motion carried. (1 Abstain, Schipske).

Ms. Wright then made a motion to authorize the Board President to create a task force to work with staff and interested parties to develop a plan to incorporate the consumer concerns for informing the public about physicians who are on probation and also ask staff to work on finding a better way to convey this information on the Board's website; s/Ms. Yaroslavsky.

Motion carried unanimously.

Agenda Item 15 Discussion and Possible Action of Legislation/Regulations

Ms. Simoes began by stating she had contacted several legislative offices in the San Diego area and invited them to attend the Board Meeting. Ms. Simoes noted that the 2015 legislative session has ended and the Legislature does not reconvene until January 4, 2016. Ms. Simoes stated this is the first year of a two-year session, so if a bill did not pass this year, it could come back to the Legislature in the 2016 session. She pointed out that some of these 2-year bills are on the tracker list found under tab 15 of the Board packet.

Agenda Item 15A 2015 Legislation Update and Implementation

Ms. Simoes noted the bills in pink are Board-sponsored bills, the bills in green were signed into law by the Governor, the bill in orange was vetoed, and the bills in blue are 2-year bills. She stated she will be discussing all bills in green and pink that were signed into law and will only be giving a brief summary of each bill and then presenting the Board's implementation plan. She stated that every implementation plan will include an article in the winter Newsletter and notifying and/or training of Board staff. She did not mention those implementation items, but asked Members to please know they are included in the implementation plan for all bills.

SB 396 (Hill) 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. She noted that for unannounced inspections, AAs must provide at least a 60-day window to the outpatient setting. This bill allows an accredited outpatient setting and a "Medicare certified ambulatory surgical center" (ASC) to access 805 reports from the Board when credentialing, granting or renewing staff privileges for providers at that facility. Finally, it delays the report from the Board on the vertical enforcement and prosecution model from March 1, 2015, to March 1, 2016. Ms. Simoes stated the Board's implementation plan is to include a stand-alone article in the Newsletter for physicians that work in outpatient settings as well as meeting with the AAs to explain the bill's provisions and ensure that they understand the new outpatient setting requirements. The Board will draft an all facilities type letter for all accredited outpatient settings on the new requirements of this bill, including any guidance from the Board and send the letter to the AAs for dissemination to all accredited outpatient settings. Staff will update the Board's website and work with Board staff on processes to allow accredited outpatient settings and ASCS to access 805 reports from the Board, as well as work with DCA to complete the VE report by March 1, 2016.

SB 408 (Morrell) 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. Ms. Simoes noted the Board's implementation plan is to notify the Health Quality Investigation Unit (HQIU), and the AG's Office and hold an interested parties' meeting regarding training requirements for midwife assistants around the end of January 2016. The plan will also update and develop regulations to set forth the training requirements for midwife assistants similar to what is required for medical assistants. The Board will also update the website to include information on what is required to be a midwife assistant, what duties a midwife assistant can perform, and frequently asked questions. Ms. Simoes noted the Board will use the medical assistant information on the Board's website as a guide for the midwife assistant information.

SB 800 (Sen. B&P Com.) is the Board's omnibus bill that includes the technical changes requested by the 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. She noted the Board's implementation plan is only to notify the HQIU, and the AG's Office that these technical changes have been made.

AB 637 (Campos) allows nurse practitioners (NPs) and physician assistants (PAs), under physician supervision, to sign off on the Physician Orders for Life Sustaining Treatment (POLST) forms. The Board's implementation plan is only to notify the HQIU, and the AG's Office of this change.

AB 679 (Allen) 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. Ms. Simoes noted that this bill contains an urgency clause, so it becomes effective immediately. She stated the Department of Justice is currently in the process of updating CURES. 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 January 1, 2016. She noted 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. She stated this bill was introduced at the end of session in order 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. She noted the Board's implementation plan is to include a stand-alone boxed article in the Newsletter to inform physicians of the delayed registration date for CURES; send an email blast to all physicians to provide notification that the CURES registration date has been extended until July 1, 2016; and, update the Board's website to reflect the new July 1, 2016 date for required CURES registration.

AB 684 (Alejo) 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 Board to the California State Board of Optometry (SBO). Ms. Simoes stated this bill replaces one optometrist Board Member on the SBO with an RDO Board Member and establishes an RDO Advisory Committee in the SBO. Also, this bill establishes a three-year transition period for companies that directly employ optometrists to transition to leasing arrangements. This bill is a result of numerous stakeholder meetings convened by the Governor's office, and attended by all stakeholders, including the Board, SBO and DCA. She noted that Board staff have attended these meetings and offered feedback and technical input and that most of the Board's staff suggestions have been taken and amended into the bill. Ms. Simoes noted, however, there are some technical fixes and changes that are still needed, as this bill was being worked on until the very end of session. The Governor's Office, DCA, and SBO 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 SBO. She stated the Board will continue to work with all interested parties, including SBO, DCA, and the Governor's Office, to provide any assistance needed during the transition of the RDO Program to SBO. Ms. Simoes noted the Board's implementation plan is to transfer all RDO Program applications and files including all pending cases to SBO, both hard copies and electronic files as well. The plan will also allow SBO to access RDO Program files in BreEZe and to update the Board's RDO Program webpage, forms, and certificates. Board staff will train SBO staff on the RDO Program, including the new staff position that will be hired to support the RDO Program. Staff will post a transition webpage on the Board's website to inform consumers and RDO Program registrants that the RDO program is moving to SBO and ensure that all interested parties are notified of the RDO Program moving to SBO effective January 1, 2016.

ABX2 15 (Eggman) establishes the End of Life Option Act (Act) in California, which will become effective 90 days after the special session on healthcare financing ends and remain in effect until January 1, 2026. Ms. Simoes stated 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. She stated this bill is very similar to SB 128 (Wolk) and the specifics are included in the analysis. This bill allows the Board to update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow-up form. Ms. Simoes noted, however, this bill already includes the actual forms to be used, until and unless they are updated by the Board. The Board's implementation plan is once this bill becomes effective, to include a stand-alone article in the Board's Newsletter for physicians; to notify the HQIU and the AG's Office; and to update the Board's website to include information on the End of Life Option Act and links to California Department of Public Health's (CDPH) webpage for links to the forms required for attending and consulting physicians.

Mr. Killoran spoke on behalf of a group of people with amyotrophic lateral sclerosis (ALS) who he stated literally have no voice. He stated the Board should adopt special continuing medical education requirements for physicians who counsel severely disable people about aid in dying. He noted that ALS patients often struggle with whether it is better to be alive or dead. Too often ALS patients are not getting the care and equipment needed for their hospice care. He believes the reason for this is because many physicians do not know the options for care and equipment for these patients and that needs to change before this bill takes effect.

ACR 29 (Frazier) makes findings and declarations regarding the importance of organ donation. Ms. Simoes stated 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. There are no additional implementation items for this resolution.

SB 19 (Wolk) establishes the California Physician Orders for Life Sustaining Treatment (POLST) eRegistry Pilot. This bill was significantly amended since the Board took a support in concept position on this bill. Ms. Simoes noted this bill was amended to make the POLST Registry a pilot project and now requires the Emergency Medical Services Authority (EMSA) to establish the 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. She stated this bill only allows 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. There are no additional implementation items for this resolution.

SB 277 (Pan) 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. Ms. Simoes stated the Board's implementation plan is to notify the HQIU and the AG's Office and to update the Board's website to include information on new vaccine requirements and medical exemptions, including what a physician should consider before issuing a medical exemption. The plan will also include updating citation and fine regulations to include improper medical exemptions or non-compliance with the provisions of the bill.

SB 337 (Pavley) establishes alternative means for a supervising physician to ensure adequate supervision of a PA for routine care and the administration, provision, or issuance of a Schedule II drug order. Ms. Simoes noted this bill added medical records review meeting, training, and countersignature on 20 percent of Schedule II orders. The Board's implementation plan is to notify the HQIU and the AG's Office and to update the Board's website.

SB 464 (Hernandez) authorizes specified health care practitioners to use a self-screening tool and after an appropriate examination, prescribe, furnish, or dispense self-administered hormonal contraceptives to the patient. Ms. Simoes stated the Board's only implementation item is to notify the HQIU and the AG's office.

SB 643 (McGuire) 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 DCA, the Department of Food and Agriculture (CDFA), and other state entities. Ms. Simoes noted that the portions of the bill that impact the Board are very similar to the provisions in medical marijuana bills that the Board supported. She noted the three bills related to medical cannabis were re-written and now SB 643 contains the provisions related to physicians recommending cannabis. The bill

includes cases related to marijuana recommendations in the Board's priorities. It also creates a new section in law related to recommending 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 also 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); includes advertising, financial kick back and employment restrictions; and requires the Board to consult with the California Marijuana Research Program on developing and adopting medical guidelines for the appropriate administration and use of cannabis. It also specifies that a violation of the new section of law regulating cannabis recommendations is a misdemeanor and punishable by up to one year in county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars. She noted the Board's implementation plan is to notify the HQIU and the AG's Office, as well as include a stand-alone article in the Newsletter regarding the new requirements for recommending cannabis. In addition, the Board will need to update its statement on recommending marijuana and consult and solicit input on needed revisions. Ms. Simoes stated the plan will also require staff to update the Board's website with the revised statement and update the Board's publications.

SB 738 (Huff) provides liability protection for physicians writing standing order prescriptions for epinephrine auto-injectors for school districts, county offices of education, and charter schools. Ms. Simoes noted the Board's only additional implementation item is to notify the HQIU and the AG's office.

SJR 7 (Pan) 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. Ms. Simoes noted there are no additional implementation items for this resolution.

Agenda Item 15B 2016 Legislative Proposals

Ms. Simoes stated that as was presented in the Public Outreach, Education, and Wellness Committee, Board staff is working on launching an outreach campaign to encourage all patients to verify their physician's license on the Board's website. Part of the plan for this campaign is to focus outreach efforts in March. She stated 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 patients.

Ms. Yaroslavsky made a motion to approve a proposal to seek a legislative resolution for the verify (or check) a physician license month and/or work with DCA to make this proposal for all Boards; s/Dr. Levine. Motion carried unanimously.

Ms. Simoes stated 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 physicians 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.

Ms. Yaroslavsky made a motion to approve a proposal to seek legislation to have this option available for physicians during the disciplinary process; s/ Dr. Krauss. Motion carried unanimously.

Ms. Simoes stated 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). She added 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, to revoke or deny a license for registered sex offenders, to allow allied health licensees to petition for license reinstatement, to allow the Board to use probation as a disciplinary option for allied health licensees, and to obtain payment for the costs of probation monitoring.

Ms. Simoes stated 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.

Ms. Simoes stated this amendment would include a clean up to the provisions in the Medical Practice Act that include the Board of Podiatric Medicine (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.

Ms. Simoes stated another amendment being sought is clarification that the Board 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 Business and Professions Code (BPC) section 2221.

Ms. Simoes added 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 recommend making it clear in law that the limited practice license is an option for all licensees.

Ms. Simoes pointed out that 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 pursuant to BPC section 2221, it is not specified in law how long that information should be made available to the public. Board staff recommends 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.

Finally Ms. Simoes stated that existing law related to investigations that involve the death of a patient 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 the 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 recommends amending 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.

Ms. Yaroslavsky made a motion to approve seeking legislation for the allied health and major clean up proposals; s/Dr. Lewis. Motion carried unanimously.

Ms. Simoes stated Board staff recommending some omnibus proposals. The proposals include deleting BPC section 852 related to the Task Force on Culturally and Linguistically Competent Physicians and Dentists, as this task force no longer exists; Deleting BPC sections 2380 – 2392, as the Bureau of Medical Statistics does not exist in the Board; and deleting BPC section 2029 related to the retention of complaints, as this section is not relevant since the Board has its own records retention schedule and BPC section 2227.5 also specifies how long the Board retains complaints.

Finally Ms. Simoes state that BPC section 2441 is related to limited practice licenses should be amended to clarify that the Board must also agree to the practice limitation that the reviewing physician is suggesting for the applicant/licensee.

Dr. Lewis made a motion to approve the omnibus items; s/Dr. Krauss.

Ms. Choong, CMA, stated they feel the BPC section 2441 should be included in the major clean up category rather than the Omnibus Technical Clean Up.

Ms. Simoes stated there is no problem moving the BPC Section 2441 to the major clean up category.

Motion carried unanimously with the movement of the BPC section 2441 amendment to not be omnibus.

Agenda Item 15C Status of Regulatory Actions

Ms. Simoes referred the Members to tab 15C in their packets. Ms. Simoes provided an update to the Board regarding the regulations that would allow the Board to accept ABMS maintenance

of certification (MOC) CME as meeting the Board's Continued Medical Education (CME) requirements for license renewal. She noted the Board has received information from ABMS that all member board's MOC CME meets the Board's CME requirements (category 1), with the exception of one ABMS board, the American Board of Pediatrics, and this board is slated to meet the Board's CME requirements in January 2016. As such, the Board's proposed regulation is no longer necessary. Board staff is suggesting that this regulatory proposal be withdrawn.

Ms. Yaroslavsky made a motion to withdraw this CME regulatory proposal; s/Dr. Lewis. Motion carried. (1 Recusal – Levine).

Ms. Webb stated that upon further review of Title 16, section 1355.35(a)(10), an error was identified due to a recent legislative amendment. Accordingly staff recommends the language be amended as indicated in the Board packet, and noticed for a 15-day comment period.

Dr. Levine made a motion to approve the modified language, and authorize staff to notice the modified language for a 15-day comment period. If no adverse comments are received, the Board would authorize the Executive Director to make any non-substantive changes required to complete the rulemaking process and submit the matter to the Office of Administrative Law (OAL); s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 16 Update from the Department of Consumer Affairs

Ms. Lally stated she will take the comments that came today from the public and the Members regarding the petition for patient notification back to Director Kidane for discussion and looks forward to working with the Executive Director on these issues.

Ms. Lally continued with an update on the DCA executive team. She stated that after 36 years of service, their Deputy Director Amy Cox Farrell of their IT division is retiring and her replacement will be Jason Piccione.

Ms. Lally presented an update on the DCA's pro-rata study. As a result of the findings of the study, DCA has moved its annual cost distribution meeting with the boards from January 2016 to November 17, 2015. The purpose of this meeting is to give all boards and bureaus information regarding the distributed costs of the DCA. She stated what will be different this year is that the various units within the DCA will have staff available to answer questions and discuss those services they provide to the boards. They believe this "open house" format will allow the boards a greater opportunity to connect with the units they are currently working with, as well as explore other services that may not yet have been utilized.

Ms. Lally reminded the Members of the required training requirements and asked that they get them completed as soon as possible.

Ms. Lally then announced the upcoming online e-file program, called Net File, which will be available for the 2016 filing of the Form 700, Conflict of Interest Forms. In preparation for the April 1, 2016 filing deadline, access to the new online filing system will be available in February, 2016, at which

time DCA will distribute an updated conflict of interest procedure memo to all filers as well as the necessary training modules to properly educate, register and prepare users for the new paperless system.

Agenda Item 17 **Presentation and Discussion on the *North Carolina State Board of Dental Examiners v. Federal Trade Commission* Decision and Attorney General's Opinion**

Ms. Webb stated this decision was made by the Supreme Court on February 25, 2015, and noted it is important for regulatory boards nationwide. This case was brought forward because the North Carolina State (NC) Board of Dental Examiners sent out cease and desist letters to non-dentist teeth whiteners, claiming that they were engaged in unauthorized practice of dentistry. Ultimately, the non-dentist teeth whiteners stopped offering the service in North Carolina. The Federal Trade Commission found that the Dental Board's actions violated the federal antitrust law and sued the NC Board. Ms. Webb stated that the NC Board argued that its actions did not violate the law because it was a state agency and therefore immune from the antitrust law. The Supreme Court stated 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. Ms. Webb noted that teeth whitening was not covered under the definition of the practice of dentistry and the NC Board did not have statutory authority to pursue individuals for unlicensed practice. She stated that although the NC Board's authority is different than the Medical Board's, it is important for the Boards Members to understand the decision and its implications. This decision prompted Senator Hill to request an AG's Opinion on what constitutes active state supervision. Ms. Webb noted the AG's opinion stated that 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.

Ms. Webb stated the AG further found that there are some broad areas of operation where the Board Members can act with reasonable confidence that their immunity will remain intact. She noted the Federal Trade Commission has recently come out with guidelines relating to this decision, and those guidelines make it clear that changing the composition of the boards to have a majority of public members will not necessarily shield Board Members from antitrust liability. The AG's opinion made some suggestions for increasing active state supervision, which are currently under review by the legislature and other stakeholders.

Ms. Webb noted the AG indicated that a State cannot grant blanket immunity for anti-competitive activity, so training of Board Members to recognize market sensitive areas is important.

Ms. Webb closed by noting that with regard to indemnification, the AG's opinion did recommend that the legislature clarify that treble damages in antitrust awards are not punitive damages. She stated this is important because the State, in general, is liable for injuries caused by an act within the scope of employment, but is not liable for punitive damages.

Ms. Webb stated this is an ongoing discussion and that the DCA will be releasing a memo soon and expects they will be adding this subject to the new Board Member Orientation Training.

Agenda Item 18 Update on the BreEZe System

Ms. Lowe gave an update on the BreEZe System from the Board's perspective stating she has been part of the BreEZe project from the very beginning and acting as the Board's licensing and cashiering expert, as well as assisting with Enforcement and general issues with the system. She stated she also co-chaired the licensing user group for DCA, so with that experience, she feels she has enough experience to speak on behalf of the Board.

Ms. Lowe noted that after having used BreEZe for the past two years and using the system on a daily basis in her position, that BreEZe does work and meets the Boards basic needs. However, she feels that the system at this time does not have all of the functionality that is needed. She noted the system can get the process completed; however, there are several work arounds that must be done in order to complete the processes. She gave the example of when a new license is issued or a license is renewed, a pocket card is generated and sent to the licensee. Since transitioning to BreEZe, this once automated process now requires Board staff to manually manipulate a data extract on a weekly basis to remove duplicate records, and records with invalid data before printing of the cards can be done. A request for change to this process is pending with DCA.

She stated there are several change requests currently pending at DCA. DCA determines if the request is something that can be completed by their staff or if the change needs to be completed by the vendor. All requests for change are reviewed to determine if the request is possible, who is responsible for making the changes and how much time it will take to complete. In order for any changes to be put into production, it must go in with a release. With each release, the Board prioritizes its top 10 pending change requests and then notifies DCA of those. The list is then reviewed by DCA and the vendor and each item is calculated into how many hours the request would take to complete. The time and resources available are limited, and divided between all of the boards and bureaus of DCA. She stated that because the scope of a few of the Board's change requests are so extensive, they have not made it into any releases yet.

Ms. Lowe stated the Board obtaining reports is still an issue that is being resolved. When the transition first took place, there were very few reports available in the system. However, Board staff have been able to program the majority of the licensing reports and are working on enforcement reports that are needed. It is a time consuming process, but progress is being made. She noted that in addition to the current staff working to create the needed reports, the Board's Information Systems Branch (ISB) will be hiring two limited-term positions that will focus on report writing. This should allow for a greater output of the necessary reports.

Mr. Piccione, DCA, gave an update on the BreEZe System. He stated the current BreEZe production statistics shows a demand for DCA online services, online applications and online payments. The BreEZe system has had over 806,000 unique account registrations, and a very large number of licensees are using the BreEZe system. Mr. Piccione noted data shows that when a program chooses to enable the renewals in the system, between 50 and 70 percent of total renewals are completed online. Although the Medical Board is on the front end of that range, 50 percent still demonstrates a solid online cultural adoption. He stated the BreEZe system and the DCA community are adapting.

Mr. Piccione stated Board staff continues to work to make sure that BreEZe can accommodate the Boards' work appropriately. Board staff accomplishes this by working through the BreEZe IT

governance process and submitting change requests and system investigation requests (SIR). He noted the DCA BreEZe maintenance team has implemented five to seven week releases. Mr. Piccione reported that there will be one more production release before the release 2, go live date scheduled for January 2016. He noted the accelerated maintenance team will resume after that January date. In addition to the maintenance team, the past 6-8 months have seen training and knowledge transfer between the contract integrator and DCA staff in the areas of configuration, technical architecture and interfaces. He stated knowledge transfer will continue and after the next group of DCA programs go live with BreEZe, this team will join the existing maintenance team to address system requests at an increased rate.

Mr. Piccione thanked Mr. Eichelkraut, Ms. Smith and Ms. Lowe for their assistance and participation in the user group.

Mr. Piccione moved into the reporting part of the BreEZe system. He noted that the system has a growing report offering, currently 34 standing reports and 126 custom reports. He also commended the effort of staff for producing the needed Enforcement reports that contain a wide range of valuable statistics, and many DCA programs are currently using these reports, during their sunset proceedings. The DCA reports unit also provide bi-monthly data extracts that provide similar data for licensing. The user group understands the need for the expansion of their reporting capabilities. He stated they believe the effective date of strategy must affect security, self-service, agility and a reasonable development life cycle. This means quickly putting the board's data in the hands of the board's users, management and constituents in a structured and secure manner in order to facilitate management in day-to-day operations, make strategic management decisions, and effectively allocate resources to achieve program goals.

Mr. Piccione stated the DCA is implementing a business intelligence platform known as the Quality Business Intelligence Reporting Tool. With this tool, DCA will be able to navigate through the data profile. The DCA Office of Information Services (OIS) has scheduled a preliminary demonstration of this system in early December 2015. He noted the DCA is working with Board staff to supplement its current report writing staff for both acute reporting needs and will include Board staff in the early stages of the intelligence development for more mid-term goals.

Mr. Piccione stated the DCA wants consumers to search for licensed physicians and to be able to do so quickly and easily. DCA recognizes the opportunities the BreEZe system offers with the online functionality and are focused on the online user experience and plan to address these opportunities post release 2 go live, which is scheduled for January 2016.

Ms. Clavreul stated she is concerned when computer technology is not working.

Ms. Fellmeth stated there is an area where BreEZe is causing a violation of the law. She noted BPC section 2027 requires the Board to disclose detailed information about multiple medical malpractice settlements entered into by a physician within a certain period of time. For two years, none of that has been disclosed on the BreEZe system, where prior to BreEZe, that information was available on the website.

Ms. Kirchmeyer stated that issue is on the top of the priority list.

Agenda Item 19 Discussion and Possible Action on Universidad Iberoamericana (UNIBE) Medical School Application for Recognition

Mr. Worden gave a brief description on the medical school application stating Board staff and Dr. Nuovo have completed their initial review of the UNIBE medical school application. He stated this school is a nonprofit private institution in the Dominican Republic and is fully accredited by the Dominican Republic Ministry of Higher Education. The school was founded in 1982 and offers 15 undergraduate programs and 30 graduate programs. This medical school is a five year, four month program and the first year and four months are pre-med and if the students have a bachelor degree that meets those pre-med requirements they move directly on to the basic medical school. The medical school itself has a traditional track that is taught in Spanish and an international track that is taught in English. However, all third year clinical rotations are done in the Dominican Republic and students must be proficient in Spanish to proceed.

Mr. Worden stated that he and Dr. Nuovo agree the school is ready for a site visit to determine if it meets all of the requirements for recognition. The school has done a great job of providing the Board all necessary information; however, in order to proceed and finalize the evaluation, it will require a site visit where some very specific items will be requested from the school.

Dr. Lewis made a motion to authorize a site visit team to conduct a site inspection of UNIBE and the clinical teaching hospitals in the Dominican Republic; to approve the composition if the site team to include at least one Board Member, one Executive Staff Member, Legal Counsel and a Medical Consultant; to delegate to staff the determination of the hospital training sites to be evaluated; and to 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; s/Dr. Levine. Motion carried unanimously.

Agenda Item 20 Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting

Ms. Sparrevohn stated the MAC has been working on updating the licensed midwife annual report data collection tool so that the statistics will more accurately reflect the outcomes in California. She stated they hope to have their recommendations to the Board in early 2016. The MAC is looking forward to the crafting of regulations pursuant to SB 408, the bill that authorized midwife assistants. She noted that regulations remain stalled pursuant to AB 1308, but she anticipates movement in 2016. She stated SB 407, which passed this year, allows for licensed midwives to provide medical services through the Comprehensive Perinatal Services Program, but only after the regulations for AB 1308 are enacted.

Ms. Sparrevohn asked for a motion to approve the following items for the next MAC meeting scheduled for December 2015: task force update on the licensed midwife annual report data collection tool and interested parties' meeting that was held October 13, 2015; discussion, update and approval of changes to the data collection tool; update on continuing regulatory efforts required by AB 1308; an update on any legislation related to midwifery that was passed during the current year; and an update on the challenge mechanism being re-approved for the National Midwifery Institute.

Ms. Yaroslavsky made a motion to approve the above listed agenda items for the next MAC meeting; s/Dr. Krauss. Motion carried. (Dr. Lewis absent from vote).

Agenda Item 21 **Update, Discussion and Possible Action of Recommendations from the Enforcement Committee**

Dr. Yip gave an update on the Enforcement Committee Meeting. He stated Ms. Webb gave a presentation on utilization review (UR) including the process of UR in the workers' compensation and managed care system. She pointed out that UR is considered the practice of medicine. He stated Ms. Webb also provided the manner by which complaints regarding UR are handled by the Board. Ms. Webb also pointed out the problems encountered by the Board staff in processing these complaints, specifically expert reviewers do not have to be licensed in California and a name of the expert reviewer is required to be kept confidential in certain circumstances. He noted that Ms. Webb provided a suggestion to the Committee to improve the Board's oversight. The Committee requests the full Board to approve supporting any legislative changes for UR and independent medical review physicians to be licensed in California, to have similar certification and/or training as the treating physician and to identify themselves in the report.
Dr. Yip made a motion for the full Board to approve supporting legislative changes for UR and independent medical review physicians to be licensed in California, to have similar certification and/or training as the treating physician, and to identify themselves in the report; s/Ms. Yaroslavsky Motion carried. (Dr. Lewis absent from vote).

Dr. Yip then stated Ms. Robinson provided an update on the demographic study. She stated she had been in contact with the California Research Bureau and advised the study is ongoing and hopes to provide an update on the study at the next Board meeting. He stated Ms. Delp provided an update on the Enforcement Program.

He noted that Ms. Delp mentioned an issue raised by the AG's Office regarding the use of the same investigator to work a criminal case and administrative investigation. The AG's office is asking for the HQIU to develop a parallel policy for these types of investigations. In November the Board staff will reach out to the HQIU and the AG's Office to address the concerns of conducting parallel investigations with the goal of reaching an agreement that works best for all agencies.

Dr. Yip stated the Committee was also updated on the vertical enforcement (VE) report. The Board staff will meet with DCA and the AG's Office to discuss the highlights and challenges of the VE process. The report is due to the Legislature in March 2016 and the Board intends to have two Board Members provide feedback on the content. A draft report is expected to be completed and provided to the Board at the next meeting; however, if the report is not completed by that time, a special Board meeting may have to be held in February to review the report.

Ms. Delp also advised of the development of a "cloud" to share case information electronically via a secure system that will be utilized by Board staff, DCA, HQIU, and the AG's Office. A meeting is scheduled for November 3, 2015 to discuss implementation of this electronic process. Ms. Kirchmeyer and Ms. Delp also advised the Committee of a meeting with the Office of Administrative Hearing (OAH) with the purpose of introducing Ms. Delp as the Board's new Chief of Enforcement and to discuss the new uniform standards for substance abusing licensees. During the meeting, they discussed training to provide to the ALJ's on topics including prescribing expectations, impairment and how it impacts the practice of medicine and medical record keeping standards and expectations.

Dr. Yip noted that Ms. Delp also updated the Committee regarding the expert reviewer training, which is expected to be conducted in March 2016 in Southern California. In addition to the training, a

recruitment plan to expand the number of experts within specific specialties is being developed. The expert reviewer database is expected to be enhanced to make it user friendly for Board staff, investigators, and medical consultants.

Dr. Yip stated Ms. Delp provided an update on the Board's involvement in the issue of overprescribing psychotropic medication to children in foster care. It has been challenging for Board staff of find an expert to give an opinion on data that was provided by the DHCS and DSS. However, staff will meet with a potential consultant on November 9, 2015 and it is hopeful that this physician will be interested in working with the Board. Dr. Yip noted that on October 12, 2015, the Board staff met with DHCS and DSS to give them an update regarding the Board's analysis of the data and explained that the data may not be sufficient to make a determination regarding physicians overprescribing. The Board, DHCS and DSS developed a notification process whereby the individuals in the system for foster care can contact the Board if they believe a physician is inappropriately prescribing medication to children in foster care.

Agenda Item 22 Update and Discussion Regarding the Interim Suspension Order (ISO) Study

Ms. Kirchmeyer referred the Members to pages BRD 22-1 and 22-2 in the Board packets. She stated that in a prior meeting, the Board directed Board staff to work with the AG's Office and the HQIU to find ways and strategies to expedite cases that Board staff thought would be ISO cases. After reviewing several cases, the workgroup established a list of improvements/policy changes that can be made.

The first improvement would be 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.

The next improvement would be if an expert report states that the individual needs to have restrictions in order to practice safely, an ISO should be considered to institute those restrictions. Ms. Kirchmeyer stated the Board needs to monitor all investigation/prosecution cases on a monthly basis to ensure all cases that could be an ISO are moving forward.

In addition, the Board needs to closely monitor the requirement in BPC section 2220(a), which 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.

Ms. Kirchmeyer noted that another improvement needed is to have the Central Complaint Unit's (CCU) immediate transfer of BPC 805 and 805.01 reports. The Board's CCU would then immediately transfer these reports via email to both the HQIU and AG's Office upon receipt in order to expedite the process.

In addition, the Board, HQIU, and AG's Office report reconciliation where the Board, HQIU, and AG's Office staff would reconcile reports on a monthly basis the cases that have been referred to the AG's

Office requesting an ISO. This would ensure the cases that have been identified as ISO cases are prioritized by the Board, HQIU, and the AG's Office.

Another improvement would be to 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 (OAH) 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 OAH. Ms. Kirchmeyer noted that 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.

Ms. Kirchmeyer also recommended training to the OAH on impairment and how it impacts the practice of medicine. Such training could also be provided by the Physician Assessment and Clinical Training Program Staff.

Another recommendation would be to update the investigation report synopsis. The HQIU would clearly identify in the case the synopsis of a Report of Investigation that the case was being transmitted for an ISO and an accusation.

Ms. Kirchmeyer recommended that the Lead Prosecutor (LP) and the Supervising Investigator I 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 should 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 (DAG) and the Investigator assigned should then alert their chain of command that the evidence has changed the matter to an ISO.

Another recommendation was to add ISO cases to the Monthly Investigative Case Activity Report (MICAR). Ms. Kirchmeyer stated adding these cases to the MICAR report would immediately inform the Senior Assistant Attorney General that a case is being transmitted for an ISO, so that the case can be closely monitored.

Ms. Kirchmeyer noted that 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.

She also noted that as soon as possible, staff should establish a parallel criminal/administrative investigation policy and process for cases where the HQIU designates a Board investigation as criminal. Providing for a parallel policy would help protect the Board's integrity in its investigation process when these dual pathways arise. Additionally, staff anticipates this policy would 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). That process 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.

Finally, Ms. Kirchmeyer recommended creating an activity code within the BreEZe system to identify a case as an ISO case for monitoring and statistics.

Ms. Kirchmeyer stated several of these recommendations have already been either fully implemented or are in the process of completion. Board staff will continue to work with the 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.

Ms. Castro added some information to Item 13. She stated the policy of an overriding Board such as this is to coordinate, compliment, triage and maximize its resources while preserving the constitutional rights of the physicians. This body has both criminal and civil components to the Board's mandate, and this Board is no different and should pursue all of its remedies with vigor. Parallel proceedings involve criminal and civil actions against the same individual for conduct arising under the same set of facts and generally consist of simultaneous sequential or overlapping criminal, civil and administrative proceedings. The AG's office has always had a parallel proceedings policy in place so staff has always been bound to not participate in criminal proceedings against physicians. She noted it has become incumbent upon HQIU and DCA to bind its investigators. In B&P Code Section 2006, it states that any investigation by the Board shall be deemed to refer to a joint investigation conducted by employees of the DOJ and HQIU under the VE prosecution model as specified in section 12529.6 of the Government Code. However, the AG staff does not direct criminal investigations, as their policy is two different attorneys assigned and two different investigators assigned. Unfortunately, the VE model never contemplated the AG's Office directing of criminal cases. With that, the AG's Office is not monitoring or directing criminal cases being developed by HQIU against physicians. Ms. Castro stated the AG's Office is requesting a second investigator be assigned where probable cause exists for criminal issues to arise. She stated the Board needs to properly administrate its investigations and precautions must be taken, which is why a parallel proceedings policy must be put in place by the DCA. This would avoid claims that the Board and DCA investigators have violated a physician's constitutional rights by the use of civil discovery.

Mr. Gomez stated this issue has a broader application to the entire DCA because not only does DCA have the HQIU, but it also has the Investigation Enforcement Unit, which also does investigations in the licensing division for the AG's Office. He stated the DCA needs to be sure that whatever is being done, is being done with equity, justice and consumer protection in mind for all licensees. Mr. Gomez stated this is a subject that needs much more discussion.

Ms. Choong, CMA, stated they believe that further discussion is needed on number 13 of this agenda item. She requested more information as they have some concerns that pertain to a particular case from 2005. She stated as this process is developed they want to be sure the Gray case is strictly followed to the extent that the Board is proposing to get license restrictions imposed as a condition of bail.

Ms. Castro stated these PC23's were not discussed during the ISO discussions because the bail restrictions actually prohibit the person from using the license and is ordered by a judge. The Board is the only entity who has the authority to bind any license or its use.

Ms. Kirchmeyer stated that she wanted to point out that although staff is working on expediting ISO's, it does not mean the Board will no longer request PC23 restrictions. PC23s are a lot more expedient to obtain in several instances and the Board will continue to use this important tool.

Agenda Item 23 Investigation and Vertical Enforcement Program Report

Mr. Gomez announced that Ms. Sweet has retired recently and Ms. Nicholls has been promoted to Deputy Chief.

Ms. Nicholls gave a presentation and stated their main focus is consumer protection. She stated the HQIU would identify and prioritize ISO cases and those that present the biggest threat to the public. They will also focus on time gaps in investigations and provide high quality, thorough investigations, and ensure that the lower priority cases be rotated to keep them moving. Ms. Nicholls stated the HQIU is also focusing on investigator retention, which is crucial to the success of their program.

Ms. Nicholls announced some upcoming events such as the California Narcotics Officers Association (CNOA) training that will be taking place in November 2015. She stated they also have a Medical Consultant Statewide Meeting scheduled to take place in January 2016. She noted that HQIU is in the process of finalizing a lesson plan with the AG's Office HQE staff for joint training on 805 investigations. The target date for that training is February 2016.

Ms. Nicholls noted the Field Training Officer (FTO) pay differential request has been approved by the Director and has been forwarded to CalHR for final processing. An HQIU retention pay proposal drafted by former Deputy Chief, Laura Sweet, was submitted to the Director and will be included in the collective bargaining process set for Spring 2016. She stated numerous hiring panels are taking place throughout the state to fill investigative vacancies, and is a top priority.

Ms. Nicholls announced a new program being rolled out to all HQIU offices. This program is an electronic case binder system. The system was developed by the San Diego Sheriff's Department and has been adopted by Sheriff's, San Diego's Police Department Homicide Units and the San Diego District Attorney's (DA) Office. This system was recommended to the HQIU and was given to the HQIU free of charge. She noted besides the obvious cost savings, this system is a much more efficient way to share information. Ms. Nicholls stated this system will not only be used in expert packages, but also for transmittals to the AG's Office. She noted the AG's office is supportive of this method and she feels it will be a great asset to both entities.

Ms. Nicholls transitioned into the HQIU's current vacancies. She stated there are currently 25 investigator vacancies out of 76 positions, which makes a 33% vacancy rate. They have identified 16 investigator candidates that are currently in background. She noted that they have recently identified five more candidates that are also currently in background. Ms. Nicholls stated there are six more anticipated investigator vacancies whom are currently in background with other agencies.

Ms. Nicholls noted that the retention pay proposal is crucial to retaining investigators. She stated it is not realistic to pay 18.5% lower, have a more complex case load and have double the volume of work than other agencies. Ms. Nicholls noted that the investigators who have chosen to stay with the HQIU have had their caseloads doubled. The ideal caseload is 15-18 per investigator, yet in many areas, some investigators have been assigned 30 or more complex cases. She stated that HQIU will focus on identifying and working priority cases and eliminating time gaps in non-priority cases by rotating those cases in a systematic fashion. She stated budget allowed overtime is also being offered to assist with the workload.

Ms. Nicholls then explained the data parameters for the case aging statistics. She noted that statistical figures are still unavailable from BreEZe, so staff is manually compiling the data. She stated there was no retrievable data for February 2015 or for July/August 2014. Ms. Nicholls presented slides that showed monthly comparison statistics that were manually calculated based on month end. She noted that for cases over one year old, there was a slight reduction from August to September, with a similar slight reduction for cases over 550 days old. She stated the additional slides show the comparison of this year with 2014, and can be found in the Board packets for review.

Ms. Yaroslavsky expressed her concerns about the HQIU's vacancy rate and the backlog of pending cases.

Agenda Item 24 Update from the Attorney General's Office

Ms. Castro gave the Board an update on the *Lewis vs Medical Board* case. She reminded Members that the Lewis case involves a court of appeal decision that ruled the Board's access to CURES during the course of a disciplinary investigation did not constitute a serious invasion of the patient's right to informational privacy. She stated there were two compelling state interests weighing in favor of the Board's use of CURES, including controlling the diversion and abuse of controlled substances and exercising its regulatory power to protect the public against incompetent, impaired or negligent physicians. The Second Court of Appeal also held that to impose a good clause requirement before accessing CURES data would necessarily involve litigating the privacy issue in advance and that this delay would defeat the legislative purpose of CURES.

Ms. Castro noted that Dr. Lewis appealed this decision to the California Supreme Court and it adopted his petition. She stated they are not done briefing the case due to the fact that recently new amicus briefs were filed. The ACLU filed an amicus brief on behalf of Dr. Lewis on October 27, 2015 and the Electronic Frontier Foundation filed one on October 28, 2015. The CMA, the AMA, the California Psychiatric Association, the California Dental Association and American Dental Association also filed a brief in support of petitioner. She stated the Board will file a brief in response to the recently filed amicus briefs and believes the oral argument in this case will be in the Spring of 2016.

Ms. Castro then provided a brief personnel update noting that Supervising Deputy Attorney General, Thomas Lazar would be retiring after 30 years as the Board's Attorney. She stated they will fill his position as soon as they are able.

Agenda Item 25 Agenda Items for the January 2016 Meeting in Sacramento

Ms. Schipske requested an update on the Fictitious Name Permits as well as a discussion on the Corporate Practice of Medicine.

Dr. Lewis asked to hear from some of the Deans from the medical schools regarding the changes of medical education as it has advanced greatly in the last several years as well as how medical schools deal with psychosocial issues in their applicants. .

