

**State of California
Business, Consumer Services and Housing Agency**

MEDICAL BOARD OF CALIFORNIA

**Board, Committee
and Task Force Meetings**

May 5-6, 2016



**MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE**

Los Angeles Airport Hilton
5711 W. Century Blvd
Los Angeles, CA 90045

May 5-6, 2016

Thursday, May 5, 2016

- **9:00 am – 12:00 pm** **Panel A (Room: Los Angeles Ballroom)**
(Members: Wright (Chair), Lewis, Bishop, Feinstein, Hawkins, Warmoth, Yip)
- **10:00 am – 12:00 pm** **Panel B (Room: La Jolla Ballroom)**
(Members: Krauss (Chair), Bholat, GnanaDev, Lawson, Levine, Pines, Sutton-Wills)
- **12:00 pm – 1:00 pm** **Lunch Break**
- **1:00 pm – 2:00 pm** **Licensing Committee (La Jolla Ballroom)**
(Members: Bishop (Chair), GnanaDev, Hawkins, Pines, Wright)
- **2:15 pm – 3:15 pm** **Public Outreach, Education/Wellness Committee (Room: La Jolla B/R)**
(Members: Lewis (Chair), Hawkins, Krauss, Levine, Pines, Serrano Sewell)
- **3:30 pm – 5:30 pm** **Full Board Meeting (Room: La Jolla Ballroom)**
(All Members)

Friday, May 6, 2016

- **9:00 a.m. – 2:00 p.m.** **Full Board Meeting (Room: La Jolla Ballroom)**
(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.

Judge Katherine Feinstein (Ret.)

David Warmoth

Felix Yip, M.D.

Los Angeles Airport Hilton
5711 West Century Blvd.
Los Angeles, CA 90045
(310) 410-4000

Thursday, May 5, 2016
Los Angeles Ballroom
9:00 a.m. to 12:00 p.m.
(or until completion of business)

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

1. Call to order/Roll Call
2. **Oral Argument on Judicial Remand**

CHO, Kisuk Jay, M.D.

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

CHO, Kisuk Jay, M.D.

10:15 a.m. OPEN SESSION

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

KUEMMERLE, Nathan Brian, M.D.

11:00 a.m. CLOSED SESSION – Petition for Reconsideration

KUEMMERLE, Nathan Brian, M.D.

**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.

4. ***CLOSED SESSION**

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

5. **OPEN SESSION**

Adjournment

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
Brenda Sutton-Wills, J.D.

Los Angeles Airport Hilton
5711 West Century Blvd.
Los Angeles, CA 90045
(310) 410-4000

Thursday, May 5, 2016
La Jolla Ballroom
10:00 a.m. to 12:00 p.m.
(or until completion of business)

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

10:00 a.m. OPEN SESSION

1. Call to Order/Roll Call
2. **Oral Argument on Nonadopted Proposed Decision**

VUKSINICH, Matthew Joseph, Jr., M.D.

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

VUKSINICH, Matthew Joseph, Jr., 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. 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.*

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MEDICAL BOARD OF CALIFORNIA LICENSING COMMITTEE MEETING AGENDA



COMMITTEE MEMBERS

Michael Bishop, M.D., Chair
Dev GnanaDev, M.D.
Randy Hawkins, M.D.
Denise Pines
Jamie Wright, J.D.

Los Angeles Airport Hilton
5711 W. Century Blvd
Los Angeles, CA 90045
La Jolla Ballroom

Thursday, May 5, 2016
1:00 p.m. – 2:00 p.m.
(or until the conclusion of business)

Public Telephone Access – 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 or
technical difficulties.

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 Comments on Items not on the Agenda
Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting. [Government Code Sections 11125, 11125.7 (a)]
3. Approval of Minutes from the July 30, 2015 Meeting
4. Overview and Discussion of Minimum Requirements for Board Recognized Accredited Postgraduate Training
5. Overview and Discussion of Special Faculty Permits
6. Overview and Discussion of Special Programs
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:

Thursday May 5, 2016 - (888) 221-9518

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
LICENSING COMMITTEE MEETING



San Francisco Airport Marriott Waterfront
1800 Old Bayshore Hwy.
Burlingame, CA 94010
(650) 692-9100

Thursday July 30, 2015
MINUTES

Agenda Item 1 Call to Order / Roll Call

The Licensing Committee of the Medical Board of California (Board) was called to order by Chair Dr. Michael Bishop at 1:45 p.m. A quorum was present, and due notice was provided to all interested parties.

Licensing Committee Members Present:

Michael Bishop, M.D., Chair
Dev Gnanadev, M.D.
Denise Pines
Jamie Wright, Esq.

Licensing Committee Members Absent:

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

Other Members not on the Committee Present:

Michelle Bholat, M.D.
Randy Hawkins, M.D.
Howard Krauss, M.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.

Staff Present:

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

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

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Karen Ehrlich, Licensed Midwife
Julie D'Angelo Fellmeth, Center for Public Interest Law
Lou Galiano, Videographer, Department of Consumer Affairs
Bridget Gramme, Center for Public Interest Law
Doug Grant, Investigator, Health Quality Investigation Unit
Marian Hollingsworth, Consumers Union
Todd Iriyama, Investigator, Health Quality Investigation Unit
Lisa McGiffert, Consumers Union
Michelle Monserrat-Ramos, Consumers Union

Agenda Item 2 Public Comment on Items Not on the Agenda

No public comment was provided.

Agenda Item 3 Approval of Minutes from the July 24, 2014 Licensing Committee Meeting

Ms. Wright made a motion to approve the minutes from the July 24, 2014 Licensing Committee meeting; s/Gnanadev. Motion carried unanimously.

Agenda Item 4 Licensing Program Update

Mr. Worden began by thanking the Licensing Program staff for their hard work in trying to meet the Licensing Program goals in the last fiscal year. He stated the year was especially difficult due to several vacancies, various types of leave, and training. The Licensing Program was able to meet the 45-day goal of initial reviews for physician's and surgeon's applications for 32 weeks out of 52 weeks. In addition, staff did not exceed, at any time, the 60-day initial review time as specified in regulation. The Licensing Program issued 5,873 licenses in fiscal year 2014-2015, which was an increase of 351 licenses from the previous fiscal year.

Mr. Worden stated licensing staff was requested to work overtime in order to process all of the applications, and issue licenses for residents who needed licensure by July 1, 2015. Licensing managers and staff worked very hard during that period of time, and put in a lot of hours to get that accomplished. There were approximately 45 applicants who did not receive their licenses by July 1, 2015. He stated it was important to note that the 45 applicants either applied late, did not provide all of the required primary source documentation timely, or had fingerprint responses pending. Some also were out of the country applicants waiting for the immigration process and the issuance of their social security numbers. He added a few of the applicants did not take their United States Medical Licensing Examination (USMLE) Step 3 until June 25, 2015 and results are received approximately 30 days after the exam. Staff was keeping track of these applicants to ensure they

receive priority processing and are licensed as quickly as possible.

Mr. Worden stated the Consumer Information Unit received 155,092 calls in fiscal year 2014-2015, an increase of 6,634 more calls than last fiscal year. There were 107 international medical schools pending recognition. He added seven of the medical schools must complete self-assessment reports. The Licensing Program has received 45 midwifery applications, issued 42 licenses, and renewed 153 licenses in the fiscal year.

Dr. Bishop asked if Mr. Schunke was still doing Licensing Outreach Fairs.

Mr. Worden replied that Mr. Schunke was attending the Licensing Outreach Fairs on a regular basis and had recently done one for the new residents who are going to need licensure by next year.

Dr. Bishop stated that he was pleased to hear that as the Licensing Outreach Fairs are very well received by all.

Dr. Bishop asked if there was a reason for the increase in the volume of calls received.

Mr. Worden replied that it was related to no longer having the Web Applicant Access System (WAAS). Due to the implementation of BreZE, applicants and programs are no longer able to look up the deficient items needed for licensure.

Dr. Bishop asked if there was any mechanism in BreZE to mitigate the issue.

Mr. Worden informed him that as of June 30, 2015, there was a new BreZE update that would allow staff to input deficiencies into the system that would be viewable to applicants. Unfortunately, it would only be deficiencies identified from that day forward, not any from the past so it would take a while for it to become useful, and it is not as detailed as WAAS.

Agenda Item 5 Update on June 30, 2015 Postgraduate Training Requirements and Physician Reentry to Practice Interested Parties Meeting

Mr. Worden began his presentation informing the Committee that on June 30, 2015, the Board held an Interested Parties Meeting regarding the minimum number of years the Board requires of accredited postgraduate training to obtain a physician's and surgeon's license, and requirements for physicians who want to reenter the practice of medicine after an absence of an extended period of time. He stated Dr. Bishop chaired the interested parties meeting and it was held in Sacramento. The current minimum requirements for a U.S. and Canadian medical school graduate is one year of residency, and he or she must be licensed by the end of 24 months if in California. The minimum requirement for an international medical school graduate is 24 months of residency and he or she must be licensed by the end of 36 months if in California. He added all of the accredited postgraduate training, including training in other states and Canada, counts towards the 24 and 36 months. Mr. Worden stated the specific requirements for postgraduate training by state, and the issues that have been identified by Board staff, Graduate Medical Education (GME) deans, GME staff, and GME program directors to consider prior to seeking changes to California statutes and regulations, were identified in the June 30, 2015, materials. He stated these were provided from the limited meetings Ms. Kirchmeyer and Mr. Worden had with some of the GME deans and other program directors. Mr. Worden explained the Board was considering increasing the minimum requirements to three years for U.S. and Canadian, and international medical school graduates. One

of the other things the Board would consider is the process of how international medical schools are reviewed.

Dr. Bishop thanked the Board staff for their hard work on this project and asked the Board to include in the assessment, financial or fiscal impact on the Board for having two levels of licensure, and identify any burdens.

Agenda Item 6 Future Agenda Items

Dr. Bishop asked for input on agenda items for the next Licensing Committee Meeting. No suggestions were made for future agenda items.

Agenda Item 7 Adjournment

Dr. Bishop adjourned the meeting at 2:04 p.m.



**PROPOSED CHANGES TO
GRADUATE MEDICAL EDUCATION
(RESIDENCY TRAINING)
LICENSURE REQUIREMENTS**



CURRENT CALIFORNIA APPROVED GRADUATE MEDICAL EDUCATION PROGRAMS

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



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

US and Canada Medical School Graduates:

- Successful completion of one year (12 continuous months in same program) of ACGME or RCPSC accredited GME

International Medical School Graduates:

- Successful completion of two years (last 12 months continuous in same program) of ACGME or RCPSC accredited GME



CALIFORNIA'S CURRENT LICENSE EXEMPTIONS FOR RESIDENTS

US and Canada medical school graduates:

- Must be licensed by the completion of the second year of ACGME and/or RCPSC accredited training anywhere in the US and/or Canada
(BPC Section 2065)

International medical school graduates:

- Must be licensed by the completion of the third year of ACGME and/or RCPSC accredited training anywhere in the US and/or Canada
(BPC Section 2066)



NUMBER OF YEARS TO COMPLETE AN ACGME OR RCPSC ACCREDITED RESIDENCY

Examples of minimum number of years:

- Internal Medicine (General); Pediatrics; Family Medicine - Three Years
- Obstetrics and Gynecology; Psychiatry – Four Years
- Surgery – Five Years
- Neurosurgery - Seven Years

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



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

- The practice of medicine and delivery of medical education is very different today than when BPC Sections 2065 and 2066 were implemented into law in 1980 (BPC 2065) and 1985 (BPC 2066).



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

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

	1 Year	2 Years	3 Years	Full Program
US/CAN:				
Number of States:	31	16	2	1
IMG:				
Number of States:	2	19	27	1

1 State is 30 Months



Note: Some states will accept non-ACGME accredited GME

WHAT IS THE FEDERATION OF STATE MEDICAL BOARDS' RECOMMENDATION?

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

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



HOW MANY YEARS OF ACGME OR RCPSC TRAINING SHOULD THE BOARD CONSIDER AS THE MINIMUM TO BE ELIGIBLE FOR LICENSURE IN CALIFORNIA TO ENSURE APPLICANT IS SAFE AND COMPETENT TO PRACTICE INDEPENDENTLY AND PROVIDE THE BEST CONSUMER PROTECTION?

- Two years for both US/CAN and IMG
- or
- Three years for both US/CAN and IMG



TWO YEARS OF ACGME AND/OR RCPSC?

US/CAN and IMG Two Years:

PROS:

- Adds one year to US/CAN
- US/CAN and IMG would have the same minimum requirement

CONS:

- Does not meet the minimum number of years for any ACGME and/or RCPSC accredited training program
- Does not meet the FSMB minimum requirement for licensure under the Interstate Compact, which requires ABMS affiliate Board Certification



THREE YEARS OF ACGME AND/OR RCPSC?

US/CAN and IMG Three Years:

PROS:

- Adds two years to US/CAN and one year to IMG
- US/CAN and IMG would have the same minimum requirement
- Meets the minimum number of years to complete some ACGME and/or RCPSC accredited residency programs (i.e., internal medicine training program)
- Meets the FSMB minimum recommendation for licensure under the Interstate Compact
- Increases consumer protection



THREE YEARS OF ACGME AND/OR RCPSC?

US/CAN and IMG Three Years:

CONS:

- Increases the length of time to become eligible for a California license by adding two years to US/CAN and one year to IMG
- Moonlighting while in an ACGME/RCPSC accredited program would be limited to current hospital

ADDITIONAL CONSIDERATIONS

- Will the Board still need to have a medical school recognition process?
- BPC Section 2135.7 allows an applicant from unrecognized medical schools to apply for licensure if he or she meets certain requirements, including, but not limited to, the following:
 - ABMS affiliate board certified
 - Licensed in another state(s) or Canada for 10 years
 - Has not done anything that is a ground for denial

Note: ACGME/RCPSC training after two years counts towards licensure

ADDITIONAL CONSIDERATIONS

- BPC Section 2135.7 allows applicants from disapproved medical schools to apply for licensure if applicant meets certain requirements, including, but not limited to, the following:
 - ABMS affiliate board certified
 - Licensed in another state(s) or Canada for 12 years
 - Has not done anything that is a ground for denial

Note: ACGME/RCPSC training after two years counts towards licensure

ADDITIONAL CONSIDERATIONS

- International medical schools are recognized pursuant to Business and Professions Code (BPC) 2089; BPC 2089.5; and Title 16, Division 13, California Code of Regulations (CCR) 1314.1(a)(1) or CCR 1314.1(a)(2):
 - CCR 1314.1(a)(1): Government owned or a bona fide nonprofit medical school for the primary purpose of educating its own citizens to practice medicine in that country.

ADDITIONAL CONSIDERATIONS

- CCR 1314.1(a)(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.....
- International medical schools that need to be evaluated pursuant to CCR 1314.1(a)(2) must submit a Medical Board of California Self-Assessment Report:
 - Note: this is a very long detail-oriented process that consumes significant staff time and resources and requires the retention of medical consultants to assist staff in the review process.

ADDITIONAL CONSIDERATIONS

- Alternatives to the Board's medical school recognition process:
 - The Educational Commission for Foreign Medical Graduates (ECFMG); the World Federation for Medical Education (WFME); and the Foundation for Advancement of International Medical Education and Research (FAIMER) are schedule to have jointly approved Recognized Accreditation Agencies in place by 2023
 - Accept medical schools listed in the “World Directory of Medical Schools” if three years of ACGME or RCPSC is required for licensure



IDENTIFIED ISSUES

- 1) What type of licensure exemption is needed?
- 2) If the resident/applicant entering a California ACGME accredited program has completed ACGME/RCPSC training in another state or Canada, is this a concern?
- 3) If “Yes” to #2, how will the Board be able to identify these individuals prior to resident entering a California ACGME program?



IDENTIFIED ISSUES

- 4) How and when will residents apply for a training license?
 - Prior to starting an ACGME accredited training program?
 - During the first year of an ACGME accredited training program?
- 5) What documents are needed for a training license?
- 6) How much will the training license cost?
- 7) How long will the training license be valid?
- 8) Does the training license need to be renewed? If “Yes” what is the process?

IDENTIFIED ISSUES

- 9) What will a training license allow the residents to perform?
- Write prescriptions without a co-signer?
 - Qualify for a DEA registration?
 - Sign birth and death certificates?
 - Moonlight (current hospital where the resident is training)?

IDENTIFIED ISSUES

10) How and when will residents apply for a full license?

- 90 days prior to completing the ACGME accredited program?
- After completing the ACGME accredited training program?
- If after completing the ACGME accredited training program, how long after completing the training program?
- How much time will Board staff need to process a full license?



IDENTIFIED ISSUES

- 11) How much time would current California ACGME programs need to implement the proposed changes of minimum of two or three years of ACGME accredited program requirement?
- 12) How much time will the Board need to obtain the necessary amendments to statutes and regulations?

QUESTIONS





SPECIAL FACULTY PERMITS



WHAT IS A SPECIAL FACULTY PERMIT?

- A California Special Faculty Permit (SFP) is a license exemption for a physician and surgeon who possesses 1) a current valid license in another state, country, or jurisdiction; 2) does not qualify for a California license but is academically eminent or clearly outstanding in their specialty; 3) has been recruited by a California medical school as a tenured faculty (academically eminent), or a full professor or assistant professor (clearly outstanding) and the medical school has a great need to fill that position.
- The SFP only allows the permit holder to practice medicine in California at the sponsoring medical school and/or a formally affiliated hospital(s) the Board has approved.



CALIFORNIA MEDICAL SCHOOLS

- California Northstate University College of Medicine
- Loma Linda University School of Medicine
- Stanford University School of Medicine
- University of California Davis School of Medicine
- University of California Irvine School of Medicine
- University of California Los Angeles David Geffen School of Medicine
- University of California Riverside School of Medicine
- University of California San Diego School of Medicine
- University of California San Francisco School of Medicine
- University of Southern California Keck School of Medicine



HISTORY

- Business and Professions Code (BPC) section 2168 – Special Faculty Permit: was added to statute and became effective January 1, 1997. BPC section 2168 was amended with a January 1, 2007 effective date.
- BPC section 2168.1 – Eligibility Requirements; Review Committee: was added to statute and became effective January 1, 1997, and was amended twice with effective dates of January 1, 2007 and January 1, 2008.



HISTORY

- Business and Professions Code (BPC) section 2168.2 – Information on Application Form: was added to statute and became effective January 1, 1997, and was amended twice with effective dates of January 1, 1999 and January 1, 2007.
- BPC section 2168.3 – Violations: was added to statute and became effective January 1, 1997.



HISTORY

- Business and Professions Code (BPC) section 2168.4 – Expiration and Renewal: was added to statute and became effective January 1, 1997 and was amended with effective date of January 1, 2009.
- BPC section 2168.5 – was added to statute with an effective date of January 1, 1997, was amended with a January 1, 2007 effective date and was repealed effective January 1, 2013.



HISTORY

- Business and Professions Code (BPC) section 2169 – Continuing Education Requirements: was added to statute and became effective January 1, 2010.
- The first SFP was issued on 08/18/1999.
 - License Number: SFP 1
 - License Status: Canceled
- How many SFPs issued to date?
 - 30 SFPs have been issued to date

Note: License numbers SFP 13 and SFP 26 were not generated in the licensing system and do not exist as SFP license numbers.



SPECIAL FACULTY PERMIT REVIEW COMMITTEE (SFPRC)

- Medical Board of California Members:
 - One Physician Member.
 - One Public Member.
- School Members:
 - One representative from each California Medical School.
- SFPRC meetings are scheduled quarterly. However, the SFPRC only meets if the Board has a completed application to review.
- The SFPRC makes a recommendation to the Board regarding the SFP applicant.
- The Chair of the SFPRC presents the SFPRC's recommendation to the Board at next quarterly meeting.



SFP APPLICATION PROCESS

- A California medical school has identified a need for a faculty member with specific specialty skills to teach the school's medical school students, residents, fellows and to provide medical care to patients who are in need of these specialized skills.
- The medical school conducts a national or worldwide search for the physician with the expertise the medical school needs in the identified specialty.
- The medical school identifies a physician who does not qualify for a California license. However, the identified physician possesses a current valid license to practice medicine issued by another, state, country or other jurisdiction, and the medical school has determined the physician is academically eminent or clearly outstanding in a specific field of medicine or surgery.



SFP APPLICATION PROCESS

- The medical school and the identified physician submit an application, the application fees, Live Scan form or Board/CA-DOJ approved fingerprint cards, and all of the required documents to the Board.
- After the Board determines the SFP application is complete (with the exception of the appropriate U.S. Visa and Social Security Number), the SFP applicant will be presented to the SFPRC at its next scheduled meeting.
- At the SFPRC meeting the sponsoring medical school SFPRC Member will present the applicant to the other SFPRC Members.
- The SFPRC will make a decision on whether to recommend the applicant to the Board for an SFP.



SFP APPLICATION PROCESS

- The SFPRC Chair will present the SFPRC's recommendation at the next Board meeting.
- The Board Members make the final decision.
- The sponsoring medical school and SFP applicant are notified of the Board's decision.
- If the Board approved the applicant for an SFP, staff will issue the SFP once the Board receives a copy of the appropriate U.S. Visa and Social Security Number and license fee.



SFP RENEWAL PROCESS

- The SFP expires and becomes invalid at midnight on the last day of the permit holder's birth month during the second year of a two-year term, if not renewed.
- The Board sends the SFP holder a renewal notice 90 days prior to the expiration date.
- The SFP holder must complete the renewal, pay the renewal fees and the Dean of the sponsoring medical school must attest to the fact the SFP holder still meets the requirements to hold a renewed and current SFP.

SFP RENEWAL PROCESS

➤ SPONSORING MEDICAL SCHOOL DEAN'S CERTIFICATION

I declare under penalty of perjury under the laws of the State of California that this permit holder continues to meet the eligibility criteria set forth in Section 2168, is still employed solely at the sponsoring institution, continues to possess a current medical license in another state or country, and is not subject to permit denial under Section 480 of the Business and Professions Code.

Signature _____ Date _____



SPECIAL FACULTY PERMITS

How many SFPs has the Board issued as of April 19, 2016?

- 30 SFPs have been issued since 1997.

How many SFPs have been canceled?

- 5 SFPs have been canceled.

How many SFPs are renewed and current?

- 25 SFPs are renewed and current.

Has the Board disciplined any SFP holders?

- No SFP holders have been disciplined by the Board as of April 2016.

Note: The Board has one approved SFP applicant who has not been issued an SFP pending U.S. Visa and SSN.



SPECIAL FACULTY PERMITS

Last Name	First Name	Academically Eminent or Clearly Outstanding	School	Title	Department	Permit #	Original Issue Date	Expiration Date	Status
Ratib	Osman	Academically Eminent	UCLA	Professor in Residence	Radiology	SFP 1	8/18/1999	N/A (6/30/2005)	Canceled
Tarin	David	Academically Eminent	UCSD	Professor	Pathology	SFP 2	10/4/1999	N/A (8/31/2007)	Canceled
Abbas	Abul	Academically Eminent	UCSF	Chair	Pathology	SFP 3	1/4/2000	6/30/2017	Current
Muizelaar	Jan	Academically Eminent	UCD	Professor	Neurosurgery	SFP 4	8/10/2000	N/A (5/31/2014)	Canceled
Whybrow	Peter	Academically Eminent	UCLA	Professor	Neurology	SFP 5	9/19/2001	6/30/2017	Current
Jiala	Ishwarlal	Academically Eminent	UCD	Professor	Pathology	SFP 6	10/9/2002	10/31/2016	Current
Rachmilewitz	Daniel	Academically Eminent	UCI	Professor	Gastroenterology	SFP 7	5/21/2004	N/A (5/31/2006)	Canceled
Goadsby	Peter	Academically Eminent	UCSF	Professor	Neurology	SFP 8	11/16/2007	9/30/2017	Current
Medeiros	Felipe	Clearly Outstanding	UCSD	Associate Professor	Ophthalmology	SFP 9	3/7/2008	2/28/2018	Current
Bydder	Graeme	Clearly Outstanding	UCSD	Professor	Radiology	SFP 10	3/7/2008	5/31/2017	Current
Horgan	Santiago	Clearly Outstanding	UCSD	Professor	Surgery	SFP 11	4/11/2008	9/30/2017	Current
Everall	Ian	Clearly Outstanding	UCSD	Professor	Psychiatry	SFP 12	4/11/2008	N/A (8/31/2011)	Canceled

SPECIAL FACULTY PERMITS

Last Name	First Name	Academically Eminent or Clearly Outstanding	School	Title	Department	Permit #	Original Issue Date	Expiration Date	Status
McGovern	Dermot	Clearly Outstanding	UCLA	Associate Professor	Gastroenterology	SFP 14	11/14/2008	8/31/2016	Current
Shiota	Takahiro	Clearly Outstanding	UCLA	Professor	Cardiology	SFP 15	11/25/2008	8/31/2016	Current
Tylen	Ulf	Clearly Outstanding	UCD	Professor	Radiology	SFP 16	12/4/2008	12/31/2016	Current
Ukimura	Osama	Clearly Outstanding	USC	Professor	Urology	SFP 17	2/3/2010	8/31/2017	Current
Yoshioka	Hiroshi	Clearly Outstanding	UCI	Professor	Radiology	SFP 18	2/24/2010	4/30/2017	Current
Wieselthaler	Georg	Clearly Outstanding	UCSF	Professor	Surgery	SFP 19	12/7/2011	3/31/2017	Current
Hommes	Daniel	Clearly Outstanding	UCLA	Professor	Medicine	SFP 20	12/7/2011	6/30/2017	Current
Cilio	Maria	Clearly Outstanding	UCSF	Professor	Neurology	SFP 21	8/16/2012	4/30/2016	Current
Yersiz	Hasan	Clearly Outstanding	UCLA	Professor	Surgery	SPF 22	9/26/2012	8/31/2016	Current
Galassetti	Pietro	Clearly Outstanding	UCI	Associate Professor	Pediatrics	SPF 23	10/17/2012	7/31/2016	Current
Damato	Bertil	Academically Eminent	UCSF	Professor	Ophthalmology	SFP 24	6/21/2013	11/30/2016	Current
Roncarolo	Maria-Grazia	Academically Eminent	Stanford	Professor	Pediatrics	SFP 25	5/23/2014	12/31/2017	Current

SPECIAL FACULTY PERMITS

Last Name	First Name	Academically Eminent or Clearly Outstanding	School	Title	Department	Permit #	Original Issue Date	Expiration Date	Status
Moore	Anthony	Clearly Outstanding	UCSF	Professor	Ophthalmology	SFP 27	1/29/2015	3/31/2018	Current
Ohayon	Maurice	Academically Eminent	Stanford	Professor	Psychiatry	SFP 28	1/23/2015	6/30/2016	Current
Okada	Hideho	Academically Eminent	UCSF	Professor	Neurosurgery	SFP 29	3/11/2015	10/31/2016	Current
Del Campo Casanelles	Miguel	Clearly Outstanding	UCSD	Associate Professor	Pediatrics	SFP 30	7/17/2015	5/31/2017	Current
Sotelo	Rene	Academically Eminent	USC	Professor	Urology	SFP 31	8/7/2015	11/30/2016	Current
Massoud	Tarik	Clearly Outstanding	Stanford	Professor	Neurology / Neuroradiology	SFP 32	3/15/2016	9/30/2017	Current

SURVEY QUESTIONS

Special Faculty Permit Program Survey

* 1. Do you believe the Special Faculty Permit Program is still needed today?

- Yes
- No

* 2. Does the Special Faculty Permit Program provide the medical school with faculty who are eminent or clearly outstanding in their specialty field and who have the expertise and skills the medical school would not be able to obtain from physicians who meet all of the requirements for licensure in California?

- Yes
- No

* 3. Is the Special Faculty Permit Program currently meeting the needs of your medical school?

- Yes
- No
- If you answered no, please explain why not and provide recommendations for improvement.

4. If you have used the Special Faculty Permit Program, please explain the quality and quantity of value delivered by the faculty that is participating in the Program.

Done



SURVEY MONKEY RESPONSES

Note: Responses will be provided at the meeting



SPECIAL FACULTY PERMITS

QUESTIONS



CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168 – Special Faculty Permit

(a) A special faculty permit authorizes the holder to practice medicine only within the medical school itself and any affiliated institution in which the permit holder is providing instruction as part of the medical school's educational program and for which the medical school has assumed direct responsibility. The holder of a special faculty permit shall not engage in the practice of medicine except as provided above.

(b) Time spent in a faculty position under a special faculty permit shall not be counted toward the postgraduate training required for licensure and shall not qualify the holder of the permit for waiver of any written examination required for licensure.

(c) The medical school shall not appoint the holder of a special faculty permit to a position as a division chief or head of a department without express written authorization from the division.



CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.1 – Eligibility Requirements; Review Committee

(a) Any person who meets all of the following eligibility requirements may apply for a special faculty permit:

(1) Is academically eminent. For purposes of this article, “academically eminent” means the applicant meets either of the following criteria:

(A) He or she holds or has been offered a full-time appointment at the level of full professor in a tenure track position, or its equivalent, at a California medical school approved by the Division of Licensing.

(B) He or she is clearly outstanding in a specific field of medicine or surgery and has been offered by the dean of a medical school in this state a full-time academic appointment at the level of full professor or associate professor, and a great need exists to fill that position.

(2) Possesses a current valid license to practice medicine issued by another state, country, or other jurisdiction.

(3) Is not subject to denial under Section 480 or any provision of this chapter.

(4) Pays the fee prescribed for application for, and initial licensure as, a physician and surgeon.



CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.1 – Eligibility Requirements; Review Committee

(5) Has not held a position under Section 2113 for a period of two years or more preceding the date of the application. The Division of Licensing may, in its discretion, waive this requirement.

(b) The Division of Licensing shall exercise its discretion in determining whether an applicant satisfies the requirements of paragraph (1) of subdivision (a).

(c) (1) The division shall establish a review committee comprised of two members of the division, one of whom shall be a physician and surgeon and one of whom shall be a public member, and one representative from each of the medical schools in California. The committee shall review and make recommendations to the division regarding the applicants applying pursuant to this section, including those applicants that a medical school proposes to appoint as a division chief or head of a department or as nontenure track faculty.

(2) The representative of the medical school offering the applicant an academic appointment shall not participate in any vote on the recommendation to the division for that applicant.



CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.2 – Information on Application Form

An application for a special faculty permit shall be made on a form prescribed by the Division of Licensing and shall include any information that the Division of Licensing may prescribe to establish an applicant's eligibility for a permit. This information shall include, but is not limited to, the following:

(a) A statement from the dean of the medical school at which the applicant will be employed describing the applicant's qualifications and justifying the dean's determination that the applicant satisfies the requirements of paragraph (1) of subdivision (a) of Section 2168.1.

(b) A statement by the dean of the medical school listing every affiliated institution in which the applicant will be providing instruction as part of the medical school's educational program and justifying any clinical activities at each of the institutions listed by the dean.



CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.3 – Violations

A special faculty permit may be denied, suspended, or revoked for any violation that would be grounds for denial, suspension, or revocation of a physician and surgeon's certificate, or for violation of any provision of this article. The holder of a special faculty permit shall be subject to all the provisions of this chapter applicable to the holder of a physician's and surgeon's certificate.

CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.4 – Expiration and Renewal

(a) A special faculty permit expires and becomes invalid at midnight on the last day of the permit holder's birth month during the second year of a two-year term, if not renewed.

(b) A person who holds a special faculty permit shall show at the time of license renewal that he or she continues to meet the eligibility criteria set forth in Section 2168.1. After the first renewal of a special faculty permit, the permit holder shall not be required to hold a full-time faculty position, and may instead be employed part-time in a position that otherwise meets the requirements set forth in paragraph (1) of subdivision (a) of Section 2168.1.

CALIFORNIA BUSINESS AND PROFESSIONS CODES

BPC Section 2168.4 – Expiration and Renewal

(c) A person who holds a special faculty permit shall show at the time of license renewal that he or she meets the continuing medical education requirements of Article 10 (commencing with Section 2190).

(d) In addition to the requirements set forth above, a special faculty permit shall be renewed in accordance with Article 19 (commencing with Section 2420) in the same manner as a physician's and surgeon's certificate.

(e) Those fees applicable to a physician's and surgeon's certificate shall also apply to a special faculty permit and shall be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California.

BPC Section 2169 – Continuing Medical Education Requirements

A person who holds a special faculty permit shall meet the continuing medical education requirements set forth in Article 10 (commencing with Section 2190).





CALIFORNIA SPECIAL PROGRAMS



CALIFORNIA SPECIAL PROGRAMS

What are California Special Programs?

- California Special Programs are license exemption programs for California medical schools or teaching hospitals that have been approved by the Board pursuant to the Business and Professions Code (BPC) and Title 16, Division 13 of the California Code of Regulations (CCR).

Note: Special Faculty Permits are not included in this presentation.



CALIFORNIA SPECIAL PROGRAMS

What are the most common California Special Programs?

- BPC 2111 – Fellowship (California medical schools)
- BPC 2112 – Fellowship (Board approved hospital)
- BPC 2113 – Faculty Member Registration (California Medical Schools)
- CCR 1327 – Clinical Training Programs (International Medical Students)



BPC 2111 – Fellowship (California medical schools)

The BPC 2111 registration is for an international physician and surgeon who is licensed in another country who is coming to a California medical school to participate in a fellowship to learn a new skill to take back to the physician's home country.

Note: Time spent participating in a BPC 2111 registration program cannot be used to qualify for licensure in California.



BPC 2111 – Fellowship (California medical schools)

- The BPC 2111 registrant may only practice medicine in California at the sponsoring medical school, under direct supervision of the California licensed physician who is training the BPC 2111 fellow.
- The BPC 2111 registration is valid for one year. It may be renewed no more than two times with the Board's approval.

Note: Almost all BPC 2111 registrations are for one year only, and requests for renewals are rare.



BPC 2112 – Fellowship (Board Approved Hospital)

The BPC 2112 registration is for an international physician and surgeon who is licensed in another country who is coming to a California Board-approved teaching hospital to participate in a fellowship to learn a new skill to take back to the physician's home country.

Note: Time spent participating in a BPC 2112 registration program cannot be used to qualify for licensure in California.



BPC 2112 – Fellowship (Board Approved Hospital)

- The BPC 2112 registrant may only practice medicine in California at the sponsoring California Board-approved teaching hospital, under direct supervision of the California licensed physician who is training the BPC 2112 fellow.
- The BPC 2112 registration is valid for one year. It may be renewed no more than two times with the Board's approval.

Note: To date all BPC 2112 registrations have been for only one year, with no renewals requested.



BPC 2113 – Faculty Registration (California medical schools)

The BPC 2113 registration is for an international physician and surgeon who is licensed in another country who is coming to a California medical school to teach at the sponsoring medical school.

Note: Time spent participating in a BPC 2113 registration program may be used in lieu of the approved postgraduate training requirement to qualify for licensure in California.



BPC 2113 – Faculty Registration (California medical schools)

- The BPC 2113 faculty registrant may only practice medicine in California at the sponsoring California medical school or formally affiliated hospitals.
- The BPC 2113 registration is valid for one year. It may be renewed two times with the Board's approval.



BPC 2113 – Faculty Registration (California medical schools)

- Prior to the end of the third year, the sponsoring medical school and the registrant may submit a licensing plan and request the BPC 2113 registrant's registration be renewed upon the Board's approval of the licensing plan for an additional year.

Note: The licensing plan must include the estimated timeframes the registrant will be taking the required examinations.



BPC 2113 – Faculty Registration (California medical schools)

- Prior to the end of the fourth year, the sponsoring medical school and the registrant may submit an updated licensing plan and request the BPC 2113 registrant's registration be renewed upon the Board's approval of the licensing plan for an additional year.

Note: The maximum amount of time a BPC 2113 registrant may hold a registration is five (5) years.

CCR 1327 – Clinical Training Programs for International Medical School Students

- California teaching hospitals that do not have an Accreditation Council for Graduate Medical Education (ACGME) accredited postgraduate training program for the specific area of instruction must apply to the Board for approval, prior to providing clinical clerkship rotations to international medical school students.
- The Board's approval of the hospital and specific clinical clerkship rotation(s) is for one year and may be renewed annually.



CCR 1327 – Clinical Training Programs for International Medical School Students

- The hospital shall be accredited for continuing education programs by the California Medical Association (Institute for Medical Quality) or by the Accreditation Council for Continuing Medical Education
- The program shall have a ratio of one (1) student per physician supervisor or one (1) student per two (2) residents.
- The clinical training program shall not exceed 12 weeks.
- All students shall have completed at least two (2) years of medical education and shall be in good academic standing.



CALIFORNIA SPECIAL PROGRAMS

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

Hilton Los Angeles Airport
5711 W. Century Blvd.
Los Angeles, CA 90045
(310) 410-4000
(directions only)

Thursday, May 5, 2016
2:15 p.m. – 3:15 p.m.
(or until the conclusion of business)

Public Telephone Access – 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 or
technical difficulties.

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 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 January 21, 2016, Public Outreach, Education and Wellness Committee Meeting
4. Update and Discussion on the Public Outreach Plan – Dr. Lewis
5. Update and Discussion on the Public Affairs Strategic Plan Activities – Ms. Kirchmeyer and Ms. Simoes
6. Update, Discussion and Possible Future Action on Enhancements to the Website – 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.

Thursday May 5, 2016

The call-in number for teleconference comments is: (888) 221-9518

Please wait until the operator has introduced you before you make your comments.

To request to make a comment during the public comment period, press *1; you will hear a tone indicating you are in the queue for comment. If you change your mind and do not want to make a comment, press #. Assistance is available throughout the teleconference meeting. To request a specialist, press *0.

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

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

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

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

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

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

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



MEDICAL BOARD OF CALIFORNIA
Executive Office



Public Outreach, Education and Wellness Committee Meeting

Cal Expo Courtyard Marriott
1782 Tribute Road
Sacramento, CA 95815

Thursday, January 21, 2016

MINUTES

Agenda Item 1 Call to Order/Roll Call

The Public Outreach, Education and Wellness Committee of the Medical Board of California (Board) was called to order by Chair Ronald Lewis, M.D., at 2:31p.m. A quorum was present, and due notice had been mailed to all interested parties.

Members of the Committee Present:

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

Staff Present:

Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Charlotte Clark, Staff Information Systems Analyst
Sean Eichelkraut, Data Processing Manager II
Dennis Frankenstein, Staff Services Analyst
Virginia Gerard, Associate Governmental Program Analyst
Cassandra Hockenson, Public Affairs Manager
Kimberly Kirchmeyer, Executive Director
Nicole Kraemer, Business Services Office Manager
Lois Ranftle, Management Services Technician
Regina Rao, Associate Governmental Program Analyst
Letitia Robinson, Research Specialist
Elizabeth Rojas, Business Services Office
Reylina Ruiz, Administration Manager
Jennifer Saucedo, Staff Services Manager
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II

Public Outreach, Education and Wellness Committee

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Kerrie Webb, Staff Counsel
Susan Wolbarst, Public Information Officer
Curt Worden, Chief of Licensing

Members of the Audience:

Aaron Barnett, Investigator, Health Quality Investigation Unit
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Zennie Coughlin, Kaiser Permanente
Karen Erlich, LM, Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Rae Greulich, Consumers Union Safe Patient Project
Marianne Hollingsworth, Consumers Union Safe Patient Project
Sarah Huchel, Consultant, Senate Business and Professions Committee
Terry Jones, Supervising Deputy Attorney General, Attorney General's Office
Christine Lally, Deputy Director, Boards and Bureaus, Department of Consumer Affairs
Lisa McGiffert, Director, Consumers Union Safe Patient Project
Tina Minasian, Consumers Union Safe Patient Project
Janelle Miyashiro, Consultant, Senate Office of Research
Michelle Monserrat-Ramos, Consumers Union Safe Patient Project
Danielle Sullivan, Center for Public Interest Law
Kimberly Tejada, Investigator, Health Quality Investigation Unit

Agenda Item 2 Public Comment on Items Not on the Agenda

No public comments were provided.

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

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

Agenda Item 4 Presentation, Discussion and Possible Action on the Public Outreach Campaign and Plan

Dr. Lewis stated that at the Board meeting in October 2015 there was a presentation by staff on the outreach plan regarding informing patients how to verify doctors' licenses and view their doctors' disciplinary history. After the presentation some of the Board Members and members of the audience made comments on how to make the plan more patient friendly.

Dr. Lewis continued by explaining that he met with Board staff to look at the plan and rebrand it so that it would reach as many patients and consumers as possible. The new outreach campaign slogan is "Check up on your doctor's license." He talked about the goal, the target audience, the lack of a budget, and the two strategies to implement: 1) current and ongoing event participation and outreach and 2) partnering with

numerous organizations to help with the campaign. There are two things that need to be completed, one is to develop a public service announcement and the other is to develop a tutorial for the website to inform patients how to look up information on a physician.

Dr. Lewis talked about the groups that reach large segments of the population continuously, such as state, city and county payroll or the utility companies where flyers, and information can be placed into mailings or unions where the Board can either attend their conventions or meetings or provide flyers for them to hand out. This is considered priority one, which should be completed before going on to priority two. In priority two, various other regulatory boards can assist the Board using their membership, school publications, community newspapers, etc. Dr. Lewis emphasized that this is an ongoing effort. Dr. Lewis also stated that Board staff is working on planning a Legislative day (or two) where the Board will talk about this outreach campaign and Legislators will be asked to reach out to their constituents and assist the Board with this campaign.

Agenda Item 5 Presentation, Discussion and Possible Action on the Public Outreach Brochure

Dr. Lewis asked everyone to look at the brochure that was developed by the Board staff and asked for their opinions. He continued by explaining the different sections of the brochure. Dr. Lewis spoke about the information inside the brochure that walks consumers through the website. He also noted that staff is working on developing a tutorial on how to look up a doctor's license. Dr. Lewis stated that if a consumer calls the Board's 800 number they can get the same information that is available on the website.

Ms. Kirchmeyer stated that the Board's call center staff is trained to answer the phone call in a timely manner and that calls are being returned. The system will continue to be tested, and statistics on the hold time on the phone are being gathered.

Ms. Yaroslavsky asked if there were any statistics on how often that search button is pushed to verify a license.

Dr. Lewis stated that her question would be answered when they do the demo on the website.

Agenda Item 6 Presentation, Discussion and Possible Action on Enhancements to the Website

Ms. Kirchmeyer explained the reason for the new look of the website.

Ms. Clark stated that of the 50 states only about 15 still use the term "verify a license" or some version, however, most are using similar terminology that MBC has chosen, which is "check up on your doctor's license."

Ms. Kirchmeyer walked everyone through the website with all its functions and stated that it would be sent out to individuals for their thoughts. Staff is hoping the website is understandable and not so bureaucratic.

Ms. Yaroslavsky suggested that when it is put out to the public for clarification, to send it to some group who has no idea what the Board does.

Public Outreach, Education and Wellness Committee

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Dr. Hawkins stated that he liked the changes and the growth and development in this area and commented that he would use some of his patients to try the website and see where they might get stuck. Dr. Hawkins suggested going to the churches for a large gathering of people.

Dr. Krauss congratulated the Board staff on their efforts and asked what the metrics of the website usage were regarding how many hits there were and how those numbers compared with last year's numbers.

Ms. Clark said that she did not have the statistics available from last year to compare, but that last month there was a total of 335,000 hits and that 254,000 were unique hits to the site. Unique means initial contact.

Mr. Eichelkraut talked about what kinds of data can be gathered through Google Analytics and that he would be helping Ms. Hockenson put together some charts and statistics for future meetings.

Ms. Clark said that last month there were 91,000 hits on the license search button, and if they are coming through the Medical Board's website it can be tracked. The ones that go through Breeze cannot be tracked.

Dr. Levine said that she was surprised at the number of hits and stated that it is very reassuring. She stated Google Analytics will be incredibly important in being able to track spikes based on specific activities in the outreach campaign. She said enough time should be allowed to measure the impact of a PSA or a health fair locally, to see if there are spikes.

Ms. Hollingsworth, Consumers Union Safe Patient Project (CUSPP), stated that the new campaign has been reviewed, and that the most effective way to keep patients informed is for the physicians themselves to tell the patient. She then recommended some edits to the sign that is required to be posted in the doctor's office. The edits should state where to look up your doctor's history and where to file a complaint against the doctor, including a website link and phone number. In addition every patient should be handed a piece of paper that includes the information that was suggested to be included on the sign. CUSPP urges the Board to attempt to make these changes by regulation, however, if the Board does not believe that it is feasible, perhaps the Board should sponsor legislation. Ms. Hollingsworth also suggested targeting high schoolers because they are a captive audience who must take CPR prior to graduating and would take this information home.

Ms. McGiffert, CUSPP, stated that she supports what the Board is doing regarding outreach. Ms. McGiffert had several ideas: 1) a statement at the top of the profile page that says the doctor has a disciplinary order or has been disciplined; 2) a summary of the action, maybe placed in the box where the actions are; 3) a monthly update of the list of doctors on probation by county to be put on the website, as well as sent to the Board's email list; 4) a budget for the outreach plan; and 5) she suggested using social media and possibly interns to keep social media updated. She suggests that the work be ongoing, not just one month and hopes that the statistics will be used to measure progress from time to time. She suggested that a polling question be used to ask if people know about the Board, so the effectiveness of the outreach efforts can be tested a year from now.

Ms. Greulich, CUSPP, applauded the campaign and suggested a dedicated hotline number for people who do not have internet access. She gave some statistics regarding the percentage of people who do not use the internet.

Ms. Monserrat-Ramos, CUSPP, requested that the target audience be expanded to include the chronically ill, stating that these patients regularly receive information in the form of paperwork and the Board could easily add its information. The system is already set in place where a flyer or pamphlet can be developed that will provide information on who the Board is, what information the website provides to consumers, how to check the doctor's background, how to file a complaint, or even how to find a doctor in their area by specialty.

Ms. Monserrat-Ramos, suggested that a brief summary stating the reasons for the discipline, the timeline for probation, and any practice restrictions should be readily visible to the patient and written in plain, easy-to-understand language. The brief summary should be located under the physician's name and license number so that it is the first thing that they see. Also, there are a number of BreZE problems that need to be addressed. CUSPP is requesting that an additional search entry be added to the physician profile search, for a search to include a multiple entry search and a physician discipline search be included on the physician profile. It will make it easier to find out which doctors have public reprimands or are on probation.

Ms. Erlich had several suggestions: 1) that licensed midwives and other professionals be placed on the brochure; 2) that malpractice settlements and malpractice judgments be placed together, with definitions for both terms to show that they are not the same thing; and 3) regarding outreach consider adding parent-teacher associations, school boards and the many private schools.

Ms. Minasian, CUSPP, had several suggestions for outreach: 1) put the Board's website address on state cars; 2) use auto dialers for public service announcements; 3) the Board's website under public documents is confusing and needs to be rewritten; and 4) add a blurb stating that if there is a pending investigation or complaint against a licensee, this is not a public record and will not appear on the Board's website.

Agenda Item 7 Future Agenda Items

Ms. Erlich suggested following up on the ideas made by individuals from CUSPP.

Dr. Levine stated that a lot of good information and feedback was discussed at the meeting today. Dr. Levine suggested that it might be helpful to report on the timeline and have dates added to the priority on outreach activities in the plan at the next meeting.

Agenda Item 8 Adjournment

Dr. Lewis adjourned the meeting at 3:45 p.m.

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

Outreach Activity	Status Update
<p>Develop a tutorial for the Medical Board of California's (Board's) website on how to lookup a physician's license and what the information means on the website.</p>	<p>A script for a tutorial has been completed and the public affairs staff gathered the materials needed to produce it. Work will begin with DCA on April 22, to shoot and edit the tutorial. The tutorial should be completed and posted online by the July 2016 Board Meeting.</p>
<p>Develop a PSA that can be provided to entities to air.</p>	<p>The PSA will be developed after the tutorial is completed. Public affairs staff is in the process of determining the talent to use. The PSA will be completed by September 2016.</p>
<p>Include information about the Board on utility bills throughout the state.</p>	<p>Research has determined that there are two types of utilities, municipalities and private, investor-owned. The municipalities are basically publicly owned and are quasi governmental while private, investor-owned utilities are for profit. Both have stated they will not consider putting something in their billing unless it specifically relates to what they do. However, the Public Affairs Manager reached out to the PG&E Public Affairs Director, who put her in touch with a nurse practitioner recently hired with PG&E, Ms. Tammi Watts. Ms. Watts was hired to create a health center for PG&E employees and she is very interested in working with the Board. It was discussed that the Board could provide information via brochures, newsletters, Op Ed's, and possibly participate in future outreach events for PG&E employees. Ms. Watts will be getting back to the Board with more details.</p>
<p>Include information about the Board on city, county, and state employee paystubs.</p>	<p>A message encouraging state employees, vendors and contractors to "Check Up on Their Doctor's License" will appear on all California warrants issued by the State Controller's Office during the period of 6/1/16 to 6/30/16 (this is subject to change). This will reach approximately 439,916 individuals.</p> <p>At this time, Board staff has not been successful with any other cities/counties contacted, but staff plans to continue outreach to numerous cities and counties in California.</p>

<p>Work with the AARP to provide Board information at their conferences, in their publications, and on their website.</p>	<p>The Board’s Public Affairs Manager has reached out to Charee Gillins who handles media for AARP in Southern California and Mark Beach who handles media in Northern California. Board staff has heard from Ms. Gillins who is going to look into the issue of promoting the Board’s messaging in Southern California to AARP members. Board staff is waiting to hear back from Mr. Beach who represents Northern California.</p>
<p>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.</p>	<p>Board Staff wrote a short article for CalSTRS, which was sent to publications editor Krista Noonan on February 8, 2016. CalSTRS has an active teachers group that will be publishing its next newsletter in the spring. They also have a retired teachers group and their publication will be out in the summer. CalSTRS has confirmed that the article will be published in each publication, as long as space is available. The total target readership is 900,000.</p> <p>The same short article was also submitted to the California State Retirees Association. Managing editor, Trinda Lundholm, confirmed the story will run in their April issue. The total target readership is 34,000 retired state employees.</p> <p>The American Federation of State, County, and Municipal Employees (AFSCME) is a national union and has two District Councils, #36 serves Southern California and #57 serves Northern California. The Board’s Public Affairs Manager has spoken with Erica Lichtman from District 36, and on April 4, an email was sent to Ms. Lichtman providing a copy of the Board’s brochure and a short write up detailing the campaign. Potential target readership is 120,000 California members.</p>
<p>Provide an interview and PSA to iHeart Radio with the Board staff and/or with Board Members.</p> <p>Interview/PSA on NPR and Capitol Public Radio.</p>	<p>The Board’s Public Affairs Manager will work to get these interviews scheduled after the Board’s PSA is completed – September 2016.</p>

<p>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.</p> <p>Hold a Legislative Day (possibly two) at the Capitol where Board staff passes out brochures and Members meet with key Legislators.</p>	<p>The Board's Leg Day will be held on May 11, 2016. At meetings with Legislators, Board Members and Staff will encourage Legislators to distribute information on the Board and its website to their constituents.</p>
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“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

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Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.3	Identify methods to help ensure the Board is receiving all the mandated reports.	High - 3	
Activities	Date	Responsible Parties	
c.	Identify opportunities for placement of articles on mandatory reporting in professional newsletters/publications and provide content to be used.	July-2014 and ongoing	Public Information Officer
<ul style="list-style-type: none"> • A “CURES Update” was in the 2015 Summer <i>Newsletter</i>. It addressed CURES status and registration requirements. This was re-printed by the Santa Clara County Medical Association’s publication titled <i>The Bulletin</i>, in addition to the Merced-Mariposa County Medical Society’s publication. • “Reporting Lapses of Consciousness/What is your Legal Responsibility” was in the 2015 Summer <i>Newsletter</i> and also picked up by the Santa Clara <i>Bulletin</i>. • “Patient Protection is Paramount – File Your 805.01 Reports” was in the Fall 2015 <i>Newsletter</i> and picked up by the Santa Clara <i>Bulletin</i> and the Merced-Mariposa County Medical Society. • “Mandatory Reporting Requirements for Physicians and Others” was in the Winter 2016 <i>Newsletter</i> and picked up by the Santa Clara <i>Bulletin</i>. 			
d.	Conduct outreach on reporting requirements to all mandated reporters, as resources allow.	July-2014 and ongoing	Public Information Officer
<ul style="list-style-type: none"> • On September 18, 2015, the Executive Director and Chief of Enforcement attended the California Association Medical Staff Services (CAMSS) Mid-Valley Legal and Regulatory Seminar. Topics included training on 805 and 805.01 mandatory reporting. • On December 10, 2015, the Executive Director gave a presentation to the California Hospital Association. Topics included the physician health program, postgraduate training requirements, 805 and 805.1 reporting, and the mandatory hospital transfer reporting form. 			

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Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.		
3.2	Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board’s laws, regulations, and responsibilities.	High - 2
Activities		Date
Responsible Parties		
a.	Engage in two or more consumer outreach events with area organizations, as travel permits.	Quarterly
	<ul style="list-style-type: none"> • On July 21, 2015, the Public Affairs Manager gave a presentation at a Town Hall Meeting hosted by Assemblyman Bill Dodd and the California State Bar Association. The topic was the Board’s role in consumer protection, how to look up a license and file a complaint. • On July 28, 2015, the Public Affairs Manager did a radio interview with iHeart Radio’s PSA Show on the Board’s prescription drug abuse and misuse campaign. The interview was aired on Sunday, August 9, 2015, and was also a statewide podcast. • On August 29, 2015, a Health Quality Investigation Unit Supervising Investigator gave a presentation at the Napa Pain Conference on the laws and regulations and the new Guidelines for Prescribing Controlled Substances for Pain. • On September 17, 2015, the Executive Director attended a general medical staff meeting at the Sonora Medical Center in Sonora. The subject was “Bending the Curve: the Opioid Epidemic in Tuolumne County.” The presentation included educating physicians on the Board’s Enforcement Process and the new Guidelines for Prescribing Controlled Substances for Pain. • On September 17, 2015, the Chief of Legislation participated in a Think Tank Round Table with the California Healthline on SB 396 (Hill) and increased regulations and oversight of outpatient surgery centers in California. • On September 23, 2015, the Public Affairs Manager attended a forum at the Sacramento Bee to discuss the Public Records Act and Freedom of Information Act and how it applies to government and state agencies. 	

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Activities	Date	Responsible Parties
a. Engage in two or more consumer outreach events with area organizations, as travel permits. (continued)	Quarterly	Public Information Officer
<ul style="list-style-type: none"> • On September 29, 2015, the Public Affairs Manager gave a presentation at the California State University Sacramento Campus Consumer Health Class. The topic was the role of the Medical Board, licensing, and enforcement, as well as the issues of prescription drug abuse and misuse. • On September 30, 2015, the Public Affairs Manager gave a second presentation at the California State University Sacramento Campus to another Consumer Health Class on the above topics. • On October 4, 2015, the Public Affairs Manager attended the Yolo County Outreach Event sponsored by the Yolo County District Attorney’s Office and the California State Bar. The presentation was on the Board’s role and mission but concentrated on how to look up a physician’s license, what the information means, and how to file a complaint. • On October 23 and October 24, 2015, the Board held an outreach event at Arden Fair Mall in Sacramento. Board staff showed consumers how to look up a physician’s license, answered questions on the Board’s role, and discussed how to file a complaint. • On October 28 and 29, 2015, the Board held another outreach event at Horton Plaza in San Diego. Board staff showed consumers how to look up a physician’s license, answered questions on the Board’s role, and discussed how to file a complaint. • On October 30, 2015, the Board held another outreach event at the Fashion Valley Mall in San Diego. Board staff showed consumers how to look up a physician’s license, answered questions on the Board’s role, and discussed how to file a complaint. • On November 12, 2015, the Public Affairs Manager joined Assemblyman Bill Dodd, and the California State Bar at a Town Hall in Dixon, California. The topic was consumer protection and the Medical Board’s role. • On February 29, 2016, the Executive Director gave a presentation on the enforcement process at the California Association of Medical Staff Services, Managed Care Chapter (CAMSS MCC). 		

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Activities	Date	Responsible Parties
a. Engage in two or more consumer outreach events with area organizations, as travel permits. (continued)	Quarterly	Public Information Officer
<ul style="list-style-type: none"> • On February 29, 2016, the Public Affairs Manager was a presenter/speaker at the 2nd Annual Dose of Awareness 5K Walk and Health Expo in San Ramon, held by the National Coalition Against Prescription Drug Abuse (NCAPDA). She spoke on the importance of checking on your physician’s license and how to file a complaint with the Board, in addition to the Board’s mission of consumer protection. • On March 11, 2016, the Executive Director and Staff Counsel gave a presentation to the California Certifying Board of Medical Assistants and the California Medical Assistants Association on the scope of practice of medical assistants. • On March 28, 2016, the Chief of Licensing gave a presentation at the University of Southern California, Keck School of Medicine. • On April 18, 2016, the Public Affairs Manager attended a senior scam stopper event hosted by Assemblyman Jim Cooper. The topic was the Board’s mission of consumer protection, the importance of checking up on your doctor’s license, and how to file a complaint. 		
b. Continue to provide articles and information in the Newsletter regarding potential violations to assist physicians in understanding the laws and regulations.	Quarterly	Public Information Officer
<ul style="list-style-type: none"> • The Summer 2015 <i>Newsletter</i> had an article on “New California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care.” • The Summer 2015 <i>Newsletter</i> had an article on the “Rollout of Uniform Standards for Substance Abusing Licensees.” • The Summer 2015 <i>Newsletter</i> had an article on “Report Lost or Stolen Prescription Pads.” • The Fall 2015 <i>Newsletter</i> had an article on “Warnings About Workers Compensation Fraud.” • The Fall 2015 <i>Newsletter</i> had an article on “Medical Records and Patients’ Rights.” • The Fall 2015 <i>Newsletter</i> had an article on “Implementing a Provider Compliance Program.” 		

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Activities	Date	Responsible Parties
b. Continue to provide articles and information in the Newsletter regarding potential violations to assist physicians in understanding the laws and regulations.	Quarterly	Public Information Officer
<ul style="list-style-type: none"> • The Fall 2015 <i>Newsletter</i> had an article on “Telehealth and the Law: What You Need to Know.” (The article was re-printed in a publication called “San Francisco Medicine” that reaches the San Francisco Medical Society.) • The Fall 2015 <i>Newsletter</i> had an article on “Trauma Informed Care: A Challenge for Physicians.” • The Fall 2015 <i>Newsletter</i> had an article on “Medical Assistants Scope of Practice Clarified.” • The Winter 2016 <i>Newsletter</i> had an article on the “Overview of the California End of Life Option Act.” • The Winter 2016 <i>Newsletter</i> had an article on the “Importance of Discussing Potential Risk of Pain Medication on Vehicle Operations.” 		
c. Launch a Twitter account to provide stakeholders with updates on best practices, changes in laws and regulations, and recent Board activities.	Aug-2014	Public Information Officer
<ul style="list-style-type: none"> • Since launching Twitter at the End of January 2015, the impressions and followers continue to grow. • In July 2015, the Board had 211 profile visits and 2,515 tweet impressions. • In August 2015, the Board sent 3 tweets, had 225 profile visits and 1901 impressions. • In September 2015, the Board sent 15 tweets, had 234 profile visits and 4,509 impressions. • In October 2015, the Board sent 13 tweets, had 350 profile visits and 5,655 total impressions. • In November 2015, the Board sent 2 tweets, had 121 profile visits and 2086 impressions. • In December 2015, the Board sent 3 tweets, had 126 profile visits and 2684 impressions. • In January 2016, the Board sent 14 tweets, had 311 profile visits and 7808 impressions. • In February 2016, the Board sent 9 tweets, had 353 profile visits and 6,034 impressions. • In March 2016, the Board sent 2 tweets, had 281 profile visits and 4,289 impressions • Total Twitter followers as of March 31, 2016, is 250. 		

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Activities		Date	Responsible Parties
d.	Provide two or more articles to appropriate media outlets regarding laws and regulations and what they mean to stakeholders.	Quarterly	Public Information Officer
<ul style="list-style-type: none"> As mentioned above in 2.3(c) the Board has successfully provided four mandatory reporting articles to the Santa Clara Medical Association's <i>Bulletin</i> publication as well as two to the Merced-Mariposa Medical Society and the Telehealth Article was provided to the San Francisco Medical Society's <i>San Francisco Medicine</i>. 			
3.3	Examine opportunities for the Board to provide training to licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.		High - 3
Activities		Date	Responsible Parties
a.	Work with DCA to establish webinar protocol and tools needed to hold a successful webinar	ongoing	Public Information Officer
<ul style="list-style-type: none"> On April 22, 2016, the Public Affair Manager will meet with DCA and discuss the practicality and possibilities of webinars, in addition to assistance in shooting and editing tutorials. 			
b.	Work with healthcare agencies and organizations regarding topics of interest for training purposes.	Sep-2014	Public Information Officer
<ul style="list-style-type: none"> The Board continues to partner with the California Department of Public Health (CDPH) regarding the statewide work group that seeks to curb prescription drug misuse and abuse. Additional plans for this campaign are in discussion. The Board has partnered with the California State Bar and various legislators to educate consumers on the Board's mission of consumer protection. As outlined in 3.2a the Board staff have provided numerous training and educational presentations to healthcare agencies and organizations. 			

**Education and Wellness Committee
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Activities		Date	Responsible Parties
c.	Develop interactive webinar content for licensees to promote public protection.	Jan-2015	Public Information Officer
<ul style="list-style-type: none"> • Due to staffing resources and other priorities, the Board staff has not developed an interactive webinar for licensees. 			
d.	Conduct webinars to promote public protection.	Apr-2015 and bi-annually	Public Information Officer
<ul style="list-style-type: none"> • On December 10, 2015, the Executive Director gave a webinar presentation to the California Hospital Association. Topics included the physician health program, postgraduate training requirements, BreZE, 805 and 805.1 reporting, the Licensed Midwife hospital Reporting Form, and public outreach. 			
3.4	Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.		High - 4
Activities		Date	Responsible Parties
a.	Expand and continue to cultivate relationships with various ethnic communities through their individual media outlets by providing information and education on the Board's role and responsibilities. Provide updates to the Board.	Quarterly	Public Information Officer
<ul style="list-style-type: none"> • On July 23, 2015, the Public Affairs Manager attended the All-State Information Officers and Communication Managers event to network with a variety of communication specialists from a number of California Agencies. A main topic of discussion was ethnic outreach. • On August 19, 2015, the Public Affairs Manager attended a presentation held by the Northern California Chapter of the Public Relations Society of America. One topic of discussion was international media. 			

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Activities	Date	Responsible Parties
b. Engage in television and radio interviews promoting transparency and providing needed information as requested.	Ongoing	Public Information Officer
<ul style="list-style-type: none"> • Staff continues to work with the San Jose Mercury News regarding the issue involving the prescribing psychotropic drugs to foster children. • The Public Affairs Manager has given several interviews and quotes to a variety of media outlets on a variety of topics, including the Check up On your Doctor’s License Campaign to the San Francisco Chronicle, Sacramento Bee, Orange County Register, LA Times, Merced Sun-Star, San Jose Mercury News, News Channel 3 in Santa Barbara, KGET Bakersfield, Wall Street Journal, Center for Investigative Reporting, California Health Report, Channel 29 Bakersfield, 10 News San Diego, KTVU Channel 2 Oakland, Modesto Bee, Consumer Reports Magazine, News 10 Sacramento, the Business Journal, and others. • On March 11, 2016, the Executive Director was interviewed by a journalist from the Sacramento Business Journal on the Board’s Enforcement Program and the vertical enforcement model. • The Public Affairs Manager worked with and continues to work with LA Times reporter Alan Zarembo regarding his investigation of a “stem-cell treatment clinic” operating in California and Mexico. • The Public Affairs Manager continues to work with both state and national news on the topic of physicians on probation. • Three News Releases have gone out: on October 20, 2015, “Be An Informed Patient – Verify your Physician’s License Status;” on February 19, 2016, “ Los Angeles/Glendale Physician’s License Suspended for Sexual Misconduct and Overprescribing;” and on March 10, 2016, “Accusation Filed Against Los Angeles/Glendale Physician for Sexual Misconduct and Excessive Prescribing.” 		

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Activities	Date	Responsible Parties
<p>c. Create PSAs and videos that can be placed online for viewing that address topics of interest as well as educate stakeholders.</p>	<p>Aug-2014 and ongoing</p>	<p>Public Information Officer</p>
<ul style="list-style-type: none"> • On September 28, 2015, the Public Affairs Manager made arrangements to air the Natalie Coughlin PSA on Prescription Drug Abuse and Misuse “One Pill Can Kill” on CBS affiliates CBS-13 in Sacramento, KPIX in the Bay Area, and CBS-2 in Los Angeles. The PSA aired twice at each affiliate between 7:00 – 9:00am. Once aired the PSA was placed on each station’s website and received an additional 63,547 viewings on CBS-13, 63,491 viewings on KPIX, and 63,512 viewings on CBS-2. • On April 22, 2016, the Public Affairs Manager began working with DCA to shoot the script for the tutorial on “How to Check Up On Your Doctor’s License.” Completion date will be July 2016. • The Public Affairs Manager will begin work on a second PSA addressing the Check Up On your Doctor’s License Campaign with a completion date of September 2016. • The Public Affairs Manager will begin work on a tutorial on “how to file a complaint” in late fall. 		
<p>d. Promote the Board’s website and provide consumer friendly information on how to file a complaint.</p>	<p>Ongoing</p>	<p>Public Information Officer</p>
<ul style="list-style-type: none"> • At the January 21, 2016 Public Outreach, Education, and Wellness Committee, the Board staff presented numerous changes to the Board’s website, including making it easier to search for a physician, file a complaint, and review disciplinary documents. • After the January 21, 2016 Public Outreach, Education, and Wellness Committee, the Board staff added a document that identifies what the information in a physician’s profile means and how to obtain that information. 		

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3.5	Establish a method for hosting public seminars taught by legal or enforcement personnel on disciplinary cases, laws violated, and other issues of importance to the profession and the public.		Med - 5
Activities		Date	Responsible Parties
a.	Develop a list of groups who have shown interest for Board speakers in the past, in order to identify similar groups that the Board can reach out to for potential seminars.	Sep-2014	Public Information Officer
<ul style="list-style-type: none"> • The Board staff has a list, and will continue to expand it in the future. Board public affairs staff maintains a chart detailing speaker and outreach requests for various Board speakers that is regularly updated. • The <i>Newsletter</i> has a regular add offering speakers to provide presentations at meetings and events regarding the Board’s mission and functions. Several of the speaking engagements have been requested based upon seeing this offer in the Newsletter. 			
b.	Cultivate relationships with groups not previously engaged, in order to provide seminars.	Sep-2014	Public Information Officer
<ul style="list-style-type: none"> • See 3.2a to identify all the new entities the Board has been able to provide a presentation to on the Board’s roles and functions. • The Public Affairs Manager makes contacts at various outreach events that result in being invited to more outreach events. 			

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Goal 4: Organizational Relationships: Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.		
4.2	Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.	High - 2
Activities	Date	Responsible Parties
b.	Provide presentations on the Board's roles, responsibilities, mandatory reporting requirements, and processes at hospitals, health systems, and similar organizations, as travel permits.	Quarterly Public Information Officer and Appropriate Subject Matter Expert
<ul style="list-style-type: none"> • On September 11, 2015, the Executive Director attended the California Ambulatory Surgery Association Annual Conference in Huntington Beach to discuss outpatient surgery settings. • On February 3, 2016, the Executive Director and Chief of Licensing Curt Worden had a meeting with the University of California Graduate Medical Education Directors. • On February 18, 2016, the Executive Director and a Board Member provided a presentation at UCSF, Fresno, to 50 family medicine residents on the Board and how to be in compliance with the law. • On February 25, 2016, the Medical Board Staff toured the Fort Sutter Surgery Center, a new outpatient surgery setting. 		

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4.3	Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, consumer organizations, professional associations and societies, the Federation of State Medical Boards, federal government agencies, and other state agencies, including the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency.	High - 3	
Activities		Date	Responsible Parties
a.	Develop a contact list of representatives for stakeholder organizations.	Mar-2014 and update annually	Public Information Officer
<ul style="list-style-type: none"> • The Public Affairs Manager maintains a contact list for stakeholder organizations who have contacted the Board and will continue to add to this list. 			
b.	Offer to make presentations to all stakeholder organizations to provide educational information and updates on the Board's current activities, as travel permits.	May-2014 and ongoing	Public Information Officer
<ul style="list-style-type: none"> • See 2.3d, 3.2a, and 4.2d above. 			
c.	Maintain regular communication with stakeholders, including attending stakeholder meetings as appropriate, as travel permits.	Ongoing	Public Information Officer
<ul style="list-style-type: none"> • Board staff meets on a quarterly basis with the California Medical Association on issues of interest. • Board staff meets with Consumer's Union on issues of interest. • Board staff has attended webinars provided by the Federation of State Medical Boards (FSMB) and have provided input on issues raised by the FSMB. • Board staff meets with Department of Consumer Affairs Executive Staff on an ongoing basis. • Board Staff is working closely with CDPH. 			

**Education and Wellness Committee
Strategic Plan Update May 5, 2016**

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

d.	Invite stakeholders to participate in the Board's Newsletter with articles and information, approved by the Editorial Committee, pertinent to licensees.	Mar-2014 and ongoing	Public Information Officer
<ul style="list-style-type: none"> • The Spring 2015 Newsletter included articles from Donate Life California, the Department of Health Care Services, the Drug Enforcement Agency, and the Physician Assistant Board. • The Summer 2015 Newsletter included articles from the Department of Health Care Services, a guest physician writer, who is a professor at the University of California – San Diego, Food and Drug Administration, and the Athletic Commission. • The Fall 2015 Newsletter included articles from the Department of Industrial Relations – Division of Workers' Compensation, Centers for Medicare/Medicaid Services, and University of California, Davis. • The Winter 2016 Newsletter included articles from a guest physician writer, who is a professor at the University of California Davis School of Medicine. 			
e.	Provide activity reports to the Education and Wellness Committee.	At each committee meeting	Public Information Officer
<ul style="list-style-type: none"> • Completed at each meeting. 			
<p>Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.</p>			
6.1	Inform the Board and stakeholders on the Affordable Care Act (ACA) and how it will impact the physician practice, workforce, and utilization of allied healthcare professionals, and access to care for patients.		High
Activities		Date	Responsible Parties
b.	Identify and obtain ACA articles to print in the Board's Newsletter.	Bi-annually	Public Information Officer
<ul style="list-style-type: none"> • The Fall 2015 Newsletter had an article on “Implementing a Provider Compliance Program.” 			

Seeking Doctor Information Online: A Survey and Ranking of State Medical and Osteopathic Board Websites in 2015

March 29, 2016



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DISCLOSURE: Martin Schneider serves as Chairman of the Board of the Informed Patient Institute and also serves on the Board of Consumer Reports. He had no input into this report in either capacity.

Executive Summary

There are a variety of reasons that patients and families may need to find a new doctor—moving to a new town, getting new insurance, or receiving a diagnosis. Many of us turn to the Internet for information about doctors. One place to look in every state is a state medical board website. Medical boards are government agencies that protect the public from the unprofessional, improper and incompetent practice of medicine. In addition to licensing doctors, they accept and investigate complaints about doctors from the public.

After evaluating 65 medical and osteopathic board websites, this report concludes that the information you find on these sites varies greatly—and all can be improved to provide the public with easier access to important information about their doctors. In some states, a site may be easy to use, but have little information about a doctor of interest. In others, the information may be comprehensive, but you cannot easily get to it, cannot tell where it comes from or how current it is.

The highest rated websites had comprehensive information gathered in a “physician profile” for each licensee. But most sites were difficult to navigate, with a variety of user barriers such as confusing entry points (“verify a license”), long drop down menus, security codes, or information in multiple places.

We used 61 criteria to evaluate the sites based on: search capabilities, the types of information one could find about a doctor, instructions and ease of filing a complaint, and what general information was available about the medical board’s operations. Weighted scores were applied to identify the best and worst websites:

HIGHEST SCORING STATES

- [Medical Board of California - 84](#)
- [New York State Physician Profile and State Boards of the Professions - 79](#)
- [Massachusetts Board of Registration in Medicine - 78](#)
- [Illinois Department of Professional Regulation - 76](#)
- [North Carolina Medical Board - 76](#)
- [Virginia Board of Medicine - 72](#)
- [New Jersey State Board of Medical Examiners - 70](#)
- [Florida Board of Medicine - 70](#)
- [Texas Medical Board - 68](#)
- [Florida Board of Osteopathic Medicine - 67](#)
- [Oregon Medical Board - 66](#)

LOWEST SCORING STATES

- [Mississippi Board of Medical Licensure - 6](#)
- [Medical Licensing Board of Indiana - 20](#)
- [New Mexico Board of Osteopathic Medical Examiners - 22](#)
- [Hawaii Board of Medical Examiners - 22](#)
- [Montana Board of Medical Examiners - 26](#)
- [Wyoming Board of Medicine - 27](#)
- [Washington Board of Osteopathic Medicine and Surgery - 29](#)
- [Arkansas State Medical Board - 29](#)
- [Vermont Board of Osteopathic Physicians - 29](#)

- [Oklahoma State Board of Osteopathic Examiners - 30](#)

All but one medical board site had “physician profiles” but they varied widely in the scope of information provided about doctors—such as their educational background and specialty, medical board disciplinary actions, malpractice payouts, actions by hospitals and federal agencies, and criminal convictions. Only four states had at least some information in each category we evaluated. Most states provided a link to the actual board disciplinary orders, which is important. However, profiles generally failed to provide plain language summaries that included the reasons that physicians had been disciplined and specific limitations on their licenses. Users often have to wade through long legal documents to figure this out.

States varied in informing users how often their profiles were updated and how long they kept historical disciplinary information. And, it was not always clear which information on a physician profile was verified by the medical board and which was self-reported by the doctor.

Many states allow users to file a complaint online and almost all include an explanation of their complaint process. Most sites provided links to the laws and regulations governing their work, minutes of their meetings, and names of board members. Few boards are using available methods to engage the public such as webcasting meetings, remote public participation and social media.

Medical board website physician profiles have been around since 1996 and 20 years later people generally have better access to public information about doctors. However, many sites still fall far short of helping the public easily find accurate and comprehensive information. Although medical boards can be constrained by state laws and budgetary concerns, we found examples of innovation that indicate the possibilities for improving these vitally important public resources.

We make the following recommendations for such improvements:

Doctor Search

- Use easily understandable search terms on medical board website homepages and eye catching graphics to help consumers quickly find doctor-specific information.
- Eliminate barriers to accessing physician profiles in terms of security codes.
- In states where medical boards are part of aggregate sites with many professions, provide a direct link from the medical board homepage to the search for doctors, thereby eliminating long drop-down menus and simplify the number of terms describing licensees.
- Consider the needs of users who are looking at multiple doctors by making the search process more seamless and easier to use. Don't make users start over every time with data entry up front, drop down menus, security codes, multiple screens etc., but allow them to quickly start a new search if they want to.
- Incorporate other best practices from the federal government's usability.gov website in terms of making medical board websites useful, usable, findable, desirable, accessible, credible and valuable.

Physician Profile Information

- Include comprehensive information on a physician profile for all physicians that have ever held a license in the state including information about the doctor's background, current and historic information on board disciplinary actions, complete malpractice information, hospital actions, criminal convictions and Federal actions. Provide links to official documents—especially those created by the board such as orders and letters of reprimand.
- Compile all information on the physician profile, minimizing a user's need to go to multiple places to find it.

- Clearly indicate whether a doctor has a disciplinary action of some type early in the search process and at the top of the physician profile.
- The National Practitioner Data Base (NPDB) should be free to states checking for information about their licensees.
- Provide information on the doctor profile about the number and nature of complaints that the board has received against a doctor.
- Include a “plain English” summary of board actions on a physician's profile that provides the date, reason, duration, and restrictions tied to disciplinary actions, as well as links to the actual board orders.
- Clearly indicate when information on the physician profile was last updated.
- Clearly note on the physician profile which information is verified by the medical board and which information is provided by the doctor.
- State laws should give medical boards full leeway in publishing public information they hold about doctors. If it is public information, it should be on the website.

Complaints

- Allow the public to file complaints online, and include instructions regarding mailing in relevant copies of medical records if not available electronically.
- Provide clear information about how complaints are handled, including expected time frames and when and how the complainant will be notified of what happens.
- Clearly describe any time frames regarding filing a complaint. If there is no statute of limitations, state that someone can file a complaint at any time in the future.

General Medical Board Information

- Consider creating a readily apparent “consumer” section of the website where plain English information about the medical board is housed including what the board does, how to file a complaint, FAQs, how to access doctor information.
- Provide live web casts of every board meeting and archive them on the website. Consider allowing the public to call in to make comments during meetings.
- Use social media platforms to do outreach to the public about the board's activities and to inform the public about actions taken on particular doctors.

INTRODUCTION

You've just been diagnosed with a new medical condition. Or you've moved to a new town—or have a new job with different health insurance. These common scenarios often mean finding a new doctor. You may also want to know more about the doctors you already go to. In addition to asking friends, family and other trusted health professionals, many of us will turn to the Internet to search for information. What you'll find there are a variety of sites that provide bits and pieces of information about the over 900,000 doctors in the United States—such as where they went to medical school or whether they're board certified in a particular specialty.

One place to look online for information about doctors is on every state's medical board website. What this report concludes, however, is that the information you find there will vary greatly. In some states, a site may be easy to use, but have little information about a doctor of interest. In others, the information may be comprehensive, but you don't know where it comes from or how old it is. If you live near state borders, you may have to navigate several medical board websites. In no state did we find an “ideal” medical board website—one where a user can:

- 1) Easily search for information about doctors of interest
- 2) View comprehensive and timely information about a doctor, in plain language
- 3) Easily file a complaint about a doctor
- 4) Learn more about how the medical boards regulate and discipline doctors

Medical boards are state government agencies established to protect the public from the unprofessional, improper and incompetent practice of medicine. They oversee doctors and issue licenses to practice medicine to those who meet certain educational and training requirements. Medical boards also investigate complaints and discipline doctors who violate the law. Some states have two boards—one that licenses medical school graduates (doctors with “MD” after their name) and another for osteopathic doctors (“DO” after their name). Osteopathic doctors receive special training in the musculoskeletal system. In some states, medical boards also license other health professionals like podiatrists, acupuncturists, and physician assistants.

There are 65 state medical and osteopathic boards in the country (not including the American territories). State law—usually called a “Medical Practice Act”—defines their mission and work and therefore their scope and operations vary from state-to-state. Some medical boards are part of a broader umbrella agency (such as the Department of Health or a general state professional licensing agency) while others are independent agencies. The boards are typically made up of volunteer physicians and some members of the “public” (non-physicians) who are usually appointed by the Governor. Boards are supported by a staff of state employees, including investigators and lawyers. For a list of medical boards, [click here](#).

Medical boards review and investigate complaints about doctors' unprofessional conduct. These complaints come from a variety of sources including patients and their families, health professionals, government agencies and health organizations (such as hospitals or medical groups). Each state has a process for receiving and investigating complaints, taking action if warranted and publicly reporting information about the outcome. According to the Federation of State Medical Boards (FSMB)¹ (a national organization that represents all of the state medical boards) examples of unprofessional conduct include:

- Alcohol and substance abuse
- Sexual misconduct

- Neglect of a patient
- Failing to meet the accepted standard of care in a state
- Prescribing drugs in excess or without legitimate reason
- Conviction of a felony
- Fraud

The primary way that medical boards communicate with the public is through their websites. Every state medical board has a website that provides some level of information about what they do—including information for doctors about the licensing process. Of particular interest to consumers is the “physician profile” which is an individual web page (or pages) that provides a variety of information about a specific doctor. Generally, these profiles enable you to search for a doctor and find some information about where a doctor practices, their education, specialty and whether there are any disciplinary actions taken against them by the medical board. It is particularly important that medical board physician data is accurate and current as the information feeds other popular “doctor ratings” websites targeting consumers. Other health care entities, such as hospitals and health plans, also use this information.

In 1996, the Massachusetts state legislature passed the first law requiring the state to provide information about physicians online.² Since then, the Internet has created a platform for medical boards to make more information readily available to the public. Every medical board, except Mississippi, has such a profile available on its website. However, this report reveals that each state’s profile contains different information, often depending on their state laws or budget resources.

In 2015, FSMB launched [DocInfo](#) which allows users to put in a doctor's name and state and then be directed to state medical board website(s) where that doctor currently, or previously, was licensed. Many doctors are licensed in more than one state—22% of doctors held two or more active licenses from different state medical boards in 2012 according to the FSMB.³ While very helpful as a national database of doctors, the DocInfo website still requires the user to navigate each state medical board website to find relevant information about the disciplinary actions against a particular doctor.

There is another national database that includes comprehensive information about all disciplined doctors in the country. The National Practitioner Data Bank (NPDB) is a federal repository created by Congress in 1986 and started operations in 1990.⁴ It contains information on doctors who have malpractice payments and other adverse actions against their license—including sanctions by federal agencies for Medicare fraud and drug offenses, by hospitals, and by multiple state medical boards. This type of comprehensive information is usually not available on medical board websites. While the NPDB does make general information available to the public, the information is not linked to physicians’ names, which are confidential by law. If that law were changed, full access to the physicians’ names in the NPDB would allow consumers a “one-stop” resource to check on any doctor of interest.

State medical boards, however, do have access to the NPDB, which among other things was intended to “to prevent incompetent practitioners from moving state to state without disclosure or discovery of previous damaging or incompetent performance.”⁵ There is significant variation, though, in how often and completely the states access the NPDB to supplement the information they have about doctors in their state. In some cases this is due to budget constraints, as there is a charge for the medical boards to check the NPDB. State oversight of doctors would be improved by increasing the ease and decreasing the cost—even making it free—of information exchange between the NPDB and state medical boards.

This report aims to see how well state medical board websites did at providing comprehensive

information to the public in a user friendly way. It builds on similar work of Public Citizen's Health Research Group (a Washington, DC-based non-profit that works on health and safety issues) in 2000, 2002 and 2006. Their most recent report in 2006, [Report on Doctor Disciplinary Information on State Websites: A Survey and Ranking of State Medical and Osteopathic Board Websites](#) ranked the states based on over 50 criteria.

This report concludes with recommendations on how medical boards can improve their website search function, expand information about doctors on their physician profiles, facilitate the complaint process, provide more explanatory information about the medical board's duties and responsibilities, and to generally make the public more aware of their doctors' disciplinary history.

METHODOLOGY

Criteria

We evaluated each state's information using criteria in two categories: Usability/General Information and Content. Usability addressed how easy it was to find and view information. Content addressed the types of information one could find about an individual doctor (such as disciplinary actions). Each category was further sub-divided into criteria, which were the actual items that we looked for and scored in each site review. There were a total of 61 criteria reviewed in the following eight categories:

Usability/General Information

- Search capabilities (such as clearly finding and using a “Look-up” doctor function)
- Complaint and board information (such as how to file a complaint and medical board laws)

Medical Board Website Content

- Identifying doctor information (such as education, specialty training)
- Medical board disciplinary actions
- Hospital disciplinary actions
- Federal disciplinary actions
- Malpractice payouts
- Criminal convictions

We developed the report criteria off those used in the 2006 Public Citizen Report. Staff at Consumer Reports' Safe Patient Project and Informed Patient Institute reviewed Public Citizen's criteria for relevance and then submitted a proposed set to the members of the Medical Board Roundtable for comment. The Medical Board Roundtable is a group of patient and family advocates from around the country who are interested in, and follow issues related to, state medical boards. Over several discussions the criteria were finalized—including the addition of new criteria. **See Appendix B for a complete list of the criteria.**

Review Process

Two reviewers each independently reviewed each medical board website against the criteria, entering a “Yes” or “No” in a spreadsheet to indicate the presence or absence of the information on the websites. In conducting the reviews, they were instructed to replicate how consumers might search for information about their doctors, so not to spend an unreasonable amount of time digging for the information as a researcher might. Also, most of the “content” criteria were linked to whether or not the

information was present on the medical boards' physician profiles, as opposed to scattered about the website.

The two reviewers looked at 65 state board websites. Thirty-seven websites had information about both medical and osteopathic doctors combined, while 14 states (28 websites) had separate boards and websites for medical doctors and osteopathic doctors. Through research on the medical board website, another assistant found names of doctors who had been disciplined in each state during certain periods of time. This allowed the reviewers to check the timeliness of posting information and archiving past information. We also searched federal databases of sanctioned doctors, such as those maintained by the Department of Health and Human Service's Office of Inspector General (OIG), the Drug Enforcement Agency (DEA) and the Food and Drug Administration (FDA) to find names of doctors with federal actions so we could see if these were included in doctor profiles wherever possible. The site reviews were conducted between March and May 2015.

After the independent review of the websites, the two reviewers met to compare each difference and resolve it to an agreed upon "Yes" or "No". A third reviewer conducted spot reviews of random websites to confirm the final outcomes. This resulted in one report for each of the licensing boards.

Confirmation of Website Evaluation with the Medical Boards

In order to confirm and clarify the information gleaned during the reviews, we sent each state medical and osteopathic board our findings about their website. We used various sources to identify contact information including the Administrator's in Medicine, the [DocFinder site](#), FSMB, and the "contact us" section of each state's website. We addressed our request to the Executive Director of the board and asked them to review and verify the information on their state's website. If a specific staff e-mail address was available, we used that. We asked each state to submit any corrections or additional information, accompanied by proof of the change (such as a URL linking to the correct information). We advised them that we would publish the review, as is, if they did not reply within a certain time frame.

Follow-up reminders were e-mailed and we called numerous boards when we did not hear from them. If, after these attempts, we still did not receive information from a particular board, we scored the board based on the information in our review. Fifty-four out of 65 boards responded to our request.

One original reviewer and another staff member reviewed each board's responses and made changes when appropriate. Most boards did not provide links and we did not change answers without verification, unless it was obvious. Some said state law did not allow disclosing certain information – in those cases we gave them a "no."

This confirmation process took place over several months, concluding in January 2016.

We recognize that website updates are done regularly by medical boards and that some of them may have changed since our review was completed. We invited state medical boards to send information about changes they have made since our survey and we have posted their [comments here](#).

Scoring

To determine the relative weight of each category and criterion in scoring the sites, the information was submitted to two outside experts in the field of medical boards and physician discipline. They were asked to distribute 100 points among the eight content categories and then among the criteria

within each of the eight categories. This information, together with final input from Consumer Reports and Informed Patient Institute staff, resulted in the weighting scheme used to rate the websites. Consumer Reports' statisticians applied the weighting to come up with the overall scoring.

RESULTS

Our review found that where you live determines the level of information available to you about doctors.

HIGHEST SCORING STATES

Overall, the report found the highest scoring states, based on the total weighted scores from all criteria, were:

- [Medical Board of California - 84](#)
- [New York State Physician Profile and State Boards of the Professions - 79](#)
- [Massachusetts Board of Registration in Medicine - 78](#)
- [Illinois Department of Professional Regulation - 76](#)
- [North Carolina Medical Board - 76](#)
- [Virginia Board of Medicine - 72](#)
- [New Jersey State Board of Medical Examiners - 70](#)
- [Florida Board of Medicine - 70](#)
- [Texas Medical Board - 68](#)
- [Florida Board of Osteopathic Medicine - 67](#)
- [Oregon Medical Board - 66](#)

LOWEST SCORING STATES

The lowest scoring states, based on the total weighted scores from all criteria, were:

- [Mississippi Board of Medical Licensure - 6](#)
- [Medical Licensing Board of Indiana - 20](#)
- [New Mexico Board of Osteopathic Medical Examiners - 22](#)
- [Hawaii Board of Medical Examiners - 22](#)
- [Montana Board of Medical Examiners - 26](#)
- [Wyoming Board of Medicine - 27](#)
- [Washington Board of Osteopathic Medicine and Surgery - 29](#)
- [Arkansas State Medical Board - 29](#)
- [Vermont Board of Osteopathic Physicians - 29](#)
- [Oklahoma State Board of Osteopathic Examiners - 30](#)

For complete state scores, see Appendix A.

SEARCHING FOR DOCTORS

When a user lands on a state medical board website homepage, it should be easy to see where to find information about specific doctors. We looked for a well-labeled search process that most people would understand and that would quickly get you to the information about doctors. Once there, people should be able to search based on several factors such as name, location, specialty and hospitals where the doctor practices. The search process should also accommodate users interested in looking up more than one doctor—for example when checking on all of the specialists participating in a particular health plan network.

Starting your Search

There were a variety of search phrases that medical board websites used on their homepage to help users find information about doctors. Only 29% of the state medical board websites featured consumer-friendly search terms such as:

- “Doctor search”
- “Find a doctor”
- “Look up a doctor”
- “Look up a health professional”
- “Physician profile”

These phrases are most useful because they contain the words “doctor”, “physician” or “health professional” to help orient users to what they would find when they click on the link. Though we still gave credit, more difficult search terms included “Find a healthcare provider” or “Find a healthcare practitioner”. We did not give credit for “find a provider” because we think most people are not familiar with that term for doctors.

On the other hand, 71% of medical board websites used terms that would be unfamiliar to consumers such as:

- “Verify a license”
- “Licensee look-up”
- “License search”

While the terms “licensee”, “license” and “verify” are familiar words within the medical board world, they are not familiar to most consumers. Interestingly, several of our highest scoring states—the California and New Jersey medical boards—have a good amount of information available, but site visitors might miss it by not knowing to click “Verify a License” or “NJ Health Care Profile” to find that information. In New Jersey, a simple change to the home page could take consumers to a treasure trove of information that is relatively easy to navigate.

Using Search Functions

The best medical board websites take the user directly from the home page to a doctor search function without a lot of intervening steps. Once there, almost all states (95%) allowed users to search by a doctor's last name and license number. The Mississippi board—the lowest ranking website in our evaluation—merely lists the names and addresses of doctors in their state and a “Yes” or “No”

regarding whether they have a “public record.” For additional information regarding a doctor's public record, the website sends you to a page indicating you have to pay a \$25 “verification fee” to have the information sent by mail or email. This highlights the dual nature of these websites—physicians use them to apply for or renew a license, or to have their license officially verified for employment or other reasons. The public, however, uses them to access information about doctors in their state and should not be charged a fee for this information.

The Washington medical and osteopathic boards are the only websites that require the use of a doctor's partial first and last names in their search function—such as an initial or the first three letters of a name. This practice is very consumer unfriendly as many people might not know the first name of a doctor of interest and it provides opportunities for additional spelling errors.

In terms of searching for doctors using other criteria:

- 78% allowed search by location such as city
- 45% allowed search by specialty
- 9% allowed search by hospital

Several states allowed the user to search on all five criteria (name, location, specialty, hospital and license): Massachusetts, New Jersey, New York and the Oklahoma medical board. On the other hand, many states allowed searches on only two criteria: name and license number (which is not known by most users). These included the medical boards in the District of Columbia, Hawaii, Maryland, New Mexico, Oklahoma Osteopathic board, Rhode Island, South Dakota, the Utah medical and osteopathic boards, the Washington medical and osteopathic boards and Wisconsin.

One of the best practices is the Oklahoma medical board. It has a box on the homepage that clearly indicates: “Find a Doctor by Name, Specialty, County, License Number and More” and takes you directly to a doctor search function. The site allows you to search by the languages spoken by the doctor, whether they accept new patients, participate in Medicare and Medicaid, and are affiliated with certain health plans. It also allows you to search for licensees with disciplinary actions. But the site falls short because after the easy access, their physician profiles don't include full information about a doctor's disciplinary record.

The New Jersey board (one of the top scoring sites) also has a good search function that includes the ability to search by type of practice (allergy, cardiology etc.), hospital, and license status (whether the doctor's license is active, expired, suspended, surrendered or revoked). It helps users who aren't sure how to spell a doctor's name by entering the first three letters and then providing a list of names that begin with those letters. Unfortunately, it is hard to find the link that leads to this search function “at a glance” from the home page.

Getting to the Physician Profile

Users are likely to face challenges when navigating websites to find information about doctors. Many sites combine doctor profiles into aggregated websites that include many other licensed professionals in the state. This typically requires a confusing process of trying to find the right words (such as “doctor”, “medical” or “physician”) in drop down menus that include dozens of professions. These drop down boxes—in states such as Washington, Colorado, and Montana —have doctors listed along with accountants, animal massage certification, architects, athletic trainers, barbers, home inspectors, massage therapists, interior designers and other professions requiring a license.

Even if one can find the “doctor”, “physician” or “medical” section of the drop down menus, there are sometimes multiple and confusing entries. In Washington, for example, the list includes:

- Physician and Surgeon County/City Health Department License
- Physician and Surgeon Fellowship License
- Physician and Surgeon Institution License
- Physician and Surgeon Residency License
- Physician and Surgeon Teaching Residence License
- Physician and Surgeon Temporary Permit

The Colorado site includes:

- Medical: Foreign Teaching Physician
- Medical: Physician Training License
- Medical: Physician
- Medical: Physician in a Training Program
- Medical: Pro Bono Physician

Both of these sites provide an unnecessary level of detail that is likely to cause many users to click back and forth numerous times before finding the profile section they are looking for.

A couple of aggregated medical board sites have short-cuts that allow you to skip other professions and go directly to information about doctors or other regulated health professionals from the “search for a doctor” link. For example, California aggregates licensing information for many health professions, but the medical board site directly links to an intermediary page that makes it relatively easy to choose physicians and surgeons from a static list rather than a drop down menu of every profession licensed by the state. After clicking on the search function on the Maine osteopathic and medical boards' home pages, the sites pre-populate the resulting search box with the words “Osteopathic licensure” or “Medicine” so the user doesn't have to find those terms in long drop down menus.

Some sites create another barrier to access by requiring users to enter a security code before they get to the information they want. For example, sites in Hawaii, Minnesota, Tennessee and Washington require users to enter characters or text in a box in order to proceed in a search. For users who are researching several doctors, it can be frustrating and time consuming to have to continually re-enter security codes for each doctor search. Tennessee's code expires after 90 seconds, requiring one to enter a new code for each search. Some sites (such as those in Louisiana, North Dakota, and West Virginia medical) use a slightly easier security process of having the user click on a button that indicates: “I am not a robot”.

While limited financial resources and concern about security may lead states to aggregate information about all licensees on a single web portal, these practices affect the usability of this vitally important doctor information. Medical boards are governmental entities that generate information that should be easily accessible to the public. Those states using aggregated sites should create links that facilitate easier access to the doctor information.

And finally, as with all websites, optimal site function can degrade over time. We found medical board websites that were very slow in bringing up names (such as California and Hawaii), dropped part of names, and sent us to dead pages. Each medical board should have staff responsible for routinely checking site performance so that consumers, physicians, and others can readily find the information they provide.

INFORMATION AVAILABLE ON DOCTOR PROFILES

Once the medical board website user finds their way to a physician profile, the ideal profile would include a robust and timely range of information about doctors. This includes documentation of medical board disciplinary actions and information from other sources such as malpractice insurers, hospitals, the court system and the federal government. In addition, users should have access to both current and historical information, and they should know where the information came from. The profile should clearly state which information is supplied by the doctors about themselves and which is verified, or provided, by the medical board. This report details the variation in how well state medical boards did on all of these criteria.

Information about the Doctor's Background

Almost all states provided some level of information on their physician profile about doctors licensed by that state. The most common types of information were:

- Name of the physician – 98%
- License status – 98%
- License number – 97%
- Physician location – 88%
- Specialty – 72%

Less commonly provided information:

- Name of medical school attended – 66%
- Year of graduation from medical school - 63%
- Name of residency program – 37%
- Year of residency program completion – 32%
- Year of birth – 15%
- Whether doctor holds license in another state – 11%

In order to determine a doctor's specialty, some states, provide a link to the homepage of the American Board of Medical Specialties (ABMS) website. Here users must then go to another website—<http://certificationmatters.org>—where they have to register with the site before getting any information. Given that this process takes many clicks to get to the actual data, we did not give states credit for providing specialty information unless they provided it directly to consumers on the physician profile.

Board Disciplinary Action

Disciplinary information about a physician is the most important information that a medical board can provide to the public. It indicates that a physician has violated the conditions of their license or has failed to meet the standard of care for patients. These criteria were rated highly in our scoring methodology. According to the FSMB, there were over 9,000 state medical board actions in 2012.⁶

The process for disciplining doctors varies from state to state but often starts with a complaint. Board investigators, sometimes with staff from other agencies such as an Attorney General's office, decide whether to act on the complaint based on the law. If they find evidence of unprofessional, improper or

incompetent medical practice, they follow a process that generally starts with a “charge” or “accusation” (the alleged offense committed by the doctor) followed by a series of meetings and hearings if the case goes forward. If the board finds that the doctor has violated the law, they can take disciplinary action against the doctor's license—generally called a “sanction”. Sanctions include suspension or revocation of a doctor's license, probation, sending a letter of concern (or reprimand), collecting a fine, or imposing supervision or educational requirements on the doctor. The description of the process and outcome against a doctor is generally written up in a legal document called a “board order.” Almost 4,500 doctors nationwide were either put on probation, had their license suspended or had their license revoked in 2012.⁷

Our research found that there is a wide variety of public information available online about physician disciplinary actions. And again, reviewers were instructed to be able to find information about doctors relatively quickly on physician profiles and not have to dig in the site for the information.

We found that no board's physician profile provided information about complaints against a doctor, unless the complaint led to formal charges or board action against them. While all physicians should have access to due process, and some number of complaints could be viewed as out of the medical board's scope, it is troubling that the public has no way of knowing if a doctor has received multiple substantive complaints about their clinical performance.

Hawaii has a separate complaints office within their Department of Commerce and Consumer Affairs that oversees and enforces the state's professional licensing laws, including their medical and osteopathic boards. On this Regulated Industries Complaints Office site, you can search for complaints about doctors and, in some cases, find out about the disposition of the complaint. The site has a long disclaimer that you must agree to before getting information, makes it difficult to figure out the profession of the individuals listed (for example, doctors are “MD+a number” and RS+a number are Real Estate Salespersons), but the tenacious user can find the general cause and disposition of some complaints. One physician we looked up had two complaints that led to actions (a warning letter and a fine) but her profile, which was accessible in a different part of the site, gives no indication of any issues. Placing this information in a physician profile would be much more helpful for consumers.

On the other hand, almost all states (92%) had a list somewhere on their site (other than on the physician profile) of medical board actions against doctors. The actions are often listed by month or year and sanctioned doctors are usually listed alphabetically with varying degrees of information about the case. Sixty-two percent of the sites' lists included links to the underlying board orders that provided details of the case. While this is helpful, particularly for those who follow the work of the medical board, for someone looking for information about specific doctors, it is most useful if board actions also appear on an individual doctor's physician profile.

Some sites have archival information by year with similar disciplinary action lists. The West Virginia medical board includes a down-loadable spreadsheet of all disciplinary actions dating back to 1953. The California medical board site provides access to annual actions since 2008 that can be downloaded into excel spreadsheets but it is difficult to find it under the “About Us” tab.

In terms of what was found on physician profiles, most gave the outcome of the board action (83%) such as whether a doctor was disciplined and, if so, the kind of action (i.e. “suspended” or “revoked”). Most (89%) also provided some information on doctors who no longer practice in the state. For example, doctors who were deceased, retired or no longer lived in the state.

Less commonly found on physician profiles were the following:

- The date of the board action against the doctor – 68%
- A link to the actual board order that provided details of the case – 69%
- A “plain English” summary/description of the board action – 46%
- Information on actions against a doctor from other states – 28%
- A description of the offense or specific charges against the doctor - 18%

Some states provide information early in the search process about whether a doctor has a license problem. For example, after you enter a doctor's name in the search engine and get a list of doctors, you can see the license status of each of the doctors on the list (such as “active”, “suspended”, “revoked”). This provides an early signal to the user to learn more about that doctor if there are problems.

Once you are on a physician profile, it is important for boards to clearly signal that there is a license problem. The Maine medical board, for example, puts a sentence in red at the very top of their profile indicating when a doctor has been the subject of board disciplinary action. They then direct the user to details below in the physician profile.

It is important for medical board websites to include access to full legal documents about a disciplinary case, including accusations/charges and board orders. But many consumers will find these difficult to understand as often the serious reasons for the discipline (such as gross negligence, sexual misconduct or substance abuse) are buried in complicated legal language. Some states provide summaries of the board actions on the physician's profile. For example, the physician profile in Georgia includes the date of the disciplinary action and a plain English description of the type of violation and the action taken by the board. The Illinois and Maryland boards also include good consumer oriented summaries. Finally, the Iowa medical board includes a copy of the press release about sanctions on the physician profile so users can read the details of the case in more accessible language.

Malpractice

Medical malpractice information on medical board websites is probably the most difficult for the public to decipher. Some states differentiated between settlements and judgments; others between arbitrations or claims filed in courts. The criterion we used was simply “malpractice payouts” meaning any cases involving a payment. We actually spent more time on this section than an average consumer might spend. Generally, profiles were often not clear whether malpractice information was verified by the board or simply reported by the physician. In their responses to our findings, numerous boards indicated they received this information directly from malpractice insurers. We counted those as verified.

A little over a third (35%) of the medical board websites had any information about malpractice on their physician profiles. Only six sites (9%)—Illinois, Massachusetts, Oregon, Vermont medical and Nevada medical and osteopathic boards—had information on all malpractice payouts. More common was for the profile to include only certain malpractice information. For example, a profile might include only the most recent cases, those above a certain dollar amount, or only when a doctor had a certain number of cases within a particular time period, for example, three payouts within five years. Many boards indicated these limits were set in state laws. Several states—including Virginia, New York and Vermont—did not list the amount of payouts, but rather ranked them as low, average or high based on a comparative formula with other physicians within a particular specialty.

Only Massachusetts and Illinois got a “yes” on every one of the medical malpractice questions: They

listed all payouts that were verified by the board, had at least 10 years of records, and included the amount of the payouts.

Several of the sites have somewhat lengthy explanations for users that limit the impact of the malpractice information. For example the Oregon site requires you to read this statement before getting the malpractice information:

“The settlement of a medical malpractice claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the provider. Therefore, there may be no disciplinary action appearing for a licensee, even though there is a closed malpractice claim on file. A payment in the settlement of a medical malpractice action does not create a presumption that medical malpractice occurred.”

The Tennessee medical board also has a very long statement about medical malpractice liability claims that could cause users to question the value of the information. And the Maryland medical board has a similar statement, but they give the user the option to read it or not by clicking on a link.

Hospital Disciplinary Actions

Most doctors are affiliated with hospitals where they can admit patients if needed. Many states require hospitals to report to the medical board if a hospital takes certain actions to limit a doctor's ability to practice (often called their “privilege” to practice within a hospital). And federal law requires that these reports go to the NPDB. Our review of medical board websites found that only about a quarter (23%) included information about hospital actions against doctors on their physician profile. And only 18% provided any additional information about the hospital action, such as the date of the action or a summary of why the hospital took action.

The Kansas medical board, for example, indicates whether there are any “Health Care Facility Privilege Actions” on their physician profile. The Tennessee medical board profile has several sections on hospital issues, including where the doctor has staff privileges, whether there are any “resignations from a hospital in lieu of termination” and any actions taken by a hospital. And the Vermont medical board profile includes information on “revocations or involuntary restriction on hospital privileges,” as well as other hospital restrictions.

Federal Disciplinary Actions

Federal agencies occasionally discipline doctors. The Centers for Medicare and Medicaid Services (CMS)/Department of Health and Human Services, the Food and Drug Administration (FDA) and the Drug Enforcement Agency (DEA) all have authority to sanction doctors who have committed Medicare fraud, engaged in criminal conduct with respect to the development or approval of drugs, or committed drug related crimes, respectively. All of these federal agencies maintain websites that publish national lists of doctors who are excluded or debarred from their programs.

Only a small number of state medical board websites (11%) had information available on their physician profiles about any federal actions against a doctor. Examples of those that do: the North Carolina medical board includes actions taken by federal agencies under their “Actions - Adverse and Administrative” tab while the Kansas board lists “Other Public License Actions, DEA Actions, Criminal Actions or Miscellaneous Information” and the Virginia medical board includes a tab for “Proceedings, Actions and Convictions” that includes actions taken by organizations other than the Virginia medical

board.

An even smaller number (5%) provided a link to more information about any federal agencies' actions.

Convictions

According to the FSMB, 45 states require criminal background checks of doctors as a condition of initial licensure.⁸ Research conducted by FSMB in 2006 found that two to-five percent of physicians applying for licensure had criminal histories and one to-three percent did not report them on their applications. After they receive their license, most states require that doctors self-report any convictions. In 2000, the Florida medical board reported that after the board began requiring fingerprinting, approximately three percent of doctors showed a criminal history. Of the applicants with a criminal history, 44% failed to report that information on their license application.⁹

In our review, we found that a little over a third of medical board websites (34%) had information on their physician profiles about whether a doctor had any criminal convictions. Only 13 states (20%) had any additional information such as the number of criminal convictions or details about the convictions.

Timeliness

There were a number of ways that we assessed the issue of timeliness in the review of medical board websites. We were interested in whether the site clearly indicated how often content was updated and specifically, whether there was an indication on the physician profile that told the viewer when that information was last updated. We were also interested in whether medical boards archived information about doctors who had been disciplined in the past, thus providing their full history.

Twenty percent of the sites included information about how often the website was updated. A higher number of sites, over half (51%), indicated when their physician profiles were last updated. For example, the homepage of the New Jersey medical board indicates when the contents of the page you are viewing was "Last Modified" and also clearly indicates on the physician profile when some of the information was last updated. North Carolina also indicates when information provided by the doctor was last updated on their physician profile.

Other medical boards, such as California, Colorado, Louisiana and North Dakota, indicate the date and time you are viewing the physician profile. This information is useful if you want to print out the information and know when you viewed it, but doesn't necessarily indicate when that particular profile has been updated. In our validation of responses with each board, however, we gave credit to the boards that told us their site was updated daily or as soon as information became available.

With regard to archiving board actions, we found that 37% of sites clearly stated how long they kept medical board actions on their physician profile. Since all historic licensing about physicians is public information in most states, users should be able to see the full history of a physician online. To test this, we gathered names of disciplined doctors by reviewing lists of sanctioned doctors for various periods in each state. Wherever possible, we then checked to see if their profile included these actions. Eighty percent of sites (52 boards) included actions against physicians that occurred between 1-5 years ago on the physician profile and 50 boards (77%) included the most recent actions we could find on the physician profile. This indicated that the majority of states are updating profile information in a timely manner. Also, most states included disciplinary actions from 5-10 years ago (77%) and actions from more than 10 years ago (62%).

Verification of Information about Doctors

The public expects to view accurate information on government-sponsored websites. Knowing what doctor information has been verified by the medical board as accurate versus what is self-reported by doctors (who may not report in a timely or accurate manner), is key to ensuring user confidence in the information. Several of our criteria addressed the issue of whether and how medical boards conveyed these distinctions to the public. We looked for a clear indication on what information on the physician profile had been verified by the medical board (and could therefore be confirmed as accurate) and what information was provided by doctors.

We found that nearly half of the reviewed profiles (45%) indicated which information was self-reported by the physician. However, often sites provided this notice in hard to find or read disclaimers, or through other links, making the source of the information less clear.

The Texas medical board does a good job of delineating and titling information that is self-reported. It puts a box around information and notes: “The Information in this Box has been Verified by the Texas Medical Board.” In another box, they indicate: “The Information in this Box was Reported by the Licensee and has not been Verified by the Texas Medical Board.” The Minnesota board clearly indicates whether certain information is “Self-Reported Information” or “Self-Reported, Not Verified by Board”.

When we looked at whether specific types of information on the profiles were verified by the medical board, the numbers were much smaller:

- 15% of conviction information was verified
- 6% indicated that they verified the specialty of the physician
- 6% indicated malpractice actions were verified
- 5% indicated hospital actions were verified
- 3% indicated federal actions were verified

As previously noted, some states provide specialty information on the physician profile, but require you to follow a link to the American Board of Medical Specialties (ABMS) website to verify it.

Searching for Information in Multiple Places on Medical Board Websites

A key concept of website usability is the ability to see information in one place so a user doesn't have to hunt around for information—particularly when words and concepts may not be familiar. The best place in a medical board website to put comprehensive physician specific information is on each doctor's physician profile. The best sites made these profiles a one-stop location to find all about each licensed doctor. Some states use tabs on their profile to indicate the different types of information that are available such as General Information, Education/Certification, Board Disciplinary Action, Malpractice, Convictions, and Other Adverse Actions (which might include hospital and federal actions). Some also offer the ability to see all of that information on one page so a user could easily print it.

On the other hand, we found some medical board websites put physician-specific information in multiple places, making it difficult for the user to pull together a full picture of doctors' licensing records. For example:

- The Louisiana medical board website has a list of all disciplinary actions dating back to the early 1970s. However, some of this information is not fully included on the physician profile so the user would need to check two places for a complete history.
- The Tennessee medical board presents a confusing array of information sources on their search page, stating: “While searching for information on a particular health care professional, consumers should be aware that there are several locations available to aid them with their research. (License Verification, Abuse Registry, Monthly Disciplinary Actions and Recently Suspended Licenses for Failure to Pay Child Support).”

Some states even have information on completely separate websites. As discussed previously, Hawaii provides complaint information on a site separate from the medical board site. It would be much more user friendly if these states placed all of their information into the physician’s profile, or at least provided a link within the profile.

And New York is unique, with a well designed and easy to navigate physician profile site that is separate from the medical board’s site. In 2015, the state’s Governor slated the site for elimination by zeroing out its budget. But a coalition of determined consumer and public interest groups, including Consumers Reports, fought against the proposal and succeeded in saving the website.

FILING A COMPLAINT

One of the most important functions of state medical boards is to accept, investigate and act on complaints about doctors sent to them by the public. Medical boards depend on complaints to flag doctors of concern. Several of our criteria examined information in this area.

Almost all sites (97%) had an explanation of their complaint process, while a little more than half (54%), allowed users to file a complaint online—in many cases by completing and submitting an online form. Being able to file complaints online simplifies the process for patients. However, including all of the medical records needed to back up their complaint could be a challenge, since these records are often unavailable in an electronic form. Any online complaint forms should include instructions regarding where to mail medical records to accompany the complaint. Staff conducting the initial review of the complaint could decide to summarily dismiss it if they do not have the full information backing up the allegations.

We also examined whether the site indicated if consumers had to file a complaint within a certain time frame in order to have it considered by the board—generally called a “statute of limitations.” We found that only 13 states (20%) clearly conveyed this information on their site. In the verification process with medical board staff, some said that they had no time frames listed on their website because they had no statute of limitations. In these cases, we did give them credit for this criterion. However, we find it hard to believe, for example, that boards would accept and investigate complaints that were 10 or 20 years old. If there really is no statute of limitations at all, the website should say so.

In terms of best practice, we found that in addition to having an online complaint process, the Maine medical board has a “Consumer Assistant” on staff to help consumers with the process. On the other hand, the Minnesota Board indicates that complaints must be notarized, which could present a barrier to people who wish to file.

OTHER MEDICAL BOARD INFORMATION

Finally our analysis included criteria about other aspects of medical board websites that addressed general information about the board and its operations. We found that:

- 98% provided information or links to laws and regulations governing the medical board's work
- 95% listed the names of the medical board—indicating which ones were public members
- 82% of medical board meeting minutes were available on the website
- 74% had archived board minutes available (prior to 2014)
- 74% provided consumer-oriented Frequently Asked Questions (FAQs) about the medical board
- 11% web cast board meetings

States that webcast meetings include both medical and osteopathic boards in California, Tennessee and Florida, and Arizona's medical board.

Though we didn't ask if they allowed the public to remotely comment on agenda items in this research, Consumer Reports activists in California pushed for this option given the size of the state and the challenges to the public to attend in person. As a result, the board now allows comments over the phone during medical board meetings. This function is used regularly by consumers and physicians who wish to officially comment during board meetings.

Several states have sections of their website marked for "consumers" or "public." For example, the Iowa site has a section called "Consumers" which notes "How may we help you?" The section includes information on how to file a complaint, find a physician, link to other health sites and get other consumer information. The Nevada medical board site also has a section for "Patients and Consumers" that points out where to find doctors and file a complaint, as well as explaining the investigative process and ordering public records—though they also charge for providing public records.

Some medical boards use social media to convey information to the public. For example, medical boards in Alabama, California, the District of Columbia, Florida, Georgia, Kansas, North Carolina, Ohio, Rhode Island and Washington have Twitter accounts. Facebook is also used by states such as California, Iowa, Maryland, North Carolina and Tennessee. North Carolina in particular is an active user of social media and posts meeting minutes and other announcements on Facebook. Boards should explore using social media to reach people interested in their work and to inform the public about disciplinary actions taken and board operations.

DISCUSSION: TWENTY YEARS OF MEDICAL BOARD WEBSITES (1996 – 2016)

Ten years after the first law passed in Massachusetts to require a state medical board to provide information about physicians online, Public Citizen conducted their study of medical board websites in 2006. And now, 10 years after that, Consumers Reports and the Informed Patient Institute have examined 65 medical board websites. What has changed over the past 20 years?

Overall, it is still too difficult for people to find important information about their physicians on medical board websites. There are not enough direct links to physician profiles and too many clicks and other barriers to get to them. Once there, many sites lack complete doctor information and often what is there is not presented in plain language.

In some respects, however, there has been progress 20 years after Massachusetts' pioneering effort. Almost all states have online physician profiles available to the public—Mississippi being the only state that does not. In addition, over 90% of state medical board websites:

- Provide a way to search for a doctor by their name or license
- Give information on the license status of a doctor
- Provide information somewhere on the site about doctors who have been disciplined
- Provide information about state medical board laws and regulations
- List the names of the medical board members and indicate which ones are public members
- Provide an explanation of their complaint process

Similar to 2006, most states provide some level of information about board disciplinary actions, though often the user must review legal documents that may be hard to understand. Fewer than half the states (46%) help users by providing a more “plain English” summary of what happened. And most of these lack details—such as why actions were taken against a doctor or what limitations were placed on the license. In some states, users may have to go multiple places to get a full picture of a particular doctor’s record. As previously noted, no state physician profiles included information about complaints that patients and others filed against a doctor. Only four board websites (California medical, Maryland, New York, and Texas) had all of the criteria we were looking for regarding information about physician disciplinary actions.

The largest variation among states, as was the case in 2006, is the availability of other types of disciplinary information such as malpractice, hospital actions, criminal convictions, and federal actions. Overall, some information about malpractice and convictions was available on about one-third of the physician profiles. Only a quarter included either information about hospital actions or disciplinary actions from other states—and just over 10% included information on federal actions. Only four medical board websites had at least some information from all five categories: California, New York, North Carolina and Virginia. However, states still varied substantially in the breadth of information provided within each of these categories.

Conveying both the timeliness of information, as well as making historic information available are both features of interest to website users. Given the ability to quickly update online information, users expect that what they see is current—and they should be able to see that by viewing “update” dates on physician profiles and other website pages. They should also be able to easily find complete historic information about a doctor's disciplinary activities in one place and not have to click around to pull together the available information.

We recognize that state medical boards can only do as much as the laws governing their work allow. However, even when they have some latitude, medical boards may be reluctant to do more than is explicitly legally required given powerful forces, such as state medical associations, which are generally opposed to complete public information. Also, the significant costs and staff time associated with having robust, user-friendly and comprehensive medical board websites may not be a legislative budget priority. In addition, states with aggregate sites that provide information on numerous professions face particular constraints in terms of their ability to control the design and usability of their doctor information.

Our review indicated, however, that it is possible to provide comprehensive timely information about doctors in an easily accessible and user-friendly fashion. On the other hand, we also found that the worst websites provided little information about doctors in their state—or put the burden on users to piece together information from multiple places. As the only places where the public can get information about the status of doctors’ licenses and, given the reach of that on other websites used

by consumers, medical boards should strive to produce websites that provide robust, comprehensive and timely information about doctors. The mission of medical boards—to protect the public—requires a commitment to transparency by publicly sharing as much information as possible in a user-friendly fashion.

RECOMMENDATIONS

We make the following recommendations for how to improve the usability and comprehensiveness of medical board websites.

I. Doctor Search

- Use easily understandable search terms on medical board website homepages and eye catching graphics to help consumers quickly find doctor-specific information. Examples of search terms include simple phrases such as “Find a Doctor” or “Look-up a Doctor” that are featured with highlighted links.
- Eliminate barriers to accessing physician profiles in terms of security codes. If state policy requires this, consider using security approaches that are less onerous on users, such as checking “I am not a robot” rather than typing in a string of letters and numbers.
- In states where medical boards are part of aggregate sites with many professions, provide a direct link from the medical board homepage to the search for doctors, thereby eliminating long drop-down menus. Simplify the number of terms describing licensees to “Doctor” or “Physician” rather than using multiple categories (such as “Physician Fellowship license”, “Physician Institution license” etc.).
- Consider the needs of users who are looking at multiple doctors by making the search process more seamless and easier to use. Don't make users start over every time with data entry up front, drop down menus, security codes, multiple screens etc., but allow them to quickly start a new search if they want to.
- Incorporate other best practices from the federal government's usability.gov website in terms of making medical board websites useful, usable, findable, desirable, accessible, credible and valuable.

II. Physician Profile Information

- Include comprehensive information on a physician profile for all physicians that have ever held a license in the state including information about the doctor's background, current and historic information on board disciplinary actions, complete malpractice information, hospital actions, criminal convictions and federal actions. Provide links to official documents—especially those created by the board such as orders and letters of reprimand.
- Compile all information on the physician profile, minimizing a user's need to go to multiple places to find it.

- Clearly indicate whether a doctor has a disciplinary action of some type early in the search process and at the top of the physician profile.
- Ensure medical board access to the National Practitioner Data Bank (NPDB) to efficiently get more comprehensive information not easily available in the state. The NPDB should be free to states checking for information about their licensees.
- Provide information on the doctor profile about the number and nature of complaints that the board has received against a doctor.
- Include both a “plain English” summary of board actions on a physician's profile that provides the date, reason, duration, and restrictions tied to disciplinary actions, as well as links to more detailed information.
- Clearly indicate when information on the physician profile was last updated.
- Clearly note on the physician profile what information is verified by the medical board and what information is provided by the doctor.
- State laws should give medical boards full leeway in publishing public information they hold about doctors. If it is public information, it should be on the website.

III. Complaints

- Allow the public to file complaints online, and include instructions regarding mailing in relevant copies of medical records if not available electronically.
- Provide clear information about how complaints are handled, including expected time frames and when and how the complainant will be notified of what happens.
- Clearly describe any time frames regarding filing a complaint. If there is no statute of limitations, state that someone can file a complaint at any time in the future.

IV. General Medical Board Information

- Consider creating a readily apparent “consumer” section of the website where plain English information about the medical board is housed including what the board does, how to file a complaint, FAQs, how to access doctor information etc.
- Provide live web casts of every board meeting and archive them on the website. Consider allowing the public to call in make comments during meetings.
- Use social media platforms to do outreach to the public about the board's activities and to inform the public about actions taken on particular doctors.

¹ Federation of State Medical Boards (FSMB), “[US Medical Regulatory Trends and Actions](#)”, May 2014;– page 7.

² D. Johnson, and H. Chaudry, *Medical Licensing and Discipline in America*, 2012, Lanham, MD: Lexington Books – page 220.

³ Op.cit. FSMB - page 20.

⁴ See NPDB history at <http://www.npdb.hrsa.gov/topNavigation/timeline.jsp>; accessed 3-18-16

⁵ Ibid.

⁶ Op.cit. FSMB – page 19

⁷ Ibid.

⁸ Federation of State Medical Boards, [Criminal Background Checks: Board by Board Overview](#)
; Accessed 2/17/16; Page linked from: <https://www.fsmb.org/policy/advocacy-policy/key-issues>.

⁹ Federation of State Medical Boards, [“Trends in Physician Regulation”](#), April 2006 – page 10. \

Appendix A

ConsumerReports Medical Board Website Ratings

● Excellent ● Very Good ○ Good ● Fair ● Poor

Site	Overall Score	Search Capabilities	Complaint and Board Information	Identifying Doctor Information	Board Disciplinary Actions	Hospital Disciplinary Actions	Federal Disciplinary Actions	Malpractice Payouts	Convictions
California	84	●	●	●	●	●	●	●	●
New York	79	●	○	●	●	●	●	○	●
Massachusetts	78	●	○	●	○	●	●	●	●
Illinois	76	●	●	●	●	●	●	●	●
North Carolina	76	●	●	●	●	●	●	○	●
Virginia	72	●	●	●	○	●	○	○	●
New Jersey	70	●	●	●	●	●	●	○	●
Florida	70	○	●	●	●	●	●	○	●
Texas	68	●	●	●	●	●	○	○	●
Florida Osteopathic	67	○	●	●	●	●	●	○	●
Oregon	66	●	●	●	●	●	●	●	●
Nevada Osteopathic	61	●	●	●	●	●	●	●	●
Colorado	61	○	●	●	●	●	●	○	○
Arizona	59	●	●	●	●	●	●	●	●
Connecticut	58	○	○	●	●	●	●	○	○
Tennessee Osteopathic	58	●	○	●	●	○	●	○	○
Maryland	57	●	○	●	●	●	●	○	●
Kansas	56	●	○	●	●	●	●	●	●
California Osteopathic	56	○	●	○	●	●	○	○	●
Georgia	55	○	●	●	●	●	●	○	○
Iowa	53	●	●	●	●	●	●	●	●
Nevada	53	○	●	●	●	●	●	●	●
Tennessee	53	●	○	●	○	○	●	○	○

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ConsumerReports Medical Board Website Ratings Continued

● Excellent ● Very Good ○ Good ● Fair ● Poor

Site	Overall Score	Search Capabilities	Complaint and Board Information	Identifying Doctor Information	Board Disciplinary Actions	Hospital Disciplinary Actions	Federal Disciplinary Actions	Malpractice Payouts	Convictions
North Dakota	51	●	●	●	●	●	●	●	●
Arizona Osteopathic	50	●	●	●	●	●	●	●	●
Oklahoma	49	●	●	●	●	●	●	●	○
Ohio	48	●	●	●	●	●	●	●	●
Maine Osteopathic	48	●	●	●	●	●	●	●	●
Vermont	47	●	●	●	●	○	●	●	○
District of Columbia	46	○	○	●	●	●	●	○	○
South Carolina	45	●	●	●	○	●	●	●	●
Minnesota	45	●	●	●	●	●	●	●	●
Maine	44	●	●	●	●	●	●	●	●
West Virginia	43	●	○	○	●	●	●	○	●
Idaho	42	●	○	●	●	●	●	●	●
New Hampshire	42	●	●	●	○	●	●	●	●
South Dakota	40	●	●	○	●	●	●	●	●
Alabama	40	○	●	●	●	●	●	●	●
Kentucky	40	●	○	●	○	●	●	●	●
Michigan	39	○	○	●	●	●	●	●	●
Michigan Osteopathic	39	○	○	●	●	●	●	●	●
Pennsylvania Osteopathic	39	○	●	○	●	●	●	●	●
West Virginia Osteopathic	38	○	●	●	●	●	●	●	●
Missouri	38	○	○	○	●	●	●	●	●
Wisconsin	37	●	●	○	●	●	●	●	●
Delaware	37	○	●	○	○	●	●	●	●

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ConsumerReports Medical Board Website Ratings Continued

● Excellent ● Very Good ○ Good ● Fair ● Poor

Site	Overall Score	Search Capabilities	Complaint and Board Information	Identifying Doctor Information	Board Disciplinary Actions	Hospital Disciplinary Actions	Federal Disciplinary Actions	Malpractice Payouts	Convictions
Louisiana	36	●	○	●	●	●	●	●	●
Pennsylvania	36	○	●	○	○	●	●	●	●
Washington	36	●	●	○	●	●	●	●	●
Nebraska	35	○	○	○	●	●	●	●	●
Utah Osteopathic	35	●	●	○	○	●	●	●	●
New Mexico	34	●	●	●	○	●	●	●	●
Rhode Island	34	●	●	●	○	●	●	●	●
Utah	34	●	●	●	●	●	●	●	●
Alaska	32	○	●	○	○	●	●	●	●
Oklahoma Osteopathic	30	○	○	○	●	●	●	●	●
Vermont Osteopathic	29	○	●	○	●	●	●	●	●
Arkansas	29	●	○	○	●	●	●	●	●
Washington Osteopathic	29	●	●	○	●	●	●	●	●
Wyoming	27	●	○	○	●	●	●	●	●
Montana	26	○	○	○	●	●	●	●	●
Hawaii	22	●	○	○	●	●	●	●	●
New Mexico Osteopathic	22	○	●	○	●	●	●	●	●
Indiana	20	○	●	○	●	●	●	●	●
Mississippi	6	●	●	●	●	●	●	●	●

Consumer Reports and the Informed Patient Institute, a nonprofit group that gives consumers information about healthcare quality and cost, analyzed the websites of state boards that regulate doctors to see how complete their information was and how easy the websites were to use. We then rated the websites on a 1-to-100 scale. The Ratings include medical boards as well as boards that oversee osteopathic doctors, who are physicians with special training in the musculoskeletal system.



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Appendix B
2015 MEDICAL BOARD WEBSITE REVIEW CRITERIA
Criteria used in Survey
Provided to State Medical Boards for review of Survey findings
7-14-15

NOTE: a “physician profile” is generally defined in this survey as an online record of each individual physician’s license information, status, disciplinary actions, and other information that is searchable by doctor’s name or other identifying information.

WEB SITE SEARCH CAPABILITIES

- 1) Profile can be searched By Physician Last Name Only
- 2) Site requires both Physician Last Name and First Name to Search for profile
- 3) The profile can be Searched By Location
- 4) The profile can be Searched By Specialty
- 5) The profile can be Searched By Hospital
- 6) Website homepage clearly indicates to consumers where to find a physician profile. (i.e. consumer tabs, “find a doctor” language, etc.; “verify a doctor” is not clear to most consumers)
- 7) The profile can be Searched by License number

IDENTIFYING PHYSICIAN INFORMATION

Is the following information available on the physician profile?

- 8) Name Of Physician
- 9) Year Of Birth
- 10) Practice Address (city/state OK)
- 11) License Number
- 12) License Status (clear statement of status without having to read legal documents)
- 13) Specialty
- 14) The specialty is verified by the medical board, as indicated on the Physician Profile. (Note: A mere link to ABMS database gets a NO.)
- 17) Name of Residency Program(s)
- 18) Year of Residency Program(s) Completion
- 19) Medical Licenses Held in Other States
- 20) Does the profile clearly state which information is physician self-reported or not verified by the medical board?

PHYSICIAN SPECIFIC BOARD DISCIPLINARY ACTIONS

Is the following information available on the physician profile (may include links to documents)

- 21) Complaint/Accusations against the doctor (Before investigation)
- 22) Offense (i.e. The specific charge against the doctor is listed)
- 23) Date Of Board Action Against the Physician: (i.e., When did the action take place?)
- 24) Board Action (i.e., A general description of the outcome; e.g., Restricted license, probation, fine etc.)

- 25) Actual Board Order (i.e. Link to legal document, which details the offense and the action taken by the board)
- 26) Summary Of Board Action (i.e. Plain English summary of Board action)
- 27) Is there a listing of all board actions taken against doctors somewhere (other than the profile) on the website?
- 28) The list of board actions taken against doctors (in #27) includes links to the actual Board orders (i.e. Link to a legal document, which details the offense and the action taken by the board).
- 29) Actions are listed On Web Site For Physicians Without Active License (i.e. Information about doctors that were previously licensed in the state, "inactive" doctors)
- 30) Does the profile include board actions From Other States

WEBSITE UPDATING

- 31) The website indicates when a doctor profile was last updated
- 32) There is a regular Update Schedule Stated On Web Site

ARCHIVES OF DISCIPLINARY ACTIONS ON PHYSICIAN PROFILES

- 33) Length of Time That Actions Are Archived (kept on the profile) is Stated Clearly On Web Site (FAQ Or Elsewhere); e.g., "any actions older than 10 years are not included on the profile"
- 34) Information about disciplinary actions are on the profile for 1-5 years (2010-2014)
- 35) Information about disciplinary actions are on the profile for 5 -10 years (2005-2009)
- 36) Information about disciplinary action is on the profile for over 10 years? (Prior to 2005)
- 37) Information about the most recent disciplinary action is on the profile?

HOSPITAL DISCIPLINARY ACTIONS

NOTE: Since so few websites had any specific information about hospital actions, we combined the questions #40-#44 into one question (#40) - states got credit for #40 if they had **any** additional information about hospital actions.

- 38) Hospital Actions are available on the Physician Profile
- 39) Hospital Actions are verified By the Medical Board (as indicated on the profile)
- 40) Date Of Hospital Action
- 41) Hospital Offense
- 42) Hospital Action
- 43) Summary Of Order
- 44) Actual Order Included

FEDERAL DISCIPLINARY ACTIONS: (including OIG, FDA/DEA)

- 45) Federal Actions Available on the Physician Profile
- 46) Federal Actions are Verified by the Medical Board (the profile indicates that the board verifies this information)
- 47) Provides Link to federal actions

MALPRACTICE

- 48) Malpractice Information Available on the Physician Profile
- 49) All Malpractice Payouts Are Included
- 50) Amount Of All Malpractice Payouts Is Included
- 51) Malpractice Verified by the Medical Board (as indicated on the profile)
- 52) Malpractice Archives Are Present (i.e. Has historical information about all malpractice payouts)

CONVICTIONS

- 53) Conviction Information on the Physician Profile (i.e. non-medical issues such as DUI, larceny, fraud etc.)
- 54) Conviction Information Verified by the Medical Board (as indicated on the profile)
- 55) Number Of Criminal Convictions/No Contest Pleas
- 56) Details Of Convictions Are Provided

OTHER WEB SITE ITEMS

- 57) States That Statutes/Rules For Physicians Available Online: (i.e. Link to Medical Practice Act/Regulations)
- 58) Complaint Form that can be submitted Online
- 59) Consumer FAQ/Explanation Of What is On Site
- 60) Is there a Plain English Explanation of the Complaints Process?
- 61) Is there information on timeframes for filing a complaint (statute of limitations)?
- 62) Does the Site include the names of Medical Board Members and indicate which are public members?
- 63) Are the minutes of the Medical Board meetings available on the website?
- 64) Are minutes of the Medical Board meetings prior to 2014 available on the website?
- 65) Does the medical board webcast its meetings?



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.

Judge Katherine Feinstein (ret.)

Randy Hawkins, M.D.

Howard Krauss, M.D.

Kristina Lawson, J.D.

Sharon Levine, M.D.

Ronald Lewis, M.D.

Brenda Sutton-Wills, J.D.

David Warmoth

Jamie Wright, J.D.

Felix Yip, M.D.

Los Angeles Airport Hilton
5711 W. Century Blvd.
Los Angeles, CA 90045

Thursday, May 5, 2016

3:30 p.m. – 5:30 p.m.

Friday, May 6, 2016

9:00 a.m. – 2:00 p.m.

(or until the conclusion of business)

Public Telephone Access – 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 or
technical difficulties.

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

Thursday May 5, 2016

3:30 p.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 January 22, 2016 and February 26, 2016 Meetings
4. President's Report – Mr. Serrano Sewell
 - A. Swearing In of New Board Members – Ms. Sutton-Wills and Mr. Warmoth
 - B. Committee Roster Updates
5. Board Member Communications with Interested Parties – Mr. Serrano Sewell
6. Discussion and Possible Action on 2017 Proposed Board Meeting Dates – Ms. Kirchmeyer

7. 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 Health Professions Education Foundation
 - F. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children
8. Update on the Federation of State Medical Boards – Ms. Kirchmeyer
9. Update, Presentation, and Possible Action on the Sunset Review Process/New Sunset Issues – Ms. Kirchmeyer
10. 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
11. Update, Discussion and Possible Action on Recommendations from the Public Outreach, Education, and Wellness Committee – Dr. Lewis
12. Update on the Physician Assistant Board – Dr. Bishop

Friday May 6, 2016

9:00 a.m.

13. Call to Order/Roll Call
14. Public Comments on Items not on the Agenda
*Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting.
 [Government Code Sections 11125, 11125.7 (a)]*
15. Discussion and Possible Action on Legislation/Regulations – Ms. Simoes
 - A. 2016 Legislation

AB 796	AB 2638	SB 1033
AB 1306	AB 2744	SB 1039
AB 1977	AB 2745	SB 1174
AB 1992	SB 22	SB 1177
AB 2024	SB 323	SB 1189
AB 2216	SB 482	SB 1195
AB 2422	SB 538	SB 1204
AB 2507	SB 563	SB 1261
AB 2592	SB 622	SB 1471
AB 2606	SB 994	SB 1478

B. Legislative Items for Future Meeting

C. Status of Regulatory Actions

1. Physician and Surgeon Licensing Examinations Minimum Passing Scores
 2. Outpatient Surgery Setting Accreditation Agency Standards
 3. Disclaimers and Explanatory Information Applicable to Internet Postings
 4. Disciplinary Guidelines
16. Update, Discussion and Possible Action on Recommendations from the Licensing Committee – Dr. Bishop
 17. Discussion and Possible Action on Universidad Autonoma de Guadalajara Application for Recognition – Dr. Nuovo and Mr. Worden
 18. Discussion and Possible Action on Proposed Regulations for Midwife Assistants, adding Title 16, Division 13, CCR sections 1379.01 through 1379.09 – Mr. Worden and Ms. Webb
 19. Update, Discussion and Possible Action on Recommendations from the Midwifery Advisory Council Meeting – Ms. Sparrevohn
 20. Discussion and Possible Action on Midwifery Advisory Council Appointments – Mr. Worden
 21. Investigation and Vertical Enforcement Program Report
 - A. Program Update from the Department of Consumer Affairs – Mr. Chriss and Ms. Nicholls
 - B. Program Update from the Health Quality Enforcement Section – Ms. Castro
 22. Update from the Attorney General’s Office – Ms. Castro
 23. Discussion and Possible Action on Proposed Regulations on Citable Offenses, Citation Disclosure, and Citation and Fine Authority for Allied Health Professionals, amending Title 16, Division 13, CCR sections 1364.10, 1364.11, 1364.13, and 1364.15 – Ms. Delp and Ms. Webb
 24. Discussion and Possible Action on Proposed Regulations on Requirements for Physicians on Probation, amending Title 16, Division 13, CCR section 1358 – Ms. Delp and Ms. Webb
 25. Agenda Items for the July 2016 Meeting in the San Francisco Area
 26. Adjournment

Meeting Information

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

The call-in number for teleconference comments is:

Thursday May 5, 2016 - (888) 221-9518

Friday May 6, 2016 – (888) 254-2817

Please wait until the operator has introduced you before you make your comments.

To request to make a comment during the public comment period, press *1; you will hear a tone indicating you are in the queue for comment. If you change your mind and do not want to make a comment, press #. Assistance is available throughout the teleconference meeting. To request a specialist, press *0.

During Agenda Item **2** and **13** – Public Comments on Items Not on the Agenda, the Board has limited the total public comment period via teleconference to 20 minutes. Therefore, after 20 minutes, no further comments will be accepted. Each person will be limited to three minutes per agenda item.

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

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

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

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

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

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



MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING



Cal Expo Courtyard Marriott
1782 Tribute Road
Sacramento, CA 95815

Thursday, January 21, 2016

MEETING MINUTES

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

Members Present:

David Serrano Sewell, President
Denise Pines, Secretary
Michelle Bholat, M.D.
Michael Bishop, M.D.
Judge Katherine Feinstein (ret.)
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.
Jamie Wright, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:

Dev GnanaDev, M.D.
Gerrie Schipske, R.N.P., J.D.

Staff Present:

Liz Amaral, Deputy Director
Ramona Carrasco, Staff Services Manager I
Charlotte Clark, System Information Services Analyst
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
Nicole Kraemer, Staff Services Manager I
James Nuovo, M.D., Medical Consultant
Regina Rao, Associate Government Program Analyst
Elizabeth Rojas, Staff Services Analyst
Paulette Romero, Staff Services Manager II

Medical Board of California
 Board Meeting Minutes from January 22, 2016
 Page 2

Reylina Ruiz, Staff Services Manager I
 Jennifer Saucedo, Staff Services Analyst
 Jennifer Simoes, Chief of Legislation
 Lisa Toof, Administrative Assistant II
 Cesar Victoria, Department of Consumer Affairs
 Kerrie Webb, Staff Counsel
 Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
 Carmen Balber, Consumer Watchdog
 Stephen M. Boreman, Attorney, Slate, Links and Boreman, LLP
 Jonathan Burke, Department of Consumer Affairs
 David Chriss, Chief of Enforcement, Department of Consumer Affairs
 Zennie Coughlin, Kaiser Permanente
 Juan Pablo Cuellar, M.D., Associate Dean, UAG
 Ricardo del Castillo, Dean of Students, UAG
 Long Do, California Medical Association
 Karen Ehrlich, Licensed Midwife, Midwifery Advisory Council
 Rae Gruelich, Consumers Union
 Marian Hollingsworth, Consumers Union
 Sarah Huchel, Consultant, Senate Business and Professions Committee
 Terry Jones, Supervising Deputy Attorney General, Attorney General's Office
 Juan Carlos Leano, Chief Executive Officer, UAG
 Susana Leano, Vice President for International Affairs, UAG
 Sonya Logman, Deputy Secretary - Business and Consumer Relations, Business, Consumer
 Service and Housing Agency
 Mark Loomis, Supervisor Investigator I, Health Quality Investigation Unit
 Roberto Moya, Investigator, Health Quality Investigation Unit
 Lisa McGiffert, Consumers Union
 Tina Minasian, Consumers Union
 Michelle Monseratt-Ramos, Consumers Union
 Carrie Sparrevohn, Licensed Midwife, Midwifery Advisory Council

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Board to order on January 22, 2016, at 8:32a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were offered.

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

Dr. Lewis made a motion to approve the meeting minutes as written; s/Ms. Wright. Motion carried. (11-2) (Lawson – Abstain, Feinstein – Abstain).

Agenda Item 4 President's Report

Mr. Serrano Sewell introduced and welcomed Ms. Lawson and Judge Feinstein to the Board. The ceremonial swearing in was administered for both Ms. Lawson and Judge Feinstein.

Ms. Lawson stated she is looking forward to working with her new colleagues on the important issues that are before the Board.

Judge Feinstein thanked the Governor for appointing her to the Board. She stated, she, too, is looking forward to working with her new colleagues as well as the public who are generally interested in the issues that come before the Board.

Mr. Serrano Sewell stated he is looking forward to the opportunity to look at the issues that have priority to the Board. He noted that the committees are very important and that they are moving the consumer protection priorities one piece at a time.

Mr. Serrano Sewell stated that he and Dr. GnanaDev continue to meet with Ms. Kirchmeyer and staff on the Board's business and agenda items. He then referred the Members to pages BRD 4- 1 and BRD 4-2 in the Board packet, stating these pages show the updated Standing Committees. He noted that if any of the Members have suggestions or requested changes to that list, to contact Ms. Kirchmeyer for discussion and asked Ms. Lawson and Judge Feinstein to let Ms. Kirchmeyer know if there are any specific committees they would be interested in serving on.

He then stated that Judge Feinstein will be joining Panel A, and that he will be removing himself from that Panel since there is now a full complement of Board Members.

Agenda Item 5 Board Member Communications with Interested Parties

No communication was reported.

Agenda Item 14 Discussion and Possible Action on Universidad Autonoma de Guadalajara's Application for Recognition

Mr. Worden and Dr. Nuovo stated that after review and discussion of the initial evaluation of the Universidad Autonoma de Guadalajara School of Medicine, International Program (UAG), Board staff is requesting the Board to make a determination regarding UAG's proposed four-year curriculum for recognition by the Board. Staff is requesting Members to determine if the third and fourth year clinical rotations meet the minimum requirement pursuant to Business and Professions Code (BPC) section 2089.5 based upon the current information the Board has received.

Mr. Worden stated that if the Board determines the UAG meets the requirements, staff requests the Board approve the four-year curriculum for UAG. If the Board determines more information is needed before approving the four-year curriculum, staff would request additional information from UAG or ask the Board to authorize staff to perform a site visit to the school.

Mr. Worden referred the Members to Pages BRD 14-1 through BRD 14-19 where the submitted report can be found, as well as some information from the UAG. The additional document that was

handed out was an addendum that UAG recently provided to staff. That addendum addressed many of the original concerns shown in Dr. Nuovo's report.

Mr. Worden provided a brief background stating 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.

Mr. Worden noted Board staff and Dr. Nuovo have completed the initial review, including the information that was recently received and Dr. Nuovo's report is included in the Board packet. He stated he and Dr. Nuovo have reviewed the latest information provided by UAG and one area that still needs further clarification is in the third and fourth year of clinical rotations that are completed in a UAG affiliated hospital in Mexico. He stated the percentage of time spent in ambulatory care versus in-patient care for each of the clinical rotations, needs to be clarified, especially the core rotations of the 54 weeks and the remaining 18 weeks.

Dr. Nuovo noted this is the sixth program that he has reviewed for the Board and stated he would focus his comments just on the area of concern. He stated while reviewing the information received from UAG, he found that the majority of the students experience in the third year came mostly from ambulatory care. He felt that information was inadequate to ensure the Board that the training of the four-year curriculum met the elements of BPC 2089.5. He noted that the additional information that was recently received lacks narrative to describe the nature of the experience. He needed clarification whether it is in-patient care and is of sufficient quality to ensure that the students meet the requirements of BPC 2089.5. He stated he does not feel that the information provided to date ensures that these core clerkships meet the requirements of BPC 2089.5 and feels further clarification from the school needs to be provided. He stated that in-patient experience is critical to the future development of the students and their capacity to be successful and to practice safely as they move into their internship and residency training.

Mr. Boreman introduced staff from the UAG. He introduced Susana Leano, Vice President for International Affairs; Juan Carlos Leano, Director and CEO; Ricardo del Castillo, Dean of Students; and Juan Pablo Cuellar, M.D., Associate Dean.

Mr. Boreman stated he understands Dr. Nuovo's concerns and has asked the staff from the UAG to attend the meeting to help answer any questions the Board may have. He noted that UAG already requires four weeks of family practice, and eighty hours of clinical training. He stated that UAG does require 54 weeks of in-hospital training, but understands there is some concern about how much of that is in-patient and how much is ambulatory in the surgical rotation.

Mr. Serrano Sewell asked if the report is complete. Mr. Worden stated the family practice is not an issue at this time, the biggest concern is the time spent between in-patient versus ambulatory at the end of 54 core weeks of training.

Dr. Cuellar stated in regard to the clinical rotation and the in-patient and ambulatory hours, students get 80 weeks of rotation, where in the third year, the timing could vary quite a bit. He stated that students who go to the hospitals and have an in-patient experience that could be 50% or more of the time, however, it could also be more than 50% of the time as ambulatory, but it averages out to be between 50-60% of the time in one area or the other. He noted that when a student is in the hospital setting, the student always has a teacher, professor or specialist with them when doing in-patient care. The professional asks the students to evaluate the patients under their supervision. For the ambulatory care, it is always done inside the hospital where the students practice their knowledge that they learned in the first and second semester. He stated that with the size of the hospital, the students have the opportunity to see many different types of illnesses and/or diseases to learn from them.

Dr. Nuovo stated that although there is a blend of ambulatory and in-patient training, the concern is whether the students receive adequate in-patient experience on each of the core clerkships, whether it be internal medicine, Ob/Gyn, pediatrics, psychiatry, etc. He is concerned whether they are seeing an adequate number of patients in which they do what would be expected of a student. Dr. Nuovo would expect the student to have the opportunity to take a history on a patient and to perform a physical exam on a patient, under the guidance of their supervising attending physician. Also, he expects students to formulate an assessment of that patient, create a plan of care and to write notes that are reviewed by the attending to determine if they are developing their knowledge and skills on all those different areas of medicine. Dr. Nuovo further indicated that there needs to be a methodology to assess the competence of the student.

Dr. Nuovo stated that even with the current information submitted by the UAG, it still does not provide enough sufficient detail on the requirements of the students. He feels that the documentation seems to be skewed toward ambulatory training, yet the professional development of students does require intense in-patient training in which they have the opportunity to perform a history, exam, etc. He stated he is still concerned about whether this is observational or hands on.

Dr. Lewis noted that the Board has been licensing physicians from UAG for several years and states he is seeing a difference in the focus of medical training changing from in-patient to ambulatory. He is concerned that UAG has a blend of the in-patient and ambulatory training where the traditional in-patient training seems to be less in medical education than a blend of both. He is asking if Dr. Nuovo is seeing an anomaly here where over the years the Board has been licensing these students.

Dr. Nuovo stated that many schools have restructured their curriculum to emphasize ambulatory training, where from even the first day, they are paired up with a longitudinal preceptor over the four years they are in training to get a better understanding of ambulatory medicine. But, even with that being the case, he does not feel that there is sufficient description of the in-patient experience to ensure that this four-year program meets the requirements discussed.

Ms. Kirchmeyer noted that the UAG five-year program is still being recognized by the Board. This approval is for the program that was branched off to make a four-year program where they are training individuals who are not their citizens.

Dr. Cuellar stated that they ask incoming students how many clinical hours they have done in several different areas and it is all reported in their files. He noted that in terms of internal medicine, students do 50% -60%, which varies by the number of patients that come to the hospital. The ambulatory training includes history taking and physical examinations, in groups of five including their professor,

in that ambulatory setting. The students also are asking questions, filling in questionnaires that are sent to a platform where they are used as an educational tool. The in-patient experience is when they see those same patients in the hospital should they return. The students are evaluated on their experience with the patients, their ability to talk with and examine a patient, to do their clinical history, in the right sense and right order, and also on their clinical way of thinking. He noted that they see the growth of knowledge in the students over those 12 weeks of training. These evaluations are always done by their professors.

Dr. Hawkins asked if the in-patient curriculum covers a minimum range of diagnostics, for example, the heart, the lungs, the kidneys, etc.

Dr. Cuellar stated that each third level hospital has the different areas, and the students rotate through each of those areas during their 12 weeks of training. He stated that each student has to take five clinical histories for each clinical case per week in each of the areas in the hospital.

Dr. Yip asked why they feel the need for a four-year program.

Dr. Cuellar stated the four-year program allows students to practice into the third year, which gives them the ambulatory experience in the third year, so the four-year program gives the student more tools to work directly with patients and develop the clinical thinking sooner. He noted a four-year program would introduce the students to the clinical thinking and the development of those clinical skills.

Dr. Yip stated with the four-year program, the school will probably have a higher number of enrollments and asked how many faculty the program has currently.

Dr. Cuellar stated they have 4-5 faculty per subject. So, when the students go to the hospitals in their third year, there are five students per professor.

Dr. Yip requested a roster of faculty, as his concern is the number of faculty per student if enrollment increases as expected.

Dr. Hawkins asked Dr. Nuovo if UAG understands what is needed to cure the deficiencies,

Dr. Nuovo stated that what would resolve any pending concerns would be a demonstration from the school that they keep a log of each student during their third year of clerkship and the fourth year of their ambulatory patient experience and that the students get reviewed on an annual basis to determine if the students are performing as expected.

Dr. Krauss asked Dr. Nuovo if he felt there was a need for a site visit before approval.

Dr. Nuovo stated if the school would provide a student log for review, he feels that would prevent the need for a site visit. He also would expect the UAG committee that reviews these logs, provide information that assures the adequacy of the training that is shown in the logs.

Susana Leano stated that UAG already has the process in place for student logs and that they are reviewed weekly.

Dr. Bholat asked for some clarification on who is attending the four-year school and who is attending the five-year school.

Susan Leano explained that the American citizens are currently attending the five-year program, and the four-year program is eliminating the internship which is not necessary for the U.S. students to practice in the United States. Those students who will be practicing in the U.S. will come back to the U.S. and take the USMLE exam as opposed to the Mexican Medical Exam.

Mr. Serrano Sewell felt there was no need for a site visit and recommended the Board approve the four-year curriculum to recognize UAG's international program with the four-year program with the expressed condition that they meet all condition of BPC Section 2089.5, including the log that was requested by staff. Board staff could review this and then provide the Board with the final report for approval.

Dr. Bishop stated his concerns about shorter training programs and would like more information to be provided and the May Board meeting before making a final decision.

Dr. Lewis made a motion to continue this item to the Board's May meeting, to direct staff to work with Dr. Nuovo to request additional information about the curriculum logs, to have staff review those logs for accuracy and to include Dr. Bishop, in his capacity as Licensing Committee Chair, in discussions and preparation of a report. In addition, Board staff will provide a full report back to the Member in May for action; s/Dr. Krauss. Motion carried unanimously.

Agenda Item 6 Executive Management Reports

Ms. Kirchmeyer stated she would not be going over the reports in detail unless Members have any questions, but would like to bring a few items to their attention. She began by thanking the Board's Business Services Office and the Administrative Staff. She stated these staff members are unsung heroes that are always there when something is needed, especially at the Board Meetings.

Ms. Kirchmeyer then directed the Members to page BRD 6A-4 in their packets, which shows the Board's fund condition. As mentioned at previous meetings, the general fund loans were scheduled to be repaid in fiscal years (FY) 15/16, 16/17 and 17/18, however, the Board was notified by the DCA that the repayment plan has been changed to a partial repayment of \$6 million in FY 16/17 and \$2 million in FY 17/18. The total repayment indicated now is \$8 million, which will still leave a remaining \$7 million. She noted that if the Board's fund falls below the required reserve levels, that is 204 months, those loans will need to be repaid prior to discussion of any fee increase.

Ms. Kirchmeyer stated currently the Board's fund reserve is projected to be 3.7 months at the end of the FY, and then below the mandate in 17/18.

Another budget item that Ms. Kirchmeyer brought to the Board's attention is the Budget Change Proposals (BCP). The Board had submitted a BCP to hire additional staff in the Central Complaint Unit (CCU) and to increase the Expert Reviewer funding. Those two BCPs were approved and placed in the Governor's Budget that was released in early January.

Ms. Kirchmeyer also noted that since the Budget documents were completed, staff was informed that due to Senate Bill (SB) 467, the DCA had requested an allocation of an additional \$577,000 to the

Board for the Attorney General's (AG) Office. She reminded the Board that SB 467 passed last year and requires reporting to the Legislature by the AG's office for each Board under the DCA. The AG's office requested this funding for the additional staffing needed to obtain the statistics to make the reports. Ms. Kirchmeyer noted that this BCP, as well as the two for Board staffing and increasing the Board's expert reviewer allocation will be going through the Budget Hearing process. She noted that if approved, they will be effective on July 1, 2016, as part of the Budget Bill.

Ms. Kirchmeyer then directed Members to pages BRD 6A-24 – 6A-32, which is the Board's 2014/2015 Annual Report. She encouraged the Members to review the report.

Ms. Kirchmeyer stated that as discussed in previous Board meetings, there has been an increase in the time it takes to review a complaint in the Board's CCU. The CCU is now fully staffed and managers have met with Ms. Delp to develop a plan to address the increase in the time frame, which was discussed at the Enforcement Committee meeting. In addition, staff is proposing a reclassification of another position to obtain an additional analyst to open complaints in the CCU. Ms. Kirchmeyer and staff are hopeful that by summer, complaint time frames will have significantly decreased. In addition, with the newly added non-sworn investigative staff unit, reporting has been separated out between the non-sworn investigative staff unit and the Health Quality Investigative Unit (HQIU).

Ms. Kirchmeyer then provided an update on the Vertical Enforcement Report. She stated this report is required to be submitted to the Legislature in March. Staff is still waiting for some data to complete the report, and should be done by the end of month. The report will then be provided to Dr. Yip, Chair of the Enforcement Committee, for review. She noted that an Interim Full Board Meeting will need to be scheduled for the end of February for the Board to review and approve the report. Ms. Kirchmeyer stated that this report will provide statistical information and an update since the last report in 2013.

Ms. Kirchmeyer then updated the Board on the CURES program. She noted that on January 8, 2016, the Department of Justice (DOJ) released the streamlined application for prescribers and dispensers. The registration process for those who apply on-line will no longer require a notary and the full process is now all electronic. She noted that the one caveat is that all registrants will have to use an updated or compliant browser to initially register. However, once they are registered, an older browser can be used, and, once logged into CURES, the user will be directed to version 1.0 or 2.0. She stated that version 2.0 offers more, and is encouraging everyone to get an updated browser if needed. All current users will be prompted to update their security information. Additional information will be sent out via email as well as an article in the Spring Newsletter to help remind everyone that they have to be registered in the CURES program by July 1, 2016.

Ms. Kirchmeyer then gave an update on the prescribing of psychotropic medication to foster children. She stated that in late November, the Board contracted with a pediatric psychiatrist, whom just recently finished reviewing the data that was received by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) to determine whether the data is going to be able to identify physicians who may be inappropriately prescribing. Her report shows that she is not able to make that determination based on the information that has been provided, so staff will have to go back to DHCS and DSS to see if they can provide the information the psychiatrist is requesting.

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Ms. Kirchmeyer announced that the Federation of State Medical Board's annual meeting will take place in San Diego, California from April 28-April 30. The topics of this meeting can be found on page BRD 6A-3 for review. She asked any Members who are interested in attending to let her know.

Ms. Kirchmeyer also announce that on February 4, 2016, the Little Hoover Commission is holding a public hearing on occupational licensing in California. She stated at this introductory hearing, the Commission will examine the economic linkages between occupational licensing and consumer prices, wages and employment services, and quality and availability. Commissioners will also learn about the effect of occupational licensing on upward mobility and innovation.

Finally, the Commissioners will also learn about the effects of occupational licensing on upward mobility and innovation. Finally, the Commission will consider the nexus between public interest and occupational licensing and the Legislative Sunrise and Sunset processes that govern occupational licensing in California.

Ms. Kirchmeyer stated that staff will begin the next Sunset Review process in a couple of months. The committee's questionnaire is expected to be received in March, with a due date of November 1, 2016. Once the report is completed, the Senate and Assembly Business and Professions Committees will review the report and provide follow-up questions. Responses to those follow-up questions will be provided and then in early 2017, a hearing will be scheduled.

At that time, the Legislature will hopefully draft language to extend the Board's next Sunset date for another four years, until 2022. She stated that once the questionnaire is received, she will notify the Members as this will be an ongoing process at each meeting until the final report is brought to the Board at the October meeting for Members to review and finalize.

Ms. Kirchmeyer noted that since the last Board meeting, she and Mr. Serrano Sewell had met with the executive staff at the DCA in regard to BreZE issues, such as the Board's current change requests and concerns. The DCA had reviewed the change requests and identified 45-50 that they thought would be priority for the Board. After discussion, it was decided that the Board needs to meet with the DCA to review all of the change requests and actually identify resources necessary to complete those requests. The hope is that once these changes have been discussed, that changes will be able to be completed by end of the current year. These changes are ones that would directly impact staff and cause delays in processing the work. She noted that in addition, the executive team stated that they are looking to revamp the DCA's online license lookup. She stated that once release two is finalized, the DCA will begin looking at this project. The intention is for the DCA to work with the Board's IT staff to develop requirements for the system and then work on its development to make the system more user friendly.

Ms. Kirchmeyer stated she recently attended a demonstration of a new reporting tool that is scheduled for release by DCA in the summer for producing BreZE reports. The tool should allow the Board to run most of its own reports. The more complex reports will continue to be run by the Board's IT unit, but once the reports are run, they will be saved in a location where the managers can have access to them for future needs.

Long Do, California Medical Association, stated that CMA had recently been getting several calls on being locked out of CURES when trying to register for the first time since the upgrade. He stated that CMA has been working with DOJ to resolve the issue.

Agenda Item 7 Update from the Department of Consumer Affairs

Mr. Burke, Board and Bureau Relations Manager at the DCA, began by welcoming the Board's two newest Members, Judge Feinstein and Ms. Lawson. He then noted that DCA launched the second release of the BreEZe system on Tuesday, January 19, 2016, which added seven Boards and one Bureau to the system, bringing the total to 18 programs on the BreEZe system. The first day of release, the program processed over \$131,000 in on-line transactions. Once the programs on the second release are stabilized, DCA will begin the process of conducting a cost analysis before moving any other programs over to the BreEZe system.

Mr. Burke reminded the Members that as appointees, they are required to complete a Form 700, Conflict of Interest Form, upon appointment, annually, and again when leaving the Board. He noted that the DCA is now using a paperless Form 700 filing system called NetFile for its nearly 1600 designated filers. NetFile is web based and used by several city and county governments. He stated NetFile will be sending an email to all filers by the end of the month with instructions on how to log in to the new system. The Board's designated Conflict of Interest coordinator will be the point of contact for assistance.

Mr. Burke then announced some new hiring process changes that are being implemented by CalHR. The Office of Human Resources at DCA is working on changes to the recruitment and hiring process. The new system was scheduled to go live on Friday, January 22, 2016. He noted that a memorandum with further information will be distributed to all DCA Administrators and Executive Officers.

Mr. Burke stated that in December 2015, DCA's boards, bureaus and commissions received a letter from the Little Hoover Commission (Commission) in regard to their upcoming study of occupational licensing in California. He noted the Commission is an independent State Agency comprised of members of the Legislature, and public appointees of the Governor and Legislature. The Commission studies various topics related to Government operations and provides reports and recommendations on improvements. The Commission staff met with DCA in early December to discuss the study. DCA is working with the Commission to answer any questions they have regarding occupational licensing. He noted that the Commission plans on holding two public hearings, the first on February 4, 2016, in Sacramento, to review the principals behind occupational licensing. The second hearing is scheduled for March with the intended focus on the people that are impacted by occupational licensing requirements. Mr. Burke stated that in January, DCA sent an email to all programs notifying them of the letter and the study.

Mr. Burke noted the DCA has also made changes to its Enforcement Academy. The DCA held six focus groups of board enforcement staff to look at current courses offered through the DCA enforcement academy and how to best revise and organize to meet the needs of all boards. He noted DCA is looking at a rollout of a whole new curriculum in July 2016. DCA requires trainers from the Board staff to act as subject matter experts, and is requesting each board provide one or two individuals so that only a few boards are not bearing the burden of assisting with this training.

Mr. Burke then reminded members of the annual training required. He noted there have been four Board Member Orientation Trainings (BMOT) scheduled in 2016, and new Board Members are required to attend the BMOT within one year of appointment and re-appointment to the Board. He also asked the members to be sure they are up to date with their Sexual Harassment Prevention Training, Defensive Driver, and Ethics trainings.

Agenda Item 8 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes stated the new 2016 law books are now available and offered them to any Members who are interested.

Ms. Simoes noted that the bills in the Members' packets are all two-year bills, which means they have not moved or been amended, so she will not be going over any of them unless any Members have questions. She noted there is a 2016 Legislative Calendar in the packets, which shows the deadlines in the legislative process. The 2016 legislative session has begun, however, the bill introduction deadline is not until February 19, 2016.

Ms. Simoes then referred the Members to the 2016 Tracker List in the packets. She noted there is only one new bill on the list that needs to be discussed.

Ms. Simoes gave a brief update on two proposals that were approved at the last Board meeting. The first being the clean-up proposal. The proposal included some clean-up for allied health licensees, some clean-up related to the Board of Podiatric Medicine to make the law actually reflect what happens in real practice, and some clean-up for laws pertaining to physicians. She stated those items were all approved. She noted that she has found an author for this clean-up bill, Assembly Member Holden, who sits on the Assembly Business and Professions Committee and the bill should be introduced within the next week.

Ms. Simoes noted the second proposal that was approved at the last Board meeting was related to a new resigned license discipline option. She stated that recently Board staff met with the California Medical Association (CMA) to discuss this proposal. This proposal would allow a physician who is facing discipline, that is more than a public letter of reprimand, but less than a revocation, to stipulate to resign his/her license. This option would be primarily for physicians who no longer wish to practice, who are at the end of their careers, and have never had disciplinary actions before, but cannot meet the terms and conditions of probation, for whatever reason. This resigned license would be considered discipline and the physician could not come back to the Board and petition for reinstatement. This is a necessary provision to be included to ensure consumer protection. When staff met with CMA, they expressed concerns of the permanent nature of the resigned license and they were uncertain if a resigned license would be a palatable option for physicians since it is still discipline and is permanent. Ms. Simoes stated that since there is not much room to negotiate this language, staff is recommending the proposal be withdrawn at this time.

Ms. Yaroslavsky made a motion to withdraw the resigned license legislative proposal at this time; s/Dr. Krauss. Motion carried unanimously.

Ms. Simoes moved on to SB 563 (Pan), stating this bill has to do with utilization review (UR). 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 a physician. This bill would give the administrative director the authority to review any compensation agreement, payment schedule, or contract between the employer or entity conducting UR on behalf of the employer and the UR physician. Ms. Simoes noted that CMA is the sponsor of the bill and CMA states this bill would increase transparency and accountability within the workers' compensation UR process. She noted 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.

The bill would promote the Board's mission of consumer protection and staff recommends the Board take a support position.

Dr. Lewis made a motion to take a support position on SB 563 (Pan); s/Ms. Yaroslavsky. Motion carried unanimously.

Ms. Simoes gave the Board a brief update on the next Legislative Day. She noted she would be working with Mr. Serrano Sewell on a time frame for the next Legislative Day, and, once a month has been decided, she will be reaching out to all Members to see who would be interested in participating.

Agenda Item 9 Update, Discussion ad Possible Action on Recommendations from the Public Outreach, Education and Wellness Committee

Dr. Lewis noted the Committee met and the first agenda item discussed was the newly named "Check Up On Your Doctor's License" campaign. After the Committee meeting in October, he stated that he and Board staff met to revise the outreach plan and campaign to address the concerns raised by the Committee, and Board Members, and the public. He referred the Members to their packets for a copy of the outreach plan. Dr. Lewis stated he presented a new campaign outreach plan to the Committee and that the activities have been planned and prioritized. He noted that the Committee agreed with the new campaign and plan and a newly designed brochure was presented and approved. Dr. Lewis stated staff also presented a website demonstration of possible enhancements to be made to the Board's website to make the site more user friendly. He noted the changes highlight the new campaign to allow consumers to easily check a physician's license, file a complaint, and/or look up any public document that might be related to that physician. Dr. Lewis noted there was a consensus from the Committee and the public that enhancements to the Board's website would be an improvement. He stated that he and Board staff will review the comments made by both the Committee Members as well as the public, and will bring back an updated outreach plan along with a timeline of outreach events. Dr. Lewis noted that March 6 - March 12 is designated as "National Consumer Protection" week. With that, staff is going to try and get as many outreach events scheduled for that week as possible. If the Board agrees with the direction of the outreach plan, campaign, and web design changes, staff will be directed to move forward with the caveat that the Committee will continue to fine tune the plan and outreach materials and continue the plan to enhance the website design in the future, as needed.

Dr. Levine commended Dr. Lewis and staff for the impressive array of opportunities being looked into for consumer outreach.

Lisa McGiffert, Consumers Union Safe Patient Project, stated they support the on-going work being done by the Committee. She believes the current work may eliminate the initial hurdle of patients looking for more information about their physicians. One concern they are currently having is with no budget for outreach, she wanted to remind the Board that one inexpensive way to reach many people is with social media. They encouraged staff to include more of that venue into the outreach plan.

Agenda Item 10 Update, Discussion and Possible Action on Recommendations from the Patient Notification Task Force

Mr. Serrano Sewell gave an update on the Patient Notification Task Force meeting. He stated the first duty of the task force was to create a mission statement. There was a good discussion among task force members as well as the public, after which he requested that Dr. Levine work with staff to create a revised statement for consideration by the Board. Mr. Serrano Sewell asked the Members to take a look at the revised statement. He noted that it includes a preamble, which gives the context in which the task force is operating, along with its mission statement and its objectives. Mr. Serrano Sewell noted that the most important objective is to have the task force meet and then provide the full Board with a final report and recommended course of action. The next item from the meeting was a presentation from staff on the pertinent issues, such as outreach when the physician is placed on probation, or when disciplinary action is taken, as well as information available on the Board's website regarding a physician with discipline. He stated the task force also discussed the signage that is required to be posted by physicians, which included a presentation by the Board's attorneys with the legislative history of the required signage in a physician's office. Ms. Webb stated the signage cannot be changed to include the language that the task force is requesting without a legislative change. Mr. Serrano Sewell thanked the public who added their input on possible enhancements to the website.

Mr. Serrano Sewell then asked for a motion to approve the revised language of the mission statement. Dr. Lewis suggested that even though many of the comments came from Consumers Union, he thought it best to remove Consumers Union from the mission statement and leave it as "the public and Board Members."

Dr. Lewis made a motion to approve the revised mission statement, including removing Consumers Union from the statement; s/Dr. Bholat.

Mr. Serrano Sewell asked for public comment.

Ms. McGiffert, Consumers Union noted that the mission statement and task force was created because of the petition that Consumers Union brought forward and stated they are disappointed in the task force and what was discussed at the meeting. She noted that instead of the Patient Notification Task Force discussing the concept of physicians being honest with their patients by informing them about being on probation, the task force continued down the current path that puts the burden on patients to find out something that most of them do not even know exists. Ms. McGiffert noted that though they support clearer information on the website, when a practicing physician is on probation due to their own behavior, that is not a substitute for notification to their patients. She stated, physicians withholding this information from their patients, and the Board encouraging that by the recent actions, send a clear message that this is the patient's responsibility, not the physician's and that is the worst kind of violation of physician/patient trust.

Ms. McGiffert noted that she had given the Members a revised proposal in response to the Board's concerns in the October meeting.