Dr. Hawkins stated he would like to hear from the medical schools in regard to the shortage of health care professionals and their approach on this issue.

Agenda Item 26 **Adjournment**

Dr. GnanaDev adjourned the meeting at 1:43 p.m.

_____ _____
Dr. GnanaDev, Vice 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
of the Medical Board of California
January 2016

Committee	*Members*
Executive Committee	**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
Licensing Committee	**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.
Enforcement Committee	**Felix Yip, M.D., Chair** Michelle Bholat, M.D. Howard Krauss, M.D. Barbara Yaroslavsky
Application Review & Special Programs Committee	**Gerrie Schipske, R.N.P., J.D., Chair** Ronald Lewis, M.D. Felix Yip, M.D.
Special Faculty Permit Review Committee	**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
Public Outreach, Education, and Wellness Committee	**Ronald Lewis, M.D., Chair** Randy Hawkins, M.D. Howard Krauss, M.D. Sharon Levine, M.D. Denise Pines David Serrano Sewell Barbara Yaroslavsky
Midwifery Advisory Council	**Carrie Sparrevohn, L.M., Chair** James Byrne, M.D. Karen Ehrlich, L.M. Tosi Marceline, L.M. Monique Webster Barbara Yaroslavsky

Panel A	**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.
Panel B	**Dev GnanaDev, M.D., Chair** Howard Krauss, M.D., Vice Chair Michelle Bholat, M.D. Kristina Lawson, J.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.

Revised: January 2016

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 5, 2016
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.

- Regular meetings were held with 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 continue to meet with DCA and the Department of Justice (DOJ) to discuss the implementation of the new Controlled Substance Utilization Review and Evaluation System (CURES) database.
- Board staff met with the California Medical Association (CMA) on issues of interest to both parties.
- Board staff provided a presentation and update on the Board to the California Hospital Association (CHA).
- Board staff met with Consumer's Union to discuss the Board's enforcement and outreach processes.
- Board staff attended webinars and teleconferences with staff from the Federation of State Medical Boards and the International Association of Medical Regulatory Authorities.
- Board staff met with Legislative staff providing updates on the Board, its actions, and issues of interest.
- Board staff met with staff from the Health Quality Investigative Unit (HQIU) and the Attorney General's (AG) Office on the vertical enforcement report.
- Board staff met with Dr. Yip to review the Board's Probation Unit and its processes and procedures.
- Board staff met with HQIU, AG's Office, and DCA staff to discuss a parallel policy for investigations.
- Board staff met with staff from the Bureau of State Audits to discuss the audit they are performing related to the issue of psychotropic medication for foster children.
- Board staff attended a meeting with other State Executive Directors and discussed several issues of interest, including physician health programs and telemedicine.
- Board staff attended a two-day California Prescription Drug Abuse Summit.
- Board staff met with the California Association of Midwives and the American College of Obstetricians and Gynecologists to discuss regulations to implement Assembly Bill 1308.
- Board staff met with the Office of Statewide Health Planning and Development on possible changes to the licensed midwife annual report.
- Board staff met with a representative from the Food and Drug Administration to open lines of communication and discuss common interests.
- Board staff met numerous times with the State Board of Optometry and DCA on the transition of the Registered Dispensing Optician Program.
- Board staff met with the accreditation agencies to discuss implementation of Senate Bill 396.
- Board staff attended meetings held by the CMA on the corporate practice of medicine.
- 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.

Staffing Update:
The Board has 160.1 permanent full-time positions (in addition to temporary staff). The Board is at a 7.5% vacancy rate which equates to 12 vacant positions. This is higher than the vacancy rate that was provided in the last Administrative Summary, which was 6%. Of those 12 vacant positions, the Board has 5 individuals pending a start date or verification of eligibility. However, each of the individuals pending a start date or eligibility are within the Board and therefore, the vacancy rate remains at 7.5%.

Budget Update:
The Board's budget documents are attached, beginning on page BRD 6A-4 and continuing to page BRD 6A-15. The Board's fund condition on page BRD 6A-4 identifies the Board's fund reserve was at 3.7 months at the end of FY 15-16. The Board was notified that the planned general fund loan repayment planned for FYs 15-16, 16-17, and 17-18 has been changed to a partial repayment of $6 million in FY 16-17 and $2 million in FY 17-18. With the partial 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. 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 6A-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 at the end of FY 15-16. 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 15-16 through November 30, 2015 can be found on page BRD 6A-6. Pages BRD 6A-7 to 6A-11 show the budget report specifically for licensing, enforcement, the HQIU, and the AG expenditures. Page BRD 6A-15 provides the Board Members' expenditure report as of December 14, 2015.

BreEZe Update:
A report will be provided at the January Board Meeting on specific updates and the status of pending requests. The Board continues to develop the reports necessary to identify the Board's workload and processing timeframes.

Board staff continues to submit requests for changes/fixes to DCA for the BreEZe system. Release 2 is scheduled to occur in January 19, 2016, and therefore no maintenance releases for Release 1 boards will be performed until after the roll out of Release 2. The Board has been 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
On January 8, 2016, the DOJ released its new streamlined application process. 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. For more information please see Agenda Item 6D.

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 Annual Meeting of the FSMB will be held April 28-30, 2016 in San Diego. The title of this year's meeting is *New Horizons in Medical Regulation: Successful Strategies for a Changing Health Care Environment*. Although the agenda is not finalized, some of the scheduled sessions include discussions on patient safety and errors; medical marijuana; medical error, transparency, and accountability; innovations in medical and graduate education; physician workforce; telemedicine; communication and the use of social media in a regulatory environment; and team based care and regulation.

Interstate Medical Licensure Compact

The second meeting of the Interstate Medical Licensure Compact (Compact) Commission was held December 18, 2015 in Salt Lake City, Utah. To date, 12 states have formally adopted the Compact and six states have legislation pending. The draft minutes from this second meeting can be found at 6A-16. As previously reported, 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	$ 28,410	$ 28,350	$ 19,460	$ 15,482	$ 6,279
Prior Year Adjustment	$ 515	$ (1)	$ -	$ -	$ -
Adjusted Beginning Balance	$ 28,925	$ 28,349	$ 19,460	$ 15,482	$ 6,279
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	$ 46,516
125900 Delinquent fees	$ 130	$ 106	$ 106	$ 106	$ 106
141200 Sales of documents	$ 7	$ -	$ -	$ -	$ -
142500 Miscellaneous services to the public	$ -	$ 30	$ 30	$ 30	$ 30
150300 Income from surplus money investments	$ 76	$ 69	$ 52	$ 14	$ 14
160400 Sale of fixed assets	$ 3	$ -	$ -	$ -	$ -
161000 Escheat of unclaimed checks and warrants	$ 14	$ 15	$ 15	$ 15	$ 15
161400 Miscellaneous revenues	$ 8	$ 21	$ 21	$ 21	$ 21
Totals, Revenues	$ 54,563	$ 53,282	$ 53,315	$ 53,277	$ 53,277
Transfers:					
Proposed GF Loan Repayment (Budget Act of 2008)	$ -	$ -	$ 3,000	$ -	$ -
Proposed GF Loan Repayment (Budget Act of 2011)	$ -	$ -	$ 3,000	$ 2,000	$ -
TOTALS, REVENUES AND TRANSFERS	$ 54,563	$ 53,282	$ 59,315	$ 55,277	$ 53,277
TOTAL RESOURCES	$ 83,488	$ 81,631	$ 78,775	$ 70,759	$ 59,556
EXPENDITURES					
Disbursements:					
0840 State Controller (State Operations)	$ -	$ -	$ -	$ -	$ -
8880 Financial Information System for California (State Operations)	$ 48	$ 107	$ 77	$ -	$ -
1110 Program Expenditures (State Operations)	$ 55,090	$ 59,661	$ 60,403	$ 61,670	$ 61,670
2015-16 and ongoing Approved Costs					
BreEZe Costs	$ -	$ 2,403	$ 2,494	$ -	$ -
Anticipated Future Costs					
BreEZe Costs	$ -	$ -	$ -	$ 2,499	$ 2,499
Change in Business Process	$ -	$ -	$ 113	$ 105	$ 105
Expert Reviewer	$ -	$ -	$ 206	$ 206	$ 206
Total Disbursements	$ 55,138	$ 62,171	$ 63,293	$ 64,480	$ 64,480
1110 Reimbursement/Cost Recovery		$ 1,817	$ 1,817	$ 1,817	$ 1,817
FUND BALANCE					
Reserve for economic uncertainties	$ 28,350	$ 19,460	$ 15,482	$ 6,279	$ (4,924)
Months in Reserve	5.5	3.7	2.9	1.2	-1.0

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.
$6 million will be repaid in FY 16/17 and $2 million in FY 17/18. The remainder will be paid 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.
F. The Financial Information System for California is a direct assessment which reduces the fund balance but is not reflected in the Medical Board of California's state operational budget.

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		$ 28,410	$ 28,350	$ 19,460	$ 9,482	$ (1,721)
Prior Year Adjustment		$ 515	$ (1)	$ -	$ -	$ -
Adjusted Beginning Balance		$ 28,925	$ 28,349	$ 19,460	$ 9,482	$ (1,721)
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	$ 46,516
125900	Delinquent fees	$ 130	$ 106	$ 106	$ 106	$ 106
141200	Sales of documents	$ 7	$ -	$ -	$ -	$ -
142500	Miscellaneous services to the public	$ -	$ 30	$ 30	$ 30	$ 30
150300	Income from surplus money investments	$ 76	$ 69	$ 52	$ 14	$ 14
160400	Sale of fixed assets	$ 3	$ -	$ -	$ -	$ -
161000	Escheat of unclaimed checks and warrants	$ 14	$ 15	$ 15	$ 15	$ 15
161400	Miscellaneous revenues	$ 8	$ 21	$ 21	$ 21	$ 21
Totals, Revenues		$ 54,563	$ 53,282	$ 53,315	$ 53,277	$ 53,277
Transfers:						
Proposed GF Loan Repayment (Budget Act of 2008)		$ -	$ -	$ -	$ -	$ -
Proposed GF Loan Repayment (Budget Act of 2011)		$ -	$ -	$ -	$ -	$ -
TOTALS, REVENUES AND TRANSFERS		$ 54,563	$ 53,282	$ 53,315	$ 53,277	$ 53,277
TOTAL RESOURCES		$ 83,488	$ 81,631	$ 72,775	$ 62,759	$ 51,556
EXPENDITURES						
Disbursements:						
0840 State Controller (State Operations)		$ -	$ -	$ -	$ -	$ -
8880 Financial Information System for California (State Operations)		$ 48	$ 107	$ 77	$ -	$ -
1110 Program Expenditures (State Operations)		$ 55,090	$ 59,661	$ 60,403	$ 61,670	$ 61,670
	2015-16 and ongoing Approved Costs					
	BreEZe Costs	$ -	$ 2,403	$ 2,494	$ -	$ -
	Anticipated Future Costs					
	BreEZe Costs	$ -	$ -	$ -	$ 2,499	$ 2,499
	Change in Business Process	$ -	$ -	$ 113	$ 105	$ 105
	Expert Reviewer	$ -	$ -	$ 206	$ 206	$ 206
Total Disbursements		$ 55,138	$ 62,171	$ 63,293	$ 64,480	$ 64,480
1110 Reimbursement/Cost Recovery			$ 1,817	$ 1,817	$ 1,817	$ 1,817
FUND BALANCE						
Reserve for economic uncertainties		$ 28,350	$ 19,460	$ 9,482	$ (1,721)	$ (12,924)
Months in Reserve		5.5	3.7	1.8	-0.3	-2.5

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.
F. The Financial Information System for California is a direct assessment which reduces the fund balance but is not reflected in the Medical Board of California's state operational budget.

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report
(As of November 30, 2015)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	9,446,564	3,583,283	37.9	5,863,281
Board Members	31,500	19,600	62.2	11,900
Temp Help	755,880	57,212	7.6	698,668
BL 12-03 Blanket	0	211,951	0.0	(211,951)
Overtime	44,441	32,324	72.7	12,117
Staff Benefits	5,213,036	1,928,696	37.0	5,213,036
TOTALS, PERS SERVICES	15,491,421	5,833,066	37.7	11,587,051
OPERATING EXP & EQUIP				
General Expense	204,206	168,336	82.4	35,870
Fingerprint Reports	333,448	132,277	39.7	201,171
Printing	194,755	107,341	55.1	87,414
Communications	106,190	33,695	31.7	72,495
Postage	149,511	36,191	24.2	113,320
Insurance	2,053	11,507	560.5	(9,454)
Travel In-State	130,298	55,545	42.6	74,753
Travel Out-of-State	0	0	0.0	0
Training	54,895	3,904	7.1	50,991
Facilities Operation (Rent)	928,140	1,084,675	116.9	(156,535)
Consult/Prof Services	1,317,088	1,401,094	106.4	(84,006)
Departmental Prorata	6,533,991	3,207,508	49.1	5,077,849
HQIU	16,871,000	4,915,002	29.1	11,955,998
Consolidated Data Center	650,230	35,140	5.4	615,090
Data Processing	117,492	79,392	67.6	38,100
Central Admin Svcs (Statewide Prorata)	2,851,858	1,456,142	51.1	1,395,716
Major Equipment	8,500	0	0.0	8,500
Other Items of Expense	0	0	0.0	0
Vehicle Operations	31,925	7,411	23.2	24,514
Attorney General Services	13,347,280	4,354,388	32.6	8,992,892
Office of Administrative Hearings	1,750,080	282,653	16.2	1,467,427
Evidence/Witness	1,893,439	206,603	10.9	1,686,836
Court Reporter Services	225,000	122,709	54.5	102,291
Minor Equipment	35,200	39,171	111.3	(3,971)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	47,736,579	17,740,684	37.2	31,747,261
TOTALS, EXPENDITURES	63,228,000	23,573,750	37.3	39,654,250
Scheduled Reimbursements	(384,000)	(169,312)	44.1	(214,688)
Distributed Costs	(780,000)	(158,976)	20.4	(621,024)
TOTAL, STATE OPERATIONS	62,064,000	23,245,462	37.5	38,818,538
Unscheduled Reimbursements*		(430,715)		
		22,814,748		

** no authority to spend*

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Licensing
(As of November 30, 2015)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	2,698,175	1,069,808	39.6	1,628,367
Board Members	0	0	0.0	0
Temp Help	48,396	10,236	21.2	38,160
BL 12-03 Blanket	0	2,834	0.0	(2,834)
Overtime	21,716	16,952	78.1	4,764
Staff Benefits	1,404,032	599,585	42.7	1,404,032
TOTALS, PERS SERVICES	4,172,319	1,699,415	40.7	3,072,489
OPERATING EXP & EQUIP				
General Expense	22,381	14,382	64.3	7,999
Fingerprint Reports	333,448	131,957	39.6	201,491
Printing	92,627	54,489	58.8	38,138
Communications	19,647	5,419	27.6	14,228
Postage	72,495	18,667	25.7	53,828
Insurance	0	0	0.0	0
Travel In-State	17,179	5,665	33.0	11,514
Travel Out-of-State	0	0	0.0	0
Training	18,207	0	0.0	18,207
Facilities Operation (Rent)	269,758	351,157	130.2	(81,399)
Consult/Prof Services	794,091	1,021,755	128.7	(227,664)
Departmental Prorata	2,167,114	1,063,827	49.1	1,103,287
HQIU	0	0	0.0	0
Consolidated Data Center	0	0	0.0	0
Data Processing	8,664	3,357	38.7	5,307
Central Admin Svcs (Statewide Prorata)	945,869	482,955	51.1	462,914
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	9,568	32.8	19,621
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	4,793,883	3,163,198	66.0	1,630,685
TOTALS, EXPENDITURES	8,966,202	4,862,613	54.2	4,103,589
Scheduled Reimbursements	(384,000)	(169,312)	44.1	(214,688)
Distributed Costs	(31,131)	(7,348)	23.6	(23,783)
NET TOTAL, EXPENDITURES	8,551,071	4,685,953	54.8	3,865,118
Unscheduled Reimbursements*		(124,938)		
		4,561,015		

** no authority to spend*

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Enforcement
(As of November 30, 2015)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	2,574,107	985,683	38.3	1,588,424
Board Members	0	0	0.0	0
Temp Help	608,589	0	0.0	608,589
BL 12-03 Blanket	0	198,572	0.0	(198,572)
Overtime	10,281	6,136	59.7	4,145
Staff Benefits	1,619,426	566,756	35.0	1,619,426
TOTALS, PERS SERVICES	4,812,403	1,757,147	36.5	3,622,012
OPERATING EXP & EQUIP				
General Expense	69,470	69,427	99.9	43
Fingerprint Reports	0	320	0.0	(320)
Printing	43,898	29,391	67.0	14,507
Communications	40,015	11,910	29.8	28,105
Postage	74,371	16,459	22.1	57,912
Insurance	0	0	0.0	0
Travel In-State	39,017	15,195	38.9	23,822
Travel Out-of-State	0	0	0.0	0
Training	15,087	2,104	13.9	12,983
Facilities Operation (Rent)	294,072	354,706	120.6	(60,634)
Consult/Prof Services	479,560	316,389	66.0	163,171
Departmental Prorata	1,795,726	881,514	49.1	914,212
HQIU	16,871,000	4,915,002	29.1	11,955,998
Consolidated Data Center	0	60	0.0	(60)
Data Processing	15,045	21,945	145.9	(6,900)
Central Admin Svcs (Statewide Prorata)	783,771	400,189	51.1	383,582
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	13,318,091	4,344,820	32.6	8,973,271
Office of Administrative Hearings	1,750,080	282,653	16.2	1,467,427
Evidence/Witness	1,736,958	206,453	11.9	1,530,505
Court Reporter Services	224,750	122,709	54.6	102,041
Minor Equipment	4,863	720	14.8	4,143
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	37,555,774	11,991,966	31.9	25,563,808
TOTALS, EXPENDITURES	42,368,177	13,749,113	32.5	28,619,064
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	(744,054)	(149,717)	20.1	(594,337)
NET TOTAL, EXPENDITURES	41,624,123	13,599,396	32.7	28,024,727
Unscheduled Reimbursements*		(66,298)		
		13,533,098		

** no authority to spend*

Health Quality Investigation Unit (HQIU)
Fiscal Year 2015-16
Budget Expenditure Report
(As of November 30, 2015)
(42% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,275,240	2,900,784	35.1	5,374,456
Temp Help	1,073,743	525,128	48.9	548,615
Overtime	5,559	8,072	145.2	(2,513)
Staff Benefits	4,351,289	1,663,981	38.2	2,687,308
BL 12-03 Blanket	0	7,397	0.0	(7,397)
TOTALS, PERS SERVICES	13,705,831	5,105,361	37.2	8,600,470
OPERATING EXP & EQUIP				
General Expense	108,734	162,056	149.0	(53,322)
Printing	59,000	52,339	88.7	6,661
Communications	100,000	47,530	47.5	52,470
Postage	21,000	36	0.2	20,964
Insurance	14,000	44,881	320.6	(30,881)
Travel In-State	222,000	46,976	21.2	175,024
Travel Out-of-State	7,000	0	0.0	7,000
Training	22,000	5,039	22.9	16,961
Facilities Operation (Rent)	1,574,000	1,405,970	89.3	168,030
Consult/Prof Services	91,000	81,930	90.0	9,070
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	0	0.0	15,000
Data Processing	0	35,587	0.0	(35,587)
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	30,916	110.4	(64,461)
Vehicle Operations	166,000	92,461	55.7	166,000
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	2,404	0.0	(2,404)
Court Reporter Services	0	276,824	0.0	(276,824)
Minor Equipment	8,350	17,697	211.9	(9,347)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	0	0	0.0	0
	2,635,169	2,302,648	87.4	363,437
TOTALS, EXPENDITURES	16,341,000	7,408,009	45.3	8,932,991
Scheduled Reimbursements				0
Distributed Costs				0
NET TOTAL, EXPENDITURES	16,341,000	7,408,009	45.3	8,932,991
Unscheduled Reimbursements*		0		
		7,408,009		

** no authority to spend*

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

		Number of Hours	Rate	Amount
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
				$1,120,305.50
August	Attorney Services	5763.50	$170.00	$979,795.00
	Paralegal Services	354.50	$120.00	$42,540.00
	Auditor/Analyst Services	255.50	$99.00	$25,294.50
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$2,773.85
				$1,050,403.35
September	Attorney Services	5945.75	$170.00	$1,010,777.50
	Paralegal Services	348.00	$120.00	$41,760.00
	Auditor/Analyst Services	277.75	$99.00	$27,497.25
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$3,566.45
				$1,083,601.20
October	Attorney Services	6074.50	$170.00	$1,032,665.00
	Paralegal Services	352.50	$120.00	$42,300.00
	Auditor/Analyst Services	155.00	$99.00	$15,345.00
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$199.97
				$1,090,509.97
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
				$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
				$0.00

Total July-Dec = $4,344,820.02
FY 2015-16 Budget = $13,318,091.00

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

		Number of Hours	Rate	Amount
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
				$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
				$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
				$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
				$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
				$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
				$0.00

FYTD Total =	**$4,344,820.02**
FY 2015-16 Budget =	**$1,318,091.00**

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	50	50	0								200
Criminal Cost Recovery	451	4,851	7,581	1,100	1,400								15,383
Probation Monitoring	74,221	54,139	42,860	44,930	62,069								278,219
Exam	9,593	5,778	1,922	16,948	5,721								39,962
Cite/Fine	0	0	0	0	0								0
MONTHLY TOTAL	84,315	64,818	52,413	63,028	69,190	0	0	0	0	0	0	0	333,764
FYTD TOTAL	84,315	149,133	201,546	264,574	333,764	333,764	333,764	333,764	333,764	333,764	333,764	333,764	

excel:enfreceiptsmonthlyprofile.xls.revised 12/14/2015

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

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 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 **	2,000,070	41,624,123		8,551,071	2,312,598	3,969,970	3,606,168	62,064,000
$ Spent thru 11/30*	924,720	13,599,396		4,685,953	1,080,017	1,435,506	1,519,870	23,245,462 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

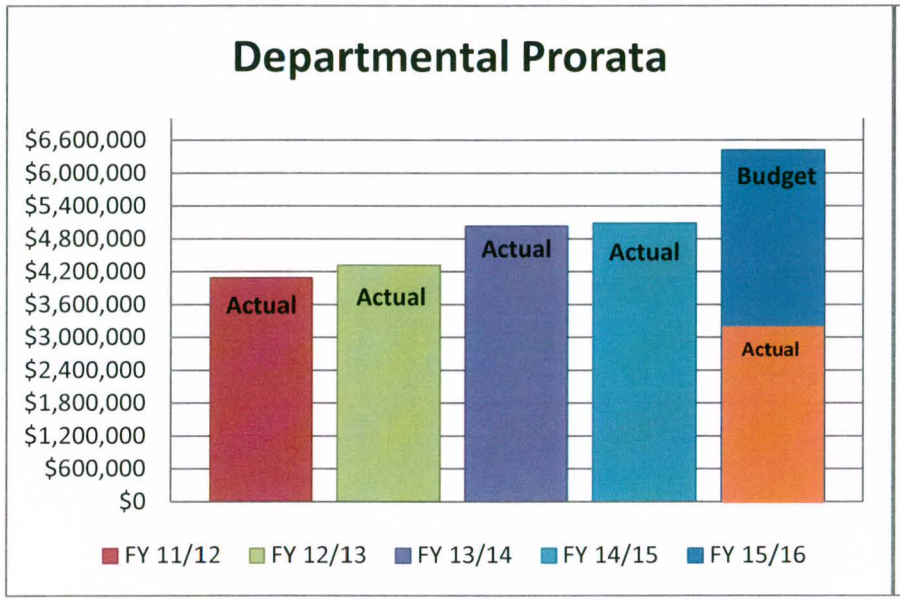
** net expenditures (excludes unscheduled reimbursements)*

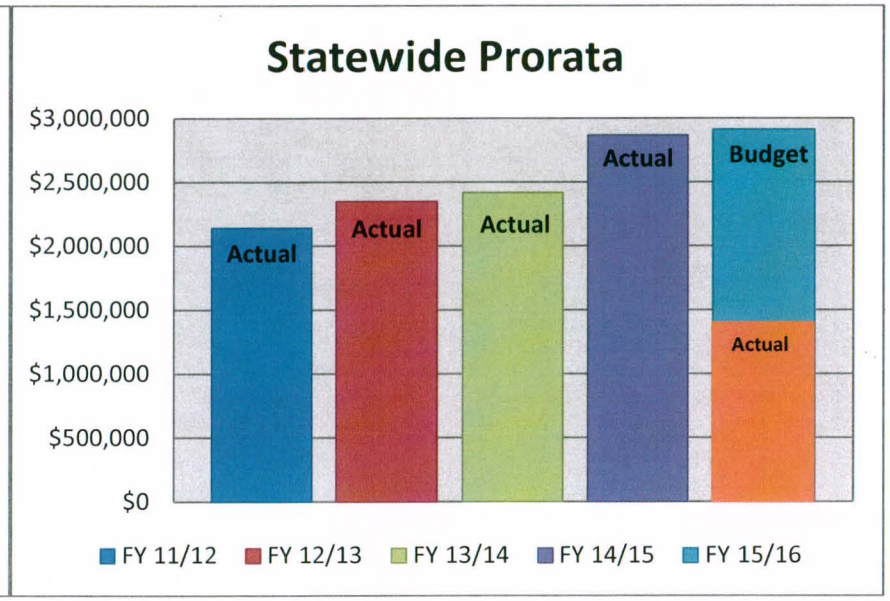
*** Budgeted does not include pending current year budget adjustments.*

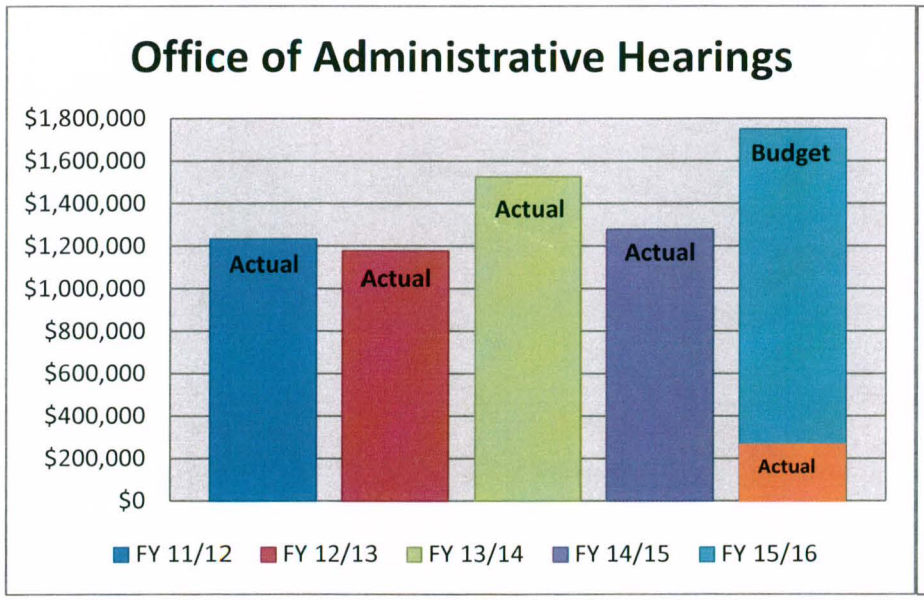
12/18/2015

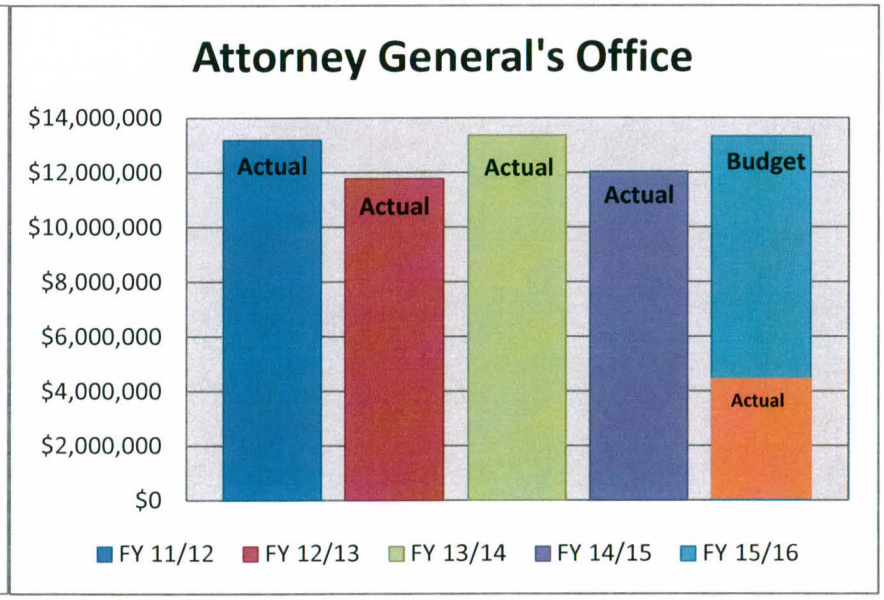
Budget Overview by Program.xls

External Agencies' Spending









FY 15/16 actual expenditures through 8/31/15

Board Members' Expenditures - Per Diem/Travel
July 1, 2015 - June 30, 2016

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	$1,000.00	$ 1,200.00									$ 4,200.00
Travel	$ 961.79			$ 610.09									$ 1,571.88
	$ 1,961.79	$1,000.00	$1,000.00	$ 1,810.09	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 5,771.88**
DR HAWKINS - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. KRAUSS - Per diem	$ 500.00			$ 1,300.00									$ 1,800.00
Travel													$ -
	$ 500.00	$ -	$ -	$ 1,300.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 1,800.00**
MS. LAWSON - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. LEVINE - Per diem													$ -
Travel	$ 479.05												$ 479.05
	$ 479.05	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 479.05**
DR. LEWIS - Per diem	$ 1,000.00	$ 700.00	$ 800.00	$ 1,100.00									$ 3,600.00
Travel	$ 750.90			$ 657.24									$ 1,408.14
	$ 1,750.90	$ 700.00	$ 800.00	$ 1,757.24	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 5,008.14**
MS. PINES - Per diem	$ 1,300.00	$1,100.00	$1,100.00	$ 1,400.00									$ 4,900.00
Travel	$ 728.51			$ 615.27									$ 1,343.78
	$ 2,028.51	$1,100.00	$1,100.00	$ 2,015.27	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 6,243.78**
MS.SCHIPSKE - Per diem	$ 1,000.00	$ 500.00	$ 700.00	$ 1,100.00									$ 3,300.00
Travel				$ 578.59									$ 578.59
	$ 1,000.00	$ 500.00	$ 700.00	$ 1,678.59	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,878.59**
MR. SERRANO SWELL- Per diem	$ 600.00	$ 600.00	$ 600.00	$ 600.00									$ 2,400.00
Travel													$ -
	$ 600.00	$ 600.00	$ 600.00	$ 600.00	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 2,400.00**
MS.WRIGHT - Per diem	$ 1,500.00	$1,300.00	$1,600.00	$ 1,300.00									$ 5,700.00
Travel	$ 921.54			$ 541.34									$ 1,462.88
	$ 2,421.54	$1,300.00	$1,600.00	$ 1,841.34	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 7,162.88**
MS. YAROSLAVSKY - Per diem		$1,300.00	$1,000.00	$ 1,400.00									$ 3,700.00
Travel	$ 924.49			$ 607.79									$ 1,532.28
	$ 924.49	$1,300.00	$1,000.00	$ 2,007.79	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 5,232.28**
DR. YIP - Per diem													$ -
Travel													$ -
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 12/14/15

TOTAL PER DIEM	$ 31,000.00
TOTAL PER DIEM BUDGETED	$ 31,500.00
TOTAL TRAVEL	$ 9,256.63
TOTAL	**$ 40,256.63**

INTERSTATE MEDICAL LICENSURE COMPACT COMMISSION
Salt Lake City, UT
December 18, 2015

The second meeting of the Interstate Medical Licensure Compact Commission convened at 8:05 AM with a call to order by Chairman Ian Marquand (MT).

Roll Call was completed by Secretary Shepard (WV) with 100% attendance of the eleven (11) member states. Karen Silas was named by Commissioner Smith (AL) to serve in his absence today and Commissioner McGill (WY) joined by teleconference.

Invited guests included: Rick Masters from The Council of State Governments and Colmon Elridge from The Council of State Governments National Center for Interstate Compacts. The public audience consisted of representatives from the AOA, AMA, the states of Utah, Illinois and Georgia and Kay Taylor from the FSMB who has been serving as the Commission's on-site coordinator. Also joining by teleconference was Lisa Robin, Jonathan Jagoda and Humayun J. Chaudhry, D.O., from the FSMB; Randall Manning from the FSMB Foundation and Mark Lane from the Federation of State Boards of Physical Therapy.

Agenda:
The draft agenda was presented for review. On a motion by Commissioner Bohnenblust (WY) and seconded by Commissioner Martinez (MN) the agenda was approved by voice vote as presented.

Minutes:
The minutes from the inaugural meeting of October 27, 2015 were presented with recommended revisions received by the Secretary after the posting of the draft minutes. On a motion by Commissioner Feist (MT) and seconded by Vice Chairman Thomas (MN), the minutes were unanimously approved by voice vote with all recommended revisions included.

The inaugural minutes were very specific and detailed for clear understanding of the discussions held and decisions made. Future recording of minutes will only reflect motions and decisions made and how those votes were taken. Details of discussion will be made available via the digital recording of the meetings. The Communications Committee will establish a consistent style for all Commission communications.

Committee Reports:
The following committee reports were made by their respective chairs. Unless noted below, reports were received as information only but Commissioners and the public were allowed comments on each report.

Coordinating Committee: Chairman Marquand (MT) shared the report of the Coordinating Committee. The majority of the report dealt with the planning for the December meeting of the Commission, including the request for Kay Taylor from FSMB to serve as the coordinator. The committee also addressed the following:

1) Seating of any new member states within the public gallery, not at the Commissioners' table. Upon official appointment to the Commission, those new Commissioners will take their seat at the table.

2) The Chairman of the Commission should be the face and voice for the Commission for those outside communications requiring an immediate response from the Commission.

3) No recommendations were made by the Coordinating Committee regarding more complex communications as the Communications Committee was scheduled to meet the following day.

Bylaws/Rules Committee: The Bylaws/Rules Committee met three times since the first meeting of the Commission and was led by Chairman Bowden (IA). Commissioner Martinez (MN) presented the following recommended changes:

1) Grammatical and language changes:
2) Establishment of an Executive Committee in Article VII, Section 1:
3) Establishment of Advisory Committees as sub-committees of the Commission, therefore, not requiring public meeting notices;
4) Prohibit Commission voting by ballot with approval of four (4) forms of voting:
   a) Voice Vote
   b) Roll Call Vote
   c) Non-Audible Vote
   d) Consensus Vote

Following much discussion regarding "advisory" committees and a roll call vote on secret balloting and several motions and motion withdrawals, a motion was made by Commissioner Schneider (IL) and seconded by Commissioner Goetter (AL) recommending the following:

Acceptance of the report and recommendations of the Bylaws/Rules Committee with the following specific changes:

1) Delete all "advisory" references.
2) Article VI, Section 4 – Delete "Ballot votes are prohibited" and replace with "Ballots are allowed only for the election of officers."
3) Article VII, Section 2 – Revise first sentence to read as follows: "The Commission may establish such Committees as it deems necessary to advise it concerning the fulfillment of its objectives, which may include, but not be limited to, …..
4) Article VII, Section 2 - Delete "No officer of the Commission or immediate past chairperson of the Commission shall concurrently serve as a chairperson on a Committee."
5) Article VII, Section 2 – Revise last sentence to read, "Committees created under this Article VII, Section 2 are not subject to the requirements of Article VI under these bylaws."

The motion was approved unanimously by roll call vote.

A motion was made by Commissioner Schneider (IL) and seconded by Vice Chair Thomas (MN) to request the Bylaws/Rules Committee look into the development of a process for dissolution of the Compact and how assessments, if assessed, would be disseminated. This should be reported back to the full Commission. Motion passed by voice vote.

Chairman Marquand called for a 20 minute recess at 9:40 AM. The Commission re-convened at 10 AM.

The Bylaws/Rules Committee continues to work on the promulgation of rules and, at this time, presented a Conflict of Interest Policy, an amendment to the adoption of rules and a procedure for the Commission's acceptance of gifts. Chairman Bowden (IA) asked Commissioner McGill (WY) to walk the Commission through the recommendations.

Motion made by Chairman Bowden (IA) for the adoption of the Conflict of Interest Policy and seconded by Commissioner Clark (IA).

With discussion about definition of "tangential" and "deminimis" gifts, the motion to adopt the Conflict of Interest Policy was withdrawn and the policy sent back to the Bylaws/Rules Committee for more in depth study and reflection.

The Committee was asked to review rules for parliamentary procedures and whether Roberts Rules of Order, which is currently required by the Commission Bylaws, is the best rule to follow. Discussion ensued on whether the Commission should appoint a Parliamentarian to assist in clarifying parliamentary procedures or obtain legal counsel on the same.

No further action was taken on the Bylaws/Rules Committee report.

Budget Committee: Chairman Zachariah (IL) presented two policies for review and approval. Motion was made by Chairman Zachariah (IL) to establish a checking account at a national bank which shall have a local branch in at least one member state and to give authority to the Commission Treasurer to deposit funds on behalf of the IMLCC and to disperse funds on behalf of the IMLCC up to one thousand (1,000) dollars on his sole authorization. Any deposit greater than one thousand (1,000) dollars would require authorization of both the Treasurer and the Chairperson of the Interstate Medical Licensure Compact Commission. The motion was seconded by Commissioner Thomas (MN).

The motion carried unanimously by voice vote.

Chairman Zachariah (IL) presented a proposed six month budget with an income of $1,000 from a donation made to the Commission and an expense budget of $176,926.05. The proposed budget was presented for informational purposes only. No action needed.

Until a home office has been established for the Commission with the hiring of an Executive Director, the Commission Secretary, along with the office of Central State Governments, will maintain all policies approved by the Commission.

Funding Committee: Chairman Thomas (MN) presented two (2) action items to the Commission.

1) Permission to explore incorporating the IMLCC as a 501 (c) 3 to benefit directly from possible grant funding while also looking at other options available for government agencies.

2) Recommend that the IMLCC work with FSMB in applying for the HRSA License Portability Grant equaling $250,000 a year for a three year duration. This application could be done three different ways but has a deadline of 01-19-16.

A) As a block grant;
B) The IMLCC could ask FSMB to assist in the application process for the IMLCC;
C) The FSMB could apply for the HRSA grant as a pass through for the IMLCC.

Motion was made by Chairman Thomas (MN) and seconded by Commissioner Cousineau (NV) to ask FSMB to work with the Commission on the most prudent process to apply for the HRSA grant.

Motion was unanimously passed with voice vote.

Commissioner Schneider (IL) moved to appoint the Funding Committee to work with FSMB in the drafting of the application for the HRSA grant. Motion seconded by Commissioner Longo (NV).

Motion was unanimously passed with voice vote.

Commissioner Schneider (IL) moved to request Chairman Marquand (MT) to write a letter on behalf of the Commission for the grant. Motion was seconded by Commissioner Goetter (AL).

Motion unanimously passed with voice vote.

Chairman Marquand (MT) recognized Randall Manning in attendance via telephone from the FSMB Foundation. Mr. Manning announced that grants are available, upon request, to any states for IMLC start up monies. Letters requesting grant monies should be sent directly to the Foundation.

Motion was made by Commissioner Hansen (SD) to ask the Commission Chairman to write a letter to the Foundation requesting a grant for the IMLCC. When asked by the Chairman if the motion contained a dollar amount, Commissioner Hansen requested the motion ask for funds to support the Commission. Motion was seconded by Commissioner Feist (MT).

A voice vote was taken with indecisive results. The Chairman asked for a show of hands with the results showing 13 Yes and 8 No. Chairman Marquand abstained. The motion carried.

Mr. Masters has to leave the meeting early today and Chairman Marquand requested permission to allow Mr. Masters to present his portion of the report from The Council of State Governments Conflict Waiver Agreement with disclosures. The agreement has been signed by the President and CEO of the Federation of State Medical Boards, Humayun J. Chaudhry, D.O.

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Motion was made by Commissioner Martinez (MN) and seconded by Vice Chairman Thomas (MN) to authorize the Commission Chairman to sign the Conflict Waiver Agreement presented by Mr. Masters.

The motion was unanimously passed by voice vote.

Personnel Committee: The committee recommends a change to the Bylaws, Article IV, Section 2, "Duties of the Executive Director." A sub-section "k" is requested to , "seek and assist in acquisition of financial grants."

Motion was made by Vice Chair Thomas (MN) and seconded by Commissioner Schaecher (UT) to approve the Bylaws change to add sub-section "k" to Article IV, Section 2.

Original motion was withdrawn and a motion to refer this change to the Bylaws/Rules Committee for consideration was made by Commissioner Knittle (WV) and seconded by Commissioner Goetter (AL).

Motion unanimously passed with voice vote.

Chairman Marquand (MT) requested a brief recess and asked the Commission to reconvene for a working lunch with Lisa Robin's report from Federation of State Medical Boards. Ms. Robin provided an update on the status of the current HRSA grant monies. To date, the Commission has operated under budget as established with the HRSA grant.

Technology Committee: The Technology Committee approached their job by surveying all member states to identify a required minimal data set for each member state's licensing process. Great consistency was found between the member states and was determined to be the initial starting point in the development of a minimal data set. It was also determined the initial licensing process and data flow should be given priority over the renewal process.

As the process moves forward, the Technology Committee, as well as all Commission appointed committees, should work closely with the Bylaws/Rules Committee to insure rules are developed to assist with the objectives as each committee does its work. The Commission requested Mr. Masters, from CSG, to work with the Technology Committee as they continue their work.

While the Federation of State Medical Boards already has a compilation of state boards data, Commissioners felt additional information would be needed from FSMB before our technology needs are more definitively identified. It was the consensus of the Commission to invite Michael Dugan, Chief Information Officer of the FSMB, to the next meeting of the IMLCC to discuss this further.

Communications Committee: The first two objectives of the committee were to:

1) Provide consistent, uniform communication to and from the IMLCC through all communication mediums;
2) Development of a dedicated IMLC website.

To meet their objectives, the committee presented a Communications Policy to address and prioritize outside requests for information and to report back to the Commission. They also designed a letterhead format for IMLCC correspondence and a power point presentation with talking points for presentations on the IMLCC. A request was made to move all contact information from the top of the letterhead to the bottom, until a Commission office has been identified.

The committee will continue to work on the development/management of a dedicated website for the IMLC.

The Commission Chairman was invited and participated in a roundtable discussion on the IMLC sponsored by the FSMB. There were over 40 participants from across the United States who participated.

Chairman Marquand (MT) called for a 15 minute recess and reconvened to vote on a recommendation from the Communications Committee.

Motion was made by Vice Chair Thomas (MN) and seconded by Commissioner Schaecher (UT) to accept the Communications Committee's "triage" process to prioritize incoming requests. Motion passed by unanimous voice vote.

Correspondence Requests: The following communication requests were reviewed:

1) AMA – Requested clarification on the Maintenance of Certification requirement for renewal of license within the compact. Motion was made by Commissioner Hansen (SD) and seconded by Commissioner Lawlor (ID) to answer by stating the IMLC currently has no requirement for board certification upon renewal. That issue is deferred to individual state requirements at time of renewal. Board certification is currently required at time of initial licensure only.

   The motion unanimously passed by voice vote. The AOA requested the same written response be sent to their organization recognizing Osteopathic Continued Certification as only being required at initial licensure.

2) A letter has been received from the Nurse Licensure Compact Administrators offering congratulations and offering their assistance. The Chair will acknowledge the letter on behalf of the IMLCC.

3) An invitation to participate in a research study on medical licensing has been received from Licentiam, Inc. A motion was made by Commissioner Schaecher (UT) and seconded by Vice Chair Thomas (MN) to decline the invitation.

4) An invitation to speak at their annual meeting in Kissimmee, Florida, has been received from the National Association of Locum Tenens Organizations and the National Association of Physician Recruiters at their expense.

Motion was made by Treasurer Zachariah (IL) and seconded by Commissioner Carpenter (SD) to authorize Chairman Marquand (MT) to speak at the national meeting in March 2016 using the current power point presentation. The motion unanimously passed by voice vote.

Public Comments: The meeting was opened for public comments. The AMA representative acknowledged that they are interested in the sharing of data whether it be through RFP or other means.

Report of Council of State Governments: Report from Council of State Governments was received from Colmon Elridge. He acknowledged the work of the Commission is being closely watched on a national level and he applauded the progress made by the Commission to date. He spoke to the work ethic of Mr. Masters and expressed his appreciation to the Commission for the signing of the Conflict of Interest Waiver. Mr. Elridge presented the work plan as it was submitted for the current HRSA grant and offered it to the Commission for their consideration.

The Commission expressed their thanks to Mr. Elridge, from CSG and Kay Taylor from the FSMB for their assistance in handling the administrative functions for these Commission meetings. Secretary Shepard requested guidance on where the digital recordings of each Commission meeting should be made available. Motion was made by Commissioner Hansen (SD) and seconded by Commissioner Feist (MT) to upload the digital recordings to the "Knowledge" section of the CSG website with a link to all member state websites until such time as the Commission has a dedicated website. The motion unanimously passed by voice vote.

Work Plan and Time Line Development: Chairman Marquand (MT) noted that Commissioner Schaecher (UT) had left the first Commission meeting prior to the committee assignments being made. He was asked if he wished to serve on a committee and he agreed to be added to the Bylaws/Rules Committee.

The Commission was asked by its Chair to establish what they wanted to accomplish over the next 60 days. The list was set as follows:

1) The Technology Committee should meet with Michael Dugan from the FSMB prior to the next Commission meeting to outline a strategic plan for information technology;
2) Remote conferencing will be made available for all committees;
3) Budget and Funding Committees will work on the HRSA Grant for submission by the January 19, 2016 deadline;
4) Bylaws/Rules Committee will work and report on the following issues by the next Commission meeting;
    a) Conflict of Interest
    b) Gifts
    c) Rulemaking
    d) Add "k" duty for Executive Director Position
    e) Rules on Policies and Policy Making
5) Chairman Marquand (MT) will draft a letter to the FSMB Foundation for presentation at the next Commission meeting;
6) For the telehealth community in support of the IMLC, the Commission Chair will reach out for cooperation and dialogue;
7) Communication Committee was requested to provide a pilot presentation at the next Commission meeting just for the Commissioners;
8) The Commission Chair will contact the FSMB about making a presentation at the Annual FSMB meeting;

9) The tabled motion on establishing a July 1, 2016 licensing deadline was withdrawn by Commissioner Steinagle (UT);
10) An orientation program will be developed by the Communication Committee with the assistance of CSG, for new commissioners;
11) Commission Secretary will contact any new commissioners with a letter of welcome and request a copy of their appointment letter;

A motion was made by Commissioner Hansen (SD) and seconded by Commissioner Steinagle (UT) to ask the Executive Committee to prepare a work plan for submission with the HRSA Grant and present it to the Commission as a working document at the next Commission meeting. The motion carried with voice vote.

Because an Executive Committee has been created at this meeting of the IMLCC, a motion was made by Vice Chair Thomas (MN) and seconded by Commissioner Goetter (AL) to dissolve the Coordinating Committee. However, Commissioner Lawler (ID) reminded members of the 30 day notice required prior to the Executive Committee meeting. Vice Chair Thomas (MN) withdrew his motion.

Next Meeting: The next meeting of the Commission will be held on March 31, 2016, beginning at 1:00 PM and through April 1, 2016, until 1:00 PM. The State of Minnesota has agreed to host the March 31st meeting with a possible gathering time for new commissioners prior to the 1:00 PM meeting.

Public Comments: Opportunity was given for those in the audience to make comments on the work of the Commission, but none were made.

Press Release: Communications Committee was asked to prepare a press release following this meeting. Commission Secretary will work with Communications Committee to develop a summary to member boards, CSG and FSMB for public consumption.

Adjournment: Chairman Marquand declared the meeting adjourned at 4:05 PM.

Respectfully submitted,

Diana Shepard, CMBE
Commission Secretary

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2014 - 2015 ANNUAL REPORT

Medical Board of California

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Executive Summary

The Medical Board of California (Board) continued its focus on the issues of prescription drug abuse and inappropriate prescribing by concentrating on educational opportunities for physicians. In September 2014, the Board hosted a free continuing medical education (CME) course in Los Angeles on Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (ER/LA Analgesics REMS) that was developed by the U.S. Food and Drug Administration. The course was well attended and physicians were able to obtain three CME credits for the three-hour course. In addition, in November 2014, after numerous Prescribing Task Force meetings with interested parties, significant public comment, and discussions with experts in the field of pain management, the Board approved a new document entitled ***Guidelines for Prescribing Controlled Substances for Pain*** (Guidelines). These Guidelines are intended to educate physicians on effective pain management in California by avoiding undertreatment, overtreatment, or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. The new Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. Lastly, in May 2015, the Board won State Information Officers Council (SIOC) Awards for both of its public service announcements (PSA), which address the issue of prescription drug abuse and misuse. The ***PSA*** directed to physicians, featuring Board Member Michael Bishop, M.D., won the SIOC Silver Award. The ***PSA*** featuring Olympic gold medalist Natalie Coughlin, directed to consumers, won the SIOC Gold Award.

The Board also continued its goal of transparency for all consumers by sponsoring ***Assembly Bill 1886*** (Eggman, Chapter 285, Statutes of 2014), which changed the requirements for information available on the Board's website regarding physicians. Prior to the passage of this

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Current Physician and Surgeon Licenses by County

Data is for physicians with a renewed and current license excluding those in an inactive, retired, or disabled license status. The breakdown of those license statuses is: California - 2,106, Out of State – 4,265, Total – 6,371.

Alameda	**5,037**	Inyo	**43**	Monterey	**898**	San Luis Obispo	**795**	Trinity	**8**
Alpine	**3**	Kern	**1,098**	Napa	**487**	San Mateo	**2,903**	Tulare	**506**
Amador	**63**	Kings	**127**	Nevada	**244**	Santa Barbara	**1,250**	Tuolumne	**121**
Butte	**490**	Lake	**69**	Orange	**9,856**	Santa Clara	**7,830**	Ventura	**1,792**
Calaveras	**46**	Lassen	**43**	Placer	**1,180**	Santa Cruz	**716**	Yolo	**526**
Colusa	**8**	Los Angeles	**29,118**	Plumas	**22**	Shasta	**420**	Yuba	**44**
Contra Costa	**3,296**	Madera	**214**	Riverside	**3,054**	Sierra	**0**	**Unidentified California county***	**1,590**
Del Norte	**31**	Marin	**1,516**	Sacramento	**4,704**	Siskiyou	**72**		
El Dorado	**311**	Mariposa	**13**	San Benito	**43**	Solano	**940**	**California total**	**108,594**
Fresno	**1,978**	Mendocino	**198**	San Bernardino	**3,905**	Sonoma	**1,438**		
Glenn	**11**	Merced	**249**	San Diego	**10,308**	Stanislaus	**996**	**Out-of-State total**	**23,776**
Humboldt	**270**	Modoc	**6**	San Francisco	**6,202**	Sutter	**191**	**Current licenses total**	**132,370**
Imperial	**144**	Mono	**32**	San Joaquin	**1,094**	Tehama	**45**		

*Due to the location listed in the address of record, the county cannot be identified.

The Mission of the Medical Board of California

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.

Executive Summary *(continued from page i)*

bill, most public disciplinary information for physicians could only be posted on the Board's website for 10 years. This Board-sponsored bill allows the Board to post the most serious disciplinary information on the Board's website for as long as it remains public.

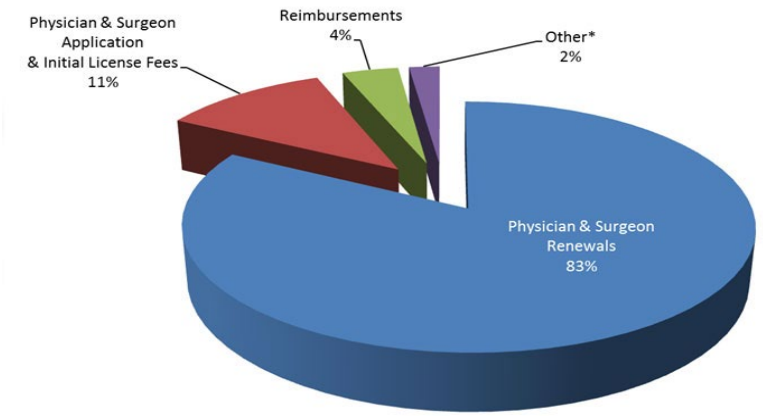
In January 2015, the Board launched a Twitter account to educate consumers and physicians by providing information on the Board's roles, laws, and regulations, as well as providing information on Board events and meetings. Twitter provides outreach on the Board's consumer protection mission to the public and encourages public engagement in the activities of the Board.

Board Members and Board staff participated in the Board's first annual Legislative Day on February 26, 2015. Board Members and staff visited legislative offices to provide Legislative Members with information on the Board and its roles and duties. The Board Members met with the Chairs of the Senate and Assembly Business and Professions Committees, as well as other Legislators and legislative staff.

Medical Board of California 2014–2015 Fiscal Year

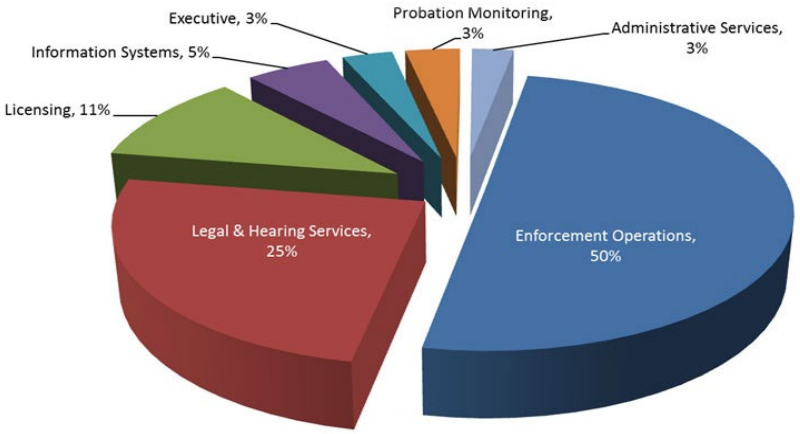
Revenues & Reimbursements

Physician & Surgeon Renewals	$46,962,000	83%
Physician & Surgeon Application & Initial License Fees	$6,420,000	11%
Reimbursements	$2,171,000	4%
Other Regulatory Fees, Delinquency/Penalty/ Reinstatement Fees, Interest on Fund, Miscellaneous*	$1,180,000	2%
Total Receipts	**$56,733,000**	**100%**



Budget Distribution

Enforcement Operations	$30,323,000	50%
Legal & Hearing Services	$14,907,000	25%
Licensing	$6,503,000	11%
Information Systems	$3,155,000	5%
Executive	$1,909,000	3%
Probation Monitoring	$2,065,000	3%
Administrative Services	$1,577,000	3%
Total	**$60,439,000**	**100%**



Licensing Summary

The Board's Licensing Program continues to achieve its mission of protecting the health care of consumers through the proper licensing of physicians and surgeons and certain allied health care professionals. The Licensing Program also issues fictitious name permits, and licenses non-nurse midwives, research psychoanalysts, spectacle and contact lens dispensers, registered dispensing optician businesses, and polysomnographic trainees, technicians and technologists. The Licensing Program also approves

Licensing Summary *(continued on page iii)*

Licensing Summary *(continued from page ii)*

accreditation agencies that accredit outpatient surgical settings in which general anesthesia is being used.

The Licensing Program issued 5,882 new physician's and surgeon's licenses. This was an increase of 360 (6.5%) more new licenses than the previous fiscal year. The Licensing Program recognized 54 international medical schools pursuant to California Code of Regulations, Title 16, Division 13, (CCR) Section 1314.1(a)(1). The Licensing Program was able to perform the initial application review of all physician's and surgeon's applications within the 60 working days regulatory time frame. Staff continues to identify opportunities to streamline and improve the application process and improve the Licensing Program's outreach efforts.

Prior to January 1, 2015, Business and Professions Code (BPC) section 30 required all applicants, prior to being licensed, to have a U.S. Social Security Number (SSN) that allowed the individual to work in the U.S. The passage of Senate Bill 1159 (Lara, Chapter 752), which became effective January 1, 2015, amended BPC section 30 to allow applicants to use a valid U.S. Individual Taxpayer Identification Number (ITIN) instead of an SSN. Individual applicants who have either a valid SSN or ITIN are now eligible to apply for a license.

On July 1, 2015, the BreEZe system was updated to allow physician's and surgeon's applicants to check certain deficiencies of their application. The information is only for date-forward applications. Applications that were filed prior to July 1, 2015 will be updated to reflect certain deficiencies when additional documents are received and reviewed by staff. This will allow applicants to identify some of the deficient items needed to complete their application without contacting the Board.

Licensing Program Activity

	FY 13-14	FY 14-15
Physician Applications Received	6,308	**6,850**
Physician Licenses Issued		
FLEX/USMLE[1]	4,571	**4,808**
NBME[1]	284	**268**
Reciprocity with other states (B&P Code §2135)	667	**806**
Total new licenses issued	5,522	**5,882**
Renewal licenses issued – with fee	59,963	**61,130**
Renewal licenses issued – fee exempt[2]	4,751	**5,181**
Total licenses renewed	64,714	**66,311**
Physician Licenses in Effect[3]		
California address	106,284	**108,594**
Out-of-state address	24, 442	**23,776**
Total	130,726[4]	**132,370[5]**
Fictitious Name Permits		
Issued	1,130[6]	**1,229[7]**
Renewed	3,833	**6,434**
Total number of permits in effect	10,835	**12,242**

1 FLEX: Federation Licensing Exam.
USMLE: United States Medical Licensing Exam.
NBME: National Board Medical Exam.
2 Includes physicians with disabled, retired, military, or voluntary services license status.
3 Excludes physicians with an inactive, retired, or disabled license status.
4 Total Physician Licenses in Effect including inactive, retired or disabled license status – 137,320.
5 Total Physician Licenses in Effect including inactive, retired or disabled license status – 138,741.
6 Includes 26 Fictitious Name Permits issued on behalf of the Board of Podiatric Medicine.
7 Includes 27 Fictitious Name Permits issued on behalf of the Board of Podiatric Medicine.

	FY 13-14	FY 14-15
Special Faculty Permits		
Permits issued	1	**3**
Permits renewed	2	**13**
Total active permits	19	**22**
Licensing Enforcement Activity		
Licenses Issued with Public Letter of Reprimand	0	**0**
Probationary license granted	15	**10**
License denied (no hearing requested)	0	**6**
Statement of Issues to deny license filed	4	**6**
Statement of Issues granted (license denied)	3	**2**
Statement of Issues denied (license granted)	0	**1**
Statement of Issues withdrawn	0	**1**

Allied Health Care Professions Licenses/Registrations

	Issued	Current
Licensed Midwife	**42**	**361**
Dispensing Optician	**63**	**991**
Contact Lens Dispenser	**81**	**993**
Non-Resident Contact Lens Seller	**0**	**7**
Spectacle Lens Dispenser	**245**	**2,143**
Research Psychoanalyst	**7**	**90**
Polysomnographic Trainee	**25**	**45**
Polysomnographic Technician	**19**	**78**
Polysomnographic Technologist	**46**	**512**
Accreditation Agencies for Outpatient Settings	**0**	**5**

Verification & Reporting Activity Summary

	FY 13-14	**FY 14-15**
License Status Verifications		
Telephone verifications	13,788	**9,763**
Non-verification telephone calls	67,366[1]	**59,880[2]**
Authorized Licensing Verification System (LVS) Internet users	534	**388**
Web license look-up	1,560,289	**1,463,837[3]**
Certification Letters and Letters of Good Standing	8,413	**10,936**
Reporting Activities		
Disciplinary reports mailed to health facilities upon written request pursuant to B&P Code §805.5	323	**144**
Adverse Actions reported to the National Practitioner Data Bank (NPDB)	640[4]	**557[5]**
B&P Code §805 & §805.1 reports of health facility discipline received	105/2[6]	**96/4[7]**

1 Does not include the 8,005 listed under Consumer Inquiries on page v.
2 Does not include the 8,775 listed under Consumer Inquiries on page v.
3 Statistics from Medical Board's 'BreEZe Online License Verification' page.
4 Includes 607 MDs, 13 Doctors of Podiatric Medicine, 15 Physician Assistants, 2 Denials by the Physician Assistant Board, 3 Registered Dispensing Opticians Program, 0 Licensed Midwives and 0 Denials by Licensing Program.
5 Includes 551 MDs, 3 Registered Dispensing Opticians Program, 0 Licensed Midwives and 3 Denials by Licensing Program.
6 Includes 98 805 Reports against MDs, 3 Doctors of Podiatric Medicine and 4 Physician Assistants; 2 805.01 Reports Against MDs.
7 Includes 96 805 Reports and 4 805.01 Reports against MDs.

2014 Licensed Midwife Annual Report Summary[1]

	2013	**2014**
Clients served as primary caregiver at the onset of care	5,052	**5,386**
Clients served with collaborative care available through or given by a licensed physician and surgeon	2,720	**2,763**
Clients served under the supervision of a licensed physician and surgeon	444	**161**
Planned out-of-hospital births at the onset of labor	3,028	**3,397**
Planned out-of-hospital births completed in an out-of-hospital setting:	2,559	**2,833**
Twin Births	6	**1**
Multiple Births (other than Twin Births)	0	**1**
Breech Births	20	**12**
VBAC (vaginal births after the performance of a Cesarean section)	109	**150**
Complications - Resulting in the mortality of the mother prior to transfer	0	**0**
Complications - Resulting in the mortality of the mother after transfer	0	**0**
Complications - Resulting in the mortality of the infant prior to transfer	3	**2**
Complications - Resulting in the mortality of the infant after transfer	10	**2**
Antepartum - Primary care transferred to another health care practitioner (elective)	308	**401**
Antepartum - Urgent or emergency transport of expectant mother	89	**113**
Intrapartum - Elective hospital transfer	398	**492**
Intrapartum - Urgent or emergency transfer of an infant or mother	58	**69**
Postpartum - Elective hospital transfer of mother	41	**57**
Postpartum - Elective hospital transfer of infant	37	**31**
Postpartum - Urgent or emergency transfer of a mother	42	**37**
Postpartum - Urgent or emergency transfer of an infant	32	**39**

1 Conclusions should not be drawn from this summary as data does not specify whether the death is fetal, intrapartum or neonatal; whether the affected perinate had congenital anomalies incompatible with life; or whether the perinate was born in or out of a hospital. Births are attended by the licensed midwife as the primary caregiver.

Enforcement Summary

On July 1, 2014, the Board established its Complaint Investigation Office (CIO). This unit, comprised of six Special Investigators (non-sworn) and a Supervising Special Investigator I, is tasked with investigating quality of care investigations following a medical malpractice settlement or judgement, cases against physicians charged with or convicted of a criminal offense, and physicians petitioning for reinstatement of a license following revocation or surrender of his or her license. During FY 2014-2015 the Special Investigators in the CIO investigated and closed 296 cases and referred 26 to the Attorney General's (AG's) Office to take disciplinary action against the licensee's physician's and surgeon's license. The 26 referrals accepted by the AG's Office consisted of 12 convictions, 13 Petitions for Reinstatement and one medical malpractice case.

Also on July 1, 2014, in compliance with Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013), the Board transferred its investigative staff to the new unit within the Department of Consumer Affairs entitled the Health Quality Investigation Unit (HQIU). Therefore, all complaints that require investigation by a sworn investigator are now transmitted to the HQIU for investigation. This law did not change the requirements for these cases to be investigated through the vertical enforcement model and therefore both an investigator and a Deputy Attorney General from the AG's Office are assigned to investigate the violations in the complaint. The Board is responsible for reviewing the outcome of the

Enforcement Summary *(continued on page vi)*

Enforcement Program Action Summary
Physicians & Surgeons

	FY 13-14	**FY 14-15**
Complaints/Investigations[1]		
Complaints received	8,329	**8,267**
Complaints closed by Complaint Unit	5,341	**7,578**
Investigations[1]		
Cases opened	1,562	**1,381**
Cases closed	1,331	**1,469**
Cases referred to the Attorney General (AG)	491	**471**
Cases referred for criminal action	67	**76**
Number of probation violation reports referred to the AG	27	**20**
Consumer Inquiries		
Consumer inquiries	8,005	**8,775**
Jurisdictional inquiries	4,403	**4,826**

[1] Some cases closed were opened in a prior fiscal year.

Physicians & Surgeons Complaints Received by Type & Source	Fraud	Health & Safety[1]	Non-Jurisdictional[2]	Gross Negligence/ Incompetence[3]	Other Category	Personal Conduct[4]	Unprofessional Conduct[5]	Unlicensed/ Unregistered	Total
Public	60	46	369	3,260	22	27	1,549	155	**5,488**
B&P Code[6]	0	8	3	659	112	101	19	0	**902**
Licensee/ Prof. Group[7]	9	14	21	66	11	25	98	24	**268**
Government Agency[8]	6	21	3	106	77	217	374	84	**888**
Misc./Anonymous	16	36	100	210	8	38	213	100	**721**
Totals	**91**	**125**	**496**	**4,301**	**230**	**408**	**2,253**	**363**	**8,267**

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

Enforcement Summary *(continued from page v)*

investigation for approval, but the investigation is now performed outside of the Board's auspices.

When SB 304 became operative on January 1, 2014, it also mandated accredited outpatient surgery settings to submit adverse events to the Board within specified time limits. These reports have to be submitted no later than five days after the adverse event has been detected, or, if that event is an ongoing threat to the health, welfare, or safety of patients, medical personnel or the public, the event must be reported to the Board no later than 24 hours upon discovery. During FY 2014-2015, 104 adverse events were reported including surgical mishaps or deaths, improper use of surgery products or devices, case management errors resulting in poor quality of patient care, environmental circumstances resulting in patient death or disability, or criminal wrongdoings by medical personnel inflicted upon a patient. The Board reviews each adverse event report and takes appropriate action either with the assistance of an approved accreditation agency or through the Board's Enforcement Program.

On January 1, 2015, Assembly Bill 1886 became effective. This bill restructured the statute related to public disclosure information, requiring the Board to restore documents previously removed from its website. Staff in the Board's Discipline Coordination Unit (DCU) identified over 7,000 disciplinary records requiring the posting of public disclosure information to the website. DCU staff worked to scan the related public disciplinary documents and make them available on the Board's website. This legislation provides transparency to the public in requiring the cases with significant disciplinary action to remain on the Board's website as long as they are public, thereby furthering the Board's mission of consumer protection.

Reports Received Based Upon Legal Requirements

	FY 13-14	FY 14-15
Medical Malpractice		
Insurers: B&P Code §801.01	570	**476**
Attorneys or Self-Reported or Employers: B&P Code §801.01	145	**125**
Courts: B&P Code §803	6	**2**
Total Malpractice Reports	721	**603**
Coroners' Reports: B&P Code §802.5	2	**5**
Criminal Charges & Convictions: B&P Code §802.1 & §803.5	41	**95**
Health Facility Discipline Reports Medical Cause or Reason: B&P Code §805	98	**96**
Health Facility Reports: B&P Code §805.01	2	**4**
Outpatient Surgery Settings Reports Patient Death: B&P Code §2240(a)	12	**9**

Malpractice Settlement Reports Received Per Business and Professions Code Section 801.01 by Specialty Practice

Specialty/Subspecialty	No. of Reports[1]	No. of Physicians[2]
Allergy and Immunology	1	651
Anesthesiology	24	6,006
Cardiology	13	3,390
Colon and Rectal	6	197
Critical Care	2	1,418
Dermatology	4	2,177
Emergency Medicine	23	4,532
Facial, Plastic, Reconstructive Surgery	1	1,010
Gastroenterology	10	1,725
General/Family Practice	63	10,115
General Surgery	42	4,000
Gynecology	20	6,019
Hematology	2	1,131
Internal Medicine	55	28,415
Neonatal/Perinatal	2	683
Nephrology	15	1,222
Neurological Surgery	20	559
Neurology	3	2,130
Obstetrics	45	6,019
Ophthalmology	13	2,868
Orthopedic Surgery	47	3,420
Otolaryngology	14	1,649
Pain Medicine	4	634
Pathology	4	4,010
Pediatrics	14	10,985
Physical Medicine & Rehabilitation	1	1,199
Plastic Surgery	21	952
Preventive Medicine	1	1,043
Psychiatry	16	7,458
Pulmonology	1	1,567
Radiology	43	6,399
Rheumatology	2	706
Thoracic Surgery	11	487
Urology	14	1,256
Vascular Surgery	4	311

[1] The procedure was performed in the practice specialty/subspecialty; however, the physician may or may not have been certified in the specialty/subspecialty area.

[2] California physicians certified in specialty according to the 2013-2014 American Board of Medical Specialties Certification Statistics Report.

Enforcement Program Action Summary

Physicians & Surgeons	FY 13-14	FY 14-15
Administrative Actions		
Accusation	273	**310**
Petition to Revoke Probation/Accusation and Petition to Revoke	30	**21**
Amended Accusation/Petition to Revoke	60	**70**
Number of completed investigations referred to the AG awaiting the filing of an Accusation as of June 30, 2015	112	**104**
Number of cases over 6 months old that resulted in the filing of an Accusation	229	**254**
Administrative Outcomes		
Revocation	51	**45**
Surrender (in lieu of Accusation or with Accusation pending)	77	**85**
Suspension	1	**0**
Probation with Suspension	16	**14**
Probation	121	**122**
Probationary License Issued	15	**10**
Public Reprimand	90	**86**
Other Actions (e.g., exam required, educational course, etc.)	4	**3**
Accusation Withdrawn[1]	17	**14**
Accusation Dismissed	0	**10**
Dispositions of Probation Filings		
Probation Revoked or License Surrendered	12	**10**
Additional Suspension and Probation	1	**1**
Additional Suspension or Probation	12	**12**
Public Reprimand	1	**0**
Petition Withdrawn/Dismissed	3	**2**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	45	**5[2]**
Petition Activity		
Petition for Reinstatement of License Filed	14	**7**
Petition for Reinstatement of License Granted	8	**11**
Petition for Reinstatement of License Denied	7	**8**
Petition for Penalty Relief Granted[3]	35	**28**
Petition for Penalty Relief Denied[3]	11	**9**
Petition to Compel Exam Filed	12	**12**
Petition to Compel Exam Granted	12	**12**
Petition to Compel Exam Denied	0	**0**
License Restrictions/Suspensions Imposed While Administrative Action Pending		
Interim Suspension Orders	21	**14[4]**
Temporary Restraining Orders	0	**0[4]**
Other Suspension Orders	53	**38[5]**
License Restrictions/Suspensions/Temporary Restraining Orders Sought and Granted by Case Type		
NOTE: *Some orders granted were sought in prior FY.*	Sought	**Granted**
Gross Negligence/Incompetence	2	**3**
Inappropriate Prescribing	9	**8**
Unlicensed Activity	0	**0**
Sexual Misconduct	6	**5**
Mental/Physical Illness	12	**6**
Self-Abuse of Drugs or Alcohol	12	**11**
Fraud	7	**5**
Criminal Charges/Conviction of a Crime	5	**1**
Unprofessional Conduct	14	**13**
Total	67	**52**

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

2 Effective 7/1/14, the Board's sworn staff within the Enforcement Program transferred to the Division of Investigation's Health Quality Investigation Unit. The authority to issue a citation by the Enforcement Program was lost due to this transition. The statistic reflects citations issued by the Board's Chief of Licensing only.

3 Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation.

4 Pursuant to B&P Code §2220.05 (c), ISOs and TROs were granted in the following priority categories: 0-gross negligence/incompetence resulting in death or serious bodily injury, 0-drug or alcohol abuse involving death or serious bodily injury, 1-excessive prescribing, 1-sexual misconduct with a patient, and 1-practicing under the influence of drugs/alcohol.

5 Includes 4-Automatic Suspension Orders per B&P Code §2236, 7-license restrictions per Penal Code §23, 7-license restrictions pursuant to court order, 11-out-of-state suspension orders per B&P Code §2310, 0-stipulated agreement to suspend or restrict the practice of medicine, and 9-suspension/cease practice orders issued for violation of probation condition.

Enforcement Program Action Summary
Physicians & Surgeons

Reports Per Business and Professions Code Sections 805 & 805.01

	805	805.01
Total Reports Received	96	4
Peer Review Body Type		
Health Care Facility/Clinic	53	4
Surgical Center	1	0
Health Care Service Plan	24	0
Professional Society	0	0
Medical Group/Employer	18	0
Outcomes of Reports Received		
Accusation Filed	0	0
Pending Disposition	30	4
Cases Closed	66	0

Enforcement Processing Time Frames

Average and median time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review:

	FY 13-14[1]		FY 14-15	
	AVG	MED	AVG	MED
Complaint Process	67	43	**141**	**113**
Investigation Process (Non-Sworn & Sworn)	245	205	**N/A**	**N/A**
Investigation Process (Non-Sworn)	N/A	N/A	**91**	**57**
Investigation Process (Sworn)	N/A	N/A	**310**	**292**
AG Process (time to file accusation)	110	86	**92**	**66**
Other stages of the legal process (e.g., after charges filed)	443	402	**417**	**382**

[1] The report used to obtain this information does not accurately exclude the days between any closed and reopened activities, resulting in the number of days being greater than the actual number of days to complete these processes.

Enforcement Field Operations Caseload	FY 14-15[1]	
Health Quality Investigation Unit Caseload[2]	**Statewide**	**Per Investigator**
Active investigations	1,087	14
AG assigned cases[3]	465	6
Probation Unit Caseload[4]	**Statewide**	**Per Inspector**
Monitoring Cases[5]	614	36

[1] Average is determined by using the total number of authorized positions, including vacant positions.
[2] Includes physicians and surgeons, licensed midwives, research psychoanalysts, dispensing opticians program, outpatient surgery settings, polysomnographic program, doctors of podiatric medicine, physician assistants, psychologists, and osteopathic physicians and surgeons.
[3] These cases are at various stages of AG processing and may require supplemental investigative work, such as subpoena services, interviewing new victims or witnesses, testifying at hearings, etc.
[4] Includes physicians and surgeons, licensed midwives, research psychoanalysts, and dispensing opticians program.
[5] 89 additional monitoring cases were inactive because the probationer was out of state as of June 30, 2015.

Administrative Outcomes by Case Type[1]

	Revocation	Surrender	Suspension Only	Probation with Suspension	Probation	Probationary License Issued	Public Reprimand	Other Action	**Total Actions**
Gross Negligence/ Incompetence	6	16	0	1	40	0	53	2	**118**
Inappropriate Prescribing	9	15	0	2	18	0	2	1	**47**
Unlicensed Activity	1	3	0	1	4	0	3	0	**12**
Sexual Misconduct	4	2	0	3	2	0	0	0	**11**
Mental/Physical Illness	6	19	0	0	11	0	0	0	**36**
Self-Abuse of Drugs/Alcohol	5	12	0	4	26	0	0	0	**47**
Fraud	3	5	0	2	1	0	0	0	**11**
Conviction of a Crime	1	2	0	1	2	0	6	0	**12**
Unprofessional Conduct	10	11	0	0	18	10	22	0	**71**
Miscellaneous Violations	0	0	0	0	0	0	0	0	**0**
Totals by Discipline Type	**45**	**85**	**0**	**14**	**122**	**10**	**86**	**3**	**365**

[1] Pursuant to B&P Code §2220.05(c), disciplinary actions were taken in the following priority categories: 26 - gross negligence/incompetence resulting in death or serious bodily injury, 0 - practicing under the influence resulting in death or serious bodily injury, 26 - excessive prescribing, 7 - sexual misconduct with a patient, and 10 - practicing under the influence of drugs/alcohol.

Enforcement Action Summary

Allied Health Care Professions[1]

	FY 13-14[1]	**FY 14-15[2]**
Complaints/Investigations		
Complaints received	126	**216**
Complaints closed by Complaint Unit	58	**184**
Investigations		
Cases opened	54	**34**
Cases closed	46	**55**
Cases referred to the AG	5	**6**
Cases referred for criminal action	2	**0**
Number of Probation Violation Reports referred to AG	0	**0**
License Restrictions/Suspensions Imposed While Administrative Action is Pending		
Interim Suspension Orders	0	**0**
Other Suspension Orders[2]	0	**1**
Administrative Actions		
Accusation	7	**4**
Petition to Revoke Probation	0	**0**
Amended Accusation/Petition to Revoke Probation	0	**0**
Statement of Issues to deny application	0	**0**
Number of completed investigations referred to AG's Office awaiting the filing of an Accusation as of June 30, 2015	0	**1**

[1] Allied Health Care Professionals include information for the programs under the Board only – licensed midwives, research psychoanalysts, dispensing opticians program, outpatient surgery settings, and polysomnographic program.
[2] Includes 1 license restriction per Penal Code §23 for the dispensing opticians program.
[3] Penalty Relief includes Petitions for Modification of Penalty and Petitions for Termination of Probation.