The new proposal requested that this requirement apply to physicians on probation for serious reasons, such as sexual misconduct, gross negligence, and serious substance abuse problems. It also requests that the manner of informing patients follow a similar procedure in the current disciplinary

guidelines to address concerns raised in October that the petition was too prescriptive regarding how the notice is given. She stated they would appreciate the Board's consideration of the new proposal and looks forward to working with the Board further.

Mr. Serrano Sewell stated the task force is committed to upholding the mission to protect consumers.

He then stated he thought it important to note that on two separate occasions, the Board has declined to pursue a petition around notification and feels it was done for good public policy reasons. He noted there has been healthy dialogue on this issue on at least two occasions and the Board decided not to pursue what was requested. He believes it is an issue where reasonable minds can differ, which means that the Board is not opposed to consumer protection it just means that the mandate is being fulfilled in a different way. He noted that the Board is sensitive to not only the Consumers Union's concerns, but any public entity or stakeholder and the Patient Notification Task Force was created with that sensitivity in mind. Whether it fulfills the mission of any particular interest group or not, the task force will deliberate in a public manner.

Motion carried. (Levine absent from vote)

Agenda Item 11 Update, Discussion and Possible Action of Recommendations from the Enforcement Committee

Dr. Yip gave an update on the Enforcement Committee meeting by noting that Ms. Delp stated the Medical Board's Expert Reviewer Training will be held on Saturday, March 19, 2016, at the UC San Diego School of Medicine. She stated the training agenda will include an overview of the Expert Program's mission and expectations, legal considerations, case scenario discussions, and segments on testifying from the perspectives of an Administrative law Judge, a Deputy Attorney General and a Defense Counsel. Ms. Delp noted a formal invitation to attend the training will be sent out to experts in the San Diego area and surrounding areas in the next couple of weeks.

Dr. Yip stated Ms. Delp also reported training with the Office of Administrative Hearings (OAH) will begin on January 29, 2016. The Judges from OAH will receive training on anatomy and systems of the body. Finding speakers to provide additional training has been difficult, so Ms. Delp may reach out to Board Members to assist with identifying a speaker that is willing to provide some training.

Dr. Yip stated that Ms. Delp informed the Committee that on January 5, 2016, Board management and staff from the Northern Probation Office met with him to discuss how the Probation Unit operates. He stated that during his visit, he learned the daily functions that staff performs to monitor licensees placed on probation. Dr. Yip noted the meeting was productive, as new policies and procedures were formulated and will be implemented to streamline and improve the probation monitoring process.

Dr. Yip noted that Ms. Delp also stated that on December 8, 2015, Board staff met with staff from the DCA, the Health Quality Investigation Unit (HQIU), and the Attorney General's (AG)'s Office to discuss an issue raised by Senior Assistant Attorney General Ms. Castro concerning the need for two investigators to work a complaint separately when a case is being investigated both criminally and administratively. Ms. Delp stated the meeting adjourned with an agreement that staff from the AG's Office and the HQIU would meet at a later date to resume discussions with hopes of drafting a parallel policy for investigations that will be presented to the DCA for consideration.

Dr. Yip stated that Ms. Delp concluded her update stating that the Enforcement Program managers had been working diligently to evaluate the complaint handling process to find ways to improve the amount of time it takes to process a complaint. Ms. Delp stated to achieve this goal, management will be adjusting staff's caseloads and would also be submitting a proposal to the DCA to reorganize the reporting structure of the Central Complaint Unit (CCU).

Dr. Yip stated that Ms. Robinson then provided the Committee with an update on the Board's Demographic Study. Ms. Robinson stated that on December 20, 2015, the California Research Bureau (Bureau) met with interested parties that included Dr. Jackson, Dr. Savage, and Dr. Lang, to discuss their concerns and the impetus behind the study. The Bureau advised that once they finalize their research design and methodology, the information would then be provided to Board Member Dr. Krauss, for review and approval. The Bureau also reported it would take them approximately two months to finish their analysis of the data and an additional two months to finalize their findings and provide a report to the Board.

Dr. Yip then noted that Ms. Robinson and Ms. Scuri provided an update on the Vertical Enforcement (VE) Report. The mandated report is due to the legislature by March 1, 2016. He stated the VE Report will consist of three primary areas. It will provide statistical data, improvements made to the VE model since that last VE Report was provided in 2013, and recommendations for changes to the law concerning the VE process. Ms. Robinson stated the final report will be presented to the Board at a special meeting at the end of February to meet the March deadline.

Dr. Yip then noted that Mr. Chriss and Ms. Nicholls from the HQIU provided VE program updates along with Ms. Castro.

Dr. Yip noted that Mr. Chriss stated as the newly appointed Chief of the Division of investigation, his priorities for the HQIU are to fill vacant investigator positions as soon as possible, to complete the staff retention project, to develop a strategic plan that will focus on updating the investigative training manual and the development of a statewide training plan for the investigators. Ms. Nicholls then provided information about how the HQIU is prioritizing its investigation cases. Ms. Nichols stated cases would be processed in accordance with the priorities already set forth in law, pursuant to Business and Professions (B&P) Code Section 2220.05. Ms. Nicholls stated cases are categorized as high or low in priority and that the investigators are working high priority cases four days a week, and low priority cases one day a week, with cases being rotated weekly to ensure all complaints are being handled. Ms. Nicholls then stated this operational plan will help to decrease case processing timeframes on high priority cases.

Dr. Yip noted that Ms. Castro stressed there are two issues that are affecting the VE model in being able to process cases in a timely manner. Ms. Castro stated the issue of vacant investigator positions continued to be a problem, but now at higher degree. Ms. Castro stated, as a result, cases get reassigned and this affects the AG's Office from being able to complete cases timely. Ms. Castro stated the second issue is cases are behind handled criminally by the HQIU and when that occurs, the cases are removed from the auspices of the AG's office and are not being prosecuted pursuant to the VE model. Ms. Castro stated that criminal cases can take years to investigate as they are complex and when a District Attorney (DA) Office decides to reject a case for criminal prosecution, the AG's Office has a short timeframe to pursue administrative action against the licensee. To resolve the two issues, Ms. Castro proposed the use of investigators from the AG's Office to assist with investigating

the Board's cases. Ms. Castro stated until the two issues are resolved, the Board is putting the public at risk because cases are not being processed in a timely fashion.

Dr. Yip stated that Ms. Delp gave a presentation on the Probation Unit's Roles and Functions. At length, Ms. Delp explained the different probation terms and conditions that could be imposed and also explained how staff in the Probation Unit monitor the probationer's compliance with each condition.

Lastly, Dr. Yip noted that Committee Member Ms. Yaroslavsky requested information about the recruitment methodology used to reach out and recruit Board experts be added as a future agenda item to be discussed at the next Enforcement Committee Meeting.

Dr. Levine requested that a hit rate analysis be included in the report on the recruitment of expert witnesses. She would like to know what reasons physicians decline to be an expert witness. Dr. Levine corrected a statement that was made earlier in meeting, when it was said that expert witnesses work pro bono. She stated it is not pro bono work, and these physicians do get paid for their time.

Dr. Yip stated he spoke with Ms. Castro requesting feedback from her office in regard to the shortage of expert training and recommended that perhaps Board Members or the Board President send a personal letter inviting physicians to the training.

Ms. Yaroslavsky recommended looking into trying to get better compensation for these physician expert reviewers.

Agenda Item 12 Update from the Attorney General's Office

Mr. Jones from the AG's Office provided an update on the hiring at the AG's Office. He stated a new attorney was hired in the San Diego office and they are in the process of hiring two new attorneys in the Los Angeles office. Interviews are scheduled for the replacement of the San Diego Supervising Deputy Attorney General (SDAG). Mr. Jones stated they are anticipating the retirement of Jose Guerrero, the SDAG in the San Francisco office in a few months and are preparing to quickly backfill that position.

Agenda Item 13 Special Faculty Permit Review Committee Recommendations: Approval of Applicants

Dr. Bholat stated that the Special Faculty Permit Review Committee (SFPRC) held a special teleconference meeting on December 3, 2015, to review two applications. One applicant is from Loma Linda University School of Medicine (LLSM) and the other from Stanford University School of Medicine (SUSM). Dr. Bholat stated that in addition, the SUSM requested a waiver of BPC section 2168.1(a) (5) for their applicant.

Dr. Bholat began with LLSM's applicant, Dr. Fabrizio Luca. Dr. Luca's area of specialty is surgery, specifically in the area of robotic rectal cancer surgery. She stated Dr. Luca's medical school and post graduate training can be reviewed on page BRD 13-2 and BRD 13-3 of the Board packet. Dr. Bholat stated Dr. Luca has a long and distinguished career in gastrointestinal and abdominopelvic surgery at the European Institute of Oncology in Milan, Italy, including, but not limited to, the

following list of responsibilities and directorships: He was the Director of Multidisciplinary Surgical Techniques, Gastrointestinal Surgery at European Institute of Oncology; Director of Integrated Abdominal Surgery, Division of Abdominopelvic Surgery at European Institute of Oncology; Director, Abdominopelvic Surgery, School of Robotic Surgery, European Institute of Oncology; and Senior Deputy Director, Abdominopelvic Surgery, European Institute of Oncology. Dr. Luca developed an original technique for the fully robotic treatment of colorectal malignancies, published in 2009 in Annals of Surgical Oncology. Dr. Luca is the Principal Investigator on the robotic vs laparoscopic resection of rectal cancer. He has performed over 300 robotic surgical procedures, has trained over 50 surgeons in robotic surgical resection of rectal cancer, has published extensively in the field of surgery for rectal cancer, and authored several seminal papers in this field.

Dr. Bholat noted that Dr. Luca will hold a full-time faculty appointment as a Professor of Surgery at LLSM if approved for a Special Faculty Permit (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. Bholat stated the Committee recommends the Board approve Dr. Luca for an SFP Appointment.

Dr. Bholat made a motion to approve Dr. Fabrizio Luca for a BPC section 2168.1(a)(1)(b), special faculty permit appointment at LLSM; s/Ms. Yaroslavsky. Motion carried with one abstention. (Hawkins).

Dr. Bholat stated the second applicant was Dr. Tarik Massoud. Dr. Massoud's area of expertise is in neuroradiology and molecular imaging. Dr. Bholat stated Dr. Massoud's education can be reviewed on page BRD 13-4 of the Board packet.

Dr. Bholat stated that Dr. Massoud is currently in a BPC section 2113 Faculty Appointment at SUSM. He recently held a position of academic neuroradiology at the University of Cambridge. Dr. Massoud has been published in top ranking scientific journals, and has won seven awards for his presentation on his innovative research at international scientific conferences from the American Society of Neuroradiology. He was also the co-author of several books and chapters and has been a peer reviewer for international medical journals.

Dr. Bholat noted that Dr. Massoud would hold a full-time faculty appointment as a Professor of Radiology at SUSM if approved for an SFP appointment by the Board. Dr. Massoud would provide in-patient and out-patient clinical care, and teach and mentor medical and graduate students and fellows. Dr. Massoud would also be doing research in the Molecular Imaging Program at Stanford. Dr. Massoud is outstanding in his fields of Neuroradiology and Molecular Imaging, and a great need exists to maintain his position and avail his services, expertise, and experience in Stanford Radiology.

Dr. Bholat stated the Committee recommends the Board waive the requirement of the BPC section 2168.1(a)(5), that prohibits an SFP appointment if the applicant is in a section 2113 appointment and to approve Dr. Massoud for a special faculty permit appointment.

Dr. Bholat made a motion for the Board to approve the waiver of the requirement of the BPC section 2168.1(a)(5), that prohibits a special faculty permit appointment if the applicant is in a section 2113 appointment, and to approve Dr. Massoud for the BPC section 2168.1(a)(b) special faculty permit appointment at SUSM; s/Ms. Yaroslavsky. Motion carried unanimously.

Agenda Item 15 Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting

Ms. Sparrevohn stated a Midwifery Advisory Council (MAC) meeting was held on December 3, 2015. At the meeting, the MAC heard recommendations regarding changes to the License Midwife Annual Report (LMAR) tool, which is used to collect data on licensed midwife attended births in California. The hope is to have it updated by the 2017 reporting year. The changes should make it easier for licensed midwives to report their statistics and make those statistics more valuable in informing the Board and community as to the quality and safety of licensed midwife attended births.

Ms. Sparrevohn noted the MAC was advised of the continuing work on regulations dictated by the passage of AB 1308 in 2013. This process continues to be stalled due to the inability for the interested parties to reach a compromise regarding Licensed Midwives providing care to women who have had a prior cesarean delivery. Ms. Sparrevohn stated the MAC is asking for several reports at their next meeting to help bring additional clarity to this issue, which is so important to California families.

Ms. Sparrevohn then asked the Board for approval of the following agenda items 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

Ms. Yaroslavsky made a motion to approve the above requested agenda items for the next MAC Meeting; s/Dr. Bholat. Motion carried unanimously.

Agenda Item 16 Update on the Physician Assistant Board

Dr. Bishop noted the Physician Assistant Board (PAB) had met twice since his last report. He stated that Governor Brown appointed Javier Esquivel-Acosta, PA-C to the PAB in November 2015. Mr. Esquivel-Acosta holds a medical degree from an international medical school and practiced in Mexico for several years. After coming to the U.S., he was awarded a PA degree from Stanford University.

Dr. Bishop stated that in January 2016, Governor Brown reappointed several members to the PAB, including himself as an ex officio member to serve another term. Also at the January 2016 PAB meeting, Robert Sachs was re-elected as Board President and Jed Grant was elected as Vice-President.

Dr. Bishop noted that the Senate Committee on Business, Professions and Economic Development and Assembly Committee on Business and Professions had begun their Sunset Oversight Review of PAB. The PAB is scheduled to be reviewed in early 2016. He noted that at the PAB's November 2015 meeting, Members discussed the draft report, made several changes, and approved the final report. Staff will submit the report to the Legislature.

Dr. Bishop stated that at the PAB's November 2015 meeting, Members discussed new legislation going into effect in January. He stated there were some changes to law that pertain to adequate supervision of physician assistants and for record keeping when it comes to recording the supervising physician supervision of the physician assistant. Dr. Bishop noted that the PAB also discussed that regulations should reflect technological changes on how supervision is noted using electronic medical records (EMR). EMRs have replaced paper records in most medical practices. These discrepancies may result in confusion with physician assistants attempting to comply with the laws and regulations.

Dr. Bishop stated that the PAB's January 2016 meeting proposed amendments to California Code of Regulations (CCR), Title 16, Section 1399.546 were presented. After discussion and public comment, the PAB voted to initiate the formal rulemaking process and set the proposed regulation for hearing.

Dr. Bishop noted there are seven new California-based PA training programs on the pathway to accreditation. ARC-PA is the national physician assistant accreditation organization. To better assist the PAB in addressing health-care workforce shortage issues, the PAB directed the Committee to contact ARC-PA and request information about how many seats each of these programs will have, when the accreditation process will be concluded, and when the first matriculating class will occur. He stated the answers to these questions will enable the PAB to have information on what the physician's assistant workforce will look like and assist in addressing workforce shortages.

Dr. Bishop stated the PAB discussed a recently passed State of Georgia law that provides tax deductions for physicians who serve as a community based faculty physician for a medical core clerkship (a preceptor) provided by the community based faculty. He noted the PAB discussed that physician assistant training programs are experiencing difficulty in finding physicians willing to work as preceptors for the clinical portion of the physician assistant training program. The PAB is concerned that the inability to train new physician assistants will negatively impact the health care needs of California consumers. He stated the PAB voted to form an advisory committee to further explore this issue.

Agenda Item 17 Update on the Health Professions Education Foundation

Ms. Yaroslavsky announced that participation by the Board Members on the Health Professions Education Foundation (HPEF) has come to a conclusion. It was sunsetted as of January 1, 2016. Ms. Yaroslavsky stated she has participated in the HPEF for many years with an attempt to reinvent the opportunity to ensure access to people who want to go into the medical profession to work in underserved communities. She stated it has been an honor for her to do so and that she is very disappointed in the change. She stated the Stephen Thompson Loan Repayment Program was

implemented by the Board to encourage physicians to work in underserved communities for a minimum of three years with the intention of trying to change the culture of the physician and the community, and to have the physician come, stay and be an integral part of the community.

Ms. Yaroslavsky thanked the California Endowment for all of its support. She then stated that applications are currently being accepted from December 7, 2015, through February 29, 2016, for new loan repayment applicants.

Ms. Yaroslavsky noted that the HPEF is a state non-profit, established in 1987 and has awarded more than 10,500 scholarships and loan repayments totaling more than \$124 million dollars. Ms. Yaroslavsky stated that the HPEF provides support to cultural and linguistic competent healthcare workers dedicated to delivering direct patient care in California's underserved communities and encouraged anyone who can become involved in some way to do so. She stated again what an honor it has been to be a part of the HPEF.

Dr. Yip stated that while also participating on the HPEF alongside Ms. Yaroslavsky, he has found that Ms. Yaroslavsky is the most dedicated and committed member of the HPEF. He noted that the current chair of the HPEF has recently retired due to health issues, and believes that Ms. Yaroslavsky would make a terrific replacement as Chair. He would like to find a way through the proper channels, to recommend Ms. Yaroslavsky as a nominee for the Chair of the HPEF.

Mr. Serrano Sewell stated that there needs to be some way to get the Board's participation back on the HPEF in some capacity and thanked both Ms. Yaroslavsky and Dr. Yip for their service on the HPEF. He also noted that this should be a topic that is discussed in the Board's sunset review report.

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

Dr. Lewis recommended a discussion on updates on medical education since it is progressing and is much more sophisticated now than it used to be. Dr. Nation had originally agreed to give a presentation on this subject at this meeting, but was unable to and asked that it be put on the next meeting agenda.

Ms. Kirchmeyer recommended moving the presentation to the July Board meeting as it would be more convenient for Dr. Nation to attend.

Ms. Wright requested a discussion on the shortage of genetic counselors who advise about the risks of inheriting disorders after someone has been tested. She would like to find out why there is a shortage in this field and what the Board can do to promote more people going into this profession.

Dr. Levine requested staff provide a look back at the Special Faculty Permit Program in terms of what the experience has been in the state, and whether it has been successful or if there have been problems. She would like to see some sense of quality and quantity of value delivered by the program to the State of California.

Mr. Serrano Sewell requested that staff give the Board sufficient enough time to review and comment on the Sunset Review Report, which he recalls being quite a voluminous document.

Dr. Levine suggested that part of the discussion on the Sunset Review Report include a reminder of what the Sunset Review is, the purpose of it, and what the elements of it will and should include. Ms. Kirchmeyer stated that discussion can begin at the next meeting, as by then, staff will have the questions and the Board can get an idea of what will be needed for the report.

Ms. Kirchmeyer recommended inviting the former Oregon Medical Board President to attend a future meeting to offer his input on the End of Life Option Act bill. She stated this physician has been very involved in the End of Life Option Act in Oregon and he could offer some information on how this bill may impact the Board and Members.

Agenda Item 19 Adjournment

Mr. Serrano Sewell then thanked staff for putting together the Board and Committee meetings.

Mr. Serrano Sewell adjourned the meeting at 11:15 a.m.

Mr. Serrano Sewell, President

Date

Denise Pines, Secretary

Date

Kimberly Kirchmeyer, Executive Director

Date

The full meeting can be viewed at <http://www.mbc.ca.gov/AboutUs/Meetings/2015/>



MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING



**Interim Board Meeting
February 26, 2015**

Meeting Minutes

TELECONFERENCE

Medical Board of California
Hearing Room
2005 Evergreen Street
Sacramento, CA 95815

Additional Various Locations:

Arrowhead Regional, Medical Center, 400 North Pepper Avenue, Room #3M308-5, Colton, CA; 12750 Center Court Drive, South, Ste. 750, Cerritos, CA; Attorney General's Office, 455 Golden Gate Avenue, 11th Floor, San Francisco, CA; Asm. Chad Mayes' District Office, 41608 Indian Trail Rd, Suite D-1, Rancho Mirage, CA; One Embarcadero Center, 30th Floor, San Francisco, CA; 600 N Garfield Ave. # 308, Monterey Park, CA; UCLA Family Health Center, 1920 Colorado Avenue, Room # 269, Santa Monica, CA; Saban Community Clinic, 8405 Beverly Blvd. Los Angeles, CA

February 26, 2016

MEETING MINUTES

Members Present:

David Serrano Sewell, President
Michelle Bholat, M.D.
Dev GnanaDev, M.D., Vice President
Randy Hawkins, M.D.
Kristina Lawson, J.D.
Ronald H. Lewis, M.D.
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, J.D.
Barbara Yaroslavsky
Felix Yip, M.D.

Members Absent:

Michael Bishop, M.D.
Judge Katherine Feinstein (ret.)
Howard Krauss, M.D.
Sharon Levine, M.D.
Denise Pines

Staff Present:

Kimberly Kirchmeyer, Executive Director
Letitia Robinson, Research Program Specialist
Liz Rojas, Business Services Officer
David Ruswinkle, Associate Governmental Program Analyst
Jennifer Saucedo, Business Services Analyst
Anita Scuri, Consultant
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:

Gloria Castro, Supervising Senior Assistant Attorney General, Attorney General's Office
David Chriss, Chief, Division of Investigation, Department of Consumer Affairs
Andrew Hegelein, Supervising Investigator II, Division of Investigation, Department of Consumer Affairs

Agenda Item 1 8:00 a.m. Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on February 26, 2016, at 8:10 am. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were offered.

Agenda Item 3 Review and Consideration of Vertical Enforcement Report Pursuant to Government Code Section 12529.7

Dr. Yip, Chair of the Enforcement Committee, thanked all Members for being available to attend the meeting. He stated that this interim meeting is taking place because, unfortunately the data reports that were needed to complete the Vertical Enforcement (VE) report were not available prior to the January Board meeting. Dr. Yip noted that this report is required pursuant to Government Code Section 12529.7 and is due to the Legislature on March 1, 2016. He thanked Ms. Scuri, Ms. Robinson, and Ms. Kirchmeyer for their time and work on the report and also thanked Mr. Chriss, Ms. Nicholls and Ms. Rhine from the Department of Consumer Affairs (DCA) and Ms. Castro and Mr. Jones from the Attorney General's (AG's) Office for their assistance as their input was very helpful.

Dr. Yip pointed out that after discussion with the AG's Office, there were a few data markers that needed to be changed in the original report, so an amended version of the report was provided to all Members and placed on the Board's website. He noted that these edits only made changes to the graphs and added two footnotes.

Dr. Yip stated the law is not specific about what should be in the report. However, he noted this is the sixth report the Board has submitted regarding the VE model. Staff thought that it was

important to provide the same statistical reports that were provided in the previous report, with the addition of subsequent fiscal years.

Dr. Yip noted that staff decided to not include the breakdown by complaint category, but rather to provide an overall report. In addition, staff used the median processing times because staff felt it would provide a more accurate picture of the timeframes. This report provides a brief introduction and history of the VE Program, as well as costs of the Program. It also describes the improvements that have occurred since the last report in 2013. He noted these improvements can be found on page eight of the report. Dr. Yip stated lastly, the report contains four recommendations regarding the VE Program. He went over the four recommendations.

The first recommendation discussed the language of Government Code section 12529.6(b). The language states the investigator of the case is “under the direction but not supervision of the deputy attorney general.” Dr. Yip noted that after reviewing this language, it was determined it may interfere with the investigators and attorneys being a true team and the Board should recommend that a mechanism be found to more fully utilize the expertise brought to the team by both the investigator and the deputy attorney general (DAG).

The second recommendation would request that the same Government Code section be amended to allow Board staff, at its discretion, to consult with the AG’s Office on cases handled by Board’s non-sworn staff.

The third recommendation would remove a reference to the Medical Board from subdivision (e) in the same Government Code section to reflect the transition of the investigators from the Board to the DCA. Dr. Yip noted this section of law states the Board has to enhance the VE Program by increasing computer capabilities, by co-locating the investigators and attorneys, and by performing team building of both parties. However, with the transition of the investigators, the Board no longer oversees the individuals who are involved in the VE Program. Therefore this should be a requirement of those entities.

The last recommendation was for the DCA and AG’s Office to utilize the new joint manual and develop additional strategies and procedures to further improve the VE Program.

Dr. Yip stated he had reviewed and discussed this report with staff and agrees with its content. He noted he believes that, based upon the fact that this Program is now a collaboration with the other entities, it is important for these recommendations and the report to move forward. He then asked Ms. Scuri and Ms. Robinson to add any additional information and answer any questions. He stated he would then like to ask for a motion to approve the report.

Ms. Scuri noted there was a reference made in Government Code Section 12529.7, which requires the Board, in consultation with the Department of Justice (DOJ), and the DCA to report and make recommendations to the Governor and the Legislature on the Vertical Enforcement and Prosecution Model and requires the report be submitted on March 1, 2016. She stated the Board began creating the report in October 2015, when she was asked to assist staff with the preparation of the report due to her work on the VE joint protocol in 2014/2015. The goal was to develop a report that was neutral in tone and easy to read. She stated she personally worked with the Division of Investigation (DOI) and the AG’s Office. Ms. Scuri noted she had extensive discussions with Ms. Castro and

Mr. Jones to address some of their areas of concern and Board staff worked hard to make this as close as possible to a joint report by making several modifications and adjustments to address issues raised in particular by the AG's Office. Ms. Scuri started the consultation process at the beginning rather than wait until the end. She noted those who participated in this process were asked what they wanted to see in the report. Board staff then came up with a time line for receiving the statistical data by October 31, 2015, and circulated a draft report by December 1, 2015. She noted that although the data was requested on October 8, 2015, with several follow up inquiries, staff did not receive the data until the end of January due to technical difficulties with attempting to obtain the same data markers from two different data systems.

Ms. Scuri noted that while waiting for the data, in October, staff shared with the DOI and the AG's Office the proposed concept of the report to receive feedback on the report contents. Ms. Scuri stated several changes were based on that feedback. Ms. Scuri stated the discussion included suggestions from the AG's Office such as what items should be included in the report and explained why certain items should more appropriately be included in the next Sunset Review Report. She noted the basic narrative of the report was drafted, excluding the data and recommendations in November and that narrative was shared with other parties involved. She stated staff received input on the draft report from the AG's Office and DOI in both November 2015 and again in February 2016. A draft of the narrative, without the charts was provided in early January and the data was finally provided to the AG's Office and DOI on February 16, 2016.

Dr. GnanaDev stated he was fine with the recommendations but stated he had some concerns about the timelines in the report as they seemed to have gotten a bit better over the past few years, but as this year shows, the timelines are worsening again.

Dr. Bholat agreed with Dr. GnanaDev's statement with regard to the timelines and asked how often meetings with all parties are held and what metrics would be used to know that staff is on target.

Ms. Kirchmeyer stated that the metrics shown in the report will continue to be used in order to measure this pattern. She added the increase in the days over the past couple of years have been due to the vacancies in the investigative unit as well as the timeframes at the Office of Administrative Hearings (OAH). Ms. Kirchmeyer stated that staff will be reporting back to the Enforcement Committee and recommended using the same data markers shown in the report to show if progress is improving or not along with the performance measures.

Dr. Lewis stated that after looking at the graphs, he asked if the metrics are possibly being looked at periodically to assess progress.

Ms. Kirchmeyer stated that the metrics shown in the report will be used going forward, now that there are reports. She noted there are several items not included since only Vertical Enforcement is being looked at and if these numbers were to be run overall with all of the other case types, she felt that numbers would be a bit different because some of the easier cases have been pulled out, such as out-of-state cases. Ms. Kirchmeyer noted the out-of-state cases are easier to move through the upfront process, in most circumstances, but then they still have the same waiting time at the OAH. Ms. Kirchmeyer stated if those cases were to be put in, there would be a bit of a difference in numbers as far as the Board is concerned as compared to the more complex cases that go into the

Vertical Enforcement and Prosecution Model. Ms. Kirchmeyer stated reports can be run both ways, with everything and also breaking them out, which staff will do in the future for easier comparison.

Dr. Lewis then asked what the difference is between “from investigation initiated to accusation filed” and “from investigation completed to accusation filed.”

Ms. Kirchmeyer stated the time frame for “investigation initiated” is when the accusation first is assigned to both an investigator at the DOI, as well as being assigned to a Deputy Attorney General, all the way until the accusation is filed. The time frame from “investigation completed” is from when they believe the investigation is complete and ready for the accusation to be filed and referred to the AG’s Office for the final closure of investigation until the accusation is filed.

Ms. Yaroslavsky stated that through all of the past meetings, there has been an issue with receiving reports. This report in the packet looks like it is filled with information. She is asking how this information is now being able to be supplied, but could not be in the past.

Ms. Kirchmeyer stated that this information was not easy to get and/or was not available before, which is why the interim meeting had to take place. She stated that staff programmers had to write these reports manually and now that they are completed, they can be used in the future.

Dr. Yip stated he would like the reports supplied to the Enforcement Committee regularly, now that staff is able to do so.

Dr. Bholat asked who oversees the blue bar in the report, which is “investigation initiated to accusation filed” as opposed to the red bar, which is “investigation completed to accusation filed.” She also asked what is being done to make that significant delta closer.

Ms. Kirchmeyer stated the blue bar represents the DOI as well as the AG’s Office since there is the VE team that is working together during that time, all the way to the end. She noted the red bar represents the point where the investigation is complete and the AG takes over for the filing of the accusation.

Ms. Castro stated she and Mr. Jones reviewed the draft report including the recommendations regarding the VE program. She noted the agreed upon tasks in October 2015 between the AG’s Office, DCA and the Board were to communicate any issues in any areas needing improvement to enhance the usefulness of the VE in investigating Board complaints regarding patient care in the State of California. She noted that while the AG’s Office was consulted in the preparation of the Board’s draft report, some of their submitted input did not appear in the current draft and they were not given adequate time to review the produced statistics, so they will respond to the Board’s invitation to make recommendations to the legislature. Ms. Castro stated those recommendations and further comments will be forthcoming and will only be covered briefly at this meeting.

Ms. Castro then gave a presentation that provided background of the VE, context and legal perspectives. She then stated that the VE program should not be eliminated, and it should not be returned to the handoff model, as she believes it hurts consumers.

Ms. Castro stated the AG's Office's recommendation is that the VE program continue, that the six-month protocol be allowed to be practiced and that the HQIU leadership be allowed to work with HQE, which was just put into effect in July 2014.

Ms. Castro stated the Board needs to decide what it values most in this process, whether it be time and money, meaning being focused on how quickly the AG's Office gets thing done, or whether quality is of more importance. She noted once that decision is made, it needs to be made very clear to the them as part of the team.

Mr. Chriss noted the HQIU was given the opportunity to provide input to the report, which they did, and after having reviewed the final draft report, he felt it is accurate and was prepared with data that was input into BreZE by DCA staff. He noted there have been improvements since the last report and they were detailed accurately in the report, one being the new protocol, and the new VE manual. Mr. Chriss stated there has been training provided to staff regarding the manual. He noted there are two joint training sessions on 805 investigations that will be provided in March 2016. He stated that, as Ms. Kirchmeyer had mentioned previously, the increasing computer capabilities in order to share case information is another improvement that has been made and is currently being used. He noted as far as parallel prosecution, HQIU is developing guidelines for this process. Mr. Chriss stated the draft guidelines had been sent to Ms. Kirchmeyer and Ms. Castro for review and input. He noted there will be a final draft soon.

Dr. Lewis made a motion to approve the Vertical Enforcement and Prosecution Report as written; s/Ms. Yaroslavsky. Motion carried unanimously.

Mr. Serrano Sewell adjourned the meeting at 9:05 a.m.

 David Serrano Sewell, President

 Date

 Denise Pines, Secretary

 Date

 Kimberly Kirchmeyer, Executive Director

 Date

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

*Standing Committees, Task Forces & Councils
of the Medical Board of California
April 2016*

<i>Committee</i>	<i>Members</i>
Executive Committee	David Serrano Sewell, President Dev GnanaDev, M.D., Vice President Denise Pines, Secretary 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 Felix Yip, M.D., Enforcement Committee Chair
Licensing Committee	Michael Bishop, M.D., Chair Dev GnanaDev, M.D. Randy Hawkins, M.D. Denise Pines Jamie Wright, J.D.
Enforcement Committee	Felix Yip, M.D., Chair Michelle Bholat, M.D. Howard Krauss, M.D.
Application Review and Special Programs Committee	VACANT, 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)
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
Midwifery Advisory Council	Carrie Sparrevohn, L.M., Chair James Byrne, M.D. Karen Ehrlich, L.M. Tosi Marceline, L.M. Barbara Yaroslavsky

Panel A	Jamie Wright, J.D., Chair Ronald Lewis, M.D., Vice Chair Michael Bishop, M.D. Judge Katherine Feinstein, (ret.) Randy Hawkins, M.D. David Warmoth Felix Yip, M.D.
Panel B	Howard Krauss, M.D., Chair Michelle Bholat, M.D., Vice Chair Dev GnanaDev, M.D. Kristina Lawson, J.D. Sharon Levine, M.D. Denise Pines Brenda Sutton-Wills, J.D.
Prescribing Task Force	Michael Bishop, M.D.
Editorial Committee	Sharon Levine, M.D. Denise Pines
Patient Notification Task Force	David Serrano Sewell, Chair Kristina Lawson, J.D. Sharon Levine, M.D. Ron Lewis, M.D.

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



MEDICAL BOARD OF CALIFORNIA
Executive Office



**2017 BOARD MEETING DATES
FOR CONSIDERATION**

January 26 – 27

Sacramento Area

April 27-28
(FSMB Meeting April 20-22)

Los Angeles Area

July 27 – 28

San Francisco Bay Area

October 26 – 27

San Diego Area

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 20, 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.
- Regular meetings were held with David Chriss, Chief of Enforcement, and Kathleen Nicholls, Deputy Chief of Enforcement, Division of Investigation, Health Quality Investigation Unit regarding the Board's investigations.
- Board staff continues to meet with DCA and the Department of Justice (DOJ) to discuss the 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 Board Orientation to three new Board Members.
- Board staff met the Graduate Medical Education Deans to discuss the Board's licensing program and any other items of mutual interest.
- Board staff attended a Little Hoover Commission hearing on occupational licensing.
- Board staff attends monthly meetings with the California Department of Public Health and other entities regarding safe injection practices.
- Board staff attended meetings with the Psychotropic Medication Implementation (PMI) Workgroup, which is a workgroup to improve the safe and appropriate use of psychotropic medication for children and youth in foster care.
- Board staff and Dr. Lewis provided a presentation to approximately 50 residents at the University of California, San Francisco, Fresno Family Medicine Residency Program.
- Board staff has met with numerous legislative offices, both Members and staff, to provide updates, discuss pending legislation, and provide education on the Board's functions.
- Board staff toured an outpatient surgery setting to be educated in the functions/procedures at the setting. This tour assisted in staff's understanding, both from the licensing and enforcement perspective.
- Board staff provided a presentation to the California Association of Medical Staff Services.
- Board staff provided testimony at the Legislative Sunset Review Hearing on the vertical enforcement program.
- Board staff provided a presentation to the California Certifying Board for Medical Assistants (CCBMA) and the California Medical Assistants Association (CMAA) regarding medical assistants.
- Board staff had two meetings with the Acting Agency Secretary, Business, Consumer Services, and Housing Agency, the DCA, and other boards regarding the End of Life Option Act and its implementation.
- Board staff attended California's Macy Regional Conference on *Innovations in GME: Building a Better Workforce for Better Health*.
- 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 Bureau of State Audits to discuss the audit they are performing related to the issue of psychotropic medication for foster children.
- Board staff attended several legislative and budget hearings and provided testimony as necessary.
- Board staff continues to meet with representatives from the California Department of Public Health, the Board of Pharmacy, Dental Board, the Department of Health Care Services (DHCS), DOJ, the Emergency Medical Services Authority, and 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 4.4% vacancy rate which equates to 7 vacant positions. This is lower than the vacancy rate that was provided in the last Administrative Summary, which was 7.5%. The Board is working to fill those positions.

Budget Update

The Board's budget documents are attached, beginning on page BRD 7A-4 and continuing to page BRD 7A-15. The Board's fund condition on page BRD 7A-4 identifies the Board's fund reserve was at 3.8 months at the end of FY 15-16. 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. Board staff will be closely monitoring the Board's budget to determine whether future changes are needed. The second fund condition on page BRD 7A-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 being 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 March 31, 2016 can be found on page BRD 7A-6. Pages BRD 7A-7 to 7A-11 show the budget report, specifically for licensing, enforcement, the HQIU, and the AG expenditures. Page BRD 7A-15 provides the Board Members' expenditure report as of April 14, 2015.

BreEZe Update

Board staff continues to submit requests for changes/fixes to DCA for the BreEZe system. Board staff is working on streamlining the physician and surgeon renewal process via the online experience. Once this process is complete, staff is going to move to the physician and surgeon online application. These improvements will help both the licensees and the applicants when they use the Board's online functions.

Controlled Substance Utilization Review and Evaluation System (CURES) Update

The Board continues to provide information to physicians via emails and the Newsletter regarding the need to register by July 1, 2016. The Board has received numerous calls from physicians who are trying to register for CURES and have been unable to do so. Board staff is assisting the physicians. The reoccurring issue seems to be that the date of birth or the social security number they are using to register does not match the one on file with the Board. The Board updated its website page regarding CURES and provided links to helpful documents such as "CURES 2.0 Tips and Tricks," "CURES 2.0 Registration User Guide," and "CURES 2.0 Publications and Training Videos." There is also a frequently asked questions document.

Prescribing Psychotropic Medications to Foster Children

As stated at the last Board meeting, in late November, the Board contracted with a pediatric psychiatrist to review the data that was received by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS). This data included a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more, a list of the medications prescribed, the start and stop date for each medication, and the child's date of birth. The child's information was de-identified. The pediatric psychiatrist reviewed the data to identify physicians who may be inappropriately prescribing psychotropic medications or to determine additional data was needed to make this determination.

On January 21, 2016, the pediatric psychiatrist provided her report to the Board. Her report indicated that more information is needed in order to identify any physician who may be inappropriately prescribing. The additional information includes diagnosis associated with the medication, dosage of medication prescribed, schedule of dosage, and weight of the child/adolescent.

On February 16, 2016, Board staff met with staff from DHCS and DSS to explain the additional information that was needed. DHCS and DSS were going to determine if they could obtain the additional data elements being requested. On March 22, 2016, DHCS notified the Board that they could not obtain the specific data requested by the Board, however, DSS stated that they could obtain the weight of the child. DHCS stated they could provide alternative data that could be used for the pediatric psychiatrist's review. The Board is currently waiting for this additional data from DHCS and DSS.

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

(Dollars in Thousands)

Fund Condition with General Fund Loan Repayments

	ACTUAL 2014-15	CY 2015-16	BY 2016-17	BY+1 2017-18	BY+2 2018-19
BEGINNING BALANCE	\$ 28,151	\$ 28,091	\$ 20,089	\$ 16,998	\$ -
Prior Year Adjustment	\$ 515	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,666	\$ 28,091	\$ 20,089	\$ 16,998	\$ -
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
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	\$ 8	\$ 8	\$ 8	\$ 8
Totals, Revenues	\$ 54,563	\$ 53,269	\$ 53,302	\$ 53,264	\$ 53,264
Transfers and Other Adjustments:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ -	\$ 3,000	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ -	\$ 3,000	\$ 2,000	\$ -
TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS	\$ 54,563	\$ 53,269	\$ 59,302	\$ 55,264	\$ 53,264
TOTAL RESOURCES	\$ 83,229	\$ 81,360	\$ 79,391	\$ 72,262	\$ 53,264
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1110 Program Expenditures (State Operations)	\$ 55,090	\$ 59,661	\$ 59,865	\$ 61,132	\$ 61,132
<u>2015-16 and Ongoing Approved/Pending Costs</u>					
BreEZe Costs	\$ -	\$ 2,403	\$ 2,494	\$ -	\$ -
Staff Augmentation	\$ -	\$ -	\$ 113	\$ 105	\$ 105
Expert Reviewer	\$ -	\$ -	\$ 206	\$ 206	\$ 206
Department of Justice			\$ 577	\$ 577	\$ 577
Registered Dispensing Opticians			\$ (39)	\$ (39)	\$ (39)
<u>Anticipated Future Costs</u>					
BreEZe Costs	\$ -	\$ -	\$ -	\$ 2,499	\$ 2,499
1110 Program Expenditures (State Operations) Subtotal	\$ 55,090	\$ 62,064	\$ 63,216	\$ 64,480	\$ 64,480
Expenditure Adjustments:					
0840 State Controller (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
8880 Financial Information System for California (State Operations)	\$ 48	\$ 107	\$ 77	\$ -	\$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	\$ 55,138	\$ 62,171	\$ 63,293	\$ 64,480	\$ 64,480
Unscheduled Reimbursements		\$ 900	\$ 900	\$ 900	\$ 900
FUND BALANCE					
Reserve for economic uncertainties	\$ 28,091	\$ 20,089	\$ 16,998	\$ 8,682	\$ (10,316)
Months in Reserve	5.4	3.8	3.2	1.6	-2.1

NOTES:

- A. Assumes workload and revenue projections are realized for FY 15/16 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$9 million was loaned to the General Fund by the Board in FY 11/12 and \$6 million was loaned to the General Fund in FY 08/09. \$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. 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.
- F. Unscheduled reimbursements result in a net increase in the fund balance.

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

(Dollars in Thousands)

Fund Condition without General Fund Loan Repayments

	ACTUAL 2014-15	CY 2015-16	BY 2016-17	BY+1 2017-18	BY+2 2018-19
BEGINNING BALANCE	\$ 28,151	\$ 28,091	\$ 20,089	\$ 10,998	\$ 682
Prior Year Adjustment	\$ 515	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,666	\$ 28,091	\$ 20,089	\$ 10,998	\$ 682
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
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	\$ 8	\$ 8	\$ 8	\$ 8
Totals, Revenues	\$ 54,563	\$ 53,269	\$ 53,302	\$ 53,264	\$ 53,264
Transfers and Other Adjustments:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ -	\$ -	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ -	\$ -	\$ -	\$ -
TOTALS, REVENUES AND TRANSFERS	\$ 54,563	\$ 53,269	\$ 53,302	\$ 53,264	\$ 53,264
TOTAL RESOURCES	\$ 83,229	\$ 81,360	\$ 73,391	\$ 64,262	\$ 53,946
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1110 Program Expenditures (State Operations)	\$ 55,090	\$ 59,661	\$ 59,865	\$ 61,132	\$ 61,132
<u>2015-16 and Ongoing Approved/Pending Costs</u>					
BreEZe Costs	\$ -	\$ 2,403	\$ 2,494	\$ -	\$ -
Staff Augmentation	\$ -	\$ -	\$ 113	\$ 105	\$ 105
Expert Reviewer	\$ -	\$ -	\$ 206	\$ 206	\$ 206
Department of Justice SB 467			\$ 577	\$ 577	\$ 577
Registered Dispensing Opticians AB 684			\$ (39)	\$ (39)	\$ (39)
<u>Anticipated Future Costs</u>					
BreEZe Costs	\$ -	\$ -	\$ -	\$ 2,499	\$ 2,499
1110 Program Expenditures (State Operations) Subtotal	\$ 55,090	\$ 62,064	\$ 63,216	\$ 64,480	\$ 64,480
Expenditure Adjustments:					
0840 State Controller (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
8880 Financial Information System for California (State Operations)	\$ 48	\$ 107	\$ 77	\$ -	\$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	\$ 55,138	\$ 62,171	\$ 63,293	\$ 64,480	\$ 64,480
Unscheduled Reimbursements		\$ 900	\$ 900	\$ 900	\$ 900
FUND BALANCE					
Reserve for economic uncertainties	\$ 28,091	\$ 20,089	\$ 10,998	\$ 682	\$ (9,634)
Months in Reserve	5.4	3.8	2.0	0.1	-1.8

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. 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.
- F. Unscheduled Reimbursements will result in a net increase in the fund balance.

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report
(As of March 31, 2016)
(75% 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	6,400,218	67.8	3,046,346
Board Members	31,500	52,000	165.1	(20,500)
Temp Help	755,880	123,195	16.3	632,685
BL 12-03 Blanket	0	436,487	0.0	(436,487)
Overtime	44,441	67,095	151.0	(22,654)
Staff Benefits	5,213,036	3,575,567	68.6	1,637,469
TOTALS, PERS SERVICES	15,491,421	10,654,563	68.8	4,836,858
OPERATING EXP & EQUIP				
General Expense	204,206	223,079	109.2	(18,873)
Fingerprint Reports	333,448	252,837	75.8	80,611
Printing	194,755	248,564	127.6	(53,809)
Communications	106,190	77,948	73.4	28,242
Postage	149,511	65,605	43.9	83,906
Insurance	2,053	11,508	560.5	(9,455)
Travel In-State	130,298	106,759	81.9	23,539
Travel Out-of-State	0	874	0.0	(874)
Training	54,895	9,164	16.7	45,731
Facilities Operation (Rent)	928,140	1,088,829	117.3	(160,689)
Consult/Prof Services	1,317,088	1,783,293	135.4	(466,205)
Departmental Prorata	6,473,849	4,892,252	75.6	1,581,597
HQIU	16,871,000	9,780,240	58.0	7,090,760
Consolidated Data Center	650,230	94,148	14.5	556,082
Data Processing	117,492	239,509	203.9	(122,017)
Central Admin Svcs (Statewide Prorata)	2,912,000	2,184,212	75.0	727,788
Major Equipment	8,500	0	0.0	8,500
Other Items of Expense	0	0	0.0	0
Vehicle Operations	31,925	18,016	56.4	13,909
Attorney General Services	13,347,280	9,471,970	71.0	3,875,310
Office of Administrative Hearings	1,750,080	738,880	42.2	1,011,200
Evidence/Witness	1,893,439	448,556	23.7	1,444,883
Court Reporter Services	225,000	213,813	95.0	11,187
Minor Equipment	35,200	55,471	157.6	(20,271)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	47,736,579	32,005,528	67.0	15,731,051
TOTALS, EXPENDITURES	63,228,000	42,660,090	67.5	20,567,910
Scheduled Reimbursements	(384,000)	(310,461)	80.8	(73,539)
Distributed Costs	(780,000)	(324,091)	41.6	(455,909)
TOTAL, STATE OPERATIONS	62,064,000	42,025,538	67.7	20,038,462
Unscheduled Reimbursements*		(1,414,114)		
		40,611,425		

* no authority to spend

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Licensing
(As of March 31, 2016)
(75% 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	1,907,270	70.7	790,905
Board Members	0	0	0.0	0
Temp Help	48,396	15,149	31.3	33,247
BL 12-03 Blanket	0	32,685	0.0	(32,685)
Overtime	21,716	29,814	137.3	(8,098)
Staff Benefits	1,404,032	1,102,388	78.5	1,404,032
TOTALS, PERS SERVICES	4,172,319	3,087,306	74.0	2,187,401
OPERATING EXP & EQUIP				
General Expense	22,381	18,437	82.4	3,944
Fingerprint Reports	333,448	252,007	75.6	81,441
Printing	92,627	91,647	98.9	981
Communications	19,647	13,263	67.5	6,385
Postage	72,495	35,004	48.3	37,491
Insurance	0	0	0.0	0
Travel In-State	17,179	9,450	55.0	7,729
Travel Out-of-State	0	0	0.0	0
Training	18,207	0	0.0	18,207
Facilities Operation (Rent)	269,758	353,901	131.2	(84,143)
Consult/Prof Services	794,091	1,021,755	128.7	(227,664)
Departmental Prorata	2,147,167	1,622,759	75.6	524,408
HQIU	0	0	0.0	0
Consolidated Data Center	0	0	0.0	0
Data Processing	8,664	6,338	73.1	2,326
Central Admin Svcs (Statewide Prorata)	965,816	724,433	75.0	241,383
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	27,497	94.2	1,693
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	1,644	55.5	1,320
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	4,793,883	4,178,133	87.2	615,750
TOTALS, EXPENDITURES	8,966,202	7,265,439	81.0	1,700,763
Scheduled Reimbursements	(384,000)	(310,461)	80.8	(73,539)
Distributed Costs	(31,131)	(14,696)	47.2	(16,435)
NET TOTAL, EXPENDITURES	8,551,071	6,940,282	81.2	1,610,789
Unscheduled Reimbursements*		0		
		6,940,282		

* no authority to spend

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Enforcement
(As of March 31, 2016)
(75% 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	1,794,043	69.7	780,064
Board Members	0	0	0.0	0
Temp Help	608,589	0	0.0	608,589
BL 12-03 Blanket	0	384,821	0.0	(384,821)
Overtime	10,281	17,637	171.6	(7,356)
Staff Benefits	1,619,426	1,065,797	65.8	553,629
TOTALS, PERS SERVICES	4,812,403	3,262,298	67.8	1,550,105
OPERATING EXP & EQUIP				
General Expense	69,470	81,759	117.7	(12,289)
Fingerprint Reports	0	830	0.0	(830)
Printing	43,898	38,203	87.0	5,695
Communications	40,015	27,566	68.9	12,449
Postage	74,371	28,998	39.0	45,373
Insurance	0	0	0.0	0
Travel In-State	39,017	37,128	95.2	1,889
Travel Out-of-State	0	874	0.0	(874)
Training	15,087	4,689	31.1	10,398
Facilities Operation (Rent)	294,072	379,941	129.2	(85,869)
Consult/Prof Services	479,560	731,388	152.5	(251,828)
Departmental Prorata	1,795,726	1,344,391	74.9	451,335
HQIU	16,871,000	9,780,240	58.0	7,090,760
Consolidated Data Center	0	60	0.0	(60)
Data Processing	15,045	22,059	146.6	(7,014)
Central Admin Svcs (Statewide Prorata)	783,771	600,283	76.6	183,488
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	9,444,474	70.9	3,873,617
Office of Administrative Hearings	1,750,080	738,880	42.2	1,011,200
Evidence/Witness	1,736,958	448,406	25.8	1,288,552
Court Reporter Services	224,750	213,813	95.1	10,937
Minor Equipment	4,863	4,839	99.5	24
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	37,555,774	23,928,822	63.7	13,626,952
TOTALS, EXPENDITURES	42,368,177	27,191,121	64.2	15,177,056
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	(744,054)	(305,573)	41.1	(438,481)
NET TOTAL, EXPENDITURES	41,624,123	26,885,548	64.6	14,738,575
Unscheduled Reimbursements*		(66,298)		
		26,819,250		

* no authority to spend

Health Quality Investigation Unit (HQIU)
Fiscal Year 2015-16
Budget Expenditure Report
(As of March 31, 2016)
 (75% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,177,000	5,001,292	61.2	3,175,708
Temp Help	1,074,000	1,049,092	97.7	24,908
Overtime	6,000	14,501	241.7	(8,501)
Staff Benefits	4,644,000	2,953,018	63.6	1,690,982
BL 12-03 Blanket	0	7,397	0.0	(7,397)
TOTALS, PERS SERVICES	13,901,000	9,025,299	64.9	4,875,701
OPERATING EXP & EQUIP				
General Expense	214,000	235,405	110.0	(21,405)
Printing	69,000	55,666	80.7	13,334
Communications	172,000	95,564	55.6	76,436
Postage	36,000	25,613	71.1	10,387
Insurance	38,000	45,099	118.7	(7,099)
Travel In-State	222,000	104,987	47.3	117,013
Travel Out-of-State	7,000	0	0.0	7,000
Training	27,000	17,269	64.0	9,731
Facilities Operation (Rent)	1,574,000	1,453,857	92.4	120,143
Consult/Prof Services	91,000	84,199	92.5	6,801
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	0	0.0	15,000
Data Processing	0	52,841	0.0	(52,841)
Central Admin Svcs (Statewide Prorata)	0	0	0.0	0
Major Equipment	199,000	0	0.0	199,000
Other Items of Expense	28,000	70,061	250.2	(131,034)
Vehicle Operations	216,000	159,034	73.6	216,000
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	3,435	0.0	(3,435)
Court Reporter Services	0	388,934	0.0	(388,934)
Minor Equipment	8,000	30,634	382.9	(22,634)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	2,916,000	2,822,597	96.8	163,464
TOTALS, EXPENDITURES	16,817,000	11,847,897	70.5	4,969,103
Scheduled Reimbursements				0
Distributed Costs				0
NET TOTAL, EXPENDITURES				
Unscheduled Reimbursements*	16,817,000	11,847,897	70.5	4,969,103
		<u>0</u>		
		11,847,897		

* no authority to spend

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

Page 1 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
July	Attorney Services	6193.50	\$170.00	\$1,052,895.00
	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			<u>\$0.00</u>
				\$1,121,155.50
August	Attorney Services	5769.75	\$170.00	\$980,857.50
	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			<u>\$2,773.85</u>
				\$1,051,465.85
September	Attorney Services	5950.75	\$170.00	\$1,011,627.50
	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			<u>\$7,132.90</u>
				\$1,088,017.65
October	Attorney Services	12168.50	\$170.00	\$2,068,645.00
	Paralegal Services	705.25	\$120.00	\$84,630.00
	Auditor/Analyst Services	368.25	\$99.00	\$36,456.75
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			<u>\$399.94</u>
				\$2,190,131.69
November	Attorney Services	4815.00	\$170.00	\$818,550.00
	Paralegal Services	312.75	\$120.00	\$37,530.00
	Auditor/Analyst Services	183.25	\$99.00	\$18,141.75
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			<u>\$2,729.50</u>
				\$876,951.25
December	Attorney Services	5400.00	\$170.00	\$918,000.00
	Paralegal Services	296.25	\$120.00	\$35,550.00
	Auditor/Analyst Services	231.50	\$99.00	\$22,918.50
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			<u>\$8,075.75</u>
				\$984,544.25

Total July-Dec = \$7,312,266.19
FY 2015-16 Budget = \$13,318,091.00
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**MEDICAL BOARD OF CALIFORNIA
 ATTORNEY GENERAL EXPENDITURES - FY 2015-16
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)**

page 2 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
January	Attorney Services	5495.50	\$170.00	\$934,235.00
	Paralegal Services	344.75	\$120.00	\$41,370.00
	Auditor/Analyst Services	246.00	\$99.00	\$24,354.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			<u>\$1,735.60</u>
				<u>\$1,001,694.60</u>
February	Attorney Services	6240.25	\$170.00	\$1,060,842.50
	Paralegal Services	349.25	\$120.00	\$41,910.00
	Auditor/Analyst Services	250.75	\$99.00	\$24,824.25
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			<u>\$2,936.12</u>
				<u>\$1,130,512.87</u>
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			<u>\$0.00</u>
				<u>\$0.00</u>
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			<u>\$0.00</u>
				<u>\$0.00</u>
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			<u>\$0.00</u>
				<u>\$0.00</u>
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			<u>\$0.00</u>
				<u>\$0.00</u>

FYTD Total = \$9,444,473.66
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	100	0	50	100				450
Criminal Cost Recovery	451	4,851	7,581	1,100	1,400	2,400	3,188	4,607	551				26,129
Probation Monitoring	74,221	54,139	42,860	44,930	62,069	102,916	359,823	222,613	91,728				1,055,299
Exam	9,593	5,778	1,922	16,948	5,721	11,506	10,926	16,650	6,225				85,269
Cite/Fine	0	0	0	0	0	0	2,500	700	5,000				8,200
MONTHLY TOTAL	84,315	64,818	52,413	63,028	69,190	116,922	376,437	244,620	103,604	0	0	0	1,175,347
FYTD TOTAL	84,315	149,133	201,546	264,574	333,764	450,686	827,123	1,071,743	1,175,347	1,175,347	1,175,347	1,175,347	

excel:enfreceiptsmonthlyprofile.xls.revised 4/11/2016

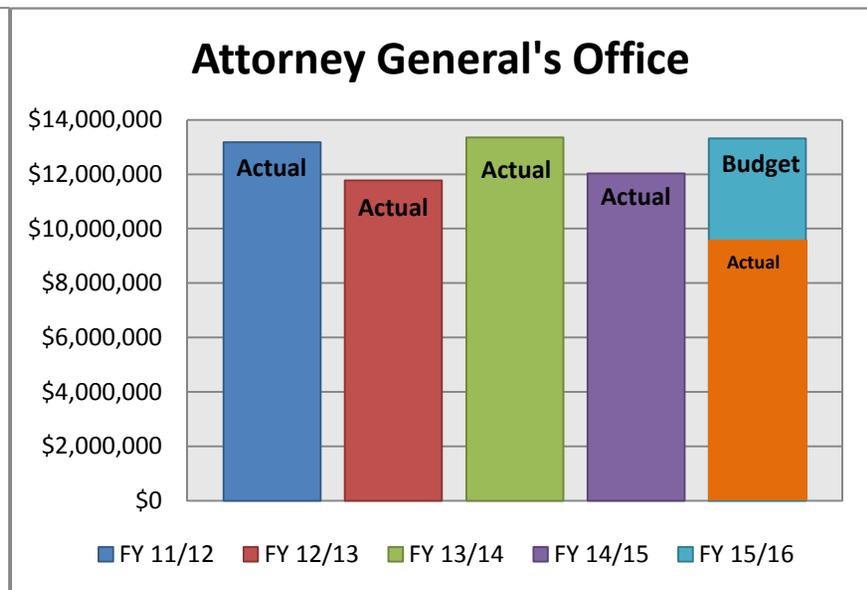
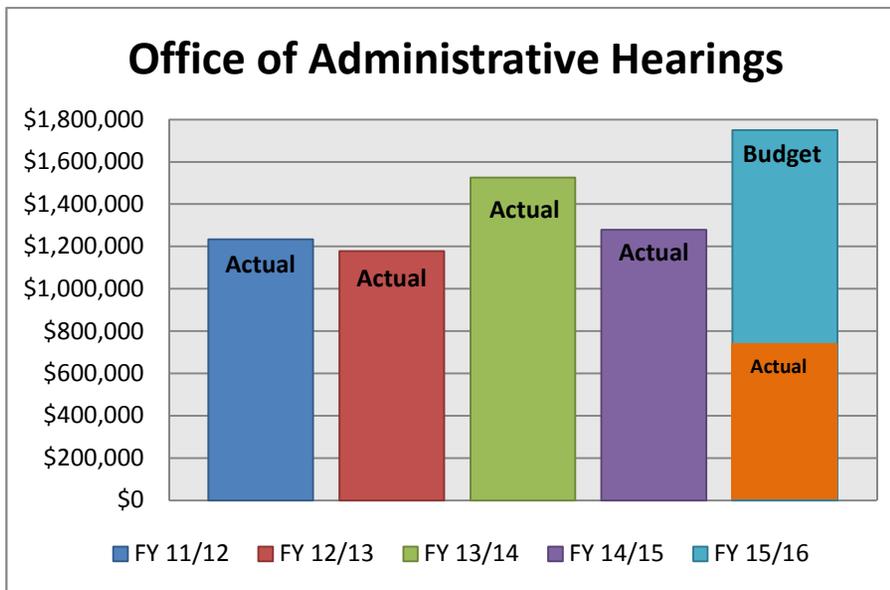
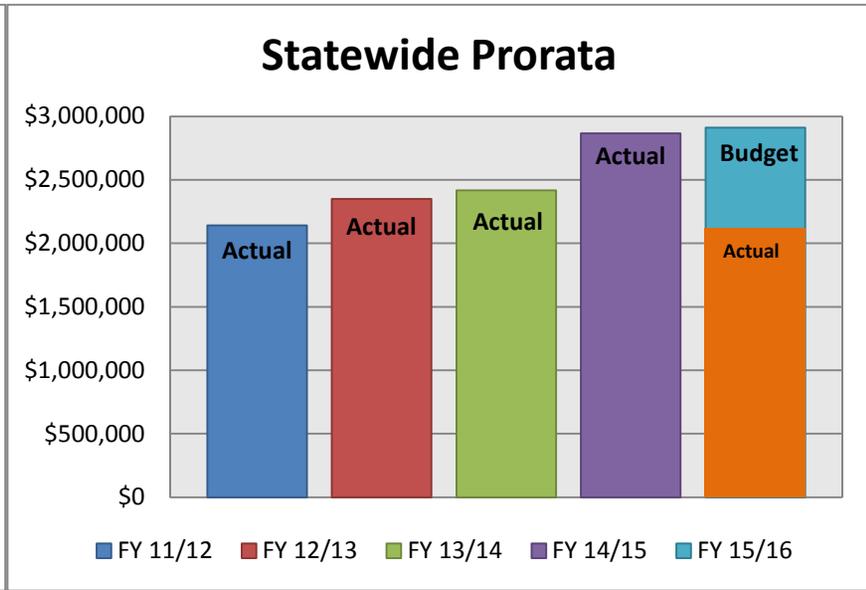
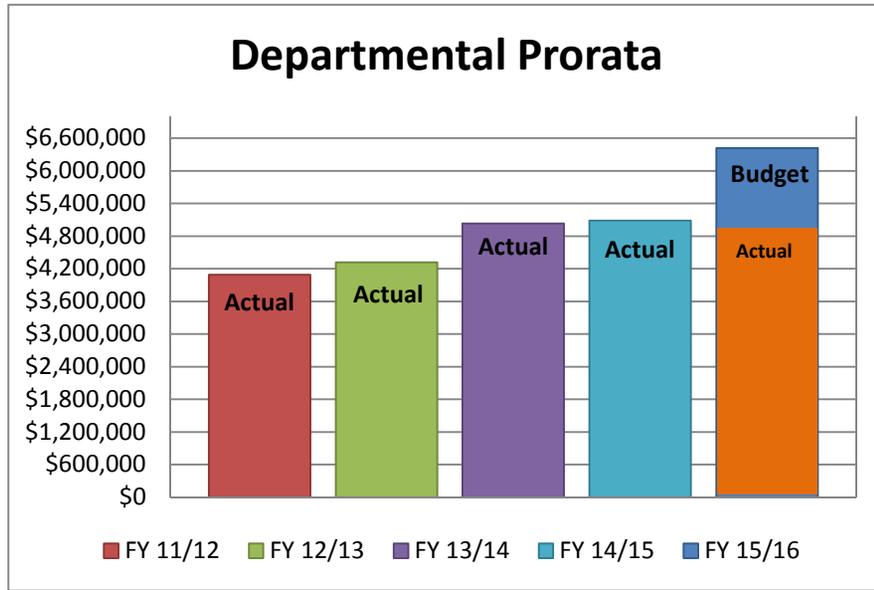
NOTE: Beginning with October 2013, payment amounts reflect payments made directly to MBC; they do not include payments made through BreZE online system. Online payment information is unavailable.

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 3/31*	1,493,444	26,885,548		6,940,282	1,737,844	2,486,079	2,482,341	42,025,538 *
Positions								
Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

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

External Agencies' Spending



FY 15/16 actual expenditures through 3/31/16

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

Agenda Item 7A

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BHOLAT - Per diem													\$ -
Travel													\$ -
Total-Dr. Bholat	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. BISHOP - Per diem	\$ 800	\$ 600	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,400
Travel	\$ 880	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 892	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,772
Total-Dr. Bishop	\$ 1,680	\$ 600	\$ -	\$ -	\$ -	\$ -	\$ 892	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,172
DR. GNANADEV - Per diem	\$ 1,000	\$ 1,000	\$ 1,000	\$ 1,200	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,200
Travel	\$ 962	\$ -	\$ -	\$ 610	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,572
Total-Dr. Gnanadev	\$ 1,962	\$ 1,000	\$ 1,000	\$ 1,810	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 5,772
DR. HAWKINS - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Hawkins	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. KRAUSS - Per diem	\$ 500	\$ -	\$ -	\$ 1,300	\$ 800	\$ 200	\$ 400	\$ 400	\$ -	\$ -	\$ -	\$ -	\$ 3,600
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Krauss	\$ 500	\$ -	\$ -	\$ 1,300	\$ 800	\$ 200	\$ 400	\$ 400	\$ -	\$ -	\$ -	\$ -	\$ 3,600
MS. LAWSON - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 300	\$ 1,000	\$ 500	\$ -	\$ -	\$ -	\$ -	\$ 1,800
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms Lawson	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 300	\$ 1,000	\$ 500	\$ -	\$ -	\$ -	\$ -	\$ 1,800
DR. LEVINE - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ 479	\$ -	\$ -	\$ 498	\$ -	\$ -	\$ 419	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,396
Total-Dr. Levine	\$ 479	\$ -	\$ -	\$ 498	\$ -	\$ -	\$ 419	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,396
DR. LEWIS - Per diem	\$ 1,000	\$ 700	\$ 800	\$ 1,100	\$ 400	\$ 700	\$ 1,100	\$ 1,100	\$ -	\$ -	\$ -	\$ -	\$ 6,900
Travel	\$ 751	\$ -	\$ -	\$ 657	\$ -	\$ 659	\$ 612	\$ 1,452	\$ -	\$ -	\$ -	\$ -	\$ 4,132
Total-Dr. Lewis	\$ 1,751	\$ 700	\$ 800	\$ 1,757	\$ 400	\$ 1,359	\$ 1,712	\$ 2,552	\$ -	\$ -	\$ -	\$ -	\$ 11,032
MS. PINES - Per diem	\$ 1,300	\$ 1,100	\$ 1,100	\$ 1,400	\$ 900	\$ 800	\$ 1,200	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ 8,600
Travel	\$ 729	\$ -	\$ -	\$ 615	\$ -	\$ -	\$ 825	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,169
Total-Ms. Pines	\$ 2,029	\$ 1,100	\$ 1,100	\$ 2,015	\$ 900	\$ 800	\$ 2,025	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ 10,769
MS. SCHIPSKE - Per diem	\$ 1,000	\$ 500	\$ 700	\$ 1,100	\$ 200	\$ 800	\$ 500	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ 5,600
Travel	\$ -	\$ -	\$ -	\$ 579	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 579
Total-Ms. Schipske	\$ 1,000	\$ 500	\$ 700	\$ 1,679	\$ 200	\$ 800	\$ 500	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ 6,179
MR. SERRANO SWELL- Per diem	\$ 600	\$ 600	\$ 600	\$ 600	\$ 500	\$ 500	\$ 600	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,000
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 266	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 266
Total-Mr. Serrano	\$ 600	\$ 600	\$ 600	\$ 600	\$ 500	\$ 500	\$ 866	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,266
MS. SUTTON - WILLS - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Mr. Serrano	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
MS. WRIGHT - Per diem	\$ 1,500	\$ 1,300	\$ 1,600	\$ 1,300	\$ 1,000	\$ 800	\$ 1,200	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ 9,700
Travel	\$ 922	\$ -	\$ -	\$ 541	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,463
Total-Ms. Wright	\$ 2,422	\$ 1,300	\$ 1,600	\$ 1,841	\$ 1,000	\$ 800	\$ 1,200	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ 11,163
MS. YAROSLAVSKY - Per diem	\$ -	\$ 1,300	\$ 1,000	\$ 1,400	\$ -	\$ 1,200	\$ 1,400	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 6,300
Travel	\$ 924	\$ -	\$ -	\$ 608	\$ -	\$ 482	\$ 866	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,880
Total-Ms. Yaroslavsky	\$ 924	\$ 1,300	\$ 1,000	\$ 2,008	\$ -	\$ 1,682	\$ 2,266	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 9,180
DR. YIP - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Yip	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

As of: 4/14/16

TOTAL PER DIEM \$ 52,100
TOTAL PER DIEM BUDGETED \$ 31,500
TOTAL TRAVEL \$ 16,228
TOTAL \$ 68,328

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 19, 2016
 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 1060 active experts in the Board's expert database. 76 experts were utilized to review 91 cases between January and March 2016. **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
- Pediatric Cardiac Surgery
- 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

Expert Reviewer training was held on March 19, 2016, at the UC San Diego School of Medicine. The training was co-hosted by the Physician Assessment and Clinical Education (PACE) Program, and PACE was gracious to dedicate the use of the school's state of the art facility for the training. A total of thirty-seven experts attended and they received information about the role and responsibilities of a Medical Board expert, how to write a clear and concise report, and proper protocols for testifying at a hearing. The feedback received from the attendees was positive, in that they stated the training was well organized and educational. Because a majority of the attendees expressed a desire to receive instruction in prescribing practices, the Expert Reviewer Program is looking into the likelihood of providing this training to the experts as an enhancement to the training curriculum. The Expert Reviewer Program is currently researching facilities in the Los Angeles and San Francisco areas to hold Expert Reviewer Training in September and October of this year. **Attachment B** provides some pictures taken at the training.

At the January 2016 Board meeting, the Enforcement Committee requested that a letter from Board President David Serrano-Sewell be sent to existing experts encouraging their participation at the training. **Attachment C** is the letter that was mailed to the experts and a similar letter is being drafted that will be sent to prospective physician and surgeons, in the medical specialties where experts are needed, urging them to join the Board's Expert Reviewer Program.

Demographic Study Update

At the January Board meeting, it was reported that the California Research Bureau is finalizing the research plan and methodology. On April 18, 2016, Dr. Krauss, Board Member, and Dr. Baker, Black American Political Association of California and the Golden State Medical Society, received the plan for review. Once Dr. Krauss has completed his review and approval of the plan, the CRB will continue with its analysis portion of the study. The analysis is expected to take approximately two months and an additional two months for the CRB to finalize the report.

Training for the Office of Administrative Hearing

In alignment with the Board's strategic plan objective to identify ongoing opportunities for training of Administrative Law Judges, the Board enlisted assistance from PACE to provide a medical record keeping course on April 29, 2016 and a prescribing practices course that will be held on May 27, 2016. Three training opportunities have been provided this calendar year and the goal of the Enforcement Program is to provide three additional training sessions by the end of the year.

Enforcement Program Restructure

The Enforcement Program submitted a request to the Department of Consumer Affairs (DCA) to re-organize the structure of the Program. The objective of the request was to split the six units of the Enforcement Program into two sections that would be managed by two Enforcement Program Managers, as opposed to one. The restructure will afford ideal oversight by senior level management to ensure policies and procedures and the daily operational tasks are being carried out effectively and efficiently by staff. In addition, by having two Program Managers, they can devote more time to supporting the managers and staff in fulfilling the Board's mission of providing consumer protection. **Attachment D** is an organizational chart depicting the new structure of the Enforcement Program that was approved by DCA.

Staffing/Program Updates

Enforcement Program

On March 7, 2016, Susan Houston was appointed as the new Enforcement Program Manager responsible for overseeing the Probation Unit, the Complaint Investigation Office and the Disciplinary Coordination Unit. Program Manager Paulette Romero is responsible for overseeing the functions of the Central Complaint Unit.

Expert Reviewer Program

On March 14, 2016, Rebecca Grisby was appointed as the new Associate Governmental Program Analyst within the Board's Expert Reviewer Program.

Complaint Investigation Office (CIO)

The CIO is fully staffed with six non-sworn Special Investigators and each investigator continues to maintain a case load of approximately 45 cases. Since the last Enforcement Summary provided at the January 2016 Board meeting, CIO has closed 73 cases and has transmitted 44 cases to the Attorney General's Office – 13 criminal/conviction cases, 19 Petitions for Reinstatement of licensure, 7 Petitions for Early Termination/Modification of probation, and 5 medical malpractice cases.

The CIO received subpoena training from the Office of the Attorney General (AGO) on February 25, 2016. During the training, staff received praises from the Deputy Attorneys General for transmitting cases to the

AGO that are clear, concise and contain all necessary information for a successful transmittal for disciplinary action. In addition, staff also received compliments for their professionalism and preparedness while conducting subject interviews.

Discipline Coordination Unit (DCU)

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. Two Student Assistants and one retired annuitant were hired to help finalize this project as it has been challenging for the permanent staff to dedicate time to the project because their daily functions of processing disciplinary documents is the DCU's priority.

Probation Unit

On March 14, 2016, Anne Potter was hired as the new Probation Unit Manager. Besides learning the intricacies of the Unit, Ms. Potter, Ms. Houston and Chief of Enforcement Christina Delp have begun discussions to develop a comprehensive training plan for the unit's inspectors. Some training topics being explored are assertiveness training, report writing, testifying, completed staff work, case management, time management, and consequences of non-compliance by probationers. The training is tentatively scheduled to take place September 2016.

On April 13, 2016, Ms. Potter, Ms. Houston and Ms. Delp meet with the executive staff from PACE. The purpose of the meeting was to introduce the new probation management to the PACE staff and to educate Board staff regarding the history and background of PACE, the PACE Competency Assessment Program, and the Physician Enhancement Program.

The Northern California Probation Unit continues its recruitment to backfill one vacant Inspector I position located in the San Jose field office. The interest of candidates for this position has been extremely low. Therefore, management is entertaining the possibility of relocating this position to the Sacramento office for recruitment purposes. Hiring interviews for the vacant Associate Governmental Program Analyst position will be conducted April 20 and 21, 2016. This analyst will assist with monitoring probationers that are ordered to submit biological fluid testing as a term of his or her probation, as well as monitor the requirements for specified training or education contained in a Public Letter of Reprimand or a Public Reprimand.

Central Complaint Unit (CCU)

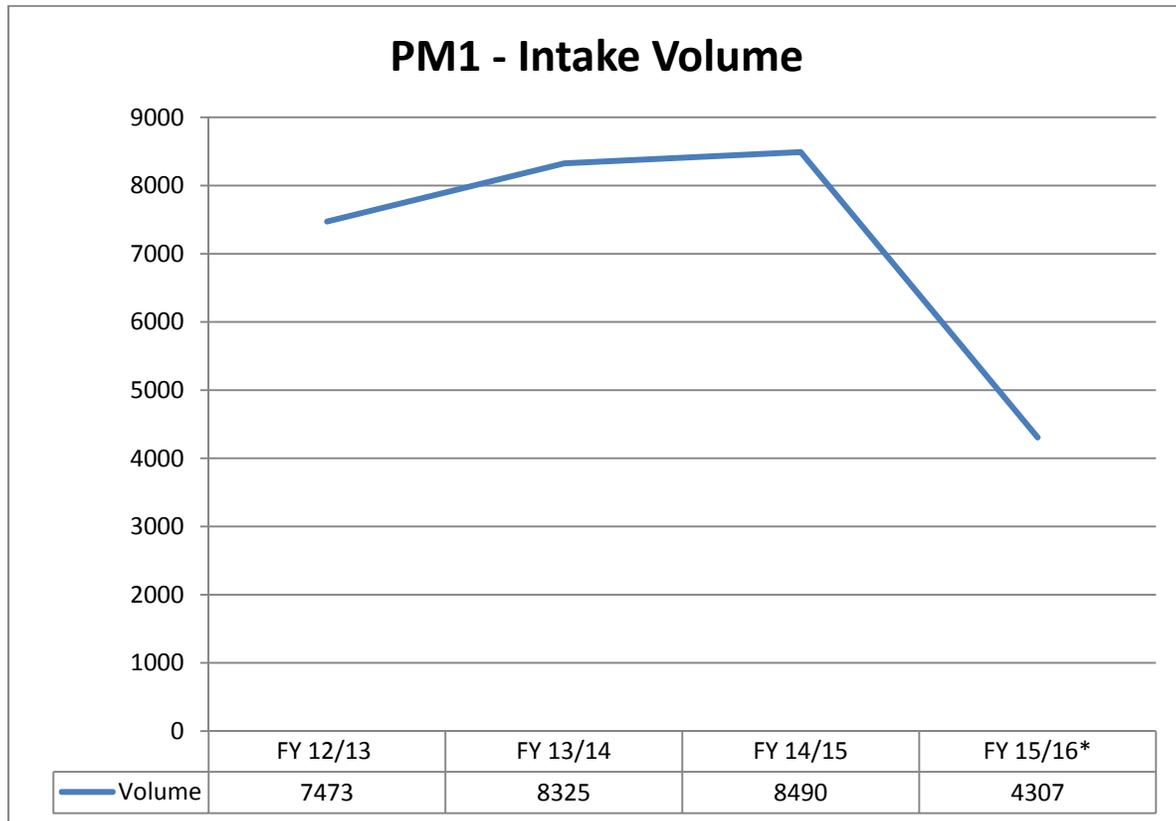
The CCU intake staff was able to reduce the number of days it takes to initiate a complaint during the third quarter of fiscal year 2015/2016 from an average of seventeen (17) days to an average of fifteen (15) days. The unit will soon receive assistance in further reducing this timeframe as DCA recently approved the hiring of one additional Management Services Technician to process the complaint intake workload. This position has been advertised and management anticipates having an individual employed by the middle of June.

Effective April 1, 2016, the CCU was reorganized in order to appropriately allocate caseloads managed by staff. The reorganization also reduced the number of employees reporting to each CCU manager. The reason of this change is to allow management more time to provide staff with individual development feedback, training, and assistance with processing complex cases, and in so doing, improve the overall efficiency of the unit and reduce the amount of time it takes to close a complaint or refer the complaint to the field for further investigation. Current CCU case processing timeframes are averaging 162 days.

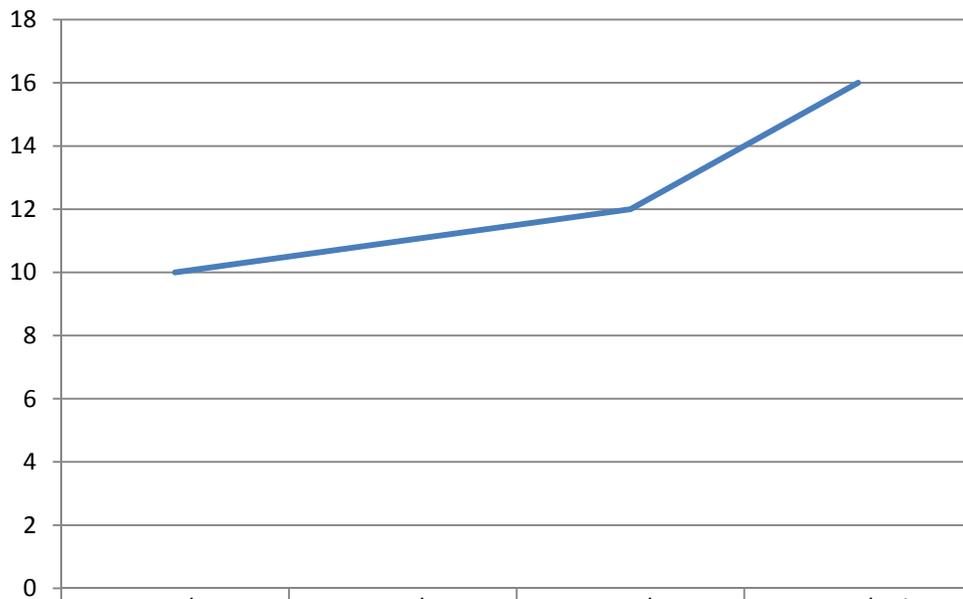
Enforcement Performance Measures

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 to a desk analyst (PM 2), complete an investigation (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 are for the time period July 1, 2015 to March 31, 2016.