	FY 13-14[1]	**FY 14-15[2]**
Administrative Outcomes		
Revocation	2	**3**
Surrender (in lieu of Accusation or with Accusation pending)	1	**1**
Probation with Suspension	0	**0**
Probation	0	**1**
Probationary License Issued	0	**0**
Public Reprimand	0	**2**
Other Actions (e.g., exam required, Education course, etc.)	0	**0**
Statement of Issues Granted (License Denied)	0	**0**
Statement of Issues Denied (License Granted)	0	**0**
Accusation/Statement of Issues Withdrawn	0	**0**
Accusation Dismissed	0	**0**
Dispositions of Probation Filings		
Additional Probation or Suspension	0	**0**
Probation Revoked or License Surrendered	0	**0**
Petition Withdrawn or Dismissed	0	**0**
Referral and Compliance Actions		
Citation and Administrative Fines Issued	0	**0**
Office Conferences Conducted	0	**0**
Petition Activity		
Petition for Reinstatement of License filed	0	**0**
Petition for Reinstatement of License granted	0	**1**
Petition for Reinstatement of License denied	0	**0**
Petition for Penalty Relief granted[3]	0	**0**
Petition for Penalty Relief denied[3]	0	**0**
Petition to Compel Exam granted	0	**0**
Petition to Compel Exam denied	0	**0**

Medical Board of California

Fiscal Year 2014 - 2015
Board Members

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Barbara Yaroslavsky
Felix Yip, M.D.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: January 6, 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 1065 experts in the Board's expert database. 293 experts were utilized to review 555 cases between January and December 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

In Mid-November, one of the analyst positions in the Expert Reviewer Program became vacant. Recruitment efforts to fill this position were initiated and interviews are scheduled to be conducted at the end of January. The vacancy caused some delay in moving forward with the Board's recruitment plan to expand the number of experts within the aforementioned specialty fields of medicine. However, staff will resume efforts to implement the plan after the new employee is hired. Meanwhile, the Board continues to advertise in its quarterly Newsletter, encouraging physicians to become participants of the Expert Reviewer Program.

The Expert Reviewer training is tentatively scheduled for March 19, 2016 at UC San Diego School of Medicine. As soon as the contract for services is finalized, invitations to participate in the training will be sent out to the experts. Additionally, the Program is looking into the possibility of conducting a second training session this summer in Southern California at the UCLA School of Medicine.

Staffing Update:
The Board recently received approval for the establishment of an additional Staff Services Manager II position within the Enforcement Program. Ms. Romero will remain the Staff Services Manager II responsible for overseeing the Central Complaint Unit's (CCU) Quality of Care, Physician Conduct and

Data Integrity Sections. The new manager will be responsible for oversight of the Complaint Investigation Office (CIO), the Discipline Coordination Unit (DCU), and the Probation Unit. Interviews for this position are expected to be conducted by February 2016.

I am pleased to report that the CCU, the CIO, and the DCU are all fully staffed as of January 2016. The new employees hired in the CCU and the CIO in the last quarter of 2015 are contributing greatly to their respective units as they each continue with their training.

In the Probation Unit, the LA Metro office filled their vacant Inspector I position and the new employee reported to work on November 2, 2015. The Northern California office has one vacant Inspector I position and one vacant Associate Governmental Program Analyst position. Interviews for these vacancies are expected to be conducted in February 2016. In addition, Staff Services Manager I Catherine Hayes retired from state service effective December 30, 2015. Ms. Hayes came to the Board in 2008 and played an integral part in the creation of the Probation Unit. The vast knowledge and insight she brought to the Probation Unit will be greatly missed. Interviews to fill this vacant Staff Services Manager I position will also be conducted in February 2016.

Finally, as previously stated, there is one vacant Associate Governmental Program Analyst position within the Board's Expert Reviewer Program.

Central Complaint Unit:

The number of days it takes to initiate a complaint during the second quarter of fiscal year 2015/2016 has increased to an average of seventeen (17) days. Staff continues to work on reducing this timeframe to ten (10) days to ensure compliance with Business and Professions Code Section 129 but it is evident further assistance is needed. As such, management is currently drafting a justification, for department approval, to hire one additional Management Services Technician to perform this function.

Case reviews for all CCU analysts were completed in November 2015 and staff is now using the instruction and guidance provided by management to aid in their efforts to reduce the number of days needed to complete the processing of complaints.

Complaint Investigation Office:

Petitions for Modification and/or Early Termination of Probation were temporarily redirected from the Probation Unit to the CIO. The vacant Probation Unit analyst position is assigned this workload, however to mitigate an increasing backlog and to address the request timely, the workload was redirected. This has resulted in the Special Investigators (non-sworn) seeing a slight increase in their caseload. Each Special Investigator is now assigned, approximately, 40-45 cases. Since the last summary report in October 2015, the unit has closed fifty-eight (58) cases and has transmitted three (3) cases to the Attorney General's Office; one (1) Petition for Reinstatement and two (2) medical malpractice cases.

Discipline Coordination Unit:

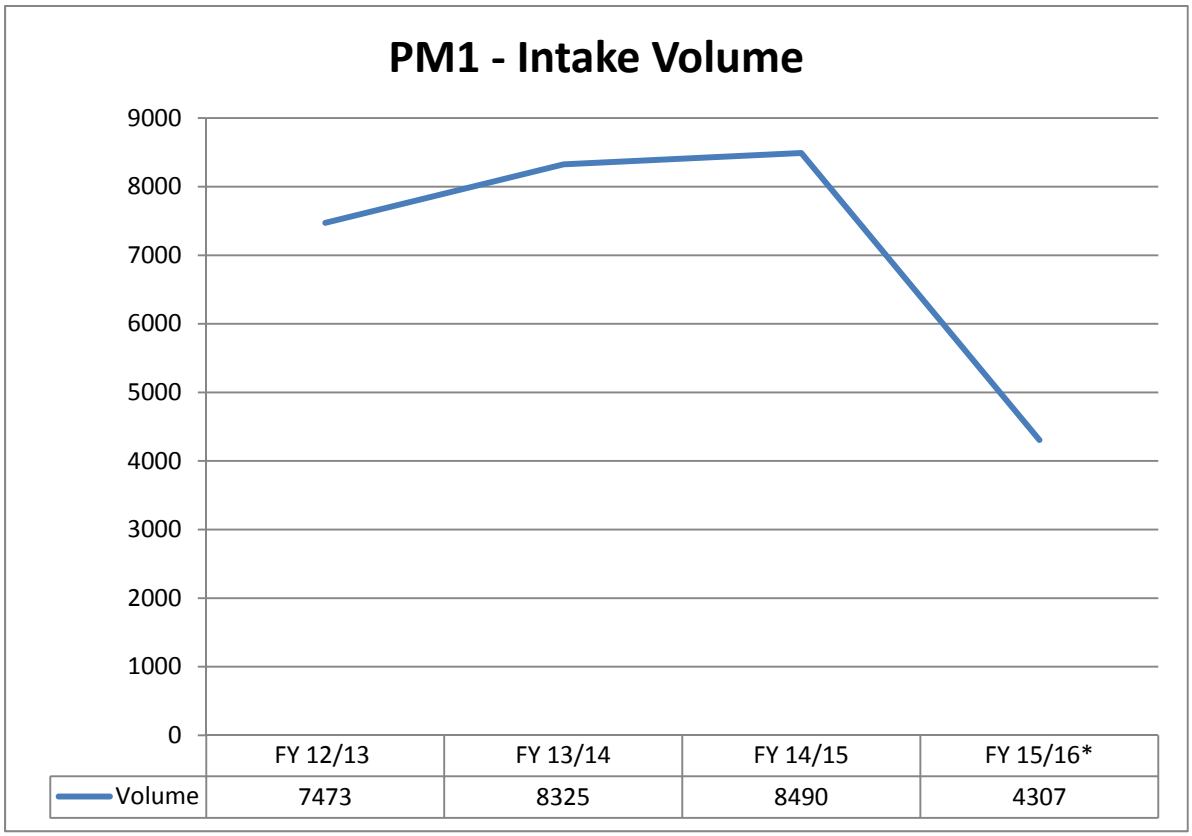
Staff in the DCU continues to focus their efforts on restoring public disciplinary documents to the Board's website to ensure compliance with Assembly Bill 1886. Staff has worked overtime in an attempt to complete the project and also follows a daily schedule to guarantee time is spent on the project, however, additional attention is still needed. As such, the Enforcement Program has received approval to hire two Student Assistants to aid in finalizing this project. Interviews for the two students are expected to occur at the beginning of February 2016.

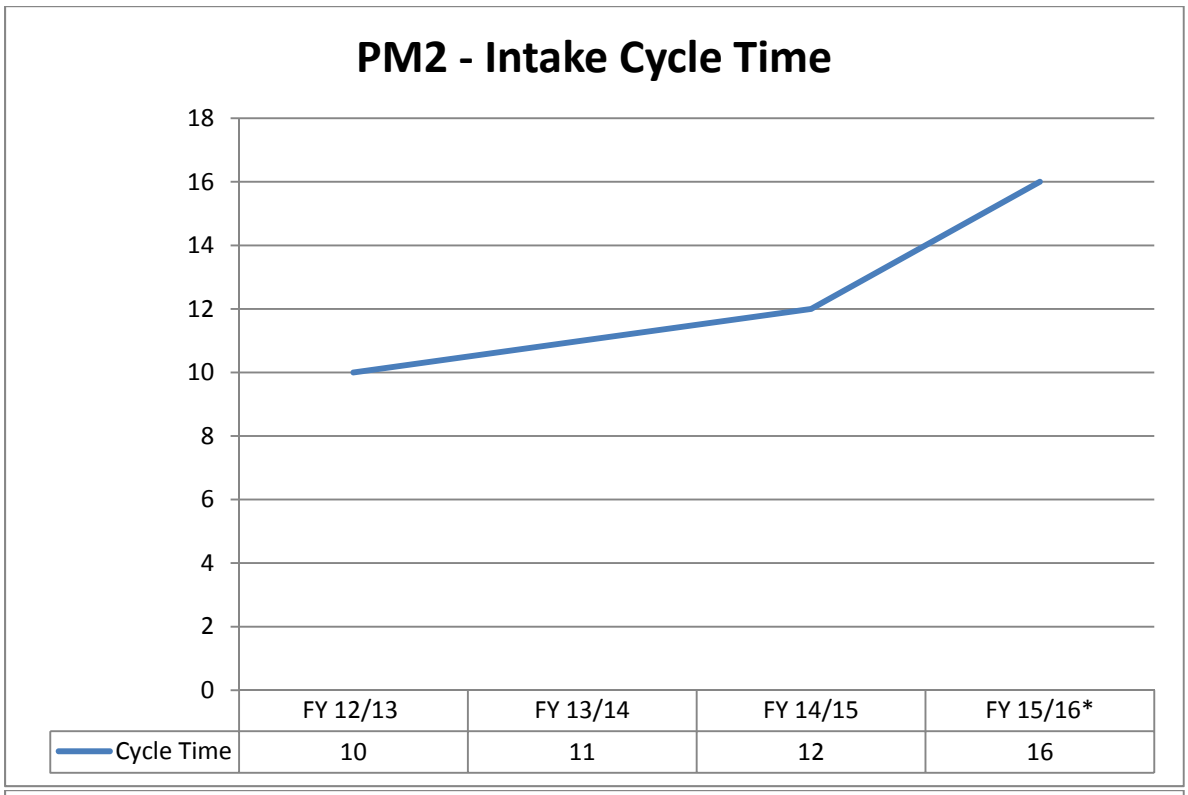
Probation Unit:
With the retirement of Ms. Hayes, coupled with the approval to hire a new Manager II position, the meeting to discuss and develop a comprehensive training plan for the unit's inspectors was placed on hold until the two new managers are hired. It is crucial to afford the new managers the opportunity to participate in the development of the unit's training plan.

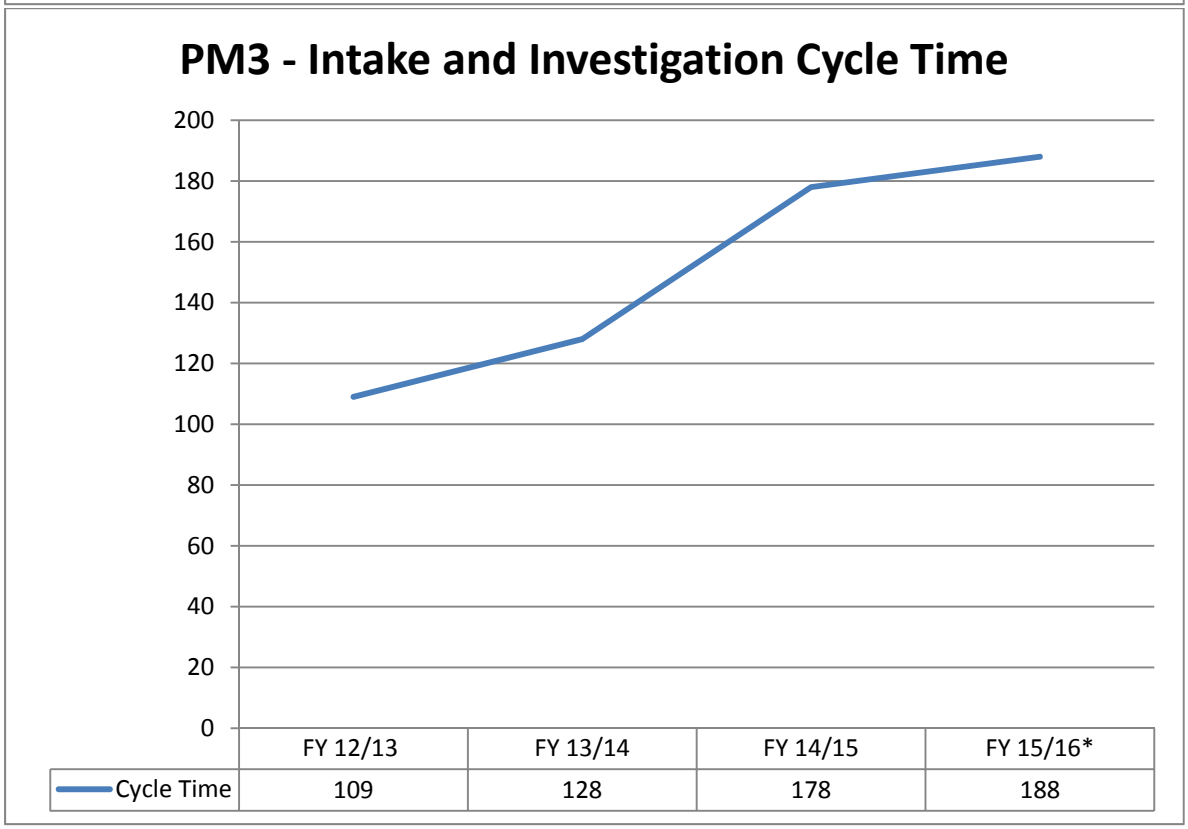
On January 5, 2015, Enforcement Committee Chair Dr. Yip spent the entire day with management and Probation North staff discussing how the Probation Unit operates. Dr. Yip reviewed the daily functions performed by staff and the methods used by staff to monitor the terms and conditions for a licensee on probation to ensure compliance. The meeting was very productive and some new policies and procedures to streamline and improve the process will be implemented based upon the meeting.

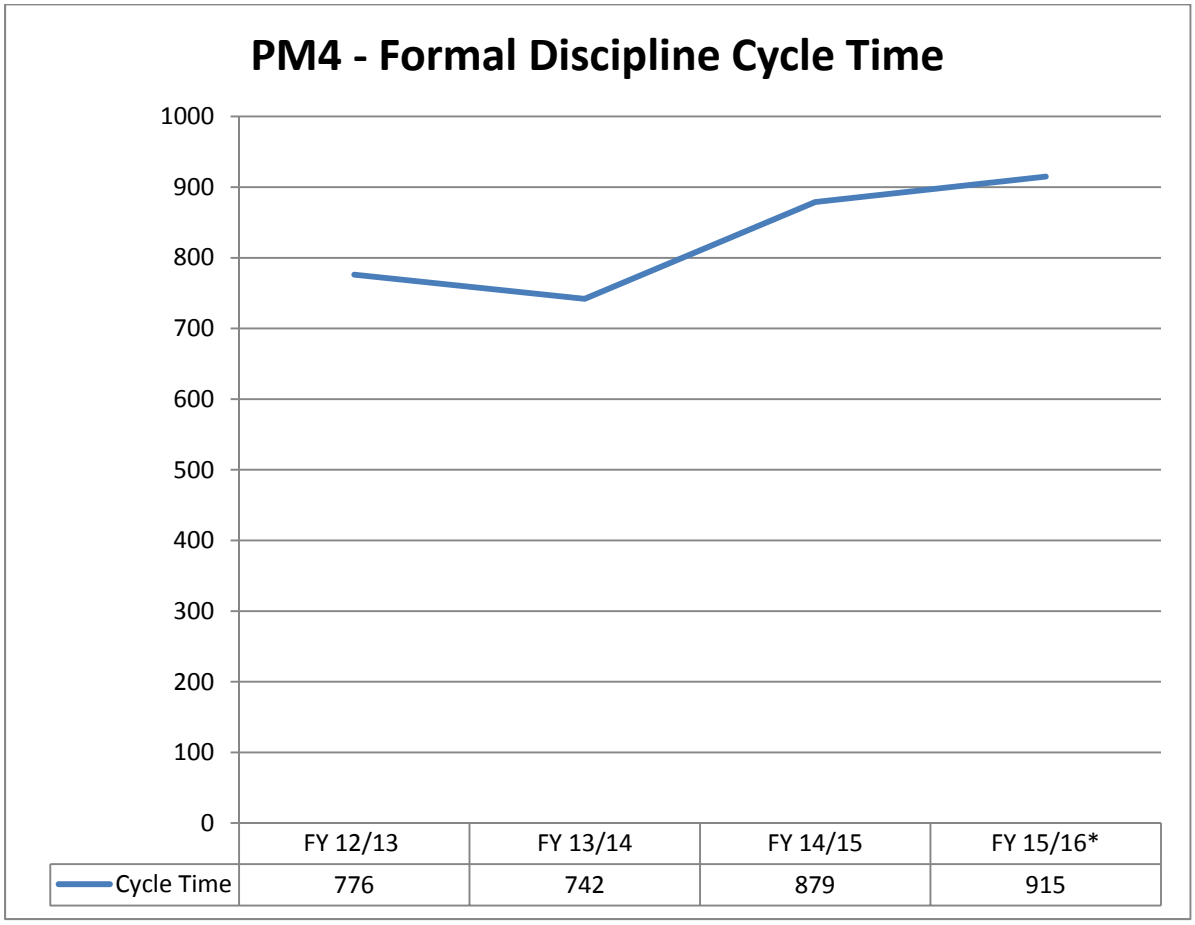
Enforcement Performance Measures:
The charts below depict workload statistics regarding the number of complaints received (PM 1; includes complaints and arrest notifications), processing times to initiate a complaint and assign it to a desk analyst (PM 2), complete an investigation (for both sworn, non-sworn, and desk investigations) (PM 3), and the average number of days it takes to complete a case that has been transmitted to the Attorney General for disciplinary action (PM 4).

*The FY 15/16 numbers represented are for the time period July 1 to December 31, 2015.




PM2 - Intake Cycle Time
18
16
14
12
10
8
6
4
2
0
FY 12/13
FY 13/14
FY 14/15
FY 15/16*
Cycle Time
10
11
12
16


PM3 - Intake and Investigation Cycle Time
200
180
160
140
120
100
80
60
40
20
0
FY 12/13
FY 13/14
FY 14/15
FY 15/16*
Cycle Time
109
128
178
188


PM4 - Formal Discipline Cycle Time
1000
900
800
700
600
500
400
300
200
100
0
FY 12/13
FY 13/14
FY 14/15
FY 15/16*
Cycle Time
776
742
879
915

Medical Board of California
Expert Reviewer Program Report

December 31, 2015

SPECIALTY	Number of cases reviewed by Experts January 1 through December 31, 2015	Number of Experts and how often utilized from January 1 through December 31, 2015	Active List Experts 1,065↑
ADDICTION	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA	9 ↓
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes)	11	6 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 7 CASES	79 ↑
COLON & RECTAL SURGERY (CRS)			3
COMPLEMENTARY/ALTERNATIVE MEDICINE	6	2 EXPERTS 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	18 ↑
DERMATOLOGY (D)	5	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 3 CASES	12
EMERGENCY (EM)	16	8 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 8 CASES	45 ↑
FAMILY (FM)	83	33EXPERTS 17 LIST EXPERTS REVIEWED 1 CASE EA 6 LIST EXPERTS REVIEWED 2 CASES EA 2 LIST EXPERTS REVIEWED 3 CASES EA 2 LIST EXPERTS REVIEWED 4 CASES EA 2 LIST EXPERTS REVIEWED 5 CASES EA 1 LIST EXPERT REVIEWED 6 CASES 1 LIST EXPERT REVIEWED 7 CASES 1 LIST EXPERT REVIEWED 9 CASES 1 LIST EXPERT REVIEWED 13 CASES	63 ↓
HAND SURGERY	1	1 EXPERT 1 LIST EXPERT	11↓
HOSPICE & PALLIATIVE MEDICINE	1	1 EXPERT 1 LIST EXPERT	15
INTERNAL (General Internal Med)	67	42 EXPERTS 27 LIST EXPERTS REVIEWED 1 CASE EA 5 LIST EXPERTS REVIEWED 2 CASES EA 5 LIST EXPERTS REVIEWED 3 CASES EA 2 LIST EXPERTS REVIEWED 4 CASES EA 3 LIST EXPERTS REVIEWED 5 CASES EA	151 ↓
Cardiovascular Disease (Cv)	10	6 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 3 CASES EA 1 LIST EXPERT REVIEWED 4 CASES EA	33 ↑

Medical Board of California
Expert Reviewer Program Report

December 31, 2015

SPECIALTY	Number of cases reviewed by Experts January 1 through December 31, 2015	Number of Experts and how often utilized from January 1 through December 31, 2015	Active List Experts 1,065↑
Endocrinology (EDM)	2	2 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA	6 ↑
Gastroenterology (Ge)	10	6 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 4 CASES	20 ↓
Nephrology (Nep)			11
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	4 ↓
NEUROLOGICAL SURGERY (NS)	8	6 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA	10
NEUROLOGY (N)	19	9 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 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	21 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3
NUCLEAR MEDICINE (NuM)			4
OBSTETRICS & GYNECOLOGY (ObG)	40	23 EXPERTS 11 LIST EXPERTS REVIEWED 1 CASE EA 7 LIST EXPERTS REVIEWED 2 CASES EA 2 LIST EXPERTS REVIEWED 3 CASES EA 2 LIST EXPERTS REVIEWED 4 CASES EA 1 LIST EXPERT REVIEWED 7 CASES	62
OCCUPATIONAL MEDICINE	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EA	6

Medical Board of California
Expert Reviewer Program Report

December 31, 2015

SPECIALTY	Number of cases reviewed by Experts January 1 through December 31, 2015	Number of Experts and how often utilized from January 1 through December 31, 2015	Active List Experts 1,065↑
OPHTHALMOLOGY (Oph)	13	8 EXPERTS 4 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	26
ORTHOPAEDIC SURGERY (OrS)	10	8 EXPERTS 7 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 3 CASES	30
OTOLARYNGOLOGY (Oto)	1	1 EXPERT 1 LIST EXPERT	17 ↑
PAIN MEDICINE (PM)	30	15 EXPERTS 9 LIST EXPERTS REVIEWED 1 CASE EA 2 LIST EXPERTS REVIEWED 2 CASES EA 1 LIST EXPERT REVIEWED 3 CASES 3 LIST EXPERTS REVIEWED 5 CASES EA	28 ↓
PATHOLOGY (Path)	6	5 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 3 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES	12 ↑
PEDIATRICS (Ped)	8	6 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	47 ↓
Pediatric Cardiology (Cd)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE	4 ↓
PHYSICAL MEDICINE & REHABILITATION (PMR)			10
PLASTIC SURGERY (PIS)	43	16 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 3 LIST EXPERTS REVIEWED 2 CASES EA 4 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 7 CASES	36 ↓

Medical Board of California
Expert Reviewer Program Report

December 31, 2015

SPECIALTY	Number of cases reviewed by Experts January 1 through December 31, 2015	Number of Experts and how often utilized from January 1 through December 31, 2015	Active List Experts 1,065↑
PSYCHIATRY (Psyc)	141	53 EXPERTS 2 OFF LIST EXPERTS REVIEWED 1 CASE EA 25 LIST EXPERTS REVIEWED 1 CASE EA 7 LIST EXPERTS REVIEWED 2 CASES EA 5 LIST EXPERTS REVIEWED 3 CASES EA 5 LIST EXPERTS REVIEWED 4 CASES EA 2 LIST EXPERTS REVIEWED 5 CASES EA 2 LIST EXPERTS REVIEWED 6 CASES EA* 1 LIST EXPERT PERFORMED 7 EVALUATIONS 1 LIST EXPERT PERFORMED 8 EVALUATIONS 1 LIST EXPERT REVIEWED 3 CASES AND PERFORMED 6 EVALUATIONS 1 LIST EXPERT REVIEWED 5 CASES AND PERFORMED 9 EVALUATIONS 1 LIST EXPERT REVIEWED 6 CASES, PREP. FOR HEARING 1 CASE, ADMINISTERED PROBATION PCE-1 CASE AND PERFORMED 16 EVALUATIONS	69 ↓
RADIOLOGY (Rad) *COMPANION CASES (5 CASES/2 SUBJECTS)	9	6 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 5 CASES*	29 ↑
Radiation Oncology (Rad RO)			5
SLEEP MEDICINE (S)	2	2 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	7
SURGERY (S)	21	15 EXPERTS 1 OFF LIST EXPERT REVIEWED 1 CASE 10 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERTS REVIEWED 2 CASES 2 LIST EXPERTS REVIEWED 3 CASES EA 1 LIST EXPERT REVIEWED 4 CASES	29
Pediatric Surgery (PdS)			2
VASCULAR SURGERY (VASCS)	2	3 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EA	7

Medical Board of California
Expert Reviewer Program Report

December 31, 2015

SPECIALTY	Number of cases reviewed by Experts January 1 through December 31, 2015	Number of Experts and how often utilized from January 1 through December 31, 2015	Active List Experts 1,065↑
THORACIC SURGERY (TS)	1	1 EXPERT 1 LIST EXPERT	10 ↓
TOXICOLOGY	1	1 EXPERT 1 LIST EXPERT	7
UROLOGY (U)	11	8 EXPERTS 7 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 6 CASES	12 ↓

TOTAL CASES REVIEWED (Calendar Year 2015)	**555**
TOTAL EXPERTS UTILIZED (Calendar Year 2015)	**293**
TOTAL ACTIVE LIST EXPERTS (Dec 31, 2015)	**1,065**

↓↑ Numbers fluctuate based on availability of experts, new experts added and experts removed from the program.

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: January 6, 2016
ATTENTION: Members, Medical Board of California
SUBJECT: Licensing Program Summary
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
The Licensing Program staffing level during the second quarter was low due to staff being out of the office for unplanned leaves, vacations, and several vacant positions. However, staff continued to work hard in the second 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 Assistant - Cashiering
- 1 Office Technician – Cashiering (in the final hiring process)
- 3 Management Services Technician - US/CAN P&S Application Reviewer (in the final hiring process)
- 1 Staff Services Analyst (in the final hiring process)
- 1 Staff Services Manager II - Licensing

Staff Training:
All of the above listed vacant positions will be in training during the third quarter.

STATISTICS:
The statistics are on pages BRD 6C - 3 through BRD 6C - 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: 18,804
  - 888 less calls answered than the previous quarter
- Consumer Information Unit telephone calls abandoned: 4,374
  - 4,539 less abandon calls than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 5,731
  - 7,057 less call back requests than the previous quarter
- P&S applications initial review completed: 1,553
- P&S licenses issued: 1,425
  - This is an increase of 188 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 nine (9) weeks out of the 13 weeks in the second quarter of

FY 2015-16. The highest number of days the initial goal was exceeded was 23 days. Licensing had several staff out of the office during this time frame. Staff is working to reduce these numbers.

INTERNATIONAL MEDICAL SCHOOLS:
The statistics for the International Medical School Reviews are on page BRD 6C – 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 recognition of an International Program at the January 22, 2016 Board meeting.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:
The Board has two pending applications 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:

License Fairs:

- October 9: Kaiser Los Angeles (and surrounding hospitals/clinics); approximately 85 residents
- October 16: Cedars Sinai; approximately 45 residents
- October 21: St Mary's Long Beach; approximately 30 residents
- October 22: Children's Hospital LA; approximately 45 residents
- October 28-29: UCLA (and affiliated hospitals/clinics); approximately 60 residents
- October 29: Olive View/UCLA; approximately 20 residents
- November 3: LAC and USC; approximately 40 residents
- November 4: Loma Linda; approximately 100 residents
- November 5-6: combined license fair for Kaiser Fontana, Arrowhead, UCRiverside; approximately 30 residents
- November 18: an in-service workshop for program coordinators at UCSF; approximately 45-50 staff

Licensing Program Report

WORKLOAD REPORT
as of December 31, 2015

Fiscal Year 2015-2016

CONSUMER INFORMATION UNIT FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**38,496**	19,692	18,804		
Calls Requesting Call Back	**18,519**	12,788	5,731		
Calls Abandoned	**13,287**	8,913	4,374		
Address Changes Completed	**2,388**	1,438	950		

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	**4,158**	2,494	1,664		
Initial Reviews Completed	**2,894**	1,341	1,553		
Total Pending	**0**	N/A			
Reviewed	**0**	N/A			
Not Reviewed	**0**	N/A			
(SR2s Pending)	**73**	35	38		
Licenses Issued	**2,662**	1,237	1,425		
Renewals Issued	**33,360**	17,123	16,237		

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

Licensing Program Report

WORKLOAD REPORT
as of December 31, 2015

Fiscal Year 2015-2016

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Beginning	**N/A**	7	**9**		
Received	**4**	4	0		
Reviewed	**4**	4	0		
Not Eligible	**0**	0	0		
Licensed	**6**	2	4		

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	**15**	7	8		
PG/Medical Knowledge	**39**	16	23		
Convictions	**25**	17	8		
Other	**63**	31	32		

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

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INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Schools Pending Recognition at Beginning of Quarter	**N/A**	107	114		
Pending Self-Assessment Reports (included above)	**N/A**	7	7		
New Self-Assessment Reports Received	**0**	0	0		
New Unrecognized Schools Received	**26**	13	13		
School Recognized Pursuant to CCR 1314(a)(1)	**10**	6	4		
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0		
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	114	123		

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	**1**	0	1		
Applications Pending	**N/A**	1	2		

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	**3**	1	2		
RP Licenses Issued	**4**	3	1		

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

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LICENSED MIDWIVES FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**9**	5	4		
Applications Pending	**N/A**	2	3		
Applications Withdrawn	**1**	1	0		
Licenses Issued	**11**	8	3		
Licenses Renewed	**80**	37	43		

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	**670**	375	295		
P&S - FNP Issued	**592**	324	268		
P&S - FNP Pending	**N/A**	N/A	N/A		
P&S - FNP Renewed	**2,458**	1,337	1,121		
Podiatric FNP Received	**13**	6	7		
Podiatric FNP Issued	**15**	6	9		
Podiatric FNP Pending	**N/A**	N/A	N/A		
Podiatric FNP Renewed	**71**	36	35		

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

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OPTICAL REGISTRATIONS FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
RDO - Business Registrations Issued	**38**	18	20		
RDO - Pending Applications Business	**N/A**	15	16		
CLS - Out-of-State - Business Registrations Issued	**0**	0	0		
CLS - Pending Out of State Applications -Business	**2**	1	1		
Spectacle Lens Registrations Issued	**138**	62	76		
Spectacle Lens - Pending Applications	**N/A**	26	31		
Contact Lens Registrations Issued	**36**	15	21		
Contact Lens - Pending Applications	**N/A**	5	6		
Spectacle Lens Registrations Renewed	**462**	214	248		
Contact Lens Registrations Renewed	**199**	93	106		

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

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SPECIAL PROGRAMS
FY 15/16

Permit	Applications Received				Applications Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn or Denied			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	22	3			13	12			14	11			14	6			17	9			0	0		
2112	1	1			1	1			0	1			0	0			1	1			0	0		
2113	6	6			4	4			5	10			18	10			15	11			0	0		
2168	0	2			0	2			2	0			2	2			0	2			0	0		
2072	0	0			0	0			0	0			0	0			0	0			0	0		
1327	0	0			0	0			0	0			0	0			0	0			0	0		

SPECIAL PROGRAMS
FY 14/15

Permit	Applications Received				Reviewed				Permits Issued				Permits Renewed				Total Pending				Applications Withdrawn or			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
2111	18	10	3	6	16	12	7	6	12	11	10	4	11	13	3	6	15	14	7	9	0	0	0	0
2112	0	0	1	0	0	0	0	1	1	1	0	1	0	0	0	0	1	0	1	0	0	0	0	0
2113	1	3	6	6	11	3	4	8	8	9	4	5	21	12	7	12	17	11	13	14	0	0	0	0
2168	0	2	0	0	2	2	0	0	0	0	3	0	4	3	1	4	3	5	2	2	0	0	0	0
2072	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
1327	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1	0	0	0	0	0	0	0	0

2111 - Visiting Fellow (doesn't satisfy postgraduate training required for licensure)
2112 - Hospital Fellowship Program Non-Citizen (does not satisfy postgraduate training required for licensure)
2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)
2168 - Special Faculty Permit (academically eminent; unrestricted practice within sponsoring medical school - not eligible for licensure)
2072 - Special Permit - Correctional Facility
1327 - Medical Student Rotations - Non-ACGME Hospital Rotation

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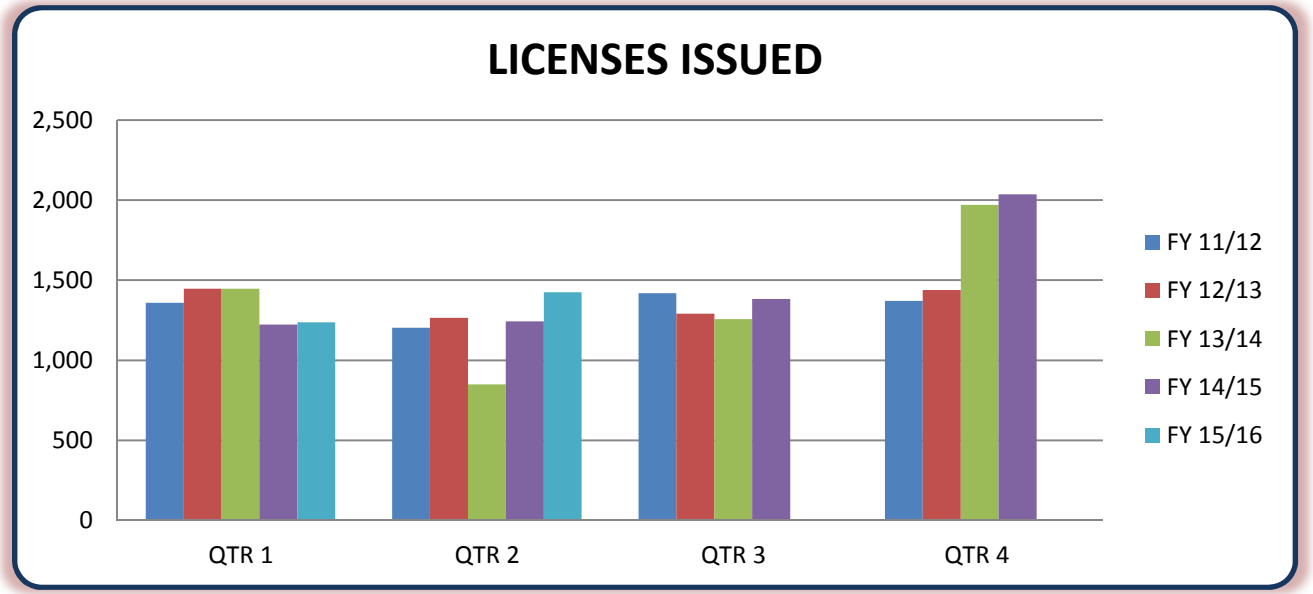
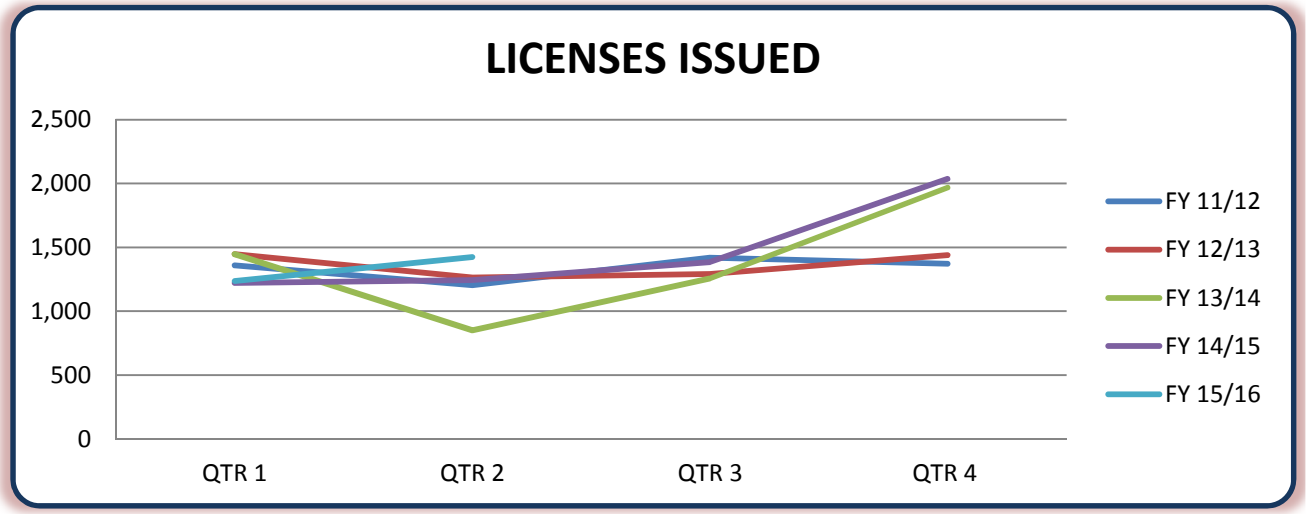
PHYSICIAN'S AND SURGEON'S LICENSES ISSUED Five Fiscal Year History					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 15/16	1,237	1,425			***2,662***
FY 14/15	1,222	1,243	1,383	2,035	***5,883***
FY 13/14	1,447	849	1,257	1,969	***5,522***
FY 12/13	1,447	1,264	1,291	1,438	***5,440***
FY 11/12	1,358	1,203	1,419	1,371	***5,351***





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Fiscal Year 2015-2016

*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED Five Fiscal Year History					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 15/16	2,494	1,664			**4,158**
FY 14/15			1,967	1,516	**6,850**
FY 13/14					***6,308***
FY 12/13	1,722	1,715	1,708	1,552	***6,697***
FY 11/12	1,711	1,666	1,862	1,390	***6,629***

CURES 2.0 UPDATE

Notice: All California-licensed health care practitioners authorized to prescribe Schedule II-IV controlled substance, and all pharmacists with an active license must be registered to use CURES before July 1, 2016. You must register for CURES access if you meet these criteria, even if you do not actively prescribe or dispense.

On January 8, 2016, the Department of Justice (DOJ) will release the upgraded Controlled Substances Utilization Review and Evaluation System, also referred to as **CURES 2.0**.

In order to utilize CURES 2.0, a user must access the system through a secure browser. The following browsers are considered secure:

- Microsoft Internet Explorer version 11 or greater
- Google Chrome
- Mozilla Firefox
- Safari

CURES 2.0 offers a significantly improved user experience and increased functionality, including:

- Allowing approved delegates to run patient report queries that prescribers and dispensers can access,
- Sending peer-to-peer communications; and,
- Receiving patient alerts.

For those without a secure browser, access to CURES 1.0 will continue; however, none of the new CURES 2.0 performance or functionality features will be available in CURES 1.0.

In order to access CURES 2.0, a new streamlined registration process is being implemented. This new process will allow prescribers and dispensers to request and receive approval to access CURES entirely online.

For new users (those who have never accessed the CURES system):

- Regardless of the browser you utilize, you must register for CURES access via a secure browser.
- To register, visit http://www.oag.ca.gov/cures, click on the registration link, and follow the instructions.
- Only California-licensed prescribers and dispensers can register. You will need your state license information and prescribers must provide federal DEA license information to register. You must provide your information for CURES access specifically as directed by DOJ. This information will be verified with the Drug Enforcement Agency and the regulatory board issuing your license. Failure to provide accurate information may result in a delay of approval for accessing CURES.
- Once you have been approved for CURES access by DOJ, you can access CURES 1.0 or 2.0 depending on which browser you utilize to query the system.

For existing CURES users:

- If you do not utilize a secure browser, you can continue accessing CURES 1.0 on your current browser.
- Regardless of what browser you will utilize, you will need to confirm your account with DOJ and update security information the first time you access CURES on January 8.

For those who have submitted a paper application to DOJ:

- You can either apply for CURES access on a secure browser as a new user or continue to wait for processing and approval from DOJ for access to CURES, at which point, you can utilize either CURES 1.0 or 2.0 depending on your browser.

To learn more, visit http://oag.ca.gov/cures-pdmp/faqs. For assistance, contact the CURES helpdesk at (916) 227-3843 or cures@doj.ca.gov.

FREQUENTLY ASKED QUESTIONS

What information may be obtained from CURES?

The Controlled substance Utilization Review and Evaluation System (CURES) stores Schedule II, III, and IV controlled substance prescription information reported as dispensed in California. CURES contains the following information: patient name, patient date of birth, patient address, prescriber name, prescriber DEA number, pharmacy name, pharmacy license number, date prescription was dispensed, prescription number, drug name, drug quantity and strength, and number of refills remaining.

Who has access to CURES information?

As outlined in Health & Safety Code section 11165.1(a)(1)(A), prescribers authorized to prescribe, order, administer, furnish, or dispense Schedule II, III, or IV controlled substances, and pharmacists, may access CURES data for patient care purposes.

Additionally, pursuant to Health & Safety Code section 11165(c)(2), CURES data is available to appropriate state, local, and federal public agencies, law enforcement, and regulatory boards for disciplinary, civil, or criminal purposes. The Department of Justice (DOJ) may also provide data to other agencies and entities for educational, peer review, statistical, or research purposes, provided that patient identity information is not disclosed.

Who is required to register for CURES?

Prescribers must submit an application before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later. Registration requirements are not based on dispensing, prescribing, or administering activities but, rather, on possession of a Drug Enforcement Administration Controlled Substance Registration Certificate AND valid California licensure as any one of the following:

Dentist	Physician Assistant
Medical Physician	Podiatrist

Naturopathic Physician	Registered Certified Nurse Midwife
Optometrist	Registered Nurse Practitioner (Furnishing)
Osteopathic Physician	Veterinarian

Pharmacists must submit an application before July 1, 2016, or upon licensure, whichever occurs later. Registration requirements are not based on dispensing, prescribing, or administering activities but, rather, on valid California licensure as a Pharmacist.

What do I do if the information in CURES is not correct?

Data contained in CURES is reported to the DOJ by pharmacies and direct dispensers. If you are a patient with incorrect information on your CURES report, please notify the reporting pharmacy of the error. Only the original reporting pharmacy or dispenser may submit prescription corrections to the DOJ.

For information on how to submit controlled substance prescription data or data corrections, pharmacies and direct dispensers may contact Atlantic Associates, Inc. by email at CACures@aainh.com or by phone at (800) 539-3370.

What Internet browsers are required for CURES 2.0 access?

CURES 2.0 users must use Microsoft Internet Explorer version 11.0 or higher, Mozilla Firefox, Google Chrome, or Safari. Earlier versions of Internet Explorer are not supported by CURES 2.0 for security considerations.

CURES 1.0 will continue to be made available to clinical users for an indeterminate time to facilitate uninterrupted access to CURES data while health care systems upgrade to CURES 2.0-compatible browsers.

What is the registration process for access to CURES 2.0?

Registration, for California licensed prescribers and pharmacists, is fully automated. Applicants must complete the online registration form and provide a valid email address, medical or pharmacist license number, and DEA registration certificate number (prescribers only.) DOJ will validate identity and license electronically with the Department of Consumer Affairs and the Drug Enforcement Administration.

Do current CURES 1.0 users need to re-apply for CURES 2.0 access?

No. Existing CURES users do not need to apply for access to CURES 2.0. These users are able to access the CURES 2.0 with their current User ID and password. Upon initial login to CURES 2.0, users are required to update their security questions and answers and re-establish a new password. The user must also review their CURES account profile to verify their information is accurate, make necessary updates, and acknowledge CURES Terms and Conditions. Once this has been completed, the user may begin searching patient prescription information in CURES 2.0.

What happens to providers who have submitted application documents under the old registration requirements but have not yet been granted access?

Prescribers and pharmacists who submitted application documents using the old registration method will continue to have their registrations processed. If approved, these applicants will be granted access to CURES.

If a current CURES user is locked out of the system, how can he/she regain access?

CURES 2.0 users are provided easy, intuitive, online assistance for password reset, forgot UserID and forgot password. Links to these services are on the CURES 2.0 login page. Additionally, users may contact the CURES Help Desk at (916) 227-3843 or cures@doj.ca.gov .

2016 Legislation

AB 611

AB 890

AB 1306

SB 22

SB 323

SB 482

SB 538

SB 622

AMENDED IN ASSEMBLY APRIL 15, 2015

AMENDED IN ASSEMBLY APRIL 13, 2015

AMENDED IN ASSEMBLY MARCH 24, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 611

Introduced by Assembly Member Dahle

February 24, 2015

An act to amend Section 11165.1 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 611, as amended, Dahle. Controlled substances: prescriptions: reporting.

Existing law requires certain health care practitioners and pharmacists to apply to the Department of Justice to obtain approval to access information contained in the Controlled Substance Utilization Review and Evaluation System (CURES) Prescription Drug Monitoring Program (PDMP) regarding the controlled substance history of a patient under his or her care. Existing law requires the Department of Justice, upon approval of an application, to provide the approved health care practitioner or pharmacist the history of controlled substances dispensed to an individual under his or her care. Existing law authorizes an application to be denied, or a subscriber to be suspended, for specified reasons, including, among others, a subscriber accessing information for any reason other than caring for his or her patients.

This bill would also authorize an individual designated to investigate a holder of a professional license to apply to the Department of Justice to obtain approval to access information contained in the CURES PDMP

regarding the controlled substance history of an applicant or a licensee for the purpose of investigating the alleged substance abuse of a licensee. The bill would, upon approval of an application, require the department to provide to the approved individual the history of controlled substances dispensed to the licensee. The bill would clarify that only a subscriber who is a health care practitioner or a pharmacist may have an application denied or be suspended for accessing subscriber information for any reason other than caring for his or her patients. The bill would also specify that an application may be denied, or a subscriber may be suspended, if a subscriber who has been designated to investigate the holder of a professional license accesses information for any reason other than investigating the holder of a professional license.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 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 January 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before January 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled

substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(iii) *(I)* An individual designated by a board, bureau, or program within the Department of Consumer Affairs to investigate a holder of a professional license may, for the purpose of investigating the alleged substance abuse of a licensee, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a licensee that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that individual the electronic history of controlled substances dispensed to the licensee based on data contained in the CURES PDMP. ~~An application for an individual designated by a board, bureau, or program that does not regulate health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150~~ *The application* shall contain facts demonstrating the probable cause to believe the licensee has violated a law governing controlled substances.

(II) This clause does not require an individual designated by a board, bureau, or program within the Department of Consumer Affairs that regulates health care practitioners to submit an application to access the information stored within 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 described in clause (i) or (ii) of subparagraph (A) accessing information for any other reason than caring for his or her patients.

(vi) Any subscriber described in clause (iii) of subparagraph (A) accessing information for any other reason than investigating the holder of a professional license.

(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 an authorized subscriber from the Department of Justice pursuant to this section shall be considered medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to an authorized subscriber 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.

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AMENDED IN ASSEMBLY MAY 5, 2015

AMENDED IN ASSEMBLY APRIL 20, 2015

AMENDED IN ASSEMBLY MARCH 26, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 890

Introduced by Assembly Member Ridley-Thomas

February 26, 2015

An act to add Chapter 7.75 (commencing with Section 3550) to Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 890, as amended, Ridley-Thomas. Anesthesiologist assistants.

Existing law provides for the licensure and regulation of specified healing arts licensees, including, among others, physicians and surgeons, physician assistants, nurses, and nurse anesthetists.

This bill would enact the Anesthesiologist Assistant Practice Act, which would make it unlawful for any person to hold himself or herself out as an anesthesiologist assistant unless he or she meets specified requirements. The bill would make it an unfair business practice to violate these provisions. The bill would require an anesthesiologist assistant to work under the *direction and* supervision of an anesthesiologist, and would require the anesthesiologist to be physically present on the premises and immediately available ~~if needed~~ to the anesthesiologist assistant when medical services are being rendered and to oversee the activities of, and accept responsibility for, the medical services being rendered by the anesthesiologist assistant. The bill would authorize an anesthesiologist assistant under the supervision of an

anesthesiologist to ~~deliver medical services, including, but not limited to,~~ *assist the supervising anesthesiologist in* developing and implementing an anesthesia care plan for a patient.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Chapter 7.75 (commencing with Section 3550) is added to Division 2 of the Business and Professions Code, to read:

Chapter 7.75. Anesthesiologist Assistant

3550. This chapter shall be known and may be cited as the Anesthesiologist Assistant Practice Act.

3551. For purposes of this section, the following definitions shall apply:

(a) "Anesthesiologist" means a physician and surgeon who has successfully completed a training program in anesthesiology accredited by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association or equivalent organizations and is licensed under Chapter 5 (commencing with Section 2000).

(b) "Anesthesiologist assistant" means a person who meets the requirements of Section 3552.

3552. (a) A person shall not hold himself or herself out to be an anesthesiologist assistant unless he or she meets the following requirements:

(1) Has graduated from an anesthesiologist assistant program recognized by the Commission on Accreditation of Allied Health Education Programs or by its successor agency.

(2) Holds an active certification by the National Commission on Certification for Anesthesiologist Assistants.

(b) It is an unfair business practice within the meaning of Chapter 5 (commencing with Section 17200) of Part 2 of Division 7 for any person to use the title "anesthesiologist assistant" or any other term, including, but not limited to, "certified," "licensed," "registered," or "AA," that implies or suggests that the person is

certified as an anesthesiologist assistant, if the person does not meet the requirements of subdivision (a).

3553. An anesthesiologist assistant shall work under the *direction and* supervision of an anesthesiologist. The supervising anesthesiologist shall do both of the following:

(a) Be physically present on the premises and immediately available ~~if needed~~ to the anesthesiologist assistant when medical services are being rendered.

(b) Oversee the activities of, and accept responsibility for, the medical services being rendered by the anesthesiologist assistant.

3554. Notwithstanding any other law, an anesthesiologist assistant under the supervision of an anesthesiologist may ~~deliver medical services, including, but not limited to,~~ *assist the supervising anesthesiologist in* developing and implementing an anesthesia care plan for a patient.

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AMENDED IN SENATE JULY 1, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1306

Introduced by Assembly Member Burke
(Coauthor: Assembly Member Mark Stone)

February 27, 2015

An act to amend Sections 650.01, *650.02*, 2725.1, 2746.2, 2746.5, 2746.51, 2746.52, 4061, 4076, and 4170 of, and to add Section 2746.6 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 1306, as amended, Burke. Healing arts: certified nurse-midwives: scope of practice.

(1) Existing law, 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 act makes the violation of any of its provisions a misdemeanor punishable upon conviction by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than $20 nor more than $1,000, or by both that fine and imprisonment.

This bill would additionally require an applicant for a certificate to practice nurse-midwifery to provide evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board. This bill would also require the board to create and appoint a Nurse-Midwifery Advisory Council

consisting of certified nurse-midwives in good standing with experience in hospital ~~and nonhospital practice~~ settings, *alternative birth settings, and home settings*, a nurse-midwife educator, as specified, and a consumer of midwifery care. This bill would require *the council to consist of a majority of certified nurse-midwives and would require* the council to make recommendations to the board on all matters related to nurse-midwifery practice, education, *disciplinary actions, standards of care*, and other matters specified by the board, and would require the council to meet regularly, but at least twice a year. This bill would ~~also~~ prohibit corporations and other artificial legal entities from having professional rights, privileges, or powers under the act, except as specified. *The bill would authorize specified entities to employ a certified nurse-midwife and charge for professional services rendered by that certified nurse-midwife, as provided.*

(2) The 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 delete those provisions and would instead authorize a certified nurse-midwife to manage a full range of ~~primary health~~ *gynecological and obstetric* care services for women from adolescence beyond menopause, ~~including, but not limited to, gynecologic and family planning services.~~ *as provided.* The bill would authorize a certified nurse-midwife to practice in ~~all~~ *specified* settings, including, but not limited to, a home *setting*. This bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the client and the resources of the medical personnel available in the setting of care, and would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care, and early detection and referral of complications to a physician and surgeon. ~~This bill would authorize a certified nurse-midwife to provide peripartum care in an out-of-hospital setting to low-risk women with uncomplicated singleton-term pregnancies who are expected to have uncomplicated birth.~~

(3) The act authorizes a certified nurse-midwife to furnish and order drugs or devices incidentally to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the certified nurse-midwife's educational preparation in specified facilities and clinics, and only in accordance with standardized procedures and protocols, as specified.

This bill would delete the requirement that drugs or devices are furnished or ordered in accordance with standardized procedures and protocols. The bill would authorize a certified nurse-midwife to furnish and order drugs or devices in connection with care rendered in a home, and would authorize a certified nurse-midwife to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and that are consistent with nurse-midwifery education preparation.

(4) The act also authorizes a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a licensed acute care hospital and a licensed alternate birth center, if certain requirements are met, including, but not limited to, that episiotomies are performed pursuant to protocols developed and approved by the supervising physician and surgeon.

This bill would also authorize a certified nurse-midwife to perform and repair episiotomies and to repair first-degree and 2nd-degree lacerations of the perineum in a home, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by the supervising physician and surgeon. The bill would require a certified nurse-midwife to provide emergency care to a patient during times when a physician and surgeon is unavailable.

This bill would provide that a consultative relationship between a certified nurse-midwife and a physician and surgeon by it self is not a basis for finding the physician and surgeon liable for any acts or omissions on the part of the certified nurse-midwife. The bill would also update cross-references as needed.

(5) Because the act makes a violation of any of its provisions a misdemeanor, this bill would expand the scope of an existing crime and therefore this bill would impose a state-mandated local program.

(6) Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home

infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing ~~law~~ *law,* the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct. *Existing law provides that, among other exceptions, this prohibition does not apply to a licensee who refers a person to a health facility if specified conditions are met.*

This bill would include a certified nurse-midwife under the definition of a licensee, which would expand the scope of an existing crime and therefore impose a state-mandated local program. The bill would ~~also~~ require the Board of Registered Nursing to review the facts and circumstances of any conviction of a certified nurse-midwife for violating that prohibition, and would require the board to take appropriate disciplinary action if the certified nurse-midwife has committed unprofessional conduct. *The bill would additionally authorize a licensee to refer a person to a licensed alternative birth center, as defined, or a nationally accredited alternative birth center.*

(7) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 650.01 of the Business and Professions
2 Code is amended to read:
3 650.01. (a) Notwithstanding Section 650, or any other law, it
4 is unlawful for a licensee to refer a person for laboratory, diagnostic
5 nuclear medicine, radiation oncology, physical therapy, physical
6 rehabilitation, psychometric testing, home infusion therapy, or
7 diagnostic imaging goods or services if the licensee or his or her
8 immediate family has a financial interest with the person or in the
9 entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing,

and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, "immediate family" includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a certified nurse-midwife as defined in Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code.

(5) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate

disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

SEC. 2. Section 650.02 of the Business and Professions Code is amended to read:

650.02. The prohibition of Section 650.01 shall not apply to or restrict any of the following:

(a) A licensee may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 650.01 if the licensee's regular practice is located where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. If an alternative provider commences furnishing the good or service for which a patient was referred pursuant to this subdivision, the licensee shall cease referrals under this subdivision within six months of the time at which the licensee knew or should have known that the alternative provider is furnishing the good or service. A licensee who refers to or seeks consultation from an organization in which the licensee has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A licensee, when the licensee or his or her immediate family has one or more of the following arrangements with another

licensee, a person, or an entity, is not prohibited from referring a patient to the licensee, person, or entity because of the arrangement:

(1) A loan between a licensee and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a licensee and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) Ownership of corporate investment securities, including shares, bonds, or other debt instruments that may be purchased on terms generally available to the public and that are traded on a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the licensee's referral of persons to the corporation, do not have a separate class or accounting for any persons or for any licensees who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three fiscal years, stockholder equity exceeding seventy-five million dollars ($75,000,000).

(4) Ownership of shares in a regulated investment company as defined in Section 851(a) of the federal Internal Revenue Code, if the company had, at the end of the company's most recent fiscal year, or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars ($75,000,000).

(5) A one-time sale or transfer of a practice or property or other financial interest between a licensee and the recipient of the referral if the sale or transfer is for commercially reasonable terms and the consideration is not affected by either party's referral of any person or the volume of services provided by either party.

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, *a licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code,* or to any facility*, or nationally accredited alternative birth center,* owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not

receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

(d) A licensee may refer a person to a nonprofit corporation that provides physician services pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code if the nonprofit corporation is controlled through membership by one or more health facilities or health facility systems and the amount of compensation or other transfer of funds from the health facility or nonprofit corporation to the licensee is fixed annually, except for adjustments caused by physicians joining or leaving the groups during the year, and is not based on the number of persons utilizing goods or services specified in Section 650.01.

(e) A licensee compensated or employed by a university may refer a person for a physician service, to any facility owned or operated by the university, or to another licensee employed by the university, provided that the facility or university does not compensate the referring licensee for the patient referral. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physicians for those referrals.

(f) The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice. Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

(g) The prohibition of Section 650.01 shall not apply to cardiac rehabilitation services provided by a licensee or by a suitably trained individual under the direct or general supervision of a licensee, if the services are provided to patients meeting the criteria for Medicare reimbursement for the services.

(h) The prohibition of Section 650.01 shall not apply if a licensee is in the office of a group practice and refers a person for services or goods specified in Section 650.01 to a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code.

(i) The prohibition of Section 650.01 shall not apply to health care services provided to an enrollee of 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).

(j) The prohibition of Section 650.01 shall not apply to a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, or a request by a radiation oncologist for radiation therapy if those services are furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

(k) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(*l*) This section shall become operative on January 1, 1995.

~~SEC. 2.~~

SEC. 3. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. (a) Notwithstanding any other law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to Section

2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) This section shall not be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) This section shall not be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

~~SEC. 3.~~

SEC. 4. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board or has at least the equivalent thereof, including evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board.

(b) The board shall create and appoint a Nurse-Midwifery Advisory Council consisting of certified nurse-midwives in good standing with experience in hospital~~ and nonhospital practice settings,~~ *settings, alternative birth center settings, and home settings*, a nurse-midwife educator who has demonstrated familiarity with~~ consumer needs, collegial practice and accompanied liability, and related~~ educational standards in the delivery of maternal-child health care,~~ and~~ a consumer of midwifery~~ care.~~ *care, and at least two qualified physicians appointed by the Medical Board of California, including an obstetrician that has experience working with nurse-midwives.* The council *membership shall consist of a majority of certified nurse-midwives and* shall make recommendations to the board on all matters related to nurse-midwifery practice, education, and

other matters as specified by the board. The council shall meet regularly, but at least twice a year.

(c) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Board of Registered Nursing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.

(d) Notwithstanding subdivision (c), the following entities may employ a certified nurse-midwife and charge for professional services rendered by a certified nurse-midwife; however, the entity shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife:

(1) A clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code.

(2) A hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code.

(3) A clinic operated primarily for the purpose of medical education or nursing education by a public or private nonprofit university medical school, which is approved by the Medical Board or the Osteopathic Medical Board of California, provided the certified nurse-midwife holds an academic appointment on the faculty of the university, including, but not limited to, the University of California medical schools and hospitals.

(4) A licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited alternative birth center owned or operated by a nursing corporation, as defined in Section 2775 of the Business and Professions Code.

~~SEC. 4.~~

SEC. 5. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to manage a full range of primary ~~health~~ *gynecological and obstetric* care services for women from adolescence to beyond ~~menopause.~~ *menopause, consistent with*

the Core Competencies for Basic Midwifery practice promulgated by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. These services include, but are not limited to, primary health care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth, and the postpartum period, immediate care of the newborn, and treatment of male partners for sexually transmitted ~~infections. A certified nurse-midwife is authorized to practice in all settings, including, but not limited to, private practice, clinics, hospitals, birth centers, and homes.~~ *infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.*

(b) A certified nurse-midwife may practice in the following settings:

~~(b)~~

(1) A licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(3) A facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(4) A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

(5) A licensed alternative birth center, as described in Section 1204 of the Health and Safety Code, or nationally accredited birth center.

(6) A nursing corporation, as defined in Section 2775 of the Business and Professions Code.

(7) A home setting.

(A) Except as provided in subparagraph (B) of this paragraph, a certified nurse-midwife shall assist during pregnancy and childbirth in the home setting only when all of the following conditions apply:

(i) There is the absence of all of the following:

(I) Any preexisting maternal disease or condition likely to complicate the pregnancy.

(II) Disease arising from the pregnancy likely to cause significant maternal and/or fetal compromise.

(III) Prior caesarean delivery.

(ii) There is a singleton fetus.

(iii) There is cephalic presentation at the onset of labor.

(iv) The gestational age of the fetus is greater than 370/7 weeks and less than 420/7 completed weeks of pregnancy at the onset of labor.

(v) Labor is spontaneous or induced in an outpatient setting.

(B) If a potential certified nurse-midwife client meets the conditions specified in clauses (ii) to (v), inclusive, of subparagraph (A), but fails to meet the conditions specified in clause (i) of subparagraph (A), and the woman still desires to be a client of the certified nurse-midwife, the certified nurse-midwife shall consult with a physician and surgeon trained in obstetrics and gynecology. A certified nurse-midwife may assist the woman in pregnancy and childbirth only if a physician and surgeon trained in obstetrics and gynecology is consulted and the physician and surgeon who performed the consultation determines that the risk factors presented by her disease or condition are not likely to significantly affect the course of pregnancy and childbirth.

(c) As used in this chapter, the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. ~~When providing peripartum care in out-of-hospital settings, the certified nurse-midwife shall only provide care to low-risk women with uncomplicated singleton-term pregnancies who are expected to have an uncomplicated birth.~~ The practice of nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications to physicians and surgeons. While practicing in a hospital setting, the certified nurse-midwife shall collaboratively care for women with more complex health needs.

(d) A certified nurse-midwife practicing under subdivision (a) shall be subject to all credentialing and quality standards held by the facility in which he or she practices. The peer review body shall include nurse-midwives as part of the peer review body that reviews nurse-midwives. The peer review body of that facility shall impose standards that assure quality and patient safety in their

facility. The standards shall be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

~~(c)~~

(e) The practice of nurse-midwifery does not include the assisting of childbirth by any forcible, or mechanical means, nor the performance of any version of those means.

(f) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

~~(d)~~

(g) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board *and the Nurse-Midwifery Advisory Council*.

~~SEC. 5.~~

SEC. 6. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when the drugs or devices are furnished or ordered related to the provision of any of the following:

(1) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(2) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(3) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(4) Care rendered in a home pursuant to subdivision (a) of Section 2746.5.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) when the drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (1) to (3), inclusive, of subdivision (b). *In a nonhospital setting, a Schedule II controlled substance shall be furnished by a certified nurse-midwife only during labor and delivery and only after a consultation with a physician and surgeon.*

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of a physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) A certified nurse-midwife is authorized to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and consistent with nurse-midwifery education preparation.

~~SEC. 6.~~

SEC. 7. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, in a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, *or a nationally accredited birth center,* and in a home pursuant to ~~subdivision (a)~~ *paragraph (7) of subdivision (b)* of Section 2746.5.

(b) The certified nurse-midwife performing and repairing first-degree and second-degree lacerations of the perineum shall do both of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or

provide emergency care for times when a physician and surgeon is not available.

~~SEC. 7.~~

SEC. 8. Section 2746.6 is added to the Business and Professions Code, to read:

2746.6. A consultative relationship between a certified nurse-midwife and a physician and surgeon shall not, by ~~it self,~~ *itself,* provide the basis for finding a physician and surgeon liable for any act or omission of the certified nurse-midwife.

~~SEC. 8.~~

SEC. 9. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) A manufacturer's sales representative shall not distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a nurse practitioner, certified nurse-midwife, physician assistant, or naturopathic doctor, shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records

shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor.

~~SEC. 9.~~

SEC. 10. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who

functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

~~SEC. 10.~~

SEC. 11. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) A prescriber shall not dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon, *if applicable,* a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

~~SEC. 11.~~

SEC. 12. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within

the meaning of Section 6 of Article XIII B of the California Constitution.

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AMENDED IN SENATE JUNE 4, 2015

AMENDED IN SENATE JUNE 2, 2015

AMENDED IN SENATE MAY 5, 2015

AMENDED IN SENATE APRIL 21, 2015

SENATE BILL No. 22

Introduced by Senator Roth

December 1, 2014

An act to add Chapter 6 (commencing with Section 128590) to Part 3 of Division 107 of the Health and Safety Code, relating to health care, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 22, as amended, Roth. Residency training.

Existing law, the Song-Brown Health Care Workforce Training Act, declares the intent of the Legislature to increase the number of students and residents receiving quality education and training in the specialty of family practice and as primary care physician's assistants and primary care nurse practitioners. Existing law establishes, for this purpose, a state medical contract program with accredited medical schools, programs that train primary care physician's assistants, programs that train primary care nurse practitioners, registered nurses, hospitals, and other health care delivery systems.

Existing law establishes the California Healthcare Workforce Policy Commission and requires the commission, among other things, to identify specific areas of the state where unmet priority needs for primary care family physicians and registered nurses exist, establish standards for family practice training programs, family practice residency programs, primary care physician assistants programs, and

programs that train primary care nurse practitioners, and review and make recommendations to the Director of Statewide Health Planning and Development concerning the funding of those programs that are submitted to the Healthcare Workforce Development Division for participation in the state medical contract program.

This bill would require the Office of Statewide Health Planning and Development to establish a nonprofit public benefit corporation, to be known as the California Medical Residency Training Foundation, to be governed by a board of trustees consisting of a total of 13 members, to be appointed as specified.

The bill would create the Medical Residency Training Fund in the State Treasury, a continuously appropriated fund, and would require the foundation to solicit and accept funds from business, industry, foundations, and other private or public sources for the purpose of establishing and funding new graduate medical residency training programs in specified areas of the state, including medically underserved areas. By creating a continuously appropriated fund, the bill would make an appropriation. The bill would require the Office of Statewide Health Planning and Development, among other responsibilities, to provide technical support and financial management for the foundation, and to enter into contracts with public and private sector institutions and other health agencies and organizations in order to fund and establish residency positions. *The bill would authorize the Governor to include in the annual budget proposal an amount, as he or she deems reasonable, to be appropriated for this purpose. The bill, if the Legislature appropriates money for this purpose, would require the office to hold the funds and distribute them into the fund, upon request of the foundation, in an amount matching the amount deposited into the fund by the foundation. The bill would require money that was appropriated, but that has not been distributed to the fund at the end of each fiscal year, to be returned to the General Fund.*

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.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Chapter 6 (commencing with Section 128590) is added to Part 3 of Division 107 of the Health and Safety Code, to read:

Chapter 6. California Medical Residency Training Foundation

128590. As used in this chapter:

(a) "Board" means the Board of Trustees of the California Medical Residency Training Foundation.

(b) "Commission" means the California Healthcare Workforce Policy Commission.

(c) "Director" means the Director of Statewide Health Planning and Development.

(d) "Foundation" means the California Medical Residency Training Foundation.

(e) "Fund" means the Medical Residency Training Fund.

(f) "Office" means the Office of Statewide Health Planning and Development.

(g) "Primary care" means the medical practice areas of family medicine, general surgery, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and related specialties and subspecialties as the office deems appropriate.

(h) "Residency position" means a graduate medical education residency position in the field of primary care.

128591. (a) (1) The office shall establish a nonprofit public benefit corporation to be known as the California Medical Residency Training Foundation.

(2) The foundation shall be governed by a board of trustees consisting of a total of 13 members. Seven members shall be appointed by the Governor, one member shall be appointed by the Speaker of the Assembly, one member shall be appointed by the Senate Committee on Rules, two members of the Medical Board of California shall be appointed by the Medical Board of California, and two members of the Osteopathic Medical Board of California shall be appointed by the Osteopathic Medical Board of California.

(3) The members of the foundation board appointed by the Governor, the Speaker of the Assembly, and the Senate Committee

on Rules shall consist of representatives of designated and nondesignated public hospitals, private hospitals, community clinics, public and private health insurance providers, the pharmaceutical industry, associations of health care practitioners, and other appropriate members of health or related professions.

(4) All persons considered for appointment shall have an interest in increasing the number of medical residencies in the state, an interest in increasing access to health care in underserved areas of California, and the ability and desire to solicit funds for the purposes of this chapter, as determined by the appointing power.

(5) The chairperson of the commission shall also be a nonvoting, ex officio member of the board.

(b) The Governor shall appoint the president of the board from among those members appointed by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California.

(c) Of the members of the board first appointed by the Governor, three members shall be appointed to serve a one-year term, three members shall be appointed to serve a two-year term, and one member shall be appointed to serve a three-year term.

(d) Of the members of the board first appointed by the Speaker of the Assembly and the Senate Committee on Rules, each member shall be appointed to serve a three-year term.

(e) The members appointed by the Medical Board of California and the Osteopathic Medical Board of California shall be appointed to serve a four-year term.

(f) Upon the expiration of the initial appointments to the board by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California, each member shall be appointed to serve a four-year term.

(g) The director, after consultation with the president of the board, may appoint a council of advisers comprised of up to nine members. The council shall advise the director and the board on technical matters and programmatic issues related to the foundation.

(h) (1) Members of the board appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules, and members of the council shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred

in connection with his or her duties as a member of the board or the council.

(2) The members appointed by the Medical Board of California and the Osteopathic Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California and the Osteopathic Medical Board of California, respectively, for any actual and necessary expenses incurred in connection with his or her duties as a member of the foundation board.

(i) Notwithstanding any law relating to incompatible activities, no member of the foundation board shall be considered to be engaged in activities inconsistent and incompatible with his or her duties solely as a result of membership on the Medical Board of California or the Osteopathic Medical Board of California.

(j) The foundation shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this chapter and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), this chapter shall prevail.

128592. The foundation shall do the following:

(a) Solicit and accept funds from business, industry, foundations, and other private or public sources for the purpose of establishing and funding new residency positions in areas of the state described in subdivision (c).

(b) Encourage public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations to identify and provide locations for the establishment of new residency positions in areas of the state described in subdivision (c). The foundation shall solicit proposals for medical residency programs, as described in subdivision (c), and provide the office a copy of all proposals it receives.

(c) Upon the sufficient solicitation of funds and at the foundation's discretion, approve proposals and recommend to the office the establishment of new residency positions. A recommendation shall include all pertinent information necessary for the office to enter into the necessary contracts to establish the residency positions. The foundation shall only approve and

recommend to the office proposals that would establish residency positions that will serve *in any of* the following medical service areas:

(1) A service area that is designated as a primary care shortage area by the office.

(2) A service area that is designated as a health professional shortage area for primary care, by either population or geographic designation, by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(3) A service area that is designated as a medically underserved area or medically underserved population by the Health Resources and Services Administration of the United States Department of Health and Human Services.

(d) Upon office approval of a recommendation, deposit into the fund necessary moneys as required to establish and fund the residency position.

(e) Recommend to the director that a portion of the funds solicited from the private sector be used for the administrative requirements of the foundation.

(f) Prepare and submit an annual report to the Legislature documenting the amount of money solicited, the amount of money deposited from the foundation into the fund, the recommendations for the location and fields of practice of residency positions, total expenditures for the year, and prospective fundraising goals.

128593. The office shall do all of the following:

(a) Provide technical and staff support to the foundation in meeting all of its responsibilities.

(b) Provide financial management for the foundation.

(c) Upon receipt of a recommendation made by the foundation pursuant to subdivision (c) of Section 128592, approve the recommendation if the recommendation fulfills the requirements of subdivision (c) of Section 128592 and the recommendation fulfills the goals of this chapter. Upon sufficient funds being available, an approval shall signal the office's intent to establish the residency position.

(d) Establish a uniform process by which the foundation may solicit proposals from public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations that train primary care residents. The office shall require that these proposals contain all

necessary and pertinent information, including, but not limited to, all of the following:

(1) The location of the proposed residency position.

(2) The medical practice area of the proposed residency position.

(3) Information that demonstrates the area's need for the proposed residency position and for additional primary care practitioners.

(4) The amount of funding required to establish and operate the residency position.

(e) Enter into contracts with public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations in order to fund and establish residency positions at, or in association with, these institutions.

(f) Ensure that the residency position has been, or will be, approved by the Accreditation Council for Graduate Medical Education.

(g) Provide all of the following information to the board:

(1) The areas of the state that are deficient in primary care services.

(2) The areas of the state that have the highest number of Medi-Cal enrollees and persons eligible to enroll in Medi-Cal, by proportion of population.

(3) Other information that the office or board finds relevant to assist the board in making its recommendations on possible locations for new residency positions.

(h) Monitor the residencies established pursuant to this chapter.

(i) (1) Prepare and submit an annual report to the foundation and the Legislature documenting the amount of money contributed to the fund by the foundation, the amount of money expended from the fund, the purposes of those expenditures, the number and location of residency positions established and funded, and recommendations for the location of future residency positions.

(2) The report pursuant to paragraph (1) shall be made to the Legislature pursuant to Section 9795 of the Government Code.

128594. (a) The Medical Residency Training Fund is hereby created within the State Treasury.

(b) The primary purpose of the fund is to allocate funding for new residency positions throughout the state. Money in the fund shall also be used to pay for the cost of administering the goals of

the foundation, and for any other purpose authorized by this chapter.

(c) The level of expenditure by the office for the administrative support of the foundation is subject to review and approval annually through the ~~State Budget~~ *state budget* process.

(d) The office and foundation may solicit and accept public and private donations to be deposited into the fund. All money in the fund is continuously appropriated to the office for the purposes of this chapter. The office shall manage this fund prudently in accordance with applicable laws.

128595. Any regulations the office adopts to implement this chapter shall be adopted as emergency regulations in accordance with Section 11346.1 of the Government Code, except that the regulations shall be exempt from the requirements of subdivisions (e), (f), and (g) of that section. The regulations shall be deemed to be emergency regulations for the purposes of Section 11346.1 of the Government Code.

128596. Notwithstanding any other law, the office may exempt from public disclosure any document in the possession of the office that pertains to a donation made pursuant to this chapter if the donor has requested anonymity.

128597. (a) The Governor may include in the annual budget proposal an amount, as he or she deems reasonable, to be appropriated to the office to be used as provided in this chapter.

(b) If the Legislature appropriates money for purposes of this chapter, the money shall be appropriated to the office, which shall hold the money for distribution to the fund.

(c) Funds appropriated to the office shall be paid into the fund, upon request of the foundation, in an amount matching the amount deposited into the fund by the foundation for the purposes of this chapter. Any money that was appropriated to the office and that has not been distributed to the fund at the end of each fiscal year shall be returned to the General Fund.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Chapter 6 (commencing with Section 128590) to Part 3 of Division 107 of 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:

The need to protect individual privacy of donations made by a donor to fund new residency positions in underserved areas of the state outweighs the interest in the public disclosure of that information.

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AMENDED IN ASSEMBLY JULY 9, 2015

AMENDED IN ASSEMBLY JULY 7, 2015

AMENDED IN ASSEMBLY JUNE 23, 2015

AMENDED IN SENATE APRIL 22, 2015

AMENDED IN SENATE MARCH 26, 2015

SENATE BILL No. 323

Introduced by Senator Hernandez
(Principal coauthor: Assembly Member Eggman)
(Coauthor: Assembly Member Mark Stone)

February 23, 2015

An act to amend Sections 650.01 and 805 of, to amend and renumber Section 2837 of, and to add Section 2837 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 323, as amended, Hernandez. Nurse practitioners: scope of practice.

The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing. The act authorizes the implementation of standardized procedures that authorize a nurse practitioner to perform certain acts, including ordering durable medical equipment in accordance with standardized procedures, certifying disability for purposes of unemployment insurance after physical examination and collaboration with a physician and surgeon, and, for an individual receiving home health services or personal care services, approving, signing, modifying, or adding to a plan of treatment

or plan of care after consultation with a physician and surgeon. A violation of those provisions is a crime.

This bill would authorize a nurse practitioner who holds a national certification from a national certifying body recognized by the board to practice without the supervision of a physician and surgeon, if the nurse practitioner meets existing requirements for nurse practitioners and practices in one of certain specified settings. The bill would prohibit entities described in those specified settings from interfering with, controlling, or otherwise directing the professional judgment of such a nurse practitioner, as specified, and would authorize such a nurse practitioner, in addition to any other practice authorized in statute or regulation, to perform specified acts, including the acts described above, without reference to standardized procedures or the specific need for the supervision of a physician and surgeon. The bill, instead, would require a nurse practitioner to refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of the patient is beyond the scope of the nurse practitioner's education and training. The bill would require a nurse practitioner practicing under these provisions to maintain professional liability insurance appropriate for the practice setting. By imposing new requirements on nurse practitioners, the violation of which would be a crime, this bill would impose a state-mandated local program.

Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing law, the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct.

This bill would include a nurse practitioner, as specified, under the definition of a licensee, which would expand the scope of an existing crime and therefore impose a state-mandated local program. The bill would also require the Board of Registered Nursing to review the facts and circumstances of any conviction of a nurse practitioner, as specified, for violating that prohibition, and would require the board to take appropriate disciplinary action if the nurse practitioner has committed unprofessional conduct.

Existing law provides for the professional review of specified healing arts licentiates through a peer review process. Existing law defines the term "licentiate" for those purposes to include, among others, a physician and surgeon.