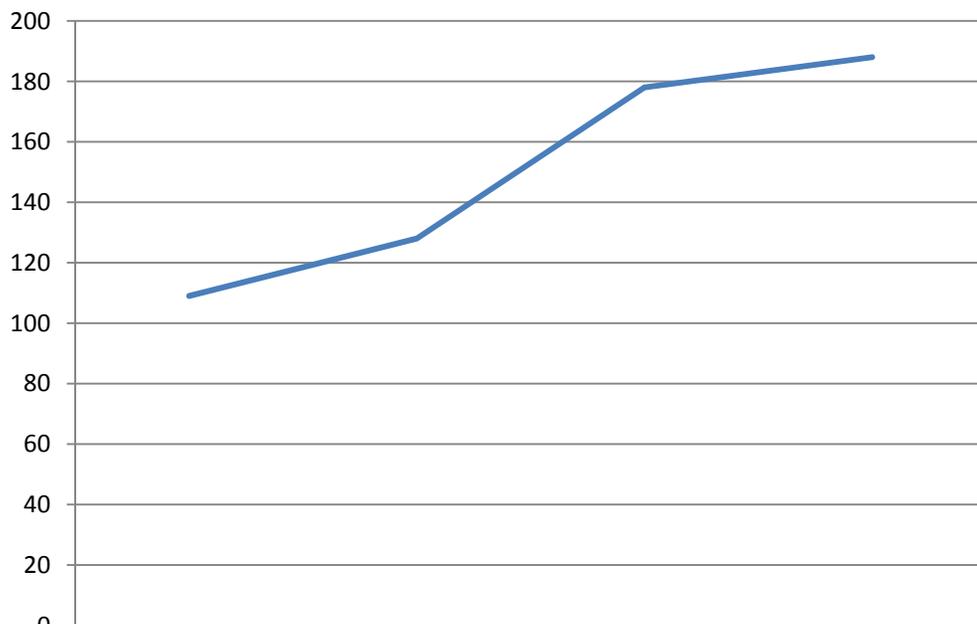


PM2 - Intake Cycle Time



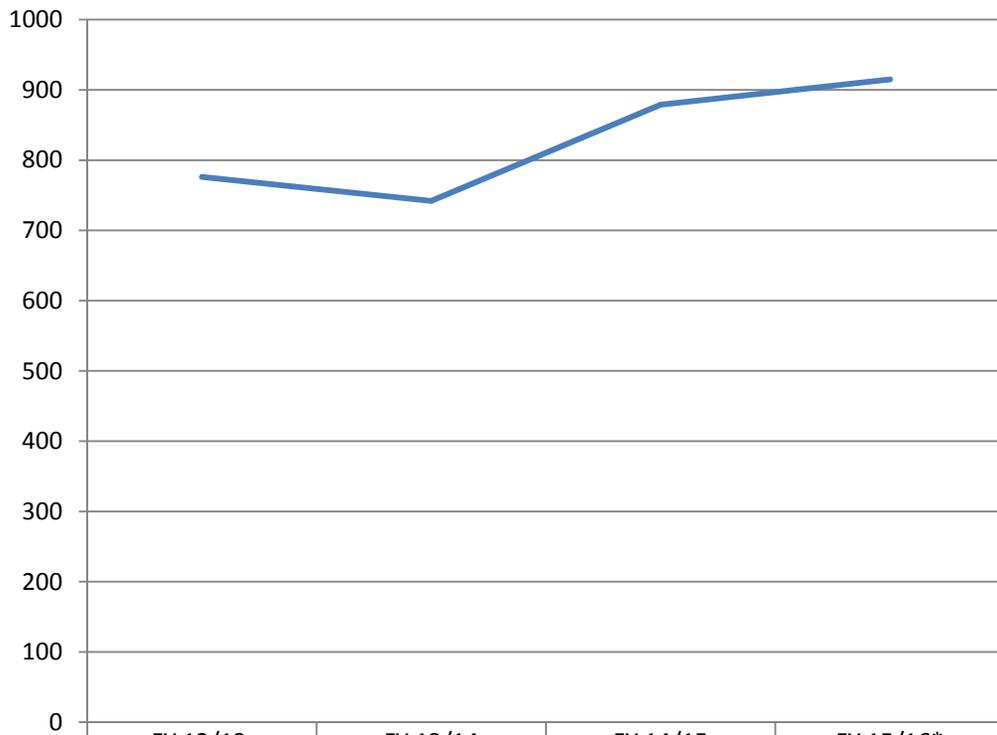
	FY 12/13	FY 13/14	FY 14/15	FY 15/16*
— Cycle Time	10	11	12	16

PM3 - Intake and Investigation Cycle Time



	FY 12/13	FY 13/14	FY 14/15	FY 15/16*
— Cycle Time	109	128	178	188

PM4 - Formal Discipline Cycle Time



	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

April 1, 2016

ATTACHMENT A

SPECIALTY	Number of Cases reviewed by Experts January 1 through March 31, 2016	Number of Experts and how often Utilized from January 1 through March 31, 2016	Active List Experts 1,060 ↓
<i>ADDICTION</i>	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	8 ↓
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes)			81 ↑
COLON & RECTAL SURGERY (CRS)	1	1 EXPERT 1 LIST EXPERT	2 ↓
<i>COMPLEMENTARY/ALTERNATIVE MEDICINE</i>	3	1 EXPERT 1 LIST EXPERT REVIEWED 3 CASES	17 ↓
DERMATOLOGY (D)	3	2 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	12
EMERGENCY (EM)	1	1 EXPERT 1 LIST EXPERT	43 ↓
FAMILY (FM)	17	11 EXPERTS 8 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASE 1 LIST EXPERT REVIEWED 3 CASE 1 LIST EXPERT REVIEWED 4 CASE	64 ↑
<i>HAND SURGERY</i>			11
<i>HOSPICE & PALLIATIVE MEDICINE</i>			14
INTERNAL (General Internal Med)	16	15 EXPERTS 14 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	148 ↓
Cardiovascular Disease (Cv)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	33
Endocrinology, Diabetes and Metabolism (EDM)			6
Gastroenterology (Ge)	1	1 EXPERT 1 LIST EXPERT	18 ↓
Infectious Disease (Inf)			8
Medical Oncology (Onc)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	11
Nephrology (Nep)	1	1 EXPERT 1 LIST EXPERT	11
Pulmonary Disease (Pul)			16

Medical Board of California Expert Reviewer Program Report

April 1, 2016

ATTACHMENT A

SPECIALTY	Number of Cases reviewed by Experts January 1 through March 31, 2016	Number of Experts and how often Utilized from January 1 through March 31, 2016	Active List Experts 1,060 ↓
Rheumatology (Rhu)			5
MIDWIFE REVIEWER			3 ↓
NEUROLOGICAL SURGERY (NS)			10
NEUROLOGY (N)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	21
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3
NUCLEAR MEDICINE (NuM)			4
OBSTETRICS & GYNECOLOGY (ObG)	5	5 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EACH	64 ↑
OCCUPATIONAL MEDICINE			8 ↑
OPHTHALMOLOGY (Oph)	1	1 EXPERT 1 LIST EXPERT	27 ↑
ORTHOPAEDIC SURGERY (OrS)	6	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EA 1 LIST EXPERT REVIEWED 2 CASES	29 ↓
OTOLARYNGOLOGY (Oto)			17
PAIN MEDICINE (PM)	8	6 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH	29 ↑
PATHOLOGY (Path)			12
PEDIATRICS (Ped)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	46
Pediatric Cardiology (Cd)	1	1 EXPERT 1 LIST EXPERT	5
<i>Pediatric Cardiothoracic Surgery</i>			0
Pediatric Emergency Medicine (PEM)			3
Pediatric Endocrinology (En)			1
Pediatric Gastroenterology (Ge)			5

Medical Board of California Expert Reviewer Program Report

April 1, 2016

ATTACHMENT A

SPECIALTY	Number of Cases reviewed by Experts January 1 through March 31, 2016	Number of Experts and how often Utilized from January 1 through March 31, 2016	Active List Experts 1,060 ↓
Pediatric Hematology-Oncology (HO)			3
Pediatric Infectious Diseases (Inf)			4
Pediatric Nephrology (Ne)			2
Pediatric Pulmonology (Pul)			0
Pediatric Rheumatology (Rhu)			0
PHYSICAL MEDICINE & REHABILITATION (PMR)			10
PLASTIC SURGERY (PIS)	6	6 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	38 ↑
PSYCHIATRY (Psyc)	18	12 EXPERTS 7 LIST EXPERTS REVIEWED 1 CASE EACH 3 LIST EXPERTS REVIEWED 2 CASES EACH 1 LIST EXPERT REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES	66 ↓
RADIOLOGY (Rad)	1	1 EXPERT 1 LIST EXPERT	28
Radiation Oncology (Rad RO)			5
SLEEP MEDICINE (S)			7
SURGERY (S)	3	3 EXPERTS 3 LIST EXPERTS	27 ↓
Pediatric Surgery (PdS)			2
Vascular Surgery (VascS)			5 ↓
THORACIC SURGERY (TS)			9 ↓
<i>(MEDICAL) TOXICOLOGY</i>			7
UROLOGY (U)	1	1 EXPERT 1 LIST EXPERT	13 ↑

TOTAL CASES REVIEWED (1 ST QUARTER)	91
TOTAL EXPERTS UTILIZED (1 ST QUARTER)	76
TOTAL ACTIVE LIST EXPERTS (4/1/2016)	1,060

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





MEDICAL BOARD OF CALIFORNIA
Executive Office



February 19, 2016

ATTACHMENT C

On behalf of the fifteen members of the Medical Board of California (Board), it is with great pleasure that I write this letter to express our gratitude for your interest and willingness to be an Expert Reviewer for the Board.

Your hard work and dedication in reviewing investigative cases, on top of fulfilling your obligation to serve in the health care community as a licensed practitioner, is noble. We understand that it is your commitment to preserving the integrity of the health care field that motivates you to remain in the program. Without your participation, it would be an on-going challenge for the Board to find experts to assist with reviewing quality of care cases to determine whether there has been a departure in the standard of care in the community. Your role as an expert reviewer is a key component of the investigative and enforcement functions of the Board because your opinion, and sometimes testimony, is highly weighted when it comes to determining whether patients have been harmed by negligent practitioners or to refute allegations of wrong-doings performed by colleagues in the profession.

One facet of a successful program is to provide the participants with proper training. Expert reviewer training is essential, because it sharpens the skills needed to write clear, concise, and comprehensive reports. In addition, it provides techniques for communicating effectively and appropriately when testifying. The training also provides the participants with a forum to share their ideas on how to strengthen the program so it remains in alignment with the Board's mission of providing consumer protection. Accordingly, whether you are an experienced expert with the Board, or new to the program, the Board's Expert Reviewer Training provides invaluable information to improve your skills as a medical expert.

The next Board sponsored Expert Reviewer Training will be held on **March 19, 2016**, at the University of California, San Diego School of Medicine. You may enroll by emailing the Expert Reviewer Program at MBCMedicalExpertProgram@mbc.ca.gov or by calling (818) 551-2129. I ask that you attend this training because by doing so, you are solidifying your commitment to the program and taking a pledge to be part of a platform that needs your support to remain steadfast when it comes to producing high quality Expert Reviewer services.

Sincerely,

A handwritten signature in black ink that reads "David Serrano-Sewell".

David Serrano-Sewell, J.D.
Board President

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Enforcement Program
 Discipline Coordination Unit
 Complaint Investigation Office
 Central Complaint Unit
 Probation Unit
 April 12, 2016

Executive Director
 629-110-7003-001

Chief of Enforcement
 629-170-7500-002

EXPERT REVIEWER PROGRAM
 Associate Governmental Program Analyst
 629-170-5393-020
 629-170-5393-816

PROBATION UNIT
 (See separate chart)

Staff Services Manager II
 629-170-4801-999

Staff Services Manager II
 629-170-4801-001

DISCIPLINE COORDINATION UNIT
 Staff Services Manager I
 629-170-4800-003

TBD
 Supervising Special Investigator
 629-170-8549-999
 VACANT (re-class SI)

COMPLAINT INVESTIGATION OFFICE
 Supervising Special Investigator
 629-170-8549-999

QUALITY OF CARE SECTION
 Staff Services Manager I
 629-170-4800-005

QUALITY OF CARE SECTION
 Staff Services Manager I
 629-170-4800-006

PHYSICIAN CONDUCT/INTAKE SECTION
 Staff Services Manager I
 629-170-4800-002

Data Integrity Program
 Associate Governmental Program Analyst
 629-170-5393-813

Discipline Coordination
 Staff Services Analyst
 629-170-5157-003
 629-170-5157-026
 629-170-5157-035
 Associate Governmental Program Analyst
 629-170-5393-007
 629-170-5393-010
 629-170-5393-013
 629-170-5393-814

TBD
 Special Investigator
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999 (.5)

Complaint Investigation
 Special Investigator
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999
 629-170-8612-999

Quality of Care Section
 Staff Services Analyst
 629-170-5157-016
 629-170-5157-031 (.5)
 629-170-5157-033
 629-170-5157-036
 Associate Governmental Program Analyst
 629-170-5393-011
 629-170-5393-805
 629-170-5393-812

Quality of Care Section
 Office Technician (Typing)
 629-170-1139-011
 629-170-1139-999
 Staff Services Analyst
 629-170-5157-807
 Associate Governmental Program Analyst
 629-170-5393-019 (.5)
 629-170-5393-021 (Bi-Lingual)
 629-170-5393-810
 629-170-5393-811
 629-170-5393-815
 629-170-5393-XXX
 VACANT

Physician Conduct/Intake Section
 Management Services Technician
 629-170-5278-001
 629-170-5278-002
 629-170-5278-004
 629-170-5278-008
 629-170-5278-999
 VACANT
 Staff Services Analyst
 629-170-5157-027
 629-170-5157-808
 629-170-5157-809
 Associate Governmental Program Analyst
 629-170-5393-016

Medical Consultant Program
 Staff Services Analyst
 629-170-5157-015
 629-170-5157-907
 Limited Term VACANT
 Associate Governmental Program Analyst
 629-170-5393-018

Support Staff Services and Central Files
 Office Technician (Typing)
 629-170-1139-004
 629-170-1139-013
 Management Services Technician
 629-170-5278-006

Public Disclosure
 Staff Services Analyst
 629-170-5157-022

Special Projects
 Student Assistant
 629-170-4870-907
 629-170-4870-907
 Associate Governmental Program Analyst
 Retired Annuitant VACANT
 629-170-5393-907

*SUPERVISING SPECIAL INVESTIGATOR (SSI)
 SPECIAL INVESTIGATOR (SI)*

ALL MBC POSITIONS DESIGNATED CORI

Cite and Fine/805/LVS Corporate Practice of Med
 Associate Governmental Program Analyst
 629-170-5393-017

 Executive Director or Designee

 Date

 Personnel Analyst

 Date

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: April 14, 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 third 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:

- Staff Services Manager I (Licensing Manager)
- Office Technician (Cashiering)

Staff in training:

- 2 - Office Technicians (P&S Application File Setup)
- 5 - Management Services Technicians (US/CAN P&S Application Review)
- 2 - Staff Services Analysts (IMG P&S Application Review)

STATISTICS:

The statistics are on pages BRD 7C-3 through BRD 7C-10. Please note that a few of the statistics normally provided are unavailable at this time due to the unavailability of reports in the BreZE system. The statistics that have been provided have been obtained from the call center phone system, tracked manually, or from the BreZE system.

Notable statistics include:

- Consumer Information Unit telephone calls answered: 19,651
 - 847 more calls answered than the previous quarter
- Consumer Information Unit telephone calls abandoned: 6,005
 - 1,631 more abandon calls than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 5,710
 - 21 less call back requests than the previous quarter
- P&S applications initial review completed: 1,884
 - 91 less applications reviewed than the previous quarter
- P&S licenses issued: 1,716
 - 291 more licenses issued than 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 13 weeks out of the 13 weeks in the third quarter of FY 2015-16. The highest number of days the initial goal was exceeded was 13 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 7C-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 is preparing for the UNIBE site visit, which will be performed during the last week of May and the first week of June 2016.

PHYSICIAN SPECIALTY BOARD APPLICATIONS:

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

OUTREACH:

The Licensing Outreach Manager has attended the following licensing workshops and when appropriate, residents from affiliated hospitals are invited to attend.

License Fairs

February 2016:

- February 17-18: Harbor UCLA – 100 residents
- February 24: Santa Clara Valley Medical Center – 50 residents

March 2016:

- March 9: Dignity Methodist Sacramento – 8 residents
- March 10: Kaiser NorCal in-service – approximately 50 program coordinators
- March 17: Kaiser San Diego in-service (first time visit) – 3 program coordinators
- March 17: UC San Diego (Day 1, VA Hospital) – approximately 45 residents
- March 18: UC San Diego (Day 2, Hillcrest Medical Center) – approximately 60 residents
- March 28: Kaiser Vallejo (first time visit) – 8 residents
- March 28: Kaiser Oakland – approximately 30 residents
- March 29: Kaiser Oakland – approximately 20 residents
- March 29: Kaiser San Francisco – approximately 30 residents
- March 30: Kaiser Santa Clara – approximately 30 residents

Medical School Outreach

- March 28, 2016: University of Southern California Keck School of Medicine – approximately 125 students and some faculty attended

CONSUMER INFORMATION UNIT FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Total Calls Answered	58,147	19,692	18,804	19,651	
Calls Requesting Call Back	24,229	12,788	5,731	5,710	
Calls Abandoned	19,292	8,913	4,374	6,005	
Address Changes Completed	3,357	1,438	950	969	

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	6,088	2,262	1,732	2,094	
Initial Reviews Completed	5,503	1,644	1,975	1,884	
Total Pending	N/A	N/A			
Reviewed	N/A	N/A			
Not Reviewed	N/A	N/A			
(SR2s Pending)	N/A	35	38	51	
Licenses Issued	4,378	1,237	1,425	1,716	
Renewals Issued	50,072	17,123	16,237	16,712	

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

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Beginning	N/A	7	9	5	
Received	5	4	0	1	
Reviewed	5	4	0	1	
Not Eligible	0	0	0	0	
Licensed	8	2	4	2	

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

SR 2 - CATEGORIES FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Alcohol/Drugs	25	7	8	10	
PG/Medical Knowledge	55	16	23	16	
Convictions	36	17	8	11	
Other	94	31	32	31	

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

Licensing Program Report

WORKLOAD REPORT
as of March 31, 2016

Fiscal Year 2015-2016

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	123	
Pending Self-Assessment Reports (included above)	N/A	7	7	7	
New Self-Assessment Reports Received	0	0	0	0	
New Unrecognized Schools Received	33	13	13	7	
School Recognized Pursuant to CCR 1314(a)(1)	18	6	4	8	
School Recognized Pursuant to CCR 1314(a)(2)	0	0	0	0	
TOTAL Schools Pending Recognition at End of Quarter	N/A	114	123	122	

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	0	
Applications Pending	N/A	0	1	1	

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

RESEARCH PSYCHOANALYST FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
RP Applications Received	6	1	2	3	
RP Licenses Issued	8	3	1	4	

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

LICENSED MIDWIVES FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	21	5	4	12	
Applications Pending	N/A	2	3	1	
Applications Withdrawn	1	1	0	0	
Licenses Issued	25	8	3	14	
Licenses Renewed	130	37	43	50	

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	988	375	295	318	
P&S - FNP Issued	929	324	268	337	
P&S - FNP Pending	N/A	N/A	N/A	N/A	
P&S - FNP Renewed	3,815	1,337	1,121	1,357	
Podiatric FNP Received	14	6	7	1	
Podiatric FNP Issued	21	6	9	6	
Podiatric FNP Pending	N/A	N/A	N/A	N/A	
Podiatric FNP Renewed	115	36	35	44	

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

Licensing Program Report

**WORKLOAD REPORT
as of March 31, 2016**

Fiscal Year 2015-2016

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

* Pursuant to: AB 684 (Alejo, Chapter 405): Effective January 1, 2016
The Registered Dispensing Program was transferred to the California State Board of Optometry

Licensing Program Report

WORKLOAD REPORT
as of March 31, 2016

Fiscal Year 2015-2016

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	6		13	12	5		14	11	8		14	6	11		17	9	7		0	0	0	
2112	1	1	0		1	1	0		0	1	0		0	0	0		1	1	1		0	0	0	
2113	6	6	12		4	4	8		5	10	4		18	10	10		15	11	19		0	0	0	
2168	0	2	0		0	2	0		2	0	1		2	2	2		0	2	1		0	0	0	
2072	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	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)

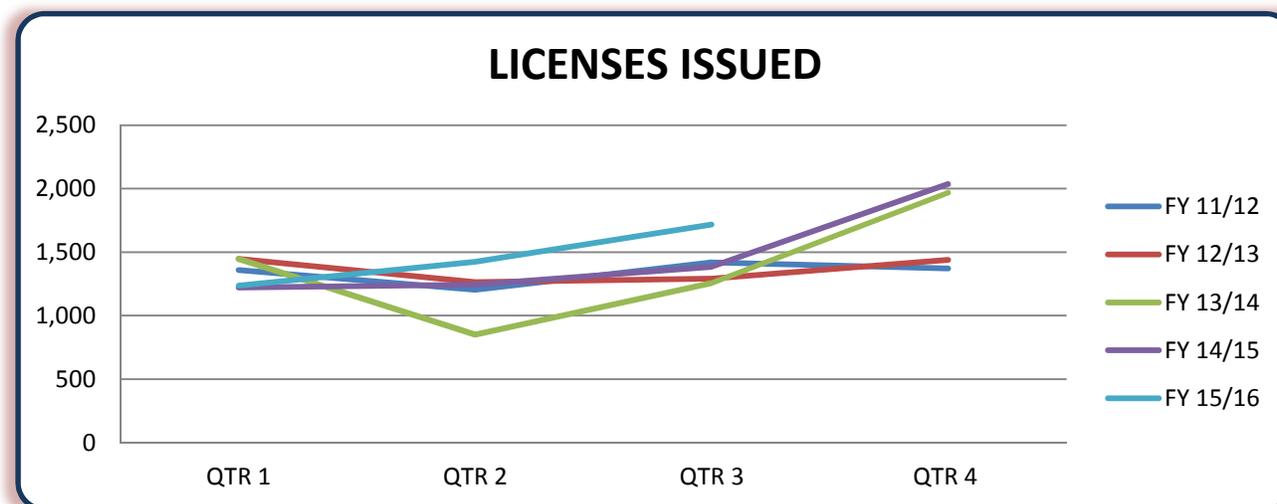
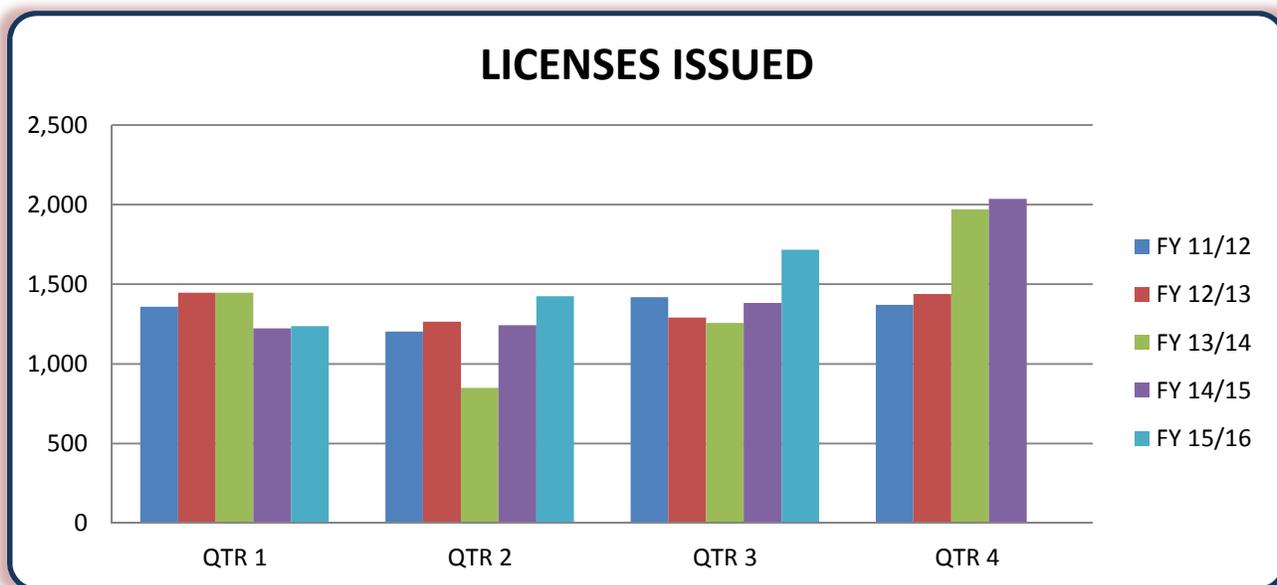
2113 - Medical School Faculty Member (may satisfy postgraduate training required for licensure)

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

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	1,716		4,378
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



*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	2,262	1,732	2,094		6,088
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

**Health Professions Education Foundation (HPEF)
Update April 12, 2016**

Steven M. Thompson Physician Corps Loan Repayment Program (STLRP):

- Thanks to the marketing and outreach assistance from the Medical Board staff, HPEF's cycle for Fiscal Year 2015-16 was very successful.
- STLRP received 186 applications of which 153 proved eligible to score.
 - Of these, 45 fulfilled both HPEF/STLRP criteria and the criteria for The California Endowment funding and are eligible to receive awards. The 45 awards will expend the full amount from TCE for \$4.1 million.
 - Another 108 will be reviewed by the STLRP Selection Committee on March 9. At this time HPEF hopes to award between 25-30 awardees expending the remaining \$2.1 million from the Medical Board licensure fees and the Managed Care Administrative Fines and Penalties Fund.
 - Applicants will be notified by mid-to-end of May of their status.

Other HPEF Scholarship and Loan Repayment Programs:

- HPEF administers 12 other financial incentive programs for medical and mental health professionals. There are six scholarship programs and seven loan repayment programs including STLRP. HPEF is in the process of completing the 2015-16 cycles for these programs by June 30, 2016. The following reflects an approximate number of awards to be made for the different professions.
 - The two mental health programs will be awarding approximately 1600 applicants.
 - The allied health programs will be awarding approximately 46 applicants.
 - The advanced practice healthcare programs will be awarding approximately 80 applicants.
 - The three nursing programs together will be awarding approximately 60 applicants.

Other HPEF News:

- Fiscal Year 2016-17 Application Cycle dates have not been set yet, but should mimic what was done in FY 2015-16:
 - HPEF's six loan repayment program cycles, including the nursing, allied health, advanced practice and mental health programs should open in early August 2016.
 - STLRP cycle should open in early December 2016.
 - The six scholarship programs should open in early January 2017.
- HPEF has six new Board of Trustee members and two are physicians.
- The heaviest period for HPEF's marketing and outreach has begun. HPEF will be visiting campuses, conferences, and workshops the next few months to get the word out for all programs.
 - Quite a few of these events will focus on physicians and future physicians. Please feel free to share with HPEF any events that your board may feel would aid in increasing awareness for HPEF programs.



*New Horizons in Medical Regulation: Successful
Strategies for a Changing Health Care Environment*

Manchester Grand Hyatt San Diego
San Diego, California

**Times and session titles are subject to change

*Denotes sessions for CME credit

Wednesday, April 27, 2016

- 8:30 a.m. – 5:00 p.m. **Administrators in Medicine Annual Meeting**
Coronado Ballroom A-B Members of Administrators in Medicine (AIM), the National Organization for State Medical & Osteopathic Board Executives, will convene for the organization's annual meeting.
- 12:00 – 6:00 p.m. **Annual Meeting and CME Registration**
Seaport Foyer
- 5:30 – 6:30 p.m. **Minnesota Welcome Reception**
Seaport Ballroom F The Minnesota Board of Medical Practice invites all FSMB meeting attendees to its Welcome Reception. The Board encourages meeting attendees to take this opportunity to network with each other, and it looks forward to sharing some Minnesota hospitality.

Thursday, April 28, 2016

- 7:00 a.m. – 5:00 p.m. **Annual Meeting and CME Registration**
Seaport Foyer
- 7:00 – 7:45 a.m. **New Attendee Orientation** (*continental breakfast provided*)
Seaport Ballroom F All first-time meeting attendees, including new state medical board members and staff, are encouraged to sit in on this informative session. This session will walk newcomers through the major highlights and structure of FSMB's Annual Meeting and provide a history of the organization, as well as tips for maneuvering through the next three days.
- 8:00 – 8:30 a.m. **Opening Ceremonies - J. Daniel Gifford, MD, FACP**
Seaport Ballroom A-D During the opening ceremonies, FSMB leaders will emphasize the theme of the meeting – *New Horizons in Medical Regulation* – making the point that over the next several days attendees will explore issues that require regulators to work together in new ways in the changing health care environment.

Invocation:

Rev. Daniel W. Morrissey, OP, Board Member, New Hampshire Board of Medicine

Welcome Remarks:

Dev A. GnanaDev, MD, MBA, Vice President, Medical Board of California
Joseph A. Zammuto, DO, President, Osteopathic Medical Board of California

8:30-9:00 a.m.
Seaport Ballroom A-D

General Session

Perspectives from the U.S. Surgeon General

The Surgeon General of the United States will offer perspectives on current health care issues.

Speaker: Vice Admiral (VADM) Vivek H. Murthy, MD, MBA, 19th United States Surgeon General

9:00 – 9:45 a.m.
Seaport Ballroom A-D

General Session - Your Federation at Work

This session will cover the new and ongoing initiatives and services undertaken by the FSMB as it works with and for its members to improve the quality, safety and integrity of health care.

Speaker: Humayun J. Chaudhry, DO, MACP, President and Chief Executive Officer, Federation of State Medical Boards

Moderator: J. Daniel Gifford, MD, FACP, Chair, Federation of State Medical Boards

9:45 – 10:15 a.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

10:15 – 11:30 a.m.
Seaport Ballroom A-D

***General Session Panel Discussion:**

A 360-Degree View of Patient Safety and Errors

This session will offer an examination of a patient safety investigative case study, offered from the patient’s perspective and examining how a hospital and state medical board responded. This session will include opportunities for audience participation.

Panelists:

David E. Buccigrossi, MD, Kaiser Permanente, San Diego

Patricia J. Skolnik, Founder and President/CEO, Citizens for Patient Safety

Arthur S. Hengerer, MD, Chair-elect, Federation of State Medical Boards

Moderator

Paul W. Larson, MS, Paul Larson Communications

11:30 a.m. – 12:00 p.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

12:00 – 1:30 p.m.
Grand Hall C-D

General Session: Dr. Herbert Platter Lecture Luncheon

Keynote Speaker: Charlie Cook, Editor and Publisher, *Cook Political Report*, and Political Analyst, *National Journal*, will offer insights on the current U.S. political environment.

Moderator: J. Daniel Gifford, MD, FACP, Chair, Federation of State Medical Boards

1:30 – 2:00 p.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

2:00 – 3:15 p.m.

Afternoon Concurrent Sessions

Sessions will be offered concurrently with each other repeated two times, allowing registrants to attend two of the three sessions.

Seaport Ballroom F

***Session 1: Update on Interstate Medical Licensure Compact**

Representatives of the new Interstate Medical Licensure Compact Commission and an expert on state compacts will discuss progress on the Compact, which offers expedited multi-state physician licensing and has been either adopted or introduced for consideration in more than 20 states.

Speakers:

Mark E. Bowden, MPA, Director, Federation of State Medical Boards

Ian Marquand, Executive Officer, Montana Board of Medical Examiners

Rick L. Masters, JD, Special Counsel, National Center for Interstate Compacts, The Council of State Governments

Jon V. Thomas, MD, MBA, Past Chair, Federation of State Medical Boards

Moderator: Donald H. Polk, DO, Immediate Past Chair, Federation of State Medical Boards

Seaport Ballroom G

***Session 2: Legal and Legislative Challenges of the Changing Medical Marijuana Landscape**

A panel of physicians will discuss national trends in medical marijuana use, the state legislative landscape, emerging policies of state medical boards and new regulatory guidelines from FSMB related to the use of medical marijuana.

Speakers:

R. Jeffrey Goldsmith, MD, President, American Society of Addiction Medicine

Eric R. Groce, DO, President, Colorado Medical Board

Howard R. Krauss, MD, Board Member, Medical Board of California

Moderator: Gregory B. Snyder, MD, Director, Federation of State Medical Boards

Seaport Ballroom G

***Session 3: Promoting Quality, Transparency and Accountability in Response to Medical Error: Perspectives from Regulators**

The session will examine the causes and prevention of medical errors, emerging models that promote quality, transparency and accountability, and the challenges of responding to medical errors in an evolving inter-professional health care environment, where care is increasingly delivered by teams.

Speakers:

Thomas H. Gallagher, MD, Associate Chair, Patient Care Quality, Safety and Value, University of Washington School of Medicine

Karen M. McGovern, JD, Executive Director, Colorado Medical Board

Michelle Terry, MD, Chair, Washington State Medical Quality Assurance Commission

Moderator: Michael D. Zanolli, MD, Director, Federation of State Medical Boards

- 3:15 – 3:45 p.m.
Seaport Foyer Break – Exhibits, Posters and Networking
- 3:45 – 5:00 p.m. ***Afternoon Concurrent Sessions Repeated**
- 5:00 – 5:30 p.m.
La Jolla A **Rules Committee**
Witness how the procedural rules used during the House of Delegates meeting are reviewed and recommended.
- 5:30 – 6:30 p.m.
Grand Hall C **Candidates’ Forum**
Candidates for leadership positions will present their views on the future of the FSMB. Attendees are invited to attend this event to personally meet the candidates.
- 6:30 – 7:30 p.m.
Grand Hall D ***Meet the Candidates Reception***

Friday, April 29, 2016

- 6:00 a.m.
Cortez A-B **American Association of Osteopathic Examiners Annual Business Meeting**
Comprised of all osteopathic physicians who sit on state licensing boards, whether it is an osteopathic board or a composite board, the AAOE supports the distinctiveness and integrity of osteopathic medical licensure. The AAOE will convene for its annual business meeting.
- 7:00 a.m. – 5:00 p.m.
Seaport Foyer **Annual Meeting and CME Registration**
- 7:00 – 7:50 a.m.
Hillcrest A-B **Public Members Breakfast** (*continental breakfast provided*)
Public Members of state boards will gather to discuss issues and trends.
- 7:00 – 7:50 a.m.
Seaport Ballroom F **Sunrise Concurrent Sessions** (*continental breakfast provided*)
- *Session 1: *United States Medical Licensing Examination (USMLE) Update***
In this session, participants will learn about changes and trends in the USMLE as well as how state board members can participate in the program. This annual session provides important new information about programs that are central to the day-to-day licensing and regulation of physicians.

Speakers:

Gerard F. Dillon, PhD, Vice President, Licensure Programs, National Board of Medical Examiners (NBME)

David A. Johnson, MA, Senior Vice President, Assessment Services, Federation of State Medical Boards (FSMB)

Peter J. Katsufrakis, MD, MBA, Senior Vice President, Assessment Services, National Board of Medical Examiners (NBME)

Moderator:

Donald E. Melnick, MD, MACP, President, National Board of Medical Examiners (NBME)

Seaport Ballroom G

Session 2: FSMB Technology and Services Update

This session will provide information about the services that FSMB provides to its member boards, including FCVS, PDC and the Uniform Application. The technology update will highlight recent accomplishments and FSMB’s plans for future innovations.

Faculty:

Michael P. Dugan, MBA, Chief Information Officer and Senior Vice President for Operations, Federation of State Medical Boards (FSMB)

8:00 – 9:00 a.m.

Seaport Ballroom E, H

Reference Committees

9:15 – 10:30 a.m.

Seaport Ballroom A-D

***General Session**

Innovations in Medical and Graduate Medical Education

Representatives of the allopathic and osteopathic medical communities will discuss trends and issues in medical and graduate medical education, including emerging innovations and models that will impact medical schools and residency programs.

Panelists:

Timothy P. Brigham, MDiv, PhD, Senior Vice President, Department of Education, Accreditation Council for Graduate Medical Education

Boyd R. Buser, DO, President-Elect, American Osteopathic Association

Susan E. Skochelak, MD, MPH, Group Vice President, Medical Education, American Medical Association

Moderator: Patricia A. King, MD, PhD, FACP, Director, Federation of State Medical Boards

10:30 – 10:45 a.m.

Seaport Foyer

Break – Exhibits, Posters and Networking

10:45 – 11:45 a.m.

Seaport Ballroom A-D

***Dr. Bryant L. Galusha Lecture**

This session honors Dr. Bryant L. Galusha, the FSMB’s chief executive officer from 1984-89, who was instrumental in enhancing the visibility of the FSMB and leading the organization toward a single examination pathway.

What are the Global Challenges Facing Regulation?

Keynote Speaker: Niall M. Dickson, MA, Chief Executive and Registrar, General Medical Council of the United Kingdom; and Chair, International Association of Medical Regulatory Authorities (IAMRA), will discuss emerging global regulatory issues.

Noon – 2:00 p.m.

Grand Hall D

***FSMB Foundation Luncheon**

Attendees will join the FSMB Foundation for its fourth annual luncheon. Space is limited and tickets will be required. Opportunities to sponsor a table (tables of eight) will be available.

Keynote Speakers:

Jenny Doll, Special Agent, State of California Department of Justice, Office of the Attorney General

John Niedermann, JD, Deputy District Attorney, Los Angeles County District Attorney's Office

Mr. Niedermann and Ms. Doll will discuss the case of California physician Hsiu-Ying "Lisa" Tseng, who last year was convicted of murder for recklessly prescribing drugs to patients. Mr. Niedermann was the prosecutor in the case, and Ms. Doll worked on the case as the special agent with the California Department of Justice.

2:00 – 3:15 p.m.

Afternoon Concurrent Sessions

Sessions will be offered concurrently with each other repeated two times, allowing registrants to attend two of the three sessions.

Seaport Ballroom F

***Session 1: Physician Workforce Projections: Implications and Issues for State Medical Boards**

This session will examine trends in the physician workforce, including projections for future workforce needs and enrollment levels in medical schools and graduate medical education programs.

Speakers:

Tyler Cymet, DO, FACP, FACOPF, Chief, Clinical Education, American Association of Colleges of Osteopathic Medicine

Len Marquez, Director, Government Relations, Association of American Medical Colleges

Moderator: Stephen E. Heretick, JD, Director, Federation of State Medical Boards

Seaport Ballroom G

***Session 2: Understanding Current Legal and Regulatory Trends in Telemedicine**

Panelists will discuss legislative and regulatory trends in telemedicine, including developments from state medical boards, pending legal cases, federal developments and emerging guidelines.

Speakers:

Jack S. Resneck, Jr., MD, Board of Trustees, American Medical Association

Lisa A. Robin, MLA, Chief Advocacy Officer, Federation of State Medical Boards

Kenneth B. Simons, MD, Chairperson, Wisconsin Medical Examining Board

Moderator: Mark A. Eggen, MD, Director, Federation of State Medical Boards

Seaport Ballroom H

***Session 3: Communication and the Use of Social Media in a Regulatory Environment**

In this session, participants will learn about the best practices and current uses of social media by regulatory agencies, including how social media and other forms of communication are used to publicize board news and information, as well as public disciplinary actions.

Speakers:

Evelyn Contre, MBA, Chief Communications Officer, North Carolina Medical Board

Debbie Jorgenson, Administrative Assistant, Iowa Board of Pharmacy

Micah T. Matthews, MPA, Deputy Executive Director, Washington Medical Quality Assurance Commission

Joey Ridenour, RN, MN, FAAN, Executive Director, Arizona State Board of Nursing

Moderator: Jerry G. Landau, JD, Director, Federation of State Medical Boards

3:15 – 3:45 p.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

3:45 – 5:00 p.m.

***Afternoon Concurrent Sessions Repeated**

5:30 – 7:00 p.m.
Marina Courtyard

Reception hosted by the Alabama State Board of Medical Examiners

Saturday, April 30, 2016

7:00 a.m. – Noon
Seaport Foyer

Annual Meeting and CME Registration

7:00 – 7:50 a.m.

Sunrise Concurrent Sessions (*continental breakfast provided*)

Seaport Ballroom F

***Session 1:** *National Board of Osteopathic Medical Examiners and the Comprehensive Osteopathic Medical Licensing Examination of the United States (COMLEX-USA) Update*

In this session, participants will hear all of the latest developments and news from NBOME about COMLEX-USA, the Comprehensive Osteopathic Medical Licensing Examination. This annual session provides important new information about programs that are central to the day-to-day licensing and regulation of osteopathic physicians.

Speaker:

John R. Gimpel, DO, MEd, President and Chief Executive Officer, National Board of Osteopathic Medical Examiners

Seaport Ballroom G

Session 2: *FSMB Technology and Services Update*

This session will provide information about the services that FSMB provides to its member boards, including FCVS, PDC and the Uniform Application. The technology update will highlight recent accomplishments and FSMB's plans for future innovations.

Speaker:

Michael P. Dugan, MBA, Chief Information Officer and Senior Vice President for Operations, Federation of State Medical Boards (FSMB)

8:00 – 9:15 a.m.
Seaport Ballroom A-D

***Joint Session: Federation of State Physician Health Programs (FSPHP) and Federation of State Medical Boards (FSMB)**

Navigating Successful PHP and Licensure Board Relationships

In this annual session, participants will learn about successful Physician Health Programs (PHPs) and hear updates about how state medical boards and PHPs are working together in new ways.

Speakers:

Doris C. Gundersen, MD, President, Federation of State Physician Health Programs

P. Bradley Hall, MD, President-Elect, Federation of State Physician Health Programs

Robert C. Knittle, MS, Executive Director, West Virginia Board of Medicine

Nathan M. Thomas, DPM, President, Montana Board of Medical Examiners

Moderator: J. Daniel Gifford, MD, FACP, Chair, Federation of State Medical Boards

9:15 – 9:30 a.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

9:30 – 10:30 a.m.
Seaport Ballroom A-D

***General Session**

Interprofessional Collaboration and Regulation

This session will examine developments in the new environment for team-based care in the United States, including trends and perspectives from the physician and nursing communities.

Speakers:

Shirley M. Brekken, MS, RN, National Council of State Boards of Nursing

Ruth M. Martinez, MA, Executive Director, Minnesota Board of Medical Practice

William M. Sage, MD, JD, Professor, The University of Texas at Austin, Dell Medical School, and The University of Texas at Austin, School of Law

Moderator:

Ralph C. Loomis, MD, Treasurer, Federation of State Medical Boards

10:30 – 11:15 a.m.
Seaport Ballroom A-D

FSMB Awards Presentation

J. Daniel Gifford, MD, FACP, and Humayun J. Chaudhry, DO, MACP

Honorees will be recognized and receive the FSMB's highest awards, including the Distinguished Service Award, the John H. Clark, M.D. Leadership Award, the Award of Merit and the Lifetime Achievement Award.

11:15 – 11:30 a.m.
Seaport Foyer

Break – Exhibits, Posters and Networking

11:30 -12:30 p.m.
Seaport Ballrooms E, F, G, H

Regional Board Forums (4 groups)

12:30 – 1:45 p.m.
Gaslamp A-B

Public Members Forum (*boxed lunches provided*)

During this session, meeting faculty will discuss the special role public members have and the importance of public member participation in medical regulation. Faculty will also discuss the possibility of establishing a Public Members Taskforce. The session will be useful for both veteran public members and those just beginning their term of service on a state medical board.

12:30 – 1:45 p.m.
Gaslamp C-D

Physician Assistant Forum (*boxed lunches provided*)

This session will focus on the licensing and regulation of Physician Assistants. The session will include licensing data specifically on PA's as well as common disciplinary issues state medical boards share.

12:30 – 1:45 p.m.
Grand Hall D

Board Attorney Roundtable (*boxed lunches provided*)

The dialogue at this session will focus on board attorneys as they share and exchange valuable information on case experiences, best practices and current challenges. Attendees will focus their attention on discussing issues pertinent to a medical board attorney.

Speakers:

Ruth A. Carter, MBA, Chief, Liaison and Policy Section, Office of Diversion Control, Drug Enforcement Administration

Kathleen J. Selzler Lippert, JD, Executive Director, Kansas State Board of Healing Arts

Aaron Young, PhD, Assistant Vice President, Research and Data Integration, Federation of State Medical Boards

Note: This session is open only to representatives of state medical and osteopathic boards.

2:00 – 4:00 p.m.
Grand Hall C

House of Delegates

The annual business meeting of the House of Delegates is open to all attendees.

6:00 – 6:30 p.m.
Seaport Foyer

Chair's Reception

6:30 – 7:30 p.m.
Seaport Ballroom A-D

Investiture of the Chair (*black tie optional*)

Arthur S. Hengerer, MD, will be installed as chair and elected officers and directors will be recognized during the occasion.

7:30 p.m.
Seaport Ballroom F-H

Dr. Walter L. Bierring Dinner and Entertainment (*black tie optional*)

This event celebrates the installation of the FSMB's new leadership team and honors Dr. Bierring, a pivotal leader during the FSMB's formative years. Dr. Bierring edited the *Federation Bulletin* (now the *Journal of Medical Regulation*) for 45 years while simultaneously serving as the organization's secretary and treasurer.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 19, 2016
 ATTENTION: Members, Medical Board of California
 SUBJECT: Overview of the Sunset Review Process
 STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

This report is intended to provide the Members with an overview of the sunset review process for the Medical Board of California (Board). Included in this report is a section entitled New Issues. After review and consideration of the New Issues section, determine which items the Board Members want to direct staff to present as issues in the Board's Sunset Report.

Background on the Sunset Review Process:

Every board/bureau/committee under the auspices of the Department of Consumer Affairs (DCA), as well as other regulatory entities, goes through a sunset review process every four years (unless the legislature has requested a shorter time frame between reviews). The timing of a board's sunset review process is usually in coordination with the date set in statute for the repeal of the laws pertaining to that board, or its "sunset date." For example, Business and Professions Code section 2001, which authorizes the Board, is repealed as of January 1, 2018, unless a later enacted statute deletes or extends that date. The purpose of the sunset review process is to determine if the board/bureau/committee is performing its mission of consumer protection and to identify any areas where the Legislature believes improvements need to be made.

The sunset review process is overseen jointly by the Senate Business, Professions, and Economic Development Committee and the Assembly Business and Professions Committee. The process is usually initiated in the spring two years prior to the sunset date set in statute. The sunset review process begins by the Committees sending out a questionnaire to the Board requesting completion by the following November or December. This questionnaire requests information on a wide variety of issues, including, but not limited to Board Members, legislation, regulations, major studies, performance measures, customer satisfaction surveys, budget and staffing information, licensing and enforcement program information, public information policies, unlicensed activity, and workforce development and job creation. The questionnaire also discusses current issues, which could include the implementation of the Uniform Standards, the Consumer Protection Enforcement Initiative regulations, BreZE, and any other issues the Committees would like the Board to address. The next section of the questionnaire covers issues that had been brought up under the Board's prior sunset review and what action the Board took to address the issues that were raised. Lastly, the questionnaire asks for any new issues that have been raised to or by the Board and any recommended solutions to these issues where the Committees may be of assistance. This is also the section where the Board would address any issues that had been raised in a prior sunset review process that had not been addressed.

As of the date of this report, the Board has not received the sunset review questionnaire. However, **Attachment A** provides a sample of the questionnaire that was used for the boards under sunset review in 2015-2016.

Upon receipt of the questionnaire, Board staff work to develop a report that addresses all the questions in the document. Staff will develop a task plan and identify the staff that will work on each section and the due dates for the responses. Staff completes a questionnaire for each allied health entity under the Board's jurisdiction too. Upon completion of the report, the Board Members would review and approve the report. Depending

upon the timing of the receipt of the questionnaire and the due date for the report, this review may be conducted at a quarterly Board meeting or may need to take place at a special in-person meeting of the Board.

Another factor that impacts the completion of the report is that most of the data and information requested needs to go through the end of fiscal year 2015-2016, which is June 30, 2016. Therefore, reports for that specific year cannot even begin until July 2016. Ideally, the narrative of the report should be based upon the data provided. Therefore, it is difficult to provide a draft report to the Members at the July 2016 Board meeting. However, Board staff will determine if some of the narrative can be provided at that meeting for review, discussion, and approval. The Board President may wish to assign a subcommittee of the Board to assist staff in the review prior to the October 2016 meeting to oversee the preparation of the report.

Once the Board approves the report, it is submitted to the Committees. Between December and February of the following year, the Committees' staff reviews the Board's report and develops a background paper. This background paper is a snapshot of the Board's report and also includes identified issues and recommendations regarding the Board, including comments on the issues raised by the Board itself. The joint Committees then set a Legislative Hearing, which is usually set in March. Prior to the March hearing, Committee staff will contact the Board to identify the issues upon which they are seeking Board testimony. Usually, the Board President and Executive Director attend the hearing, provide testimony, address the issues raised by the Committees, and respond to any questions from the Committee Members. At the hearing, comments are also heard by members of the public, associations, etc. In some situations, the Executive Director, Chief of Legislation, and Board President may attend meetings with Members of the Committees prior to the hearing to address any specific concerns and answer any questions.

After the hearing, the Board is usually provided 30 days to provide a written response to all the issues raised in the background report. This document does not have to be reviewed and approved by the Board, but should be reviewed and approved by the Board President and/or Vice President or a subcommittee of the Board if one is appointed. These responses are then provided to the Committees.

After the hearing, the Legislature may 1) extend the sunset date of the Board, which is usually extended for four years unless there are major concerns and then it may be only extended for one or two years; 2) let the Board and its statutes/regulations sunset; or 3) sunset the Board and move its regulatory functions under DCA as a bureau. Should the Legislature decide to extend the Board's sunset date, one of the Committees will author a bill that will then go through the legislative process. This bill will also contain any changes to the Board's laws that may have been brought up as issues by the Board, a Committee Member, or the background paper.

Prior Sunset Report Issues:

The Board's last Sunset Review Report was completed in 2012 and the hearing was held in 2013. The background paper that was provided to the Board contained 39 issues where the Board had to provide responses. It is important to note that 20 of the issues were issues identified by the Board in its Sunset Review Report. **Attachment B** provides a listing of the 39 issues for the Board during the last sunset review process. Almost all of the issues have been addressed and completed. With the exception of issue number 4, those that are pending are those that need additional discussion with the Committees to determine if they are still warranted or if further action is needed. Board staff will be working with Committee staff to determine how to proceed on these matters.

Possible New Sunset Issues:

As indicated above, part of the sunset review process is the Board bringing up new issues that have been raised to or by the Board and any recommended solutions to these issues where the Committees may be of assistance. Board staff has identified several issues that should be placed in this section of the report. In addition, a few issues have been raised at Board meetings by Board Members. The Board Members should review each of these issues to determine if Board staff should include the issues in the sunset review report. In addition, Board Members should determine if any additional issues should be brought forward in the report.

- **Expiration date of licenses:** Currently, a physician pays a full licensure fee at the time of application or when they have been notified that their application is complete and is ready for licensure. The Board's laws state that the expiration of a license is determined by the birth month of the physician. Depending upon when the applicant's licensure file is complete, the physician could be paying a full licensure fee for 13-23 months, instead of the full 24 months (or two years). Legislation has been proposed, but not passed, that would require proration of the Board's licensure fees. However, in order to prorate, the Board would have to change several business processes and the BreZE system. In addition, proration will result in additional time for licensure based upon these business process changes. Therefore, staff is requesting that the expiration date be two years from the month of issuance instead of the birth month. The Board supported this legislative change previously, but the provision of the bill related to the Board was removed from the bill.
- **Postgraduate Training Requirements:** The Board has requested discussion on the issue of lengthening the years required for postgraduate training from one or two years (U.S./Canadian applicant or International Medical Graduate applicant) to two or three years. There has been extensive discussion by the Board and an interested parties meeting regarding this issue.
- **Data Collection for Outpatient Surgery Settings (OSS):** In 2015, the Board sought legislation that would require OSSs to provide certain data to the Board. Currently, any OSS that is licensed by the California Department of Public Health is required to report aggregate utilization and patient encounter data to the Office of Statewide Health, Planning and Development (OSHPD). However, most OSSs are required to be accredited instead of licensed, and therefore there is no requirement to report data to OSHPD. This has resulted in a serious deficiency of OSS data for accredited outpatient surgery settings. The requirements for reporting were originally placed into Senate Bill (SB) 396 (Hill, 2015), however, due to opposition and the need for further discussion, the requirements were removed. The Board agreed to work with interested parties to determine what specific information was actually needed for the Board and for trend analysis. The Board has an interested parties meeting scheduled for May 26, 2016 to discuss this issue.
- **Amendments to Adverse Event Reporting for OSSs:** SB 304 (Lieu, 2013) required OSSs to report certain adverse events to the Board. The events required to be reported are those included in Health and Safety Code section 1279.1, which are the same requirements for a hospital to report. OSSs are different than hospitals and the reporting requirements should be tailored to an OSS and not a hospital.
- **Posting of Information Related to a Probationary License:** 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 (Business and Professions Code section 2221), it is not specified in law how long that information should be made available to the public. This information should follow the law related to physicians placed on probation, and the documents related to probationary licenses should be posted on the Board's website as long as they are public.

- **Reporting Penalties for 805.01:** SB 700 (Negrete McLeod, 2010) required entities to report peer review findings to the Board after a final decision recommendation but prior to the action being taken (which would require reporting pursuant to Business and Professions Code section 805). The required reporting is only to be reported if certain findings are made – incompetence or gross or repeated deviation from the standard of care involving death or serious bodily injury, self-prescribing controlled substances, the use of any dangerous drug or alcohol to the extent or in such a manner as to be dangerous to the licensee or another person, repeated acts of clearly excessive prescribing, and sexual misconduct with a patient during the course of treatment or examination. This “805.01 report” would be received prior to the filing of an “805 report.” The statistics over the past several years, since the bill was implemented indicates that entities are not providing these reports. In fiscal year (FY) 11/12 to FY 14/15 the number of 805.01 reports received by the Board was 16, 9, 2, and 4, respectively. During that same timeframe, the Board received on average 104 805 reports each year. The Board believes entities are not submitting 805.01 reports as required. One issue that could be a factor in not reporting is that there is no penalty for failing to report pursuant to section 805.01. However, if an entity fails to file an 805 report, they can receive a fine of up to \$50,000 per violation for failing to submit the report to the Board or \$100,000 per violation if it is determined that the failure to report was willful.
- **Enforcement Program Clean Up:** There are a few legislative changes that would improve the enforcement process including, strengthening Business and Professions Code section 2334 regarding the exchange of expert witness information, which was in the prior sunset review report; strengthening the subpoena enforcement process; and amending Government Code section 11529(f) to add in petitions to revoke probation.
- **Licensing Program Clean Up:** Business and Professions Code section 2420 governs provisions for license renewal of several license types under the jurisdiction of the Board. However, with the movement of the Registered Dispensing Optician Program and other allied health professions that used to be under the jurisdiction of the Board, amendments need to be made for consistency.
- **Health Professions Education Foundation (HPEF) Membership:** Until January 1, 2016, the Board was required to appoint two standing Board Members to the HPEF. The HPEF improves access to healthcare in underserved areas of California by providing scholarships, loan repayments, and programs to health professional students and graduates who are dedicated to providing direct patient care in those areas. In return for this support, individuals agree to provide direct patient care in an underserved area of California for one to three years. On January 1, 2016, the Board’s participation on HPEF was sunset. As the HPEF oversees the awarding of loan repayments from the Stephen M. Thompson Loan Repayment Program, the Board should remain involved and should have members on the HPEF.
- **Specialty Board Approval:** Business and Professions Code section 651(h) prohibits physicians from advertising they are "board certified" or "board eligible" unless they are certified by any of the following: 1) An ABMS approved specialty board; 2) A board that has specialty training that is approved by the Accreditation Council for Graduate Medical Education (ACGME); or 3) A board that has met requirements equivalent to ABMS and has been approved by the Board. The law asks the Board to essentially perform most of the same tasks as the ABMS, the ACGME, and the specialty boards and their residency review committees – with a fraction of their resources. For an ABMS specialty board to become recognized, it takes years, developing model training standards for the specialty, establishing residency training programs at medical schools and medical facilities, operating training programs and obtaining accreditation, undergoing regular oversight by residency review committees, etc. All of the individuals within this system are experts in medical training and the specialty. In addition, since the program's inception, the Board has only denied two specialty boards. The first specialty board filed four suits against the Board, including one in Federal Court. The second

specialty board applied for approval twice, was denied both times, and filed suit on the second denial. The Board and the law have prevailed in all litigation, but the cost was considerable. This statute should be amended to strike the option of seeking recognition as a specialty board by the Board, while continuing to recognize the four specialty boards already approved by the Board.

[BOARD NAME]
BACKGROUND INFORMATION AND OVERVIEW OF THE CURRENT REGULATORY PROGRAM
As of [date]

Section 1 – Background and Description of the Board and Regulated Profession

Provide a short explanation of the history and function of the board.¹ Describe the occupations/profession that are licensed and/or regulated by the board (Practice Acts vs. Title Acts).

1. Describe the make-up and functions of each of the board’s committees (cf., Section 12, Attachment B).

Table 1a. Attendance			
[Enter board member name]			
Date Appointed:		[Enter date appointed]	
Meeting Type	Meeting Date	Meeting Location	Attended?
Meeting 1	[Enter Date]	[Enter Location]	[Y/N]
Meeting 2	[Enter Date]	[Enter Location]	[Y/N]
Meeting 3	[Enter Date]	[Enter Location]	[Y/N]
Meeting 4	[Enter Date]	[Enter Location]	[Y/N]

Table 1b. Board/Committee Member Roster					
Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)

2. In the past four years, was the board unable to hold any meetings due to lack of quorum? If so, please describe. Why? When? How did it impact operations?
3. Describe any major changes to the board since the last Sunset Review, including:
 - Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)

¹ The term “board” in this document refers to a board, bureau, commission, committee, department, division, program, or agency, as applicable. Please change the term “board” throughout this document to appropriately refer to the entity being reviewed.

- All legislation sponsored by the board and affecting the board since the last sunset review.
 - All regulation changes approved by the board the last sunset review. Include the status of each regulatory change approved by the board.
4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).
 5. List the status of all national associations to which the board belongs.
 - Does the board’s membership include voting privileges?
 - List committees, workshops, working groups, task forces, etc., on which board participates.
 - How many meetings did board representative(s) attend? When and where?
 - If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

Section 2 – Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report for the board as published on the DCA website
7. Provide results for each question in the board’s customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Describe the board’s current reserve level, spending, and if a statutory reserve level exists.
9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

Table 2. Fund Condition						
(Dollars in Thousands)	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17
Beginning Balance						
Revenues and Transfers						
Total Revenue	\$	\$	\$	\$	\$	\$
Budget Authority						
Expenditures						
Loans to General Fund						
Accrued Interest, Loans to General Fund						
Loans Repaid From General Fund						
Fund Balance	\$	\$	\$	\$	\$	\$

Months in Reserve					
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10. Describe the history of general fund loans. When were the loans made? When have payments been made to the board? Has interest been paid? What is the remaining balance?

11. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Table 3. Expenditures by Program Component									(list dollars in thousands)
	FY 2011/12		FY 2012/13		FY 2013/14		FY 2014/15		
	Personnel Services	OE&E							
Enforcement									
Examination									
Licensing									
Administration *									
DCA Pro Rata									
Diversion (if applicable)									
TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	\$

*Administration includes costs for executive staff, board, administrative support, and fiscal services.

12. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

Table 4. Fee Schedule and Revenue								(list revenue dollars in thousands)
Fee	Current Fee Amount	Statutory Limit	FY 2011/12 Revenue	FY 2012/13 Revenue	FY 2013/14 Revenue	FY 2014/15 Revenue	% of Total Revenue	

13. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)								
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	\$ Requested	\$ Approved	\$ Requested	\$ Approved

Staffing Issues

- 14. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.
- 15. Describe the board's staff development efforts and how much is spent annually on staff development (cf., Section 12, Attachment D).

Section 4 – Licensing Program

- 16. What are the board's performance targets/expectations for its licensing² program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
- 17. Describe any increase or decrease in the board's average time to process applications, administer exams and/or issue licenses. Have pending applications grown at a rate that exceeds completed applications? If so, what has been done by the board to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?
- 18. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

Table 6. Licensee Population					
		FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				

² The term "license" in this document includes a license certificate or registration.

Table 7a. Licensing Data by Type											
	Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2011/12	(Exam)					-	-	-	-	-	-
	(License)					-	-	-	-	-	-
	(Renewal)			n/a		-	-	-	-	-	-
FY 2012/13	(Exam)										
	(License)										
	(Renewal)			n/a							
FY 2013/14	(Exam)										
	(License)										
	(Renewal)			n/a							

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data				
	FY 2012/13	FY 2013/14	FY 2014/15	
Initial Licensing Data:				
Initial License/Initial Exam Applications Received				
Initial License/Initial Exam Applications Approved				
Initial License/Initial Exam Applications Closed				
License Issued				
Initial License/Initial Exam Pending Application Data:				
Pending Applications (total at close of FY)				
Pending Applications (outside of board control)*				
Pending Applications (within the board control)*				
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):				
Average Days to Application Approval (All - Complete/Incomplete)				
Average Days to Application Approval (incomplete applications)*				
Average Days to Application Approval (complete applications)*				
License Renewal Data:				
License Renewed				

* Optional. List if tracked by the board.

19. How does the board verify information provided by the applicant?
- a. What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?
 - b. Does the board fingerprint all applicants?
 - c. Have all current licensees been fingerprinted? If not, explain.

- d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?
 - e. Does the board require primary source documentation?
20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.
21. Describe the board's process, if any, for considering military education, training, and experience for purposes of licensing or credentialing requirements, including college credit equivalency.
- a. Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?
 - b. How many applicants offered military education, training or experience towards meeting licensing or credentialing requirements, and how many applicants had such education, training or experience accepted by the board?
 - c. What regulatory changes has the board made to bring it into conformance with BPC § 35?
 - d. How many licensees has the board waived fees or requirements for pursuant to BPC § 114.3, and what has the impact been on board revenues?
 - e. How many applications has the board expedited pursuant to BPC § 115.5?
22. Does the board send No Longer Interested notifications to DOJ on a regular and ongoing basis? Is this done electronically? Is there a backlog? If so, describe the extent and efforts to address the backlog.

Examinations

Table 8. Examination Data			
California Examination (include multiple language) if any:			
	License Type		
	Exam Title		
FY 2011/12	# of 1 st Time Candidates		
	Pass %		
FY 2012/13	# of 1 st Time Candidates		
	Pass %		
FY 2013/14	# of 1 st Time Candidates		
	Pass %		
FY 2014/15	# of 1 st time Candidates		
	Pass %		
	Date of Last OA		
	Name of OA Developer		
	Target OA Date		
National Examination (include multiple language) if any:			
	License Type		
	Exam Title		
FY 2011/12	# of 1 st Time Candidates		
	Pass %		

FY 2012/13	# of 1 st Time Candidates			
	Pass %			
FY 2013/14	# of 1 st Time Candidates			
	Pass %			
FY 2014/15	# of 1 st time Candidates			
	Pass %			
Date of Last OA				
Name of OA Developer				
Target OA Date				

23. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?
24. What are pass rates for first time vs. retakes in the past 4 fiscal years? (*Refer to Table 8: Examination Data*)
25. Is the board using computer based testing? If so, for which tests? Describe how it works. Where is it available? How often are tests administered?
26. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

School approvals

27. Describe legal requirements regarding school approval. Who approves your schools? What role does BPPE have in approving schools? How does the board work with BPPE in the school approval process?
28. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?
29. What are the board’s legal requirements regarding approval of international schools?

Continuing Education/Competency Requirements

30. Describe the board’s continuing education/competency requirements, if any. Describe any changes made by the board since the last review.
 - a. How does the board verify CE or other competency requirements?
 - b. Does the board conduct CE audits of licensees? Describe the board’s policy on CE audits.
 - c. What are consequences for failing a CE audit?
 - d. How many CE audits were conducted in the past four fiscal years? How many fails? What is the percentage of CE failure?
 - e. What is the board’s course approval policy?
 - f. Who approves CE providers? Who approves CE courses? If the board approves them, what is the board application review process?
 - g. How many applications for CE providers and CE courses were received? How many were approved?

- h. Does the board audit CE providers? If so, describe the board’s policy and process.
- i. Describe the board’s effort, if any, to review its CE policy for purpose of moving toward performance based assessments of the licensee’s continuing competence.

Section 5 – Enforcement Program

- 31. What are the board’s performance targets/expectations for its enforcement program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
- 32. Explain trends in enforcement data and the board’s efforts to address any increase in volume, timeframes, ratio of closure to pending cases, or other challenges. What are the performance barriers? What improvement plans are in place? What has the board done and what is the board going to do to address these issues, i.e., process efficiencies, regulations, BCP, legislation?

Table 9a. Enforcement Statistics			
	FY 2012/13	FY 2013/14	FY 2014/15
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received			
Closed			
Referred to INV			
Average Time to Close			
Pending (close of FY)			
Source of Complaint (Use CAS Report 091)			
Public			
Licensee/Professional Groups			
Governmental Agencies			
Other			
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received			
CONV Closed			
Average Time to Close			
CONV Pending (close of FY)			
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied			
SOIs Filed			
SOIs Withdrawn			
SOIs Dismissed			
SOIs Declined			
Average Days SOI			
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed			
Accusations Withdrawn			
Accusations Dismissed			
Accusations Declined			
Average Days Accusations			
Pending (close of FY)			

Table 9b. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions			
Stipulations			
Average Days to Complete			
AG Cases Initiated			
AG Cases Pending (close of FY)			
Disciplinary Outcomes (Use CAS Report 096)			
Revocation			
Voluntary Surrender			
Suspension			
Probation with Suspension			
Probation			
Probationary License Issued			
Other			
PROBATION			
New Probationers			
Probations Successfully Completed			
Probationers (close of FY)			
Petitions to Revoke Probation			
Probations Revoked			
Probations Modified			
Probations Extended			
Probationers Subject to Drug Testing			
Drug Tests Ordered			
Positive Drug Tests			
Petition for Reinstatement Granted			
DIVERSION			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			

Table 9c. Enforcement Statistics (continued)			
	FY 2012/13	FY 2013/14	FY 2014/15
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned			
Closed			
Average days to close			
Pending (close of FY)			
Desk Investigations (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed			
Average days to close			
Pending (close of FY)			
Sworn Investigation			
Closed (Use CAS Report EM 10)			
Average days to close			
Pending (close of FY)			
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued			
PC 23 Orders Requested			
Other Suspension Orders			
Public Letter of Reprimand			
Cease & Desist/Warning			
Referred for Diversion			
Compel Examination			
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued			
Average Days to Complete			
Amount of Fines Assessed			
Reduced, Withdrawn, Dismissed			
Amount Collected			
CRIMINAL ACTION			
Referred for Criminal Prosecution			

Table 10. Enforcement Aging						
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year						
2 Years						
3 Years						
4 Years						
Over 4 Years						
Total Cases Closed						
Investigations (Average %)						
Closed Within:						
90 Days						
180 Days						
1 Year						
2 Years						
3 Years						
Over 3 Years						
Total Cases Closed						

33. What do overall statistics show as to increases or decreases in disciplinary action since last review.
34. How are cases prioritized? What is the board's compliant prioritization policy? Is it different from DCA's *Complaint Prioritization Guidelines for Health Care Agencies* (August 31, 2009)? If so, explain why.
35. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report to the board actions taken against a licensee. Are there problems with the board receiving the required reports? If so, what could be done to correct the problems?
36. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases have been lost due to statute of limitations? If not, what is the board's policy on statute of limitations?
37. Describe the board's efforts to address unlicensed activity and the underground economy.

Cite and Fine

38. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and describe the last time regulations were updated and any changes that were made. Has the board increased its maximum fines to the \$5,000 statutory limit?
39. How is cite and fine used? What types of violations are the basis for citation and fine?
40. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals of a citation or fine in the last 4 fiscal years?
41. What are the 5 most common violations for which citations are issued?
42. What is average fine pre- and post- appeal?
43. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Cost Recovery and Restitution

- 44. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.
- 45. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.
- 46. Are there cases for which the board does not seek cost recovery? Why?
- 47. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.
- 48. Describe the board's efforts to obtain restitution for individual consumers, any formal or informal board restitution policy, and the types of restitution that the board attempts to collect, i.e., monetary, services, etc. Describe the situation in which the board may seek restitution from the licensee to a harmed consumer.

Table 11. Cost Recovery					(list dollars in thousands)
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	
Total Enforcement Expenditures					
Potential Cases for Recovery *					
Cases Recovery Ordered					
Amount of Cost Recovery Ordered					
Amount Collected					
* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.					

Table 12. Restitution					(list dollars in thousands)
	FY 2011/12	FY 2012/13	FY 2013/14	FY 2014/15	
Amount Ordered					
Amount Collected					

Section 6 – Public Information Policies

- 49. How does the board use the internet to keep the public informed of board activities? Does the board post board meeting materials online? When are they posted? How long do they remain on the board's website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?
- 50. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings? How long to webcast meetings remain available online?
- 51. Does the board establish an annual meeting calendar, and post it on the board's web site?
- 52. Is the board's complaint disclosure policy consistent with DCA's *Recommended Minimum Standards for Consumer Complaint Disclosure*? Does the board post accusations and disciplinary actions consistent with DCA's *Web Site Posting of Accusations and Disciplinary Actions* (May 21, 2010)?

53. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

54. What methods are used by the board to provide consumer outreach and education?

Section 7 – Online Practice Issues

55. Discuss the prevalence of online practice and whether there are issues with unlicensed activity. How does the board regulate online practice? Does the board have any plans to regulate internet business practices or believe there is a need to do so?

Section 8 – Workforce Development and Job Creation

56. What actions has the board taken in terms of workforce development?

57. Describe any assessment the board has conducted on the impact of licensing delays.

58. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

59. Provide any workforce development data collected by the board, such as:

- a. Workforce shortages
- b. Successful training programs.

Section 9 – Current Issues

60. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

61. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

62. Describe how the board is participating in development of BreZE and any other secondary IT issues affecting the board.

Section 10 – Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.
2. Short discussion of recommendations made by the Committees/Joint Committee during prior sunset review.

3. What action the board took in response to the recommendation or findings made under prior sunset review.
4. Any recommendations the board has for dealing with the issue, if appropriate.

Section 11 – New Issues

This is the opportunity for the board to inform the Committees of solutions to issues identified by the board and by the Committees. Provide a short discussion of each of the outstanding issues, and the board's recommendation for action that could be taken by the board, by DCA or by the Legislature to resolve these issues (i.e., policy direction, budget changes, legislative changes) for each of the following:

1. Issues that were raised under prior Sunset Review that have not been addressed.
2. New issues that are identified by the board in this report.
3. New issues not previously discussed in this report.
4. New issues raised by the Committees.

Section 12 – Attachments

Please provide the following attachments:

- A. Board's administrative manual.
- B. Current organizational chart showing relationship of committees to the board and membership of each committee (cf., Section 1, Question 1).
- C. Major studies, if any (cf., Section 1, Question 4).
- D. Year-end organization charts for last four fiscal years. Each chart should include number of staff by classifications assigned to each major program area (licensing, enforcement, administration, etc.) (cf., Section 3, Question 15).

Section 13 – Board Specific Issues

THIS SECTION ONLY APPLIES TO SPECIFIC BOARDS, AS INDICATED BELOW.

Diversion

Discuss the board's diversion program, the extent to which it is used, the outcomes of those who participate, the overall costs of the program compared with its successes

Diversion Evaluation Committees (DEC) (for BRN, Dental, Osteo and VET only)

1. DCA contracts with a vendor to perform probation monitoring services for licensees with substance abuse problems, why does the board use DEC? What is the value of a DEC?
2. What is the membership/makeup composition?
3. Did the board have any difficulties with scheduling DEC meetings? If so, describe why and how the difficulties were addressed.
4. Does the DEC comply with the Open Meetings Act?
5. How many meetings held in each of the last three fiscal years?
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. How is DEC used? What types of cases are seen by the DEC?
11. How many DEC recommendations have been rejected by the board in the past four fiscal years (broken down by year)?

Disciplinary Review Committees (Board of Barbering and Cosmetology and BSIS only)

1. What is a DRC and how is a DRC used? What types of cases are seen by the DRCs?
2. What is the membership/makeup composition?
3. Does the DRC comply with the Open Meetings Act?
4. How many meeting held in last three fiscal years?
5. Did the board have any difficulties with scheduling DRC meetings? If so, describe why and how the difficulties were addressed.
6. Who appoints the members?
7. How many cases (average) at each meeting?
8. How many pending? Are there backlogs?
9. What is the cost per meeting? Annual cost?
10. Provide statistics on DRC actions/outcomes.

Board Recommendation (B)=20 Committee Recommendation (C)=19

ATTACHMENT B

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
1	Licensing	C	How many physicians and surgeons have been exempted from licensure under AB 2699?	The MBC should inform the Committee how many physicians and surgeons have been exempted from licensure pursuant to the regulations adopted to implement AB 2699.	The Board provided the data in the Sunset Response dated April 8, 2013.
2	Licensing	B	Is a statutory change needed to accommodate changes to the United States Medical Licensing Examination?	The MBC should submit to the Committee specific language to amend BPC § 2177 to accommodate two parts to Step 3 of the USMLE, and to accommodate future examination changes.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
3	Licensing	B	Should changes be made to allow Medical School Programs to utilize Accelerated 3-Year and Competency-Based Medical School Programs?	The MBC should commence, in cooperation with the appropriate stakeholders, a review of the applicable provisions of California law to determine if increased flexibility is needed in order to authorize LCME-accredited accelerated medical degree curriculum to meet the requirements for licensure in California. If it is determined that a legislative change is required, the MBC should submit to the Committee the appropriate amendment language.	AB 1838 Bonilla (2014) authorizes a 3-yr med school program
4	Licensing	B	There should be consistency in the amount of time a physician and surgeon may be out of practice without receiving additional clinical training before renewing their license and/or allowing them to continue practice.	The MBC should study the issue of whether allowing a physician to return to practice after a lapse in licensure or of practice of more than 18 months without completing additional training provides adequate public protection. The MBC should make recommendations to the Committee on its findings.	The Board has held an interested party meeting on this issue, but more discussion and research needs to be completed prior to proposing any legislative change.
5	Licensing	B	Should there be a mandatory requirement for licensees to submit their Email address to the MBC, if they possess one?	The MBC should address the concerns of Committee staff stated above, and submit to the Committee appropriate amendment language regarding licensees providing email addresses to the Board, if they possess one. The language should additionally require the MBC to keep a provided email address confidential.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
6	Posting Information	B	Should the MBC continue to provide to the public information regarding a physician and surgeon's postgraduate training?	The MBC should further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those discussions, and if appropriate the MBC should submit to the Committee amendment language to eliminate the requirement for the MBC to post a physician's approved postgraduate training.	At the July 1, 2014 Board meeting, after discussion, the Board approved staff's recommendation to not pursue elimination of the requirement for the Board do disclose postgraduate training on the physician's website profile as this was now possible in the current BreEZe system.
7	Licensing	B	Clarify that the employment of physicians and surgeons in Accredited Residency Training Programs and/or Fellowship Programs does not violate the prohibition against the Corporate Practice of Medicine.	Committee staff agrees that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The MBC should submit to the Committee specific language to clarify that participation in an accredited physician residency training program is not a violation of the prohibition against the corporate practice of medicine.	Enacted SB 304, (2013) Lieu. Healing arts: boards.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
8	Licensing	B	Should the requirement for the MBC to approve non-American Board of Medical Specialties be eliminated?	The MBC should submit a specific legislative proposal to the Committee to delete the provision requiring the MBC to approve non-ABMS specialty boards, and to prevent the use of other misleading terms. Consideration should be given to amending BPC § 651(h) to delete the MBC's authority to approve non-ABMS specialty boards, and to prevent the use of other misleading terms in physician and surgeon advertising, as recommended by the MBC.	This amendment was in the April 13, 2013 version of SB 304, however, due to opposition, it was removed from the bill on August 12, 2013.
9	Enforcement	C	Enforcement program shortfalls.	The VE program should be continued, and additional improvements should be identified which would further enhance the collaborative efforts of the MBC investigators and HQE prosecutors.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
10	Enforcement	C	Should the Medical Board investigate complaints that relate to utilization review decisions in the workers' compensation system regarding physicians and surgeons who may have violated the standard of care?	The MBC should have jurisdiction over medical decisions made by California-licensed physicians and surgeons who conduct utilization reviews. The MBC should also report to the Committee on its plan to direct enforcement staff to implement enforcement oversight over these decisions. The MBC should also make the worker' compensation system aware of this requirement.	The Medical Board had this item on several agendas and indicated that utilization review was the practice of medicine. In addition, when the complaints pertain to quality of care, those complaints are processed and action is taken, if warranted. In addition, the Board has made presentations at Board meetings and placed an article in the Newsletter regarding this issue.
11	Public Information	C	To what extent have the recommendations made by the California Research Bureau regarding public disclosure been implemented?	The MBC should inform the Committee to what extent the 11 policy options recommendations made by the California Research Bureau have been implemented? In its response, the MBC should identify and recommend to the Committee whether additional MBC policies or regulations should be changed and whether additional legislation should be enacted to implement the recommendations made by the CRB.	The Board provided a response on the implementation of the 11 policy options in the Sunset Response dated April 8, 2013.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
12	Licensing/ Enforcement	C	Has MBC fully implemented all the provisions of SB 100? Are there functions that the MBC should continue to improve as it implements SB 100?	The MBC should update the Committee on its efforts to implement SB 100, including: (1) The findings and recommendations of the Advisory Committee and whether the Board has adopted regulations relating to physician availability at clinics or settings that use laser or intense pulse light devices; (2) How many outpatient settings that offer in vitro fertilization are currently accredited, and whether any new standards were adopted for outpatient settings that offer in vitro fertilization; (3) Whether the Board has adopted regulations for clinics that are outside the definition of outpatient settings; (4) Whether the Board has established an arrangement or a memorandum of understanding with DPH to obtain information on outpatient settings with adverse reports. The MBC should further do the following, and report back to the Committee: (1) Inform licensees and the public that settings that offer in vitro fertilization must be accredited. (2) Inform of any regulations for clinics that are outside the definition of outpatient settings that are adopted by the Board. (3) Notify all outpatient settings of the reporting requirement under Health and Safety Code § 1279.1 and inform accrediting agencies of its obligation to report adverse events that are found during inspections to the DPH. (4) Update the database lookup so that consumers may more easily find useful information on outpatient settings.	The Board provided a response on the implementation of SB 100 and other questions in the Sunset Response dated April 8, 2013. In addition, a legislative change was made to require the adverse event reports to be reported to the Board, not CDPH. Lastly, the Board has made significant improvements to the Outpatient Setting Program. However, Board staff is looking for ways to improve this Program even further.
13	Enforcement	C	Implementation of peer review requirements pursuant to SB 700.	The MBC should report to the Committee regarding the implementation of SB 700, and the extent to which it is receiving the reports required under SB 700.	The Board provided a response on the implementation of SB 700 in the Sunset Response dated April 8, 2013.
14	Data collection	C	Should the MBC engage stakeholders to identify areas in which alternative approaches may be used to analyze current data collected on healthcare facilities and practices in order to improve or enhance the practice of health care providers?	Recommend that the MBC take steps toward creating a Task Force to discuss how aggregate data can be utilized for each task force member's respective purposes. The group would be requested to examine the aggregate data already required to be reported to federal government in order to identify trend lines across the state. Ultimately, these findings could be used to identify standards for best practices.	The Board explained in its Sunset Response that the Board may not be the appropriate entity to create this task force. No action has been taken on this item. Board staff will reach out to Committee staff.
15	Enforcement	C	Has the MBC adopted all of the Uniform Standards developed by the Department of Consumer Affairs Substance Abuse Coordination Committee? If not, why not?	The MBC should fully implement the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as required by SB1441. The MBC should report back to the Committee by July 1, 2013 of its progress in implementing the Uniform Standards.	The Board adopted the Uniform Standards regulations and they were approved by the Office of Administrative Law and became effective July 1, 2015.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
16	Enforcement	C	Stipulated settlements below the Disciplinary Guidelines.	The MBC should discuss with the Committee its policies regarding stipulated settlements and the reasons why it would settle a disciplinary case for terms less than those stated in the Board's Disciplinary Guidelines. What is the consumer protection rationale for settling administrative cases for terms that are below those in the Disciplinary Guidelines? Are these recommendations of the Attorney General's Office or decisions made by the MBC staff independent of the AG?	The Board provided a response on this issue in the Sunset Response dated April 8, 2013. No further action is necessary.
17	Enforcement	C	Why has the MBC not filled staffing positions provided under CPEI in FY 2010-11?	The MBC should update the Committee on the current status of its efforts to fill the CPEI positions. The MBC should further advise the Committee of the appropriate level of staffing necessary to implement the goals of CPEI.	The Board provided a response on the CPEI positions in the Sunset Response dated April 8, 2013. On July 1, 2014 the Board initiated a non-sworn Complaint Investigation Unit to investigate some of the less complex cases for the Board.
18	Enforcement	C	Reporting of Patient Deaths to the MBC.	The MBC should inform the Committee how many deaths were reported pursuant to Section 2240. Additionally, the MBC should take steps to inform, not only licensees but also accrediting agencies that accredit outpatient settings about the reporting requirement in Section 2240. MBC should also coordinate with accrediting agencies how this requirement can be incorporated in the accrediting agencies' inspection reports of outpatient settings.	The Board provided a response on this issue in the Sunset Response dated April 8, 2013.
19	Enforcement	C	There has been a steady decline in the use of the MBC's Interim Suspension Authority.	The MBC should inform the Committee of the reasons why it believes that the number of ISO and TROs has fallen off in recent years. The MBC should further advise the Committee on whether Government Code § 11529 should be amended to provide for changes to the ISO or TRO process, so that it may enhance its use by the MBC to quickly remove dangerous physicians from practice.	The Board provided a response on this issue in the Sunset Response dated April 8, 2013. In addition, Enacted SB 304, (2013) Lieu assisted by extending the date upon which an accusation has to be filed after an ISO has been issued. In addition, the Board has requested ISOs (and other types of suspensions/restrictions) be utilized when possible to protect the public, and it has been made a priority.
20	Enforcement	C	Use of MBC's Authority to cite and fine physicians who fail to produce records within 15 days.	The MBC should inform the Committee of its use of cite and fine authority under BPC § 2225. How many citations have been issued? What are the fine amounts that have been assessed? How has this authority worked to obtain compliance with the 15 day record production requirement?	The Board provided a response on this issue in the Sunset Response dated April 8, 2013. No further action is necessary.
21	Enforcement	B	Require Coroner Reporting of Prescription Drug Overdose Cases to the MBC.	Statutory changes should be made to require a coroner to file a report with the MBC and any other relevant health care boards when the coroner receives information that is based on findings by, or documented and approved by a pathologist that indicates that a death may be the result of prescription drug use. MBC should also inform all coroners in the state about any statutory changes to the coroner reporting requirements.	SB 62, (2013, Lieu) requiring certain reporting from coroners was introduced, however, it was vetoed. As an alternative, the Board has developed a data use agreement to obtain death certificate information from the California Department of Public Health and is opening complaints/investigations as necessary.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
22	Enforcement	B	Controlled Substance Utilization Review and Evaluation System (CURES) and California Prescription Drug Monitoring Program (PDMP) Funding.	The MBC should advise the Committee whether CURES is currently working for its investigatory and regulatory purposes. Does MBC query CURES as a tool in its investigations? Should it do so? MBC should provide an update on its usage by the Board, and how it can be improved. Does the MBC recommend that consideration should be given to using licensing fees of various health related boards to adequately funding CURES in the future and the these licensing boards have primary responsibility for any actions to be taken against its licensees?	The Board provided a response on this issue in the Sunset Response dated April 8, 2013. In addition, SB 809, (2013, DeSaulnier) was enacted. Controlled substances: reporting.
23	Enforcement	B	Exclude medical malpractice reports from requirements of a medical expert review by the MBC.	Legislation should be enacted to exclude medical malpractice reports from the requirements of a medical expert review under BPC § 2220.08.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
24	Enforcement	B	Require medical facilities to produce medical records within 15 days.	BPC § 2225.5 (b) should be amended to require a facility to produce medical records within 15 days, if the facility has implemented Electronic Health Records (EHR).	Enacted SB 304, (2013) Lieu. Healing arts: boards.
25	Enforcement	B	Consider requiring the Department of Public Health and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility.	The MBC should further discuss with the Committee the proposal, and consideration should be given to amending the law to require CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC; and to further require that these entities notify the Board if a hospital is not performing peer review.	The Board submitted statutory language to the Committee to require CDPH and hospital accrediting agencies to send these incidents to the Board. However, legislation has not been authored regarding this issue. No further action is needed by the Board.
26	Enforcement	B	Require that Expert Reviewer Reports be provided to the MBC in a timely fashion.	Consideration should be given to amending BPC § 2334 to: (1) require a respondent to provide the full expert witness report; (2) clarify the timeframes for providing the reports, such as 90 days from the filing of an accusation.	This amendment was in the April 13, 2013 version of SB 304, however, it was removed from the bill on August 12, 2013.
27	Other Allied Health	B	Licensed Midwives: Physician Supervision.	The MBC should reach a consensus with stakeholders on this important issue and then submit a specific legislative proposal to the Committee regarding the appropriate level of supervision required for the practice of midwifery.	Enacted AB 1308, (2013) Bonilla. Midwifery.
28	Other Allied Health	B	Allow Licensed Midwives to have Lab Accounts and obtain Medical Supplies.	Legislation should be enacted to clarify that a licensed midwife may order laboratory tests, and obtain medical supplies. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.	Enacted AB 1308, (2013) Bonilla. Midwifery.
29	Other Allied Health	B	Clarify Midwifery education and clinical training.	Recommend legislation should be enacted to clarify when an individual is considered a bona fide student, and to clarify that a written agreement does not meet the requirement of a program of supervised clinical training. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
30	Other Allied Health	B	Clarify the role of a Midwife Assistant.	The MBC should provide more information regarding the proposal to address the issue of midwife assistants in legislation.	Enacted SB 408, (2015) Morrell. Midwife assistants.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
31	Licensing	C	SB 122 implementation for Out-of-State Licensed Physicians.	The MBC should advise the Committee of its implementation of SB 122. How many licenses have been issued under the new provisions? How does the MBC propose to handle those cases of physicians who have a mixed combination of medical education, having received part of their education at an unapproved medical school, and part at a disapproved medical school? Does the MBC anticipate that regulations could authorize a physician with a mixed combination of education to become licensed under the 10 year requirement? Does the MBC think that further legislation is needed to clarify such cases?	The Board provided a response on the implementation and data on this issue in the Sunset Response dated April 8, 2013.
32	Enforcement	C	Continued Utilization by the MBC of Vertical Enforcement Prosecution (VE).	Recommend continuing the VE program, and explore further ways to improve the collaborative relationship between investigators and prosecutors to improve the effectiveness of the MBC enforcement program.	Enacted SB 304, (2013) Lieu. Healing arts: boards.
33	Enforcement	B	Should the MBC's authority to issue a cease practice order be expanded to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination?	Recommend amendments to the MBC's authority to issue a cease practice order to expand to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination.	This amendment was in the April 13, 2013 version of SB 304, however, it was removed from the bill on August 12, 2013.
34	Licensing	C	Should the exemption for accredited outpatient settings to obtain a fictitious permit be removed?	In order for the public to get accurate information on outpatient settings that do business under a fictitious name, BPC § 2285 (c) should be amended to delete the exemption for outpatient settings that are accredited.	The Board discussed this issue with Committee staff, however, no legislation was carried regarding this issue. In addition, the Board is unsure if the change will obtain the desired result. To date this issue has not been brought forward to the Board by Committee staff.
35	Technology	C	What is the status of BReEZe implementation by the MBC?	The MBC should update the Committee about the current status of its implementation of BreEZe. What have been the challenges to implementing this new system? What are the costs of implementing this system? Is the cost of BreEZe consistent with what the MBC was told the project would cost? Will BreEZe interact with the AG's information technology to allow seamless and usable data to be transferred between the MBC and the DOJ?	The Board provided a response on this issue in the Sunset Response dated April 8, 2013.
36	Public Information	B	The limited ten year posting requirement for the MBC's Website should be removed.	Recommend that in the interest of transparency and disclosure of information to the public, BPC § 2027 should be amended to remove the 10 year limit on how long information should be posted on the MBC's Internet Website.	Enacted by AB 1886, Eggman (2014). Medical Board of California.
37	Other Allied Health	B	Registered Dispensing Optician Program: Should the RDO Program be Transferred to Another State Agency?	Recommend the MBC to initiate discussions with the Department of Consumer Affairs, the State Board of Optometry, stakeholders from each of the interested professional groups, and interested consumer representatives to discuss the potential need, usefulness, or problems with transferring regulation of the RDO Program from the MBC to another board or program. The MBC should report its findings and recommendations back to the Committee by July 1, 2014.	Enacted AB 684, Alejo. (2015) State Board of Optometry: optometrists: nonresident contact lens sellers: registered dispensing opticians. Transferred the program to the Board of Optometry.