This bill would include a nurse practitioner, as specified, under the definition of licentiate, and would require the Board of Registered Nursing to disclose reports, as specified.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares all of the following:

(a) Nurse practitioners are a longstanding, vital, safe, effective, and important part of the state's health care delivery system. They are especially important given California's shortage of physicians, with just 16 of 58 counties having the federally recommended ratio of physicians to residents.

(b) Nurse practitioners will play an especially important part in the implementation of the federal Patient Protection and Affordable Care Act (Public Law 111-148), which will bring an estimated five million more Californians into the health care delivery system, because they will provide for greater access to primary care services in all areas of the state. This is particularly true for patients in medically underserved urban and rural communities.

(c) In the interest of providing patients with comprehensive care and consistent with the spirit of the federal Patient Protection and Affordable Care Act, this measure is supportive of the national health care movement towards integrated and team-based health care models.

~~(c)~~

(d) Due to the excellent safety and efficacy record that nurse practitioners have earned, the Institute of Medicine of the National Academies has recommended full practice authority for nurse

practitioners. Currently, 20 states allow nurse practitioners to practice to the full extent of their training and education.

~~(d)~~

(e) Furthermore, nurse practitioners will assist in addressing the primary care provider shortage by removing delays in the provision of care that are created when dated regulations require a physician's signature or protocol before a patient can initiate treatment or obtain diagnostic tests that are ordered by a nurse practitioner.

SEC. 2. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other provision of law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training

program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, "immediate family" includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a nurse practitioner practicing pursuant to Section 2837.

(5) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when licensure or certification is required by law.

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed

pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the

same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a nurse practitioner functioning pursuant to Section 2837, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

SEC. 3. Section 805 of the Business and Professions Code is amended to read:

805. (a) As used in this section, the following terms have the following definitions:

(1) (A) “Peer review” means both of the following:

(i) A process in which a peer review body reviews the basic qualifications, staff privileges, employment, medical outcomes, or professional conduct of licentiates to make recommendations for quality improvement and education, if necessary, in order to do either or both of the following:

(I) Determine whether a licentiate may practice or continue to practice in a health care facility, clinic, or other setting providing medical services, and, if so, to determine the parameters of that practice.

(II) Assess and improve the quality of care rendered in a health care facility, clinic, or other setting providing medical services.

(ii) Any other activities of a peer review body as specified in subparagraph (B).

(B) "Peer review body" includes:

(i) A medical or professional staff of any health care facility or clinic licensed under Division 2 (commencing with Section 1200) of the Health and Safety Code or of a facility certified to participate in the federal Medicare program as an ambulatory surgical center.

(ii) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that contracts with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code.

(iii) Any medical, psychological, marriage and family therapy, social work, professional clinical counselor, dental, or podiatric professional society having as members at least 25 percent of the eligible licentiates in the area in which it functions (which must include at least one county), which is not organized for profit and which has been determined to be exempt from taxes pursuant to Section 23701 of the Revenue and Taxation Code.

(iv) A committee organized by any entity consisting of or employing more than 25 licentiates of the same class that functions for the purpose of reviewing the quality of professional care provided by members or employees of that entity.

(2) "Licentiate" means a physician and surgeon, doctor of podiatric medicine, clinical psychologist, marriage and family therapist, clinical social worker, professional clinical counselor, dentist, physician assistant, or nurse practitioner practicing pursuant to Section 2837. "Licentiate" also includes a person authorized to practice medicine pursuant to Section 2113 or 2168.

(3) "Agency" means the relevant state licensing agency having regulatory jurisdiction over the licentiates listed in paragraph (2).

(4) "Staff privileges" means any arrangement under which a licentiate is allowed to practice in or provide care for patients in a health facility. Those arrangements shall include, but are not limited to, full staff privileges, active staff privileges, limited staff privileges, auxiliary staff privileges, provisional staff privileges, temporary staff privileges, courtesy staff privileges, locum tenens arrangements, and contractual arrangements to provide professional services, including, but not limited to, arrangements to provide outpatient services.

(5) "Denial or termination of staff privileges, membership, or employment" includes failure or refusal to renew a contract or to renew, extend, or reestablish any staff privileges, if the action is based on medical disciplinary cause or reason.

(6) "Medical disciplinary cause or reason" means that aspect of a licentiate's competence or professional conduct that is reasonably likely to be detrimental to patient safety or to the delivery of patient care.

(7) "805 report" means the written report required under subdivision (b).

(b) The chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic shall file an 805 report with the relevant agency within 15 days after the effective date on which any of the following occur as a result of an action of a peer review body:

(1) A licentiate's application for staff privileges or membership is denied or rejected for a medical disciplinary cause or reason.

(2) A licentiate's membership, staff privileges, or employment is terminated or revoked for a medical disciplinary cause or reason.

(3) Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a cumulative total of 30 days or more for any 12-month period, for a medical disciplinary cause or reason.

(c) If a licentiate takes any action listed in paragraph (1), (2), or (3) after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason or after receiving notice that his or her application for membership or staff privileges is

denied or will be denied for a medical disciplinary cause or reason, the chief of staff of a medical or professional staff or other chief executive officer, medical director, or administrator of any peer review body and the chief executive officer or administrator of any licensed health care facility or clinic where the licentiate is employed or has staff privileges or membership or where the licentiate applied for staff privileges or membership, or sought the renewal thereof, shall file an 805 report with the relevant agency within 15 days after the licentiate takes the action.

(1) Resigns or takes a leave of absence from membership, staff privileges, or employment.

(2) Withdraws or abandons his or her application for staff privileges or membership.

(3) Withdraws or abandons his or her request for renewal of staff privileges or membership.

(d) For purposes of filing an 805 report, the signature of at least one of the individuals indicated in subdivision (b) or (c) on the completed form shall constitute compliance with the requirement to file the report.

(e) An 805 report shall also be filed within 15 days following the imposition of summary suspension of staff privileges, membership, or employment, if the summary suspension remains in effect for a period in excess of 14 days.

(f) A copy of the 805 report, and a notice advising the licentiate of his or her right to submit additional statements or other information, electronically or otherwise, pursuant to Section 800, shall be sent by the peer review body to the licentiate named in the report. The notice shall also advise the licentiate that information submitted electronically will be publicly disclosed to those who request the information.

The information to be reported in an 805 report shall include the name and license number of the licentiate involved, a description of the facts and circumstances of the medical disciplinary cause or reason, and any other relevant information deemed appropriate by the reporter.

A supplemental report shall also be made within 30 days following the date the licentiate is deemed to have satisfied any terms, conditions, or sanctions imposed as disciplinary action by the reporting peer review body. In performing its dissemination functions required by Section 805.5, the agency shall include a

copy of a supplemental report, if any, whenever it furnishes a copy of the original 805 report.

If another peer review body is required to file an 805 report, a health care service plan is not required to file a separate report with respect to action attributable to the same medical disciplinary cause or reason. If the Medical Board of California, the Board of Registered Nursing, or a licensing agency of another state revokes or suspends, without a stay, the license of a physician and surgeon, a peer review body is not required to file an 805 report when it takes an action as a result of the revocation or suspension.

(g) The reporting required by this section shall not act as a waiver of confidentiality of medical records and committee reports. The information reported or disclosed shall be kept confidential except as provided in subdivision (c) of Section 800 and Sections 803.1 and 2027, provided that a copy of the report containing the information required by this section may be disclosed as required by Section 805.5 with respect to reports received on or after January 1, 1976.

(h) The Medical Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, and the Dental Board of California shall disclose reports as required by Section 805.5.

(i) An 805 report shall be maintained electronically by an agency for dissemination purposes for a period of three years after receipt.

(j) No person shall incur any civil or criminal liability as the result of making any report required by this section.

(k) A willful failure to file an 805 report by any person who is designated or otherwise required by law to file an 805 report is punishable by a fine not to exceed one hundred thousand dollars ($100,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. A violation of this subdivision may constitute unprofessional conduct by the licentiate. A person who is alleged to have violated this subdivision may assert any defense available

at law. As used in this subdivision, "willful" means a voluntary and intentional violation of a known legal duty.

(*l*) Except as otherwise provided in subdivision (k), any failure by the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report, shall be punishable by a fine that under no circumstances shall exceed fifty thousand dollars ($50,000) per violation. The fine may be imposed in any civil or administrative action or proceeding brought by or on behalf of any agency having regulatory jurisdiction over the person regarding whom the report was or should have been filed. If the person who is designated or otherwise required to file an 805 report is a licensed physician and surgeon, the action or proceeding shall be brought by the Medical Board of California. The fine shall be paid to that agency but not expended until appropriated by the Legislature. The amount of the fine imposed, not exceeding fifty thousand dollars ($50,000) per violation, shall be proportional to the severity of the failure to report and shall differ based upon written findings, including whether the failure to file caused harm to a patient or created a risk to patient safety; whether the administrator of any peer review body, the chief executive officer or administrator of any health care facility, or any person who is designated or otherwise required by law to file an 805 report exercised due diligence despite the failure to file or whether they knew or should have known that an 805 report would not be filed; and whether there has been a prior failure to file an 805 report. The amount of the fine imposed may also differ based on whether a health care facility is a small or rural hospital as defined in Section 124840 of the Health and Safety Code.

(m) A health care service plan licensed under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code or a disability insurer that negotiates and enters into a contract with licentiates to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, when determining participation with the plan or insurer, shall evaluate, on a case-by-case basis, licentiates who are the subject of an 805 report, and not automatically exclude or deselect these licentiates.

SEC. 4. Section 2837 of the Business and Professions Code is amended and renumbered to read:

2837.5. Nothing in this article shall be construed to limit the current scope of practice of a registered nurse authorized pursuant to this chapter.

SEC. 5. Section 2837 is added to the Business and Professions Code, to read:

2837. (a) Notwithstanding any other law, a nurse practitioner who holds a national certification from a national certifying body recognized by the board may practice under this section without supervision of a physician and surgeon, if the nurse practitioner meets all the requirements of this article and practices in one of the following:

(1) A clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(3) A facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(4) An accountable care organization, as defined in Section 3022 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(5) A group practice, including a professional medical corporation, as defined in Section 2406, another form of corporation controlled by physicians and surgeons, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

(6) A medical group, independent practice association, or any similar association.

(b) An entity described in subdivision (a) shall not interfere with, control, or otherwise direct the professional judgment of a nurse practitioner functioning pursuant to this section in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding any other law, in addition to any other practice authorized in statute or regulation, a nurse practitioner who meets the qualifications of subdivision (a) may do any of the following without physician and surgeon supervision:

(1) Order durable medical equipment. Notwithstanding that authority, this paragraph shall not operate to limit the ability of a third-party payer to require prior approval.

(2) After performance of a physical examination by the nurse practitioner and collaboration, if necessary, with a physician and surgeon, certify disability pursuant to Section 2708 of the Unemployment Insurance Code.

(3) For individuals receiving home health services or personal care services, after consultation, if necessary, with the treating physician and surgeon, approve, sign, modify, or add to a plan of treatment or plan of care.

(4) Assess patients, synthesize and analyze data, and apply principles of health care.

(5) Manage the physical and psychosocial health status of patients.

(6) Analyze multiple sources of data, identify a differential diagnosis, and select, implement, and evaluate appropriate treatment.

(7) Establish a diagnosis by client history, physical examination, and other criteria, consistent with this section, for a plan of care.

(8) Order, furnish, prescribe, or procure drugs or devices.

(9) Delegate tasks to a medical assistant pursuant to Sections 1206.5, 2069, 2070, and 2071, and Article 2 of Chapter 3 of Division 13 of Title 16 of the California Code of Regulations.

(10) Order hospice care, as appropriate.

(11) Order diagnostic procedures and utilize the findings or results in treating the patient.

(12) Perform additional acts that require education and training and that are recognized by the nursing profession as appropriate to be performed by a nurse practitioner.

(d) A nurse practitioner shall refer a patient to a physician and surgeon or other licensed health care provider if a situation or condition of the patient is beyond the scope of the education and training of the nurse practitioner.

(e) A nurse practitioner practicing under this section shall maintain professional liability insurance appropriate for the practice setting.

SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of

the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 16, 2015

SENATE BILL No. 482

Introduced by Senator Lara

February 26, 2015

An act to add Section 11165.4 to the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

SB 482, as amended, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require all prescribers, as defined, prescribing a Schedule II or Schedule III controlled substance, ~~and all dispensers, as defined, dispensing a Schedule II or Schedule III controlled substance,~~ to consult a patient's electronic history in the CURES database before prescribing ~~or dispensing~~ the controlled substance to the patient for the first time. The bill would also require the prescriber to consult the CURES database at least annually when the prescribed controlled substance remains part of the patient's treatment. The bill would prohibit prescribing an additional Schedule II or Schedule III controlled

substance to a patient with an existing prescription until the prescriber determines that there is a legitimate need for the controlled substance.

The bill would make the failure to consult a patient's electronic history in the CURES database a cause for disciplinary action by the prescriber's ~~or dispenser's~~ licensing board and would require the ~~respective licensing boards~~ *licensing boards* to notify all ~~licensees~~ *prescribers* authorized to prescribe ~~or dispense~~ controlled substances of these requirements. The bill would provide that a prescriber ~~or dispenser~~ is not in violation of these requirements during any time that the CURES database is suspended or not accessible, or during any time that the Internet is not operational. The bill would make its provisions operative upon the Department of Justice's certification that the CURES database is ready for statewide use.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) A prescriber shall access and consult the CURES database for the electronic history of controlled substances dispensed to a patient under his or her care before prescribing a Schedule II or Schedule III controlled substance for the first time to that patient and at least annually when that prescribed controlled substance remains part of his or her treatment. If the patient has an existing prescription for a Schedule II or Schedule III controlled substance, the prescriber shall not prescribe an additional controlled substance until the prescriber determines that there is a legitimate need for that controlled substance.

~~(b) A dispenser shall access and consult the CURES database for the electronic history of controlled substances dispensed to a patient under his or her care before dispensing a Schedule II or Schedule III controlled substance for the first time to that patient. If the patient has an existing prescription for a Schedule II or Schedule III controlled substance, the dispenser shall not dispense an additional controlled substance until the dispenser checks the CURES database.~~

~~(c)~~

(b) Failure to consult a patient's electronic history as required by subdivision (a) ~~or (b)~~ is cause for disciplinary action by the ~~respective licensing board of the prescriber or dispenser~~ *prescriber's licensing board.* The licensing boards of all prescribers ~~and dispensers~~ authorized to write or issue prescriptions for controlled substances shall notify these licensees of the requirements of this section.

~~(d)~~

(c) Notwithstanding any other law, a prescriber ~~or dispenser~~ is not in violation of this section during any period of time in which the CURES database is suspended or not accessible or any period of time in which the Internet is not operational.

~~(e)~~

(d) This section shall not become operative until the Department of Justice certifies that the CURES database is ready for statewide use.

~~(f)~~

(e) For purposes of this section, ~~the following terms shall have the following meanings:~~ *"prescriber" means a health care practitioner who is authorized to write or issue prescriptions under Section 11150, excluding veterinarians.*

~~(1) "Dispenser" means a person who is authorized to dispense a controlled substance under Section 11011.~~

~~(2) "Prescriber" means a health care practitioner who is authorized to write or issue prescriptions under Section 11150, excluding veterinarians.~~

~~(g)~~

(f) A violation of this section shall not be subject to the provisions of Section 11374.

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AMENDED IN ASSEMBLY AUGUST 17, 2015

AMENDED IN ASSEMBLY JULY 7, 2015

AMENDED IN SENATE APRIL 16, 2015

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL No. 538

Introduced by Senator Block
(Coauthor: Senator Hueso)
(Coauthor: Assembly Member Nazarian)

February 26, 2015

An act to amend Sections 3640 and 3640.5 of the Business and Professions Code, relating to naturopathic doctors.

LEGISLATIVE COUNSEL'S DIGEST

SB 538, as amended, Block. Naturopathic doctors.

(1) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee in the Osteopathic Medical Board of California. Existing law authorizes a naturopathic doctor to perform certain tasks, including physical and laboratory examinations for diagnostic purposes and to order diagnostic imaging studies, consistent with naturopathic training as determined by the committee. Under the act, a naturopathic doctor is authorized to dispense, administer, order, prescribe, furnish, or perform certain things, including health education and health counseling.

This bill would, instead, authorize a naturopathic doctor to perform certain tasks, consistent with the practice of naturopathic medicine, and would additionally authorize a naturopathic doctor to dispense, administer, order, prescribe, provide, or ~~furnish,~~ *furnish* devices and

durable medical equipment consistent with the naturopathic training as determined by the committee.

(2) Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitation generally placed on controlled substances classified in Schedule V.

Existing law states that nothing in the Naturopathic Doctors Act or any other law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when, among other requirements, the naturopathic doctor is functioning pursuant to standardized procedure, as defined, or protocol developed and approved, as specified, and the Naturopathic Medicine Committee has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered. Existing law requires that the furnishing or ordering of drugs by a naturopathic doctor occur under the supervision of a physician and surgeon. Existing law also authorizes a naturopathic doctor to furnish or order controlled substances classified in Schedule III, IV, or V of the California Uniform Controlled Substances Act, but limits this authorization to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. Existing law further requires that drugs classified in Schedule III be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician.

This bill would instead provide that, except as specified, nothing in the provisions governing naturopathic doctors or any other law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs and would make a conforming change to the scope of the certification duties of the Naturopathic Medicine Committee. The bill would delete certain provisions described above restricting the authority of naturopathic doctors to furnish or order drugs, including the requirements that the naturopathic doctor function pursuant to a standardized procedure, or furnish or order drugs under the supervision of a physician and surgeon for Schedule V controlled substances and for any drug approved by the federal Food and Drug Administration and labeled “for prescription only,” except chemotherapeutics, that is not classified.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 3640 of the Business and Professions Code is amended to read:

3640. (a) A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests.

(b) A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with the practice of naturopathic medicine, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results.

(c) A naturopathic doctor may dispense, administer, order, prescribe, provide, furnish, or perform the following:

(1) Food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, all dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, consistent with the routes of administration identified in subdivision (d).

(2) Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise.

(3) Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment consistent with the naturopathic training as determined by the committee.

(4) Health education and health counseling.

(5) Repair and care incidental to superficial lacerations and abrasions, except suturing.

(6) Removal of foreign bodies located in the superficial tissues.

(d) A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.

(e) The committee may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) ~~Nothing in this~~ *This* section shall *not* exempt a naturopathic doctor from meeting applicable licensure requirements for the performance of clinical laboratory tests, including the requirements imposed under Chapter 3 (commencing with Section 1200).

SEC. 2. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. (a) Except as set forth in this section, nothing in this chapter or any other provision of law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs when functioning pursuant to this section.

(b) Schedule III and Schedule IV controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) shall be administered, furnished, ordered, and prescribed by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(c) The naturopathic doctor shall function pursuant to a standardized procedure, as defined by paragraphs (1) and (2) of subdivision (c) of Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(d) The standardized procedure or protocol covering the administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs shall specify which naturopathic doctors may administer, furnish, order, or prescribe Schedule III and Schedule IV drugs, which Schedule III through Schedule IV drugs may be administered, furnished, ordered, or prescribed and under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, which shall be subject to the reporting requirement in Section 805, and review of the provisions of the standardized procedure.

(e) The administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs by a naturopathic doctor shall occur under physician and surgeon supervision. Physician and

surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(f) When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are administered, furnished, ordered, or prescribed by a naturopathic doctor, the controlled substances shall be administered, furnished, ordered, or prescribed in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure or protocol relating to controlled substances shall be provided, upon request, to a licensed pharmacist who dispenses drugs when there is uncertainty about the naturopathic doctor furnishing the order.

(g) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(h) Notwithstanding subdivision (c), drugs administered, furnished, ordered, or prescribed by a naturopathic doctor without the supervision of a physician and surgeon shall include Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and any drug approved by the federal Food and Drug Administration and labeled "for prescription only" or words of similar import, except chemotherapeutics, that is not classified.

(i) The committee shall certify that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be administered, furnished, ordered, or prescribed under this section. The committee shall establish the requirements for satisfactory completion of this subdivision.

(j) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of the Health and Safety Code, shall include both of the following for Schedule III through Schedule IV controlled substances.

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(k) For purposes of this section, “drug order” or “order” means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(*l*) Notwithstanding any other law, all of the following shall apply:

(1) A Schedule III through Schedule IV drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

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AMENDED IN SENATE MAY 4, 2015

AMENDED IN SENATE APRIL 9, 2015

SENATE BILL No. 622

Introduced by Senator Hernandez

February 27, 2015

An act to amend ~~Section~~ *Sections* 3041 *and 3110* of, to add Sections 3041.4, 3041.5, 3041.6, 3041.7, and 3041.8 to, and to repeal and add Sections 3041.1, 3041.2, and 3041.3 of, the Business and Professions Code, relating to optometry, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 622, as amended, Hernandez. Optometry.

The Optometry Practice Act provides for the licensure and regulation of the practice of optometry by the State Board of Optometry, and defines the practice of optometry to include, among other things, the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of rehabilitative optometric services, and doing certain things, including, but not limited to, the examination of the human eyes, the determination of the powers or range of human vision, and the prescribing of contact and spectacle lenses. Existing law authorizes an optometrist certified to use therapeutic pharmaceutical agents to diagnose and treat specified conditions, use specified pharmaceutical agents, and order specified diagnostic tests. The act requires optometrists treating or diagnosing eye disease, as specified, to be held to the same standard of care to which physicians and surgeons and osteopathic physician and surgeons are held. *The act requires an optometrist, in certain circumstances, to refer a patient to an opthamologist or a physician and surgeon,*

including when a patient has been diagnosed with a central corneal ulcer and the central corneal ulcer has not improved within 48 hours of the diagnosis. The act makes a violation of any of its provisions a crime. All moneys collected pursuant to the act, except where otherwise provided, are deposited in the Optometry Fund and continuously appropriated to the board to carry out the act.

This bill would revise and recast those provisions. *The bill would delete certain requirements that an optometrist refer a patient to an opthamologist or a physician and surgeon, including when a patient has been diagnosed with a central corneal ulcer and the central corneal ulcer has not improved within 48 hours of the diagnosis.* The bill would additionally define the practice of optometry as the provision of habilitative optometric services, and would authorize the board to allow optometrists to use nonsurgical technology to treat any authorized condition under the act. The bill would *additionally* authorize an optometrist *certified* to use ~~diagnostic~~ *therapeutic* pharmaceutical ~~agents, as specified, including, but not limited to, oral and topical diagnostic pharmaceutical agents that are not controlled substances.~~ *agents to collect a blood specimen by finger prick method, to perform skin tests, as specified, to diagnose ocular allergies, and to use mechanical lipid extraction of meibomian glands and nonsurgical techniques.* The bill would ~~authorize an optometrist to independently initiate and administer vaccines, as specified, for a person 3 years of age and older, if the optometrist meets certain requirements, including, but not limited to,~~ *require the board to grant an optometrist certified to treat glaucoma a certificate for the use of specified immunizations if certain conditions are met, including, among others,* that ~~he or she~~ *the optometrist* is certified in basic life ~~support for health care professionals.~~ *support.* The bill would additionally authorize an optometrist certified to use therapeutic pharmaceutical agents to, among other things, be certified to use anterior segment lasers, as specified, and to be certified to perform specified minor procedures, as specified, if certain requirements are met.

The bill would require the board to charge a fee of not more than $150 to cover the reasonable regulatory cost of certifying an optometrist to use anterior segment ~~lasers.~~ *lasers, a fee of not more than $150 to cover the reasonable regulatory cost of certifying an optometrist to use minor procedures, and a fee of not more than $100 to cover the reasonable regulatory cost of certifying an optometrist to use*

immunizations. Because this bill would increase those moneys deposited in a continuously appropriated fund, it would make an appropriation.

Existing law establishes the Office of Statewide Health Planning and Development, which is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development.

This bill would declare the intent of the Legislature that the Office of Statewide Health Planning designate a pilot project to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia.

Because a violation of the act is a crime, this bill would expand the scope of an existing crime and would, therefore, result in a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: yes. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

SECTION 1. Section 3041 of the Business and Professions Code is amended to read:

3041. (a) The practice of optometry includes the prevention and diagnosis of disorders and dysfunctions of the visual system, and the treatment and management of certain disorders and dysfunctions of the visual system, as well as the provision of habilitative or rehabilitative optometric services, and is the doing of any or all of the following:

(1) The examination of the human eye or eyes, or its or their appendages, and the analysis of the human vision system, either subjectively or objectively.

(2) The determination of the powers or range of human vision and the accommodative and refractive states of the human eye or eyes, including the scope of its or their functions and general condition.

(3) The prescribing or directing the use of, or using, any optical device in connection with ocular exercises, visual training, vision training, or orthoptics.

(4) The prescribing of contact and spectacle lenses for, or the fitting or adaptation of contact and spectacle lenses to, the human eye, including lenses that may be classified as drugs or devices by any law of the United States or of this state.

(5) The use of topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition.

(b) The State Board of Optometry shall, by regulation, establish educational and examination requirements for licensure to ensure the competence of optometrists to practice pursuant to this ~~chapter.~~ *chapter, except as specified in Section 3041.3 related to the use of anterior segment lasers and in Section 3041.4 related to minor procedures.* Satisfactory completion of the required educational and examination requirements shall be a condition for the issuance of an original optometrist license or required certifications pursuant to this chapter.

(c) The board may ~~authorize~~ *promulgate regulations authorizing* optometrists to use *noninvasive,* nonsurgical technology to treat a condition authorized by this chapter. *The board shall require a licensee to take a minimum of four hours of education courses on the new technology and perform an appropriate number of complete clinical procedures on live human patients to qualify to use each new technology authorized by the board pursuant to this subdivision.*

SEC. 2. Section 3041.1 of the Business and Professions Code is repealed.

SEC. 3. Section 3041.1 is added to the Business and Professions Code, to read:

3041.1. (a) (1) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to this section may also diagnose and treat the human eye or eyes, or any of its or their appendages, for all of the following conditions:

(A) Through medical treatment, infections of the anterior segment and adnexa.

(B) Ocular allergies of the anterior segment and adnexa.

~~(C) Ocular inflammation that is nonsurgical in cause, except when comanaged with the treating physician and surgeon.~~

(C) Ocular inflammation, nonsurgical in cause except when comanaged with the treating physician and surgeon, limited to inflammation resulting from traumatic iritis, peripheral corneal inflammatory keratitis, episcleritis, and unilateral nonrecurrent nongranulomatous idiopathic iritis in patients over 18 years of age.

(D) Traumatic or recurrent conjunctival or corneal abrasions and erosions.

(E) Corneal and conjunctival surface disease and dry eyes disease.

(F) Ocular pain that is nonsurgical in cause, except when comanaged with the treating physician and surgeon.

(G) ~~Eyelid disorders, including, but not limited to, hypotrichosis and blepharitis.~~ *Hypotrichosis and blepharitis.*

(2) For purposes of this section, "treat" means the use of therapeutic pharmaceutical agents, as described in subdivision (b), and the procedures described in subdivision (c).

(3) For purposes of this chapter, "adnexa" means ocular adnexa.

(b) In diagnosing and treating the conditions listed in subdivision (a), an optometrist certified to use therapeutic pharmaceutical agents pursuant to this section may use all of the following ~~diagnostic and~~ therapeutic pharmaceutical agents:

~~(1) Oral and topical diagnostic and therapeutic pharmaceutical agents that are not controlled substances. The use of pharmaceutical agents shall be limited to the use for which the drug has been approved for marketing by the federal Food and Drug Administration (FDA).~~

~~(2) Notwithstanding paragraph (1), an optometrist certified to use therapeutic pharmaceutical agents may use a drug in a way for which the drug has not been approved for marketing by the FDA if all of the following requirements are met:~~

~~(A) The drug is approved by the FDA.~~

~~(B) The drug has been recognized for treatment of the condition by either of the following:~~

~~(i) The American Hospital Formulary Service's Drug Information.~~

~~(ii) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective, unless there is clear and convincing~~

~~contradictory evidence presented in a major peer reviewed medical journal.~~

~~(3) Notwithstanding paragraph (1), codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the federal Controlled Substances Act (21 U.S.C. Sec. 801, et seq.) may be used. The use of these controlled substances shall be limited to five days.~~

(1) Topical pharmaceutical agents for the purpose of the examination of the human eye or eyes for any disease or pathological condition, including, but not limited to, topical miotics.

(2) Topical lubricants.

(3) Antiallergy agents. In using topical steroid medication for the treatment of ocular allergies, an optometrist shall consult with an ophthalmologist if the patient's condition worsens 21 days after diagnosis.

(4) Topical and oral anti-inflammatories.

(5) Topical antibiotic agents.

(6) Topical hyperosmotics.

(7) Topical and oral antiglaucoma agents pursuant to the certification process defined in Section 3041.2.

(8) Nonprescription medications used for the rational treatment of an ocular disorder.

(9) Oral antihistamines.

(10) Prescription oral nonsteroidal anti-inflammatory agents.

(11) Oral antibiotics for medical treatment of ocular disease.

(12) Topical and oral antiviral medication for the medical treatment of herpes simplex viral keratitis, herpes simplex viral conjunctivitis, periocular herpes simplex viral dermatitis, varicella zoster viral keratitis, varicella zoster viral conjunctivitis, and periocular varicella zoster viral dermatitis.

(13) Oral analgesics that are not controlled substances.

(14) Codeine with compounds and hydrocodone with compounds as listed in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and the United States Uniform Controlled Substances Act (21 U.S.C. Sec. 801 et seq.). The use of these agents shall be

limited to five days, with a referral to an ophthalmologist if the pain persists.

(c) An optometrist who is certified to use therapeutic pharmaceutical agents pursuant to this section may also perform all of the following:

(1) Corneal scraping with cultures.

(2) Debridement of corneal epithelia.

(3) Mechanical epilation.

(4) Collection of a blood specimen by finger prick method or venipuncture for testing patients suspected of having diabetes.

(5) Suture removal, with prior consultation with the treating health care provider.

(6) Treatment or removal of sebaceous cysts by expression.

(7) Administration of oral fluorescein to patients suspected as having diabetic retinopathy.

(8) Use of an auto-injector to counter anaphylaxis.

~~(9) Ordering of clinical laboratory and imaging tests related to the practice of optometry.~~

~~(10) A clinical laboratory test or examination classified as waived under CLIA and related to the practice of optometry.~~

(9) Ordering of smears, cultures, sensitivities, complete blood count, mycobacterial culture, acid fast stain, urinalysis, tear fluid analysis, and X-rays necessary for the diagnosis of conditions or diseases of the eye or adnexa. An optometrist may order other types of images subject to prior consultation with the appropriate physician and surgeon.

(10) A clinical laboratory test or examination classified as waived under the Clinical Laboratory Improvement Amendments of 1988 (CLIA)(42 U.S.C. Sec. 263a; Public Law 100-578) or any regulations adopted pursuant to CLIA, and that are necessary for the diagnosis of conditions and diseases of the eye or adnexa, or if otherwise specifically authorized by this chapter.

(11) Skin test to diagnose ocular allergies. Skin tests shall be limited to the superficial lawyer of the skin.

(12) Punctal occlusion by plugs, excluding laser, diathermy, cryotherapy, or other means constituting surgery as defined in this chapter.

(13) The prescription of therapeutic contact lenses, diagnostic contact lenses, or biological or technological corneal ~~devices.~~

devices that diagnose or treat a condition authorized under this chapter.

(14) Removal of foreign bodies from the cornea, eyelid, and conjunctiva with any appropriate instrument other than a ~~scalpel or needle.~~ *scalpel*. Corneal foreign bodies shall be nonperforating, be no deeper than the midstroma, and require no surgical repair upon removal.

(15) For patients over 12 years of age, lacrimal irrigation and dilation, excluding probing of the nasal lacrimal tract. The board shall certify any optometrist who graduated from an accredited school of optometry before May 1, 2000, to perform this procedure after submitting proof of satisfactory completion and confirmation of 10 procedures under the supervision of an ophthalmologist or optometrist who is certified in lacrimal irrigation and dilation. Any optometrist who graduated from an accredited school of optometry on or after May 1, 2000, shall be exempt from the certification requirement contained in this paragraph.

(16) Use of mechanical lipid extraction of meibomian glands and nonsurgical techniques.

~~(17) Notwithstanding subdivision (b), administration of injections for the diagnoses or treatment of conditions of the eye and adnexa, excluding intraorbital injections and injections administered for cosmetic effect, provided that the optometrist has satisfactorily received four hours of continuing education on performing all injections authorized by this paragraph.~~

(d) In order to be certified to use therapeutic pharmaceutical agents and authorized to diagnose and treat the conditions listed in this section, an optometrist shall apply for a certificate from the board and meet all requirements imposed by the board.

(e) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who graduated from a California accredited school of optometry prior to January 1, 1996, is licensed as an optometrist in California, and meets all of the following requirements:

(1) Satisfactorily completes a didactic course of no less than 80 classroom hours in the diagnosis, pharmacological, and other treatment and management of ocular disease provided by either an accredited school of optometry in California or a recognized residency review committee in ophthalmology in California.

(2) Completes a preceptorship of no less than 65 hours, during a period of not less than two months nor more than one year, in either an ophthalmologist's office or an optometric clinic. The training received during the preceptorship shall be on the diagnosis, treatment, and management of ocular, systemic disease. The preceptor shall certify completion of the preceptorship. Authorization for the ophthalmologist to serve as a preceptor shall be provided by an accredited school of optometry in California, or by a recognized residency review committee in ophthalmology, and the preceptor shall be licensed as an ophthalmologist in California, board certified in ophthalmology, and in good standing with the Medical Board of California. The individual serving as the preceptor shall schedule no more than three optometrist applicants for each of the required 65 hours of the preceptorship program. This paragraph shall not be construed to limit the total number of optometrist applicants for whom an individual may serve as a preceptor, and is intended only to ensure the quality of the preceptorship by requiring that the ophthalmologist preceptor schedule the training so that each applicant optometrist completes each of the 65 hours of the preceptorship while scheduled with no more than two other optometrist applicants.

(3) Successfully completes a minimum of 20 hours of self-directed education.

(4) Passes the National Board of Examiners in Optometry's "Treatment and Management of Ocular Disease" examination or, in the event this examination is no longer offered, its equivalent, as determined by the State Board of Optometry.

(5) Passes the examination issued upon completion of the 80-hour didactic course required under paragraph (1) and provided by the accredited school of optometry or residency program in ophthalmology.

(6) When any or all of the requirements contained in paragraph (1), (4), or (5) have been satisfied on or after July 1, 1992, and before January 1, 1996, an optometrist shall not be required to fulfill the satisfied requirements in order to obtain certification to use therapeutic pharmaceutical agents. In order for this paragraph to apply to the requirement contained in paragraph (5), the didactic examination that the applicant successfully completed shall meet equivalency standards, as determined by the board.

(7) Any optometrist who graduated from an accredited school of optometry on or after January 1, 1992, and before January 1, 1996, shall not be required to fulfill the requirements contained in paragraphs (1), (4), and (5).

(f) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who graduated from a California accredited school of optometry on or after January 1, 1996, who is licensed as an optometrist in California, and who meets all of the following requirements:

(1) Passes the National Board of Examiners in Optometry's national board examination, or its equivalent, as determined by the State Board of Optometry.

(2) Of the total clinical training required by a school of optometry's curriculum, successfully completed at least 65 of those hours on the diagnosis, treatment, and management of ocular, systemic disease.

(3) Is certified by an accredited school of optometry as competent in the diagnosis, treatment, and management of ocular, systemic disease to the extent authorized by this section.

(4) Is certified by an accredited school of optometry as having completed at least 10 hours of experience with a board-certified ophthalmologist.

(g) The board shall grant a certificate to use therapeutic pharmaceutical agents to any applicant who is an optometrist who obtained his or her license outside of California if he or she meets all of the requirements for an optometrist licensed in California to be certified to use therapeutic pharmaceutical agents.

(1) In order to obtain a certificate to use therapeutic pharmaceutical agents, any optometrist who obtained his or her license outside of California and graduated from an accredited school of optometry prior to January 1, 1996, shall be required to fulfill the requirements set forth in subdivision (e). In order for the applicant to be eligible for the certificate to use therapeutic pharmaceutical agents, the education he or she received at the accredited out-of-state school of optometry shall be equivalent to the education provided by any accredited school of optometry in California for persons who graduated before January 1, 1996. For those out-of-state applicants who request that any of the requirements contained in subdivision (e) be waived based on fulfillment of the requirement in another state, if the board

determines that the completed requirement was equivalent to that required in California, the requirement shall be waived.

(2) In order to obtain a certificate to use therapeutic pharmaceutical agents, any optometrist who obtained his or her license outside of California and who graduated from an accredited school of optometry on or after January 1, 1996, shall be required to fulfill the requirements set forth in subdivision (f). In order for the applicant to be eligible for the certificate to use therapeutic pharmaceutical agents, the education he or she received by the accredited out-of-state school of optometry shall be equivalent to the education provided by any accredited school of optometry for persons who graduated on or after January 1, 1996. For those out-of-state applicants who request that any of the requirements contained in subdivision (f) be waived based on fulfillment of the requirement in another state, if the board determines that the completed requirement was equivalent to that required in California, the requirement shall be waived.

(3) The State Board of Optometry shall decide all issues relating to the equivalency of an optometrist's education or training under this subdivision.

(h) Other than for prescription ophthalmic devices described in subdivision (b) of Section 2541, any dispensing of a therapeutic pharmaceutical agent by an optometrist shall be without charge.

(i) Except as authorized by this chapter, the practice of optometry does not include performing surgery. "Surgery" means any procedure in which human tissue is cut, altered, or otherwise infiltrated by mechanical or laser means. "Surgery" does not include those procedures specified in subdivision (c). This section does not limit an optometrist's authority to utilize diagnostic laser and ultrasound technology within his or her scope of practice.

(j) In an emergency, an optometrist shall stabilize, if possible, and immediately refer any patient who has an acute attack of angle closure to an ophthalmologist.

SEC. 4. Section 3041.2 of the Business and Professions Code is repealed.

SEC. 5. Section 3041.2 is added to the Business and Professions Code, to read:

3041.2. (a) For purposes of this chapter, "glaucoma" means any of the following:

(1) All primary open-angle glaucoma.

(2) Exfoliation and pigmentary glaucoma.

(3) Increase in intraocular pressure caused by steroid ~~medication.~~ *medication prescribed by the optometrist.*

(4) Increase in intraocular pressure caused by steroid medication not prescribed by the optometrist, after consultation and treatment approval by the prescribing physician.

(b) An optometrist certified pursuant to Section 3041.1 shall be certified for the treatment of glaucoma, as described in subdivision (a), in patients over 18 years of age after the optometrist meets the following applicable requirements:

(1) For licensees who graduated from an accredited school of optometry on or after May 1, 2008, submission of proof of graduation from that institution.

(2) For licensees who were certified to treat glaucoma under this section prior to January 1, 2009, submission of proof of completion of that certification program.

(3) For licensees who completed a didactic course of not less than 24 hours in the diagnosis, pharmacological, and other treatment and management of glaucoma, submission of proof of satisfactory completion of the case management requirements for certification established by the board.