Issue No.	Topic	Bd/Comm.	Issue	Recommendation	Action Needed/Completed
38	Other Allied Health	C	Consolidate the licensing and regulation of osteopathic physicians and surgeons under the MBC.	The MBC should discuss with the Committee the possibility of consolidating the OMBC into the MBC to provide a single regulatory authority over all physicians and surgeons in California.	The Board has not discussed this issue nor has Committee staff reached out to the Board. Board staff will reach out to Committee staff.
39	Regulation of Board	C	Should the licensing and regulation of physicians and surgeons be continued and be regulated by the current Board membership?	Recommend that the licensing and regulation of physicians and surgeons and allied health professions continue to be regulated by the current board members of the Medical Board of California in order to protect the interests of the public and be reviewed once again in four years.	Enacted SB 304, (2013) Lieu. Healing arts: boards.

**State of California
Business, Consumer Services and Housing Agency**

MEDICAL BOARD OF CALIFORNIA

May 5-6, 2016

Board Meeting

Legislative Packet



MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
April 27, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1977	Wood & Waldron	Opioid Abuse Task Force	Asm. Health	Reco: Support	4/13/16
AB 1992	Jones	Pupil Health: Physical Examinations	Asm. AESTM	Reco: Oppose Unless Amended	
AB 2024	Wood	Critical Access Hospitals: Employment	Asm. Approps	Reco: Neutral	4/11/16
AB 2216	Bonta	Primary Care Residency Programs: Grant Program	Asm. Approps	Reco: Support	4/14/16
AB 2507	Gordon	Telehealth: Access	Assembly	Reco: Neutral	4/26/16
AB 2592	Cooper	Controlled Substances: Medicine Locking Closure Packages: Grant Program	Asm. Approps	Reco: Support	4/25/16
AB 2606	Grove	Crimes Against Children, Elders, Dependent Adults, and Persons with Disabilities	Asm. Approps	Reco: Support	
AB 2744	Gordon	Healing Arts: Referrals	Asm. Approps	Reco: Neutral	4/11/16
AB 2745	Holden	Healing Arts: Licensing and Certification	Asm. Approps	Sponsor/Support	4/25/16
SB 22	Roth, Cannella & Galgiani	Residency Training: Funding	Assembly	Reco: Support	2/29/16
SB 482	Lara	Controlled Substances: CURES Database	Assembly	Reco: Support	4/7/16
SB 563	Pan	Workers' Compensation: Utilization Review	Assembly	Support	1/4/16
SB 1033	Hill	Medical Board: Disclosure of Probationary Status	Sen. Approps	Reco: Neutral if Amended	3/17/16
SB 1039	Hill	Professions and Vocations	Sen. Approps	Support BPM	4/21/16

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
April 27, 2016

	Provisions				
SB 1174	McGuire	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications	Sen. Approps	Reco: Support if Amended	3/28/16
SB 1177	Galgiani	Physician and Suregon Health and Wellness Program	Sen. Approps	Reco: Support	4/20/16
SB 1189	Pan & Jackson	Postmortem Examinations or Autopsies	Senate	Reco: Support	4/26/16
SB 1195	Hill	Professions and Vocations: Board Actions: Competitive Impact	Sen. Approps		4/6/16
SB 1261	Stone	Physicians and Surgeons: Licensure Exemption	Sen. Approps	Reco: Oppose	
SB 1471	Hernandez	Health Professions Development: Loan Repayment	Sen. Health	Reco: Support	4/21/16
SB 1478	Sen. B&P	Health Omnibus	Sen. Approps	Sponsor/Support MBC Provisions	

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1977
Author: Wood and Waldron
Bill Date: April 13, 2016, Amended
Subject: Opioid Abuse Task Force
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish an Opioid Abuse Task Force (Task Force) to develop recommendations regarding the abuse and misuse of opioids.

BACKGROUND

The issue of preventing inappropriate prescribing and misuse and abuse of opioids is of great importance to the Medical Board of California (Board). In September 2014, the Board hosted a free continuing medical education course in Los Angeles on Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy that was developed by the U.S. Food and Drug Administration. 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 prescribing for pain in California by avoiding under treatment, overtreatment or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. Lastly, the Board produced two public service announcements (PSAs) that address the issue of prescription drug abuse and misuse. One was directed towards physicians and one was directed towards consumers and featured gold medalist Natalie Coughlin. These PSAs have been aired on television stations throughout California and are posted on the Board's website.

ANALYSIS

This bill would make findings and declarations regarding opioid abuse and misuse in California and the number of drug overdose deaths involving prescription opioid pain relievers.

This bill would require, on or before February 1, 2017, health care service plans and health insurer representatives, in collaboration with advocates, experts, health care professionals, and other entities and stakeholders that they deem appropriate, to convene a Task Force. The Task Force would be required to develop recommendations regarding the abuse and misuse of opioids as a serious problem that affects the health, social welfare, and economic welfare of persons in California. The Task Force shall address the following:

- Interventions that have been scientifically validated and have demonstrated clinical

efficacy.

- Interventions that have measurable treatment outcomes.
- Collaborative, evidence-based approaches to resolving opioid abuse and misuse that incorporate both the provider and the patient into the solution.
- Education that engages and encourages providers to be prudent in prescribing opioids and to be proactive in defining care plans that include a plan to taper and stop opioid use.
- Review and consideration of medication coverage policies and formulary management and development of an interdisciplinary case management program that addresses quality, fraud, waste, and abuse.

This bill would require the Task Force to submit a report detailing its findings and recommendations to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and Assembly and Senate Health Committees by December 31, 2017. The Task Force is required to be dissolved by June 1, 2018.

This bill furthers the Board's mission of consumer protection and is in line with the Board's work on the important issue of preventing misuse and abuse and inappropriate prescribing of prescription drugs. Board staff thinks the issues assigned to the Task Force would be helpful to the Board's work as well, and Board staff would like to participate in the Task Force if this bill is signed into law to ensure the discussions are in line with the Board's Guidelines. Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 13, 2016

AMENDED IN ASSEMBLY MARCH 30, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 1977

Introduced by Assembly Members Wood and Waldron

February 16, 2016

An act to ~~add Sections 2241.8 and 4069 to the Business and Professions Code, to add Section 1367.217 to add and repeal Division 10.10 (commencing with Section 11999.30) to the Health and Safety Code, and to add Section 10123.203 to the Insurance Code,~~ relating to prescription drugs.

LEGISLATIVE COUNSEL'S DIGEST

AB 1977, as amended, Wood. ~~Healing arts: prescriptions: health coverage: abuse-deterrent opioid analgesics: Opioid Abuse Task Force.~~

~~(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. A violation of specified provisions of the Medical Practice Act is a crime.~~

~~This bill would prohibit a physician and surgeon from prescribing more than a 5-day supply of an opioid analgesic drug product to a patient the first time that physician and surgeon prescribes a patient such an opioid for acute pain due to surgery or injury. The bill would apply that 5-day supply limitation even if the patient has previously been prescribed such an opioid from a different physician and surgeon. Because the violation of those limitation requirements would be a crime under the Medical Practice Act, the bill would impose a state-mandated local program.~~

~~(2) Existing law, the Pharmacy Law, provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy.~~

~~This bill would require a pharmacist to inform a patient receiving for the first time an opioid analgesic drug product on proper storage and disposal of the drug. The bill would also require the California State Board of Pharmacy to adopt regulations to implement that requirement.~~

~~Because a knowing violation of these provisions would be a crime, this bill would impose a state-mandated local program.~~

~~(3) Existing~~

~~Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of that act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. These provisions require specified services and drugs to be covered by the various health care service plans and health insurers.~~

~~This bill would require an individual or group health care service plan or disability insurance policy issued, amended, or renewed after January 1, to provide coverage on its formulary, drug list, or other lists of similar construct for at least one abuse-deterrent opioid analgesic drug product per opioid analgesic active ingredient. The bill would require that the total amount of copayments and coinsurance an enrollee or insured is required to pay for brand name abuse-deterrent opioid analgesic drug products covered pursuant to the bill not exceed the lowest cost-sharing level applied to brand name or generic prescription drugs covered under the applicable health care service plan or insurer, as specified. The bill would prohibit a health care service plan or insurer from requiring an enrollee or an insured to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product, subject to uniformly applied utilization review requirements described in the bill. *require health care service plans and health insurers representatives, in collaboration with certain entities, to convene an Opioid Abuse Task Force on or before February 1, 2017, for the purpose of developing recommendations regarding the abuse and misuse of opioids, as specified. The bill would require the task force to submit a report detailing its findings and recommendations to specified government entities on or before December 31, 2017. The bill would require the task force to be dissolved on June 1, 2018. The bill would provide that a violation of these provisions by a health care service plan does not constitute a crime under the Knox-Keene Health*~~

Care Service Plan Act of 1975. The bill would make related legislative findings and declarations.

~~Because a willful violation of these requirements with respect to health care service plans would be a crime, this bill would impose a state-mandated local program.~~

~~(4) 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~~-no.
State-mandated local program: ~~yes~~-no.

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

1 SECTION 1. The Legislature finds and declares as follows:

2 (a) Abuse and misuse of opioids is a serious problem that affects
3 the health, social, and economic welfare of the state.

4 (b) After alcohol, prescription drugs are the most commonly
5 abused substances by Americans over 12 years of age.

6 (c) Almost 2,000,000 people in the United States suffer from
7 substance use disorders related to prescription opioid pain relievers.

8 (d) Nonmedical use of prescription opioid pain relievers can be
9 particularly dangerous when the products are manipulated for
10 snorting, injection, or combination with other drugs.

11 (e) Deaths involving prescription opioid pain relievers represent
12 the largest proportion of drug overdose deaths, greater than the
13 number of overdose deaths involving heroin or cocaine.

14 (f) The number of unintentional overdose deaths involving
15 prescription opioid pain relievers has more than quadrupled since
16 1999.

17 ~~SEC. 2. Section 2241.8 is added to the Business and Professions~~
18 ~~Code, to read:~~

19 ~~2241.8. (a) (1) No physician and surgeon shall prescribe more~~
20 ~~than a five-day supply of an opioid analgesic drug product to a~~
21 ~~patient the first time that physician and surgeon prescribes a patient~~
22 ~~such an opioid for acute pain due to surgery or injury.~~

23 ~~(2) The initial prescription in paragraph (1) may be for a~~
24 ~~non-abuse-deterrent opioid analgesic drug product and the five-day~~
25 ~~supply limitation shall still apply.~~

1 ~~(3) This subdivision does not apply to an opioid prescription~~
2 ~~for a patient in chronic pain.~~

3 ~~(b) Subdivision (a) shall apply even if the patient has previously~~
4 ~~been prescribed such an opioid from a different physician and~~
5 ~~surgeon.~~

6 ~~(c) For the purposes of this section, “opioid analgesic drug~~
7 ~~product” has the same meaning as defined in Section 1367.217 of~~
8 ~~the Health and Safety Code.~~

9 ~~SEC. 3. Section 4069 is added to the Business and Professions~~
10 ~~Code, to read:~~

11 ~~4069. (a) A pharmacist shall inform a patient receiving for the~~
12 ~~first time an opioid analgesic drug product on proper storage and~~
13 ~~disposal of the drug. The board shall adopt regulations to~~
14 ~~implement this section.~~

15 ~~(b) For the purposes of this section, “opioid analgesic drug~~
16 ~~product” has the same meaning as defined in Section 1367.217 of~~
17 ~~the Health and Safety Code.~~

18 ~~SEC. 4. Section 1367.217 is added to the Health and Safety~~
19 ~~Code, immediately following Section 1367.215, to read:~~

20 ~~1367.217. (a) Notwithstanding any other law, an individual~~
21 ~~or group health care service plan issued, amended, or renewed on~~
22 ~~or after January 1, that provides coverage for an opioid analgesic~~
23 ~~drug product shall comply with all of the following:~~

24 ~~(1) The plan shall provide coverage on its formulary, drug list,~~
25 ~~or other lists of similar construct for at least one abuse-deterrent~~
26 ~~opioid analgesic drug product per opioid analgesic active~~
27 ~~ingredient.~~

28 ~~(2) Notwithstanding any deductible, the total amount of~~
29 ~~copayments and coinsurance an enrollee is required to pay for~~
30 ~~brand name abuse-deterrent opioid analgesic drug products covered~~
31 ~~pursuant to this section shall not exceed the lowest cost-sharing~~
32 ~~level applied to brand name prescription drugs covered under the~~
33 ~~applicable health care service plan.~~

34 ~~(3) Notwithstanding any deductible, the total amount of~~
35 ~~copayments and coinsurance an enrollee is required to pay for~~
36 ~~generic abuse-deterrent opioid analgesic drug products covered~~
37 ~~pursuant to this section shall not exceed the lowest cost-sharing~~
38 ~~level applied to generic prescription drugs covered under the~~
39 ~~applicable health care service plan.~~

1 ~~(4) The plan shall not require an enrollee to first use a~~
2 ~~non-abuse-deterrent opioid analgesic drug product before providing~~
3 ~~coverage for an abuse-deterrent opioid analgesic drug product.~~
4 ~~This paragraph shall not be construed to prevent a health care~~
5 ~~service plan from applying utilization review requirements,~~
6 ~~including prior authorization, to abuse-deterrent opioid analgesic~~
7 ~~drug products, provided that those requirements are applied to all~~
8 ~~opioid analgesic drug products with the same type of drug release,~~
9 ~~immediate or extended. This paragraph shall not be construed to~~
10 ~~preclude the use of a non-abuse-deterrent opioid for the initial~~
11 ~~prescription for a five-day supply.~~

12 ~~(b) The following definitions shall apply for purposes of this~~
13 ~~section:~~

14 ~~(1) “Abuse-deterrent opioid analgesic drug product” means a~~
15 ~~brand or generic opioid analgesic drug product approved by the~~
16 ~~federal Food and Drug Administration (FDA) with~~
17 ~~abuse-deterrence labeling claims indicating its abuse-deterrent~~
18 ~~properties are expected to deter or reduce its abuse.~~

19 ~~(2) “Cost sharing” means any coverage limit, copayment,~~
20 ~~coinsurance, deductible, or other out-of-pocket expense~~
21 ~~requirement.~~

22 ~~(3) “Opioid analgesic drug product” means a drug product that~~
23 ~~contains an opioid agonist and that is indicated by the FDA for the~~
24 ~~treatment of pain, whether in an immediate release or extended~~
25 ~~release formulation and whether or not the drug product contains~~
26 ~~any other drug substance.~~

27 ~~SEC. 5. Section 10123.203 is added to the Insurance Code, to~~
28 ~~read:~~

29 ~~10123.203. (a) Notwithstanding any other law, an insurer~~
30 ~~issuing, amending, or renewing a policy of individual or group~~
31 ~~disability insurance on or after January 1, that provides coverage~~
32 ~~for an opioid analgesic drug product shall comply with all of the~~
33 ~~following:~~

34 ~~(1) The insurer shall provide coverage on its formulary, drug~~
35 ~~list, or other lists of similar construct for at least one~~
36 ~~abuse-deterrent opioid analgesic drug product per opioid analgesic~~
37 ~~active ingredient.~~

38 ~~(2) Notwithstanding any deductible, the total amount of~~
39 ~~copayments and coinsurance an insured is required to pay for brand~~
40 ~~name abuse-deterrent opioid analgesic drug products covered~~

1 pursuant to this section shall not exceed the lowest cost-sharing
2 level applied to brand name prescription drugs covered under the
3 applicable policy.

4 (3) Notwithstanding any deductible, the total amount of
5 copayments and coinsurance an insured is required to pay for
6 generic abuse-deterrent opioid analgesic drug products covered
7 pursuant to this section shall not exceed the lowest cost-sharing
8 level applied to generic prescription drugs covered under the
9 applicable policy.

10 (4) The insurer shall not require an insured to first use a
11 non-abuse-deterrent opioid analgesic drug product before providing
12 coverage for an abuse-deterrent opioid analgesic drug product.
13 This paragraph shall not be construed to prevent an insurer from
14 applying utilization review requirements, including prior
15 authorization, to abuse-deterrent opioid analgesic drug products,
16 provided that those requirements are applied to all opioid analgesic
17 drug products with the same type of drug release, immediate or
18 extended. This paragraph shall not be construed to preclude the
19 use of a non-abuse-deterrent opioid for the initial prescription for
20 a five-day supply.

21 (b) The following definitions shall apply for purposes of this
22 section:

23 (1) “Abuse-deterrent opioid analgesic drug product” means a
24 brand or generic opioid analgesic drug product approved by the
25 federal Food and Drug Administration (FDA) with
26 abuse-deterrence labeling claims indicating its abuse-deterrent
27 properties are expected to deter or reduce its abuse.

28 (2) “Cost sharing” means any coverage limit, copayment,
29 coinsurance, deductible, or other out-of-pocket expense
30 requirement.

31 (3) “Opioid analgesic drug product” means a drug product that
32 contains an opioid agonist and that is indicated by the FDA for the
33 treatment of pain, whether in an immediate release or extended
34 release formulation and whether or not the drug product contains
35 any other drug substance.

36 SEC. 6. No reimbursement is required by this act pursuant to
37 Section 6 of Article XIII B of the California Constitution because
38 the only costs that may be incurred by a local agency or school
39 district will be incurred because this act creates a new crime or
40 infraction, eliminates a crime or infraction, or changes the penalty

1 ~~for a crime or infraction, within the meaning of Section 17556 of~~
2 ~~the Government Code, or changes the definition of a crime within~~
3 ~~the meaning of Section 6 of Article XIII B of the California~~
4 ~~Constitution.~~

5 *SEC. 2. Division 10.10 (commencing with Section 11999.30)*
6 *is added to the Health and Safety Code, to read:*

7
8 *DIVISION 10.10. OPIOID ABUSE TASK FORCE*
9

10 *11999.30. (a) On or before February 1, 2017, health care*
11 *service plans and health insurer representatives, in collaboration*
12 *with advocates, experts, health care professionals, and other*
13 *entities and stakeholders that they deem appropriate, shall convene*
14 *an Opioid Abuse Task Force. The task force shall develop*
15 *recommendations regarding the abuse and misuse of opioids as a*
16 *serious problem that affects the health, social welfare, and*
17 *economic welfare of persons in the state. The task force shall*
18 *address all of the following:*

19 *(1) Interventions that have been scientifically validated and*
20 *have demonstrated clinical efficacy.*

21 *(2) Interventions that have measurable treatment outcomes.*

22 *(3) Collaborative, evidence-based approaches to resolving*
23 *opioid abuse and misuse that incorporate both the provider and*
24 *the patient into the solution.*

25 *(4) Education that engages and encourages providers to be*
26 *prudent in prescribing opioids and to be proactive in defining care*
27 *plans that include a plan to taper and stop opioid use.*

28 *(5) Review and consideration of medication coverage policies*
29 *and formulary management and development of an*
30 *interdisciplinary case management program that addresses quality,*
31 *fraud, waste, and abuse.*

32 *(b) On or before December 31, 2017, the task force shall submit*
33 *a report detailing its findings and recommendations to the*
34 *Governor, the President pro Tempore of the Senate, the Speaker*
35 *of the Assembly, the Senate Committee on Health, and the Assembly*
36 *Committee on Health.*

37 *(c) The task force shall be dissolved and shall cease to exist on*
38 *June 1, 2018.*

39 *(d) A violation of this section is not subject to Section 1390.*

1 11999.31. *This division shall remain in effect only until January*
2 *1, 2019, and as of that date is repealed, unless a later enacted*
3 *statute, that is enacted before January 1, 2019, deletes or extends*
4 *that date.*

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1992
Author: Jones
Bill Date: February 16, 2016, Introduced
Subject: Pupil Health: Physical Examinations
Sponsor: California Chiropractic Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill would allow doctors of chiropractic, naturopathic doctors, and nurse practitioners to perform physical examinations for students in interscholastic athletic programs.

ANALYSIS:

The California Interscholastic Federation (CIF) oversees the protocols related to physical examinations for school interscholastic athletic programs. Existing law only allows these exams to be performed by a physician or a physician assistant in Section 49458 of the Education Code. In the past, schools have allowed chiropractors to execute sports physical forms. However, the Schools Insurance Authority published an Informational Review of the Use of Chiropractors in School Sports Programs and raised concerns about the use of chiropractors for these physical exams, as the examinations may exceed the chiropractic scope. The review also brings up a concern that possibly an injury could have possibly been avoided through an examination by a physician, so the school may have liability if it has accepted a sports physical form from a chiropractor. Because of this review and existing law, schools in California currently do not allow chiropractors to perform sports physicals.

The sponsor of this bill believes that doctors of chiropractic can practice chiropractic as taught in chiropractic schools and colleges. According to the sponsor, doctors of chiropractic are highly trained in the evaluation and management for concussions; this is the foundation for the argument that doctors of chiropractic can go beyond the chiropractic scope of practice. The fact sheet for this bill states, "Since 1922, doctors of chiropractic in California are authorized and licensed to diagnose and treat any condition, disease, or injury in any patient and to serve as portal of entry/primary care providers".

As noted by the California Attorney General, a chiropractor must not engage in any care or treatment that is not based on "...a system of treatment by manipulation of the joints of the human body, by manipulation of anatomical displacements, articulation of the spinal column, including its vertebrae and cord, and he may use all necessary, mechanical, hygienic and sanitary measures incident to the care of the body in connection with said system of treatment, but not for the purpose of treatment, and not including measures as would constitute the practice of medicine, surgery, osteopathy, dentistry, or optometry, and without the use of

any drug or medicine included in materia medica.” 59 Op.Atty.Gen 420, 8-26-76, citing *Crees* at p. 214.

Chiropractors are authorized to perform certain types of limited examinations and evaluations, but there is currently no authorization for a chiropractor to perform sports physicals for student athletes. Existing law only allows physician assistants and physician and surgeons to perform physical examinations for interscholastic athletic programs. These sports physicals require a review of cardiac, neurologic and internal organ functioning, which is outside of the chiropractic scope of practice. Allowing a chiropractor to perform and sign off on these examinations, which include an evaluation and possible diagnosis, could negatively impact the students receiving these examinations, as chiropractors do not receive the same level of medical education and training as physicians. The Board’s primary mission is consumer protection and the Board should oppose this change. However, allowing a nurse practitioner, who is under the supervision of a physician, to perform these examinations, , seems reasonable. Physician assistants are already allowed to perform these examinations in existing law. Board staff suggests that the Board oppose this bill unless it is amended to only add nurse practitioners to the list of providers who can perform the physical examinations for student athletes.

FISCAL: None

SUPPORT: California Chiropractic Association
Board of Chiropractic Examiners

OPPOSITION: California Medical Association

POSITION: Recommendation: Oppose Unless Amended

ASSEMBLY BILL

No. 1992

Introduced by Assembly Member Jones

February 16, 2016

An act to amend Section 49458 of the Education Code, relating to pupil health.

LEGISLATIVE COUNSEL'S DIGEST

AB 1992, as introduced, Jones. Pupil health: physical examinations.

Existing law authorizes a physician and surgeon or physician assistant to perform a physical examination that is required for participation in an interscholastic athletic program, as specified.

This bill would additionally authorize a doctor of chiropractic, naturopathic doctor, or nurse practitioner practicing in compliance with the respective laws governing their profession.

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

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

1 SECTION 1. Section 49458 of the Education Code is amended
2 to read:
3 49458. When a school district or a county superintendent of
4 schools requires a physical examination as a condition of
5 participation in an interscholastic athletic program, the physical
6 examination may be performed by a physician and ~~surgeon or~~
7 *surgeon*, physician assistant practicing in compliance with Chapter
8 7.7 (commencing with Section 3500) of Division 2 of the Business
9 and Professions ~~Code~~. *Code, doctor of chiropractic practicing in*

1 *compliance with Chapter 2 (commencing with Section 1000) of*
2 *Division 2 of the Business and Professions Code, naturopathic*
3 *doctor practicing in compliance with Chapter 8.2 (commencing*
4 *with Section 3610) of Division 2 of the Business and Professions*
5 *Code, or nurse practitioner practicing in compliance with Article*
6 *8 (commencing with Section 2834) of Chapter 6 of Division 2 of*
7 *the Business and Professions Code.*

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2024
Author: Wood
Bill Date: April 11, 2016, amended
Subject: Critical Access Hospitals: Employment
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. This bill would specify that the CAH must not interfere with, control or otherwise direct the professional judgement of a physician. This bill would require the Legislative Analyst, on or before July 1, 2023, to provide a report to the Legislature regarding the impact of CAH's employing physicians.

BACKGROUND:

Current law (commonly referred to as the "Corporate Practice of Medicine" - B&P Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, and certain non-profit organizations. California is one of only a few states that prohibits the employment of physicians by hospitals.

SB 376 (Chesbro, Chapter 411, Statutes of 2003) directed the Board to establish a pilot program to provide for the direct employment of physicians by qualified district hospitals. The bill was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire, and employ physicians as full-time, paid staff in rural or underserved communities meeting specified criteria. The goal of the legislation was to improve the ability of district hospitals to attract physicians. However, participation in the pilot was very limited, only five participating hospitals and six participating physicians, and the Board was hindered in making a full evaluation due to lack of participation. The pilot expired on January 1, 2011.

ANALYSIS

This bill would establish a pilot program for federally certified CAHs to employ physicians and would require the Legislative Analyst to provide a report to the Legislature

containing data about the impact of CAH's employing physicians. The report would be due on or before July 1, 2023 and the pilot program would end on January 1, 2024. This bill would specify that the CAH shall not interfere with, control, or otherwise direct the professional judgment of a physician in a manner prohibited by the ban on the corporate practice of medicine.

The author states that he is sympathetic to the concerns about interference with the clinical judgment of any health care provider. There are a number of exceptions to the ban on the corporate practice of medicine currently allowed. The 26 CAHs are in rural communities that have difficulty recruiting and retaining physicians. Allowing these CAHs to employ physicians will help to provide economic security adequate to recruit physicians who will have to relocate to these rural communities where CAHs are located.

The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. That being said, CAHs are in remote, rural areas and this bill would help these hospitals to recruit and retain physicians, which will improve access to care in these rural communities. In addition, this bill is a pilot program that will be evaluated and the bill makes it clear that the CAH must not interfere with, control or otherwise direct the professional judgement of a physician. As such, Board staff is suggesting that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: Banner Lassen Medical Center; California Hospital Association; Catalina Island Medical Center; Fairchild Medical Center; Healdsburg District Hospital; Health Access California; Rural County Representatives of California; Jerold Phelps Community Hospital; Last Frontier Healthcare District Modoc Medical Center; Mayers Memorial Hospital District; Plumas District Hospital; San Bernardino Mountains Community Hospital; Santa Ynez Valley Cottage Hospital; St. Helena Hospital Clear Lake; Sutter Health; and Trinity Hospital

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2024

**Introduced by Assembly Member Wood
(Coauthors: Assembly Members Bigelow, Dahle, Gallagher, and
Oberholte)**

February 16, 2016

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2024, as amended, Wood. Critical access hospitals: employment. Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons and doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions.

This ~~bill~~ *bill*, until January 1, 2024, would also authorize a federally certified critical access hospital to employ those medical professionals and charge for professional services rendered by those medical professionals, and would prohibit the critical access hospital from directing or interfering with the professional judgment of a physician and surgeon, as specified. *The bill would require the Legislative Analyst, on or before July 1, 2023, to provide a report to the Legislature containing data on the impact of this authorization on federally certified critical access hospitals.*

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

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

1 SECTION 1. Section 2401 of the Business and Professions
2 Code is amended to read:

3 2401. (a) Notwithstanding Section 2400, a clinic operated
4 primarily for the purpose of medical education by a public or
5 private nonprofit university medical school, which is approved by
6 the board or the Osteopathic Medical Board of California, may
7 charge for professional services rendered to teaching patients by
8 licensees who hold academic appointments on the faculty of the
9 university, if the charges are approved by the physician and surgeon
10 in whose name the charges are made.

11 (b) Notwithstanding Section 2400, a clinic operated under
12 subdivision (p) of Section 1206 of the Health and Safety Code
13 may employ licensees and charge for professional services rendered
14 by those licensees. However, the clinic shall not interfere with,
15 control, or otherwise direct the professional judgment of a
16 physician and surgeon in a manner prohibited by Section 2400 or
17 any other law.

18 (c) Notwithstanding Section 2400, a narcotic treatment program
19 operated under Section 11876 of the Health and Safety Code and
20 regulated by the State Department of Health Care Services, may
21 employ licensees and charge for professional services rendered by
22 those licensees. However, the narcotic treatment program shall
23 not interfere with, control, or otherwise direct the professional
24 judgment of a physician and surgeon in a manner prohibited by
25 Section 2400 or any other law.

26 (d) Notwithstanding Section 2400, a hospital that is owned and
27 operated by a licensed charitable organization, that offers only
28 pediatric subspecialty care, that, prior to January 1, 2013, employed
29 licensees on a salary basis, and that has not charged for professional
30 services rendered to patients may, commencing January 1, 2013,
31 charge for professional services rendered to patients, provided the
32 following conditions are met:

33 (1) The hospital does not increase the number of salaried
34 licensees by more than five licensees each year.

35 (2) The hospital does not expand its scope of services beyond
36 pediatric subspecialty care.

1 (3) The hospital accepts each patient needing its scope of
2 services regardless of his or her ability to pay, including whether
3 the patient has any form of health care coverage.

4 (4) The medical staff concur by an affirmative vote that the
5 licensee’s employment is in the best interest of the communities
6 served by the hospital.

7 (5) The hospital does not interfere with, control, or otherwise
8 direct a physician and surgeon’s professional judgment in a manner
9 prohibited by Section 2400 or any other law.

10 (e) (1) Notwithstanding Section 2400, *until January 1, 2024*,
11 a federally certified critical access hospital may employ licensees
12 and charge for professional services rendered by those licensees.
13 However, the critical access hospital shall not interfere with,
14 control, or otherwise direct the professional judgment of a
15 physician and surgeon in a manner prohibited by Section 2400 or
16 any other law.

17 (2) *On or before July 1, 2023, the Legislative Analyst shall*
18 *provide a report to the Legislature containing data about the*
19 *impact of paragraph (1) on federally certified critical access*
20 *hospitals between January 1, 2017, and January 1, 2024, inclusive.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2216
Author: Bonta
Bill Date: April 14, 2016, Amended
Subject: Primary Care Residency Programs: Grant Program
Sponsor: California Primary Care Association (CPCA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would establish the Teaching Health Center Primary Care Graduate Medical Education Fund (Fund) for purposes of funding primary care residency programs.

BACKGROUND

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

The Teaching Health Center Graduate Medical Education (THCGME) Program has been funded since 2011, and is set to expire in 2015. The THCGME has increased the number of primary care physicians and dentists training to care for underserved populations nationwide. Teaching Health Centers (THCs) were created under the Patient Protection and Affordable Care Act and since their creation, six THCs have opened in California. They are located in Modesto, Fresno, San Bernardino, Redding, Bakersfield, and San Diego. Without continued federal funding, most of the Teaching Health Centers (THCs) report they would be unlikely to continue current residency recruitment and enrollment, threatening the viability of the THCGME Program.

ANALYSIS

This bill would establish the Fund in the State Treasury and would require the Director of the Office of Statewide Health Planning and Development (OSHPD) to award planning and development grants from the Fund to THCs for the purpose of establishing new accredited or expanded primary care residency programs. This bill would provide that the grants awarded must not be for more than three years and that the maximum award to a THC must not be more than \$500,000. This bill would specify that grants be used to cover the costs of establishing or expanding a primary care residency training program, including costs associated with curriculum development, recruitment, training, retention of residents and faculty, accreditation,

faculty salaries during the development phase, and technical assistance. This bill would define a sustaining grant as a grant awarded to ensure the continued operation of an accredited THC, whether that accreditation was first awarded by this bill or prior to the enactment of this bill. This bill would require OSHPD, subject to an appropriation by the Legislature, to award grants from the Fund to the THC's operating accredited primary care residency programs, and would require OSHPD to determine the amount of grants awarded per resident by taking into account the direct and indirect costs of graduate medical education.

According to the author, THCs are a proven model for addressing the primary care provider shortage that six of nine California regions face and notes that 40% of THC graduates enter into primary care practice in nonprofit community health centers in underserved communities. The author believes that this bill will help ensure California has a sufficient supply of health workforce professionals to serve the needs of this diverse state.

This bill will increase funding for residency programs in California, which will help promote the Board's mission of increasing access to care for consumers. Board staff is suggesting that the Board take a support position on this bill.

FISCAL: None

SUPPORT: CPCA (sponsor); Alameda Health Consortium; AltaMed Services Corporation; Ampla Health; Association of California Healthcare Districts; Community Clinic Association of Los Angeles County; California School Employees Association; Clinica Sierra Vista; Community Clinic Consortium; Community Health Center Network; County Health Executives Association of California; Family Health Centers of San Diego; Health Alliance of Northern California; Health and Life Organization, Inc.; Kheir Center; Marin Community Clinics; Mountain Valleys Health Centers; North Coast Clinics Network; North County Health Services; Omni Family Health; Open Door Community Health Centers; Ravenswood Family Health Center; Redwood Community Health Coalition, San Ysidro Health Center; St. John's Well Child and Family Center; Tiburcio Vasquez Health Center, Inc.; Valley Community Healthcare; Western Sierra Medical Clinic; and White Memorial Community Health Center

OPPOSITION: California Right to Life Committee, Inc.

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 14, 2016

AMENDED IN ASSEMBLY MARCH 28, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2216

Introduced by Assembly Member Bonta

February 18, 2016

An act to add Article 1.5 (commencing with Section 128245) to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, relating to health workforce development.

LEGISLATIVE COUNSEL'S DIGEST

AB 2216, as amended, Bonta. Primary care residency programs: grant program.

Existing federal and state laws contain programs that authorize loan forgiveness to physicians, dentists, and individuals enrolled in a postsecondary institution studying medicine or dentistry who agree to practice in medically or dentally underserved areas. Under existing law, the Teaching Health Center Graduate Medical Education (THCGME) program was created by the federal Patient Protection and Affordable Care Act for the purpose of awarding grants to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

This bill would establish the Teaching Health Center Primary Care Graduate Medical Education Fund for purposes of funding primary care residency programs, as specified, subject to appropriation by the Legislature. The bill would establish criteria for the awarding of grants under these provisions to teaching health centers, as defined. The bill would require the Office of Statewide Health Planning and Development

and the Director of Statewide Health Planning and Development to administer these provisions, as specified. The bill would require the office to adopt emergency regulations to implement these provisions.

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

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

1 SECTION 1. Article 1.5 (commencing with Section 128245)
2 is added to Chapter 4 of Part 3 of Division 107 of the Health and
3 Safety Code, to read:

4
5 Article 1.5. Teaching Health Center Primary Care Graduate
6 Medical Education Act of 2016
7

8 128245. For purposes of this article, the following terms have
9 the following meanings:

10 (a) "Director" means the Director of Statewide Health Planning
11 and Development.

12 (b) "Fund" means the Teaching Health Center Primary Care
13 Graduate Medical Education Fund.

14 (c) "Office" means the Office of Statewide Health Planning and
15 Development.

16 (d) *"Sustaining grant" means a grant awarded to ensure the*
17 *continued operation of an accredited teaching health center,*
18 *whether that accreditation was first awarded pursuant to the*
19 *process created by this article or the accreditation was awarded*
20 *prior to the enactment of this article.*

21 (~~Ⓢ~~)

22 (e) "Teaching health center" has the same meaning as defined
23 in Article 1 (commencing with Section 128200).

24 128246. There is in the State Treasury the Teaching Health
25 Center Primary Care Graduate Medical Education Fund, which
26 fund is hereby created.

27 128247. (a) Subject to appropriation by the Legislature, the
28 director shall award planning and development grants from the
29 fund to teaching health centers for the purpose of establishing new
30 accredited or expanded primary care residency programs.

31 (b) Grants awarded under this section shall be for a term of not
32 more than three years and the maximum award to a teaching health

1 center shall not be more than five hundred thousand dollars
2 (\$500,000).

3 (c) A grant awarded pursuant to this section shall be used to
4 cover the costs of establishing or expanding a primary care
5 residency training program described in subdivision (a), including
6 costs associated with curriculum development, recruitment,
7 training, and retention of residents and faculty, accreditation by
8 the Accreditation Council for Graduate Medical Education
9 (ACGME), the American Dental Association (ADA), or the
10 American Osteopathic Association (AOA), faculty salaries during
11 the development phase, and technical assistance.

12 (d) A teaching health center seeking a grant under this section
13 shall submit an application to the office in the format prescribed
14 by the office. The director shall evaluate those applications and
15 award grants based on criteria consistent with a teaching health
16 center's readiness and other factors indicating the likelihood of
17 success at implementing a primary care residency program.

18 128248. (a) Subject to appropriation by the Legislature, the
19 director shall award sustaining grants from the fund to teaching
20 health centers operating primary care residency programs
21 accredited by the Accreditation Council for Graduate Medical
22 Education (ACGME), the American Dental Association (ADA),
23 or the American Osteopathic Association (AOA).

24 (b) The office shall determine the amount of grants awarded
25 per resident by taking into account the direct and indirect costs of
26 graduate medical education. The amount of grants awarded per
27 resident shall be updated, as appropriate, on an annual basis.

28 128249. The office shall promulgate emergency regulations
29 to implement this article.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2507
Author: Gordon
Bill Date: April 26, 2016, Amended
Subject: Telehealth: Access
Sponsor: Stanford Health Care

DESCRIPTION OF CURRENT LEGISLATION:

This bill would provide a minor expansion to existing telehealth laws in the Medical Practice Act.

BACKGROUND

Telehealth is the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management and self-management of a patient's health care while the patient is at the originating site (e.g. patient's home) and the health care provider is at a distant site (e.g. clinic).

Telehealth is seen as a tool in medical practice, not a separate form of medicine. There are no legal prohibitions to using technology in the practice of medicine, as long as the practice is done by a California licensed physician. The standard of care is the same whether the patient is seen in-person, through telehealth or other methods of electronically enabled health care. Physicians need not reside in California, as long as they have a valid, current California license.

ANALYSIS

This bill would specify that the definition of telehealth includes video and telephone communications. The bill would allow the acceptable forms of prior consent to include digital consent, in addition to the verbal and oral consent allowed in existing law. This bill would prohibit health care providers from requiring the use of telehealth when it is not appropriate. This bill would specify that a patient shall not be precluded from receiving in-person health care delivery services.

This bill would also provide a telehealth reimbursement infrastructure and would require the same coverage and reimbursement for services provided to a patient through telehealth as is required when the patient receives equivalent services in person. This bill would specify that all laws regarding the confidentiality of health care information and a patient's right to his or her medical information shall apply to telehealth services.

According to the author, there have been rapid developments in recent years in the delivery of health care through telehealth and telehealth offers improved access to quality health care for all. The author believes this bill will remove barriers to health care services provided via telehealth and ensure patient access, choice and convenience. Per the author, the intent of this bill is to provide access, patient choice, cost savings and innovations, but this bill does not change what services are covered; it clarifies that telehealth should be treated and reimbursed the same as an equivalent in-person service.

Board staff believes the changes this bill would make to existing telehealth law will not have a negative impact on consumer protection and may increase access to care. Board staff recommends that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: Stanford Health Care (Sponsor); Adventist Health; ALS Association Golden West Chapter; American Association for Marriage and Family Therapy; Association of California Healthcare Districts; California Academy of Family Physicians; California Children’s Hospital Association; California Life Sciences Association; California Medical Association; California Primary Care Association; Center for Information Technology Research in the Interest of Society; Center for Technology and Aging; El Camino Hospital; Health Care Interpreter Network; John Muir Health; Lucile Packard Children’s Hospital; National Multiple Sclerosis Society – CA Action Network; Occupational Therapy Association of California; Providence Health & Services; Sutter Health; and the Children’s Partnership

OPPOSITION: America’s Health Insurance Plans
Association of California Life and Health Insurance Companies
California Association of Health Plans
California Chamber of Commerce
California Right to Life Committee

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 26, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2507

Introduced by Assembly Member Gordon

February 19, 2016

An act to amend Section 2290.5 of the Business and Professions Code, to amend Section 1374.13 of the Health and Safety Code, and to amend Section 10123.85 of the Insurance Code, relating to telehealth.

LEGISLATIVE COUNSEL'S DIGEST

AB 2507, as amended, Gordon. Telehealth: access.

(1) Existing law defines “telehealth” as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient’s health care while the patient is at the originating site and the health care provider is at a distant site, and that facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers. Existing law requires that prior to the delivery of health care via telehealth, the health care provider initiating the use of telehealth inform the patient about the use of telehealth and obtain documented verbal or written consent from the patient for the use of telehealth.

This bill would add video—communications, telephone communications, email communications, and synchronous text or chat conferencing communications and telephone communications to the definition of telehealth. The bill would also provide that the required prior consent for telehealth services may be digital as well as oral or written.

(2) Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law prohibits health care service plans and health insurers from limiting the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee, insured, subscriber, or policyholder and the plan or insurer, and between the plan or insurer and its participating providers or provider groups.

This bill would also prohibit a health care provider from requiring the use of telehealth when a patient prefers to receive health care services ~~in person~~ *it is not appropriate* and would require health care service plans and health insurers to include coverage and reimbursement for services provided to a patient through telehealth to the same extent as though provided in person or by some other means, as specified. The bill would prohibit a health care service plan or health insurer from limiting coverage or reimbursement based on a contract entered into between the plan or insurer and an independent telehealth provider. The bill would prohibit a health care service plan or a health insurer from ~~interfering with the physician-patient~~ *altering the provider-patient* relationship based on the modality utilized for services appropriately provided through telehealth. *The bill would provide that all laws regarding the confidentiality of health care information and a patient's right to his or her medical information shall apply to telehealth services.*

Because a willful violation of the bill's provisions by a health care service plan would be a crime, it would impose a state-mandated local program.

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

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

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

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

1 SECTION 1. Section 2290.5 of the Business and Professions
2 Code is amended to read:

3 2290.5. (a) For purposes of this division, the following
4 definitions apply:

5 (1) “Asynchronous store and forward” means the transmission
6 of a patient’s medical information from an originating site to the
7 health care provider at a distant site without the presence of the
8 patient.

9 (2) “Distant site” means a site where a health care provider who
10 provides health care services is located while providing these
11 services via a telecommunications system.

12 (3) “Health care provider” means either of the following:

13 (A) A person who is licensed under this division.

14 (B) A marriage and family therapist intern or trainee functioning
15 pursuant to Section 4980.43.

16 (4) “Originating site” means a site where a patient is located at
17 the time health care services are provided via a telecommunications
18 system or where the asynchronous store and forward service
19 originates.

20 (5) “Synchronous interaction” means a real-time interaction
21 between a patient and a health care provider located at a distant
22 site.

23 (6) “Telehealth” means the mode of delivering health care
24 services and public health via information and communication
25 technologies to facilitate the diagnosis, consultation, treatment,
26 education, care management, and self-management of a patient’s
27 health care while the patient is at the originating site and the health
28 care provider is at a distant site. Telehealth facilitates patient
29 self-management and caregiver support for patients and includes
30 synchronous interactions and asynchronous store and forward
31 transfers, ~~including, but not limited to, including~~ video
32 ~~communications, telephone communications, email~~
33 ~~communications, and synchronous text or chat conferencing.~~
34 *communications and telephone communications.*

35 (b) Prior to the delivery of health care via telehealth, the health
36 care provider initiating the use of telehealth shall inform the patient
37 about the use of telehealth and obtain oral, written, or digital
38 consent from the patient for the use of telehealth as an acceptable

1 mode of delivering health care services and public health. The
2 consent shall be documented.

3 (c) Nothing in this section shall preclude a patient from receiving
4 in-person health care delivery services during a specified course
5 of health care and treatment after agreeing to receive services via
6 telehealth.

7 (d) The failure of a health care provider to comply with this
8 section shall constitute unprofessional conduct. Section 2314 shall
9 not apply to this section.

10 (e) This section shall not be construed to alter the scope of
11 practice of any health care provider or authorize the delivery of
12 health care services in a setting, or in a manner, not otherwise
13 authorized by law.

14 (f) All laws regarding the confidentiality of health care
15 information and a patient's rights to his or her medical information
16 shall apply to telehealth interactions.

17 (g) This section shall not apply to a patient under the jurisdiction
18 of the Department of Corrections and Rehabilitation or any other
19 correctional facility.

20 (h) (1) Notwithstanding any other provision of law and for
21 purposes of this section, the governing body of the hospital whose
22 patients are receiving the telehealth services may grant privileges
23 to, and verify and approve credentials for, providers of telehealth
24 services based on its medical staff recommendations that rely on
25 information provided by the distant-site hospital or telehealth
26 entity, as described in Sections 482.12, 482.22, and 485.616 of
27 Title 42 of the Code of Federal Regulations.

28 (2) By enacting this subdivision, it is the intent of the Legislature
29 to authorize a hospital to grant privileges to, and verify and approve
30 credentials for, providers of telehealth services as described in
31 paragraph (1).

32 (3) For the purposes of this subdivision, "telehealth" shall
33 include "telemedicine" as the term is referenced in Sections 482.12,
34 482.22, and 485.616 of Title 42 of the Code of Federal Regulations.

35 SEC. 2. Section 1374.13 of the Health and Safety Code is
36 amended to read:

37 1374.13. (a) For the purposes of this section, the definitions
38 in subdivision (a) of Section 2290.5 of the Business and Professions
39 Code apply.

1 (b) It is the intent of the Legislature to recognize the practice
2 of telehealth as a legitimate means by which an individual may
3 receive health care services from a health care provider without
4 in-person contact with the health care provider.

5 (c) A health care service plan shall not require that in-person
6 contact occur between a health care provider and a patient before
7 payment is made for the covered services appropriately provided
8 through telehealth, subject to the terms and conditions of the
9 contract entered into between the enrollee or subscriber and the
10 health care service plan, and between the health care service plan
11 and its participating providers or provider groups.

12 (d) A health care service plan shall not limit the type of setting
13 where services are provided for the patient or by the health care
14 provider before payment is made for the covered services
15 appropriately provided through telehealth, subject to the terms and
16 conditions of the contract entered into between the enrollee or
17 subscriber and the health care service plan, and between the health
18 care service plan and its participating providers or provider groups.

19 (e) The requirements of this section shall also apply to health
20 care service plan and Medi-Cal managed care plan contracts with
21 the State Department of Health Care Services pursuant to Chapter
22 7 (commencing with Section 14000) or Chapter 8 (commencing
23 with Section 14200) of Part 3 of Division 9 of the Welfare and
24 Institutions Code.

25 (f) Notwithstanding any law, this section shall not be interpreted
26 to authorize a health care service plan to require the use of
27 telehealth when the health care provider has determined that it is
28 not appropriate.

29 (g) Notwithstanding any law, this section shall not be interpreted
30 to authorize a health care provider to require the use of telehealth
31 when ~~a patient prefers to be treated in an in-person setting.~~
32 ~~Telehealth services should be physician- or practitioner-guided~~
33 ~~and patient-preferred. it is not appropriate. Nothing in this section~~
34 ~~shall preclude a patient from receiving in-person health care~~
35 ~~delivery services.~~

36 (h) A health care service plan shall include in its plan contract
37 coverage and reimbursement for services provided to a patient
38 through telehealth to the same extent as though provided in person
39 or by some other means.

1 (1) A health care service plan shall reimburse the health care
 2 provider for the diagnosis, consultation, or treatment of the enrollee
 3 when the service is delivered through telehealth at a rate that is at
 4 least as favorable to the health care provider as those established
 5 for the equivalent services when provided in person or by some
 6 other means.

7 (2) A health care service plan may subject the coverage of
 8 services delivered via telehealth to copayments, coinsurance, or
 9 deductible provided that the amounts charged are at least as
 10 favorable to the enrollee as those established for the equivalent
 11 services when provided in person or by some other means.

12 (i) A health care service plan shall not limit coverage or
 13 reimbursement based on a contract entered into between the health
 14 care service plan and an independent telehealth provider or ~~interfere~~
 15 ~~with the physician-patient~~ *alter the provider-patient* relationship
 16 based on the modality utilized for services appropriately provided
 17 through telehealth.

18 (j) *Notwithstanding any other law, this section shall not be*
 19 *interpreted to prohibit a health care service plan from undertaking*
 20 *a utilization review of telehealth services, provided that the*
 21 *utilization review is made in the same manner as a utilization*
 22 *review for equivalent services when provided in person or by other*
 23 *means.*

24 (k) *This section shall not be construed to alter the scope of*
 25 *practice of any health care provider or authorize the delivery of*
 26 *health care services in a setting, or in a manner, not otherwise*
 27 *authorized by law.*

28 (l) *All laws regarding the confidentiality of health care*
 29 *information and a patient’s right to his or her medical information*
 30 *shall apply to telehealth services.*

31 SEC. 3. Section 10123.85 of the Insurance Code is amended
 32 to read:

33 10123.85. (a) For purposes of this section, the definitions in
 34 subdivision (a) of Section 2290.5 of the Business and Professions
 35 Code shall apply.

36 (b) It is the intent of the Legislature to recognize the practice
 37 of telehealth as a legitimate means by which an individual may
 38 receive health care services from a health care provider without
 39 in-person contact with the health care provider.

1 (c) No health insurer shall require that in-person contact occur
2 between a health care provider and a patient before payment is
3 made for the services appropriately provided through telehealth,
4 subject to the terms and conditions of the contract entered into
5 between the policyholder or contractholder and the insurer, and
6 between the insurer and its participating providers or provider
7 groups.

8 (d) No health insurer shall limit the type of setting where
9 services are provided for the patient or by the health care provider
10 before payment is made for the covered services appropriately
11 provided by telehealth, subject to the terms and conditions of the
12 contract between the policyholder or contract holder and the
13 insurer, and between the insurer and its participating providers or
14 provider groups.

15 (e) Notwithstanding any other provision, this section shall not
16 be interpreted to authorize a health insurer to require the use of
17 telehealth when the health care provider has determined that it is
18 not appropriate.

19 (f) Notwithstanding any law, this section shall not be interpreted
20 to authorize a health care provider to require the use of telehealth
21 when a patient prefers to be treated in an in-person setting.
22 ~~Telehealth services should be physician- or practitioner-guided
23 and patient-preferred. it is not appropriate. Nothing in this section
24 shall preclude a patient from receiving in-person health care
25 delivery services.~~

26 (g) A health insurer shall include in its policy coverage and
27 reimbursement for services provided to a patient through telehealth
28 to the same extent as though provided in person or by some other
29 means.

30 (1) A health insurer shall reimburse the health care provider for
31 the diagnosis, consultation, or treatment of the insured when the
32 service is delivered through telehealth at a rate that is at least as
33 favorable to the health care provider as those established for the
34 equivalent services when provided in person or by some other
35 means.

36 (2) A health insurer may subject the coverage of services
37 delivered via telehealth to copayments, coinsurance, or deductible
38 provided that the amounts charged are at least as favorable to the
39 insured as those established for the equivalent services when
40 provided in person or by some other means.

1 (h) A health insurer shall not limit coverage or reimbursement
 2 based on a contract entered into between the health insurer and an
 3 independent telehealth provider or ~~interfere with the~~
 4 ~~physician-patient~~ alter the provider-patient relationship based on
 5 the modality utilized for services appropriately provided through
 6 telehealth.

7 (i) *Notwithstanding any other law, this section shall not be*
 8 *interpreted to prohibit a health insurer from undertaking a*
 9 *utilization review of telehealth services, provided that the*
 10 *utilization review is made in the same manner as a utilization*
 11 *review for equivalent services when provided in person or by other*
 12 *means.*

13 (j) *This section shall not be construed to alter the scope of*
 14 *practice of any health care provider or authorize the delivery of*
 15 *health care services in a setting, or in a manner, not otherwise*
 16 *authorized by law.*

17 (k) *All laws regarding the confidentiality of health care*
 18 *information and a patient’s right to his or her medical information*
 19 *shall apply to telehealth services.*

20 SEC. 4. No reimbursement is required by this act pursuant to
 21 Section 6 of Article XIII B of the California Constitution because
 22 the only costs that may be incurred by a local agency or school
 23 district will be incurred because this act creates a new crime or
 24 infraction, eliminates a crime or infraction, or changes the penalty
 25 for a crime or infraction, within the meaning of Section 17556 of
 26 the Government Code, or changes the definition of a crime within
 27 the meaning of Section 6 of Article XIII B of the California
 28 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2592
Author: Cooper
Bill Date: April 25, 2016, Amended
Subject: Controlled Substances: Medicine Locking Closure Packages: Grant Program
Sponsor: Gatekeeper Innovations

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the California Department of Public Health (CDPH), to the extent funding is available, to establish a pilot program to award grants to combat opioid abuse through the safe maintenance of opioids.

BACKGROUND

The issue of preventing inappropriate prescribing and misuse and abuse of opioids is of great importance to the Medical Board of California (Board). In September 2014, the Board hosted a free continuing medical education course in Los Angeles on Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy that was developed by the U.S. Food and Drug Administration. 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 prescribing for pain in California by avoiding under treatment, overtreatment or other inappropriate treatment of a patient's pain. The Guidelines' primary objective is improved patient outcomes and reduction of prescription overdose deaths. Lastly, the Board produced two public service announcements (PSAs) that address the issue of prescription drug abuse and misuse. One was directed towards physicians and one was directed towards consumers and featured gold medalist Natalie Coughlin. These PSAs have been aired on television stations throughout California and are posted on the Board's website.

ANALYSIS

This bill would make findings and declarations regarding opioid abuse and misuse in California and the grant recently received by CDPH of more than \$3.7 million to improve the safe prescribing of opioid painkillers.

This bill would authorize CDPH to establish a pilot program, if funding is available, to award grants to combat opioid abuse through the safe maintenance of opioids. CDPH would determine the amount of grants to award to individual pharmacies that choose to participate in the program. Grants must target areas where the prevalence of prescription drug abuse is high,

as determined by data that has been collected by CDPH and the California Health Care Foundation. A pharmacy that applies for and receives a grant, would be required to offer all patients who are prescribed an opioid a medicine locking closure package. A patient would not receive the medicine locking closure package unless he or she consents either orally or in writing . This bill would define a medicine locking closure package as a locking closure container, accessible only by the designated patient with a passcode, an alphanumeric code, a key, or by another secure mechanism. A medicine locking closure package includes, but is not limited to, an amber prescription container combined with a resettable alphanumeric code.

This bill would specify that CDPH shall not expend General Fund moneys on this program unless those moneys are specifically appropriated for this purpose. This bill would allow CDPH to seek funds from private entities, including foundations and nonprofit organizations, and CDPH may apply for federal or other grants to fund this pilot program. This bill would require CDPH to evaluate the effectiveness of the pilot program and to report its findings to the Legislature no later than December 31, 2019. This bill would sunset the pilot program on January 1, 2020.

According to the sponsor, California has taken steps to address the prescription drug abuse epidemic, but there is one prevention initiative that has gone widely unaddressed, the safe storage of prescription medications. The purpose of this bill is to examine whether increasing the safe storage of prescription drugs would reduce the number of drug abuse cases amongst teens and young adults. This bill is permissive for both the pharmacy and the patient, and it may help to address access to prescription drugs in the home. This bill furthers the Board's mission of consumer protection and is in line with the Board's work on the important issue of preventing misuse and abuse of prescription drugs. For these reasons, Board staff suggests that the Board support this bill.

FISCAL: None

SUPPORT: Gatekeeper Innovations, Inc. (Sponsor)
Capitol Health Network
C.O.R.E. Medical Clinic, Inc.

OPPOSITION: None on File

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 25, 2016

AMENDED IN ASSEMBLY APRIL 11, 2016

AMENDED IN ASSEMBLY MARCH 18, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2592

Introduced by Assembly Member Cooper

February 19, 2016

An act to add and repeal Section 11209.3 of the Health and Safety Code, relating to controlled substances.

LEGISLATIVE COUNSEL'S DIGEST

AB 2592, as amended, Cooper. Controlled substances: medicine locking closure packages: grant program.

Existing law, the California Uniform Controlled Substances Act, specifies the proper uses of, and means of prescribing, controlled substances, as defined. Existing law prohibits a person other than a pharmacist or an intern pharmacist, as specified, from compounding, preparing, filling, or dispensing a prescription for a controlled substance. A violation of these provisions is generally a misdemeanor unless another punishment is specifically provided.

Existing law establishes the State Department of Public Health, which has authority over various programs promoting public health and which may investigate, apply for, and enter into agreements to secure federal or nongovernmental funding opportunities for the purposes of advancing public health.

This bill, until January 1, 2020, would ~~require~~ *authorize* the department to establish a pilot program, as specified, to award grants to combat opioid abuse through the safe prescribing of opioids. The bill

would require the department to award grants, in an amount to be determined by the department, to individual pharmacies that choose to participate in the program. The bill would require a pharmacy that applies for and receives a grant to offer all patients who are prescribed an opioid a medicine locking closure package, as defined. The bill would prohibit the department from using General Fund moneys on this program unless those moneys are specifically appropriated for this purpose. The bill would require the department to evaluate the effectiveness of the program and report its findings to the Legislature no later than December 31, 2019.

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

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

1 SECTION 1. The Legislature finds and declares all of the
 2 following:
 3 (a) More than 4,300 people died from drug poisoning in
 4 California in 2013.
 5 (b) Most drug poisonings stem from prescription medications,
 6 and opioids are the most commonly prescribed.
 7 (c) Recent research by the federal Centers for Disease Control
 8 and Prevention finds that 98 percent of all sources for abused
 9 prescription drugs originate within the home. Only 3 percent of
 10 homes lock up their medications.
 11 (d) The State Department of Public Health recently received a
 12 new grant of more than \$3.7 million to improve the safe prescribing
 13 of opioid painkillers.
 14 SEC. 2. Section 11209.3 is added to the Health and Safety
 15 Code, to read:
 16 11209.3. (a) The State Department of Public Health ~~shall~~, *may*,
 17 to the extent funding is available, establish a pilot program to award
 18 grants to combat opioid abuse through the safe prescribing of
 19 opioids. Grants, in an amount determined by the department, shall
 20 be awarded to individual pharmacies that choose to participate in
 21 the program. Grants shall target areas where the prevalence of
 22 prescription drug abuse is high as determined by data that have
 23 been collected by the department and the California Health Care
 24 Foundation.

1 (b) A pharmacy that applies for and receives a grant pursuant
2 to this section shall offer all patients who are prescribed an opioid
3 a medicine locking closure package. A patient shall not receive a
4 medicine locking closure package unless he or she consents either
5 orally or in writing. Every medicine locking closure package shall
6 be dispensed with instructions for patient use unless the patient
7 indicates orally or in writing that instructions are not needed.

8 (c) The State Department of Public Health shall not expend
9 General Fund moneys on this program unless those moneys are
10 specifically appropriated for this purpose. The department may
11 seek funds from private entities, including foundations and
12 nonprofit organizations, and may apply for federal or other grants,
13 to fund the grant program.

14 (d) For purposes of this section, “medicine locking closure
15 package” means a locking closure container, ~~unlocked only with~~
16 ~~a user-generated code, that only allows the person with the~~
17 ~~prescription to access the medicine.~~ *accessible only by the*
18 *designated patient with a passcode, an alphanumeric code, a key,*
19 *or by another secure mechanism.* A medicine locking closure
20 package includes, but is not limited to, an amber prescription
21 container combined with a resettable alphanumeric code.

22 (e) The department shall evaluate the effectiveness of the pilot
23 program to combat prescription drug abuse in targeted areas and
24 report its findings to the Legislature no later than December 31,
25 2019. The report shall be submitted in compliance with Section
26 9795 of the Government Code.

27 (f) This section shall remain in effect only until January 1,
28 2020, and as of that date is repealed, unless a later enacted statute,
29 that is enacted before January 1, 2020, deletes or extends that date.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2606
Author: Grove
Bill Date: February 19, 2016, Introduced
Subject: Crimes Against Children, Elders, Dependent Adults and Persons with Disabilities
Sponsor: The Arc & United Cerebral Palsy California Collaboration

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require law enforcement to send a copy of a report alleging specified crimes committed against elderly or developmentally disabled people to state licensing agencies, including the Medical Board of California (Board).

ANALYSIS

This bill would require a law enforcement agency that receives or makes a report of the commission of specified crimes by a person who holds a state professional or occupational credential, license, or permit allowing the person to provide services to children, elders, dependent adults, or persons with disabilities, to provide a copy of that report to the state agency which issued the credential, license, or permit. This bill would apply the reporting requirements to the following crimes:

- Sexual exploitation by a physician and surgeon, psychotherapist, or drug/alcohol abuse counselor;
- Rape and other sex crimes;
- Elder or dependent adult abuse, failure to report by a mandated reporter, or interfering with a report;
- A hate crime motivated by anti-disability bias;
- Sexual abuse, as specified; and
- Child abuse, failure to report by a mandated reporter, or interfering with a report.

According to the author, the developmentally disabled, elderly, and children are the most vulnerable members of the State's community and the State has an obligation to help protect them. People with disabilities are subject to violent crimes at much higher rates than the general population and many of these crimes are committed by caretakers. Those who are not arrested or convicted are only fired and are legally free to go on to other jobs and continue their abuse because their licenses are not affected. The purpose of this bill is to address this problem by strengthening the law protecting mandated reporters from anyone who would impede their reports or retaliate against them for making the reports. Additionally, it requires law enforcement agencies to cross-report abuse, neglect, and sexual misconduct to the provider's state licensing agency.

Board staff believes that this information would be very helpful to the Board to identify physicians that could possibly pose a threat to vulnerable consumers and need Board review. Once the Board receives this information, it would still go through the Board's normal complaint and investigation process, which is confidential. This bill will further the Board's mission of consumer protection and Board staff suggests that the Board support this bill.

FISCAL: Minor and absorbable

SUPPORT: The Arc & United Cerebral Palsy California Collaboration (Sponsor)
The Arc of Riverside County
Association of Regional Center Agencies
California Advocates for Nursing Home Reform
California Long-Term Care Ombudsman Association
Disability Rights California
The Alliance

OPPOSITION: California Association of Psychiatric Technicians
California Attorneys for Criminal Justice
California Public Defenders Association
California State Sheriffs' Association
Legal Services for Prisoners with Children

POSITION: Recommendation: Support

ASSEMBLY BILL

No. 2606

Introduced by Assembly Member Grove

February 19, 2016

An act to add Chapter 14 (commencing with Section 368.7) to Title 9 of Part 1 of the Penal Code, relating to crimes.

LEGISLATIVE COUNSEL'S DIGEST

AB 2606, as introduced, Grove. Crimes against children, elders, dependent adults, and persons with disabilities.

The Child Abuse and Neglect Reporting Act requires a law enforcement agency that receives a report of child abuse to report to an appropriate licensing agency every known or suspected instance of child abuse or neglect that occurs while the child is being cared for in a child day care facility or community care facility or that involves a licensed staff person of the facility.

Existing law proscribes the commission of certain crimes against elders and dependent adults, including, but not limited to, inflicting upon an elder or dependent adult unjustifiable physical pain or mental suffering, as specified. Existing law proscribes the commission of a hate crime, as defined, against certain categories of persons, including disabled persons.

Existing law provides for the licensure of various healing arts professionals, and specifies that the commission of any act of sexual abuse, misconduct, or relations with a patient, client, or customer constitutes unprofessional conduct and grounds for disciplinary action against the licensee. Existing law also establishes that the crime of sexual exploitation by a physician and surgeon, psychotherapist, or alcohol and drug abuse counselor has occurred when the licensee

engages in specified sexual acts with a patient, client, or former patient or client.

This bill would require, if a law enforcement agency receives a report, or if a law enforcement officer makes a report, that a person who holds a state professional or occupational credential, license, or permit that allows the person to provide services to children, elders, dependent adults, or persons with disabilities is alleged to have committed one or more of specified crimes, the law enforcement agency to promptly send a copy of the report to the state licensing agency that issued the credential, license, or permit. By imposing additional duties on law enforcement agencies, this bill would impose a state-mandated local program.

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

This bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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. Chapter 14 (commencing with Section 368.7) is
2 added to Title 9 of Part 1 of the Penal Code, to read:

3
4 CHAPTER 14. REPORTING CRIMES AGAINST CHILDREN, ELDERS,
5 DEPENDENT ADULTS, AND PERSONS WITH DISABILITIES

6
7 368.7. If a law enforcement agency receives a report, or if a
8 law enforcement officer makes a report, that a person who holds
9 a state professional or occupational credential, license, or permit
10 that allows the person to provide services to children, elders,
11 dependent adults, or persons with disabilities is alleged to have
12 committed one or more of the crimes described in subdivisions (a)
13 to (f), inclusive, the law enforcement agency shall promptly send
14 a copy of the report to the state agency that issued the credential,
15 license, or permit.

1 (a) Sexual exploitation by a physician and surgeon,
2 psychotherapist, or drug or alcohol abuse counselor, as described
3 in Section 729 of the Business and Professions Code.

4 (b) Rape or other crimes described in Chapter 1 (commencing
5 with Section 261).

6 (c) Elder or dependent adult abuse, failure to report elder or
7 dependent adult abuse, interfering with a report of elder or
8 dependent adult abuse or other crimes, as described in Chapter 13.

9 (d) A hate crime motivated by antidisability bias, as described
10 in Chapter 1 (commencing with Section 422.55) of Title 11.6.

11 (e) Sexual abuse, as defined in Section 11165.1.

12 (f) Child abuse, failure to report child abuse, or interfering with
13 a report of child abuse.

14 SEC. 2. If the Commission on State Mandates determines that
15 this act contains costs mandated by the state, reimbursement to
16 local agencies and school districts for those costs shall be made
17 pursuant to Part 7 (commencing with Section 17500) of Division
18 4 of Title 2 of the Government Code.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2744
Author: Gordon
Bill Date: April 11, 2016, Amended
Subject: Healing Arts: Referrals
Sponsor: The Internet Association

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the payment or receipt of consideration for advertising where a licensee offers or sells services on the internet shall not constitute a referral of patients that is prohibited in existing law.

BACKGROUND

Existing law, Business and Professions Code Section 650, prohibits the offer of a commission as compensation for referring a patient. Existing law does allow payment for services other than the referral of a patient. This statute is several decades old, and was put into place before online advertising became available. In the past, if a physician wanted to advertise for his or her services, they could take out an advertisement in the yellow pages, a newspaper, a billboard, or run a commercial on radio or television. In these instances, the advertisement could include a coupon or special offer.

Now, physicians and other healthcare professionals can advertise online and offer purchase vouchers for service in online market places such as Groupon, Living Social, and others. For online voucher advertising companies, the healthcare professional decides whether to advertise and what service to make available for purchase (which is not an essential health benefit), the cost of the service, how many vouchers to offer, and for how long. The healthcare professional pays the online advertising network for making the offer available, generally a percentage of the price of the purchased service. Once a consumer purchases a voucher through this form of online advertising, the consumer contacts the health care professional to set an appointment, just as they would if responding to any other form of advertisement.

Per a 1994 Attorney General Opinion, a referral exists when a third party independent entity who individually has contact with a person in need of health care selects a professional to render the same. Online marketplaces do not select a healthcare professional, but rather make the advertisements and vouchers available on its website.

ANALYSIS

This bill would expressly provide that payment or receipt of consideration for advertising, where a licensee offers or sells services on the Internet, shall not constitute a

referral of patients. This bill would require the licensee to fully refund the purchaser if, after consultation, the licensee determines the service is not appropriate for the purchaser. This bill would specify that it does not apply to basic health care services or essential health benefits. This bill would require the entity that provides the advertising to demonstrate that the licensee consented in writing to the requirements of this bill.

Board staff has already looked at the issue of Internet advertising for physicians with companies like Groupon and Living Social, and does not believe that these arrangement are in violation of existing referral law. This bill would make it clear that this type of advertising is not in violation of existing law and would add protections for consumers to be refunded if the service is not appropriate. For these reasons, Board staff suggests that the Board take a neutral position on this bill.

FISCAL: None

SUPPORT: The Internet Association (Sponsor)
Groupon

OPPOSITION: None on file

POSITION: Recommendation: Neutral

AMENDED IN ASSEMBLY APRIL 11, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2744

Introduced by Assembly Member Gordon
(Coauthor: Senator Hill)

February 19, 2016

An act to amend Section 650 of the Business and Professions Code, relating to the healing arts.

LEGISLATIVE COUNSEL'S DIGEST

AB 2744, as amended, Gordon. Healing arts: referrals.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, it is unlawful for licensed healing arts practitioners, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person. Existing law makes a violation of this provision a public offense punishable upon a first conviction by imprisonment, as specified, or a fine not exceeding \$50,000, or by imprisonment and that fine.

This bill would provide that the payment or receipt of consideration for advertising, wherein a licensed healing arts practitioner offers or sells ~~prepaid services~~, *services on an Internet platform*, does not constitute a referral of ~~services~~ *patients*. *The bill would require the purchaser of the service to receive a refund of the full purchase price if the licensee determines, after consultation with the purchaser, that the service is not appropriate for the purchaser. The bill would specify*

that these provisions do not apply to basic health care services or essential health benefits, as defined. The bill would also provide that the entity that provides advertising is required to be able to demonstrate that the licensee consented in writing to these provisions.

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

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

1 SECTION 1. Section 650 of the Business and Professions Code
2 is amended to read:

3 650. (a) Except as provided in Chapter 2.3 (commencing with
4 Section 1400) of Division 2 of the Health and Safety Code, the
5 offer, delivery, receipt, or acceptance by any person licensed under
6 this division or the Chiropractic Initiative Act of any rebate, refund,
7 commission, preference, patronage dividend, discount, or other
8 consideration, whether in the form of money or otherwise, as
9 compensation or inducement for referring patients, clients, or
10 customers to any person, irrespective of any membership,
11 proprietary interest, or coownership in or with any person to whom
12 these patients, clients, or customers are referred is unlawful.

13 (b) The payment or receipt of consideration for services other
14 than the referral of patients which is based on a percentage of gross
15 revenue or similar type of contractual arrangement shall not be
16 unlawful if the consideration is commensurate with the value of
17 the services furnished or with the fair rental value of any premises
18 or equipment leased or provided by the recipient to the payer.

19 (c) The offer, delivery, receipt, or acceptance of any
20 consideration between a federally qualified health center, as defined
21 in Section 1396d(l)(2)(B) of Title 42 of the United States Code,
22 and any individual or entity providing goods, items, services,
23 donations, loans, or a combination thereof to the health center
24 entity pursuant to a contract, lease, grant, loan, or other agreement,
25 if that agreement contributes to the ability of the health center
26 entity to maintain or increase the availability, or enhance the
27 quality, of services provided to a medically underserved population
28 served by the health center, shall be permitted only to the extent
29 sanctioned or permitted by federal law.

30 (d) Except as provided in Chapter 2.3 (commencing with Section
31 1400) of Division 2 of the Health and Safety Code and in Sections

1 654.1 and 654.2 of this code, it shall not be unlawful for any person
2 licensed under this division to refer a person to any laboratory,
3 pharmacy, clinic (including entities exempt from licensure pursuant
4 to Section 1206 of the Health and Safety Code), or health care
5 facility solely because the licensee has a proprietary interest or
6 coownership in the laboratory, pharmacy, clinic, or health care
7 facility, provided, however, that the licensee's return on investment
8 for that proprietary interest or coownership shall be based upon
9 the amount of the capital investment or proportional ownership of
10 the licensee which ownership interest is not based on the number
11 or value of any patients referred. Any referral excepted under this
12 section shall be unlawful if the prosecutor proves that there was
13 no valid medical need for the referral.

14 (e) Except as provided in Chapter 2.3 (commencing with Section
15 1400) of Division 2 of the Health and Safety Code and in Sections
16 654.1 and 654.2 of this code, it shall not be unlawful to provide
17 nonmonetary remuneration, in the form of hardware, software, or
18 information technology and training services, as described in
19 subsections (x) and (y) of Section 1001.952 of Title 42 of the Code
20 of Federal Regulations, as amended October 4, 2007, as published
21 in the Federal Register (72 Fed. Reg. 56632 and 56644), and
22 subsequently amended versions.

23 (f) "Health care facility" means a general acute care hospital,
24 acute psychiatric hospital, skilled nursing facility, intermediate
25 care facility, and any other health facility licensed by the State
26 Department of Public Health under Chapter 2 (commencing with
27 Section 1250) of Division 2 of the Health and Safety Code.

28 (g) The payment or receipt of consideration for advertising,
29 wherein a licensee offers or sells ~~prepaid services~~, *services on an*
30 *Internet platform*, shall not constitute a referral of patients. To the
31 extent the licensee determines, after consultation with the purchaser
32 of the ~~prepaid~~ service, that a ~~prepaid~~ *the* service is not appropriate
33 for the purchaser, the licensee shall provide the purchaser *shall*
34 *receive* a refund of the full purchase price. *This subdivision shall*
35 *not apply to basic health care services, as defined in subdivision*
36 *(b) of Section 1345 of the Health and Safety Code, or essential*
37 *health benefits, as defined in Section 1367.005 of the Health and*
38 *Safety Code and Section 10112.27 of the Insurance Code. The*
39 *entity that provides the advertising shall be able to demonstrate*

1 *that the licensee consented in writing to the requirements of this*
2 *subdivision.*

3 (h) A violation of this section is a public offense and is
4 punishable upon a first conviction by imprisonment in a county
5 jail for not more than one year, or by imprisonment pursuant to
6 subdivision (h) of Section 1170 of the Penal Code, or by a fine not
7 exceeding fifty thousand dollars (\$50,000), or by both that
8 imprisonment and fine. A second or subsequent conviction is
9 punishable by imprisonment pursuant to subdivision (h) of Section
10 1170 of the Penal Code, or by that imprisonment and a fine of fifty
11 thousand dollars (\$50,000).

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2745
Author: Holden
Bill Date: April 25, 2016, Amended
Subject: Healing Arts: Licensing and Certification
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would make clarifying changes to existing law to assist the Board in its licensing and enforcement functions.

ANALYSIS

This bill would clarify the Board's authority for the allied health licensees licensed by the Board. It would allow the Board to revoke or deny a license for registered sex offenders, allow the Board to take disciplinary action for excessive use of drugs or alcohol, allow allied health licensees to petition the Board for license reinstatement, and would allow the Board to use probation as a disciplinary option for allied health licensees.

Existing law only allows new physician and surgeon applicants and disabled status licensees to apply for a limited practice license (LPL). This bill would allow all physician and surgeon licensees to apply for a LPL at any time. This bill would ensure that physicians who have a disabled status license and want to change to a LPL meet the same requirements in existing law for a LPL.

This bill would clarify that the Board can deny a post graduate training authorization letter for the same reasons it can deny a physician applicant's license in existing law.

This bill would clarify existing law related to investigations of a deceased patient. Existing law allows the Board to obtain a copy of the medical records of a deceased patient without the approval of the next of kin if the Board is unsuccessful in locating or contacting the patients' next of kin after reasonable efforts. Existing law requires the Board to contact the physician that owns the records, however, in many cases the records do not reside with the physician. This bill would allow the Board to send a written request for medical records to the facility where the care occurred or where the records are located. This will ensure that the Board's investigation is not hindered.

This bill would clean up existing law to ensure that the Board's authority to perform its regulatory oversight of licensees is clearly defined and aligned with current law. This is a Board-sponsored bill.

FISCAL: None

SUPPORT: Medical Board of California (Sponsor)

OPPOSITION: None on file

AMENDED IN ASSEMBLY APRIL 25, 2016

AMENDED IN ASSEMBLY APRIL 12, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL

No. 2745

Introduced by Assembly Member Holden

February 19, 2016

An act to amend Sections 2088, 2221, 2225, 2441, 2519, 2520, 2529, 3576, and 3577 of, and to add Sections 2522, 2523, 2529.1, 2529.6, 3576.1, 3576.2, and 3576.3 to, the Business and Professions Code, relating to healing arts, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

AB 2745, as amended, Holden. Healing arts: licensing and certification.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes an applicant for a physician's and surgeon's license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license ~~renewal~~ fee and signs an agreement agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. Existing law makes any person who knowingly provides false information in this agreement subject to any sanctions available to the board. Existing law authorizes the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license. Violation

of the act is a crime. Existing law establishes the Contingent Fund of the Medical Board of California, a continuously appropriated fund.

This bill would specify that a licensee who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability is authorized to receive the limited license if the above-described conditions are ~~met~~ *met, including payment of the appropriate fee*. By adding fees for deposit into the Contingent Fund of the Medical Board of California, this bill would make an appropriation.

This bill would also authorize the board to deny a postgraduate training authorization to an applicant who is guilty of unprofessional conduct or of any cause for revocation or suspension of a license.

(2) Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician.

This bill would require the board to agree to this limit, would authorize the board to require an independent clinical evaluation, and would subject a person who knowingly provides false information in the agreement to sanctions. By expanding the scope of a crime, this bill would impose a state-mandated local program.

(3) Existing law authorizes the board, in any investigation that involves the death of a patient, to inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely to determine the extent to which the death was the result of the physician and surgeon's violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.

This bill would authorize the board to provide the written request to the facility where the medical records are located or the care to the deceased patient was provided.

(4) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Board of Licensing of the Medical Board of California. Under the act, the board

is authorized to suspend or revoke the license of a midwife for specified conduct, including unprofessional conduct consisting of, among other things, incompetence or gross negligence in carrying out the usual functions of a licensed midwife. A violation of the act is a crime.

This bill would authorize the board to place a license on probation and establish a fee for monitoring a licensee on probation. The bill would also authorize a person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a license for a person required to register as a sex offender, except as specified.

(5) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified.

The bill would include within the definition of unprofessional conduct, among other things, the use of any controlled substance, or the use of any dangerous drugs, as specified, or of alcoholic beverages, as specified. The bill would also require the revocation of a registration for a person required to register as a sex offender, except as specified.

(6) Existing law prohibits a person from using the title “certified polysomnographic technologist” or engaging in the practice of polysomnography unless he or she is registered as a certified polysomnographic technologist, is supervised and directed by a licensed physician and surgeon, and meets certain other requirements. Existing law requires polysomnographic technologists to apply to and register with the Medical Board of California and to pay specified fees to be fixed by the board at no more than \$100 each, and to renew their registration biennially for a fee of no more than \$150. Existing law requires the deposit of those fees in the Contingent Fund of the Medical Board of California. Existing law authorizes a registration to be suspended, revoked, or otherwise subject to discipline for specified conduct.

This bill would also authorize a registration to be placed on probation if a registrant engages in that conduct and would establish a fee for monitoring a registrant on probation. By increasing fees for deposit into the Contingent Fund, this bill would make an appropriation. The bill

would authorize a person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a registration for a person required to register as a sex offender, except as specified. The bill would authorize the suspension or revocation of a registration for unprofessional conduct, as defined.

(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: yes. Fiscal committee: yes. State-mandated local program: yes.

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

1 SECTION 1. Section 2088 of the Business and Professions
2 Code is amended to read:

3 2088. (a) An applicant for a physician’s and surgeon’s license
4 or a physician’s and surgeon’s licensee who is otherwise eligible
5 for that license but is unable to practice some aspects of medicine
6 safely due to a disability may receive a limited license if he or she
7 does both of the following:

- 8 (1) Pays the appropriate initial or renewal license fee.
- 9 (2) Signs an agreement on a form prescribed by the board in
10 which the applicant or licensee agrees to limit his or her practice
11 in the manner prescribed by the reviewing physician and agreed
12 to by the board.

13 (b) The board may require the applicant or licensee described
14 in subdivision (a) to obtain an independent clinical evaluation of
15 his or her ability to practice medicine safely as a condition of
16 receiving a limited license under this section.

17 (c) Any person who knowingly provides false information in
18 the agreement submitted pursuant to subdivision (a) shall be subject
19 to any sanctions available to the board.

20 SEC. 2. Section 2221 of the Business and Professions Code is
21 amended to read:

1 2221. (a) The board may deny a physician's and surgeon's
2 certificate or postgraduate training authorization letter to an
3 applicant guilty of unprofessional conduct or of any cause that
4 would subject a licensee to revocation or suspension of his or her
5 license. The board in its sole discretion, may issue a probationary
6 physician's and surgeon's certificate to an applicant subject to
7 terms and conditions, including, but not limited to, any of the
8 following conditions of probation:

9 (1) Practice limited to a supervised, structured environment
10 where the licensee's activities shall be supervised by another
11 physician and surgeon.

12 (2) Total or partial restrictions on drug prescribing privileges
13 for controlled substances.

14 (3) Continuing medical or psychiatric treatment.

15 (4) Ongoing participation in a specified rehabilitation program.

16 (5) Enrollment and successful completion of a clinical training
17 program.

18 (6) Abstention from the use of alcohol or drugs.

19 (7) Restrictions against engaging in certain types of medical
20 practice.

21 (8) Compliance with all provisions of this chapter.

22 (9) Payment of the cost of probation monitoring.

23 (b) The board may modify or terminate the terms and conditions
24 imposed on the probationary certificate upon receipt of a petition
25 from the licensee. The board may assign the petition to an
26 administrative law judge designated in Section 11371 of the
27 Government Code. After a hearing on the petition, the
28 administrative law judge shall provide a proposed decision to the
29 board.

30 (c) The board shall deny a physician's and surgeon's certificate
31 to an applicant who is required to register pursuant to Section 290
32 of the Penal Code. This subdivision does not apply to an applicant
33 who is required to register as a sex offender pursuant to Section
34 290 of the Penal Code solely because of a misdemeanor conviction
35 under Section 314 of the Penal Code.

36 (d) An applicant shall not be eligible to reapply for a physician's
37 and surgeon's certificate for a minimum of three years from the
38 effective date of the denial of his or her application, except that
39 the board may, in its discretion and for good cause demonstrated,

1 permit reapplication after not less than one year has elapsed from
2 the effective date of the denial.

3 SEC. 3. Section 2225 of the Business and Professions Code is
4 amended to read:

5 2225. (a) Notwithstanding Section 2263 and any other law
6 making a communication between a physician and surgeon or a
7 doctor of podiatric medicine and his or her patients a privileged
8 communication, those provisions shall not apply to investigations
9 or proceedings conducted under this chapter. Members of the
10 board, the Senior Assistant Attorney General of the Health Quality
11 Enforcement Section, members of the California Board of Podiatric
12 Medicine, and deputies, employees, agents, and representatives of
13 the board or the California Board of Podiatric Medicine and the
14 Senior Assistant Attorney General of the Health Quality
15 Enforcement Section shall keep in confidence during the course
16 of investigations, the names of any patients whose records are
17 reviewed and shall not disclose or reveal those names, except as
18 is necessary during the course of an investigation, unless and until
19 proceedings are instituted. The authority of the board or the
20 California Board of Podiatric Medicine and the Health Quality
21 Enforcement Section to examine records of patients in the office
22 of a physician and surgeon or a doctor of podiatric medicine is
23 limited to records of patients who have complained to the board
24 or the California Board of Podiatric Medicine about that licensee.

25 (b) Notwithstanding any other law, the Attorney General and
26 his or her investigative agents, and investigators and representatives
27 of the board or the California Board of Podiatric Medicine, may
28 inquire into any alleged violation of the Medical Practice Act or
29 any other federal or state law, regulation, or rule relevant to the
30 practice of medicine or podiatric medicine, whichever is applicable,
31 and may inspect documents relevant to those investigations in
32 accordance with the following procedures:

33 (1) Any document relevant to an investigation may be inspected,
34 and copies may be obtained, where patient consent is given.

35 (2) Any document relevant to the business operations of a
36 licensee, and not involving medical records attributable to
37 identifiable patients, may be inspected and copied if relevant to
38 an investigation of a licensee.

39 (c) (1) Notwithstanding subdivision (b) or any other law, in
40 any investigation that involves the death of a patient, the board

1 may inspect and copy the medical records of the deceased patient
2 without the authorization of the beneficiary or personal
3 representative of the deceased patient or a court order solely for
4 the purpose of determining the extent to which the death was the
5 result of the physician and surgeon's conduct in violation of the
6 Medical Practice Act, if the board provides a written request to
7 either the physician and surgeon or the facility where the medical
8 records are located or the care to the deceased patient was provided,
9 that includes a declaration that the board has been unsuccessful in
10 locating or contacting the deceased patient's beneficiary or personal
11 representative after reasonable efforts. Nothing in this subdivision
12 shall be construed to allow the board to inspect and copy the
13 medical records of a deceased patient without a court order when
14 the beneficiary or personal representative of the deceased patient
15 has been located and contacted but has refused to consent to the
16 board inspecting and copying the medical records of the deceased
17 patient.

18 (2) The Legislature finds and declares that the authority created
19 in the board pursuant to this section, and a physician and surgeon's
20 compliance with this section, are consistent with the public interest
21 and benefit activities of the federal Health Insurance Portability
22 and Accountability Act (HIPAA).

23 (d) In all cases in which documents are inspected or copies of
24 those documents are received, their acquisition or review shall be
25 arranged so as not to unnecessarily disrupt the medical and business
26 operations of the licensee or of the facility where the records are
27 kept or used.

28 (e) If documents are lawfully requested from licensees in
29 accordance with this section by the Attorney General or his or her
30 agents or deputies, or investigators of the board or the California
31 Board of Podiatric Medicine, the documents shall be provided
32 within 15 business days of receipt of the request, unless the licensee
33 is unable to provide the documents within this time period for good
34 cause, including, but not limited to, physical inability to access
35 the records in the time allowed due to illness or travel. Failure to
36 produce requested documents or copies thereof, after being
37 informed of the required deadline, shall constitute unprofessional
38 conduct. The board may use its authority to cite and fine a
39 physician and surgeon for any violation of this section. This remedy

1 is in addition to any other authority of the board to sanction a
2 licensee for a delay in producing requested records.

3 (f) Searches conducted of the office or medical facility of any
4 licensee shall not interfere with the recordkeeping format or
5 preservation needs of any licensee necessary for the lawful care
6 of patients.

7 SEC. 4. Section 2441 of the Business and Professions Code is
8 amended to read:

9 2441. (a) Any licensee who demonstrates to the satisfaction
10 of the board that he or she is unable to practice medicine due to a
11 disability may request a waiver of the license renewal fee. The
12 granting of a waiver shall be at the discretion of the board and may
13 be terminated at any time. Waivers shall be based on the inability
14 of a licensee to practice medicine. A licensee whose renewal fee
15 has been waived pursuant to this section shall not engage in the
16 practice of medicine unless and until the licensee pays the current
17 renewal fee and does either of the following:

18 (1) Establishes to the satisfaction of the board, on a form
19 prescribed by the board and signed under penalty of perjury, that
20 the licensee’s disability either no longer exists or does not affect
21 his or her ability to practice medicine safely.

22 (2) Signs an agreement on a form prescribed by the board, signed
23 under penalty of perjury, in which the licensee agrees to limit his
24 or her practice in the manner prescribed by the reviewing physician
25 and agreed to by the board.

26 (b) The board may require the licensee described in paragraph
27 (2) of subdivision (a) to obtain an independent clinical evaluation
28 of his or her ability to practice medicine safely as a condition of
29 receiving a ~~disability~~ *disabled status* license under this section.

30 (c) Any person who knowingly provides false information in
31 the agreement submitted pursuant to paragraph (2) of subdivision
32 (a) shall be subject to any sanctions available to the board.

33 SEC. 5. Section 2519 of the Business and Professions Code is
34 amended to read:

35 2519. The board may suspend, revoke, or place on probation
36 the license of a midwife for any of the following:

37 (a) Unprofessional conduct, which includes, but is not limited
38 to, all of the following:

39 (1) Incompetence or gross negligence in carrying out the usual
40 functions of a licensed midwife.

- 1 (2) Conviction of a violation of Section 2052, in which event,
2 the record of the conviction shall be conclusive evidence thereof.
- 3 (3) The use of advertising that is fraudulent or misleading.
- 4 (4) Obtaining or possessing in violation of law, or prescribing,
5 or except as directed by a licensed physician and surgeon, dentist,
6 or podiatrist administering to himself or herself, or furnishing or
7 administering to another, any controlled substance as defined in
8 Division 10 (commencing with Section 11000) of the Health and
9 Safety Code or any dangerous drug as defined in Article 8
10 (commencing with Section 4210) of Chapter 9 of Division 2 of
11 the Business and Professions Code.
- 12 (5) The use of any controlled substance as defined in Division
13 10 (commencing with Section 11000) of the Health and Safety
14 Code, or any dangerous drug as defined in Article 8 (commencing
15 with Section 4210) of Chapter 9 of Division 2 of the Business and
16 Professions Code, or alcoholic beverages, to an extent or in a
17 manner dangerous or injurious to himself or herself, any other
18 person, or the public or to the extent that this use impairs his or
19 her ability to conduct with safety to the public the practice
20 authorized by his or her license.
- 21 (6) Conviction of a criminal offense involving the prescription,
22 consumption, or self-administration of any of the substances
23 described in paragraphs (4) and (5), or the possession of, or
24 falsification of, a record pertaining to, the substances described in
25 paragraph (4), in which event the record of the conviction is
26 conclusive evidence thereof.
- 27 (7) Commitment or confinement by a court of competent
28 jurisdiction for intemperate use of or addiction to the use of any
29 of the substances described in paragraphs (4) and (5), in which
30 event the court order of commitment or confinement is prima facie
31 evidence of such commitment or confinement.
- 32 (8) Falsifying, or making grossly incorrect, grossly inconsistent,
33 or unintelligible entries in any hospital, patient, or other record
34 pertaining to the substances described in subdivision (a).
- 35 (b) Procuring a license by fraud or misrepresentation.
- 36 (c) Conviction of a crime substantially related to the
37 qualifications, functions, and duties of a midwife, as determined
38 by the board.
- 39 (d) Procuring, aiding, abetting, attempting, agreeing to procure,
40 offering to procure, or assisting at, a criminal abortion.

1 (e) Violating or attempting to violate, directly or indirectly, or
2 assisting in or abetting the violation of, or conspiring to violate
3 any provision or term of this chapter.

4 (f) Making or giving any false statement or information in
5 connection with the application for issuance of a license.

6 (g) Impersonating any applicant or acting as proxy for an
7 applicant in any examination required under this chapter for the
8 issuance of a license or a certificate.

9 (h) Impersonating another licensed practitioner, or permitting
10 or allowing another person to use his or her license or certificate
11 for the purpose of providing midwifery services.

12 (i) Aiding or assisting, or agreeing to aid or assist any person
13 or persons, whether a licensed physician or not, in the performance
14 of or arranging for a violation of any of the provisions of Article
15 12 (commencing with Section 2221) of Chapter 5.

16 (j) Failing to do any of the following when required pursuant
17 to Section 2507:

18 (1) Consult with a physician and surgeon.

19 (2) Refer a client to a physician and surgeon.

20 (3) Transfer a client to a hospital.

21 SEC. 6. Section 2520 of the Business and Professions Code is
22 amended to read:

23 2520. (a) (1) The fee to be paid upon the filing of a license
24 application shall be fixed by the board at not less than seventy-five
25 dollars (\$75) nor more than three hundred dollars (\$300).

26 (2) The fee for renewal of the midwife license shall be fixed by
27 the board at not less than fifty dollars (\$50) nor more than two
28 hundred dollars (\$200).

29 (3) The delinquency fee for renewal of the midwife license shall
30 be 50 percent of the renewal fee in effect on the date of the renewal
31 of the license, but not less than twenty-five dollars (\$25) nor more
32 than fifty dollars (\$50).

33 (4) The fee for the examination shall be the cost of administering
34 the examination to the applicant, as determined by the organization
35 that has entered into a contract with the board for the purposes set
36 forth in subdivision (a) of Section 2512.5. Notwithstanding
37 subdivision (c), that fee may be collected and retained by that
38 organization.

39 (b) The fee for monitoring a licensee on probation shall be the
40 cost of monitoring, as fixed by the board.

1 (c) The fees prescribed by this article shall be deposited in the
2 Licensed Midwifery Fund, which is hereby established, and shall
3 be available, upon appropriation, to the board for the purposes of
4 this article.

5 SEC. 7. Section 2522 is added to the Business and Professions
6 Code, to read:

7 2522. (a) A person whose license has been voluntarily
8 surrendered while under investigation or while charges are pending
9 or whose license has been revoked or suspended or placed on
10 probation, may petition the board for reinstatement or modification
11 of penalty, including modification or termination of probation.

12 (b) The person may file the petition after a period of not less
13 than the following minimum periods have elapsed from the
14 effective date of the surrender of the license or the decision
15 ordering that disciplinary action:

16 (1) At least three years for reinstatement of a license surrendered
17 or revoked for unprofessional conduct, except that the board may,
18 for good cause shown, specify in a revocation order that a petition
19 for reinstatement may be filed after two years.

20 (2) At least two years for early termination of probation of three
21 years or more.

22 (3) At least one year for modification of a condition, or
23 reinstatement of a license surrendered or revoked for mental or
24 physical illness, or termination of probation of less than three years.

25 (c) The petition shall state any facts as may be required by the
26 board. The petition shall be accompanied by at least two verified
27 recommendations from midwives licensed in any state who have
28 personal knowledge of the activities of the petitioner since the
29 disciplinary penalty was imposed.

30 (d) The petition may be heard by a panel of the board. The board
31 may assign the petition to an administrative law judge designated
32 in Section 11371 of the Government Code. After a hearing on the
33 petition, the administrative law judge shall provide a proposed
34 decision to the board, which shall be acted upon in accordance
35 with Section 2335.

36 (e) The panel of the board or the administrative law judge
37 hearing the petition may consider all activities of the petitioner
38 since the disciplinary action was taken, the offense for which the
39 petitioner was disciplined, the petitioner's activities during the
40 time the license was in good standing, and the petitioner's

1 rehabilitative efforts, general reputation for truth, and professional
2 ability. The hearing may be continued from time to time as the
3 administrative law judge designated in Section 11371 of the
4 Government Code finds necessary.

5 (f) The administrative law judge designated in Section 11371
6 of the Government Code reinstating a license or modifying a
7 penalty may recommend the imposition of any terms and conditions
8 deemed necessary.

9 (g) No petition shall be considered while the petitioner is under
10 sentence for any criminal offense, including any period during
11 which the petitioner is on court-imposed probation or parole. No
12 petition shall be considered while there is an accusation or petition
13 to revoke probation pending against the person. The board may
14 deny without a hearing or argument any petition filed pursuant to
15 this section within a period of two years from the effective date
16 of the prior decision following a hearing under this section.

17 SEC. 8. Section 2523 is added to the Business and Professions
18 Code, to read:

19 2523. (a) Except as provided in subdivisions (b) and (c), the
20 board shall revoke the license of any person who has been required
21 to register as a sex offender pursuant to Section 290 of the Penal
22 Code for conduct that occurred on or after January 1, 2017.

23 (b) This section shall not apply to a person who is required to
24 register as a sex offender pursuant to Section 290 of the Penal
25 Code solely because of a misdemeanor conviction under Section
26 314 of the Penal Code.

27 (c) This section shall not apply to a person who has been relieved
28 under Section 290.5 of the Penal Code of his or her duty to register
29 as a sex offender, or whose duty to register has otherwise been
30 formally terminated under California law.

31 (d) A proceeding to revoke a license pursuant to this section
32 shall be conducted in accordance with chapter 5 (commencing
33 with Section 11500) of Part 1 of Division 3 of Title 2 of the
34 Government Code.

35 SEC. 9. Section 2529 of the Business and Professions Code is
36 amended to read:

37 2529. (a) Graduates of the Southern California Psychoanalytic
38 Institute, the Los Angeles Psychoanalytic Society and Institute,
39 the San Francisco Psychoanalytic Institute, the San Diego
40 Psychoanalytic Center, or institutes deemed equivalent by the

1 Medical Board of California who have completed clinical training
2 in psychoanalysis may engage in psychoanalysis as an adjunct to
3 teaching, training, or research and hold themselves out to the public
4 as psychoanalysts, and students in those institutes may engage in
5 psychoanalysis under supervision, if the students and graduates
6 do not hold themselves out to the public by any title or description
7 of services incorporating the words “psychological,”
8 “psychologist,” “psychology,” “psychometrists,” “psychometrics,”
9 or “psychometry,” or that they do not state or imply that they are
10 licensed to practice psychology.

11 (b) Those students and graduates seeking to engage in
12 psychoanalysis under this chapter shall register with the Medical
13 Board of California, presenting evidence of their student or
14 graduate status. The board may suspend or revoke the exemption
15 of those persons for unprofessional conduct as defined in Sections
16 726, 2234, 2235, and 2529.1

17 SEC. 10. Section 2529.1 is added to the Business and
18 Professions Code, to read:

19 2529.1. (a) The use of any controlled substance or the use of
20 any of the dangerous drugs specified in Section 4022, or of
21 alcoholic beverages, to the extent, or in such a manner as to be
22 dangerous or injurious to the registrant, or to any other person or
23 to the public, or to the extent that this use impairs the ability of
24 the registrant to practice safely or more than one misdemeanor or
25 any felony conviction involving the use, consumption, or
26 self-administration of any of the substances referred to in this
27 section, or any combination thereof, constitutes unprofessional
28 conduct. The record of the conviction is conclusive evidence of
29 this unprofessional conduct.

30 (b) A plea or verdict of guilty or a conviction following a plea
31 of nolo contendere is deemed to be a conviction within the meaning
32 of this section. The board may order discipline of the registrant in
33 accordance with Section 2227 or may order the denial of the
34 registration when the time for appeal has elapsed or the judgment
35 of conviction has been affirmed on appeal or when an order
36 granting probation is made suspending imposition of sentence,
37 irrespective of a subsequent order under the provisions of Section
38 1203.4 of the Penal Code allowing this person to withdraw his or
39 her plea of guilty and to enter a plea of not guilty, or setting aside

1 the verdict of guilty, or dismissing the accusation, complaint,
2 information, or indictment.

3 SEC. 11. Section 2529.6 is added to the Business and
4 Professions Code, to read:

5 2529.6. (a) Except as provided in subdivisions (b) and (c), the
6 board shall revoke the registration of any person who has been
7 required to register as a sex offender pursuant to Section 290 of
8 the Penal Code for conduct that occurred on or after January 1,
9 2017.

10 (b) This section shall not apply to a person who is required to
11 register as a sex offender pursuant to Section 290 of the Penal
12 Code solely because of a misdemeanor conviction under Section
13 314 of the Penal Code.

14 (c) This section shall not apply to a person who has been relieved
15 under Section 290.5 of the Penal Code of his or her duty to register
16 as a sex offender, or whose duty to register has otherwise been
17 formally terminated under California law.

18 (d) A proceeding to revoke a registration pursuant to this section
19 shall be conducted in accordance with ~~chapter~~ *Chapter 5*
20 (commencing with Section 11500) of Part 1 of Division 3 of Title
21 2 of the Government Code.

22 SEC. 12. Section 3576 of the Business and Professions Code
23 is amended to read:

24 3576. (a) A registration under this chapter may be denied,
25 suspended, revoked, placed on probation, or otherwise subjected
26 to discipline for any of the following by the holder:

27 (1) Incompetence, gross negligence, or repeated similar
28 negligent acts performed by the registrant.

29 (2) An act of dishonesty or fraud.

30 (3) Committing any act or being convicted of a crime
31 constituting grounds for denial of licensure or registration under
32 Section 480.

33 (4) Violating or attempting to violate this chapter or any
34 regulation adopted under this chapter.

35 (b) Proceedings under this section shall be conducted in
36 accordance with Chapter 5 (commencing with Section 11500) of
37 Part 1 of Division 3 of Title 2 of the Government Code, and the
38 board shall have all powers granted therein.

39 SEC. 13. Section 3576.1 is added to the Business and
40 Professions Code, to read:

1 3576.1. (a) A person whose registration has been voluntarily
2 surrendered while under investigation or while charges are pending
3 or whose registration has been revoked or suspended or placed on
4 probation, may petition the board for reinstatement or modification
5 of penalty, including modification or termination of probation.

6 (b) The person may file the petition after a period of not less
7 than the following minimum periods have elapsed from the
8 effective date of the surrender of the registration or the decision
9 ordering that disciplinary action:

10 (1) At least three years for reinstatement of a registration
11 surrendered or revoked for unprofessional conduct, except that the
12 board may, for good cause shown, specify in a revocation order
13 that a petition for reinstatement may be filed after two years.

14 (2) At least two years for early termination of probation of three
15 years or more.

16 (3) At least one year for modification of a condition, or
17 reinstatement of a registration surrendered or revoked for mental
18 or physical illness, or termination of probation of less than three
19 years.

20 (c) The petition shall state any facts as may be required by the
21 board. The petition shall be accompanied by at least two verified
22 recommendations from polysomnographic technologists registered
23 in any state who have personal knowledge of the activities of the
24 petitioner since the disciplinary penalty was imposed.

25 (d) The petition may be heard by a panel of the board. The board
26 may assign the petition to an administrative law judge designated
27 in Section 11371 of the Government Code. After a hearing on the
28 petition, the administrative law judge shall provide a proposed
29 decision to the board, which shall be acted upon in accordance
30 with Section 2335.

31 (e) The panel of the board or the administrative law judge
32 hearing the petition may consider all activities of the petitioner
33 since the disciplinary action was taken, the offense for which the
34 petitioner was disciplined, the petitioner's activities during the
35 time the registration was in good standing, and the petitioner's
36 rehabilitative efforts, general reputation for truth, and professional
37 ability. The hearing may be continued from time to time as the
38 administrative law judge designated in Section 11371 of the
39 Government Code finds necessary.

1 (f) The administrative law judge designated in Section 11371
2 of the Government Code reinstating a registration or modifying a
3 penalty may recommend the imposition of any terms and conditions
4 deemed necessary.

5 (g) No petition shall be considered while the petitioner is under
6 sentence for any criminal offense, including any period during
7 which the petitioner is on court-imposed probation or parole. No
8 petition shall be considered while there is an accusation or petition
9 to revoke probation pending against the person. The board may
10 deny without a hearing or argument any petition filed pursuant to
11 this section within a period of two years from the effective date
12 of the prior decision following a hearing under this section.

13 SEC. 14. Section 3576.2 is added to the Business and
14 Professions Code, to read:

15 3576.2. (a) Except as provided in subdivisions (b) and (c), the
16 board shall revoke the registration of any person who has been
17 required to register as a sex offender pursuant to Section 290 of
18 the Penal for conduct that occurred on or after January 1, 2017.

19 (b) This section shall not apply to a person who is required to
20 register as a sex offender pursuant to Section 290 of the Penal
21 Code solely because of a misdemeanor conviction under Section
22 314 of the Penal Code.

23 (c) This section shall not apply to a person who has been relieved
24 under Section 290.5 of the Penal Code of his or her duty to register
25 as a sex offender, or whose duty to register has otherwise been
26 formally terminated under California law.

27 (d) A proceeding to revoke a registration pursuant to this section
28 shall be conducted in accordance with ~~chapter~~ *Chapter 5*
29 (commencing with Section 11500) of Part 1 of Division 3 of Title
30 2 of the Government Code.

31 SEC. 15. Section 3576.3 is added to the Business and
32 Professions Code, to read:

33 3576.3. (a) The board may suspend or revoke the registration
34 of a polysomnographic technologist, polysomnographic technician,
35 or polysomnographic trainee for unprofessional conduct as
36 described in this section.

37 (b) The use of any controlled substance or the use of any of the
38 dangerous drugs specified in Section 4022, or of alcoholic
39 beverages, to the extent, or in such a manner as to be dangerous
40 or injurious to the registrant, or to any other person or to the public,

1 or to the extent that this use impairs the ability of the registrant to
2 practice safely or more than one misdemeanor or any felony
3 conviction involving the use, consumption, or self-administration
4 of any of the substances referred to in this section, or any
5 combination thereof, constitutes unprofessional conduct. The record
6 of the conviction is conclusive evidence of this unprofessional
7 conduct.

8 (c) A plea or verdict of guilty or a conviction following a plea
9 of nolo contendere is deemed to be a conviction within the meaning
10 of this section. The board may order discipline of the registrant in
11 accordance with Section 2227 or may order the denial of the
12 registration when the time for appeal has elapsed or the judgment
13 of conviction has been affirmed on appeal or when an order
14 granting probation is made suspending imposition of sentence,
15 irrespective of a subsequent order under the provisions of Section
16 1203.4 of the Penal Code allowing this person to withdraw his or
17 her plea of guilty and to enter a plea of not guilty, or setting aside
18 the verdict of guilty, or dismissing the accusation, complaint,
19 information, or indictment.

20 SEC. 16. Section 3577 of the Business and Professions Code
21 is amended to read:

22 3577. (a) Each person who applies for registration under this
23 chapter shall pay into the Contingent Fund of the Medical Board
24 of California a fee to be fixed by the board at a sum not in excess
25 of one hundred dollars (\$100).

26 (b) Each person to whom registration is granted under this
27 chapter shall pay into the Contingent Fund of the Medical Board
28 of California a fee to be fixed by the board at a sum not in excess
29 of one hundred dollars (\$100).

30 (c) The registration shall expire after two years. The registration
31 may be renewed biennially at a fee which shall be paid into the
32 Contingent Fund of the Medical Board of California to be fixed
33 by the board at a sum not in excess of one hundred fifty dollars
34 (\$150).

35 (d) The fee for monitoring a licensee *registrant* on probation
36 shall be the cost of monitoring, as fixed by the board.

37 (e) The money in the Contingent Fund of the Medical Board of
38 California that is collected pursuant to this section shall be used
39 for the administration of this chapter.

1 SEC. 17. No reimbursement is required by this act pursuant to
2 Section 6 of Article XIII B of the California Constitution because
3 the only costs that may be incurred by a local agency or school
4 district will be incurred because this act creates a new crime or
5 infraction, eliminates a crime or infraction, or changes the penalty
6 for a crime or infraction, within the meaning of Section 17556 of
7 the Government Code, or changes the definition of a crime within
8 the meaning of Section 6 of Article XIII B of the California
9 Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 22
Author: Roth, Cannella and Galgiani
Bill Date: February 29, 2016, Amended
Subject: Residency Training: Funding
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill was substantially amended since the last Board Meeting. This bill would make findings and declarations regarding the availability of primary care residency positions in California and the shortage of primary care physicians in California. This bill would appropriate \$300,000,000 from the General Fund to the Office of Statewide Health Planning and Development (OSHPD) to fund physician residency positions in California.

BACKGROUND

Graduate medical education (GME) or residency training, is the second phase of the educational process that prepares physicians for independent practice. Resident physicians typically spend three to seven years in GME training. Medicare has been the largest single funder of GME, but in 1997 Congress capped the number of residency slots for which hospitals could receive Medicare GME funding and has not increased this cap. In California, there are many more individuals that would like a residency slot in California, than there are residency positions available.

The Song-Brown Health Care Workforce Training Act was established in 1973 to increase the number of family physicians to provide needed medical services to the people of California. The program encourages universities and primary care health professionals to provide healthcare in medically underserved areas, and provides financial support to family medicine, internal medicine, OB/GYN, and pediatric residency programs, family nurse practitioner, physician assistant, and registered nurse education programs throughout California. The Song-Brown program is aided by the California Healthcare Workforce Policy Commission (CHWPC). CHWPC is a 15-member citizen advisory board that provides expert guidance and statewide perspectives on health professional education issues, reviews applications and recommends contract awards to the Director of OSHPD. The CHWPC meets four times annually and OSHPD provides administrative support to the CHWPC and the accredited training programs.

ANALYSIS

This bill would make the following findings and declarations:

- More than \$40 million of funding for the training of California's primary care physicians is expiring in 2016.
- Each year in California, only 368 slots are available to the thousands of medical students seeking to train in family medicine. If the funding is not replaced, 158 of those slots will be lost, creating a deficit of primary care physicians in California's underserved communities.
- Only 36 percent of California's active patient care physicians practice primary care. Twenty-three of California's 58 counties fall below the minimum required primary care physician to population ratio.
- As of 2010, California needed an estimated additional 8,243 primary care physicians by 2030 to prevent projected shortages in the state, which is about 412 new primary care physicians per year.
- More than 32 percent of California's practicing primary care physicians are 60 years of age or older.
- States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, and stroke.
- The Song-Brown Program provides an existing state infrastructure to support an increase in the number of primary care providers serving California's underserved populations. By investing in Song-Brown, California will realize an immediate return on investment as each primary care resident provides an average of 600 additional patient visits per physician per year during training alone.
- California's long-term workforce will also grow significantly as the vast majority of physicians who train in a region stay there to practice. California leads all fifty states in the percentage of residency program graduates who stay in the state in which they are trained.

This bill would continuously appropriate \$300 million from the General Fund (over a three-year period) to OSHPD for the purpose of funding new and existing graduate medical education physician residency positions, and supporting training faculty, pursuant to the Song-Brown Health Care Workforce Training Act.

This bill would increase funding for residency programs in California, which will help promote the Board's mission of increasing access to care for consumers. This bill would also allow more physicians to receive residency training and potentially end up practicing in California. As such, Board staff is suggesting that the Board continue to support this bill.

FISCAL: None

SUPPORT: (Verified 1/26/16) - AARP; Association of California Healthcare Districts; California Academy of Physician Assistants; California Chapter of the American College of Emergency Physicians; California Physical Therapy Association; California Primary Care Association; and Community Clinic Association of Los Angeles County

OPPOSITION: (Verified 1/26/16) - None on file

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY FEBRUARY 29, 2016

AMENDED IN SENATE JANUARY 25, 2016

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~~ *Senators Roth, Cannella, and Galgiani*
(Principal coauthors: Assembly Members Alejo, Brown, Calderon, Eduardo Garcia, Gipson, Gonzalez, Gray, Jones-Sawyer, Linder, Olsen, Ridley-Thomas, and Salas)

December 1, 2014

An act to add Article 7 (commencing with Section 128590) to Chapter 5 of 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~~. *training: funding.*

The Song-Brown Health Care Workforce Training Act creates a state medical contract program to increase the number of students and residents receiving quality education and training in specified primary care specialties or in nursing, and to maximize the delivery of primary care and family physician services to specific areas of California where there is a recognized unmet priority need for those services. The act requires the Director of Statewide Health Planning and Development to, among other things, contract with accredited medical schools,

teaching health centers, training programs, hospitals, and other health care delivery systems for those purposes, based on recommendations of the California Healthcare Workforce Policy Commission and in conformity with the contract criteria and program standards established by the commission.

This bill would appropriate \$300,000,000 from the General Fund to the director for the purpose of funding new and existing graduate medical education physician residency positions, and supporting training faculty, pursuant to the act, for expenditure as specified. The bill would also make related findings and declarations.

~~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 requires the Office of Statewide Health Planning and Development to establish the Health Professions Education Foundation to solicit and receive funds for the purpose of providing financial assistance in the form of scholarships or loans to medical students from underrepresented groups. Under existing law, the foundation also administers other programs for the advancement of health professions, including the Registered Nurse Education Program.~~

~~This bill would establish the Medical Residency Training Advisory Panel, consisting of a total of 13 members to be appointed as specified, within the Health Professions Education Foundation.~~

~~The bill would create the Medical Residency Training Fund in the State Treasury, a continuously appropriated fund, and would require the panel 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 foundation to provide technical support and financial management for the panel and to approve and send panel recommendations for new residency programs to the Office of Statewide Health Planning and Development for~~

~~implementation if specified requirements are met, including sufficient funding. The bill would require the office to enter into contracts with public and private sector institutions and other health agencies and organizations in order to fund and establish recommended 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 panel, in an amount matching the amount deposited into the fund, as specified. 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 ²/₃. Appropriation: yes. Fiscal committee: yes. State-mandated local program: no.~~

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

- 1 SECTION 1. *The Legislature finds and declares as follows:*
- 2 (a) *More than \$40 million of funding for the training of*
- 3 *California’s primary care physicians is expiring in 2016.*
- 4 (b) *Each year in California, only 368 slots are available to the*
- 5 *thousands of medical students seeking to train in family medicine.*
- 6 *If the funding is not replaced, 158 of those slots will be lost,*
- 7 *creating a terrible deficit of primary care physicians in California’s*
- 8 *underserved communities.*
- 9 (c) *Only 36 percent of California’s active patient care physicians*
- 10 *practice primary care. Twenty-three of California’s 58 counties*
- 11 *fall below the minimum required primary care physician to*
- 12 *population ratio.*
- 13 (d) *As of 2010, California needed an estimated additional 8,243*
- 14 *primary care physicians by 2030 to prevent projected shortages*
- 15 *in the state, which is about 412 new primary care physicians per*
- 16 *year.*

1 (e) More than 32 percent of California’s practicing primary
2 care physicians are 60 years of age or older – only four other
3 states have a larger percentage of soon-to-rotate physicians.

4 (f) States with higher ratios of primary care physicians to
5 population have better health outcomes, including decreased
6 mortality from cancer, heart disease, and stroke.

7 (g) The Song-Brown program provides an existing state
8 infrastructure to support an increase in the number of primary
9 care providers serving California’s underserved populations. By
10 investing in Song-Brown, California will realize an immediate
11 return on investment as each primary care resident provides an
12 average of 600 additional patient visits per physician per year
13 during training alone.

14 (h) California’s long-term workforce will also grow significantly
15 as the vast majority of physicians who train in a region stay there
16 to practice. California leads all fifty states in the percentage of
17 residency program graduates who stay in the state in which they
18 are trained.

19 SEC. 2. Notwithstanding Section 13340 of the Government
20 Code, there is hereby continuously appropriated from the General
21 Fund the sum of three hundred million dollars (\$300,000,000) to
22 the Director of Statewide Health Planning and Development, for
23 the purpose of funding new and existing graduate medical
24 education physician residency positions, and supporting training
25 faculty, pursuant to the Song-Brown Health Care Workforce
26 Training Act (Article 1 (commencing with Section 128200) of
27 Chapter 4 of Part 3 of Division 107 of the Health and Safety Code).
28 The moneys shall be expended as follows:

29 (a) The sum of one hundred million dollars (\$100,000,000) shall
30 be expended in the 2016–17 fiscal year.

31 (b) The sum of one hundred million dollars (\$100,000,000) shall
32 be expended in the 2017–18 fiscal year.

33 (c) The sum of one hundred million dollars (\$100,000,000) shall
34 be expended in the 2018–19 fiscal year.

35 SECTION 1. ~~Article 7 (commencing with Section 128590) is~~
36 ~~added to Chapter 5 of Part 3 of Division 107 of the Health and~~
37 ~~Safety Code, to read:~~

1 ~~Article 7. California Medical Residency Training Program~~

2
3 ~~128590. As used in this article:~~

4 ~~(a) “Director” means the Director of Statewide Health Planning~~
5 ~~and Development.~~

6 ~~(b) “Foundation” means the Health Professions Education~~
7 ~~Foundation.~~

8 ~~(c) “Fund” means the Medical Residency Training Fund.~~

9 ~~(d) “Office” means the Office of Statewide Health Planning and~~
10 ~~Development.~~

11 ~~(e) “Panel” means the Medical Residency Training Advisory~~
12 ~~Panel, established pursuant to Section 128591.~~

13 ~~(f) “Primary care” means the medical practice areas of family~~
14 ~~medicine, general surgery, internal medicine, obstetrics and~~
15 ~~gynecology, pediatrics, psychiatry, and related specialties and~~
16 ~~subspecialties as the office deems appropriate.~~

17 ~~(g) “Residency position” means a graduate medical education~~
18 ~~residency position in the field of primary care.~~

19 ~~128591. (a) (1) There is established within the foundation the~~
20 ~~Medical Residency Training Advisory Panel.~~

21 ~~(2) The panel shall consist of 13 members. Seven members shall~~
22 ~~be appointed by the Governor, one member shall be appointed by~~
23 ~~the Speaker of the Assembly, one member shall be appointed by~~
24 ~~the Senate Committee on Rules, two members of the Medical~~
25 ~~Board of California shall be appointed by the Medical Board of~~
26 ~~California, and two members of the Osteopathic Medical Board~~
27 ~~of California shall be appointed by the Osteopathic Medical Board~~
28 ~~of California.~~

29 ~~(3) The members of the panel appointed by the Governor, the~~
30 ~~Speaker of the Assembly, and the Senate Committee on Rules~~
31 ~~shall consist of representatives of designated and nondesignated~~
32 ~~public hospitals, private hospitals, community clinics, public and~~
33 ~~private health insurance providers, the pharmaceutical industry,~~
34 ~~associations of health care practitioners, and other appropriate~~
35 ~~members of health or related professions.~~

36 ~~(4) All persons considered for appointment shall have an interest~~
37 ~~in increasing the number of medical residencies in the state, an~~
38 ~~interest in increasing access to health care in underserved areas of~~
39 ~~California, and the ability and desire to solicit funds for the~~
40 ~~purposes of this article, as determined by the appointing power.~~

1 ~~(b) The Governor shall appoint the president of the panel from~~
2 ~~among those members appointed by the Governor, the Speaker of~~
3 ~~the Assembly, the Senate Committee on Rules, the Medical Board~~
4 ~~of California, and the Osteopathic Medical Board of California.~~

5 ~~(e) (1) Of the members of the panel first appointed by the~~
6 ~~Governor, three members shall be appointed to serve a one-year~~
7 ~~term, three members shall be appointed to serve a two-year term,~~
8 ~~and one member shall be appointed to serve a three-year term.~~

9 ~~(2) Each member of the panel first appointed by the Speaker of~~
10 ~~the Assembly and the Senate Committee on Rules shall be~~
11 ~~appointed to serve a three-year term.~~

12 ~~(3) Each member of the panel appointed by the Medical Board~~
13 ~~of California and the Osteopathic Medical Board of California~~
14 ~~shall be appointed to serve a four-year term.~~

15 ~~(4) Upon the expiration of the initial appointments to the panel~~
16 ~~by the Governor, the Speaker of the Assembly, the Senate~~
17 ~~Committee on Rules, the Medical Board of California, and the~~
18 ~~Osteopathic Medical Board of California, each member shall be~~
19 ~~appointed to serve a four-year term.~~

20 ~~(d) (1) Members of the panel appointed by the Governor, the~~
21 ~~Speaker of the Assembly, and the Senate Committee on Rules~~
22 ~~shall serve without compensation, but shall be reimbursed for any~~
23 ~~actual and necessary expenses incurred in connection with their~~
24 ~~duties as members of the panel.~~

25 ~~(2) The members appointed by the Medical Board of California~~
26 ~~and the Osteopathic Medical Board of California shall serve~~
27 ~~without compensation, but shall be reimbursed by the Medical~~
28 ~~Board of California and the Osteopathic Medical Board of~~
29 ~~California, respectively, for any actual and necessary expenses~~
30 ~~incurred in connection with their duties as members of the panel.~~

31 ~~(e) Notwithstanding any law relating to incompatible activities,~~
32 ~~no member of the panel shall be considered to be engaged in~~
33 ~~activities inconsistent and incompatible with his or her duties solely~~
34 ~~as a result of membership on the Medical Board of California or~~
35 ~~the Osteopathic Medical Board of California.~~

36 ~~(f) The panel shall be subject to the Nonprofit Public Benefit~~
37 ~~Corporation Law (Part 2 (commencing with Section 5110) of~~
38 ~~Division 2 of Title 2 of the Corporations Code), except that if there~~
39 ~~is a conflict with this article and the Nonprofit Public Benefit~~
40 ~~Corporation Law (Part 2 (commencing with Section 5110) of~~

1 Division 2 of Title 2 of the Corporations Code), this article shall
2 prevail.

3 ~~128592. The panel shall do all of the following:~~

4 ~~(a) Solicit and accept funds from business, industry, foundations,~~
5 ~~and other private or public sources for the purpose of establishing~~
6 ~~and funding new residency positions in areas of the state described~~
7 ~~in subdivision (c).~~

8 ~~(b) Encourage public and private sector institutions, including~~
9 ~~hospitals, colleges, universities, community clinics, and other~~
10 ~~health agencies and organizations to identify and provide locations~~
11 ~~for the establishment of new residency positions in areas of the~~
12 ~~state described in subdivision (c). The panel shall solicit proposals~~
13 ~~for medical residency programs, as described in subdivision (c);~~
14 ~~and shall provide to the foundation a copy of all proposals it~~
15 ~~receives.~~

16 ~~(c) Upon the sufficient solicitation of funds and at the panel's~~
17 ~~discretion, recommend to the foundation the establishment of new~~
18 ~~residency positions. A recommendation shall include all pertinent~~
19 ~~information required to enter into the necessary contracts to~~
20 ~~establish the residency positions. The panel shall only approve and~~
21 ~~recommend to the foundation proposals that would establish~~
22 ~~residency positions that will serve in any of the following medical~~
23 ~~service areas:~~

24 ~~(1) A service area that is designated as a primary care shortage~~
25 ~~area by the office.~~

26 ~~(2) A service area that is designated as a health professional~~
27 ~~shortage area for primary care, by either population or geographic~~
28 ~~designation, by the Health Resources and Services Administration~~
29 ~~of the United States Department of Health and Human Services.~~

30 ~~(3) A service area that is designated as a medically underserved~~
31 ~~area or medically underserved population by the Health Resources~~
32 ~~and Services Administration of the United States Department of~~
33 ~~Health and Human Services.~~

34 ~~(d) Upon foundation approval of a recommendation, deposit~~
35 ~~into the fund necessary moneys required to establish and fund the~~
36 ~~residency position.~~

37 ~~(e) Recommend to the director that a portion of the funds~~
38 ~~solicited from the private sector be used for the administrative~~
39 ~~requirements of the panel and the foundation.~~

1 (f) Prepare and submit an annual report to the Legislature
2 documenting the amount of money solicited, the amount of money
3 deposited by the panel into the fund, the recommendations for the
4 location and fields of practice of residency positions, total
5 expenditures for the year, and prospective fundraising goals.

6 128593. The foundation shall do all of the following:

7 (a) Provide technical and staff support to the panel in meeting
8 all of its responsibilities.

9 (b) Upon receipt of a recommendation made by the panel
10 pursuant to subdivision (e) of Section 128592, approve the
11 recommendation if the recommendation fulfills the requirements
12 of subdivision (e) of Section 128592 and the recommendation
13 fulfills the goals of this article. Upon sufficient funds being
14 available, an approval shall be sent to the office for implementation
15 pursuant to Section 128594.

16 128594. The office shall do all of the following:

17 (a) Establish a uniform process by which the panel may solicit
18 proposals from public and private sector institutions, including
19 hospitals, colleges, universities, community clinics, and other
20 health agencies and organizations that train primary care residents.
21 The office shall require that the proposals contain all necessary
22 and pertinent information, including, but not limited to, all of the
23 following:

24 (1) The location of the proposed residency position.

25 (2) The medical practice area of the proposed residency position.

26 (3) Information that demonstrates the area's need for the
27 proposed residency position and for additional primary care
28 practitioners.

29 (4) The amount of funding required to establish and operate the
30 residency position.

31 (b) Enter into contracts with public and private sector
32 institutions, including hospitals, colleges, universities, community
33 clinics, and other health agencies and organizations in order to
34 fund and establish residency positions at, or in association with,
35 these institutions.

36 (c) Ensure that the residency position has been, or will be,
37 approved by the Accreditation Council for Graduate Medical
38 Education.

39 (d) Provide all of the following information to the panel and the
40 foundation as requested:

1 ~~(1) The areas of the state that are deficient in primary care~~
2 ~~services:~~
3 ~~(2) The areas of the state that have the highest number of~~
4 ~~Medi-Cal enrollees and persons eligible to enroll in Medi-Cal, by~~
5 ~~proportion of population.~~
6 ~~(3) Other information relevant to assist the panel and the~~
7 ~~foundation in making recommendations on possible locations for~~
8 ~~new residency positions:~~
9 ~~(e) Monitor the residencies established pursuant to this article.~~
10 ~~(f) (1) Prepare and submit an annual report to the panel, the~~
11 ~~foundation, and the Legislature documenting the amount of money~~
12 ~~contributed to the fund by the panel, the amount of money~~
13 ~~expended from the fund, the purposes of those expenditures, the~~
14 ~~number and location of residency positions established and funded,~~
15 ~~and recommendations for the location of future residency positions.~~
16 ~~(2) The report pursuant to paragraph (1) shall be made to the~~
17 ~~Legislature pursuant to Section 9795 of the Government Code.~~
18 ~~128595. (a) The Medical Residency Training Fund is hereby~~
19 ~~created within the State Treasury.~~
20 ~~(b) The primary purpose of the fund is to allocate funding for~~
21 ~~new residency positions throughout the state. Money in the fund~~
22 ~~shall also be used to pay for the cost of administering the goals of~~
23 ~~the panel and the foundation as established by this article, and for~~
24 ~~any other purpose authorized by this article.~~
25 ~~(c) The level of expenditure by the office for the administrative~~
26 ~~support of the panel and the foundation is subject to review and~~
27 ~~approval annually through the state budget process.~~
28 ~~(d) In addition to funds raised by the panel, the office and the~~
29 ~~foundation may solicit and accept public and private donations to~~
30 ~~be deposited into the fund. All money in the fund is continuously~~
31 ~~appropriated to the office for the purposes of this article. The office~~
32 ~~shall manage this fund prudently in accordance with applicable~~
33 ~~laws.~~
34 ~~128596. Any regulations the office adopts to implement this~~
35 ~~article shall be adopted as emergency regulations in accordance~~
36 ~~with Section 11346.1 of the Government Code, except that the~~
37 ~~regulations shall be exempt from the requirements of subdivisions~~
38 ~~(e), (f), and (g) of that section. The regulations shall be deemed to~~
39 ~~be emergency regulations for the purposes of Section 11346.1 of~~
40 ~~the Government Code.~~

1 128597. Notwithstanding any other law, the office may exempt
2 from public disclosure any document in the possession of the office
3 that pertains to a donation made pursuant to this article if the donor
4 has requested anonymity.

5 128598. (a) The Governor may include in the annual budget
6 proposal an amount, as he or she deems reasonable, to be
7 appropriated to the office to be used as provided in this article.

8 (b) If the Legislature appropriates money for purposes of this
9 article, the money shall be appropriated to the office, which shall
10 hold the money for distribution to the fund.

11 (c) Funds appropriated to the office shall be paid into the fund,
12 upon request of the panel, in an amount matching the amount
13 deposited into the fund by the panel or by the foundation and office
14 pursuant to subdivision (d) of Section 128595 for the purposes of
15 this article. Any money that was appropriated to the office and
16 that has not been distributed to the fund at the end of each fiscal
17 year shall be returned to the General Fund.

18 SEC. 2. The Legislature finds and declares that Section 1 of
19 this act, which adds Article 7 (commencing with Section 128590)
20 to Chapter 5 of Part 3 of Division 107 of the Health and Safety
21 Code, imposes a limitation on the public's right of access to the
22 meetings of public bodies or the writings of public officials and
23 agencies within the meaning of Section 3 of Article I of the
24 California Constitution. Pursuant to that constitutional provision,
25 the Legislature makes the following findings to demonstrate the
26 interest protected by this limitation and the need for protecting
27 that interest:

28 The need to protect individual privacy of donations made by a
29 donor to fund new medical residency positions in underserved
30 areas of the state outweighs the interest in the public disclosure of
31 that information.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 482
Author: Lara
Bill Date: April 7, 2016, Amended
Subject: Controlled Substances: CURES Database
Sponsor: Consumer Attorneys of California and
California Narcotics Officers
Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all prescribers issuing Schedule II and III drugs to access and consult the CURES database before prescribing a Schedule II or III controlled substance under specified conditions.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license prescribers and dispensers, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities is now operational and available online, as long as the prescriber uses the compliant browser.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General's Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

According to the author's office, other states that have required prescribers to check their drug monitoring systems have seen significantly improved public health outcomes. In 2012, Tennessee required prescribers to check the state's PDMP before prescribing painkillers and within one year, they saw a 36% drop in patients who were

seeing multiple prescribers to obtain the same drugs. In Virginia, the number of doctor-shoppers fell by 73% after use of the database became mandatory. In Oklahoma, which requires mandatory checks for methadone, overdoses fell about 21% in one year. New York also requires prescribers to check their state drug monitoring systems and has seen dramatic decreases in drug overdoses and deaths.

ANALYSIS

This bill would require a prescriber to 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 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 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.

This bill would specify that failure by a prescriber to consult a patient's electronic history as required by this bill would be cause for disciplinary action by the respective licensing board of the prescriber. The licensing boards of all prescribers authorized to write prescriptions for controlled substances shall notify licensees of the requirements of this bill.

This bill would specify that a prescriber is not liable in a civil action solely for failing to consult the CURES database as required by this bill.

This bill would specify that the requirement to consult the CURES database does not apply if any of the following conditions are met:

- The CURES database is suspended or inaccessible, the Internet is not operational, the data in the CURES database is inaccurate or incomplete, or it is not possible to query the CURES database in a timely manner because of an emergency.
- The controlled substance is prescribed to a patient receiving hospice care.
- The controlled substance is prescribed to a patient as part of a surgical procedure that has or will occur in a licensed health care facility and the prescription is non-refillable.
- The controlled substance is directly administered to the patient by the prescriber or another person authorized to prescribe a controlled substance.

This bill would specify that is not operative until DOJ certifies that the CURES database is ready for statewide use. DOJ would be required to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

This bill would specify that the provisions of the bill are severable and if any provision is held invalid, that invalidity shall not affect other provisions of this bill.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping". Requiring all

prescribers to consult the CURES system will allow prescribers to make informed decisions about their patient's care. This bill only requires the CURES database to be checked for an initial prescription of a Schedule II or III controlled substance, on an annual basis if that controlled substance is still being prescribed, or if the same controlled substance has already been prescribed. This bill would also ensure that the CURES system will have the capacity to handle this workload before the bill becomes operative.

This bill would further the Board's goal of consumer protection and take steps forward in addressing the issue of doctor shopping and opioid abuse. For these reasons, Board staff is suggesting that the Board support this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Consumer Attorneys of California (Sponsor); California Narcotics Officers (Sponsor); California Association of Code Enforcement Officers; California College and University Police Chiefs Association; California Conference Board of the Amalgamated Transit Union; California Conference of Machinists; California Correctional Supervisors Organization; California Teamsters Public Affairs Council; Consumer Federation of California; Consumer Watchdog; Engineers and Scientists of California; IFPTE Local 20, AFL-CIO; International Faith Based Coalition; International Longshore and Warehouse Union; Los Angeles Police Protective League; Professional and Technical Engineers, IFPTE Local 21, AFL-CIO; Riverside Sheriffs Organization; UNITE-HERE, AFL-CIO; and Utility Workers Union of America

OPPOSITION: California Medical Association and The Doctor's Company

POSITION: Recommendation: Support

AMENDED IN ASSEMBLY APRIL 7, 2016

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, to consult a patient's electronic history in the CURES database before prescribing 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 licensing board and would require the licensing boards to notify all prescribers authorized to prescribe controlled substances of these requirements. The bill would provide that a prescriber 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.~~ *if a specified condition exists, including any time that the CURES database is suspended or not accessible, an inability to access the CURES database in a timely manner because of an emergency, when the controlled substance is prescribed to a patient receiving hospice care, or when the controlled substance is directly administered to the patient by the person prescribing the controlled substance.* 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:

1 SECTION 1. Section 11165.4 is added to the Health and Safety
2 Code, to read:
3 11165.4. (a) A prescriber shall access and consult the CURES
4 database for the electronic history of controlled substances
5 dispensed to a patient under his or her care before prescribing a
6 Schedule II or Schedule III controlled substance for the first time
7 to that patient and at least annually when that prescribed controlled
8 substance remains part of his or her treatment. If the patient has
9 an existing prescription for a Schedule II or Schedule III controlled
10 substance, the prescriber shall not prescribe an additional controlled
11 substance until the prescriber determines that there is a legitimate
12 need for that controlled substance.
13 (b) Failure to consult a patient's electronic history as required
14 by subdivision (a) is cause for disciplinary action by the
15 prescriber's licensing board. The licensing boards of all prescribers
16 authorized to write or issue prescriptions for controlled substances
17 shall notify these licensees of the requirements of this section.

1 ~~(e) Notwithstanding any other law, a prescriber is not in~~
2 ~~violation of this section during any period of time in which the~~
3 ~~CURES database is suspended or not accessible or any period of~~
4 ~~time in which the Internet is not operational.~~

5 *(c) A prescriber is not liable in a civil action solely for failing*
6 *to consult the CURES database as required pursuant to subdivision*
7 *(a).*

8 *(d) The requirement in subdivision (a) does not apply, and a*
9 *prescriber is not in violation of this section, if any of the following*
10 *conditions are met:*

11 *(1) The CURES database is suspended or inaccessible, the*
12 *Internet is not operational, the data in the CURES database is*
13 *inaccurate or incomplete, or it is not possible to query the CURES*
14 *database in a timely manner because of an emergency.*

15 *(2) The controlled substance is prescribed to a patient receiving*
16 *hospice care.*

17 *(3) The controlled substance is prescribed to a patient as a part*
18 *of a surgical procedure that has or will occur in a licensed health*
19 *care facility and the prescription is nonrefillable.*

20 *(4) The controlled substance is directly administered to the*
21 *patient by the prescriber or another person authorized to prescribe*
22 *a controlled substance.*

23 ~~(e)~~

24 *(e) This section shall not become operative until the Department*
25 *of Justice certifies that the CURES database is ready for statewide*
26 *use. The department shall notify the Secretary of State and the*
27 *Office of Legislative Counsel of the date of that certification.*

28 ~~(e)~~

29 *(f) For purposes of this section, “prescriber” means a health care*
30 *practitioner who is authorized to write or issue prescriptions under*
31 *Section 11150, excluding veterinarians.*

32 ~~(f)~~

33 *(g) A violation of this section shall not be subject to the*
34 *provisions of Section 11374.*

35 *(h) All applicable state and federal privacy laws govern the*
36 *duties required by this section.*

37 *(i) The provisions of this section are severable. If any provision*
38 *of this section or its application is held invalid, that invalidity shall*

- 1 *not affect other provisions or applications that can be given effect*
- 2 *without the invalid provision or application.*

O

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)
Position: Support

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 the Board took 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

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:

- 1 SECTION 1. Section 4610 of the Labor Code is amended to
2 read:
- 3 4610. (a) For purposes of this section, “utilization review”
4 means utilization review or utilization management functions that
5 prospectively, retrospectively, or concurrently review and approve,
6 modify, delay, or deny, based in whole or in part on medical
7 necessity to cure and relieve, treatment recommendations by
8 physicians, as defined in Section 3209.3, prior to, retrospectively,
9 or concurrent with the provision of medical treatment services
10 pursuant to Section 4600.
- 11 (b) Every employer shall establish a utilization review process
12 in compliance with this section, either directly or through its insurer
13 or an entity with which an employer or insurer contracts for these
14 services.
- 15 (c) Each utilization review process shall be governed by written
16 policies and procedures. These policies and procedures shall ensure
17 that decisions based on the medical necessity to cure and relieve
18 of proposed medical treatment services are consistent with the
19 schedule for medical treatment utilization adopted pursuant to
20 Section 5307.27. These policies and procedures, and a description

1 of the utilization process, shall be filed with the administrative
2 director and shall be disclosed by the employer to employees,
3 physicians, and the public upon request.

4 (d) If an employer, insurer, or other entity subject to this section
5 requests medical information from a physician in order to
6 determine whether to approve, modify, delay, or deny requests for
7 authorization, the employer shall request only the information
8 reasonably necessary to make the determination. The employer,
9 insurer, or other entity shall employ or designate a medical director
10 who holds an unrestricted license to practice medicine in this state
11 issued pursuant to Section 2050 or Section 2450 of the Business
12 and Professions Code. The medical director shall ensure that the
13 process by which the employer or other entity reviews and
14 approves, modifies, delays, or denies requests by physicians prior
15 to, retrospectively, or concurrent with the provision of medical
16 treatment services, complies with the requirements of this section.
17 Nothing in this section shall be construed as restricting the existing
18 authority of the Medical Board of California.

19 (e) No person other than a licensed physician who is competent
20 to evaluate the specific clinical issues involved in the medical
21 treatment services, and where these services are within the scope
22 of the physician's practice, requested by the physician may modify,
23 delay, or deny requests for authorization of medical treatment for
24 reasons of medical necessity to cure and relieve. *The employer, or*
25 *any entity conducting utilization review on behalf of the employer,*
26 *shall neither offer nor provide any financial incentive or*
27 *consideration to a physician based on the number of modifications,*
28 *delays, or denials made by the physician under this section. The*
29 *administrative director has authority pursuant to this section to*
30 *review any compensation agreement, payment schedule, or contract*
31 *between the employer, or any entity conducting utilization review*
32 *on behalf of the employer, and the utilization review physician.*

33 (f) The criteria or guidelines used in the utilization review
34 process to determine whether to approve, modify, delay, or deny
35 medical treatment services shall be all of the following:

36 (1) Developed with involvement from actively practicing
37 physicians.

38 (2) Consistent with the schedule for medical treatment utilization
39 adopted pursuant to Section 5307.27.

40 (3) Evaluated at least annually, and updated if necessary.

1 (4) Disclosed to the physician and the employee, if used as the
2 basis of a decision to modify, delay, or deny services in a specified
3 case under review.

4 (5) Available to the public upon request. An employer shall
5 only be required to disclose the criteria or guidelines for the
6 specific procedures or conditions requested. An employer may
7 charge members of the public reasonable copying and postage
8 expenses related to disclosing criteria or guidelines pursuant to
9 this paragraph. Criteria or guidelines may also be made available
10 through electronic means. No charge shall be required for an
11 employee whose physician's request for medical treatment services
12 is under review.

13 (g) In determining whether to approve, modify, delay, or deny
14 requests by physicians prior to, retrospectively, or concurrent with
15 the provisions of medical treatment services to employees all of
16 the following requirements shall be met:

17 (1) Prospective or concurrent decisions shall be made in a timely
18 fashion that is appropriate for the nature of the employee's
19 condition, not to exceed five working days from the receipt of the
20 information reasonably necessary to make the determination, but
21 in no event more than 14 days from the date of the medical
22 treatment recommendation by the physician. In cases where the
23 review is retrospective, a decision resulting in denial of all or part
24 of the medical treatment service shall be communicated to the
25 individual who received services, or to the individual's designee,
26 within 30 days of receipt of information that is reasonably
27 necessary to make this determination. If payment for a medical
28 treatment service is made within the time prescribed by Section
29 4603.2, a retrospective decision to approve the service need not
30 otherwise be communicated.

31 (2) When the employee's condition is such that the employee
32 faces an imminent and serious threat to his or her health, including,
33 but not limited to, the potential loss of life, limb, or other major
34 bodily function, or the normal timeframe for the decisionmaking
35 process, as described in paragraph (1), would be detrimental to the
36 employee's life or health or could jeopardize the employee's ability
37 to regain maximum function, decisions to approve, modify, delay,
38 or deny requests by physicians prior to, or concurrent with, the
39 provision of medical treatment services to employees shall be made
40 in a timely fashion that is appropriate for the nature of the

1 employee's condition, but not to exceed 72 hours after the receipt
2 of the information reasonably necessary to make the determination.

3 (3) (A) Decisions to approve, modify, delay, or deny requests
4 by physicians for authorization prior to, or concurrent with, the
5 provision of medical treatment services to employees shall be
6 communicated to the requesting physician within 24 hours of the
7 decision. Decisions resulting in modification, delay, or denial of
8 all or part of the requested health care service shall be
9 communicated to physicians initially by telephone or facsimile,
10 and to the physician and employee in writing within 24 hours for
11 concurrent review, or within two business days of the decision for
12 prospective review, as prescribed by the administrative director.
13 If the request is not approved in full, disputes shall be resolved in
14 accordance with Section 4610.5, if applicable, or otherwise in
15 accordance with Section 4062.

16 (B) In the case of concurrent review, medical care shall not be
17 discontinued until the employee's physician has been notified of
18 the decision and a care plan has been agreed upon by the physician
19 that is appropriate for the medical needs of the employee. Medical
20 care provided during a concurrent review shall be care that is
21 medically necessary to cure and relieve, and an insurer or
22 self-insured employer shall only be liable for those services
23 determined medically necessary to cure and relieve. If the insurer
24 or self-insured employer disputes whether or not one or more
25 services offered concurrently with a utilization review were
26 medically necessary to cure and relieve, the dispute shall be
27 resolved pursuant to Section 4610.5, if applicable, or otherwise
28 pursuant to Section 4062. Any compromise between the parties
29 that an insurer or self-insured employer believes may result in
30 payment for services that were not medically necessary to cure
31 and relieve shall be reported by the insurer or the self-insured
32 employer to the licensing board of the provider or providers who
33 received the payments, in a manner set forth by the respective
34 board and in such a way as to minimize reporting costs both to the
35 board and to the insurer or self-insured employer, for evaluation
36 as to possible violations of the statutes governing appropriate
37 professional practices. No fees shall be levied upon insurers or
38 self-insured employers making reports required by this section.

39 (4) Communications regarding decisions to approve requests
40 by physicians shall specify the specific medical treatment service

1 approved. Responses regarding decisions to modify, delay, or deny
2 medical treatment services requested by physicians shall include
3 a clear and concise explanation of the reasons for the employer's
4 decision, a description of the criteria or guidelines used, and the
5 clinical reasons for the decisions regarding medical necessity. If
6 a utilization review decision to deny or delay a medical service is
7 due to incomplete or insufficient information, the decision shall
8 specify the reason for the decision and specify the information that
9 is needed.

10 (5) If the employer, insurer, or other entity cannot make a
11 decision within the timeframes specified in paragraph (1) or (2)
12 because the employer or other entity is not in receipt of all of the
13 information reasonably necessary and requested, because the
14 employer requires consultation by an expert reviewer, or because
15 the employer has asked that an additional examination or test be
16 performed upon the employee that is reasonable and consistent
17 with good medical practice, the employer shall immediately notify
18 the physician and the employee, in writing, that the employer
19 cannot make a decision within the required timeframe, and specify
20 the information requested but not received, the expert reviewer to
21 be consulted, or the additional examinations or tests required. The
22 employer shall also notify the physician and employee of the
23 anticipated date on which a decision may be rendered. Upon receipt
24 of all information reasonably necessary and requested by the
25 employer, the employer shall approve, modify, or deny the request
26 for authorization within the timeframes specified in paragraph (1)
27 or (2).

28 (6) A utilization review decision to modify, delay, or deny a
29 treatment recommendation shall remain effective for 12 months
30 from the date of the decision without further action by the employer
31 with regard to any further recommendation by the same physician
32 for the same treatment unless the further recommendation is
33 supported by a documented change in the facts material to the
34 basis of the utilization review decision.

35 (7) Utilization review of a treatment recommendation shall not
36 be required while the employer is disputing liability for injury or
37 treatment of the condition for which treatment is recommended
38 pursuant to Section 4062.

39 (8) If utilization review is deferred pursuant to paragraph (7),
40 and it is finally determined that the employer is liable for treatment

1 of the condition for which treatment is recommended, the time for
2 the employer to conduct retrospective utilization review in
3 accordance with paragraph (1) shall begin on the date the
4 determination of the employer's liability becomes final, and the
5 time for the employer to conduct prospective utilization review
6 shall commence from the date of the employer's receipt of a
7 treatment recommendation after the determination of the
8 employer's liability.

9 (h) Every employer, insurer, or other entity subject to this section
10 shall maintain telephone access for physicians to request
11 authorization for health care services.

12 (i) If the administrative director determines that the employer,
13 insurer, or other entity subject to this section has failed to meet
14 any of the timeframes in this section, or has failed to meet any
15 other requirement of this section, the administrative director may
16 assess, by order, administrative penalties for each failure. A
17 proceeding for the issuance of an order assessing administrative
18 penalties shall be subject to appropriate notice to, and an
19 opportunity for a hearing with regard to, the person affected. The
20 administrative penalties shall not be deemed to be an exclusive
21 remedy for the administrative director. These penalties shall be
22 deposited in the Workers' Compensation Administration Revolving
23 Fund.

24
25
26 **All matter omitted in this version of the bill**
27 **appears in the bill as amended in the**
28 **Senate, April 30, 2015. (JR11)**
29

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1033
Author: Hill
Bill Date: March 17, 2016, Amended
Subject: Medical Board: Disclosure of Probationary Status
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require physicians and surgeons, osteopathic physicians and surgeons, podiatrists, acupuncturists, chiropractors and naturopathic doctors to notify patients of their probationary status before seeing a patient for the first time.

BACKGROUND

The Medical Board of California's (Board's) Disciplinary Guidelines currently require a licensee to provide a copy of the disciplinary decision and accusation to the Chief of Staff or Chief Executive Officer at every hospital where privileges or membership are extended to the licensee. A copy of the decision or accusation must also be provided at any facility where the licensee engages in the practice of medicine, and to the Chief Executive Officer at every malpractice insurance carrier that extends malpractice insurance coverage to the licensee. Under optional condition 25 in the Board's Disciplinary Guidelines, the Board may require a licensee to provide written notification to patients in circumstances where the licensee is required to have a third-party chaperone present during the consultation, examination, or treatment by the licensee. Notification to patients may also be required if optional condition 26, regarding prohibited practice, is included in the licensee's probationary order.

The Board's website currently includes disciplinary information for all physicians, including if the physician is currently, or has been, on probation. This information is posted on the Board's website indefinitely. In addition, the Board has a call center that members of the public can contact to obtain any public disciplinary information for Board licensees, including probationary status and history.

The Consumers Union Safe Patient Project (CUSPP) petitioned the Board in October of 2015 to amend the Board's Disciplinary Guidelines to require physicians on probation to notify their patients of this fact. At the October 2015 Board Meeting, the Board voted to deny the petition, but established a Patient Notification Task Force to explore options for enhancing and improving the public's awareness of the Board's oversight of physicians and the physician information available on the Board's website. At the Board's January 2016 Board Meeting, the Task Force discussed improving the Board's online license look up on its website, modifying the Notice to Consumers that all physicians are required to post or provide patients, increasing public outreach regarding physicians on probation, and revising the Board's

disciplinary guidelines.

ANALYSIS

This bill requires the Board, the Osteopathic Medical Board of California, the Board of Podiatric Medicine, the California Acupuncture Board, the Board of Chiropractic Examiners, and the Naturopathic Medicine Committee, by July 1, 2018, to include a standardized, single paragraph, plain-language summary that contains the listing of causes that led to the licensee's probation, the length of the probation and the end date, and all practice restrictions placed on the license. This information is required to be included on any Board documents informing the public of probation orders and probationary licenses, including, but not limited to, the Board's Newsletter. This summary information is also required to be posted on the BreEZe licensee profile for each licensee subject to probation.

This bill requires physicians and licensees of the other named boards, to disclose their probationary status to patients or their guardians or health care surrogates prior to the patient's first visit while the licensee is on probation, if the licensee was placed on probation for any of the following:

- Gross negligence;
- Repeated negligent acts involving a departure from the standard of care with multiple patients;
- Repeated acts of inappropriate and excessive prescribing of controlled substances, including, but not limited to, prescribing controlled substances without an appropriate prior examination or without medical reason documented in the medical records;
- Drug or alcohol abuse that threatens to impair a licensee's ability to practice medicine safely, including practicing under the influence of drugs or alcohol;
- Felony conviction arising from or occurring during patient care or treatment; and
- Mental illness or other cognitive impairment that impedes a licensee's ability to safely practice.

These licensees, including physicians, would also be required to disclose their probationary status to patients if their licensing board ordered any of the following in conjunction with placing the licensee on probation:

- That a third party chaperone be present when the licensee examines patients as a result of sexual misconduct;
- That the licensee submit to drug testing as a result of drug or alcohol abuse;
- That the licensee have a monitor;
- Restricting the licensee totally or partially from prescribing controlled substances; or

Licensees would also be required to notify patients that they are on probation if they have not successfully completed a clinical training program or any exams required by the Board as a condition of probation, or if they have been on probation repeatedly.

This bill would require the licensee, including physicians, to obtain from each patient a

signed receipt following the disclosure that includes a written explanation of how the patient can find further information on the licensee's probation on the Board's website.

This bill does provide an exemption if the patient is unconscious or otherwise unable to comprehend the disclosure and sign the receipt and a guardian or health care surrogate is unavailable to comprehend the disclosure and sign the receipt. In these instances, the licensee would be required to disclose his or her probationary status as soon as either the patient can comprehend the disclosure and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.

The supporters of this bill strongly believe that patients have a right to know if their physician is on probation and that the burden should not be on the patient to look up this information. They believe it should be the responsibility of the physician on probation to notify the patients. Although this bill only requires physicians on probation for specific violations/conditions to notify their patients of their probationary status, the violations and the probation conditions listed in this bill cover the majority of violations that result in probationary orders for physicians or in decisions that include the conditions listed. Per the Board's 2014/15 Annual Report, there are 614 practicing physicians on probation in California.

The probationary status of a physician is public information and available on the Board's website. Ensuring that patients are informed promotes the Board's mission of consumer protection. However, in emergency situations it may not be prudent for physicians to provide this notification, as the circumstance may not allow a patient the opportunity to make an informed decision. There are also instances in which a patient will not know who their physician will be prior to seeing that physician, including being assigned an anesthesiologist for a surgical procedure or being assigned an OB/GYN who is on call for labor and delivery, etc. Again, in these situations the patient may not have the opportunity to make an informed decision. In addition, all health care consumers should have the same right to make an informed decision. It should not be dependent upon what type of health care practitioner is serving them. Therefore, all healing arts boards and licensees should be held to the same notification requirements.

Board staff is recommending that the Board take a neutral position on this bill if it is amended to address the emergency situations and situations in which patients do not know who their physician will be ahead of time and to require all healing arts boards and licensees to comply with the requirements in this bill.

FISCAL: This bill will likely result in more cases going to hearing because physicians will not want to agree to probation if they have to notify their patients. Board staff is estimating that cases that result in stipulated settlements of three years of probation or less will go to hearing instead of settling. Board staff is working on obtaining the number of cases that were settled for three years of probation or less in the last year. For those cases, the fiscal would consist of AG costs for going to hearing,

and hearing costs for the Office of Administrative Hearings.

SUPPORT:

Californians for Patients' Rights
CALPIRG
Center for Public Interest Law
Consumer Attorneys of California
Consumer Federation of California
Consumers Union's Safe Patient Project
Consumer Watchdog
One Individual

OPPOSITION:

California Academy of Family Physicians
California Chapter of the American College of Emergency Room
Physicians (Unless Amended)
California Medical Association
California Psychiatric Association

POSITION:

Recommendation: Neutral with Amendments

AMENDED IN SENATE MARCH 17, 2016

SENATE BILL

No. 1033

Introduced by Senator Hill

February 12, 2016

An act to amend Sections 803.1, 2027, ~~and 2228~~ of 2221, 2221.05, 2228, and 3663 of, and to add Sections 1006 and 4962 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1033, as amended, Hill. Medical Board: disclosure of probationary status.

Existing law, the Medical Practice Act, establishes the Medical Board of California for the licensing, regulation, and discipline of physicians and surgeons. *Existing law establishes the California Board of Podiatric Medicine within the Medical Board of California for the licensing, regulation, and discipline of podiatrists. Existing law, the Osteopathic Act, enacted by an initiative measure, establishes the Osteopathic Medical Board of California for the licensing and regulation of osteopathic physicians and surgeons and requires the Osteopathic Medical Board of California to enforce the Medical Practice Act with respect to its licensees. Existing law, the Naturopathic Doctors Act, establishes the Naturopathic Medicine Committee in the Osteopathic Medical Board of California for the licensing and regulation of naturopathic doctors. Existing law, the Chiropractic Act, enacted by an initiative measure, establishes the State Board of Chiropractic Examiners for the licensing and regulation of chiropractors. Existing law, the Acupuncture Licensure Act, establishes the Acupuncture Board for the licensing and regulation of acupuncturists. Existing law authorizes the board each of these regulatory agencies to discipline a*

~~physician or a surgeon~~ *its licensee* by placing her or him on probation, which may include requiring the physician or surgeon to complete specified trainings, examinations, or community service or restricting the extent, scope, or type of practice, *probation*, as specified.

This bill would require ~~the board~~ *these regulatory entities* to require a ~~physician or surgeon~~ *licensee* to disclose *on a separate document* her or his probationary status to ~~patients before each a patient, the patient's guardian, or the health care surrogate prior to the patient's first visit following the probationary order while the physician or surgeon licensee~~ is on probation under specified circumstances, including ~~the board an accusation alleging, a statement of issues indicating, or an administrative law judge's legal conclusion finding the physician or surgeon licensee~~ committed gross negligence or the ~~physician or surgeon licensee~~ having been on probation ~~repeatedly, more than once~~, among others. The bill would require the board, by July 1, 2018, to adopt related regulations that include requiring the ~~physician or surgeon licensee~~ to obtain from the patient a signed receipt containing specified information following the disclosure. *The bill would exempt a licensee from disclosing her or his probationary status prior to a visit or treatment if the patient is unable to comprehend the disclosure or sign an acknowledgment and a guardian or health care surrogate is unavailable. The bill would require in that instance that the doctor disclose his or her status as soon as either the patient can comprehend and sign the receipt or a guardian or health care surrogate is available to comprehend the disclosure and sign the receipt.*

Existing law requires ~~the board~~ *Medical Board of California, the Osteopathic Medical Board of California, and the California Board of Podiatric Medicine* to disclose to an inquiring member of the public and to post on ~~its their~~ Internet Web ~~site sites~~ specified information concerning each ~~physician and surgeon, licensee~~ including revocations, suspensions, probations, or limitations on practice.

~~This~~

The bill would require the board, the Medical Board of California, the Osteopathic Medical Board of California, the California Board of Podiatric Medicine, the State Board of Chiropractic Examiners, the Naturopathic Medicine Committee, and the Acupuncture Board by July 1, 2018, to include in each order of probation a written summary containing specified information develop a standardized format for listing specified information related to the probation and to include the summary in the disclosure provide that information to an inquiring

member of the public, on any ~~board~~ documents informing the public of probation orders, and on a specified profile ~~web~~ *Internet Web* page of each ~~physician and surgeon licensee~~ subject to ~~probation~~, *probation, as specified.*

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

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

1 SECTION 1. Section 803.1 of the Business and Professions
2 Code is amended to read:

3 803.1. (a) Notwithstanding any other provision of law, the
4 Medical Board of California, the Osteopathic Medical Board of
5 California, the California Board of Podiatric Medicine, and the
6 Physician Assistant Board shall disclose to an inquiring member
7 of the public information regarding any enforcement actions taken
8 against a licensee, including a former licensee, by the board or by
9 another state or jurisdiction, including all of the following:

- 10 (1) Temporary restraining orders issued.
- 11 (2) Interim suspension orders issued.
- 12 (3) Revocations, suspensions, probations, or limitations on
13 practice ordered by the board, including those made part of a
14 probationary order or stipulated agreement.
- 15 (4) Public letters of reprimand issued.
- 16 (5) Infractions, citations, or fines imposed.

17 (b) Notwithstanding any other provision of law, in addition to
18 the information provided in subdivision (a), the Medical Board of
19 California, the Osteopathic Medical Board of California, the
20 California Board of Podiatric Medicine, and the Physician Assistant
21 Board shall disclose to an inquiring member of the public all of
22 the following:

- 23 (1) Civil judgments in any amount, whether or not vacated by
24 a settlement after entry of the judgment, that were not reversed on
25 appeal and arbitration awards in any amount of a claim or action
26 for damages for death or personal injury caused by the physician
27 and surgeon’s negligence, error, or omission in practice, or by his
28 or her rendering of unauthorized professional services.
- 29 (2) (A) All settlements in the possession, custody, or control
30 of the board shall be disclosed for a licensee in the low-risk
31 category if there are three or more settlements for that licensee

1 within the last 10 years, except for settlements by a licensee
2 regardless of the amount paid where (i) the settlement is made as
3 a part of the settlement of a class claim, (ii) the licensee paid in
4 settlement of the class claim the same amount as the other licensees
5 in the same class or similarly situated licensees in the same class,
6 and (iii) the settlement was paid in the context of a case where the
7 complaint that alleged class liability on behalf of the licensee also
8 alleged a products liability class action cause of action. All
9 settlements in the possession, custody, or control of the board shall
10 be disclosed for a licensee in the high-risk category if there are
11 four or more settlements for that licensee within the last 10 years
12 except for settlements by a licensee regardless of the amount paid
13 where (i) the settlement is made as a part of the settlement of a
14 class claim, (ii) the licensee paid in settlement of the class claim
15 the same amount as the other licensees in the same class or
16 similarly situated licensees in the same class, and (iii) the
17 settlement was paid in the context of a case where the complaint
18 that alleged class liability on behalf of the licensee also alleged a
19 products liability class action cause of action. Classification of a
20 licensee in either a “high-risk category” or a “low-risk category”
21 depends upon the specialty or subspecialty practiced by the licensee
22 and the designation assigned to that specialty or subspecialty by
23 the Medical Board of California, as described in subdivision (f).
24 For the purposes of this paragraph, “settlement” means a settlement
25 of an action described in paragraph (1) entered into by the licensee
26 on or after January 1, 2003, in an amount of thirty thousand dollars
27 (\$30,000) or more.

28 (B) The board shall not disclose the actual dollar amount of a
29 settlement but shall put the number and amount of the settlement
30 in context by doing the following:

31 (i) Comparing the settlement amount to the experience of other
32 licensees within the same specialty or subspecialty, indicating if
33 it is below average, average, or above average for the most recent
34 10-year period.

35 (ii) Reporting the number of years the licensee has been in
36 practice.

37 (iii) Reporting the total number of licensees in that specialty or
38 subspecialty, the number of those who have entered into a
39 settlement agreement, and the percentage that number represents
40 of the total number of licensees in the specialty or subspecialty.

1 (3) Current American Board of Medical Specialties certification
2 or board equivalent as certified by the Medical Board of California,
3 the Osteopathic Medical Board of California, or the California
4 Board of Podiatric Medicine.

5 (4) Approved postgraduate training.

6 (5) Status of the license of a licensee. By January 1, 2004, the
7 Medical Board of California, the Osteopathic Medical Board of
8 California, and the California Board of Podiatric Medicine shall
9 adopt regulations defining the status of a licensee. The board shall
10 employ this definition when disclosing the status of a licensee
11 pursuant to Section 2027. By July 1, 2018, the Medical Board of
12 ~~California~~ *California, the Osteopathic Medical Board of California,*
13 *and the California Board of Podiatric Medicine* shall include the
14 ~~summary of each probation order as written pursuant to information~~
15 ~~described in subdivision (e)~~ *(f)* of Section 2228.

16 (6) Any summaries of hospital disciplinary actions that result
17 in the termination or revocation of a licensee’s staff privileges for
18 medical disciplinary cause or reason, unless a court finds, in a final
19 judgment, that the peer review resulting in the disciplinary action
20 was conducted in bad faith and the licensee notifies the board of
21 that finding. In addition, any exculpatory or explanatory statements
22 submitted by the licensee electronically pursuant to subdivision
23 (f) of that section shall be disclosed. For purposes of this paragraph,
24 “peer review” has the same meaning as defined in Section 805.

25 (c) Notwithstanding any other provision of law, the Medical
26 Board of California, the Osteopathic Medical Board of California,
27 the California Board of Podiatric Medicine, and the Physician
28 Assistant Board shall disclose to an inquiring member of the public
29 information received regarding felony convictions of a physician
30 and surgeon or doctor of podiatric medicine.

31 (d) The Medical Board of California, the Osteopathic Medical
32 Board of California, the California Board of Podiatric Medicine,
33 and the Physician Assistant Board may formulate appropriate
34 disclaimers or explanatory statements to be included with any
35 information released, and may by regulation establish categories
36 of information that need not be disclosed to an inquiring member
37 of the public because that information is unreliable or not
38 sufficiently related to the licensee’s professional practice. The
39 Medical Board of California, the Osteopathic Medical Board of
40 California, the California Board of Podiatric Medicine, and the

1 Physician Assistant Board shall include the following statement
2 when disclosing information concerning a settlement:

3
4 “Some studies have shown that there is no significant correlation
5 between malpractice history and a doctor’s competence. At the
6 same time, the State of California believes that consumers should
7 have access to malpractice information. In these profiles, the State
8 of California has given you information about both the malpractice
9 settlement history for the doctor’s specialty and the doctor’s history
10 of settlement payments only if in the last 10 years, the doctor, if
11 in a low-risk specialty, has three or more settlements or the doctor,
12 if in a high-risk specialty, has four or more settlements. The State
13 of California has excluded some class action lawsuits because
14 those cases are commonly related to systems issues such as product
15 liability, rather than questions of individual professional
16 competence and because they are brought on a class basis where
17 the economic incentive for settlement is great. The State of
18 California has placed payment amounts into three statistical
19 categories: below average, average, and above average compared
20 to others in the doctor’s specialty. To make the best health care
21 decisions, you should view this information in perspective. You
22 could miss an opportunity for high-quality care by selecting a
23 doctor based solely on malpractice history.

24 When considering malpractice data, please keep in mind:

25 Malpractice histories tend to vary by specialty. Some specialties
26 are more likely than others to be the subject of litigation. This
27 report compares doctors only to the members of their specialty,
28 not to all doctors, in order to make an individual doctor’s history
29 more meaningful.

30 This report reflects data only for settlements made on or after
31 January 1, 2003. Moreover, it includes information concerning
32 those settlements for a 10-year period only. Therefore, you should
33 know that a doctor may have made settlements in the 10 years
34 immediately preceding January 1, 2003, that are not included in
35 this report. After January 1, 2013, for doctors practicing less than
36 10 years, the data covers their total years of practice. You should
37 take into account the effective date of settlement disclosure as well
38 as how long the doctor has been in practice when considering
39 malpractice averages.

1 The incident causing the malpractice claim may have happened
2 years before a payment is finally made. Sometimes, it takes a long
3 time for a malpractice lawsuit to settle. Some doctors work
4 primarily with high-risk patients. These doctors may have
5 malpractice settlement histories that are higher than average
6 because they specialize in cases or patients who are at very high
7 risk for problems.

8 Settlement of a claim may occur for a variety of reasons that do
9 not necessarily reflect negatively on the professional competence
10 or conduct of the doctor. A payment in settlement of a medical
11 malpractice action or claim should not be construed as creating a
12 presumption that medical malpractice has occurred.

13 You may wish to discuss information in this report and the
14 general issue of malpractice with your doctor.”

15 (e) The Medical Board of California, the Osteopathic Medical
16 Board of California, the California Board of Podiatric Medicine,
17 and the Physician Assistant Board shall, by regulation, develop
18 standard terminology that accurately describes the different types
19 of disciplinary filings and actions to take against a licensee as
20 described in paragraphs (1) to (5), inclusive, of subdivision (a). In
21 providing the public with information about a licensee via the
22 Internet pursuant to Section 2027, the Medical Board of California,
23 the Osteopathic Medical Board of California, the California Board
24 of Podiatric Medicine, and the Physician Assistant Board shall not
25 use the terms “enforcement,” “discipline,” or similar language
26 implying a sanction unless the physician and surgeon has been the
27 subject of one of the actions described in paragraphs (1) to (5),
28 inclusive, of subdivision (a).