(4) For licensees who graduated from an accredited school of optometry on or before May 1, 2008, and are not described in paragraph (2) or (3), submission of proof of satisfactory completion of the requirements for certification established by the board.

SEC. 6. Section 3041.3 of the Business and Professions Code is repealed.

SEC. 7. Section 3041.3 is added to the Business and Professions Code, to read:

3041.3. (a) For the purposes of this chapter, "anterior segment laser" means any of the following:

(1) Therapeutic lasers appropriate for treatment of glaucoma.

(2) Notwithstanding subdivision (a) of Section 3041.2, peripheral iridotomy for the prophylactic treatment of angle closure glaucoma.

(3) Therapeutic lasers used for posterior capsulotomy secondary to cataract surgery.

(b) An optometrist certified to treat glaucoma pursuant to Section 3041.2 shall be additionally certified for the use of anterior segment lasers after submitting proof of satisfactory completion

of a course that is approved by the board, provided by an accredited school of optometry, and developed in consultation with an ophthalmologist who has experience educating optometric students. *The board shall issue a certificate pursuant to this section only to an optometrist that has graduated from an approved school of optometry.*

(1) The board-approved course shall be ~~a minimum of 16~~ *at least 25* hours in length, and include a test for competency of the following:

(A) Laser physics, hazards, and safety.

(B) Biophysics of laser.

(C) Laser application in clinical optometry.

(D) Laser tissue interactions.

(E) Laser indications, contraindications, and potential complications.

(F) Gonioscopy.

(G) Laser therapy for open-angle glaucoma.

(H) Laser therapy for angle closure glaucoma.

(I) Posterior capsulotomy.

(J) Common complications of the lids, lashes, and lacrimal system.

(K) Medicolegal aspects of anterior segment procedures.

(L) Peripheral iridotomy.

(M) Laser trabeculoplasty.

(2) The school of optometry shall require each applicant for certification to perform a sufficient number of *complete* anterior segment laser procedures to verify that the applicant has demonstrated competency to practice independently. At a minimum, each applicant shall complete ~~14~~ *24* anterior segment laser procedures on live ~~humans.~~ *humans as follows:*

(A) Eight YAG capsulotomy procedures.

(B) Eight laser trabeculoplasty procedures.

(C) Eight peripheral iridotomy procedures.

(c) The board, by regulation, shall set the fee for issuance and renewal of a certificate authorizing the use of anterior segment lasers at an amount no higher than the reasonable cost of regulating anterior segment laser certified optometrists pursuant to this section. The fee shall not exceed one hundred fifty dollars ($150).

(d) An optometrist certified to use anterior segment lasers pursuant to this section shall complete four hours of continuing

education on anterior segment lasers as part of the required 50 hours of continuing education required to be completed every two years on the diagnosis, treatment, and management of glaucoma.

SEC. 8. Section 3041.4 is added to the Business and Professions Code, to read:

3041.4. (a) For the purposes of this chapter, "minor procedure" means either of the following:

(1) Removal, destruction, or drainage of lesions of the eyelid and adnexa clinically evaluated by the optometrist to be noncancerous, not involving the eyelid margin, lacrimal supply or drainage systems, no deeper than the orbicularis muscle, and smaller than five millimeters in diameter.

(2) Closure of a wound resulting from a procedure described in paragraph (1).

(3) Administration of injections for the diagnoses or treatment of conditions of the eye and adnexa authorized by this chapter, excluding intraorbital injections and injections administered for cosmetic effect.

(4) "Minor procedures" does not include blepharoplasty or other cosmetic surgery procedures that reshape normal structures of the body in order to improve appearance and self-esteem.

(b) An optometrist certified to treat glaucoma pursuant to Section 3041.2 shall be additionally certified to perform minor procedures after submitting proof of satisfactory completion of a course that is approved by the board, provided by an accredited school of optometry, and developed in consultation with an ophthalmologist who has experience teaching optometric students. *The board shall issue a certificate pursuant to this section only to an optometrist that has graduated from an approved school of optometry.*

(1) The board-approved course shall be ~~a minimum of 32 hours~~ *at least 25 hours* in length and include a test for competency of the following:

(A) Minor surgical procedures.

(B) Overview of surgical instruments, asepsis, and the state and federal Occupational Safety and Health Administrations.

(C) Surgical anatomy of the eyelids.

(D) Emergency surgical procedures.

(E) Chalazion management.

(F) Epiluminescence microscopy.

(G) Suture techniques.
(H) Local anesthesia techniques and complications.
(I) Anaphylaxsis and other office emergencies.
(J) Radiofrequency surgery.
(K) Postoperative wound care.
(L) Injection techniques.

(2) The school of optometry shall require each applicant for certification to perform a sufficient number of minor procedures to verify that the applicant has demonstrated competency to practice independently. At a minimum, each applicant shall *perform 32* complete ~~five~~ minor procedures on live humans.

(c) The board, by regulation, shall set the fee for issuance and renewal of a certificate authorizing the use of minor procedures at an amount no greater than the reasonable cost of regulating minor procedure certified optometrists pursuant to this section. The fee shall not exceed one hundred fifty dollars ($150).

(d) An optometrist certified to perform minor procedures pursuant to Section 3041.1 shall complete five hours of continuing education on the diagnosis, treatment, and management of lesions of the eyelid and adnexa as part of the 50 hours of continuing education required every two years in Section 3059.

~~SEC. 9. Section 3041.5 is added to the Business and Professions Code, to read:~~

~~3041.5. (a) An optometrist may independently initiate and administer vaccines listed on the routine immunization schedules recommended by the federal Advisory Committee on Immunization Practices (ACIP), in compliance with individual ACIP vaccine recommendations, and published by the federal Centers for Disease Control and Prevention (CDC) for persons three years of age and older.~~

~~(b) In order to initiate and administer an immunization described in subdivision (a), an optometrist shall do all of the following:~~

~~(1) Complete an immunization training program endorsed by the CDC or the Accreditation Council for Pharmacy Education that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and shall maintain that training.~~

~~(2) Be certified in basic life support for health care professionals.~~

~~(3) Comply with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.~~

SEC. 9. Section 3041.5 is added to the Business and Professions Code, to read:

3041.5. (a) The board shall grant to an optometrist a certificate for the use of immunizations described in subdivision (b), if the optometrist is certified pursuant to Section 3041.2 and after the optometrist meets all of the following requirements:

(1) Completes an immunization training program endorsed by the federal Centers for Disease Control (CDC) that, at a minimum, includes hands-on injection technique, clinical evaluation of indications and contraindications of vaccines, and the recognition and treatment of emergency reactions to vaccines, and maintains that training.

(2) Is certified in basic life support.

(3) Complies with all state and federal recordkeeping and reporting requirements, including providing documentation to the patient's primary care provider and entering information in the appropriate immunization registry designated by the immunization branch of the State Department of Public Health.

(b) For the purposes of this section, "immunization" means the administration of immunizations for influenza, herpes zoster virus, and pneumococcus in compliance with individual Advisory Committee on Immunization Practices (ACIP) vaccine recommendations published by the CDC for persons 18 years of age or older.

(c) The board, by regulation, shall set the fee for issuance and renewal of a certificate for the use of immunizations at the reasonable cost of regulating immunization certified optometrists pursuant to this section. The fee shall not exceed one hundred dollars ($100).

SEC. 10. Section 3041.6 is added to the Business and Professions Code, to read:

3041.6. An optometrist licensed under this chapter is subject to the provisions of Section 2290.5 for purposes of practicing telehealth.

SEC. 11. Section 3041.7 is added to the Business and Professions Code, to read:

3041.7. Optometrists diagnosing or treating eye disease shall be held to the same standard of care to which physicians and surgeons and osteopathic physicians and surgeons are held. An optometrist shall consult with and, if necessary, refer to a physician and surgeon or other appropriate health care provider when a situation or condition occurs that is beyond the optometrist's scope of practice.

SEC. 12. Section 3041.8 is added to the Business and Professions Code, to read:

3041.8. It is the intent of the Legislature that the Office of Statewide Health Planning and Development, under the Health Workforce Pilot Projects Program, designate a pilot project to test, demonstrate, and evaluate expanded roles for optometrists in the performance of management and treatment of diabetes mellitus, hypertension, and hypercholesterolemia.

SEC. 13. Section 3110 of the Business and Professions Code is amended to read:

3110. The board may take action against any licensee who is charged with unprofessional conduct, and may deny an application for a license if the applicant has committed unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:

(a) Violating or attempting to violate, directly or indirectly assisting in or abetting the violation of, or conspiring to violate any provision of this chapter or any of the rules and regulations adopted by the board pursuant to this chapter.

(b) Gross negligence.

(c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions.

(d) Incompetence.

(e) The commission of fraud, misrepresentation, or any act involving dishonesty or corruption, that is substantially related to the qualifications, functions, or duties of an optometrist.

(f) Any action or conduct that would have warranted the denial of a license.

(g) The use of advertising relating to optometry that violates Section 651 or 17500.

(h) Denial of licensure, revocation, suspension, restriction, or any other disciplinary action against a health care professional license by another state or territory of the United States, by any other governmental agency, or by another California health care professional licensing board. A certified copy of the decision or judgment shall be conclusive evidence of that action.

(i) Procuring his or her license by fraud, misrepresentation, or mistake.

(j) Making or giving any false statement or information in connection with the application for issuance of a license.

(k) Conviction of a felony or of any offense substantially related to the qualifications, functions, and duties of an optometrist, in which event the record of the conviction shall be conclusive evidence thereof.

(*l*) Administering to himself or herself any controlled substance or using any of the dangerous drugs specified in Section 4022, or using alcoholic beverages to the extent, or in a manner, as to be dangerous or injurious to the person applying for a license or holding a license under this chapter, or to any other person, or to the public, or, to the extent that the use impairs the ability of the person applying for or holding a license to conduct with safety to the public the practice authorized by the license, or the conviction of a misdemeanor or felony involving the use, consumption, or self-administration of any of the substances referred to in this subdivision, or any combination thereof.

(m) (1) Committing or soliciting an act punishable as a sexually related crime, if that act or solicitation is substantially related to the qualifications, functions, or duties of an optometrist.

(2) Committing any act of sexual abuse, misconduct, or relations with a patient. The commission of and conviction for any act of sexual abuse, sexual misconduct, or attempted sexual misconduct, whether or not with a patient, shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee. This paragraph shall not apply to sexual contact between any person licensed under this chapter and his or her spouse or person in an equivalent domestic relationship when that licensee provides optometry treatment to his or her spouse or person in an equivalent domestic relationship.

(3) Conviction of a crime that requires the person to register as a sex offender pursuant to Chapter 5.5 (commencing with Section

290) of Title 9 of Part 1 of the Penal Code. A conviction within the meaning of this paragraph means a plea or verdict of guilty or a conviction following a plea of nolo contendere. A conviction described in this paragraph shall be considered a crime substantially related to the qualifications, functions, or duties of a licensee.

(n) Repeated acts of excessive prescribing, furnishing, or administering of controlled substances or dangerous drugs specified in Section 4022, or repeated acts of excessive treatment.

(o) Repeated acts of excessive use of diagnostic or therapeutic procedures, or repeated acts of excessive use of diagnostic or treatment facilities.

(p) The prescribing, furnishing, or administering of controlled substances or drugs specified in Section 4022, or treatment without a good faith prior examination of the patient and optometric reason.

(q) The failure to maintain adequate and accurate records relating to the provision of services to his or her patients.

(r) Performing, or holding oneself out as being able to perform, or offering to perform, any professional services beyond the scope of the license authorized by this chapter.

(s) The practice of optometry without a valid, unrevoked, unexpired license.

(t) The employing, directly or indirectly, of any suspended or unlicensed optometrist to perform any work for which an optometry license is required.

(u) Permitting another person to use the licensee's optometry license for any purpose.

(v) Altering with fraudulent intent a license issued by the board, or using a fraudulently altered license, permit certification or any registration issued by the board.

(w) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of bloodborne infectious diseases from optometrist to patient, from patient to patient, or from patient to optometrist. In administering this subdivision, the board shall consider the standards, regulations, and guidelines of the State Department of Public Health developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, guidelines, and regulations pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the

transmission of HIV, hepatitis B, and other bloodborne pathogens in health care settings. As necessary, the board may consult with the Medical Board of California, the Board of Podiatric Medicine, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision.

(x) Failure or refusal to comply with a request for the clinical records of a patient, that is accompanied by that patient's written authorization for release of records to the board, within 15 days of receiving the request and authorization, unless the licensee is unable to provide the documents within this time period for good cause.

(y) Failure to refer a patient to an appropriate ~~physician in either of the following circumstances:~~

~~(1) Where~~ *physician if* an examination of the eyes indicates a substantial likelihood of any pathology that requires the attention of that physician.

~~(2) As required by subdivision (c) of Section 3041.~~

~~SEC. 13.~~

SEC. 14. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

O

2016 LEGISLATIVE CALENDAR

(See S.C.R. 37, Chapter 48, Statutes of 2015)
COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK
Revised 10-7-15

JANUARY

	S	M	T	W	TH	F	S
Interim Recess						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
Wk. 4	24	25	26	27	28	29	30
Wk. 1	31						

FEBRUARY

	S	M	T	W	TH	F	S
Wk. 1		1	2	3	4	5	6
Wk. 2	7	8	9	10	11	12	13
Wk. 3	14	15	16	17	18	19	20
Wk. 4	21	22	23	24	25	26	27
Wk. 1	28	29					

MARCH

	S	M	T	W	TH	F	S
Wk. 1			1	2	3	4	5
Wk. 2	6	7	8	9	10	11	12
Wk. 3	13	14	15	16	17	18	19
Spring Recess	20	21	22	23	24	25	26
Wk. 4	27	28	29	30	31		

APRIL

	S	M	T	W	TH	F	S
Wk. 4						1	2
Wk. 1	3	4	5	6	7	8	9
Wk. 2	10	11	12	13	14	15	16
Wk. 3	17	18	19	20	21	22	23
Wk. 4	24	25	26	27	28	29	30

MAY

	S	M	T	W	TH	F	S
Wk. 1	1	2	3	4	5	6	7
Wk. 2	8	9	10	11	12	13	14
Wk. 3	15	16	17	18	19	20	21
Wk. 4	22	23	24	25	26	27	28
No Hrgs.	29	30	31				

*Holiday schedule subject to final approval by Rules Committee.

DEADLINES

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

Jan. 4 Legislature reconvenes (J.R. 51(a)(4)).

Jan. 10 Budget Bill must be submitted by Governor (Art. IV, Sec. 12(a)).

Jan. 15 Last day for **policy committees** to hear and report to **fiscal committees** fiscal bills introduced in their house in the odd-numbered year. (J.R. 61(b)(1)).

Jan. 18 Martin Luther King, Jr. Day observed.

Jan. 22 Last day for any committee to hear and report to the **Floor** bills introduced in their house in 2015 (J.R. 61(b)(2)). Last day to submit **bill requests** to the Office of Legislative Counsel.

Jan. 31 Last day for each house to pass **bills** introduced in that house in the odd-numbered year (J.R. 61(b)(3)), (Art. IV, Sec. 10(c)).

Feb. 15 Presidents' Day observed.

Feb. 19 Last day for bills to be **introduced** (J.R. 61(b)(4), J.R. 54(a)).

Mar. 17 **Spring Recess** begins upon adjournment (J.R. 51(b)(1)).

Mar. 28 Legislature reconvenes from Spring Recess (J.R. 51(b)(1)).

Apr. 1 Cesar Chavez Day observed.

Apr. 22 Last day for **policy committees** to hear and report to fiscal committees **fiscal bills** introduced in their house (J.R. 61(b)(5)).

May 6 Last day for **policy committees** to hear and report to the Floor **nonfiscal** bills introduced in their house (J.R. 61(b)(6)).

May 13 Last day for **policy committees** to meet prior to June 6 (J.R. 61(b)(7)).

May 27 Last day for **fiscal committees** to hear and report to the Floor bills introduced in their house (J.R. 61(b)(8)). Last day for **fiscal committees** to meet prior to June 6 (J.R. 61(b)(9)).

May 30 Memorial Day observed.

May 31 - June 3 **Floor Session only**. No committee may meet for any purpose except Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(b)(10), J.R. 61(h)).

2016 LEGISLATIVE CALENDAR

(See S.C.R. 37, Chapter 48, Statutes of 2015)
COMPILED BY THE OFFICE OF THE ASSEMBLY CHIEF CLERK
Revised 10-7-15

JUNE							
	S	M	T	W	TH	F	S
No Hrgs.				1	2	3	4
Wk. 1	5	6	7	8	9	10	11
Wk. 2	12	13	14	15	16	17	18
Wk. 3	19	20	21	22	23	24	25
Wk. 4	26	27	28	29	30		

June 3 Last day for each house to pass bills introduced in that house (J.R. 61(b)(11)).

June 6 Committee meetings may resume (J.R. 61(b)(12)).

June 15 Budget Bill must be passed by midnight (Art. IV, Sec. 12(c)(3)).

June 30 Last day for a legislative measure to qualify for the Nov. 8 General Election ballot (Elections Code Section 9040).

JULY							
	S	M	T	W	TH	F	S
Wk. 4						1	2
Summer Recess	3	4	5	6	7	8	9
Summer Recess	10	11	12	13	14	15	16
Summer Recess	17	18	19	20	21	22	23
Summer Recess	24	25	26	27	28	29	30
Wk. 1	31						

July 1 Last day for **policy committees** to meet and report bills (J.R. 61(b)(13)). **Summer Recess** begins upon adjournment, provided Budget Bill has been passed (J.R. 51(b)(2)).

July 4 Independence Day observed.

AUGUST							
	S	M	T	W	TH	F	S
Wk. 1		1	2	3	4	5	6
Wk. 2	7	8	9	10	11	12	13
No Hrgs.	14	15	16	17	18	19	20
No Hrgs.	21	22	23	24	25	26	27
No Hrgs.	28	29	30	31			

Aug. 1 Legislature reconvenes from Summer Recess (J.R. 51(b)(2)).

Aug. 12 Last day for **fiscal committees** to meet and report bills (J.R. 61(b)(14)).

Aug. 15 - 31 Floor Session only. No committee may meet for any purpose except Rules Committee, bills referred pursuant to Assembly Rule 77.2, and Conference Committees (J.R. 61(b)(15), J.R. 61(h)).

Aug. 19 Last day to **amend** on the Floor (J.R. 61(b)(16)).

Aug. 31 Last day for each house to pass bills, except bills that take effect immediately or bills in Extraordinary Session (Art. IV, Sec. 10(c), J.R. 61(b)(17)). **Final Recess** begins upon adjournment (J.R. 51(b)(3)).

IMPORTANT DATES OCCURRING DURING FINAL RECESS

2016

Sept. 30 Last day for Governor to sign or veto bills passed by the Legislature before Sept. 1 and in the Governor's possession on or after Sept. 1 (Art. IV, Sec.10(b)(2)).

Oct. 2 Bills enacted on or before this date take effect January 1, 2017 (Art. IV, Sec. 8(c)).

Nov. 8 General Election.

Nov. 30 Adjournment *sine die* at midnight (Art. IV, Sec. 3(a)).

Dec. 5 2017-18 Regular Session convenes for Organizational Session at 12 noon (Art. IV, Sec. 3(a)).

2017

Jan. 1 Statutes take effect (Art. IV, Sec. 8(c)).

*Holiday schedule subject to final approval by Rules Committee.

MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
January 13, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 611	Dahle	Controlled Substances: Prescriptions: Reporting	Asm. B&P		4/15/15
AB 890	Ridley-Thomas	Anesthesiologist Assistants	Asm. Approps	Support if Amended	5/5/15
AB 1306	Burke	Healing Arts: Certified Nurse-Midwives: Scope of Practice	Sen. B&P	Oppose Unless Amended	7/1/15
SB 22	Roth	Residency Training	Inactive File	Support	6/4/15
SB 323	Hernandez	Nurse Practitioners	Asm. B&P	Oppose	7/9/15
SB 482	Lara	Controlled Substances: CURES Database	Assembly	Support	4/30/15
SB 538	Block	Naturopathic Doctors	Asm. Approps	Oppose	8/17/15
SB 563	Pan	Worker's Compensation: Utilization Review	Sen. Labor & Industrial Relations	Reco: Support	1/4/16
SB 622	Hernandez	Optometry	Asm. B&P	Oppose Unless Amended	5/4/15

Orange – For Discussion, Blue – No Discussion Needed (Bills not moving)

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 563
Author: Pan
Bill Date: January 4, 2016, Amended
Subject: Workers' Compensation: Utilization Review
Sponsor: California Medical Association (CMA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would ensure that physicians involved in authorizing injured worker medical care on behalf of the employer and/or payor are not being inappropriately incentivized to modify, delay, or deny requests for medically necessary services.

BACKGROUND

In California's workers' compensation system, an employer or insurer cannot deny treatment. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to utilization review (UR). UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

In April 2013, the Medical Board of California (Board) reaffirmed that engaging in UR is the practice of medicine and that the Board will not automatically deem UR complaints as non-jurisdictional; the Board will review UR complaints against California-licensed physicians to determine if a quality of care issue is present, and if so, the complaint will undergo the normal complaint review process.

ANALYSIS

This bill would prohibit an employer, or any entity conducting UR on behalf of an employer, from providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. This bill would give the administrative director the authority to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting UR on behalf of the employer, and the UR physician.

According to the sponsor, this bill would increase transparency and accountability within the workers' compensation UR process. There is currently no explicit prohibition in law related to UR to ensure that a physician's judgment for medical necessity is not compromised by financial incentives. This bill will promote the Board's mission of consumer protection and staff recommends that the Board take a support position on this bill.

FISCAL: None to the Board

SUPPORT: California Medical Association (sponsor)
California Labor Federation, AFL-CIO
California Orthopedic Association

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE JANUARY 4, 2016

AMENDED IN SENATE APRIL 30, 2015

AMENDED IN SENATE APRIL 13, 2015

SENATE BILL No. 563

Introduced by Senator Pan

February 26, 2015

An act to amend Section 4610 ~~of, and to add Section 4610.2 to,~~ *of* the Labor Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

SB 563, as amended, Pan. Workers' compensation: utilization review.

Existing law requires every employer, for purposes of workers' compensation, to establish a utilization review process to prospectively, retrospectively, or concurrently review requests by physicians for authorization to provide recommended medical treatment to injured employees. Existing law establishes timeframes for an employer to make a determination regarding a physician's request. Existing law requires the utilization review process to be governed by written policies and procedures, and requires that these policies and procedures be filed with the Administrative Director of the Division of Workers' Compensation and disclosed by the employer to employees, physicians, and the public upon request.

This bill would ~~require that the method of compensation, and any incentive payments contingent upon the approval, modification, or denial of a claim, for an individual or entity providing services pursuant to the utilization review process, as specified, be filed with the administrative director and disclosed by the employer to employees, physicians, and the public upon request. The bill would exempt a request~~

~~for medical treatment by a physician to cure or relieve an injured worker from the effect of an industrial injury from these requirements if the request meets specified conditions, including that a final award of permanent disability made by the appeals board specifies the provision of future medical treatment and that the request for medical treatment is for medical treatment that is specified by the award. The bill would also include a statement of legislative intent.~~ *prohibit the employer, or any entity conducting utilization review on behalf of the employer, from offering or providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. The bill would grant the administrative director authority pursuant to this provision to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician.*

Vote: majority. Appropriation: no. Fiscal committee: ~~no~~ *yes*. State-mandated local program: no.

The people of the State of California do enact as follows:

SECTION 1. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description

of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. 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.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve. *The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician under this section. The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician.*

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the

employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service

approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment

of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

All matter omitted in this version of the bill appears in the bill as amended in the Senate, April 30, 2015. (JR11)

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MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 11	Gonzalez	Employment: Paid Sick Days: In-Home Supportive Services	Asm. Approps	03/11/15
AB 12	Cooley	State Government: Administrative Regulations: Review	Sen. Approps	08/19/15
AB 19	Chang	GO BIZ: Small Business: Regulations	Asm. Approps	05/06/15
AB 26	Jones-Sawyer	Medical Cannabis	Asm. B&P	01/04/16
AB 41	Chau	Health Care Coverage: Discrimination	Asm. Approps	
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Asm. Judiciary	01/06/16
AB 70	Waldron	Emergency Medical Services: Reporting	Asm. Health	03/26/15
AB 73	Waldron	Patient Access to Prescribed Antiretroviral Drugs for HIV/AIDS	Asm. Approps	01/05/16
AB 83	Gatto	Personal Data	Sen. Inactive File	07/15/15
AB 170	Gatto	Newborn Screening: Genetic Diseases: Blood Samples	Sen. Health	07/08/15
AB 174	Gray	UC: Medical Education	Sen. Approps	06/01/15
AB 259	Dababneh	Personal Information: Privacy	Sen. Approps	
AB 322	Waldron	Privacy: Social Security Numbers	Asm. P&CP	03/26/15
AB 330	Chang	State Government	Assembly	
AB 344	Chavez	Medi-Cal	Asm. Approps	
AB 351	Jones-Sawyer	Public Contracts: Small Business Participation	Asm. Approps	
AB 366	Bonta	Medi-Cal: Annual Access Monitoring Report	Sen. Approps	07/07/15
AB 383	Gipson	Public Health: Hepatitis C	Asm. Approps	04/30/15
AB 411	Lackey	Public Contracts	Assembly	
AB 419	Kim	Go BIZ: Regulations	Sen. B&P	05/04/15
AB 463	Chiu	Pharmaceutical Cost Transparency Act of 2016	Asm. Health	01/04/16
AB 466	McCarty	State Civil Service: Employment Procedures	Sen. Inactive File	07/06/15
AB 507	Olsen	DCA: BreEZe System: Annual Report	Sen. B&P	07/09/15
AB 508	Garcia, C.	Public Health: Maternal Care	Asm. Health	01/04/16
AB 513	Jones-Sawyer	Professions and Vocations	Assembly	

MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 533	Bonta	Health Care Coverage: Out-of-Network Coverage	Assembly	09/04/15
AB 537	Allen, T.	Public Employees' Benefits	Asm. PER&SS	
AB 570	Allen, T.	Cardiovascular Disease: High Blood Pressure	Assembly	
AB 572	Gaines	California Diabetes Program	Sen. Approps	07/02/15
AB 574	Patterson	General Acute Care Hospitals: Cardiovascular Surgical Teams	Asm. Health	03/26/15
AB 584	Cooley	Public Employee Retirement Systems	Assembly	04/06/15
AB 595	Alejo	Forfeiture	Asm. Public Safety	01/04/16
AB 618	Maienschein	Parole: Primary Mental Health Clinicians	Asm. Approps	
AB 623	Wood	Abuse-Deterrent Opioid Analgesic Drug Products	Asm. Approps	05/04/15
AB 635	Atkins	Medical Interpretation Services	Sen. Inactive File	
AB 649	Patterson	Medical Waste: Law Enforcement Drug Take back Programs	Sen. Approps	06/24/15
AB 714	Melendez	State Employees: Health Benefits	Asm. PER&SS	
AB 741	Williams	Mental Health: Community Care Facilities	Sen. Human Svcs	05/04/15
AB 750	Low	Business and Professions: Retired License Category	Asm. Approps	04/16/15
AB 756	Chang	Small Businesses: Civil Fines and Penalties	Asm. Rev. & Tax	04/13/15
AB 766	Ridley-Thomas	Public School Health Center Support Program	Sen. Approps	04/27/15
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	Sen. PE&R	
AB 788	Chu	Prescriptions	Asm. Health	03/26/15
AB 789	Calderon	Contact Lens Sellers: Prohibited Practices: Fines	Asm. B&P	04/22/15
AB 791	Cooley	Electronic Health Records	Asm. Health	
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	Asm. B&P	01/04/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Sen. PE&R	
AB 843	Hadley	Controller: Internet Web Site	Asm. A&AR	03/26/15
AB 845	Cooley	Health Care Coverage: Vision Care	Asm. Approps	04/21/15
AB 859	Medina	Medi-Cal: Obesity Treatment Plans	Asm. Approps	04/30/15

MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 911	Brough	Hospitals: Closures	Asm. Health	04/14/15
AB 923	Steinorth	Respiratory Care Practitioners	Asm. B&P	01/04/16
AB 972	Jones	Ken Maddy California Cancer Registry	Asm. Health	
AB 981	Mayes	Eyeglasses	Assembly	
AB 993	Comm. P.E.R.S	State Employees: MOU	Asm. Inactive File	
AB 994	Comm. P.E.R.S	State Employees: MOU	Asm. PER&SS	
AB 1001	Gatto	Child Abuse: Reporting	Asm. Human Svcs	01/04/16
AB 1027	Gatto	Health Care Coverage: Contracted Rates	Asm. Health	03/26/15
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Asm. J, ED & E	01/04/16
AB 1046	Dababneh	Hospitals: Community Benefits	Asm. Health	04/07/15
AB 1067	Gipson	Foster Children: Rights	Asm. Human Svcs	01/04/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Sen. Approps	07/01/15
AB 1092	Mullin	Magnetic Resonance Imaging Technologists	Asm. Approps	05/04/15
AB 1102	Santiago	Health Care Coverage: Medi-Cal Access Program	Sen. Inactive File	07/09/15
AB 1117	Garcia, C.	Medi-Cal: Vaccination Rates	Sen. Approps	06/01/15
AB 1125	Weber	State Agency Contracts: Small Business	Asm. Approps	05/04/15
AB 1133	Achadjian	School-Based Early Mental Health Intervention and Prevention	Asm. Approps	04/15/15
AB 1174	Bonilla	Healing Arts: Licensee Records	Asm. B&P	1/41/16
AB 1215	Ting	California Open Data Standard	Asm. Approps	03/26/15
AB 1219	Baker	California Cancer Task Force	Asm. Health	
AB 1254	Grove	Health Care Service Plans: Abortion Coverage	Asm. Approps	04/06/15
AB 1281	Wilk	Regulations: Legislative Review	Asm. A&AR	03/26/15
AB 1294	Holden	State Government: Prompt Payment of Claims	Asm. A&AR	03/26/15
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	Sen. Approps	07/16/15
AB 1302	Brown	Public Contracts: Disabled Veterans	Asm. J, ED & E	

MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1357	Bloom	Children and Family Health Promotion Program	Asm. Health	04/29/15
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Asm. B&P	01/05/16
AB 1396	Bonta	Public Health Finance	Asm. B&P	06/03/15
AB 1434	McCarty	Health Insurance: Prohibition on Health Insurance Sales	Asm. Rev. & Tax	04/20/15
AB 1445	Brown	Public Contracts: Small Business Contracts	Asm. Approps	
AB 1460	Thurmond	Hospitals: Community Benefit Plans	Assembly	
AB 1485	Patterson	Medi-Cal: Radiology	Asm. Approps	05/05/15
AB 1566	Wilk	Reports	Assembly	
AB 1575	Bonta	Medical Marijuana	Assembly	
AB 1639	Maienschein	Pupil Health: Sudden Cardiac Arrest Prevention Act	Assembly	
AB 1648	Wilk	Public Records	Assembly	
ABX2 12	Patterson	Cadaveric Fetal Tissue	Assembly	
ABX2 13	Gipson	Medi-Cal: AIDS Medi-Cal Waiver Program	Assembly	
ACA 3	Gallagher	Public Employees' Retirement	Asm. PER&SS	
SB 3	Leno	Minimum Wage: Adjustment	Asm. Approps	03/11/15
SB 10	Lara	Health Care Coverage: Immigration Status	Senate	09/09/15
SB 26	Hernandez	California Health Care Cost and Quality Database	Sen. Approps	05/05/15
SB 52	Walters	Regulatory Boards: Healing Arts	Senate	
SB 58	Knight	Public Employees' Retirement System	Senate	
SB 131	Cannella	UC: Medical Education	Sen. Approps	05/12/15
SB 139	Galgiani	Controlled Substances	Assembly	08/18/15
SB 190	Beall	Health Care Coverage: Acquired Brain Injury	Sen. Health	04/06/15
SB 201	Wieckowski	California Public Records Act	Sen. Judiciary	
SB 202	Hernandez	Controlled Substances: Synthetic Cannabinoids	Sen. B&P	01/04/16
SB 214	Berryhill	Foster Care Services	Senate	

MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 243	Hernandez	Medi-Cal: Reimbursement: Provider Rates	Sen. Approps	05/12/15
SB 253	Monning	Juveniles: Psychotropic Medication	Asm. Inactive File	08/31/15
SB 275	Hernandez	Health Facility Data	Asm. Health	
SB 280	Stone, J	Public Employees: Compensation	Sen. PE&R	04/15/15
SB 289	Mitchell	Telephonic and Electronic Patient Management Services	Sen. Approps	05/04/15
SB 293	Pan	Public Employees: Retirement	Senate	
SB 296	Cannella	Medi-Cal: Specialty Mental Health Services: Documentation	Sen. Inactive File	08/28/15
SB 315	Monning	Health Care Access Demonstration Project Grants	Asm. Inactive File	08/31/15
SB 346	Wieckowski	Health Facilities: Community Benefits	Sen. Health	04/23/15
SB 349	Bates	Optometry: Mobile Optometric Facilities	Sen. B&P	04/06/15
SB 368	Berryhill	Employment: Work Hours	S L& IR	01/04/16
SB 370	Wolk	Immunizations: Disclosure of Information: TB Screening	Sen. Health	
SB 375	Berryhill	Public Employees' Retirement	Senate	
SB 402	Mitchell	Pupil Health: Vision Examinations	Sen. Approps	05/04/15
SB 435	Pan	Medical Home: Health Care Delivery Model	Asm. Inactive File	07/07/15
SB 447	Allen	Medi-Cal: Clinics: Enrollment Applications	Asm. Approps	08/24/15
SB 459	Liu	State Government: Data	Senate	
SB 492	Liu	Coordinate Care Initiative: Consumer Ed. & Info. Guide	Senate	06/25/15
SB 547	Liu	Aging and Long-Term Care Services, Supports and Program. Coord.	Sen. Health	01/04/16
SB 571	Liu	Long-Term Care: CalCareNet	Sen. Approps	04/21/15
SB 573	Pan	Statewide Open Data Portal	Asm. Approps	07/09/15
SB 609	Stone, J	Controlled Substances: Narcotic Replacement Treatment	Sen. Health	04/21/15
SB 614	Leno	Medi-Cal: Mental Health Services	Asm. Inactive File	08/31/15
SB 729	Wieckowski	Consumer Complaints	Senate	
SB 744	Huff	Pupil Health: Epinephrine Auto-Injectors	Senate	

MBC TRACKER II BILLS
1/13/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 779	Hall	Skilled Nursing Facilities: Certified Nurse Assistants	Sen. Approps	05/04/15
SB 780	Mendoza	Psychiatric Technicians and Assistants	Sen. Approps	

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***
CME Requirements	Board voted to withdraw this rulemaking 10/30/15	10/24/14	3/6/15	5/8/2015				
Physician and Surgeon Licensing Examinations Minimum Passing Scores	Staff working to finish the file to submit to DCA for final approval and submission to OAL	5/8/15	6/5/15	7/31/15	7/31/15			
Outpatient Surgery Setting Accreditation Agency Standards	Staff working to finish the file to submit to DCA for final approval and submission to OAL	5/8/15	6/5/15	7/31/15	7/31/15			
Disclaimers and Explanatory Information Applicable to Internet Postings	15-day notice for amended language released, public comment period closed 12/30/15; no comments received so staff will finalize the file and submit to DCA for final approval and submission to OAL	5/8/15	6/5/15	7/31/15	10/30/15			
Disciplinary Guidelines	15-day notice for amended language released, public comment period closed 12/30/15; no comments received so staff will finalize the file and submit to DCA for final approval and submission to OAL	7/25/14 7/31/15	9/4/15	10/30/15	10/30/15			

Prepared by Kevin A. Schunke
Updated on December 31, 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:	January 5, 2016
ATTENTION:	Members, Medical Board of California
SUBJECT:	Special Faculty Permit Review Committee Recommendations
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Fabrizio Luca, M.D., FASCRS
Approve the Special Faculty Permit Review Committee (SFPRC) recommendation for a Special Faculty Permit (SFP) appointment for Fabrizio Luca, M.D., FASCRS pursuant to California Business and Professions Code (BPC) section 2168.1(a)(1)(B).

Tarik Fathy Massoud, M.D., Ph.D.
Approve the SFPRC recommendation to waive the requirement in BPC section 2158.1(a)(5) that prohibits an SFP appointment if the applicant in a Section 2113 appointment for a period of two or more years. If the waiver is approved, approve the SFPRC recommendation for an SFP appointment for Tarik Fathy Massoud, M.D., Ph.D., pursuant to BPC section 2168.1(a)(1)(B).

BACKGROUND AND ANALYSIS:

The Medical Board of California (Board) is authorized to issue a SFP to a person who is academically eminent and meets all of the other requirements pursuant to BPC section 2168.1.

An individual who holds a valid SFP is authorized to practice medicine only within the medical school itself and any affiliated institutions in which the SFP holder is providing instruction as part of the medical school's educational program, and for which the medical school has assumed direct responsibility.

The SFPRC is comprised of two Board Members, one who is a physician and one who is a public member, and one representative from each of the medical schools in California. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to BPC section 2168.1.

At the SFPRC's December 3, 2015 meeting, the SFPRC reviewed the qualifications of two applicants: one applicant from Loma Linda University School of Medicine (LLSM) and one applicant from Stanford University School of Medicine (SUSM). The SFPRC was also requested to review and recommend approval of SUSM's request for waiver of BPC Section 2168.1(a)(5).

Fabrizio Luca, M.D., FASCRS - LLSM:

Daniel Giang, M.D., Professor and Chair of Neurology, Associate Dean for Graduate Medical Education, LLSM, and Carlos Gaberoglio, M.D., F.A.C.S, Professor and Chair, Department of Surgery, LLSM, presented LLSM's request for Fabrizio Luca, M.D., FASCRS to receive an SFP and provided the SFPRC with Dr. Luca's qualifications. Dr. Luca's area of expertise is surgery, specifically in the area of robotic rectal cancer surgery.

Dr. Luca has held the following positions: Director, Multidisciplinary Surgical Techniques, Division of Gastrointestinal Surgery at European Institute of Oncology, Milan, Italy; Director of Integrated Abdominal Surgery, Division of Abdomino-Pelvi Surgery at European Institute of Oncology, Milan, Italy; Director, Abdomino-Pelvic Surgery, School of Robotic Surgery, European Institute of Oncology, Milan, Italy; and Senior Deputy Director, Abdomino-Pelvic Surgery, European Institute of Oncology, Milan, Italy. Dr. Luca has a long and distinguished career in gastrointestinal and abdomino-pelvic surgery at the European Institute of Oncology. Dr. Luca has trained over 50 surgeons in robotic surgical resection of rectal cancer and he has published extensively in the field of surgery for rectal cancer and authored several seminal papers in this field. Dr. Luca has lead and participated in several committees in America and Europe in colorectal surgery, and is the Principal Investigator on the Robotic vs Laparoscopic Resection of Rectal cancer. Dr. Luca has performed more than 300 robotic surgical procedures. Dr. Luca developed an original technique for the fully robotic treatment of colorectal malignancies, published in 2009 in Annals of Surgical Oncology.