29 (f) The Medical Board of California shall adopt regulations no
30 later than July 1, 2003, designating each specialty and subspecialty
31 practice area as either high risk or low risk. In promulgating these
32 regulations, the board shall consult with commercial underwriters
33 of medical malpractice insurance companies, health care systems
34 that self-insure physicians and surgeons, and representatives of
35 the California medical specialty societies. The board shall utilize
36 the carriers’ statewide data to establish the two risk categories and
37 the averages required by subparagraph (B) of paragraph (2) of
38 subdivision (b). Prior to issuing regulations, the board shall
39 convene public meetings with the medical malpractice carriers,
40 self-insurers, and specialty representatives.

1 (g) The Medical Board of California, the Osteopathic Medical
2 Board of California, the California Board of Podiatric Medicine,
3 *and* the Physician Assistant Board shall provide each licensee,
4 including a former licensee under subdivision (a), with a copy of
5 the text of any proposed public disclosure authorized by this section
6 prior to release of the disclosure to the public. The licensee shall
7 have 10 working days from the date the board provides the copy
8 of the proposed public disclosure to propose corrections of factual
9 inaccuracies. Nothing in this section shall prevent the board from
10 disclosing information to the public prior to the expiration of the
11 10-day period.

12 (h) Pursuant to subparagraph (A) of paragraph (2) of subdivision
13 (b), the specialty or subspecialty information required by this
14 section shall group physicians by specialty board recognized
15 pursuant to paragraph (5) of subdivision (h) of Section 651 unless
16 a different grouping would be more valid and the board, in its
17 statement of reasons for its regulations, explains why the validity
18 of the grouping would be more valid.

19 (i) By July 1, 2018, ~~the board~~ *Medical Board of California, the*
20 *Osteopathic Medical Board of California, and the California Board*
21 *of Podiatric Medicine* shall include ~~each licensee's probation~~
22 ~~summary written pursuant to subdivision (e)~~ *the information listed*
23 *in subdivision (f) of Section 2228 on any board documents*
24 *informing the public of probation orders, orders and probationary*
25 *licenses*, including, but not limited to, newsletters.

26 *SEC. 2. Section 1006 is added to the Business and Professions*
27 *Code, to read:*

28 *1006. (a) Except as provided by subdivision (c), the State*
29 *Board of Chiropractic Examiners shall require a licensee to*
30 *disclose on a separate document her or his probationary status to*
31 *a patient, the patient's guardian, or health care surrogate prior*
32 *to the patient's first visit following the probationary order while*
33 *the licensee is on probation in any of the following circumstances:*

34 *(1) The accusation alleges, the statement of issues indicates, or*
35 *the legal conclusions of an administrative law judge find that the*
36 *licensee is implicated in any of the following:*

37 *(A) Gross negligence.*

38 *(B) Repeated negligent acts involving a departure from the*
39 *standard of care with multiple patients.*

- 1 (C) *Repeated acts of inappropriate and excessive prescribing*
2 *of controlled substances, including, but not limited to, prescribing*
3 *controlled substances without appropriate prior examination or*
4 *without medical reason documented in medical records.*
- 5 (D) *Drug or alcohol abuse that threatens to impair a licensee’s*
6 *ability to practice medicine safely, including practicing under the*
7 *influence of drugs or alcohol.*
- 8 (E) *Felony conviction arising from or occurring during patient*
9 *care or treatment.*
- 10 (F) *Mental illness or other cognitive impairment that impedes*
11 *a licensee’s ability to safely practice medicine.*
- 12 (2) *The board ordered any of the following in conjunction with*
13 *placing the licensee on probation:*
- 14 (A) *That a third-party chaperone be present when the licensee*
15 *examines patients as a result of sexual misconduct.*
- 16 (B) *That the licensee submit to drug testing as a result of drug*
17 *or alcohol abuse.*
- 18 (C) *That the licensee have a monitor.*
- 19 (D) *Restricting the licensee totally or partially from prescribing*
20 *controlled substances.*
- 21 (3) *The licensee has not successfully completed a clinical*
22 *training program or any associated examinations required by the*
23 *board as a condition of probation.*
- 24 (4) *The licensee has been on probation more than once.*
- 25 (b) *The licensee shall obtain from each patient a signed receipt*
26 *following the disclosure that includes a written explanation of how*
27 *the patient can find further information on the licensee’s probation*
28 *on the board’s Internet Web site.*
- 29 (c) *The licensee shall not be required to provide the disclosure*
30 *prior to the visit as required by subdivision (a) if the patient is*
31 *unconscious or otherwise unable to comprehend the disclosure*
32 *and sign the receipt pursuant to subdivision (b) and a guardian*
33 *or health care surrogate is unavailable to comprehend the*
34 *disclosure and sign the receipt. In that instance, the licensee shall*
35 *disclose her or his status as soon as either the patient can*
36 *comprehend the disclosure and sign the receipt or a guardian or*
37 *health care surrogate is available to comprehend the disclosure*
38 *and sign the receipt.*

1 (d) By July 1, 2018, the board shall develop a standardized
 2 format for listing the following information pursuant to subdivision
 3 (e):

4 (1) The listing of the causes for probation alleged in the
 5 accusation, the statement of issues, or the legal conclusions of an
 6 administrative law judge.

7 (2) The length of the probation and the end date.

8 (3) All practice restrictions placed on the licensee by the
 9 committee.

10 (e) By July 1, 2018, the board shall provide the information
 11 listed in subdivision (d) as follows:

12 (1) To an inquiring member of the public.

13 (2) On any board documents informing the public of probation
 14 orders and probationary licenses, including, but not limited to,
 15 newsletters.

16 (3) Upon availability of a licensee’s BreEZe profile Internet
 17 Web page on the BreEZe system pursuant to Section 210, in plain
 18 view on the BreEZe profile Internet Web page of a licensee subject
 19 to probation or a probationary license.

20 ~~SEC. 2.~~

21 ~~SEC. 3.~~ Section 2027 of the Business and Professions Code is
 22 amended to read:

23 2027. (a) The board shall post on its Internet Web site the
 24 following information on the current status of the license for all
 25 current and former licensees:

26 (1) Whether or not the licensee is presently in good standing.

27 (2) Current American Board of Medical Specialties certification
 28 or board equivalent as certified by the board.

29 (3) Any of the following enforcement actions or proceedings
 30 to which the licensee is actively subjected:

31 (A) Temporary restraining orders.

32 (B) Interim suspension orders.

33 (C) (i) Revocations, suspensions, probations, or limitations on
 34 practice ordered by the board or the board of another state or
 35 jurisdiction, including those made part of a probationary order or
 36 stipulated agreement.

37 (ii) By July 1, 2018, ~~the board~~ *the board, the Osteopathic Medical*
 38 *Board of California, and the California Board of Podiatric*
 39 *Medicine* shall include, in plain view on the BreEZe profile ~~web~~
 40 *Internet Web* page of each licensee subject to ~~probation,~~ *the*

1 ~~summary of each probation order as written pursuant to~~ *probation*
2 ~~or a probationary license, the information described in~~ subdivision
3 ~~(e)~~ (f) of Section 2228. For purposes of this subparagraph, a
4 BreEZe profile ~~web~~ *Internet Web* page is a profile ~~web~~ *Internet*
5 *Web* page on the BreEZe system pursuant to Section 210.

6 (D) Current accusations filed by the Attorney General, including
7 those accusations that are on appeal. For purposes of this paragraph,
8 “current accusation” means an accusation that has not been
9 dismissed, withdrawn, or settled, and has not been finally decided
10 upon by an administrative law judge and the board unless an appeal
11 of that decision is pending.

12 (E) Citations issued that have not been resolved or appealed
13 within 30 days.

14 (b) The board shall post on its Internet Web site all of the
15 following historical information in its possession, custody, or
16 control regarding all current and former licensees:

17 (1) Approved postgraduate training.

18 (2) Any final revocations and suspensions, or other equivalent
19 actions, taken against the licensee by the board or the board of
20 another state or jurisdiction or the surrender of a license by the
21 licensee in relation to a disciplinary action or investigation,
22 including the operative accusation resulting in the license surrender
23 or discipline by the board.

24 (3) Probation or other equivalent action ordered by the board,
25 or the board of another state or jurisdiction, completed or
26 terminated, including the operative accusation resulting in the
27 discipline by the board.

28 (4) Any felony convictions. Upon receipt of a certified copy of
29 an expungement order granted pursuant to Section 1203.4 of the
30 Penal Code from a licensee, the board shall, within six months of
31 receipt of the expungement order, post notification of the
32 expungement order and the date thereof on its Internet Web site.

33 (5) Misdemeanor convictions resulting in a disciplinary action
34 or accusation that is not subsequently withdrawn or dismissed.
35 Upon receipt of a certified copy of an expungement order granted
36 pursuant to Section 1203.4 of the Penal Code from a licensee, the
37 board shall, within six months of receipt of the expungement order,
38 post notification of the expungement order and the date thereof on
39 its Internet Web site.

1 (6) Civil judgments issued in any amount, whether or not
2 vacated by a settlement after entry of the judgment, that were not
3 reversed on appeal, and arbitration awards issued in any amount,
4 for a claim or action for damages for death or personal injury
5 caused by the physician and surgeon's negligence, error, or
6 omission in practice, or by his or her rendering of unauthorized
7 professional services.

8 (7) Except as provided in subparagraphs (A) and (B), a summary
9 of any final hospital disciplinary actions that resulted in the
10 termination or revocation of a licensee's hospital staff privileges
11 for a medical disciplinary cause or reason. The posting shall
12 provide any additional explanatory or exculpatory information
13 submitted by the licensee pursuant to subdivision (f) of Section
14 805. The board shall also post on its Internet Web site a factsheet
15 that explains and provides information on the reporting
16 requirements under Section 805.

17 (A) If a licensee's hospital staff privileges are restored and the
18 licensee notifies the board of the restoration, the information
19 pertaining to the termination or revocation of those privileges shall
20 remain posted on the Internet Web site for a period of 10 years
21 from the restoration date of the privileges, and at the end of that
22 period shall be removed.

23 (B) If a court finds, in a final judgment, that peer review
24 resulting in a hospital disciplinary action was conducted in bad
25 faith and the licensee notifies the board of that finding, the
26 information concerning that hospital disciplinary action posted on
27 the Internet Web site shall be immediately removed. For purposes
28 of this subparagraph, "peer review" has the same meaning as
29 defined in Section 805.

30 (8) Public letters of reprimand issued within the past 10 years
31 by the board or the board of another state or jurisdiction, including
32 the operative accusation, if any, resulting in discipline by the board.

33 (9) Citations issued within the last three years that have been
34 resolved by payment of the administrative fine or compliance with
35 the order of abatement.

36 (10) All settlements within the last five years in the possession,
37 custody, or control of the board shall be disclosed for a licensee
38 in the low-risk category if there are three or more settlements for
39 that licensee within the last five years, and for a licensee in the
40 high-risk category if there are four or more settlements for that

1 licensee within the last five years. Classification of a licensee in
2 either a “high-risk category” or a “low-risk” category depends
3 upon the specialty or subspecialty practiced by the licensee and
4 the designation assigned to that specialty or subspecialty by the
5 board pursuant to subdivision (f) of Section 803.1.

6 (A) For the purposes of this paragraph, “settlement” means a
7 settlement in an amount of thirty thousand dollars (\$30,000) or
8 more of any claim or action for damages for death or personal
9 injury caused by the physician and surgeon’s negligence, error, or
10 omission in practice, or by his or her rendering of unauthorized
11 professional services.

12 (B) For the purposes of this paragraph, “settlement” does not
13 include a settlement by a licensee, regardless of the amount paid,
14 when (i) the settlement is made as a part of the settlement of a
15 class claim, (ii) the amount paid in settlement of the class claim
16 is the same amount paid by the other licensees in the same class
17 or similarly situated licensees in the same class, and (iii) the
18 settlement was paid in the context of a case for which the complaint
19 that alleged class liability on behalf of the licensee also alleged a
20 products liability class action cause of action.

21 (C) The board shall not disclose the actual dollar amount of a
22 settlement, but shall disclose settlement information in the same
23 manner and with the same disclosures required under subparagraph
24 (B) of paragraph (2) of subdivision (b) of Section 803.1.

25 (11) Appropriate disclaimers and explanatory statements to
26 accompany the information described in paragraphs (1) to (10),
27 inclusive, including an explanation of what types of information
28 are not disclosed. These disclaimers and statements shall be
29 developed by the board and shall be adopted by regulation.

30 (c) The board shall provide links to other Internet Web sites
31 that provide information on board certifications that meet the
32 requirements of subdivision (h) of Section 651. The board may
33 also provide links to any other Internet Web sites that provide
34 information on the affiliations of licensed physicians and surgeons.
35 The board may provide links to other Internet Web sites on the
36 Internet that provide information on health care service plans,
37 health insurers, hospitals, or other facilities.

38 *SEC. 4. Section 2221 of the Business and Professions Code is*
39 *amended to read:*

1 2221. (a) The board may deny a physician's and surgeon's
2 certificate to an applicant guilty of unprofessional conduct or of
3 any cause that would subject a licensee to revocation or suspension
4 of his or her ~~license~~, or, ~~the~~ *license*.

5 (b) *The* board in its sole discretion, may issue a probationary
6 physician's and surgeon's certificate to an applicant subject to
7 terms and conditions, including, but not limited to, any of the
8 following conditions of probation:

9 (1) Practice limited to a supervised, structured environment
10 where the licensee's activities shall be supervised by another
11 physician and surgeon.

12 (2) Total or partial restrictions on drug prescribing privileges
13 for controlled substances.

14 (3) Continuing medical or psychiatric treatment.

15 (4) Ongoing participation in a specified rehabilitation program.

16 (5) Enrollment and successful completion of a clinical training
17 program.

18 (6) Abstention from the use of alcohol or drugs.

19 (7) Restrictions against engaging in certain types of medical
20 practice.

21 (8) Compliance with all provisions of this chapter.

22 (9) Payment of the cost of probation monitoring.

23 (10) *Disclosing probationary license status to patients, pursuant*
24 *to subdivision (b) of Section 2228.*

25 ~~(b)~~

26 (c) The board may modify or terminate the terms and conditions
27 imposed on the probationary certificate upon receipt of a petition
28 from the *licensee*; *however, the provisions of subdivision (b) of*
29 *Section 2228 are mandatory with any probationary licensee.* The
30 board may assign the petition to an administrative law judge
31 designated in Section 11371 of the Government Code. After a
32 hearing on the petition, the administrative law judge shall provide
33 a proposed decision to the board.

34 ~~(e)~~

35 (d) The board shall deny a physician's and surgeon's certificate
36 to an applicant who is required to register pursuant to Section 290
37 of the Penal Code. This subdivision does not apply to an applicant
38 who is required to register as a sex offender pursuant to Section
39 290 of the Penal Code solely because of a misdemeanor conviction
40 under Section 314 of the Penal Code.

1 ~~(d)~~

2 (e) An applicant shall not be eligible to reapply for a physician's
3 and surgeon's certificate for a minimum of three years from the
4 effective date of the denial of his or her application, except that
5 the board may, in its discretion and for good cause demonstrated,
6 permit reapplication after not less than one year has elapsed from
7 the effective date of the denial.

8 *SEC. 5. Section 2221.05 of the Business and Professions Code*
9 *is amended to read:*

10 2221.05. (a) Notwithstanding ~~subdivision~~ *subdivisions* (a) and
11 (b) of Section 2221, the board may issue a physician's and
12 surgeon's certificate to an applicant who has committed minor
13 violations that the board deems, in its discretion, do not merit the
14 denial of a certificate or require probationary status under Section
15 2221, and may concurrently issue a public letter of reprimand.

16 (b) A public letter of reprimand issued concurrently with a
17 physician's and surgeon's certificate shall be purged three years
18 from the date of issuance.

19 (c) A public letter of reprimand issued pursuant to this section
20 shall be disclosed to an inquiring member of the public and shall
21 be posted on the board's Internet Web site.

22 (d) Nothing in this section shall be construed to affect the
23 board's authority to issue an unrestricted license.

24 ~~SEC. 3.~~

25 *SEC. 6. Section 2228 of the Business and Professions Code is*
26 *amended to read:*

27 2228. (a) The authority of the board or the California Board
28 of Podiatric Medicine to discipline a licensee by placing him or
29 her on probation includes, but is not limited to, the following:

30 (1) Requiring the licensee to obtain additional professional
31 training and to pass an examination upon the completion of the
32 training. The examination may be written or oral, or both, and may
33 be a practical or clinical examination, or both, at the option of the
34 board or the administrative law judge.

35 (2) Requiring the licensee to submit to a complete diagnostic
36 examination by one or more physicians and surgeons appointed
37 by the board. If an examination is ordered, the board shall receive
38 and consider any other report of a complete diagnostic examination
39 given by one or more physicians and surgeons of the licensee's
40 choice.

1 (3) Restricting or limiting the extent, scope, or type of practice
2 of the licensee, including requiring notice to applicable patients
3 that the licensee is unable to perform the indicated treatment, where
4 appropriate.

5 (4) Providing the option of alternative community service in
6 cases other than violations relating to quality of care.

7 (b) ~~The board~~ *board or the California Board of Podiatric*
8 *Medicine* shall require a licensee to disclose *on a separate*
9 *document* her or his probationary status to ~~patients before each~~
10 *visit a patient, the patient's guardian, or health care surrogate*
11 *prior to the patient's first visit following the probationary order*
12 while the licensee is on probation in any of the following
13 circumstances:

14 (1) ~~The board made a finding in the probation order~~ *accusation*
15 *alleges, the statement of issues indicates, or the legal conclusions*
16 *of an administrative law judge finds* that the licensee ~~committed~~
17 *is implicated in* any of the following:

18 (A) Gross negligence.

19 (B) Repeated negligent acts involving a departure from the
20 standard of care with multiple patients.

21 (C) Repeated acts of inappropriate and excessive prescribing
22 of controlled substances, including, but not limited to, prescribing
23 controlled substances without appropriate prior examination or
24 without medical reason documented in medical records.

25 (D) Drug or alcohol abuse that threatens to impair a licensee's
26 ability to practice medicine safely, including practicing under the
27 influence of drugs or alcohol.

28 (E) Felony conviction arising from or occurring during patient
29 care or treatment.

30 (F) *Mental illness or other cognitive impairment that impedes*
31 *a licensee's ability to safely practice medicine.*

32 (2) The board ordered any of the following in conjunction with
33 placing the licensee on probation:

34 (A) That a ~~third party~~ *third-party* chaperone be present when
35 the licensee examines patients as a result of sexual misconduct.

36 (B) That the licensee submit to drug testing as a result of drug
37 or alcohol abuse.

38 (C) That the licensee have a monitor.

39 (D) Restricting totally or partially the licensee from prescribing
40 controlled substances.

1 ~~(E) Suspending the licensee from practice in cases related to~~
2 ~~quality of care.~~

3 (3) The licensee has not successfully completed a clinical
4 training program or any associated examinations required by the
5 board as a condition of probation.

6 (4) The licensee has been on probation ~~repeatedly~~; *more than*
7 *once*.

8 ~~(c) The board shall adopt regulations by July 1, 2018, to~~
9 ~~implement subdivision (b). The board shall include in these~~
10 ~~regulations a requirement that the licensee shall obtain from each~~
11 ~~patient a signed receipt following the disclosure that includes a~~
12 ~~written explanation of how the patient can find further information~~
13 ~~on the licensee's discipline probation on the board's Internet Web~~
14 ~~site.~~

15 *(d) A licensee shall not be required to provide the disclosure*
16 *prior to a visit as required by subdivision (b) if the patient is*
17 *unconscious or otherwise unable to comprehend the disclosure*
18 *and sign the receipt pursuant to subdivision (c) and a guardian*
19 *or health care surrogate is unavailable to comprehend the*
20 *disclosure and sign the receipt. In that instance, the licensee shall*
21 *disclose her or his status as soon as either the patient can*
22 *comprehend the disclosure and sign the receipt or a guardian or*
23 *health care surrogate is available to comprehend the disclosure*
24 *and sign the receipt.*

25 ~~(d)~~
26 (e) Section 2314 shall not apply to subdivision ~~(b) or (c)~~; (b),
27 (c), or (d).

28 ~~(e)~~
29 (f) By July 1, 2018, the board shall ~~include, in the first section~~
30 ~~of each order of probation, a standardized, single paragraph,~~
31 ~~plain language summary that contains the accusations that led to~~
32 ~~the licensee's probation, the develop a standardized format for~~
33 ~~listing the following information pursuant to paragraph (5) of~~
34 ~~subdivision (b) of Section 803.1, subdivision (i) of Section 803.1,~~
35 ~~and clause (ii) of subparagraph (C) of paragraph (1) of subdivision~~
36 ~~(a) of Section 2027:~~

37 (1) *The listing of the causes for probation alleged in the*
38 *accusation, the statement of issues, or the legal conclusions of an*
39 *administrative law judge.*

40 (2) *The length of the probation and the end date, and all date.*

1 (3) All practice restrictions placed on the licensee by the board.
2 SEC. 7. Section 3663 of the Business and Professions Code is
3 amended to read:

4 3663. (a) The committee shall have the responsibility for
5 reviewing the quality of the practice of naturopathic medicine
6 carried out by persons licensed as naturopathic doctors pursuant
7 to this chapter.

8 (b) The committee may discipline a naturopathic doctor for
9 unprofessional conduct. After a hearing conducted in accordance
10 with the Administrative Procedure Act (Chapter 5 (commencing
11 with Section 11500) of Part 1 of Division 3 of Title 2 of the
12 Government Code), the committee may deny, suspend, revoke, or
13 place on probation the license of, or reprimand, censure, or
14 otherwise discipline a naturopathic doctor in accordance with
15 Division 1.5 (commencing with Section 475).

16 (c) Except as provided by subdivision (e), the committee shall
17 require a naturopathic doctor to disclose on a separate document
18 her or his probationary status to a patient, the patient's guardian,
19 or health care surrogate prior to the patient's first visit following
20 the probationary order while the naturopathic doctor is on
21 probation in any of the following circumstances:

22 (1) The accusation alleges, the statement of issues indicates, or
23 the legal conclusions of an administrative law judge find that the
24 naturopathic doctor is implicated in any of the following:

25 (A) Gross negligence.

26 (B) Repeated negligent acts involving a departure from the
27 standard of care with multiple patients.

28 (C) Repeated acts of inappropriate and excessive prescribing
29 of controlled substances, including, but not limited to, prescribing
30 controlled substances without appropriate prior examination or
31 without medical reason documented in medical records.

32 (D) Drug or alcohol abuse that threatens to impair a
33 naturopathic doctor's ability to practice medicine safely, including
34 practicing under the influence of drugs or alcohol.

35 (E) Felony conviction arising from or occurring during patient
36 care or treatment.

37 (F) Mental illness or other cognitive impairment that impedes
38 a naturopathic doctor's ability to safely practice medicine.

39 (2) The committee ordered any of the following in conjunction
40 with placing the naturopathic doctor on probation:

1 (A) That a third-party chaperone be present when the
2 naturopathic doctor examines patients as a result of sexual
3 misconduct.

4 (B) That the naturopathic doctor submit to drug testing as a
5 result of drug or alcohol abuse.

6 (C) That the naturopathic doctor have a monitor.

7 (D) Restricting the naturopathic doctor totally or partially from
8 prescribing controlled substances.

9 (3) The naturopathic doctor has not successfully completed a
10 clinical training program or any associated examinations required
11 by the committee as a condition of probation.

12 (4) The naturopathic doctor has been on probation more than
13 once.

14 (d) The naturopathic doctor shall obtain from each patient a
15 signed receipt following the disclosure that includes a written
16 explanation of how the patient can find further information on the
17 naturopathic doctor's probation on the committee's Internet Web
18 site.

19 (e) The naturopathic doctor shall not be required to provide
20 the disclosure prior to the visit as required by subdivision (c) if
21 the patient is unconscious or otherwise unable to comprehend the
22 disclosure or sign the receipt pursuant to subdivision (d) and a
23 guardian or health care surrogate is unavailable to comprehend
24 the disclosure or sign the receipt. In such an instance, the
25 naturopathic doctor shall disclose her or his status as soon as
26 either the patient can comprehend the disclosure and sign the
27 receipt or a guardian or health care surrogate is available to
28 comprehend the disclosure and sign the receipt.

29 (f) By July 1, 2018, the committee shall develop a standardized
30 format for listing the following information pursuant to:

31 (1) The listing of the causes for probation alleged in the
32 accusation, the statement of issues, or the legal conclusions of an
33 administrative law judge.

34 (2) The length of the probation and the end date.

35 (3) All practice restrictions placed on the naturopathic doctor
36 by the committee.

37 (g) By July 1, 2018, the committee shall provide the information
38 listed in subdivision (f) as follows:

39 (1) To an inquiring member of the public.

1 (2) *On any committee documents informing the public of*
2 *probation orders and probationary licenses, including, but not*
3 *limited to, newsletters.*

4 (3) *In plain view on the BreEZe profile Internet Web page of a*
5 *naturopathic doctor subject to probation or a probationary license.*

6 SEC. 8. *Section 4962 is added to the Business and Professions*
7 *Code, to read:*

8 4962. (a) *Except as provided by subdivision (c), the board*
9 *shall require a licensee to disclose on a separate document her or*
10 *his probationary status to a patient, the patient's guardian, or*
11 *health care surrogate prior to the patient's first visit following the*
12 *probationary order while the licensee is on probation in any of*
13 *the following circumstances:*

14 (1) *The accusation alleges, the statement of issues indicates, or*
15 *the legal conclusions of an administrative law judge find that the*
16 *licensee is implicated in any of the following:*

17 (A) *Gross negligence.*

18 (B) *Repeated negligent acts involving a departure from the*
19 *standard of care with multiple patients.*

20 (C) *Drug or alcohol abuse that threatens to impair a licensee's*
21 *ability to practice acupuncture safely, including practicing under*
22 *the influence of drugs or alcohol.*

23 (D) *Felony conviction arising from or occurring during patient*
24 *care or treatment.*

25 (E) *Mental illness or other cognitive impairment that impedes*
26 *a licensee's ability to safely practice acupuncture.*

27 (2) *The board ordered any of the following in conjunction with*
28 *placing the licensee on probation:*

29 (A) *That a third-party chaperone be present when the licensee*
30 *examines patients as a result of sexual misconduct.*

31 (B) *That the licensee submit to drug testing as a result of drug*
32 *or alcohol abuse.*

33 (C) *That the licensee have a monitor.*

34 (3) *The licensee has not successfully completed a training*
35 *program or any associated examinations required by the board*
36 *as a condition of probation.*

37 (4) *The licensee has been on probation more than once.*

38 (b) *The licensee shall obtain from each patient a signed receipt*
39 *following the disclosure that includes a written explanation of how*

1 *the patient can find further information on the licensee's probation*
2 *on the board's Internet Web site.*

3 *(c) The licensee shall not be required to provide the disclosure*
4 *prior to the visit as required by subdivision (a) if the patient is*
5 *unconscious or otherwise unable to comprehend the disclosure or*
6 *sign the receipt pursuant to subdivision (b) and a guardian or*
7 *health care surrogate is unavailable to comprehend the disclosure*
8 *or sign the receipt. In such an instance, the licensee shall disclose*
9 *her or his status as soon as either the patient can comprehend the*
10 *disclosure and sign the receipt or a guardian or health care*
11 *surrogate is available to comprehend the disclosure and sign the*
12 *receipt.*

13 *(d) Section 4935 shall not apply to subdivision (a) or (b).*

14 *(e) By July 1, 2018, the committee shall develop a standardized*
15 *format for listing the following information pursuant to subdivision*
16 *(f):*

17 *(1) The listing of the causes for probation alleged in the*
18 *accusation, the statement of issues, or the legal conclusions of an*
19 *administrative law judge.*

20 *(2) The length of the probation and the end date.*

21 *(3) All practice restrictions placed on the licensee by the*
22 *committee.*

23 *(f) By July 1, 2018, the board shall provide the information*
24 *listed in subdivision (e) as follows:*

25 *(1) To an inquiring member of the public.*

26 *(2) On any board documents informing the public of probation*
27 *orders and probationary licenses, including, but not limited to,*
28 *newsletters.*

29 *(3) Upon availability of a licensee's BreEZe profile Internet*
30 *Web page on the BreEZe system pursuant to Section 210, in plain*
31 *view on the BreEZe profile Internet Web page of a licensee subject*
32 *to probation or a probationary license.*

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1039
Author: Hill
Bill Date: April 21, 2016, Amended
Subject: Professions and Vocations
Sponsor: Author
Position: Support Provisions Related to the Board of Podiatric Medicine (BPM)

DESCRIPTION OF CURRENT LEGISLATION:

The provisions in this bill related to the BPM would make clarifying and technical changes that clarify the BPM's authority to issue podiatric licenses.

ANALYSIS

The BPM is its own board and is completely separate from the Medical Board of California (Board). For more than the past two decades, the BPM has been issuing its own podiatric licenses, separate and apart from the Board. It came to the Board's attention that statute does not reflect this practice in all sections of the Business and Professions Code (BPC) and there are some conflicting provisions.

This bill will remove references to the Medical Board of California in the BPC sections that regulate the BPM. This bill will make it clear that the BPM is its own board that performs its own licensing functions.

At the October 2015 Board Meeting, the Board voted to sponsor legislation to make the technical, clarifying changes included in this bill. Board staff discussed these changes with the staff of the Senate Business, Professions and Economic Development Committee and they agreed that the changes needed to be made and this language was amended into this clean-up bill authored by Senator Hill. The Board believes these clarifying changes are very important, as the Board does not have any control over the BPM, and the law should accurately reflect each board's actual responsibilities.

The Board already voted to support/sponsor the provisions included in SB 1039.

FISCAL: None

SUPPORT
(BPM provisions): Medical Board of California

OPPOSITION
(BPM provisions): None on File

AMENDED IN SENATE APRIL 21, 2016

AMENDED IN SENATE APRIL 12, 2016

AMENDED IN SENATE APRIL 7, 2016

SENATE BILL

No. 1039

Introduced by Senator Hill

February 12, 2016

An act to amend Sections ~~1636.4~~, 2423, 2460, 2461, 2475, 2479, 2486, 2488, 2492, 2499, 2733, 2746.51, 2786.5, 2811, 2811.5, 2815, 2815.5, 2816, 2830.7, 2836.3, 2838.2, 4128.2, 4999, 4999.2, 7137, 7153.3, 8031, 8516, and 8518 of, to amend, repeal, and add Section 4400 of, to add Section 2499.7 to, ~~and to repeal Chapter 15 (commencing with Section 4999) of Division 2 of, Sections 4999.1, 4999.3, 4999.4, and 4999.6 of, and to repeal and add Section 4999.5 of,~~ the Business and Professions Code, to ~~repeal~~ amend Section 1348.8 of the Health and Safety Code, and to ~~repeal~~ amend Section 10279 of the Insurance Code, relating to professions and vocations, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1039, as amended, Hill. Professions and vocations.

(1) Existing law requires the Office of Statewide Health Planning and Development to establish the Health Professions Education Foundation to, among other things, solicit and receive funds for the purpose of providing scholarships, as specified.

The bill would state the intent of the Legislature to enact future legislation that would establish a Dental Corps Scholarship Program, as specified, to increase the supply of dentists serving in medically underserved areas.

~~(2) The Dental Practice Act provides for the licensure and regulation of persons engaged in the practice of dentistry by the Dental Board of California, which is within the Department of Consumer Affairs, and requires the board to be responsible for the approval of foreign dental schools by evaluating foreign dental schools based on specified criteria. That act authorizes the board to contract with outside consultants or a national professional organization to survey and evaluate foreign dental schools, as specified. That act requires the board to establish a technical advisory group to review the survey and evaluation contracted for prior to the board taking any final action regarding a foreign dental school. That act also requires periodic surveys and evaluations of all approved schools be made to ensure compliance with the act.~~

~~This bill would authorize the board, in lieu of conducting its own survey and evaluation of a foreign dental school, to accept the findings of any commission or accreditation agency approved by the board, if the findings meet specified standards and the foreign dental school is not under review by the board on January 1, 2017, and adopt those findings as the board's own. The bill would delete the requirement to establish a technical advisory group. The bill would instead authorize periodic surveys and evaluations be made to ensure compliance with that act.~~

~~(3)~~

~~(2) The Medical Practice Act creates, within the jurisdiction of the Medical Board of California, the California Board of Podiatric Medicine. Under the act, certificates to practice podiatric medicine and registrations of spectacle lens dispensers and contact lens dispensers, among others, expire on a certain date during the second year of a 2-year term if not renewed.~~

~~This bill would instead create the California Board of Podiatric Medicine in the Department of Consumer Affairs, and would make conforming and related changes. The bill would discontinue the above-described requirement for the expiration of the registrations of spectacle lens dispensers and contact lens dispensers.~~

~~(4)~~

~~(3) The Nursing Practice Act provides for the licensure and regulation of nurse practitioners by the Board of Registered Nursing, which is within the Department of Consumer Affairs, and requires the board to adopt regulations establishing standards for continuing education for licensees, as specified. That act requires providers of continuing education programs approved by the board to make records of continuing~~

education courses given to registered nurses available for board inspection. That act also prescribes various fees to be paid by licensees and applicants for licensure, and requires these fees to be credited to the Board of Registered Nursing Fund, which is a continuously appropriated fund as it pertains to fees collected by the board.

This bill would require that the content of a continuing education course be based on generally accepted scientific principles. The bill would also require the board to audit continuing education providers, at least once every 5 years, to ensure adherence to regulatory requirements, and to withhold or rescind approval from any provider that is in violation of regulatory requirements. The bill would raise specified fees, and would provide for additional fees, to be paid by licensees and applicants for licensure pursuant to that act. By increasing fees deposited into a continuously appropriated fund, this bill would make an appropriation.

(5)

(4) The Pharmacy Law provides for the licensure and regulation of pharmacists by the California State Board of Pharmacy within the Department of Consumer Affairs. That law prescribes various fees to be paid by licensees and applicants for licensure, and requires all fees collected on behalf of the board to be credited to the Pharmacy Board Contingent Fund, which is a continuously appropriated fund as it pertains to fees collected by the board.

This bill would, on and after July 1, 2017, modify specified fees to be paid by licensees and applicants for licensure pursuant to that act. By increasing fees deposited into a continuously appropriated fund, this bill would make an appropriation.

(6)

(5) Existing law requires ~~certain~~ businesses *that employ, or contract or subcontract with, the full-time equivalent of 5 or more persons functioning as health care professionals, as defined, whose primary function is to provide telephone medical advice*, that provide telephone medical advice services to a patient at a California address to be registered with the Telephone Medical Advice Services Bureau and further requires telephone medical advice services to comply with the requirements established by the Department of Consumer Affairs, ~~among other provisions~~, as specified.

~~This bill would repeal those provisions.~~

This bill would discontinue the requirement that those businesses be registered with the bureau, would instead make the respective healing

arts licensing boards responsible for enforcing those requirements and any other laws and regulations affecting those health care professionals licensed in California, and would make conforming and related changes.

(7)

(6) The Contractors' State License Law provides for the licensure and regulation of contractors by the Contractors' State License Board within the Department of Consumer Affairs. That law also prescribes various fees to be paid by licensees and applicants for licensure, and requires fees and civil penalties received under that law to be deposited in the Contractors' License Fund, which is a continuously appropriated fund as it pertains to fees collected by the board.

This bill would raise specified fees and would require the board to establish criteria for the approval of expedited processing of applications, as specified. By increasing fees deposited into a continuously appropriated fund, this bill would make an appropriation.

(8)

(7) Existing law provides for the licensure and regulation of shorthand reporters by the Court Reporters Board of California within the Department of Consumer Affairs. That law authorizes the board, by resolution, to establish a fee for the renewal of a certificate issued by the board, and prohibits the fee from exceeding \$125, as specified. Under existing law, all fees and revenues received by the board are deposited into the Court Reporters' Fund, which is a continuously appropriated fund as it pertains to fees collected by the board.

This bill would raise that fee limit to \$250. By authorizing an increase in a fee deposited into a continuously appropriated fund, this bill would make an appropriation.

(9)

(8) Existing law provides for the licensure and regulation of structural pest control operators and registered companies by the Structural Pest Control Board, which is within the Department of Consumer Affairs, and requires a licensee to pay a specified license fee. Existing law makes any violation of those provisions punishable as a misdemeanor. Existing law places certain requirements on a registered company or licensee with regards to wood destroying pests or organisms, including that a registered company or licensee is prohibited from commencing work on a contract until an inspection has been made by a licensed Branch 3 field representative or operator, that the address of each property inspected or upon which work was completed is required to be reported to the board, as specified, and that a written inspection report be prepared

and delivered to the person requesting the inspection or his or her agent. Existing law requires the original inspection report to be submitted to the board upon demand. Existing law requires that written report to contain certain information, including a foundation diagram or sketch of the structure or portions of the structure inspected, and requires the report, and any contract entered into, to expressly state if a guarantee for the work is made, and if so, the terms and time period of the guarantee. Existing law establishes the Structural Pest Control Fund, which is a continuously appropriated fund as it pertains to fees collected by the board.

This bill would require the operator who is conducting the inspection prior to the commencement of work to be employed by a registered company, except as specified. The bill would not require the address of an inspection report prepared for use by an attorney for litigation to be reported to the board or assessed a filing fee. The bill would require instead that the written inspection report be prepared and delivered to the person requesting it, the property owner, or the property owner's designated agent, as specified. The bill would allow an inspection report to be a complete, limited, supplemental, or reinspection report, as defined. The bill would require all inspection reports to be submitted to the board and maintained with field notes, activity forms, and notices of completion until one year after the guarantee expires if the guarantee extends beyond 3 years. The bill would require the inspection report to clearly list the infested or infected wood members or parts of the structure identified in the required diagram or sketch. By placing new requirements on a registered company or licensee, this bill would expand an existing crime and would, therefore, impose a state-mandated local program.

Existing law requires a registered company to prepare a notice of work completed to give to the owner of the property when the work is completed.

This bill would make this provision only applicable to work relating to wood destroying pests and organisms.

(10)

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

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

Vote: majority. Appropriation: yes. Fiscal committee: yes.
State-mandated local program: yes.

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

1 SECTION 1. It is the intent of the Legislature to enact future
2 legislation that would establish a Dental Corps Scholarship
3 Program within the Health Professions Education Foundation to
4 increase the supply of dentists serving in medically underserved
5 areas.

6 ~~SEC. 2. Section 1636.4 of the Business and Professions Code~~
7 ~~is amended to read:~~

8 ~~1636.4. (a) The Legislature recognizes the need to ensure that~~
9 ~~graduates of foreign dental schools who have received an education~~
10 ~~that is equivalent to that of accredited institutions in the United~~
11 ~~States and that adequately prepares their students for the practice~~
12 ~~of dentistry shall be subject to the same licensure requirements as~~
13 ~~graduates of approved dental schools or colleges. It is the purpose~~
14 ~~of this section to provide for the evaluation of foreign dental~~
15 ~~schools and the approval of those foreign dental schools that~~
16 ~~provide an education that is equivalent to that of similar accredited~~
17 ~~institutions in the United States and that adequately prepare their~~
18 ~~students for the practice of dentistry.~~

19 ~~(b) The board shall be responsible for the approval of foreign~~
20 ~~dental schools based on standards established pursuant to~~
21 ~~subdivision (c). The board may contract with outside consultants~~
22 ~~or a national professional organization to survey and evaluate~~
23 ~~foreign dental schools. The consultant or organization shall report~~
24 ~~to the board regarding its findings in the survey and evaluation.~~
25 ~~The board may, in lieu of conducting its own survey and evaluation~~
26 ~~of a foreign dental school, accept the findings of any commission~~
27 ~~or accreditation agency approved by the board if the findings meet~~
28 ~~the standards of subdivision (c) and adopt those findings as the~~
29 ~~board's own. This subdivision shall not apply to foreign dental~~
30 ~~schools seeking board approval that are under review by the board~~
31 ~~on January 1, 2017.~~

32 ~~(c) Any foreign dental school that wishes to be approved~~
33 ~~pursuant to this section shall make application to the board for this~~
34 ~~approval, which shall be based upon a finding by the board that~~
35 ~~the educational program of the foreign dental school is equivalent~~

1 to that of similar accredited institutions in the United States and
2 adequately prepares its students for the practice of dentistry.
3 Curriculum, faculty qualifications, student attendance, plant and
4 facilities, and other relevant factors shall be reviewed and
5 evaluated. The board shall identify by rule the standards and review
6 procedures and methodology to be used in the approval process
7 consistent with this subdivision. The board shall not grant approval
8 if deficiencies found are of such magnitude as to prevent the
9 students in the school from receiving an educational base suitable
10 for the practice of dentistry.

11 (d) Periodic surveys and evaluations of all approved schools
12 may be made to ensure continued compliance with this section.
13 Approval shall include provisional and full approval. The
14 provisional form of approval shall be for a period determined by
15 the board, not to exceed three years, and shall be granted to an
16 institution, in accordance with rules established by the board, to
17 provide reasonable time for the school seeking permanent approval
18 to overcome deficiencies found by the board. Prior to the expiration
19 of a provisional approval and before the full approval is granted,
20 the school shall be required to submit evidence that deficiencies
21 noted at the time of initial application have been remedied. A
22 school granted full approval shall provide evidence of continued
23 compliance with this section. In the event that the board denies
24 approval or reapproval, the board shall give the school a specific
25 listing of the deficiencies that caused the denial and the
26 requirements for remedying the deficiencies, and shall permit the
27 school, upon request, to demonstrate by satisfactory evidence,
28 within 90 days, that it has remedied the deficiencies listed by the
29 board.

30 (e) A school shall pay a registration fee established by rule of
31 the board, not to exceed one thousand dollars (\$1,000), at the time
32 of application for approval and shall pay all reasonable costs and
33 expenses incurred for conducting the approval survey.

34 (f) The board shall renew approval upon receipt of a renewal
35 application, accompanied by a fee not to exceed five hundred
36 dollars (\$500). Each fully approved institution shall submit a
37 renewal application every seven years. Any approval that is not
38 renewed shall automatically expire.

1 ~~SEC. 3.~~

2 *SEC. 2.* Section 2423 of the Business and Professions Code is
3 amended to read:

4 2423. (a) Notwithstanding Section 2422:

5 (1) All physician and surgeon's certificates and certificates to
6 practice midwifery shall expire at 12 midnight on the last day of
7 the birth month of the licensee during the second year of a two-year
8 term if not renewed.

9 (2) Registrations of dispensing opticians will expire at midnight
10 on the last day of the month in which the license was issued during
11 the second year of a two-year term if not renewed.

12 (b) The board shall establish by regulation procedures for the
13 administration of a birth date renewal program, including, but not
14 limited to, the establishment of a system of staggered license
15 expiration dates such that a relatively equal number of licenses
16 expire monthly.

17 (c) To renew an unexpired license, the licensee shall, on or
18 before the dates on which it would otherwise expire, apply for
19 renewal on a form prescribed by the licensing authority and pay
20 the prescribed renewal fee.

21 ~~SEC. 4.~~

22 *SEC. 3.* Section 2460 of the Business and Professions Code is
23 amended to read:

24 2460. (a) There is created within the Department of Consumer
25 Affairs a California Board of Podiatric Medicine.

26 (b) This section shall remain in effect only until January 1, 2017,
27 and as of that date is repealed, unless a later enacted statute, that
28 is enacted before January 1, 2017, deletes or extends that date.
29 Notwithstanding any other provision of law, the repeal of this
30 section renders the California Board of Podiatric Medicine subject
31 to review by the appropriate policy committees of the Legislature.

32 ~~SEC. 5.~~

33 *SEC. 4.* Section 2461 of the Business and Professions Code is
34 amended to read:

35 2461. As used in this article:

36 (a) "Board" means the California Board of Podiatric Medicine.

37 (b) "Podiatric licensing authority" refers to any officer, board,
38 commission, committee, or department of another state that may
39 issue a license to practice podiatric medicine.

1 ~~SEC. 6.~~

2 *SEC. 5.* Section 2475 of the Business and Professions Code is
3 amended to read:

4 2475. Unless otherwise provided by law, no postgraduate
5 trainee, intern, resident postdoctoral fellow, or instructor may
6 engage in the practice of podiatric medicine, or receive
7 compensation therefor, or offer to engage in the practice of
8 podiatric medicine unless he or she holds a valid, unrevoked, and
9 unsuspended certificate to practice podiatric medicine issued by
10 the board. However, a graduate of an approved college or school
11 of podiatric medicine upon whom the degree doctor of podiatric
12 medicine has been conferred, who is issued a resident's license,
13 which may be renewed annually for up to eight years for this
14 purpose by the board, and who is enrolled in a postgraduate training
15 program approved by the board, may engage in the practice of
16 podiatric medicine whenever and wherever required as a part of
17 that program and may receive compensation for that practice under
18 the following conditions:

19 (a) A graduate with a resident's license in an approved
20 internship, residency, or fellowship program may participate in
21 training rotations outside the scope of podiatric medicine, under
22 the supervision of a physician and surgeon who holds a medical
23 doctor or doctor of osteopathy degree wherever and whenever
24 required as a part of the training program, and may receive
25 compensation for that practice. If the graduate fails to receive a
26 license to practice podiatric medicine under this chapter within
27 three years from the commencement of the postgraduate training,
28 all privileges and exemptions under this section shall automatically
29 cease.

30 (b) Hospitals functioning as a part of the teaching program of
31 an approved college or school of podiatric medicine in this state
32 may exchange instructors or resident or assistant resident doctors
33 of podiatric medicine with another approved college or school of
34 podiatric medicine not located in this state, or those hospitals may
35 appoint a graduate of an approved school as such a resident for
36 purposes of postgraduate training. Those instructors and residents
37 may practice and be compensated as provided in this section, but
38 that practice and compensation shall be for a period not to exceed
39 two years.

1 ~~SEC. 7.~~

2 *SEC. 6.* Section 2479 of the Business and Professions Code is
3 amended to read:

4 2479. The board shall issue a certificate to practice podiatric
5 medicine to each applicant who meets the requirements of this
6 chapter. Every applicant for a certificate to practice podiatric
7 medicine shall comply with the provisions of Article 4
8 (commencing with Section 2080) which are not specifically
9 applicable to applicants for a physician’s and surgeon’s certificate,
10 in addition to the provisions of this article.

11 ~~SEC. 8.~~

12 *SEC. 7.* Section 2486 of the Business and Professions Code is
13 amended to read:

14 2486. The board shall issue a certificate to practice podiatric
15 medicine if the applicant has submitted directly to the board from
16 the credentialing organizations verification that he or she meets
17 all of the following requirements:

18 (a) The applicant has graduated from an approved school or
19 college of podiatric medicine and meets the requirements of Section
20 2483.

21 (b) The applicant, within the past 10 years, has passed parts I,
22 II, and III of the examination administered by the National Board
23 of Podiatric Medical Examiners of the United States or has passed
24 a written examination that is recognized by the board to be the
25 equivalent in content to the examination administered by the
26 National Board of Podiatric Medical Examiners of the United
27 States.

28 (c) The applicant has satisfactorily completed the postgraduate
29 training required by Section 2484.

30 (d) The applicant has passed within the past 10 years any oral
31 and practical examination that may be required of all applicants
32 by the board to ascertain clinical competence.

33 (e) The applicant has committed no acts or crimes constituting
34 grounds for denial of a certificate under Division 1.5 (commencing
35 with Section 475).

36 (f) The board determines that no disciplinary action has been
37 taken against the applicant by any podiatric licensing authority
38 and that the applicant has not been the subject of adverse judgments
39 or settlements resulting from the practice of podiatric medicine

1 that the board determines constitutes evidence of a pattern of
2 negligence or incompetence.

3 (g) A disciplinary databank report regarding the applicant is
4 received by the board from the Federation of Podiatric Medical
5 Boards.

6 ~~SEC. 9.~~

7 *SEC. 8.* Section 2488 of the Business and Professions Code is
8 amended to read:

9 2488. Notwithstanding any other law, the board shall issue a
10 certificate to practice podiatric medicine by credentialing if the
11 applicant has submitted directly to the board from the credentialing
12 organizations verification that he or she is licensed as a doctor of
13 podiatric medicine in any other state and meets all of the following
14 requirements:

15 (a) The applicant has graduated from an approved school or
16 college of podiatric medicine.

17 (b) The applicant, within the past 10 years, has passed either
18 part III of the examination administered by the National Board of
19 Podiatric Medical Examiners of the United States or a written
20 examination that is recognized by the board to be the equivalent
21 in content to the examination administered by the National Board
22 of Podiatric Medical Examiners of the United States.

23 (c) The applicant has satisfactorily completed a postgraduate
24 training program approved by the Council on Podiatric Medical
25 Education.

26 (d) The applicant, within the past 10 years, has passed any oral
27 and practical examination that may be required of all applicants
28 by the board to ascertain clinical competence.

29 (e) The applicant has committed no acts or crimes constituting
30 grounds for denial of a certificate under Division 1.5 (commencing
31 with Section 475).

32 (f) The board determines that no disciplinary action has been
33 taken against the applicant by any podiatric licensing authority
34 and that the applicant has not been the subject of adverse judgments
35 or settlements resulting from the practice of podiatric medicine
36 that the board determines constitutes evidence of a pattern of
37 negligence or incompetence.

38 (g) A disciplinary databank report regarding the applicant is
39 received by the board from the Federation of Podiatric Medical
40 Boards.

1 ~~SEC. 10.~~

2 *SEC. 9.* Section 2492 of the Business and Professions Code is
3 amended to read:

4 2492. (a) The board shall examine every applicant for a
5 certificate to practice podiatric medicine to ensure a minimum of
6 entry-level competence at the time and place designated by the
7 board in its discretion, but at least twice a year.

8 (b) Unless the applicant meets the requirements of Section 2486,
9 applicants shall be required to have taken and passed the
10 examination administered by the National Board of Podiatric
11 Medical Examiners.

12 (c) The board may appoint qualified persons to give the whole
13 or any portion of any examination as provided in this article, who
14 shall be designated as examination commissioners. The board may
15 fix the compensation of those persons subject to the provisions of
16 applicable state laws and regulations.

17 (d) The provisions of Article 9 (commencing with Section 2170)
18 shall apply to examinations administered by the board except where
19 those provisions are in conflict with or inconsistent with the
20 provisions of this article.

21 ~~SEC. 11.~~

22 *SEC. 10.* Section 2499 of the Business and Professions Code
23 is amended to read:

24 2499. There is in the State Treasury the Board of Podiatric
25 Medicine Fund. Notwithstanding Section 2445, the board shall
26 report to the Controller at the beginning of each calendar month
27 for the month preceding the amount and source of all revenue
28 received by the board, pursuant to this chapter, and shall pay the
29 entire amount thereof to the Treasurer for deposit into the fund.
30 All revenue received by the board from fees authorized to be
31 charged relating to the practice of podiatric medicine shall be
32 deposited in the fund as provided in this section, and shall be used
33 to carry out the provisions of this chapter relating to the regulation
34 of the practice of podiatric medicine.

35 ~~SEC. 12.~~

36 *SEC. 11.* Section 2499.7 is added to the Business and
37 Professions Code, to read:

38 2499.7. (a) Certificates to practice podiatric medicine shall
39 expire at 12 midnight on the last day of the birth month of the
40 licensee during the second year of a two-year term.

1 (b) To renew an unexpired certificate, the licensee, on or before
2 the date on which the certificate would otherwise expire, shall
3 apply for renewal on a form prescribed by the board and pay the
4 prescribed renewal fee.

5 ~~SEC. 13.~~

6 *SEC. 12.* Section 2733 of the Business and Professions Code
7 is amended to read:

8 2733. (a) (1) (A) Upon approval of an application filed
9 pursuant to subdivision (b) of Section 2732.1, and upon the
10 payment of the fee prescribed by subdivision (k) of Section 2815,
11 the board may issue a temporary license to practice professional
12 nursing, and a temporary certificate to practice as a certified public
13 health nurse for a period of six months from the date of issuance.

14 (B) Upon approval of an application filed pursuant to
15 subdivision (b) of Section 2732.1, and upon the payment of the
16 fee prescribed by subdivision (d) of Section 2838.2, the board may
17 issue a temporary certificate to practice as a certified clinical nurse
18 specialist for a period of six months from the date of issuance.

19 (C) Upon approval of an application filed pursuant to
20 subdivision (b) of Section 2732.1, and upon the payment of the
21 fee prescribed by subdivision (e) of Section 2815.5, the board may
22 issue a temporary certificate to practice as a certified nurse-midwife
23 for a period of six months from the date of issuance.

24 (D) Upon approval of an application filed pursuant to
25 subdivision (b) of Section 2732.1, and upon the payment of the
26 fee prescribed by subdivision (d) of Section 2830.7, the board may
27 issue a temporary certificate to practice as a certified nurse
28 anesthetist for a period of six months from the date of issuance.

29 (E) Upon approval of an application filed pursuant to subdivision
30 (b) of Section 2732.1, and upon the payment of the fee prescribed
31 by subdivision (p) of Section 2815, the board may issue a
32 temporary certificate to practice as a certified nurse practitioner
33 for a period of six months from the date of issuance.

34 (2) A temporary license or temporary certificate shall terminate
35 upon notice thereof by certified mail, return receipt requested, if
36 it is issued by mistake or if the application for permanent licensure
37 is denied.

38 (b) Upon written application, the board may reissue a temporary
39 license or temporary certificate to any person who has applied for
40 a regular renewable license pursuant to subdivision (b) of Section

1 2732.1 and who, in the judgment of the board has been excusably
2 delayed in completing his or her application for or the minimum
3 requirements for a regular renewable license, but the board may
4 not reissue a temporary license or temporary certificate more than
5 twice to any one person.

6 ~~SEC. 14.~~

7 *SEC. 13.* Section 2746.51 of the Business and Professions Code
8 is amended to read:

9 2746.51. (a) Neither this chapter nor any other provision of
10 law shall be construed to prohibit a certified nurse-midwife from
11 furnishing or ordering drugs or devices, including controlled
12 substances classified in Schedule II, III, IV, or V under the
13 California Uniform Controlled Substances Act (Division 10
14 (commencing with Section 11000) of the Health and Safety Code),
15 when all of the following apply:

16 (1) The drugs or devices are furnished or ordered incidentally
17 to the provision of any of the following:

18 (A) Family planning services, as defined in Section 14503 of
19 the Welfare and Institutions Code.

20 (B) Routine health care or perinatal care, as defined in
21 subdivision (d) of Section 123485 of the Health and Safety Code.

22 (C) Care rendered, consistent with the certified nurse-midwife's
23 educational preparation or for which clinical competency has been
24 established and maintained, to persons within a facility specified
25 in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the
26 Health and Safety Code, a clinic as specified in Section 1204 of
27 the Health and Safety Code, a general acute care hospital as defined
28 in subdivision (a) of Section 1250 of the Health and Safety Code,
29 a licensed birth center as defined in Section 1204.3 of the Health
30 and Safety Code, or a special hospital specified as a maternity
31 hospital in subdivision (f) of Section 1250 of the Health and Safety
32 Code.

33 (2) The drugs or devices are furnished or ordered by a certified
34 nurse-midwife in accordance with standardized procedures or
35 protocols. For purposes of this section, standardized procedure
36 means a document, including protocols, developed and approved
37 by the supervising physician and surgeon, the certified
38 nurse-midwife, and the facility administrator or his or her designee.
39 The standardized procedure covering the furnishing or ordering
40 of drugs or devices shall specify all of the following:

1 (A) Which certified nurse-midwife may furnish or order drugs
2 or devices.

3 (B) Which drugs or devices may be furnished or ordered and
4 under what circumstances.

5 (C) The extent of physician and surgeon supervision.

6 (D) The method of periodic review of the certified
7 nurse-midwife's competence, including peer review, and review
8 of the provisions of the standardized procedure.

9 (3) If Schedule II or III controlled substances, as defined in
10 Sections 11055 and 11056 of the Health and Safety Code, are
11 furnished or ordered by a certified nurse-midwife, the controlled
12 substances shall be furnished or ordered in accordance with a
13 patient-specific protocol approved by the treating or supervising
14 physician and surgeon. For Schedule II controlled substance
15 protocols, the provision for furnishing the Schedule II controlled
16 substance shall address the diagnosis of the illness, injury, or
17 condition for which the Schedule II controlled substance is to be
18 furnished.

19 (4) The furnishing or ordering of drugs or devices by a certified
20 nurse-midwife occurs under physician and surgeon supervision.
21 For purposes of this section, no physician and surgeon shall
22 supervise more than four certified nurse-midwives at one time.
23 Physician and surgeon supervision shall not be construed to require
24 the physical presence of the physician, but does include all of the
25 following:

26 (A) Collaboration on the development of the standardized
27 procedure or protocol.

28 (B) Approval of the standardized procedure or protocol.

29 (C) Availability by telephonic contact at the time of patient
30 examination by the certified nurse-midwife.

31 (b) (1) The furnishing or ordering of drugs or devices by a
32 certified nurse-midwife is conditional on the issuance by the board
33 of a number to the applicant who has successfully completed the
34 requirements of paragraph (2). The number shall be included on
35 all transmittals of orders for drugs or devices by the certified
36 nurse-midwife. The board shall maintain a list of the certified
37 nurse-midwives that it has certified pursuant to this paragraph and
38 the number it has issued to each one. The board shall make the list
39 available to the California State Board of Pharmacy upon its
40 request. Every certified nurse-midwife who is authorized pursuant

1 to this section to furnish or issue a drug order for a controlled
2 substance shall register with the United States Drug Enforcement
3 Administration.

4 (2) The board has certified in accordance with paragraph (1)
5 that the certified nurse-midwife has satisfactorily completed a
6 course in pharmacology covering the drugs or devices to be
7 furnished or ordered under this section. The board shall establish
8 the requirements for satisfactory completion of this paragraph.
9 The board may charge the applicant a fee to cover all necessary
10 costs to implement this section, that shall be not less than four
11 hundred dollars (\$400) nor more than one thousand five hundred
12 dollars (\$1,500) for an initial application, nor less than one hundred
13 fifty dollars (\$150) nor more than one thousand dollars (\$1,000)
14 for an application for renewal. The board may charge a penalty
15 fee for failure to renew a furnishing number within the prescribed
16 time that shall be not less than seventy-five dollars (\$75) nor more
17 than five hundred dollars (\$500).

18 (3) A physician and surgeon may determine the extent of
19 supervision necessary pursuant to this section in the furnishing or
20 ordering of drugs and devices.

21 (4) A copy of the standardized procedure or protocol relating
22 to the furnishing or ordering of controlled substances by a certified
23 nurse-midwife shall be provided upon request to any licensed
24 pharmacist who is uncertain of the authority of the certified
25 nurse-midwife to perform these functions.

26 (5) Certified nurse-midwives who are certified by the board and
27 hold an active furnishing number, who are currently authorized
28 through standardized procedures or protocols to furnish Schedule
29 II controlled substances, and who are registered with the United
30 States Drug Enforcement Administration shall provide
31 documentation of continuing education specific to the use of
32 Schedule II controlled substances in settings other than a hospital
33 based on standards developed by the board.

34 (c) Drugs or devices furnished or ordered by a certified
35 nurse-midwife may include Schedule II controlled substances
36 under the California Uniform Controlled Substances Act (Division
37 10 (commencing with Section 11000) of the Health and Safety
38 Code) under the following conditions:

39 (1) The drugs and devices are furnished or ordered in accordance
40 with requirements referenced in paragraphs (2) to (4), inclusive,

1 of subdivision (a) and in paragraphs (1) to (3), inclusive, of
2 subdivision (b).

3 (2) When Schedule II controlled substances, as defined in
4 Section 11055 of the Health and Safety Code, are furnished or
5 ordered by a certified nurse-midwife, the controlled substances
6 shall be furnished or ordered in accordance with a patient-specific
7 protocol approved by the treating or supervising physician and
8 surgeon.

9 (d) Furnishing of drugs or devices by a certified nurse-midwife
10 means the act of making a pharmaceutical agent or agents available
11 to the patient in strict accordance with a standardized procedure
12 or protocol. Use of the term “furnishing” in this section shall
13 include the following:

14 (1) The ordering of a drug or device in accordance with the
15 standardized procedure or protocol.

16 (2) Transmitting an order of a supervising physician and
17 surgeon.

18 (e) “Drug order” or “order” for purposes of this section means
19 an order for medication or for a drug or device that is dispensed
20 to or for an ultimate user, issued by a certified nurse-midwife as
21 an individual practitioner, within the meaning of Section 1306.03
22 of Title 21 of the Code of Federal Regulations. Notwithstanding
23 any other provision of law, (1) a drug order issued pursuant to this
24 section shall be treated in the same manner as a prescription of the
25 supervising physician; (2) all references to “prescription” in this
26 code and the Health and Safety Code shall include drug orders
27 issued by certified nurse-midwives; and (3) the signature of a
28 certified nurse-midwife on a drug order issued in accordance with
29 this section shall be deemed to be the signature of a prescriber for
30 purposes of this code and the Health and Safety Code.

31 ~~SEC. 15.~~

32 *SEC. 14.* Section 2786.5 of the Business and Professions Code
33 is amended to read:

34 2786.5. (a) An institution of higher education or a private
35 postsecondary school of nursing approved by the board pursuant
36 to subdivision (b) of Section 2786 shall remit to the board for
37 deposit in the Board of Registered Nursing Fund the following
38 fees, in accordance with the following schedule:

1 (1) The fee for approval of a school of nursing shall be fixed
2 by the board at not less than forty thousand dollars (\$40,000) nor
3 more than eighty thousand dollars (\$80,000).

4 (2) The fee for continuing approval of a nursing program
5 established after January 1, 2013, shall be fixed by the board at
6 not less than fifteen thousand dollars (\$15,000) nor more than
7 thirty thousand dollars (\$30,000).

8 (3) The processing fee for authorization of a substantive change
9 to an approval of a school of nursing shall be fixed by the board
10 at not less than two thousand five hundred dollars (\$2,500) nor
11 more than five thousand dollars (\$5,000).

12 (b) If the board determines that the annual cost of providing
13 oversight and review of a school of nursing, as required by this
14 article, is less than the amount of any fees required to be paid by
15 that institution pursuant to this article, the board may decrease the
16 fees applicable to that institution to an amount that is proportional
17 to the board's costs associated with that institution.

18 ~~SEC. 16.~~

19 *SEC. 15.* Section 2811 of the Business and Professions Code
20 is amended to read:

21 2811. (a) Each person holding a regular renewable license
22 under this chapter, whether in an active or inactive status, shall
23 apply for a renewal of his license and pay the biennial renewal fee
24 required by this chapter each two years on or before the last day
25 of the month following the month in which his birthday occurs,
26 beginning with the second birthday following the date on which
27 the license was issued, whereupon the board shall renew the
28 license.

29 (b) Each such license not renewed in accordance with this
30 section shall expire but may within a period of eight years
31 thereafter be reinstated upon payment of the fee required by this
32 chapter and upon submission of such proof of the applicant's
33 qualifications as may be required by the board, except that during
34 such eight-year period no examination shall be required as a
35 condition for the reinstatement of any such expired license which
36 has lapsed solely by reason of nonpayment of the renewal fee.
37 After the expiration of such eight-year period the board may require
38 as a condition of reinstatement that the applicant pass such
39 examination as it deems necessary to determine his present fitness
40 to resume the practice of professional nursing.

1 (c) A license in an inactive status may be restored to an active
2 status if the licensee meets the continuing education standards of
3 Section 2811.5.

4 ~~SEC. 17.~~

5 *SEC. 16.* Section 2811.5 of the Business and Professions Code
6 is amended to read:

7 2811.5. (a) Each person renewing his or her license under
8 Section 2811 shall submit proof satisfactory to the board that,
9 during the preceding two-year period, he or she has been informed
10 of the developments in the registered nurse field or in any special
11 area of practice engaged in by the licensee, occurring since the
12 last renewal thereof, either by pursuing a course or courses of
13 continuing education in the registered nurse field or relevant to
14 the practice of the licensee, and approved by the board, or by other
15 means deemed equivalent by the board.

16 (b) For purposes of this section, the board shall, by regulation,
17 establish standards for continuing education. The standards shall
18 be established in a manner to ensure that a variety of alternative
19 forms of continuing education are available to licensees, including,
20 but not limited to, academic studies, in-service education, institutes,
21 seminars, lectures, conferences, workshops, extension studies, and
22 home study programs. The standards shall take cognizance of
23 specialized areas of practice, and content shall be relevant to the
24 practice of nursing and shall be related to the scientific knowledge
25 or technical skills required for the practice of nursing or be related
26 to direct or indirect patient or client care. The continuing education
27 standards established by the board shall not exceed 30 hours of
28 direct participation in a course or courses approved by the board,
29 or its equivalent in the units of measure adopted by the board.

30 (c) The board shall audit continuing education providers at least
31 once every five years to ensure adherence to regulatory
32 requirements, and shall withhold or rescind approval from any
33 provider that is in violation of the regulatory requirements.

34 (d) The board shall encourage continuing education in spousal
35 or partner abuse detection and treatment. In the event the board
36 establishes a requirement for continuing education coursework in
37 spousal or partner abuse detection or treatment, that requirement
38 shall be met by each licensee within no more than four years from
39 the date the requirement is imposed.

1 (e) In establishing standards for continuing education, the board
2 shall consider including a course in the special care needs of
3 individuals and their families facing end-of-life issues, including,
4 but not limited to, all of the following:

- 5 (1) Pain and symptom management.
- 6 (2) The psycho-social dynamics of death.
- 7 (3) Dying and bereavement.
- 8 (4) Hospice care.

9 (f) In establishing standards for continuing education, the board
10 may include a course on pain management.

11 (g) This section shall not apply to licensees during the first two
12 years immediately following their initial licensure in California
13 or any other governmental jurisdiction.

14 (h) The board may, in accordance with the intent of this section,
15 make exceptions from continuing education requirements for
16 licensees residing in another state or country, or for reasons of
17 health, military service, or other good cause.

18 ~~SEC. 18.~~

19 *SEC. 17.* Section 2815 of the Business and Professions Code
20 is amended to read:

21 2815. Subject to the provisions of Section 128.5, the amount
22 of the fees prescribed by this chapter in connection with the
23 issuance of licenses for registered nurses under its provisions is
24 that fixed by the following schedule:

25 (a) (1) The fee to be paid upon the filing by a graduate of an
26 approved school of nursing in this state of an application for a
27 licensure by examination shall be fixed by the board at not less
28 than three hundred dollars (\$300) nor more than one thousand
29 dollars (\$1,000).

30 (2) The fee to be paid upon the filing by a graduate of a school
31 of nursing in another state, district, or territory of the United States
32 of an application for a licensure by examination shall be fixed by
33 the board at not less than three hundred fifty dollars (\$350) nor
34 more than one thousand dollars (\$1,000).

35 (3) The fee to be paid upon the filing by a graduate of a school
36 of nursing in another country of an application for a licensure by
37 examination shall be fixed by the board at not less than seven
38 hundred fifty dollars (\$750) nor more than one thousand five
39 hundred dollars (\$1,500).

1 (4) The fee to be paid upon the filing of an application for
2 licensure by a repeat examination shall be fixed by the board at
3 not less than two hundred fifty dollars (\$250) and not more than
4 one thousand dollars (\$1,000).

5 (b) The fee to be paid for taking each examination shall be the
6 actual cost to purchase an examination from a vendor approved
7 by the board.

8 (c) (1) The fee to be paid for application by a person who is
9 licensed or registered as a nurse in another state, district, or territory
10 of the United States for licensure by endorsement shall be fixed
11 by the board at not less than three hundred fifty dollars (\$350) nor
12 more than one thousand dollars (\$1,000).

13 (2) The fee to be paid for application by a person who is licensed
14 or registered as a nurse in another country for licensure by
15 endorsement shall be fixed by the board at not less than seven
16 hundred fifty dollars (\$750) nor more than one thousand five
17 hundred dollars (\$1,500).

18 (d) (1) The biennial fee to be paid upon the filing of an
19 application for renewal of the license shall be not less than one
20 hundred eighty dollars (\$180) nor more than seven hundred fifty
21 dollars (\$750). In addition, an assessment of ten dollars (\$10) shall
22 be collected and credited to the Registered Nurse Education Fund,
23 pursuant to Section 2815.1.

24 (2) The fee to be paid upon the filing of an application for
25 reinstatement pursuant to subdivision (b) of Section 2811 shall be
26 not less than three hundred fifty dollars (\$350) nor more than one
27 thousand dollars (\$1,000).

28 (e) The penalty fee for failure to renew a license within the
29 prescribed time shall be fixed by the board at not more than 50
30 percent of the regular renewal fee, but not less than ninety dollars
31 (\$90) nor more than three hundred seventy-five dollars (\$375).

32 (f) The fee to be paid for approval of a continuing education
33 provider shall be fixed by the board at not less than five hundred
34 dollars (\$500) nor more than one thousand dollars (\$1,000).

35 (g) The biennial fee to be paid upon the filing of an application
36 for renewal of provider approval shall be fixed by the board at not
37 less than seven hundred fifty dollars (\$750) nor more than one
38 thousand dollars (\$1,000).

39 (h) The penalty fee for failure to renew provider approval within
40 the prescribed time shall be fixed at not more than 50 percent of

1 the regular renewal fee, but not less than one hundred twenty-five
2 dollars (\$125) nor more than five hundred dollars (\$500).

3 (i) The penalty for submitting insufficient funds or fictitious
4 check, draft or order on any bank or depository for payment of
5 any fee to the board shall be fixed at not less than fifteen dollars
6 (\$15) nor more than thirty dollars (\$30).

7 (j) The fee to be paid for an interim permit shall be fixed by the
8 board at not less than one hundred dollars (\$100) nor more than
9 two hundred fifty dollars (\$250).

10 (k) The fee to be paid for a temporary license shall be fixed by
11 the board at not less than one hundred dollars (\$100) nor more
12 than two hundred fifty dollars (\$250).

13 (l) The fee to be paid for processing endorsement papers to other
14 states shall be fixed by the board at not less than one hundred
15 dollars (\$100) nor more than two hundred dollars (\$200).

16 (m) The fee to be paid for a certified copy of a school transcript
17 shall be fixed by the board at not less than fifty dollars (\$50) nor
18 more than one hundred dollars (\$100).

19 (n) (1) The fee to be paid for a duplicate pocket license shall
20 be fixed by the board at not less than fifty dollars (\$50) nor more
21 than seventy-five dollars (\$75).

22 (2) The fee to be paid for a duplicate wall certificate shall be
23 fixed by the board at not less than sixty dollars (\$60) nor more
24 than one hundred dollars (\$100).

25 (o) (1) The fee to be paid by a registered nurse for an evaluation
26 of his or her qualifications to use the title “nurse practitioner” shall
27 be fixed by the board at not less than five hundred dollars (\$500)
28 nor more than one thousand five hundred dollars (\$1,500).

29 (2) The fee to be paid by a registered nurse for a temporary
30 certificate to practice as a nurse practitioner shall be fixed by the
31 board at not less than one hundred fifty dollars (\$150) nor more
32 than five hundred dollars (\$500).

33 (3) The fee to be paid upon the filing of an application for
34 renewal of a certificate to practice as a nurse practitioner shall be
35 not less than one hundred fifty dollars (\$150) nor more than one
36 thousand dollars (\$1,000).

37 (4) The penalty fee for failure to renew a certificate to practice
38 as a nurse practitioner within the prescribed time shall be not less
39 than seventy-five dollars (\$75) nor more than five hundred dollars
40 (\$500).

1 (p) The fee to be paid by a registered nurse for listing as a
2 “psychiatric mental health nurse” shall be fixed by the board at
3 not less than three hundred fifty dollars (\$350) nor more than seven
4 hundred fifty dollars (\$750).

5 (q) The fee to be paid for duplicate National Council Licensure
6 Examination for registered nurses (NCLEX-RN) examination
7 results shall be not less than sixty dollars (\$60) nor more than one
8 hundred dollars (\$100).

9 (r) The fee to be paid for a letter certifying a license shall be
10 not less than twenty dollars (\$20) nor more than thirty dollars
11 (\$30).

12 No further fee shall be required for a license or a renewal thereof
13 other than as prescribed by this chapter.

14 ~~SEC. 19.~~

15 *SEC. 18.* Section 2815.5 of the Business and Professions Code
16 is amended to read:

17 2815.5. The amount of the fees prescribed by this chapter in
18 connection with the issuance of certificates as nurse-midwives is
19 that fixed by the following schedule:

20 (a) The fee to be paid upon the filing of an application for a
21 certificate shall be fixed by the board at not less than five hundred
22 dollars (\$500) nor more than one thousand five hundred dollars
23 (\$1,500).

24 (b) The biennial fee to be paid upon the application for a renewal
25 of a certificate shall be fixed by the board at not less than one
26 hundred fifty dollars (\$150) nor more than one thousand dollars
27 (\$1,000).

28 (c) The penalty fee for failure to renew a certificate within the
29 prescribed time shall be 50 percent of the renewal fee in effect on
30 the date of the renewal of the license, but not less than seventy-five
31 dollars (\$75) nor more than five hundred dollars (\$500).

32 (d) The fee to be paid upon the filing of an application for the
33 nurse-midwife equivalency examination shall be fixed by the board
34 at not less than one hundred dollars (\$100) nor more than two
35 hundred dollars (\$200).

36 (e) The fee to be paid for a temporary certificate shall be fixed
37 by the board at not less than one hundred fifty dollars (\$150) nor
38 more than five hundred dollars (\$500).

1 ~~SEC. 20.~~

2 *SEC. 19.* Section 2816 of the Business and Professions Code
3 is amended to read:

4 2816. The nonrefundable fee to be paid by a registered nurse
5 for an evaluation of his or her qualifications to use the title “public
6 health nurse” shall be equal to the fees set out in subdivision (o)
7 of Section 2815. The fee to be paid upon the application for
8 renewal of the certificate to practice as a public health nurse shall
9 be fixed by the board at not less than one hundred twenty-five
10 dollars (\$125) and not more than five hundred dollars (\$500). All
11 fees payable under this section shall be collected by and paid to
12 the Registered Nursing Fund. It is the intention of the Legislature
13 that the costs of carrying out the purposes of this article shall be
14 covered by the revenue collected pursuant to this section.

15 ~~SEC. 21.~~

16 *SEC. 20.* Section 2830.7 of the Business and Professions Code
17 is amended to read:

18 2830.7. The amount of the fees prescribed by this chapter in
19 connection with the issuance of certificates as nurse anesthetists
20 is that fixed by the following schedule:

21 (a) The fee to be paid upon the filing of an application for a
22 certificate shall be fixed by the board at not less than five hundred
23 dollars (\$500) nor more than one thousand five hundred dollars
24 (\$1,500).

25 (b) The biennial fee to be paid upon the application for a renewal
26 of a certificate shall be fixed by the board at not less than one
27 hundred fifty dollars (\$150) nor more than one thousand dollars
28 (\$1,000).

29 (c) The penalty fee for failure to renew a certificate within the
30 prescribed time shall be 50 percent of the renewal fee in effect on
31 the date of the renewal of the license, but not less than seventy-five
32 dollars (\$75) nor more than five hundred dollars (\$500).

33 (d) The fee to be paid for a temporary certificate shall be fixed
34 by the board at not less than one hundred fifty dollars (\$150) nor
35 more than five hundred dollars (\$500).

36 ~~SEC. 22.~~

37 *SEC. 21.* Section 2836.3 of the Business and Professions Code
38 is amended to read:

39 2836.3. (a) The furnishing of drugs or devices by nurse
40 practitioners is conditional on issuance by the board of a number

1 to the nurse applicant who has successfully completed the
2 requirements of subdivision (g) of Section 2836.1. The number
3 shall be included on all transmittals of orders for drugs or devices
4 by the nurse practitioner. The board shall make the list of numbers
5 issued available to the Board of Pharmacy. The board may charge
6 the applicant a fee to cover all necessary costs to implement this
7 section, that shall be not less than four hundred dollars (\$400) nor
8 more than one thousand five hundred dollars (\$1,500) for an initial
9 application, nor less than one hundred fifty dollars (\$150) nor more
10 than one thousand dollars (\$1,000) for an application for renewal.
11 The board may charge a penalty fee for failure to renew a
12 furnishing number within the prescribed time that shall be not less
13 than seventy-five dollars (\$75) nor more than five hundred dollars
14 (\$500).

15 (b) The number shall be renewable at the time of the applicant's
16 registered nurse license renewal.

17 (c) The board may revoke, suspend, or deny issuance of the
18 numbers for incompetence or gross negligence in the performance
19 of functions specified in Sections 2836.1 and 2836.2.

20 ~~SEC. 23:~~

21 *SEC. 22.* Section 2838.2 of the Business and Professions Code
22 is amended to read:

23 2838.2. (a) A clinical nurse specialist is a registered nurse with
24 advanced education, who participates in expert clinical practice,
25 education, research, consultation, and clinical leadership as the
26 major components of his or her role.

27 (b) The board may establish categories of clinical nurse
28 specialists and the standards required to be met for nurses to hold
29 themselves out as clinical nurse specialists in each category. The
30 standards shall take into account the types of advanced levels of
31 nursing practice that are or may be performed and the clinical and
32 didactic education, experience, or both needed to practice safety
33 at those levels. In setting the standards, the board shall consult
34 with clinical nurse specialists, physicians and surgeons appointed
35 by the Medical Board with expertise with clinical nurse specialists,
36 and health care organizations that utilize clinical nurse specialists.

37 (c) A registered nurse who meets one of the following
38 requirements may apply to become a clinical nurse specialist:

39 (1) Possession of a master's degree in a clinical field of nursing.

1 (2) Possession of a master's degree in a clinical field related to
2 nursing with course work in the components referred to in
3 subdivision (a).

4 (3) On or before July 1, 1998, meets the following requirements:

5 (A) Current licensure as a registered nurse.

6 (B) Performs the role of a clinical nurse specialist as described
7 in subdivision (a).

8 (C) Meets any other criteria established by the board.

9 (d) (1) A nonrefundable fee of not less than five hundred dollars
10 (\$500), but not to exceed one thousand five hundred dollars
11 (\$1,500) shall be paid by a registered nurse applying to be a clinical
12 nurse specialist for the evaluation of his or her qualifications to
13 use the title "clinical nurse specialist."

14 (2) The fee to be paid for a temporary certificate to practice as
15 a clinical nurse specialist shall be not less than thirty dollars (\$30)
16 nor more than fifty dollars (\$50).

17 (3) A biennial renewal fee shall be paid upon submission of an
18 application to renew the clinical nurse specialist certificate and
19 shall be established by the board at no less than one hundred fifty
20 dollars (\$150) and no more than one thousand dollars (\$1,000).

21 (4) The penalty fee for failure to renew a certificate within the
22 prescribed time shall be 50 percent of the renewal fee in effect on
23 the date of the renewal of the license, but not less than seventy-five
24 dollars (\$75) nor more than five hundred dollars (\$500).

25 (5) The fees authorized by this subdivision shall not exceed the
26 amount necessary to cover the costs to the board to administer this
27 section.

28 ~~SEC. 24.~~

29 *SEC. 23.* Section 4128.2 of the Business and Professions Code
30 is amended to read:

31 4128.2. (a) In addition to the pharmacy license requirement
32 described in Section 4110, a centralized hospital packaging
33 pharmacy shall obtain a specialty license from the board prior to
34 engaging in the functions described in Section 4128.

35 (b) An applicant seeking a specialty license pursuant to this
36 article shall apply to the board on forms established by the board.

37 (c) Before issuing the specialty license, the board shall inspect
38 the pharmacy and ensure that the pharmacy is in compliance with
39 this article and regulations established by the board.

1 (d) A license to perform the functions described in Section 4128
2 may only be issued to a pharmacy that is licensed by the board as
3 a hospital pharmacy.

4 (e) A license issued pursuant to this article shall be renewed
5 annually and is not transferrable.

6 (f) An applicant seeking renewal of a specialty license shall
7 apply to the board on forms established by the board.

8 (g) A license to perform the functions described in Section 4128
9 shall not be renewed until the pharmacy has been inspected by the
10 board and found to be in compliance with this article and
11 regulations established by the board.

12 ~~SEC. 25.~~

13 *SEC. 24.* Section 4400 of the Business and Professions Code
14 is amended to read:

15 4400. The amount of fees and penalties prescribed by this
16 chapter, except as otherwise provided, is that fixed by the board
17 according to the following schedule:

18 (a) The fee for a nongovernmental pharmacy license shall be
19 four hundred dollars (\$400) and may be increased to five hundred
20 twenty dollars (\$520). The fee for the issuance of a temporary
21 nongovernmental pharmacy permit shall be two hundred fifty
22 dollars (\$250) and may be increased to three hundred twenty-five
23 dollars (\$325).

24 (b) The fee for a nongovernmental pharmacy license annual
25 renewal shall be two hundred fifty dollars (\$250) and may be
26 increased to three hundred twenty-five dollars (\$325).

27 (c) The fee for the pharmacist application and examination shall
28 be two hundred dollars (\$200) and may be increased to two
29 hundred sixty dollars (\$260).

30 (d) The fee for regrading an examination shall be ninety dollars
31 (\$90) and may be increased to one hundred fifteen dollars (\$115).
32 If an error in grading is found and the applicant passes the
33 examination, the regrading fee shall be refunded.

34 (e) The fee for a pharmacist license and biennial renewal shall
35 be one hundred fifty dollars (\$150) and may be increased to one
36 hundred ninety-five dollars (\$195).

37 (f) The fee for a nongovernmental wholesaler or third-party
38 logistics provider license and annual renewal shall be seven
39 hundred eighty dollars (\$780) and may be decreased to no less
40 than six hundred dollars (\$600). The application fee for any

1 additional location after licensure of the first 20 locations shall be
2 three hundred dollars (\$300) and may be decreased to no less than
3 two hundred twenty-five dollars (\$225). A temporary license fee
4 shall be seven hundred fifteen dollars (\$715) and may be decreased
5 to no less than five hundred fifty dollars (\$550).

6 (g) The fee for a hypodermic license and renewal shall be one
7 hundred twenty-five dollars (\$125) and may be increased to one
8 hundred sixty-five dollars (\$165).

9 (h) (1) The fee for application, investigation, and issuance of
10 a license as a designated representative pursuant to Section 4053,
11 or as a designated representative-3PL pursuant to Section 4053.1,
12 shall be three hundred thirty dollars (\$330) and may be decreased
13 to no less than two hundred fifty-five dollars (\$255).

14 (2) The fee for the annual renewal of a license as a designated
15 representative or designated representative-3PL shall be one
16 hundred ninety-five dollars (\$195) and may be decreased to no
17 less than one hundred fifty dollars (\$150).

18 (i) (1) The fee for the application, investigation, and issuance
19 of a license as a designated representative for a veterinary
20 food-animal drug retailer pursuant to Section 4053 shall be three
21 hundred thirty dollars (\$330) and may be decreased to no less than
22 two hundred fifty-five dollars (\$255).