Dr. Luca will hold a full-time faculty appointment as a Professor of Surgery at LLSM if approved for a SFP appointment by the Board. Dr. Luca will provide instruction as part of LLSM's education program, which involves seeing patients along with fulfilling his clinical teaching responsibilities ranging from lectures/teaching sessions in addition to clinical research. Dr. Luca possesses the unique combination of necessary skills for colorectal surgery. LLSM has a great need for Dr. Luca's expertise in the fight against colorectal cancer.

Dr. Luca's application is complete except for the copy of the U.S. social security card, copy of the visa, clear fingerprint responses from Department of Justice (DOJ) and Federal Bureau of Investigation (FBI), and the final fee for the permit which will be required prior to issuing the SFP if the Board adopts the Committee's recommendation for approval.

Medical Education:

Medical School:

University of Milan Faculty of Medicine and Surgery Graduated October 24, 1990	Italy	1983-1990

Postgraduate Training:

- University of Milan
  First Aid and Emergency Surgery — Italy — 1990-1995

- Oncology and Surgery — Italy/Ireland 1995-1996
  Paolo Baffi (fellowship)

Tarik Fathy Massoud, M.D., Ph.D. – SUSM:

Lloyd B. Minor, M.D., The Carl and Elizabeth Naumann, Dean of SUSM, requested the Division of Licensing (Board) to grant a waiver for Dr. Massoud pursuant to BPC section 2168.1(a)(5), which prohibits the granting of a SFP to a physician who has held a position under BPC section 2113 for a period of two years or more preceding the date of the application, unless the Board waives this requirement.

The Board approved a BPC section 2113 Faculty Registration for Dr. Massoud on November 13, 2013, at SUSM, which is valid until November 13, 2016. SUSM may request the Board to renew the BPC section 2113 Faculty Registration for an additional year if SUSM and Dr. Massoud submit a license plan. The Board may renew the BPC section 2113 Faculty Registration for one additional year if needed to complete the licensing plan.

Note: Dr. Massoud may not hold a BPC section 2113 Faculty Registration for more than five years.

Laurence Katznelson, M.D., Professor of Neurosurgery and Medicine, Associate Dean of Graduate Medical Education, SUSM, presented SUSM's request for Tarik Fathy Massoud, M.D. to receive an SFP and provided the SFPRC with Dr. Massoud's qualifications. Dr. Massoud's area of expertise is in neuroradiology and molecular imaging.

The Board granted the University of California at Los Angeles, School of Medicine (UCLA), a BPC section 2111 appointment for Dr. Massoud in July 1992, until it was cancelled in July 1997.

Note: BPC section 2111 appointments could be held for a maximum of five years during the timeframe that Dr. Massoud held a BPC section 2111 appointment.

Dr. Massoud previously held several positions at UCLA in the Department of Interventional Neuroradiology, Department of Radiological Sciences: Fellow, 1992; Visiting Assistant Professor of Radiology 1993-1994; and Assistant Professor of Radiology, 1994-1997.
Dr. Massoud continued his research at UCLA as an Associate Professor of Radiology from 1997-1999. Dr. Massoud recently held the position of Academic Neuroradiologist at the University of Cambridge, 2000-2013. Dr. Massoud has been published in top ranking scientific journals, and has won seven awards for his presentations on his innovative research at international scientific conferences from the American Society of Neuroradiology. He is the co-author of several books and book chapters and has been a peer reviewer for international medical journals. Dr. Massoud is considered by his peers to be a highly accomplished clinician based on his knowledge in medicine, radiology and neuroradiology.

Dr. Massoud is currently in a BPC section 2113 Faculty Appointment at SUSM.

Dr. Massoud will hold a full-time faculty appointment as a Professor of Radiology at SUSM, if approved for an SFP appointment by the Board. Dr. Massoud will provide in-patient and out-patient clinical care, teach and mentor medical and graduate students and fellows. Dr. Massoud will also be doing research in the Molecular Imaging Program at Stanford. Dr. Gambhir states "Dr. Massoud is an academically eminent full professor at Stanford. He is outstanding in his fields of Neuroradiology and Molecular Imaging, and a great need exists to maintain his position and avail of his services, expertise, and experience in Stanford Radiology."

Dr. Tarik Fathy Massoud's application is complete except the final fee for the permit will be required prior to issuing the SFP if the Board adopts the SFPRC's recommendation for approval.

EDUCATION:

Medical School:

Royal College of Surgeons Ireland Medical School Graduated June 1, 1984	Ireland	1978-1984

Postgraduate Training:

➢ John Radcliffe Hospital/Oxford Medical School Radiology	United Kingdom	1988-1991
➢ John Radcliffe Hospital/Oxford Medical School (fellowship)	United Kingdom	1991-1992

SPECIAL FACULTY PERMIT REVIEW COMMITTEE FINDINGS:

The SFPRC recommended approval of Dr. Luca for an SFP at LLSM pursuant to BPC section 2168.1 (a)(1)(B).

The SFPRC recommended approval to waive the requirement pursuant to BPC section 2168.1(a)(5) for Dr. Massoud.

The SFPRC recommended approval of Dr. Massoud for an SFP at SUSM pursuant to BPC section 2168.1(a)(1)(B).

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED:	January 13, 2016
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of Universidad Autonoma de Guadalajara School of Medicine, International Program
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

After review and discussion of the initial evaluation of the Universidad Autonoma de Guadalajara School of Medicine, International Program (UAG), Medical Board of California (Board) staff is requesting the Board Members make a determination regarding UAG's proposed four-year curriculum for recognition by the Board. Staff is requesting the Board Members consider the following:

- Determine if the third and fourth year clinical rotations meet the minimum requirements pursuant to Business and Professions Code (BPC) section 2089.5 based upon the current information the Board has received.
    - If yes, approve the four-year curriculum to recognize UAG's International Program with a four-year curriculum.
    - If no, direct staff to request additional information and/or authorize staff to perform a site visit to UAG.

BACKGROUND AND ANALYSIS:

UAG is a private, non-profit medical school, founded in 1935, and located in Guadalajara, Mexico. UAG's medical school consists of the medical school program that primarily educates the citizens of Mexico to practice medicine in Mexico and the International Program that primarily educates citizens from other countries to practice medicine in other countries, including the United States. The Board currently recognizes UAG's medical school education that primarily educates the citizens of Mexico to practice medicine in Mexico, pursuant to California Code of Regulations (CCR) section 1314.1(a)(1). The Board also currently recognizes UAG's International Program's five-year curriculum pursuant to CCR section 1314.1(a)(2). UAG is requesting the Board to recognize a four-year curriculum for UAG's International Program.

Staff and Licensing Medical Consultant, James Nuovo, M.D., have reviewed the UAG Self-Assessment Report (SAR) for compliance with meeting the minimum requirements pursuant to BPC sections 2089 (Attachment 1) and 2089.5 (Attachment 2), and the requirements pursuant to

CCR section 1314.1 (Attachment 3). Upon completion of the review of UAG's SAR on October 28, 2015, staff requested additional information from UAG regarding the following:

1) Student Dropout Rate
2) Student Leaves of Absence and Leave of Absence Policy
3) Clarification of Curriculum Hours
4) USMLE Steps 1, Step 2 CK and Step 2 CS Outcomes
5) Explanation of Branch Campuses

The Board received UAG's responses on December 5, 2015. Upon review of the additional information, on December 28, 2015, staff requested further clarification on the following:

1) Additional Information/Table of Actual Students on a Leave of Absence
2) Clarification of Curriculum Hours for the Third and Fourth Clinical ClerkshipYears
3) USMLE Test Score Table

UAG provided a response on January 5, 2016 (Attachment 4). Staff advised UAG that the response to the third and fourth year clinical clerkships needed further clarification on specific percentages regarding inpatient versus ambulatory patients. UAG provided an additional response on January 6, 2016 (Attachment 5).

Staff and Dr. Nuovo have completed the review of the UAG SAR four-year curriculum and all of the additional documentation submitted by UAG as requested by Board staff, including the January 5, 2016, and January 6, 2016 responses. Staff has determined the four-year curriculum meets the minimum requirements pursuant to BPC section 2089 but have identified concerns that the third and fourth year clinical clerkship rotations may not meet the minimum requirements pursuant to BPC section 2089.5, specifically sections 2089.5(d) and 2089.5(e)(8) regarding the percentage of inpatient versus ambulatory patients. In addition, staff's review identified the USMLE pass rate was only in the low to mid 70 percent range (Attachment 4).

The report prepared by Dr. Nuovo has been included for your review (pages BRD 14 - 4 through 5).

FISCAL CONSIDERATIONS:

If the Board should determine that a site visit to UAG is necessary, then in accordance with BPC 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. CCR 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.

ATTACHMENTS:

1) California Business and Professions Code section 2089

2) California Business and Professions Code section 2089.5

3) California Code of Regulations, Title 16, Division 13, section 1314.1

4) UAG's January 5, 2016 response to the Board's request for additional information

5) UAG's January 6, 2016 response to the Board's request for additional information

MEMO

January 12, 2016

To: Members

Medical Board of California

From: Jim Nuovo, MD

Professor & Associate Dean of GME

UC Davis

Re: Evaluation of the Universidad Autonoma De Guadalajara Self-Assessment Report

Background: The Medical Board of California (Board) requested a review of the materials provided by the Universidad Autonoma De Guadalajara (UAG) Medical School. These were submitted as part of a self-assessment report in the evaluation of UAG's proposed four year curriculum for recognition by the Board.

My report is based on my review of the documents provided to the Board by UAG and from a response by the School to additional questions posed after review of the Self-Assessment Report.

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

Documents for Review Included the Following:

1. UAG Self-Assessment Report.
2. UAG response to questions that arose from an evaluation of the Self-Assessment Report.

Recommendations:

After review of all of the information provided by UAG, I do not feel that the description of the clinical rotations meets the requirements of Business and Professions Code 2089.5; specifically, (d) that "54 weeks shall be performed in a hospital that sponsors the instruction" and 2089.5; specifically, (e)(8) that "the hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction."

Rationale:

The tables provided for the curriculum hours for the 3rd and 4th years indicate that the clinical experience provides primarily ambulatory training. This information does not indicate that the students have at least 54 weeks of instruction in a hospital and does not include family medicine as a rotation. As hospital-based training is a critical component of the training of medical students in the 3rd and 4th years, the information provided by UAG in these tables does not demonstrate compliance with the above-cited

requirements. Sufficient inpatient experience during medical school is a critical educational element in the preparation of students for post-graduate training. The information provided in the UAG Self-Assessment Report does not clearly identify how the School meets these requirements.

Recommendations:

After review of the information described above, in my opinion, the UAG Medical School has not demonstrated that it is in substantial compliance with the requirements of Business and Professions Code Section 2089.5 (d) and (e)(8) for the reasons described. I recommend further assessment of the UAG four year program with a site visit.

Attachment 1

STATE OF CALIFORNIA
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL

State of California
BUSINESS AND PROFESSIONS CODE
DIVISION 2. HEALING ARTS
CHAPTER 5. MEDICINE
Article 4. Requirements for Licensure
§ 2089

2089. (a) Each applicant for a physician's and surgeon's certificate shall show by official transcript or other official evidence satisfactory to the Division of Licensing that he or she has successfully completed a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction, in a medical school or schools located in the United States or Canada approved by the division, or in a medical school or schools located outside the United States or Canada which otherwise meets the requirements of this section. The total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80 percent of actual attendance shall be required. If an applicant has matriculated in more than one medical school, the applicant must have matriculated in the medical school awarding the degree of doctor of medicine or its equivalent for at least the last full academic year of medical education received prior to the granting of the degree.

(b) The curriculum for all applicants shall provide for adequate instruction in the following subjects:

Alcoholism and other chemical substance dependency, detection and treatment.
Anatomy, including embryology, histology, and neuroanatomy.
Anesthesia.
Biochemistry.
Child abuse detection and treatment.
Dermatology.
Geriatric medicine.
Human sexuality.
Medicine, including pediatrics.
Neurology.
Obstetrics and gynecology.
Ophthalmology.
Otolaryngology.
Pain management and end-of-life care.
Pathology, bacteriology, and immunology.
Pharmacology.
Physical medicine.
Physiology.
Preventive medicine, including nutrition.
Psychiatry.

Radiology, including radiation safety.
Spousal or partner abuse detection and treatment.
Surgery, including orthopedic surgery.
Therapeutics.
Tropical medicine.
Urology.

(c) The requirement that an applicant successfully complete a medical curriculum that provides instruction in pain management and end-of-life care shall only apply to a person entering medical school on or after June 1, 2000.

(Amended by Stats. 1999, Ch. 403, Sec. 1. Effective January 1, 2000.)

Attachment 2

STATE OF CALIFORNIA
AUTHENTICATED
ELECTRONIC LEGAL MATERIAL
LEGISLATIVE COUNSEL BUREAU

State of California
BUSINESS AND PROFESSIONS CODE
DIVISION 2. HEALING ARTS
CHAPTER 5. MEDICINE
Article 4. Requirements for Licensure
§ 2089

2089.5. (a) Clinical instruction in the subjects listed in subdivision (b) of Section 2089 shall meet the requirements of this section and shall be considered adequate if the requirements of subdivision (a) of Section 2089 and the requirements of this section are satisfied.

(b) Instruction in the clinical courses shall total a minimum of 72 weeks in length.

(c) Instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length with a minimum of eight weeks instruction in surgery, eight weeks in medicine, six weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine, and four weeks in psychiatry.

(d) Of the instruction required by subdivision (b), including all of the instruction required by subdivision (c), 54 weeks shall be performed in a hospital that sponsors the instruction and shall meet one of the following:

(1) Is a formal part of the medical school or school of osteopathic medicine.

(2) Has a residency program, approved by the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada (RCPSC), in family practice or in the clinical area of the instruction for which credit is being sought.

(3) Is formally affiliated with an approved medical school or school of osteopathic medicine located in the United States or Canada. If the affiliation is limited in nature, credit shall be given only in the subject areas covered by the affiliation agreement.

(4) Is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada.

(e) If the institution, specified in subdivision (d), is formally affiliated with a medical school or a school of osteopathic medicine located outside the United States or Canada, it shall meet the following:

(1) The formal affiliation shall be documented by a written contract detailing the relationship between the medical school, or a school of osteopathic medicine, and hospital and the responsibilities of each.

(2) The school and hospital shall provide to the board a description of the clinical program. The description shall be in sufficient detail to enable the board to determine whether or not the program provides students an adequate medical education. The board shall approve the program if it determines that the program provides an adequate medical education. If the board does not approve the program, it shall provide its

reasons for disapproval to the school and hospital in writing specifying its findings about each aspect of the program that it considers to be deficient and the changes required to obtain approval.

(3) The hospital, if located in the United States, shall be accredited by the Joint Commission on Accreditation of Hospitals, or the American Osteopathic Association's Healthcare Facilities Accreditation Program, and if located in another country, shall be accredited in accordance with the law of that country.

(4) The clinical instruction shall be supervised by a full-time director of medical education, and the head of the department for each core clinical course shall hold a full-time faculty appointment of the medical school or school of osteopathic medicine and shall be board certified or eligible, or have an equivalent credential in that specialty area appropriate to the country in which the hospital is located.

(5) The clinical instruction shall be conducted pursuant to a written program of instruction provided by the school.

(6) The school shall supervise the implementation of the program on a regular basis, documenting the level and extent of its supervision.

(7) The hospital-based faculty shall evaluate each student on a regular basis and shall document the completion of each aspect of the program for each student.

(8) The hospital shall ensure a minimum daily census adequate to meet the instructional needs of the number of students enrolled in each course area of clinical instruction, but not less than 15 patients in each course area of clinical instruction.

(9) The board, in reviewing the application of a foreign medical graduate, may require the applicant to submit a description of the clinical program, if the board has not previously approved the program, and may require the applicant to submit documentation to demonstrate that the applicant's clinical training met the requirements of this subdivision.

(10) The medical school or school of osteopathic medicine shall bear the reasonable cost of any site inspection by the board or its agents necessary to determine whether the clinical program offered is in compliance with this subdivision.

(Amended by Stats. 2014, Ch. 316, Sec. 4. (SB 1466) Effective January 1, 2015.)

Attachment 3

Agenda Item 14

§ 1314.1. International Medical Schools.
16 CA ADC § 1314.1
BARCLAYS OFFICIAL CALIFORNIA CODE OF REGULATIONS

Barclays Official California Code of Regulations Currentness
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California [FNA1]
Chapter 1. Division of Licensing
Article 4. Schools and Colleges of Medicine (Refs & Annos)

16 CCR § 1314.1

Attachment 3

§ 1314.1. International Medical Schools.

(a) For purposes of Article 5 of Chapter 5 of Division 2 of the code (commencing with Section 2100), a medical school's resident course of instruction that leads to an M.D. degree shall be deemed equivalent to that required by Sections 2089 and 2089.5 of the code if the medical school offers the curriculum and clinical instruction described in those sections and meets one of the following:

(1) The medical school is owned and operated by the government of the country in which it is located or by a bona fide nonprofit institution registered with or otherwise approved by the country in which it is domiciled, the medical school is a component of a university offering other graduate and professional degree programs that contribute to the academic environment of the medical school, and the medical school's primary purpose is educating its own citizens to practice medicine in that country; or

(2) the medical school is chartered by the jurisdiction in which it is domiciled, the primary purpose of the medical school program is to educate non-citizens to practice medicine in other countries, and the medical school meets the standards set forth in subsection (b) below.

(b)(1) Mission and Objectives.
The institution shall have a clearly stated written purpose or mission statement and objectives that include:

(A) The institution's broad expectations concerning the education students will receive;

(B) The role of research as an integral component of its mission, including the importance, nature, objectives, processes and evaluation of research in medical education including its application to patient care; and

(C) Teaching, patient care, and service to the community.
The institution shall have institutional objectives that are consistent with preparing graduates to provide competent medical care.

(2) Organization.
The institution shall be organized as a definable academic unit responsible for a resident educational program that leads to the M.D. degree. The manner in which the institution is organized shall be set forth in writing.

(3) Curriculum.
The structure and content of the educational program shall provide an adequate foundation in the basic and clinical sciences and shall enable students to learn the fundamental principles of medicine, to acquire critical judgment skills, and to use those principles and skills to provide competent medical care. The objectives of the educational program shall state, in outcome-based terms, what students are expected to learn. When an institution provides clinical clerkships at multiple teaching sites, the institution shall demonstrate comparability of educational experiences for all students across instructional sites.

(4) Clinical Oversight
The institution shall have a system with central oversight to assure that the faculty define the types of patients and clinical conditions that students must encounter, the appropriate clinical setting for the educational experiences, and the expected

level of student responsibility. The system shall ensure that the faculty monitor and verify student experience and modify it as necessary to ensure that the objectives of the clinical education program will be met.

(5) Professionalism
The learning environment shall promote the development of appropriate professional attributes in medical students. The institution shall define the professional attributes it expects students to develop in the context of the institution's mission and of promoting the safe practice of medicine.

(6) Governance.
The administrative and governance system shall allow the institution to accomplish its objectives (i.e. its statements of the items of knowledge, skills, behavior and attitude that students are expected to learn). An institution's governance shall give faculty a formal role in the institution's decision-making process. A student enrolled in the program shall not serve as an instructor, administrator, officer or director of the school.

(7) Faculty.
The faculty shall be qualified and sufficient in number to achieve the objectives of the institution. A “qualified” faculty member is a person who possesses either a credential generally recognized in the field of instruction or a degree, professional license, or credential at least equivalent to the level of instruction being taught or evaluated. The institution shall have a formal ongoing faculty development process that will enable it to fulfill its mission and objectives.

(8) Admission and promotion standards.
The institution shall have and adhere to standards governing admission requirements and student selection and promotion that are consistent with the institution's mission and objectives. The institution shall document that its admitted students generally meet entrance requirements equivalent to those utilized by U.S. and Canadian medical schools, including an appropriate background check of all applicants admitted to the institution.

(9) Financial Resources.
The institution shall possess sufficient financial resources to accomplish its mission and objectives. Pressure for institutional self-financing must not compromise the educational mission of the institution nor cause it to enroll more students than its total resources can accommodate.

(10) Facilities.
The institution shall have, or have access to, facilities, laboratories, equipment and library resources that are sufficient to support the educational programs offered by the institution and to enable it to fulfill its mission and objectives. If an institution utilizes affiliated institutions to provide clinical instruction, the institution shall be fully responsible for the conduct and quality of the educational program at those affiliated institutions.

(11) Quality Assurance System.

If the institution provides patient care, it shall have a formal system of quality assurance for its patient care program.

(12) Records.
The institution shall maintain and make available for inspection any records that relate to the institution's compliance with this section for at least five years, except, however, that student transcripts shall be retained indefinitely.

(13) Branch Campuses.

(A) An institution with more than one campus shall have written policies and procedures governing the division and sharing of administrative and teaching responsibilities between the central administration and faculty, and the administration and faculty at the other locations. These policies shall be consistent with the institution's mission and objectives. The institution shall be fully responsible for the conduct and quality of the educational program at these sites. If an institution operates a branch campus located within the United States or Canada, instruction received at that branch campus shall be deemed to be instruction received and evaluated at that institution. For purposes of this section, the term “branch campus” means a site other than the main location of the institution but does not include any hospital at which only clinical instruction is provided.

(B) For purposes of this section, an institution shall disclose any affiliation or other relationship that it has with another institution in which either institution agrees to grant a doctor of medicine degree or its equivalent to students of the other institution who complete coursework at the affiliated institution.

(14) Evaluation of Program Effectiveness

An institution shall collect and use a variety of outcome data to demonstrate the extent to which it is meeting its educational program objectives. For purposes of this subsection, “outcome data” means specific and measurable outcome-based performance measures of knowledge, skills, attitudes, and values (for example, measures of academic progress, program completion rates, performance of graduates in residency training and on licensing and

certification examinations).

(c) The board may, on its own or at the request of an institution, determine whether that institution meets the requirements of subsections (a) and (b). The board shall have the sole discretion to determine whether a site visit is necessary in order to verify the accuracy and completeness of the data provided and to conduct an in-depth review of the program to determine whether the institution is in compliance with this regulation.

(d) An institution's failure to provide requested data regarding its educational program or to cooperate with a site team shall be grounds for disapproval of its educational program.

(e) If the board determines that a site visit is necessary, it shall appoint a site inspection team to conduct a comprehensive, qualitative onsite inspection and review of all aspects of the institution's operations to determine whether the institution complies with the requirements of subsections (a) and (b).
The fee for a site visit is all reasonable costs incurred by the board staff and the site team, payable in estimated form in advance of the site visit. If the cost of the site visit exceeds the amount previously paid, the board shall bill the institution for the remaining amount and shall not take action to determine the institution's equivalency until such time as the full amount has been paid. If the amount paid exceeds the actual costs incurred, the board shall remit the difference to the institution within 60 days.

The site team shall prepare and submit to the board a report that includes

(1) Its findings regarding the institution's compliance with the requirements of the law and this regulation;

(2) Its assessment of the quality of the institution as a whole and the quality of the institution's educational program, including any deficiencies; and

(3) Its recommendation whether or not the institution's resident course of instruction leading to an M.D. degree should be deemed equivalent to that required by Sections 2089 and 2089.5 of the code, including a recommendation regarding the correction of any deficiencies identified in the report. A copy of the report shall be provided to the institution, which shall have 60 days following the date of the report in which to respond to board staff as to any errors of fact or erroneous findings.

(f) If an institution wishes to retain the board's determination that its resident course of instruction leading to an M.D. degree is equivalent to that required by Sections 2089 and 2089.5 of the code, or if it is currently being evaluated for such equivalency, it shall do the following:

(1) It shall notify the board in writing no later than 30 days after making any change in the following:

(A) Location including addition or termination of any branch campus;

(B) Mission, purposes or objectives;

(C) Change of name;

(D) Any major change in curriculum, including but not limited to, a change that would affect its focus, design, requirements for completion, or mode of delivery, or other circumstance that would affect the institution's compliance with subsections (a) and (b).

(E) Shift or change in control. A “shift or change in control” means any change in the power or authority to manage, direct or influence the conduct, policies, and affairs of the institution from one person or group of people to another person or group of people, but does not include the replacement of an individual administrator with another natural person if the owner does not transfer any interest in, or relinquish any control of, the institution to that person.

(F) An increase in its entering enrollment above 10% of the current enrollment or 15 students in one year, whichever is less, or 20% or more in three years.

(2) Every seven years, it shall submit documentation sufficient to establish that it remains in compliance with the requirements of this section and of Sections 2089 and 2089.5 of the code.

(g) The documentation submitted pursuant to subsection (f)(2) shall be reviewed by the board or its designee to determine whether the institution remains in compliance with the requirements of these regulations and of Sections 2089 and 2089.5 of the code. The board may require a site visit as part of this review. It may also require a site visit at any other time during the seven-year period if it becomes aware of circumstances that warrant a site visit, including any change described in subsection (f).

(h) The board may at any time withdraw its determination of equivalence when any of the following occur:

(1) An institution is no longer in compliance with this section;

(2) The institution submits false or misleading information or documentation regarding its compliance with this section;

(3) Institution officials submit fraudulent documentation concerning a former student's medical curriculum; or

(4) The institution permits students to engage in clinical training in California facilities that do not satisfy the requirements of section 2089.5(c) and (d) of the code and, where applicable, section 1327 of Title 16 of the California Code of Regulations.

Prior to withdrawing its determination of equivalence, the board shall send the institution a written notice of its intent to withdraw its determination of equivalence, identifying those deficiencies upon which it is proposing to base the withdrawal and giving the institution 120 days from the date of the notice within which to respond to the notice. The board shall have the sole discretion to determine whether a site visit is necessary in order to ascertain the institution's compliance with this section. The board shall notify the institution in writing of its decision and the basis for that decision.

(i) The board may evaluate any institution described in subsection (a)(1) to determine its continued compliance with Sections 2089 and 2089.5 of the code if, in its sole discretion, the board has reason to believe that the institution may no longer be in compliance.

Note: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2018, 2089, 2089.5, 2102 and 2103, Business and Professions Code.

HISTORY

1. New section filed 11-13-2003; operative 12-13-2003 (Register 2003, No. 46).

2. Amendment filed 12-9-2009; operative 1-8-2010 (Register 2009, No. 50).

This database is current through 12/18/15 Register 2015, No. 51

16 CCR § 1314.1, 16 CA ADC § 1314.1

END OF DOCUMENT

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Documents In Sequence

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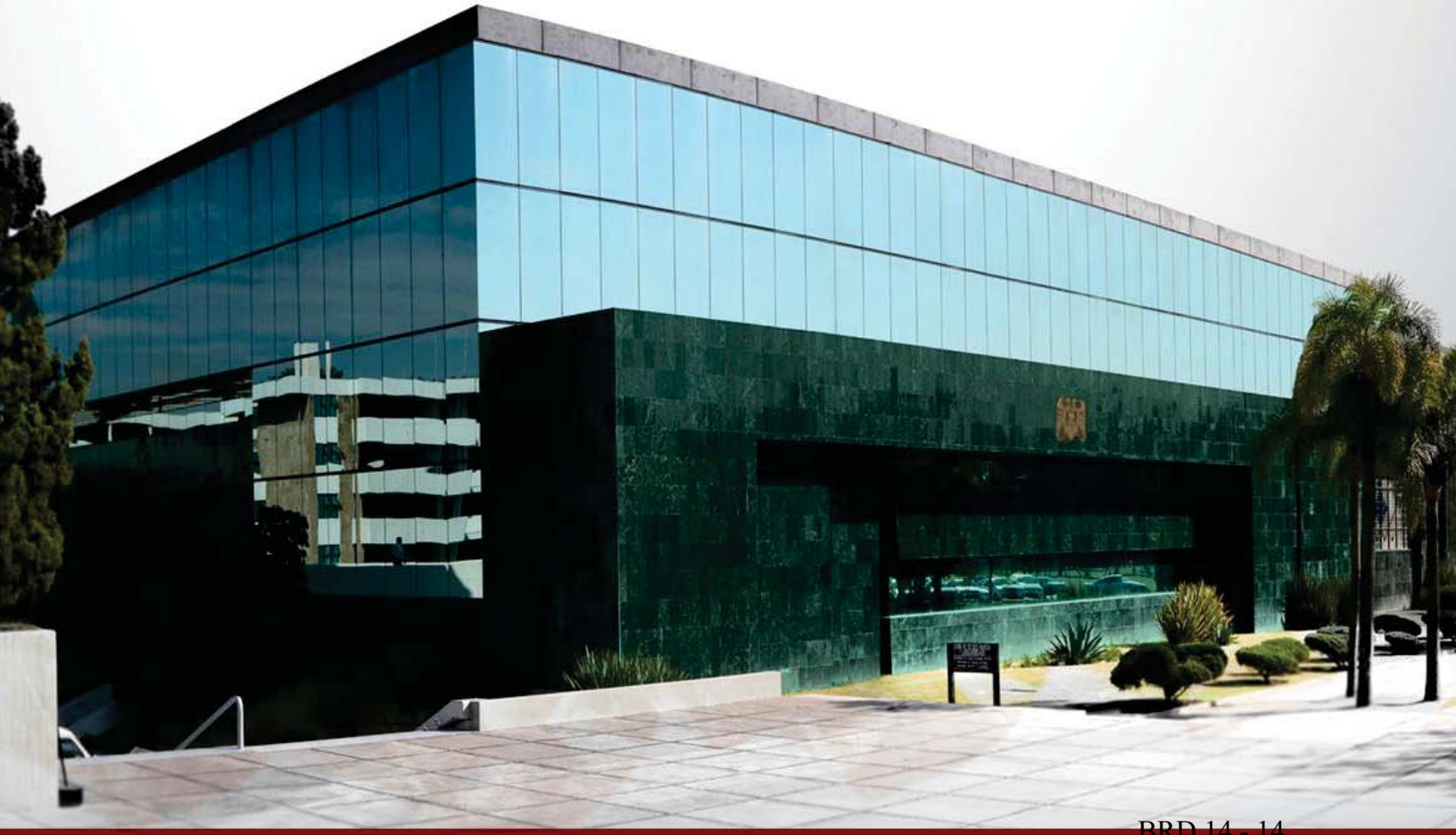
Attachment 4

MEDICAL BOARD OF CALIFORNIA

SELF ASSESMENT REPORT



Curriculum Hours Third and Fourth Years:

The tables for the 3rd and 4th years show that all clinical clerkship training is 100% ambulatory for all clinical services except for surgery. In a hospital setting, not all patients are ambulatory and not all surgery would necessarily be 100% non-ambulatory. How do the students get their inpatient experience and how much time the students dedicate towards this specific training? In addition, the charts state that all students would see about the same number of new patients per clinical rotation for each type of clinical clerkship, please explain if this is accurate. It seems that some clinical clerkships would have a higher number of patients that some other types of clinical clerkships. Please provide further clarification.

Yes in a hospital setting not all patients are ambulatory and not all surgery would necessarily be non-ambulatory, our students do treat both types of patients. It depends on the hospitals and the attending Doctor the percentage of the type of patients they actually treat. Their clinical experience can be acquired with patients either ambulatory or non-ambulatory.

As we mentioned before the students spend 8 hours a day on average, 5 days a week in a hospital to acquire their clinical experience with both types of patients.

The number of patients we mentioned in our charts is just an average, it is not possible to know if in any given week our students may see more patients or less than other weeks. The average of patients our students treat is provided to us by the hospitals where our students perform their clinical rotations.

USMLE Test Scores:

Please provide a table/spreadsheet with the USMLE results that UAG has available since 2012 for Step 1, Step 2 CK and Step 2 CS.

Attached is the USMLE Results.

USMLE RESULTS	2012	2013	2014
USMLE STEP 1	67%	72%	74%
USMLE STEP 2 CK	78%	81%	75%
USMLE STEP 2 CS	78%	71%	73%

Attachment 5

MEDICAL BOARD OF CALIFORNIA

SELF ASSESMENT REPORT

Curriculum Hours Third and Fourth Years:

The tables for the 3rd and 4th years show that all clinical clerkship training is 100% ambulatory for all clinical services except for surgery. In a hospital setting, not all patients are ambulatory and not all surgery would necessarily be 100% non-ambulatory. How do the students get their inpatient experience and how much time the students dedicate towards this specific training?

5 year Program

Clerkship	Total weeks	% Ambulatory	Number of sites used*	Typical weekly length of time for formal instruction	Average number of new patients per week	Average number of continuity patients per week	Number of hours with Teacher/Instructor	Number of Independent Study hours	Total Hours
Internal Medicine	12	70%	4		30	4-5	330	246	576
OBGyN	6	60%	3		30	4-5	110	82	192
Pediatrics	6	60%	3		30	4-5	110	82	192
Psychiatry	4	70%	3		30	4-5	55	41	96
Surgery	8	30%	4		30	4-5	51	45	96
	TOTAL HOURS THIRD YEAR								1152

Clerkship	Total weeks	% Ambulatory	Number of sites used*	Typical weekly length of time for formal instruction	Average number of new patients per week	Average number of continuity patients per week	Number of hours with Teacher/Instructor	Number of Independent Study hours	Total Hours
Legal Medicine and Forensics	4	0	2		0	0	50	46	96
Infectology	4	60%	1		10-20	10-20	55	41	96
Dermatology	4	80%	1		10-20	10-20	55	41	96
Hematology	4	0%	1		10-20	10-20	110	82	192
Traumatology	4	50%	1		10-20	10-20	110	82	192
Neurology	4	40%	2		10-20	10-20	55	41	96
Urology and Human Sexuality	4	80%	1		10-20	10-20	55	41	96
ENT	4	80%	1		10-20	10-20	55	41	96
Ophthalmology	4	90%	2		10-20	10-20	55	41	96
E.R.	4	100%	2		10-20	10-20	55	41	96
Geriatrics	4	80%	1		10-20	10-20	102	90	192
Oncology, Pain Mng. and Paliative Care	4	20%	1		10-20	10-20	102	90	192
	TOTAL HOURS FOURTH YEAR								1536

UNIVERSIDAD AUTÓNOMA DE GUADALAJARA
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4 year Program

Clerkship	Total weeks	% Ambulatory	Number of sites used*	Typical weekly length of time for formal instruction	Typical weekly from Monday to Saturday of Clinical	Average number of new patients per week	Average number of continuity patients per week	Number Of patient contact hours	Number of Independent Study hours	Total Hours
E.R	4	100%	3	3-8	40	0	0	195	77	272
Elective I								480	160	640
Elective II										
Elective III										
Elective IV										
TOTAL HOURS OF CLINICAL ROTATIONS FOR FOURTH YEAR										912

Clerkship	Total weeks	% Ambulatory	Number of sites used in the USA	Typical weekly length of time for formal instruction	Typical weekly from Monday to Saturday of Clinical Duties with	Average number of new patients per week	Average number of continuity patients per week	Number Of patient contact hours	Number of Independent Study hours	Total Hours
Endocrinology	4	60%	2	3-8	40	10-20	30	120	40	160
Infectology	4	60%	1	3-8	40	10-20	30	120	40	160
Neurology	4	40%	2	3-8	40	10-20	30	120	40	160
Ophthalmology	4	90%	2	3-8	40	10-20	30	60	20	80
Orthopaedics and Traumatology	4	50%	1	3-8	40	10-20	30	120	40	160
Urology	4	80%	1	3-8	40	10-20	30	60	20	80
Dermatology	4	80%	1	3-8	40	10-20	30	60	20	80
Clinical Nutrition	4	40%	1	3-8	40	10-20	30	60	20	80
ENT	4	80%	1	3-8	40	10-20	30	60	20	80

UNIVERSIDAD AUTÓNOMA DE GUADALAJARA
Fundada en 1935

4 year Program

Clerkship	Total weeks	% Ambulatory	Number of sites used*	Typical weekly length of time for formal instruction	Typical weekly from Monday to Saturday of Clinical	Average number of new patients per week	Average number of continuity patients per week	Number Of patient contact hours	Number of Independent Study hours	Total Hours
E.R	4	100%	3	3-8	40	0	0	195	77	272
Elective I								480	160	640
Elective II										
Elective III										
Elective IV										
TOTAL HOURS OF CLINICAL ROTATIONS FOR FOURTH YEAR										912

Clerkship	Total weeks	% Ambulatory	Number of sites used in the USA	Typical weekly length of time for formal instruction	Typical weekly from Monday to Saturday of Clinical Duties with	Average number of new patients per week	Average number of continuity patients per week	Number Of patient contact hours	Number of Independent Study hours	Total Hours
Endocrinology	4	60%	2	3-8	40	10-20	30	120	40	160
Infectology	4	60%	1	3-8	40	10-20	30	120	40	160
Neurology	4	40%	2	3-8	40	10-20	30	120	40	160
Ophthalmology	4	90%	2	3-8	40	10-20	30	60	20	80
Orthopaedics and Traumatology	4	50%	1	3-8	40	10-20	30	120	40	160
Urology	4	80%	1	3-8	40	10-20	30	60	20	80
Dermatology	4	80%	1	3-8	40	10-20	30	60	20	80
Clinical Nutrition	4	40%	1	3-8	40	10-20	30	60	20	80
ENT	4	80%	1	3-8	40	10-20	30	60	20	80

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: January 4, 2016
ATTENTION: Board Members
SUBJECT: Midwifery Advisory Council (MAC) Chair Report
CONTACT: Carrie Sparrevohn, L.M., Chair

REQUESTED ACTION:

Approval of the following agenda items is requested for the next MAC meeting:

- Task Force Update:
  - Update on Revisions to Licensed Midwife Annual Report (LMAR)
- Update on continuing regulatory efforts required by Assembly Bill (AB) 1308
- Update on midwifery related legislation expected to be introduced or followed this year
- Discussion and approval of MAC member positions that are at the end of their terms
- Update on the midwifery program
- Update on progress with midwifery assistant regulations
- Report from California Association of Midwives on data gathered regarding ability of licensed midwives to consult or collaborate as required by AB 1308
- Report on current national and international data related to vaginal birth after one or more prior cesarean sections

BACKGROUND:
The last MAC meeting was held on December 3, 2015. At this meeting, the MAC was updated by Staff regarding recommendations for moving forward with changes to the LMAR. It appears that no changes will be able to be made prior to the 2017 reporting year. The MAC received an update on regulations that will be required pursuant to the passage of Senate Bill (SB) 408 (Morrel) - Midwife Assistants. The MAC also received an update on the passage of SB 407 (Morrel) - Comprehensive Perinatal Services Program: Licensed Midwives. This important legislation will allow licensed midwives to provide care to California's low income population of birthing families and be reimbursed for that care under the Comprehensive Perinatal Services Program (CPSP).

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 and a determination that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy or childbirth, prior to the midwife continuing care for a particular client. The point of disagreement continues to focus on care for women who have had a prior cesarean. The MAC is asking for several reports at its March meeting to better discern the direction these regulations should take so they best serve and protect the birthing families of the state without creating an undue burden on them.