23 (2) The fee for the annual renewal of a license as a designated
24 representative for a veterinary food-animal drug retailer shall be
25 one hundred ninety-five dollars (\$195) and may be decreased to
26 no less than one hundred fifty dollars (\$150).

27 (j) (1) The application fee for a nonresident wholesaler or
28 third-party logistics provider license issued pursuant to Section
29 4161 shall be seven hundred eighty dollars (\$780) and may be
30 decreased to no less than six hundred dollars (\$600).

31 (2) For nonresident wholesalers or third-party logistics providers
32 that have 21 or more facilities operating nationwide the application
33 fees for the first 20 locations shall be seven hundred eighty dollars
34 (\$780) and may be decreased to no less than six hundred dollars
35 (\$600). The application fee for any additional location after
36 licensure of the first 20 locations shall be three hundred dollars
37 (\$300) and may be decreased to no less than two hundred
38 twenty-five dollars (\$225). A temporary license fee shall be seven
39 hundred fifteen dollars (\$715) and may be decreased to no less
40 than five hundred fifty dollars (\$550).

1 (3) The annual renewal fee for a nonresident wholesaler license
2 or third-party logistics provider license issued pursuant to Section
3 4161 shall be seven hundred eighty dollars (\$780) and may be
4 decreased to no less than six hundred dollars (\$600).

5 (k) The fee for evaluation of continuing education courses for
6 accreditation shall be set by the board at an amount not to exceed
7 forty dollars (\$40) per course hour.

8 (l) The fee for an intern pharmacist license shall be ninety dollars
9 (\$90) and may be increased to one hundred fifteen dollars (\$115).
10 The fee for transfer of intern hours or verification of licensure to
11 another state shall be twenty-five dollars (\$25) and may be
12 increased to thirty dollars (\$30).

13 (m) The board may waive or refund the additional fee for the
14 issuance of a license where the license is issued less than 45 days
15 before the next regular renewal date.

16 (n) The fee for the reissuance of any license, or renewal thereof,
17 that has been lost or destroyed or reissued due to a name change
18 shall be thirty-five dollars (\$35) and may be increased to forty-five
19 dollars (\$45).

20 (o) The fee for the reissuance of any license, or renewal thereof,
21 that must be reissued because of a change in the information, shall
22 be one hundred dollars (\$100) and may be increased to one hundred
23 thirty dollars (\$130).

24 (p) It is the intent of the Legislature that, in setting fees pursuant
25 to this section, the board shall seek to maintain a reserve in the
26 Pharmacy Board Contingent Fund equal to approximately one
27 year's operating expenditures.

28 (q) The fee for any applicant for a nongovernmental clinic
29 license shall be four hundred dollars (\$400) and may be increased
30 to five hundred twenty dollars (\$520) for each license. The annual
31 fee for renewal of the license shall be two hundred fifty dollars
32 (\$250) and may be increased to three hundred twenty-five dollars
33 (\$325) for each license.

34 (r) The fee for the issuance of a pharmacy technician license
35 shall be eighty dollars (\$80) and may be increased to one hundred
36 five dollars (\$105). The fee for renewal of a pharmacy technician
37 license shall be one hundred dollars (\$100) and may be increased
38 to one hundred thirty dollars (\$130).

39 (s) The fee for a veterinary food-animal drug retailer license
40 shall be four hundred five dollars (\$405) and may be increased to

1 four hundred twenty-five dollars (\$425). The annual renewal fee
2 for a veterinary food-animal drug retailer license shall be two
3 hundred fifty dollars (\$250) and may be increased to three hundred
4 twenty-five dollars (\$325).

5 (t) The fee for issuance of a retired license pursuant to Section
6 4200.5 shall be thirty-five dollars (\$35) and may be increased to
7 forty-five dollars (\$45).

8 (u) The fee for issuance or renewal of a nongovernmental sterile
9 compounding pharmacy license shall be six hundred dollars (\$600)
10 and may be increased to seven hundred eighty dollars (\$780). The
11 fee for a temporary license shall be five hundred fifty dollars (\$550)
12 and may be increased to seven hundred fifteen dollars (\$715).

13 (v) The fee for the issuance or renewal of a nonresident sterile
14 compounding pharmacy license shall be seven hundred eighty
15 dollars (\$780). In addition to paying that application fee, the
16 nonresident sterile compounding pharmacy shall deposit, when
17 submitting the application, a reasonable amount, as determined by
18 the board, necessary to cover the board's estimated cost of
19 performing the inspection required by Section 4127.2. If the
20 required deposit is not submitted with the application, the
21 application shall be deemed to be incomplete. If the actual cost of
22 the inspection exceeds the amount deposited, the board shall
23 provide to the applicant a written invoice for the remaining amount
24 and shall not take action on the application until the full amount
25 has been paid to the board. If the amount deposited exceeds the
26 amount of actual and necessary costs incurred, the board shall
27 remit the difference to the applicant.

28 (w) This section shall become inoperative on July 1, 2017, and
29 as of January 1, 2018, is repealed.

30 ~~SEC. 26.~~

31 *SEC. 25.* Section 4400 is added to the Business and Professions
32 Code, to read:

33 4400. The amount of fees and penalties prescribed by this
34 chapter, except as otherwise provided, is that fixed by the board
35 according to the following schedule:

36 (a) The fee for a nongovernmental pharmacy license shall be
37 five hundred twenty dollars (\$520) and may be increased to five
38 hundred seventy dollars (\$570). The fee for the issuance of a
39 temporary nongovernmental pharmacy permit shall be two hundred

1 fifty dollars (\$250) and may be increased to three hundred
2 twenty-five dollars (\$325).

3 (b) The fee for a nongovernmental pharmacy license annual
4 renewal shall be six hundred sixty-five dollars (\$665) and may be
5 increased to nine hundred thirty dollars (\$930).

6 (c) The fee for the pharmacist application and examination shall
7 be two hundred sixty dollars (\$260) and may be increased to two
8 hundred eighty-five dollars (\$285).

9 (d) The fee for regrading an examination shall be ninety dollars
10 (\$90) and may be increased to one hundred fifteen dollars (\$115).
11 If an error in grading is found and the applicant passes the
12 examination, the regrading fee shall be refunded.

13 (e) The fee for a pharmacist license shall be one hundred
14 ninety-five dollars (\$195) and may be increased to two hundred
15 fifteen dollars (\$215). The fee for a pharmacist biennial renewal
16 shall be three hundred sixty dollars (\$360) and may be increased
17 to five hundred five dollars (\$505).

18 (f) The fee for a nongovernmental wholesaler or third-party
19 logistics provider license and annual renewal shall be seven
20 hundred eighty dollars (\$780) and may be increased to eight
21 hundred twenty dollars (\$820). The application fee for any
22 additional location after licensure of the first 20 locations shall be
23 three hundred dollars (\$300) and may be decreased to no less than
24 two hundred twenty-five dollars (\$225). A temporary license fee
25 shall be seven hundred fifteen dollars (\$715) and may be decreased
26 to no less than five hundred fifty dollars (\$550).

27 (g) The fee for a hypodermic license shall be one hundred
28 seventy dollars (\$170) and may be increased to two hundred forty
29 dollars (\$240). The fee for a hypodermic license renewal shall be
30 two hundred dollars (\$200) and may be increased to two hundred
31 eighty dollars (\$280).

32 (h) (1) The fee for application, investigation, and issuance of
33 a license as a designated representative pursuant to Section 4053,
34 or as a designated representative-3PL pursuant to Section 4053.1,
35 shall be one hundred fifty dollars (\$150) and may be increased to
36 two hundred ten dollars (\$210).

37 (2) The fee for the annual renewal of a license as a designated
38 representative or designated representative-3PL shall be two
39 hundred fifteen dollars (\$215) and may be increased to three
40 hundred dollars (\$300).

1 (i) (1) The fee for the application, investigation, and issuance
2 of a license as a designated representative for a veterinary
3 food-animal drug retailer pursuant to Section 4053 shall be one
4 hundred fifty dollars (\$150) and may be increased to two hundred
5 ten dollars (\$210).

6 (2) The fee for the annual renewal of a license as a designated
7 representative for a veterinary food-animal drug retailer shall be
8 two hundred fifteen dollars (\$215) and may be increased to three
9 hundred dollars (\$300).

10 (j) (1) The application fee for a nonresident wholesaler or
11 third-party logistics provider license issued pursuant to Section
12 4161 shall be seven hundred eighty dollars (\$780) and may be
13 increased to eight hundred twenty dollars (\$820).

14 (2) For nonresident wholesalers or third-party logistics providers
15 that have 21 or more facilities operating nationwide the application
16 fees for the first 20 locations shall be seven hundred eighty dollars
17 (\$780) and may be increased to eight hundred twenty dollars
18 (\$820). The application fee for any additional location after
19 licensure of the first 20 locations shall be three hundred dollars
20 (\$300) and may be decreased to no less than two hundred
21 twenty-five dollars (\$225). A temporary license fee shall be seven
22 hundred fifteen dollars (\$715) and may be decreased to no less
23 than five hundred fifty dollars (\$550).

24 (3) The annual renewal fee for a nonresident wholesaler license
25 or third-party logistics provider license issued pursuant to Section
26 4161 shall be seven hundred eighty dollars (\$780) and may be
27 increased to eight hundred twenty dollars (\$820).

28 (k) The fee for evaluation of continuing education courses for
29 accreditation shall be set by the board at an amount not to exceed
30 forty dollars (\$40) per course hour.

31 (l) The fee for an intern pharmacist license shall be one hundred
32 sixty-five dollars (\$165) and may be increased to two hundred
33 thirty dollars (\$230). The fee for transfer of intern hours or
34 verification of licensure to another state shall be twenty-five dollars
35 (\$25) and may be increased to thirty dollars (\$30).

36 (m) The board may waive or refund the additional fee for the
37 issuance of a license where the license is issued less than 45 days
38 before the next regular renewal date.

39 (n) The fee for the reissuance of any license, or renewal thereof,
40 that has been lost or destroyed or reissued due to a name change

1 shall be thirty-five dollars (\$35) and may be increased to forty-five
2 dollars (\$45).

3 (o) The fee for the reissuance of any license, or renewal thereof,
4 that must be reissued because of a change in the information, shall
5 be one hundred dollars (\$100) and may be increased to one hundred
6 thirty dollars (\$130).

7 (p) It is the intent of the Legislature that, in setting fees pursuant
8 to this section, the board shall seek to maintain a reserve in the
9 Pharmacy Board Contingent Fund equal to approximately one
10 year's operating expenditures.

11 (q) The fee for any applicant for a nongovernmental clinic
12 license shall be five hundred twenty dollars (\$520) for each license
13 and may be increased to five hundred seventy dollars (\$570). The
14 annual fee for renewal of the license shall be three hundred
15 twenty-five dollars (\$325) for each license and may be increased
16 to three hundred sixty dollars (\$360).

17 (r) The fee for the issuance of a pharmacy technician license
18 shall be one hundred forty dollars (\$140) and may be increased to
19 one hundred ninety-five dollars (\$195). The fee for renewal of a
20 pharmacy technician license shall be one hundred forty dollars
21 (\$140) and may be increased to one hundred ninety-five dollars
22 (\$195).

23 (s) The fee for a veterinary food-animal drug retailer license
24 shall be four hundred thirty-five dollars (\$435) and may be
25 increased to six hundred ten dollars (\$610). The annual renewal
26 fee for a veterinary food-animal drug retailer license shall be three
27 hundred thirty dollars (\$330) and may be increased to four hundred
28 sixty dollars (\$460).

29 (t) The fee for issuance of a retired license pursuant to Section
30 4200.5 shall be thirty-five dollars (\$35) and may be increased to
31 forty-five dollars (\$45).

32 (u) The fee for issuance of a nongovernmental sterile
33 compounding pharmacy license shall be one thousand six hundred
34 forty-five dollars (\$1,645) and may be increased to two thousand
35 three hundred five dollars (\$2,305). The fee for a temporary license
36 shall be five hundred fifty dollars (\$550) and may be increased to
37 seven hundred fifteen dollars (\$715). The annual renewal fee of
38 the license shall be one thousand three hundred twenty-five dollars
39 (\$1,325) and may be increased to one thousand eight hundred
40 fifty-five dollars (\$1,855).

1 (v) The fee for the issuance of a nonresident sterile compounding
 2 pharmacy license shall be two thousand three hundred eighty
 3 dollars (\$2,380) and may be increased to three thousand three
 4 hundred thirty-five dollars (\$3,335). The annual renewal of the
 5 license shall be two thousand two hundred seventy dollars (\$2,270)
 6 and may be increased to three thousand one hundred eighty dollars
 7 (\$3,180). In addition to paying that application fee, the nonresident
 8 sterile compounding pharmacy shall deposit, when submitting the
 9 application, a reasonable amount, as determined by the board,
 10 necessary to cover the board's estimated cost of performing the
 11 inspection required by Section 4127.2. If the required deposit is
 12 not submitted with the application, the application shall be deemed
 13 to be incomplete. If the actual cost of the inspection exceeds the
 14 amount deposited, the board shall provide to the applicant a written
 15 invoice for the remaining amount and shall not take action on the
 16 application until the full amount has been paid to the board. If the
 17 amount deposited exceeds the amount of actual and necessary
 18 costs incurred, the board shall remit the difference to the applicant.

19 (w) The fee for the issuance of a centralized hospital packaging
 20 license shall be eight hundred twenty dollars (\$820) and may be
 21 increased to one thousand one hundred fifty dollars (\$1,150). The
 22 annual renewal of the license shall be eight hundred five dollars
 23 (\$805) and may be increased to one thousand one hundred
 24 twenty-five dollars (\$1,125).

25 (x) This section shall become operative on July 1, 2017.

26 ~~SEC. 27. Chapter 15 (commencing with Section 4999) of~~
 27 ~~Division 2 of the Business and Professions Code is repealed.~~

28 *SEC. 26. Section 4999 of the Business and Professions Code*
 29 *is amended to read:*

30 4999. ~~(a) Any~~ "Telephone medical advice service" means any
 31 business entity that employs, or contracts or subcontracts, directly
 32 or indirectly, with, the full-time equivalent of five or more persons
 33 functioning as health care professionals, whose primary function
 34 is to provide telephone medical advice, that provides telephone
 35 medical advice services to a patient at a California address shall
 36 ~~be registered with the Telephone Medical Advice Services Bureau.~~

37 ~~(b) A~~ address. "Telephone medical advice service" does not
 38 include a medical group that operates in multiple locations in
 39 California ~~shall not be required to register pursuant to this section~~
 40 if no more than five full-time equivalent persons at any one location

1 perform telephone medical advice services and those persons limit
2 the telephone medical advice services to patients being treated at
3 that location.

4 ~~(e) Protection of the public shall be the highest priority for the
5 bureau in exercising its registration, regulatory, and disciplinary
6 functions. Whenever the protection of the public is inconsistent
7 with other interests sought to be promoted, the protection of the
8 public shall be paramount.~~

9 *SEC. 27. Section 4999.1 of the Business and Professions Code*
10 *is repealed.*

11 ~~4999.1. Application for registration as a telephone medical
12 advice service shall be made on a form prescribed by the
13 department, accompanied by the fee prescribed pursuant to Section
14 4999.5. The department shall make application forms available.
15 Applications shall contain all of the following:~~

16 ~~(a) The signature of the individual owner of the telephone
17 medical advice service, or of all of the partners if the service is a
18 partnership, or of the president or secretary if the service is a
19 corporation. The signature shall be accompanied by a resolution
20 or other written communication identifying the individual whose
21 signature is on the form as owner, partner, president, or secretary.~~

22 ~~(b) The name under which the person applying for the telephone
23 medical advice service proposes to do business.~~

24 ~~(c) The physical address, mailing address, and telephone number
25 of the business entity.~~

26 ~~(d) The designation, including the name and physical address,
27 of an agent for service of process in California.~~

28 ~~(e) A list of all health care professionals providing medical
29 advice services that are required to be licensed, registered, or
30 certified pursuant to this chapter. This list shall be submitted to
31 the department on a form to be prescribed by the department and
32 shall include, but not be limited to, the name, state of licensure,
33 type of license, and license number.~~

34 ~~(f) The department shall be notified within 30 days of any
35 change of name, physical location, mailing address, or telephone
36 number of any business, owner, partner, corporate officer, or agent
37 for service of process in California, together with copies of all
38 resolutions or other written communications that substantiate these
39 changes.~~

1 SEC. 28. Section 4999.2 of the Business and Professions Code
2 is amended to read:

3 4999.2. (a) ~~In order to obtain and maintain a registration, a A~~
4 telephone medical advice service shall ~~comply~~ *be responsible for*
5 ~~complying with the requirements established by the department.~~
6 ~~Those requirements shall include, but shall not be limited to, all~~
7 ~~of the following:~~ *following requirements:*

8 ~~(1) (A)~~

9 (a) (1) Ensuring that all health care professionals who provide
10 medical advice services are appropriately licensed, certified, or
11 registered as a physician and surgeon pursuant to Chapter 5
12 (commencing with Section 2000) or the Osteopathic Initiative Act,
13 as a dentist, dental hygienist, dental hygienist in alternative
14 practice, or dental hygienist in extended functions pursuant to
15 Chapter 4 (commencing with Section 1600), as an occupational
16 therapist pursuant to Chapter 5.6 (commencing with Section 2570),
17 as a registered nurse pursuant to Chapter 6 (commencing with
18 Section 2700), as a psychologist pursuant to Chapter 6.6
19 (commencing with Section 2900), as a naturopathic doctor pursuant
20 to Chapter 8.2 (commencing with Section 3610), as a marriage
21 and family therapist pursuant to Chapter 13 (commencing with
22 Section 4980), as a licensed clinical social worker pursuant to
23 Chapter 14 (commencing with Section 4991), as a licensed
24 professional clinical counselor pursuant to Chapter 16
25 (commencing with Section 4999.10), as an optometrist pursuant
26 to Chapter 7 (commencing with Section 3000), or as a chiropractor
27 pursuant to the Chiropractic Initiative Act, and operating consistent
28 with the laws governing their respective scopes of practice in the
29 state within which they provide telephone medical advice services,
30 except as provided in ~~paragraph (2).~~ *subdivision (b).*

31 ~~(B)~~

32 (2) Ensuring that all health care professionals who provide
33 telephone medical advice services from an out-of-state location,
34 as identified in ~~subparagraph (A); paragraph (1),~~ are licensed,
35 registered, or certified in the state within which they are providing
36 the telephone medical advice services and are operating consistent
37 with the laws governing their respective scopes of practice.

38 ~~(2)~~

39 (b) Ensuring that the telephone medical advice provided is
40 consistent with good professional practice.

1 ~~(3)~~
2 (c) Maintaining records of telephone medical advice services,
3 including records of complaints, provided to patients in California
4 for a period of at least five years.

5 ~~(4)~~
6 (d) Ensuring that no staff member uses a title or designation
7 when speaking to an enrollee, subscriber, or consumer that may
8 cause a reasonable person to believe that the staff member is a
9 licensed, certified, or registered health care professional described
10 in ~~subparagraph (A) of paragraph (1); paragraph (1) of subdivision~~
11 ~~(a)~~, unless the staff member is a licensed, certified, or registered
12 professional.

13 ~~(5)~~
14 (e) Complying with all directions and requests for information
15 made by the department.

16 ~~(6)~~
17 (f) Notifying the department within 30 days of any change of
18 name, physical location, mailing address, or telephone number of
19 any business, owner, partner, corporate officer, or agent for service
20 of process in California, together with copies of all resolutions or
21 other written communications that substantiate these changes.

22 ~~(7) Submitting quarterly reports, on a form prescribed by the~~
23 ~~department, to the department within 30 days of the end of each~~
24 ~~calendar quarter.~~

25 ~~(b) To the extent permitted by Article VII of the California~~
26 ~~Constitution, the department may contract with a private nonprofit~~
27 ~~accrediting agency to evaluate the qualifications of applicants for~~
28 ~~registration pursuant to this chapter and to make recommendations~~
29 ~~to the department.~~

30 ~~SEC. 29. Section 4999.3 of the Business and Professions Code~~
31 ~~is repealed.~~

32 ~~4999.3. (a) The department may suspend, revoke, or otherwise~~
33 ~~discipline a registrant or deny an application for registration as a~~
34 ~~telephone medical advice service based on any of the following:~~

35 ~~(1) Incompetence, gross negligence, or repeated similar~~
36 ~~negligent acts performed by the registrant or any employee of the~~
37 ~~registrant.~~

38 ~~(2) An act of dishonesty or fraud by the registrant or any~~
39 ~~employee of the registrant.~~

1 ~~(3) The commission of any act, or being convicted of a crime,~~
2 ~~that constitutes grounds for denial or revocation of licensure~~
3 ~~pursuant to any provision of this division.~~

4 ~~(b) The proceedings shall be conducted in accordance with~~
5 ~~Chapter 5 (commencing with Section 11500) of Part 1 of Division~~
6 ~~3 of Title 2 of the Government Code, and the department shall~~
7 ~~have all powers granted therein.~~

8 ~~(c) Copies of any complaint against a telephone medical advice~~
9 ~~service shall be forwarded to the Department of Managed Health~~
10 ~~Care.~~

11 ~~(d) The department shall forward a copy of any complaint~~
12 ~~submitted to the department pursuant to this chapter to the entity~~
13 ~~that issued the license to the licensee involved in the advice~~
14 ~~provided to the patient.~~

15 *SEC. 30. Section 4999.4 of the Business and Professions Code*
16 *is repealed.*

17 ~~4999.4. (a) Every registration issued to a telephone medical~~
18 ~~advice service shall expire 24 months after the initial date of~~
19 ~~issuance.~~

20 ~~(b) To renew an unexpired registration, the registrant shall,~~
21 ~~before the time at which the registration would otherwise expire,~~
22 ~~pay the renewal fee authorized by Section 4999.5.~~

23 ~~(c) An expired registration may be renewed at any time within~~
24 ~~three years after its expiration upon the filing of an application for~~
25 ~~renewal on a form prescribed by the bureau and the payment of~~
26 ~~all fees authorized by Section 4999.5. A registration that is not~~
27 ~~renewed within three years following its expiration shall not be~~
28 ~~renewed, restored, or reinstated thereafter, and the delinquent~~
29 ~~registration shall be canceled immediately upon expiration of the~~
30 ~~three-year period.~~

31 *SEC. 31. Section 4999.5 of the Business and Professions Code*
32 *is repealed.*

33 ~~4999.5. The department may set fees for registration and~~
34 ~~renewal as a telephone medical advice service sufficient to pay~~
35 ~~the costs of administration of this chapter.~~

36 *SEC. 32. Section 4999.5 is added to the Business and*
37 *Professions Code, to read:*

38 *4999.5. The respective healing arts licensing boards shall be*
39 *responsible for enforcing this chapter and any other laws and*

1 *regulations affecting California licensed health care professionals*
2 *providing telephone medical advice services.*

3 *SEC. 33. Section 4999.6 of the Business and Professions Code*
4 *is repealed.*

5 ~~4999.6. The department may adopt, amend, or repeal any rules~~
6 ~~and regulations that are reasonably necessary to carry out this~~
7 ~~chapter. A telephone medical advice services provider who~~
8 ~~provides telephone medical advice to a significant total number~~
9 ~~of charity or medically indigent patients may, at the discretion of~~
10 ~~the director, be exempt from the fee requirements imposed by this~~
11 ~~chapter. However, those providers shall comply with all other~~
12 ~~provisions of this chapter.~~

13 ~~SEC. 28.~~

14 *SEC. 34. Section 7137 of the Business and Professions Code*
15 *is amended to read:*

16 7137. The board shall set fees by regulation. These fees shall
17 not exceed the following schedule:

18 (a) (1) The application fee for an original license in a single
19 classification shall not be more than three hundred sixty dollars
20 (\$360).

21 (2) The application fee for each additional classification applied
22 for in connection with an original license shall not be more than
23 seventy-five dollars (\$75).

24 (3) The application fee for each additional classification pursuant
25 to Section 7059 shall not be more than three hundred dollars
26 (\$300).

27 (4) The application fee to replace a responsible managing officer,
28 responsible managing manager, responsible managing member,
29 or responsible managing employee pursuant to Section 7068.2
30 shall not be more than three hundred dollars (\$300).

31 (5) The application fee to add personnel, other than a qualifying
32 individual, to an existing license shall not be more than one
33 hundred fifty dollars (\$150).

34 (b) The fee for rescheduling an examination for an applicant
35 who has applied for an original license, additional classification,
36 a change of responsible managing officer, responsible managing
37 manager, responsible managing member, or responsible managing
38 employee, or for an asbestos certification or hazardous substance
39 removal certification, shall not be more than sixty dollars (\$60).

1 (c) The fee for scheduling or rescheduling an examination for
2 a licensee who is required to take the examination as a condition
3 of probation shall not be more than sixty dollars (\$60).

4 (d) The initial license fee for an active or inactive license shall
5 not be more than two hundred twenty dollars (\$220).

6 (e) (1) The renewal fee for an active license shall not be more
7 than four hundred thirty dollars (\$430).

8 (2) The renewal fee for an inactive license shall not be more
9 than two hundred twenty dollars (\$220).

10 (f) The delinquency fee is an amount equal to 50 percent of the
11 renewal fee, if the license is renewed after its expiration.

12 (g) The registration fee for a home improvement salesperson
13 shall not be more than ninety dollars (\$90).

14 (h) The renewal fee for a home improvement salesperson
15 registration shall not be more than ninety dollars (\$90).

16 (i) The application fee for an asbestos certification examination
17 shall not be more than ninety dollars (\$90).

18 (j) The application fee for a hazardous substance removal or
19 remedial action certification examination shall not be more than
20 ninety dollars (\$90).

21 (k) In addition to any other fees charged to C-10 and C-7
22 contractors, the board may charge a fee not to exceed twenty dollars
23 (\$20), which shall be used by the board to enforce provisions of
24 the Labor Code related to electrician certification.

25 (l) The board shall, by regulation, establish criteria for the
26 approval of expedited processing of applications. Approved
27 expedited processing of applications for licensure or registration,
28 as required by other provisions of law, shall not be subject to this
29 subdivision.

30 ~~SEC. 29.~~

31 *SEC. 35.* Section 7153.3 of the Business and Professions Code
32 is amended to read:

33 7153.3. (a) To renew a home improvement salesperson
34 registration, which has not expired, the registrant shall before the
35 time at which the registration would otherwise expire, apply for
36 renewal on a form prescribed by the registrar and pay a renewal
37 fee prescribed by this chapter. Renewal of an unexpired registration
38 shall continue the registration in effect for the two-year period
39 following the expiration date of the registration, when it shall
40 expire if it is not again renewed.

1 (b) An application for renewal of registration is delinquent if
2 the application is not postmarked or received via electronic
3 transmission as authorized by Section 7156.6 by the date on which
4 the registration would otherwise expire. A registration may,
5 however, still be renewed at any time within three years after its
6 expiration upon the filing of an application for renewal on a form
7 prescribed by the registrar and the payment of the renewal fee
8 prescribed by this chapter and a delinquent renewal penalty equal
9 to 50 percent of the renewal fee. If a registration is not renewed
10 within three years, the person shall make a new application for
11 registration pursuant to Section 7153.1.

12 (c) The registrar may refuse to renew a registration for failure
13 by the registrant to complete the application for renewal of
14 registration. If a registrant fails to return the application rejected
15 for insufficiency or incompleteness within 90 days from the
16 original date of rejection, the application and fee shall be deemed
17 abandoned. Any application abandoned may not be reinstated.
18 However, the person may file a new application for registration
19 pursuant to Section 7153.1.

20 The registrar may review and accept the petition of a person who
21 disputes the abandonment of his or her renewal application upon
22 a showing of good cause. This petition shall be received within 90
23 days of the date the application for renewal is deemed abandoned.

24 ~~SEC. 30.~~

25 *SEC. 36.* Section 8031 of the Business and Professions Code
26 is amended to read:

27 8031. The amount of the fees required by this chapter is that
28 fixed by the board in accordance with the following schedule:

29 (a) The fee for filing an application for each examination shall
30 be no more than forty dollars (\$40).

31 (b) The fee for examination and reexamination for the written
32 or practical part of the examination shall be in an amount fixed by
33 the board, which shall be equal to the actual cost of preparing,
34 administering, grading, and analyzing the examination, but shall
35 not exceed seventy-five dollars (\$75) for each separate part, for
36 each administration.

37 (c) The initial certificate fee is an amount equal to the renewal
38 fee in effect on the last regular renewal date before the date on
39 which the certificate is issued, except that, if the certificate will
40 expire less than 180 days after its issuance, then the fee is 50

1 percent of the renewal fee in effect on the last regular renewal date
2 before the date on which the certificate is issued, or fifty dollars
3 (\$50), whichever is greater. The board may, by appropriate
4 regulation, provide for the waiver or refund of the initial certificate
5 fee where the certificate is issued less than 45 days before the date
6 on which it will expire.

7 (d) By a resolution adopted by the board, a renewal fee may be
8 established in such amounts and at such times as the board may
9 deem appropriate to meet its operational expenses and funding
10 responsibilities as set forth in this chapter. The renewal fee shall
11 not be more than two hundred fifty dollars (\$250) nor less than
12 ten dollars (\$10) annually, with the following exception:

13 Any person who is employed full time by the State of California
14 as a hearing reporter and who does not otherwise render shorthand
15 reporting services for a fee shall be exempt from licensure while
16 in state employment and shall not be subject to the renewal fee
17 provisions of this subdivision until 30 days after leaving state
18 employment. The renewal fee shall, in addition to the amount fixed
19 by this subdivision, include any unpaid fees required by this section
20 plus any delinquency fee.

21 (e) The duplicate certificate fee shall be no greater than ten
22 dollars (\$10).

23 (f) The penalty for failure to notify the board of a change of
24 name or address as required by Section 8024.6 shall be no greater
25 than fifty dollars (\$50).

26 ~~SEC. 31.~~

27 *SEC. 37.* Section 8516 of the Business and Professions Code
28 is amended to read:

29 8516. (a) This section, and Section 8519, apply only to wood
30 destroying pests or organisms.

31 (b) A registered company or licensee shall not commence work
32 on a contract, or sign, issue, or deliver any documents expressing
33 an opinion or statement relating to the absence or presence of wood
34 destroying pests or organisms until an inspection has been made
35 by a licensed Branch 3 field representative or operator employed
36 by a registered company, except as provided in Section 8519.5.
37 The address of each property inspected or upon which work is
38 completed shall be reported on a form prescribed by the board and
39 shall be filed with the board no later than 10 business days after
40 the commencement of an inspection or upon completed work.

1 Every property inspected pursuant to this subdivision or Section
2 8518 shall be assessed a filing fee pursuant to Section 8674.

3 Failure of a registered company to report and file with the board
4 the address of any property inspected or work completed pursuant
5 to Section 8518 or this section is grounds for disciplinary action
6 and shall subject the registered company to a fine of not more than
7 two thousand five hundred dollars (\$2,500). The address of an
8 inspection report prepared for use by an attorney for litigation
9 purposes shall not be required to be reported to the board and shall
10 not be assessed a filing fee.

11 A written inspection report conforming to this section and a form
12 approved by the board shall be prepared and delivered to the person
13 requesting the inspection and the property owner, or to the property
14 owner's designated agent, within 10 business days from the start
15 of the inspection, except that an inspection report prepared for use
16 by an attorney for litigation purposes is not required to be reported
17 to the board or the property owner. An inspection report may be
18 a complete, limited, supplemental, or reinspection report, as defined
19 by Section 1993 of Title 16 of the California Code of Regulations.
20 The report shall be delivered before work is commenced on any
21 property. The registered company shall retain for three years all
22 inspection reports, field notes, and activity forms.

23 Reports shall be made available for inspection and reproduction
24 to the executive officer of the board or his or her duly authorized
25 representative during business hours. All inspection reports or
26 copies thereof shall be submitted to the board upon demand within
27 two business days. The following shall be set forth in the report:

28 (1) The start date of the inspection and the name of the licensed
29 field representative or operator making the inspection.

30 (2) The name and address of the person or firm ordering the
31 report.

32 (3) The name and address of the property owner and any person
33 who is a party in interest.

34 (4) The address or location of the property.

35 (5) A general description of the building or premises inspected.

36 (6) A foundation diagram or sketch of the structure or structures
37 or portions of the structure or structures inspected, including the
38 approximate location of any infested or infected areas evident, and
39 the parts of the structure where conditions that would ordinarily
40 subject those parts to attack by wood destroying pests or organisms

1 exist. Reporting of the infested or infected wood members, or parts
2 of the structure identified, shall be listed in the inspection report
3 to clearly identify them, as is typical in standard construction
4 components, including, but not limited to, siding, studs, rafters,
5 floor joists, fascia, subfloor, sheathing, and trim boards.

6 (7) Information regarding the substructure, foundation walls
7 and footings, porches, patios and steps, air vents, abutments, attic
8 spaces, roof framing that includes the eaves, rafters, fascias,
9 exposed timbers, exposed sheathing, ceiling joists, and attic walls,
10 or other parts subject to attack by wood destroying pests or
11 organisms. Conditions usually deemed likely to lead to infestation
12 or infection, such as earth-wood contacts, excessive cellulose
13 debris, faulty grade levels, excessive moisture conditions, evidence
14 of roof leaks, and insufficient ventilation are to be reported.

15 (8) One of the following statements, as appropriate, printed in
16 bold type:

17 (A) The exterior surface of the roof was not inspected. If you
18 want the water tightness of the roof determined, you should contact
19 a roofing contractor who is licensed by the Contractors' State
20 License Board.

21 (B) The exterior surface of the roof was inspected to determine
22 whether or not wood destroying pests or organisms are present.

23 (9) Indication or description of any areas that are inaccessible
24 or not inspected with recommendation for further inspection if
25 practicable. If, after the report has been made in compliance with
26 this section, authority is given later to open inaccessible areas, a
27 supplemental report on conditions in these areas shall be made.

28 (10) Recommendations for corrective measures.

29 (11) Information regarding the pesticide or pesticides to be used
30 for their control or prevention as set forth in subdivision (a) of
31 Section 8538.

32 (12) The inspection report shall clearly disclose that if requested
33 by the person ordering the original report, a reinspection of the
34 structure will be performed if an estimate or bid for making repairs
35 was given with the original inspection report, or thereafter.

36 An estimate or bid shall be given separately allocating the costs
37 to perform each and every recommendation for corrective measures
38 as specified in subdivision (c) with the original inspection report
39 if the person who ordered the original inspection report so requests,

1 and if the registered company is regularly in the business of
2 performing each corrective measure.

3 If no estimate or bid was given with the original inspection
4 report, or thereafter, then the registered company shall not be
5 required to perform a reinspection.

6 A reinspection shall be an inspection of those items previously
7 listed on an original report to determine if the recommendations
8 have been completed. Each reinspection shall be reported on an
9 original inspection report form and shall be labeled "Reinspection."
10 Each reinspection shall also identify the original report by date.

11 After four months from an original inspection, all inspections
12 shall be original inspections and not reinspections.

13 Any reinspection shall be performed for not more than the price
14 of the registered company's original inspection price and shall be
15 completed within 10 business days after a reinspection has been
16 ordered.

17 (13) The inspection report shall contain the following statement,
18 printed in boldface type:

19
20 "NOTICE: Reports on this structure prepared by various
21 registered companies should list the same findings (i.e. termite
22 infestations, termite damage, fungus damage, etc.). However,
23 recommendations to correct these findings may vary from company
24 to company. You have a right to seek a second opinion from
25 another company."
26

27 (c) At the time a report is ordered, the registered company or
28 licensee shall inform the person or entity ordering the report, that
29 a separate report is available pursuant to this subdivision. If a
30 separate report is requested at the time the inspection report is
31 ordered, the registered company or licensee shall separately identify
32 on the report each recommendation for corrective measures as
33 follows:

- 34 (1) The infestation or infection that is evident.
35 (2) The conditions that are present that are deemed likely to
36 lead to infestation or infection.

37 If a registered company or licensee fails to inform as required
38 by this subdivision and a dispute arises, or if any other dispute
39 arises as to whether this subdivision has been complied with, a
40 separate report shall be provided within 24 hours of the request

1 but, in no event, later than the next business day, and at no
2 additional cost.

3 (d) When a corrective condition is identified, either as paragraph
4 (1) or (2) of subdivision (c), and the property owner or the property
5 owner's designated agent chooses not to correct those conditions,
6 the registered company or licensee shall not be liable for damages
7 resulting from a failure to correct those conditions or subject to
8 any disciplinary action by the board. Nothing in this subdivision,
9 however, shall relieve a registered company or a licensee of any
10 liability resulting from negligence, fraud, dishonest dealing, other
11 violations pursuant to this chapter, or contractual obligations
12 between the registered company or licensee and the responsible
13 parties.

14 (e) The inspection report form prescribed by the board shall
15 separately identify the infestation or infection that is evident and
16 the conditions that are present that are deemed likely to lead to
17 infestation or infection. If a separate form is requested, the form
18 shall explain the infestation or infection that is evident and the
19 conditions that are present that are deemed likely to lead to
20 infestation or infection and the difference between those conditions.
21 In no event, however, shall conditions deemed likely to lead to
22 infestation or infection be characterized as actual "defects" or as
23 actual "active" infestations or infections or in need of correction
24 as a precondition to issuing a certification pursuant to Section
25 8519.

26 (f) The report and any contract entered into shall also state
27 specifically when any guarantee for the work is made, and if so,
28 the specific terms of the guarantee and the period of time for which
29 the guarantee shall be in effect. If a guarantee extends beyond three
30 years, the registered company shall maintain all original inspection
31 reports, field notes, activity forms, and notices of completion for
32 the duration of the guarantee period and for one year after the
33 guarantee expires.

34 (g) For purposes of this section, "control service agreement"
35 means an agreement, including extended warranties, to have a
36 licensee conduct over a period of time regular inspections and
37 other activities related to the control or eradication of wood
38 destroying pests and organisms. Under a control service agreement
39 a registered company shall refer to the original report and contract
40 in a manner as to identify them clearly, and the report shall be

1 assumed to be a true report of conditions as originally issued,
2 except it may be modified after a control service inspection. A
3 registered company is not required to issue a report as outlined in
4 paragraphs (1) to (11), inclusive, of subdivision (b) after each
5 control service inspection. If after control service inspection, no
6 modification of the original report is made in writing, then it will
7 be assumed that conditions are as originally reported. A control
8 service contract shall state specifically the particular wood
9 destroying pests or organisms and the portions of the buildings or
10 structures covered by the contract.

11 (h) A registered company or licensee may enter into and
12 maintain a control service agreement provided the following
13 requirements are met:

14 (1) The control service agreement shall be in writing, signed by
15 both parties, and shall specifically include the following:

16 (A) The wood destroying pests and organisms covered by the
17 control service agreement.

18 (B) Any wood destroying pest or organism that is not covered
19 must be specifically listed.

20 (C) The type and manner of treatment to be used to correct the
21 infestations or infections.

22 (D) The structures or buildings, or portions thereof, covered by
23 the agreement, including a statement specifying whether the
24 coverage for purposes of periodic inspections is limited or full.
25 Any exclusions from those described in the original report must
26 be specifically listed.

27 (E) A reference to the original inspection report.

28 (F) The frequency of the inspections to be provided, the fee to
29 be charged for each renewal, and the duration of the agreement.

30 (G) Whether the fee includes structural repairs.

31 (H) If the services provided are guaranteed, and, if so, the terms
32 of the guarantee.

33 (I) A statement that all corrections of infestations or infections
34 covered by the control service agreement shall be completed within
35 six months of discovery, unless otherwise agreed to in writing by
36 both parties.

37 (2) The original inspection report, the control service agreement,
38 and completion report shall be maintained for three years after the
39 cancellation of the control service agreement.

1 (3) Inspections made pursuant to a control service agreement
2 shall be conducted by a Branch 3 licensee. Section 8506.1 does
3 not modify this provision.

4 (4) A full inspection of the property covered by the control
5 service agreement shall be conducted and a report filed pursuant
6 to subdivision (b) at least once every three years from the date that
7 the agreement was entered into, unless the consumer cancels the
8 contract within three years from the date the agreement was entered
9 into.

10 (5) Under a control service agreement, a written report shall be
11 required for the correction of any infestation or infection unless
12 all of the following conditions are met:

13 (A) The infestation or infection has been previously reported.

14 (B) The infestation or infection is covered by the control service
15 agreement.

16 (C) There is no additional charge for correcting the infestation
17 or infection.

18 (D) Correction of the infestation or infection takes place within
19 45 days of its discovery.

20 (E) Correction of the infestation or infection does not include
21 fumigation.

22 (6) All notice requirements pursuant to Section 8538 shall apply
23 to all pesticide treatments conducted under control service
24 agreements.

25 (i) All work recommended by a registered company, where an
26 estimate or bid for making repairs was given with the original
27 inspection report, or thereafter, shall be recorded on this report or
28 a separate work agreement and shall specify a price for each
29 recommendation. This information shall be provided to the person
30 requesting the inspection, and shall be retained by the registered
31 company with the inspection report copy for three years.

32 ~~SEC. 32.~~

33 *SEC. 38.* Section 8518 of the Business and Professions Code
34 is amended to read:

35 8518. (a) When a registered company completes work under
36 a contract, it shall prepare, on a form prescribed by the board, a
37 notice of work completed and not completed, and shall furnish
38 that notice to the owner of the property or the owner’s agent within
39 10 business days after completing the work. The notice shall

1 include a statement of the cost of the completed work and estimated
2 cost of work not completed.

3 (b) The address of each property inspected or upon which work
4 was completed shall be reported on a form prescribed by the board
5 and shall be filed with the board no later than 10 business days
6 after completed work.

7 (c) A filing fee shall be assessed pursuant to Section 8674 for
8 every property upon which work is completed.

9 (d) Failure of a registered company to report and file with the
10 board the address of any property upon which work was completed
11 pursuant to subdivision (b) of Section 8516 or this section is
12 grounds for disciplinary action and shall subject the registered
13 company to a fine of not more than two thousand five hundred
14 dollars (\$2,500).

15 (e) The registered company shall retain for three years all
16 original notices of work completed, work not completed, and
17 activity forms.

18 (f) Notices of work completed and not completed shall be made
19 available for inspection and reproduction to the executive officer
20 of the board or his or her duly authorized representative during
21 business hours. Original notices of work completed or not
22 completed or copies thereof shall be submitted to the board upon
23 request within two business days.

24 (g) This section shall only apply to work relating to wood
25 destroying pests or organisms.

26 ~~SEC. 33. Section 1348.8 of the Health and Safety Code is~~
27 ~~repealed.~~

28 ~~SEC. 34. Section 10279 of the Insurance Code is repealed.~~

29 *SEC. 39. Section 1348.8 of the Health and Safety Code is*
30 *amended to read:*

31 1348.8. (a) A health care service plan that provides, operates,
32 or contracts for telephone medical advice services to its enrollees
33 and subscribers shall do all of the following:

34 (1) Ensure that the in-state or out-of-state telephone medical
35 advice service ~~is registered pursuant to~~ *complies with the*
36 *requirements of* Chapter 15 (commencing with Section 4999) of
37 Division 2 of the Business and Professions Code.

38 (2) Ensure that the staff providing telephone medical advice
39 services for the in-state or out-of-state telephone medical advice
40 service are licensed as follows:

1 (A) For full service health care service plans, the staff hold a
2 valid California license as a registered nurse or a valid license in
3 the state within which they provide telephone medical advice
4 services as a physician and surgeon or physician assistant, and are
5 operating in compliance with the laws governing their respective
6 scopes of practice.

7 (B) (i) For specialized health care service plans providing,
8 operating, or contracting with a telephone medical advice service
9 in California, the staff shall be appropriately licensed, registered,
10 or certified as a dentist pursuant to Chapter 4 (commencing with
11 Section 1600) of Division 2 of the Business and Professions Code,
12 as a dental hygienist pursuant to Article 7 (commencing with
13 Section 1740) of Chapter 4 of Division 2 of the Business and
14 Professions Code, as a physician and surgeon pursuant to Chapter
15 5 (commencing with Section 2000) of Division 2 of the Business
16 and Professions Code or the Osteopathic Initiative Act, as a
17 registered nurse pursuant to Chapter 6 (commencing with Section
18 2700) of Division 2 of the Business and Professions Code, as a
19 psychologist pursuant to Chapter 6.6 (commencing with Section
20 2900) of Division 2 of the Business and Professions Code, as an
21 optometrist pursuant to Chapter 7 (commencing with Section 3000)
22 of Division 2 of the Business and Professions Code, as a marriage
23 and family therapist pursuant to Chapter 13 (commencing with
24 Section 4980) of Division 2 of the Business and Professions Code,
25 as a licensed clinical social worker pursuant to Chapter 14
26 (commencing with Section 4991) of Division 2 of the Business
27 and Professions Code, as a professional clinical counselor pursuant
28 to Chapter 16 (commencing with Section 4999.10) of Division 2
29 of the Business and Professions Code, or as a chiropractor pursuant
30 to the Chiropractic Initiative Act, and operating in compliance
31 with the laws governing their respective scopes of practice.

32 (ii) For specialized health care service plans providing,
33 operating, or contracting with an out-of-state telephone medical
34 advice service, the staff shall be health care professionals, as
35 identified in clause (i), who are licensed, registered, or certified
36 in the state within which they are providing the telephone medical
37 advice services and are operating in compliance with the laws
38 governing their respective scopes of practice. All registered nurses
39 providing telephone medical advice services to both in-state and
40 out-of-state business entities registered pursuant to this chapter

1 shall be licensed pursuant to Chapter 6 (commencing with Section
2 2700) of Division 2 of the Business and Professions Code.

3 (3) Ensure that every full service health care service plan
4 provides for a physician and surgeon who is available on an on-call
5 basis at all times the service is advertised to be available to
6 enrollees and subscribers.

7 (4) Ensure that staff members handling enrollee or subscriber
8 calls, who are not licensed, certified, or registered as required by
9 paragraph (2), do not provide telephone medical advice. Those
10 staff members may ask questions on behalf of a staff member who
11 is licensed, certified, or registered as required by paragraph (2),
12 in order to help ascertain the condition of an enrollee or subscriber
13 so that the enrollee or subscriber can be referred to licensed staff.
14 However, under no circumstances shall those staff members use
15 the answers to those questions in an attempt to assess, evaluate,
16 advise, or make any decision regarding the condition of an enrollee
17 or subscriber or determine when an enrollee or subscriber needs
18 to be seen by a licensed medical professional.

19 (5) Ensure that no staff member uses a title or designation when
20 speaking to an enrollee or subscriber that may cause a reasonable
21 person to believe that the staff member is a licensed, certified, or
22 registered professional described in Section 4999.2 of the Business
23 and Professions Code unless the staff member is a licensed,
24 certified, or registered professional.

25 (6) Ensure that the in-state or out-of-state telephone medical
26 advice service designates an agent for service of process in
27 California and files this designation with the director.

28 (7) Requires that the in-state or out-of-state telephone medical
29 advice service makes and maintains records for a period of five
30 years after the telephone medical advice services are provided,
31 including, but not limited to, oral or written transcripts of all
32 medical advice conversations with the health care service plan's
33 enrollees or subscribers in California and copies of all complaints.
34 If the records of telephone medical advice services are kept out of
35 state, the health care service plan shall, upon the request of the
36 director, provide the records to the director within 10 days of the
37 request.

38 (8) Ensure that the telephone medical advice services are
39 provided consistent with good professional practice.

1 (b) The director shall forward to the Department of Consumer
2 Affairs, within 30 days of the end of each calendar quarter, data
3 regarding complaints filed with the department concerning
4 telephone medical advice services.

5 (c) For purposes of this section, “telephone medical advice”
6 means a telephonic communication between a patient and a health
7 care professional in which the health care professional’s primary
8 function is to provide to the patient a telephonic response to the
9 patient’s questions regarding his or her or a family member’s
10 medical care or treatment. “Telephone medical advice” includes
11 assessment, evaluation, or advice provided to patients or their
12 family members.

13 *SEC. 40. Section 10279 of the Insurance Code is amended to*
14 *read:*

15 10279. (a) Every disability insurer that provides group or
16 individual policies of disability, or both, that provides, operates,
17 or contracts for, telephone medical advice services to its insureds
18 shall do all of the following:

19 (1) Ensure that the in-state or out-of-state telephone medical
20 advice service ~~is registered pursuant to~~ *complies with the*
21 *requirements of Chapter 15 (commencing with Section 4999) of*
22 *Division 2 of the Business and Professions Code.*

23 (2) Ensure that the staff providing telephone medical advice
24 services for the in-state or out-of-state telephone medical advice
25 service hold a valid California license as a registered nurse or a
26 valid license in the state within which they provide telephone
27 medical advice services as a physician and surgeon or physician
28 assistant and are operating consistent with the laws governing their
29 respective scopes of practice.

30 (3) Ensure that a physician and surgeon is available on an on-call
31 basis at all times the service is advertised to be available to
32 enrollees and subscribers.

33 (4) Ensure that the in-state or out-of-state telephone medical
34 advice service designates an agent for service of process in
35 California and files this designation with the commissioner.

36 (5) Require that the in-state or out-of-state telephone medical
37 advice service makes and maintains records for a period of five
38 years after the telephone medical advice services are provided,
39 including, but not limited to, oral or written transcripts of all
40 medical advice conversations with the disability insurer’s insureds

1 in California and copies of all complaints. If the records of
2 telephone medical advice services are kept out of state, the insurer
3 shall, upon the request of the director, provide the records to the
4 director within 10 days of the request.

5 (6) Ensure that the telephone medical advice services are
6 provided consistent with good professional practice.

7 (b) The commissioner shall forward to the Department of
8 Consumer Affairs, within 30 days of the end of each calendar
9 quarter, data regarding complaints filed with the department
10 concerning telephone medical advice services.

11 ~~SEC. 35.~~

12 *SEC. 41.* No reimbursement is required by this act pursuant to
13 Section 6 of Article XIII B of the California Constitution because
14 the only costs that may be incurred by a local agency or school
15 district will be incurred because this act creates a new crime or
16 infraction, eliminates a crime or infraction, or changes the penalty
17 for a crime or infraction, within the meaning of Section 17556 of
18 the Government Code, or changes the definition of a crime within
19 the meaning of Section 6 of Article XIII B of the California
20 Constitution.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1174
Author: McGuire
Bill Date: March 28, 2016, Amended
Subject: Medi-Cal: Children: Prescribing Patterns: Psychotropic Medication
Sponsor: National Center for Youth Law

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add to the Medical Board of California's (Board's) priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill would require the Board to confidentially collect and analyze data submitted by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS), related to physicians prescribing psychotropic medications to children.

BACKGROUND

In August 2014, the Board received a letter from Senator Lieu, who was the Chair of the Senate Business, Professions and Economic Development Committee at that time. The letter asked the Board to look into the issue of inappropriate prescribing of psychotropic medication to foster children. The Board receives very few complaints regarding foster children being prescribed psychotropic medications, so the Board researched other avenues to identify physicians who may be inappropriately prescribing. The Board met with DHCS and DSS regarding what data was available, what could be provided to the Board, and what data would assist in the identification of inappropriately prescribing physicians. After many meetings, a Data Use Agreement (DUA) was finalized in April 2015 requesting a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more. For each child that fit into this category, the Board requested a list of the medications prescribed, the start and stop date for each medication, the prescriber's name and contact information, the child's birth date, and any other information that DHCS and DSS thought might be relevant to assist in this process.

Upon receipt of the information requested in the DUA in 2015, the Board secured an expert pediatric psychiatrist to review the information and determine any physician who may be potentially prescribing inappropriately. It is important to note that once a physician is identified, the Board's normal complaint process will be taken, including obtaining medical records, conducting a physician interview and having an expert physician review the case. The complaint and investigation process is confidential, and nothing is public until an accusation is filed. Upon review by the Board's expert, it was determined that additional information was needed to identify physicians that may warrant additional investigation. The new information includes diagnosis associated with the medication, dosage of medication prescribed, schedule

of dosage, and weight of the child/adolescent. The Board is currently working with DHCS and DSS to obtain this additional information.

ANALYSIS

This bill would add to the Board's priorities acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor. Although the Board already has excessive prescribing of controlled substances in its priorities, many psychotropic medications are not controlled substances, so they would not be covered in the Board's existing priorities.

This bill would require DHCS, in collaboration with DSS, to provide quarterly data to the Board that includes, but is not limited to, the child welfare psychotropic medication measures and the Healthcare Effectiveness Data and Information Set measures related to psychotropic medications. This bill would specify that the data provided to the Board shall include a breakdown by population of the following, including rate and age stratifications for birth to 5 years old, 6 to 11 years old and 12-17 years old:

- Children prescribed psychotropic medications in managed care and fee-for-service settings;
- Children adjudged as dependent children placed in foster care;
- Children in juvenile halls and children placed in ranches, camps, or other facilities;
- A minor adjudged a ward of the court who has been removed from the physical custody of the parent and placed into foster care; and
- Children with developmental disabilities.

This bill would require the Board to review the data provided by DHCS and DSS on a quarterly basis to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist, and if warranted, conduct an investigation. This bill would require the Board to take disciplinary action, as appropriate. Lastly, this bill would require the Board to provide a quarterly report on the results of the data analysis to the Legislature, DHCS and DSS.

According to the author, over the past fifteen years the rate of foster youth prescribed psychotropic medication has increased 1,400 percent. Nearly 1 in 4 California foster teens are prescribed psychotropic drugs, and of those nearly 60 percent were prescribed an anti-psychotic, the drug class most susceptible to debilitating side effects. There have been several Senate hearings on this issue, and according to the hearing background information, concerns over the use of psychotropic medications among children has been well documented in research journals and the mainstream media for more than a decade.

Anecdotally, the Board does not receive complaints regarding overprescribing of psychotropic medications to foster children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the

Board has received under the DUA is only a snapshot in time, for a 6 month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. However, once a possible inappropriate prescriber is identified, the board will still have to go through its normal complaint and investigation process.

Board staff is suggesting the Board support this bill, as it will further the Board's mission of consumer protection for a very vulnerable population. However, amendments are needed to ensure that the Board will continue to receive the same data requested under the DUA, including the associated physician information and de-identified patient information. The Board would also need to receive the additional data recently requested by the Board's expert pediatric psychiatrist. Board staff is working closely with the author's office on this bill, and suggests that the Board take a Support if Amended position.

FISCAL: This bill will result in minor and absorbable fiscal impact to have an expert pediatric psychiatrist review the data and report the results to the Legislature, DHCS and DSS on an on-going basis. This is currently being done now, but not on an on-going basis.

SUPPORT: National Center for Youth Law (Sponsor); Bay Area Youth Center; California Youth Connection; Consumer Attorneys of California; Consumer Watchdog; Family Voices of California; First Focus Campaign for Children; John Burton Foundation; Kids in Common, a program of Planned Parenthood Mar Monte; Madera County Department of Social Services; Peers Envisioning and Engaging in Recovery Services; Therapists for Peace and Justice; Woodland Community College Foster and Kinship Care Education; and One individual

OPPOSITION: California Medical Association

POSITION: Recommendation: Support if Amended

AMENDED IN SENATE MARCH 28, 2016

SENATE BILL

No. 1174

**Introduced by Senator McGuire
(Coauthors: Senators Beall, Hancock, Liu, and Mitchell)**

February 18, 2016

An act to *amend Section 2220.05 of, and to add Section 2245 to, the Business and Professions Code, and to add Section 14028 to the Welfare and Institutions Code, relating to Medi-Cal.*

LEGISLATIVE COUNSEL'S DIGEST

SB 1174, as amended, McGuire. Medi-Cal: children: prescribing ~~patterns:~~ *patterns: psychotropic medications.*

Existing law, the Medical Practice Act, among other things provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board's responsibilities include enforcement of the disciplinary and criminal provisions of the act.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid Program provisions. Existing law establishes a statewide system of child welfare services, administered by the State Department of Social Services, with the intent that all children are entitled to be safe and free from abuse and neglect.

~~This bill would require the State Department of Health Care Services and the State Department of Social Services to, on an ongoing basis, conduct~~ *Medical Board of California to conduct on a quarterly basis*

an analysis of data regarding Medi-Cal prescribers and their prescribing patterns for all children enrolled in and receiving services pursuant to the Medi-Cal program. *of psychotropic medications and related services using data provided by the State Department of Health Care Services and the State Department of Social Services.* The bill would require the analysis to include the data to include a breakdown of data by specified population categories, *categories of children*, including children in foster care. Commencing July 1, 2017, the bill would require the State Department of Health Care Services and the State Department of Social Services to report quarterly to the Medical Board of California and to the Legislature of the ongoing analysis. *Medical Board of California to report quarterly to the Legislature, the State Department of Health Care Services, and the State Department of Social Services the results of the analysis of the data.* The bill would require the Medical Board of California to review the analysis data in order to determine if any potential violations of law or ~~departures from~~ *excessive prescribing of psychotropic medications inconsistent with the standard of care exist and conduct an investigation, if warranted, and would require the board to take disciplinary action, as specified. The bill would require the board to handle on a priority basis investigations of repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor, as specified.*

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

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

- 1 SECTION 1. Section 2220.05 of the Business and Professions
- 2 Code is amended to read:
- 3 2220.05. (a) In order to ensure that its resources are maximized
- 4 for the protection of the public, the Medical Board of California
- 5 shall prioritize its investigative and prosecutorial resources to
- 6 ensure that physicians and surgeons representing the greatest threat
- 7 of harm are identified and disciplined expeditiously. Cases
- 8 involving any of the following allegations shall be handled on a
- 9 priority basis, as follows, with the highest priority being given to
- 10 cases in the first paragraph:
- 11 (1) Gross negligence, incompetence, or repeated negligent acts
- 12 that involve death or serious bodily injury to one or more patients,

1 such that the physician and surgeon represents a danger to the
2 public.

3 (2) Drug or alcohol abuse by a physician and surgeon involving
4 death or serious bodily injury to a patient.

5 (3) Repeated acts of clearly excessive prescribing, furnishing,
6 or administering of controlled substances, or repeated acts of
7 prescribing, dispensing, or furnishing of controlled substances
8 without a good faith prior examination of the patient and medical
9 reason therefor. However, in no event shall a physician and surgeon
10 prescribing, furnishing, or administering controlled substances for
11 intractable pain consistent with lawful prescribing, including, but
12 not limited to, Sections 725, 2241.5, and 2241.6 of this code and
13 Sections 11159.2 and 124961 of the Health and Safety Code, be
14 prosecuted for excessive prescribing and prompt review of the
15 applicability of these provisions shall be made in any complaint
16 that may implicate these provisions.

17 (4) Repeated acts of clearly excessive recommending of cannabis
18 to patients for medical purposes, or repeated acts of recommending
19 cannabis to patients for medical purposes without a good faith
20 prior examination of the patient and a medical reason for the
21 recommendation.

22 (5) Sexual misconduct with one or more patients during a course
23 of treatment or an examination.

24 (6) Practicing medicine while under the influence of drugs or
25 alcohol.

26 (7) *Repeated acts of clearly excessive prescribing, furnishing,*
27 *or administering psychotropic medications to a minor without a*
28 *good faith prior examination of the patient and medical reason*
29 *therefor.*

30 (b) The board may by regulation prioritize cases involving an
31 allegation of conduct that is not described in subdivision (a). Those
32 cases prioritized by regulation shall not be assigned a priority equal
33 to or higher than the priorities established in subdivision (a).

34 (c) The Medical Board of California shall indicate in its annual
35 report mandated by Section 2312 the number of temporary
36 restraining orders, interim suspension orders, and disciplinary
37 actions that are taken in each priority category specified in
38 subdivisions (a) and (b).

39 *SEC. 2. Section 2245 is added to the Business and Professions*
40 *Code, to read:*

1 2245. (a) *The Medical Board of California on a quarterly*
2 *basis shall review the data provided pursuant to Section 14028 of*
3 *the Welfare and Institutions Code by the State Department of*
4 *Health Care Services and the State Department of Social Services*
5 *in order to determine if any potential violations of law or excessive*
6 *prescribing of psychotropic medications inconsistent with the*
7 *standard of care exist and, if warranted, shall conduct an*
8 *investigation.*

9 (b) *If, after an investigation, the Medical Board of California*
10 *concludes that there was a violation of law, the board shall take*
11 *disciplinary action, as appropriate, as authorized by Section 2227.*

12 (c) *If, after an investigation, the Medical Board of California*
13 *concludes that there was excessive prescribing of psychotropic*
14 *medications inconsistent with the standard of care, the board shall*
15 *take action, as appropriate, as authorized by Section 2227.*

16 (d) (1) *Notwithstanding Section 10231.5 of the Government*
17 *Code, commencing July 1, 2017, the Medical Board of California*
18 *shall report quarterly to the Legislature, the State Department of*
19 *Health Care Services, and the State Department of Social Services*
20 *the results of the analysis of data described in Section 14028 of*
21 *the Welfare and Institutions Code.*

22 (2) *A report to be submitted pursuant to this subdivision shall*
23 *be submitted in compliance with Section 9795 of the Government*
24 *Code.*

25 SEC. 3. *Section 14028 is added to the Welfare and Institutions*
26 *Code, to read:*

27 14028. (a) *The Medical Board of California shall conduct on*
28 *a quarterly basis an analysis of Medi-Cal and managed care*
29 *prescribers and their prescribing patterns of psychotropic*
30 *medications and related services using data provided quarterly*
31 *by the department in collaboration with the State Department of*
32 *Social Services that shall include, but is not limited to, the child*
33 *welfare psychotropic medication measures and the Healthcare*
34 *Effectiveness Data and Information Set measures related to*
35 *psychotropic medications.*

36 (b) (1) *The data provided to the Medical Board of California*
37 *pursuant to subdivision (a) shall include a breakdown by*
38 *population of all of the following:*

39 (A) *Children prescribed psychotropic medications in managed*
40 *care and fee-for-service settings.*

1 (B) Children adjudged as dependent children under Section 300
2 and placed in foster care.

3 (C) Children in juvenile halls, as described in Section 850, and
4 children placed in ranches, camps, or other facilities, as described
5 in Section 880.

6 (D) A minor adjudged a ward of the court under Section 601
7 or 602 who has been removed from the physical custody of the
8 parent and placed into foster care.

9 (E) Children with developmental disabilities, as described in
10 Section 4512.

11 (2) The data provided to the medical board as described in
12 paragraph (1) shall include total rate and age stratifications that
13 include the following:

14 (A) Birth to five years of age, inclusive.

15 (B) Six to 11 years of age, inclusive.

16 (C) Twelve to 17 years of age, inclusive.

17 ~~SECTION 1. Section 14028 is added to the Welfare and
18 Institutions Code, to read:~~

19 ~~14028. (a) The department and the State Department of Social
20 Services shall, on an ongoing basis, conduct an analysis of data
21 regarding Medi-Cal prescribers and their prescribing patterns for
22 all children enrolled in and receiving services pursuant to, the
23 Medi-Cal program. The analysis shall include a breakdown of data
24 by population of:~~

25 ~~(1) Children in foster care.~~

26 ~~(2) Children in juvenile hall, as described in Section 850.~~

27 ~~(3) Children placed in out-of-home care.~~

28 ~~(4) Children with developmental disabilities.~~

29 ~~(b) (1) Notwithstanding Section 10235.1 of the Government
30 Code, commencing July 1, 2017, the department and the State
31 Department of Social Services shall report quarterly to the Medical
32 Board of California and to the Legislature the results of the ongoing
33 analysis of data described in subdivision (a). The Medical Board
34 of California shall review the analysis in order to determine if any
35 potential violations of law or departures from the standard of care
36 exist and, if warranted, shall conduct an investigation. If after the
37 investigation, the Medical Board of California concludes that there
38 was a violation of law or departure from the standard of care, the
39 board shall take disciplinary action, as appropriate, as authorized
40 by Section 2220.5 of the Business and Professions Code.~~

1 ~~(2) A report to be submitted pursuant to this subdivision shall~~
2 ~~be submitted in compliance with Section 9795 of the Government~~
3 ~~Code.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1177
Author: Galgiani
Bill Date: April 20, 2016, Amended
Subject: Physician and Surgeon Health and Wellness Program
Sponsor: California Medical Association (CMA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Medical Board of California (Board). The PHWP would provide early identification of, and appropriate interventions to support a licensee in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety. This bill would authorize the Board to contract with a private third-party independent administering entity to administer the program.

BACKGROUND

The Board's Diversion Program was a monitoring program for substance abusing physicians (and some physicians with mental impairment) that ensured physicians were complying with the requirements of their agreement with the Diversion Program. The terms included abstaining from drugs and/or alcohol, biological fluid testing, attending group therapy, etc. Senate Bill 761 (Ridley-Thomas), which was the vehicle to extend the dates of the Board's Diversion Program from January 1, 2009 through January 1, 2011, did not pass out of the Legislature. During the hearings for this bill, the discussion and debate surrounding the Board's Diversion Program centered on the multiple audits indicating concerns with the Diversion Program and its protection of the consumers of California. The Board's Diversion Program was very different than any other board's Diversion Programs within the Department of Consumer Affairs (DCA). The Board's Diversion Program was run by the Board itself, not by an outside vendor, was staffed by civil service employees hired by the Board, and was subject to the budget/legislative process for any changes in the number of staff needed to run the Diversion Program. Based upon the concerns over the safety of patients, the Legislature did not approve the continuation of this Diversion Program and it became inoperative on July 1, 2008.

The Board and its staff developed a transition plan for the individuals that were in the Diversion Program on July 1, 2008. The plan not only transitioned the individuals in the Program to other monitoring programs, but also identified how the Board would perform its mission of consumer protection with individuals who were found to have a substance abuse problem without the existence of a Diversion Program for physicians. Under the Diversion

Program, physicians who were found to only have a substance abuse problem or mental impairment were allowed to enter the Diversion Program without any record of disciplinary action. If the physician successfully completed the Board's Diversion Program the public never became aware of the issue. The Board determined that the best way to ensure physicians with a substance abuse problem were not endangering the public would be to continue the biological fluid testing requirements. The Board contracted with a vendor to provide these services. Today, without the Diversion Program, when an individual is identified to have an abuse problem, the Board pursues disciplinary action and, if action is taken, the physician is normally placed on probation with terms and conditions including submitting to biological fluid testing. It is up to the physicians to seek a program that will assist them in maintaining abstinence.

With the elimination of the Board's Diversion Program, the Board also knew there would be a need for information regarding physician wellness and resources to assist physicians seeking wellness. Therefore, the Board established a Wellness Committee whose main function was to provide articles for the Board's Newsletter regarding physician wellness, locate resources for physicians who are struggling with impairment issues, and entertain presentations on physician wellness. The information gathered by the Wellness Committee was then provided to physicians via the Board's website or Newsletter. This Committee has since been consolidated with the Education Committee.

At the Board's October 2015 Board Meeting, after meetings with consumer groups, provider groups, and physician health programs, the Board adopted elements that a physician health program should include, in order to be supported by the Board. These elements are attached.

ANALYSIS

This bill would authorize establishment of a PHWP within the Board. The PHWP would provide early identification of, and appropriate interventions to support a physician in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety and maintain the integrity of the medical profession. The PHWP shall aid a physician with substance abuse issues impacting his or her ability to practice medicine.

If the Board establishes a program, it shall do all the following:

- Provide for the education of all licensed physician and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.
- Offer assistance to a physician in identifying substance abuse problems.
- Evaluate the extent of substance abuse problems and refer the physician to the appropriate treatment by executing a written agreement with the physician participant.
- Provide for the confidential participation by a physician with substance abuse

issues who is not the subject of a current investigation.

- Comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Section 315.

If the Board establishes a PHWP, it would be required to contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The administering entity would be required to have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals. The administering entity would be required to identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and would be required to establish a process for evaluating the effectiveness of such programs. The administering entity would be required to provide counseling and support for the physician participant and for the family of any physician referred for treatment. The administering entity would have to make their services available to all licensed California physicians, including those who self-refer to the PHWP. The administering entity would be required to have a system for immediately reporting a physician who is terminated from the program to the Board. The system would need to ensure absolute confidentiality in the communication to the Board. The administering entity could not provide this information to any other individual or entity unless authorized by the physician participant. The contract entered into with the Board would need to require the administering entity to do the following:

- Provide regular communication to the Board, including annual reports to the Board with program statistics, including, but not limited to, the number of participants, the number of participants referred by the Board as a condition of probation, the number of participants who successfully completed their agreement period, and the number of participants terminated from the program. The reports would not be allowed to disclose any personally identifiable information.
- Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements and its implementing rules and regulations. Any audit conducted must maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and must not disclose any information identifying a program participant.

If the Board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the Board, the Board would be able to terminate the contract.

This bill would require a physician, as a condition of participation in the PHWP, to enter into an individual agreement with the PHWP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement. The agreement shall include the following:

- A jointly agreed upon plan and mandatory conditions and procedures to

monitor compliance with the program.

- Compliance with terms and conditions of treatment and monitoring.
- Criteria for program completion.
- Criteria for termination of a physician participant from the program.
- Acknowledgement that withdrawal or termination of a physician participant from the program shall be reported to the Board.
- Acknowledgement that expenses related to treatment, monitoring, laboratory tests, and other specified activities shall be paid by the physician participant.

This bill would specify that any agreement entered into would not be considered a disciplinary action or order by the Board and shall not be disclosed if the physician did not enroll in the PHWP as a condition of probation or as a result of an action by the Board and if the physician participant is in compliance with the conditions and procedures in the agreement.

This bill would require any oral or written information reported to the Board to be confidential and shall not constitute a waiver of any existing evidentiary privileges under any provision or rule of law. This bill would specify that confidentiality would not apply if the Board has referred a physician participant as a condition of probation. This bill would specify that it does not prohibit, require, or otherwise affect the discovery or admissibility of evidence in an action by the Board against a physician based on acts or omissions within the course and scope of his or her practice. This bill would specify that any information received, developed or maintained regarding a physician in the program shall not be used for any other purposes. This bill would specify that participation in the program shall not be a defense to any disciplinary action that may be taken by the Board. The requirements in this bill would not preclude the Board from taking disciplinary action against a physician who is terminated unsuccessfully from the program but the disciplinary action may not include any confidential information unless authorized (the information is only confidential if the participant is not on probation and is complying with his or her individual agreement with the PHWP).

This bill would establish the Physician and Surgeon Health and Wellness Program Account in the contingent fund of the Board. Any fees collected by the Board from participants shall be deposited into this account and upon appropriation by the Legislature, shall be available for support of the program. This bill would require the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP shall pay. The fee is required to be set at a level sufficient to cover all costs of participating in the PHWP. This bill would allow the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP. These moneys could not be used to cover costs for individual physicians to participate in the program.

According to the sponsor, this bill will bring California in line with the majority of other states who recognize that wellness and treatment programs serve to enhance public health and provide resources for those in need of help.

The PHWP proposed by this bill is not a diversion program, it will not divert physicians from discipline; this is of utmost importance for consumer protection. The Board will not be running this program, it will be run by a private third-party independent administering entity that will be selected pursuant to the request for proposals process. This bill would require the PHWP to comply with the Uniform Standards and would require any physician participants who terminate or withdraw from the PHWP to be reported to the Board. These are both very important elements for consumer protection. This bill would also allow for communication to the Board for those physicians ordered to the PHWP as a condition of probation, which is also important for consumer protection. Currently, the bills states that physician participants under Board investigation are not allowed confidential participation, however, participants should be provided confidentiality unless they are on probation, they terminate or withdraw from the program, or are subject to disclosure pursuant to the Uniform Standards. Board staff can work with the author's office to ensure that this amendment is made if the Board agrees. Board staff believes that the PHWP proposed by this bill aligns with the Board-approved elements and suggests that the Board support this bill.

FISCAL: This bill would require the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP must pay. The fee is required to be set at a level sufficient to cover all costs of participating in the PHWP. Any fees collected by the Board from participants shall be deposited into the newly established Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Board and, upon appropriation by the Legislature, shall be available for support of the program. This bill would allow the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP.

SUPPORT: CMA (Sponsor)
California Hospital Association
California Psychiatric Association

OPPOSITION: Center for Public Interest Law
Consumer Attorneys of California
Consumers' Union Safe Patient Project
Consumer Watchdog

POSITION: Recommendation: Support

On October 30, 2015, at the Medical Board of California's (Board) Quarterly Board Meeting, the Board approved the following elements of a Physician Health Program that could be supported by the Board:

- Program would have to comply with the Uniform Standards.
- Program should not reside within the Board.
- Program should be run by a private/contracted non-profit entity.
- Program should include adequate protocols for the Program's communication with the Board.
- Program should participate in regularly scheduled meetings with the Board.
- Program should allow both self-referrals and probationers to participate.
- Program must report to the Board any physician who is terminated from the program, for any reason.
- Program does not include diversion – if a complaint/report is received, the Board's enforcement process will be followed, regardless of Program participation.
- Program should maintain clear and regular communication to the Board on the status of probationers in the Program.
- Program participants should share in cost of administering the Program.
- If the required audit finds the Program is not in compliance, there must be repercussions.
- Program should ensure that sufficient resources are available to perform clinical roles and case management roles, with sufficient expertise and experience (50 physicians per case manager).
- Program should only be provided for substance-abusing licensees.
- Program must ensure strict documentation of monitoring.

It is important to mention that the Board will not be sponsoring legislation to create a physician health program, but if legislation is introduced, the Board would want the legislation to include these Board-approved elements.

AMENDED IN SENATE APRIL 20, 2016

AMENDED IN SENATE APRIL 4, 2016

SENATE BILL

No. 1177

Introduced by Senator Galgiani

February 18, 2016

An act to add Article 14 (commencing with Section 2340) to Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1177, as amended, Galgiani. Physician and Surgeon Health and Wellness Program.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards and a designee of the State Department of Health Care Services. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a healing arts board has a formal diversion program. ~~Existing~~

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the department. *Existing law requires all moneys paid to and received by the Medical Board of California to be paid into the state treasury and credited to the Contingent Fund of the Medical Board of California, which, except for fine and penalty money, is a continuously appropriated fund.*

This bill would authorize the board to establish a Physician and Surgeon Health and Wellness Program for the early identification of,

and appropriate interventions to support a physician and surgeon in his or her rehabilitation ~~from~~ *from*, substance abuse, ~~physical or mental health, burnout, or other similar conditions~~, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with ~~an~~ *a private third-party* independent administering entity meeting certain requirements. The bill would require program participants to enter into ~~a contractual~~ *an individual* agreement ~~agreeing to cooperate with all elements of the program designed for the individual participant for successful completion of any treatment or monitoring recommendations~~; *with the program that includes, among other things, a requirement to pay expenses related to treatment, monitoring, and laboratory tests, as provided.*

~~This bill would declare the intent of the Legislature to enact legislation that would authorize an administrative fee to be established by the board to be charged to the individual licensee for participation in the program and require all costs of treatment to be paid by the participant.~~

This bill would create the Physician and Surgeon Health and Wellness Program Account within the Contingent Fund of the Medical Board of California. The bill would require the board to adopt regulations to determine the appropriate fee for a physician and surgeon to participate in the program, as specified. The bill would require these fees to be deposited in the Physician and Surgeon Health and Wellness Program Account and to be available, upon appropriation by the Legislature, for the support of the program. Subject to appropriation by the Legislature, the bill would authorize the board to use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program, except the bill would prohibit these moneys from being used to cover any costs for individual physician and surgeon participation in the program.

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

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

- 1 SECTION 1. Article 14 (commencing with Section 2340) is
- 2 added to Chapter 5 of Division 2 of the Business and Professions
- 3 Code, to read:

1 Article 14. Physician and Surgeon Health and Wellness Program

2
3 ~~2340. (a) The board may establish a Physician and Surgeon~~
4 ~~Health and Wellness Program for the early identification and~~
5 ~~appropriate interventions to support a physician and surgeon in~~
6 ~~his or her rehabilitation from substance abuse, physical or mental~~
7 ~~health, burnout, or other similar conditions to ensure that the~~
8 ~~physician and surgeon remains able to practice medicine in a~~
9 ~~manner that will not endanger the public health and safety and will~~
10 ~~maintain the integrity of the medical profession. The program, if~~
11 ~~established, shall aid a physician and surgeon with those health~~
12 ~~issues impacting his or her ability to practice medicine.~~

13 ~~(b) For the purposes of this article, “program” shall mean the~~
14 ~~Physician and Surgeon Health and Wellness Program.~~

15 ~~(c) If the board establishes a program, the program shall meet~~
16 ~~the requirements of this article.~~

17 ~~2340.2. (a) If the board establishes a program, the board shall~~
18 ~~contract for the program’s administration with an independent~~
19 ~~administering entity that shall do all of the following:~~

20 ~~(1) Provide for the education of physicians and surgeons with~~
21 ~~respect to the recognition and prevention of physical, emotional,~~
22 ~~and psychological problems and provide for intervention when~~
23 ~~necessary or under circumstances that may be established through~~
24 ~~regulations adopted by the board.~~

25 ~~(2) Offer assistance to a physician and surgeon in identifying~~
26 ~~physical, emotional, or psychological problems.~~

27 ~~(3) Evaluate the extent of physical, emotional, or psychological~~
28 ~~problems and refer the physician and surgeon to the appropriate~~
29 ~~treatment.~~

30 ~~(4) Pursuant to regulations adopted by the board addressing~~
31 ~~protocols to report compliance back to the referring entity described~~
32 ~~in paragraph (6), monitor the compliance of a physician and~~
33 ~~surgeon who has been referred for treatment.~~

34 ~~(5) Provide counseling and support for the physician and surgeon~~
35 ~~and for the family of any physician and surgeon referred for~~
36 ~~treatment.~~

37 ~~(6) Agree to receive referrals from the board and other health~~
38 ~~care entities, including, but not limited to, hospital medical staffs,~~
39 ~~well-being committees, and medical corporations.~~

1 ~~(7) Agree to make their services available to all licensed~~
2 ~~California physicians and surgeons.~~

3 ~~(b) For the purposes of the program, an administering entity~~
4 ~~shall mean a private entity contracted to perform the duties~~
5 ~~described in, and meet the requirements of, this article. A request~~
6 ~~for proposals shall be solicited by the board in the selection of the~~
7 ~~administering entity.~~

8 ~~2340.4. The administering entity of the program shall:~~

9 ~~(a) Have expertise and experience in the areas of substance or~~
10 ~~alcohol abuse, and mental disorders in healing arts professionals.~~

11 ~~(b) Evaluate the program's progress, prepare reports and provide~~
12 ~~an annual accounting to the board on noneconfidential, statistical~~
13 ~~information as determined by the board.~~

14 ~~(c) Identify and use a statewide treatment resource network,~~
15 ~~which includes treatment and screening programs and support~~
16 ~~groups.~~

17 ~~(d) Demonstrate a process for evaluating the effectiveness of~~
18 ~~such programs.~~

19 ~~(e) Be subject to an independent audit.~~

20 ~~2340.6. (a) All participants of the program shall enter into a~~
21 ~~contractual agreement agreeing to cooperate with all elements of~~
22 ~~the program designed for the individual participant for successful~~
23 ~~completion of any treatment or monitoring recommendations as~~
24 ~~determined by the administering entity.~~

25 ~~(b) If a participant referred to the program is terminated from~~
26 ~~the program for any reason other than the successful completion~~
27 ~~of the program, the administering entity shall inform the referring~~
28 ~~entity of the participant's termination. If the program determines~~
29 ~~that the continued practice of medicine by that individual creates~~
30 ~~too great a risk to public health, safety, and welfare, that fact shall~~
31 ~~be reported to the referring entity and all documents and~~
32 ~~information pertaining to and supporting that conclusion shall be~~
33 ~~provided to the referring entity.~~

34 ~~(c) Unless required under subdivision (b), all program records~~
35 ~~and documents and records and documents of participation of a~~
36 ~~physician and surgeon in the program shall be confidential and are~~
37 ~~not subject to discovery or subpoena.~~

38 ~~(d) Participation in the program shall not be a defense to any~~
39 ~~disciplinary action that may be taken by the board. This section~~
40 ~~does not preclude the board from commencing disciplinary action~~

1 against a physician and surgeon who is terminated unsuccessfully
2 from the program. However, that disciplinary action may not
3 include as evidence any confidential information, including
4 documents and records described in subdivision (c).

5 2340.8. No program employee, contractor, or agent thereof,
6 shall be liable for any civil or criminal damages because of acts
7 or omissions that may occur while acting in good faith in a program
8 established pursuant to this article.

9 2340.10. (a) It is the intent of the Legislature to enact
10 legislation that would authorize an administrative fee to be
11 established by the board to be charged to the individual licensee
12 for participation in the program and to require all costs of treatment
13 to be paid by the participant.

14 (b) It is the intent of the Legislature to enact legislation that
15 would provide that nothing in this section shall be construed to
16 prohibit additional funding from private contributions from being
17 used to support the operations of the program.

18 2340.12. The Administrative Procedure Act (Chapter 3.5
19 (commencing with Section 11340) of Part 1 of Division 3 of Title
20 2 of the Government Code) shall apply to regulations adopted
21 pursuant to this article.

22 2340. (a) *The board may establish a Physician and Surgeon*
23 *Health and Wellness Program for the early identification of, and*
24 *appropriate interventions to support a physician and surgeon in*
25 *his or her rehabilitation from, substance abuse to ensure that the*
26 *physician and surgeon remains able to practice medicine in a*
27 *manner that will not endanger the public health and safety and*
28 *that will maintain the integrity of the medical profession. The*
29 *program, if established, shall aid a physician and surgeon with*
30 *substance abuse issues impacting his or her ability to practice*
31 *medicine.*

32 (b) *For the purposes of this article, “program” shall mean the*
33 *Physician and Surgeon Health and Wellness Program.*

34 (c) *If the board establishes a program, the program shall meet*
35 *the requirements of this article.*

36 2340.2. (a) *If the board establishes a program, the program*
37 *shall do all of the following:*

38 (1) *Provide for the education of all licensed physicians and*
39 *surgeons with respect to the recognition and prevention of physical,*
40 *emotional, and psychological problems.*

1 (2) Offer assistance to a physician and surgeon in identifying
2 substance abuse problems.

3 (3) Evaluate the extent of substance abuse problems and refer
4 the physician and surgeon to the appropriate treatment by
5 executing a written agreement with a physician and surgeon
6 participant.

7 (4) Provide for the confidential participation by a physician
8 and surgeon with substance abuse issues who is not the subject of
9 a current investigation.

10 (5) Comply with the Uniform Standards Regarding
11 Substance-Abusing Healing Arts Licensees as adopted by the
12 Substance Abuse Coordination Committee of the Department of
13 Consumer Affairs pursuant to Section 315.

14 2340.4. (a) If the board establishes a program, the board shall
15 contract for the program's administration with a private third-party
16 independent administering entity pursuant to a request for
17 proposals. The process for procuring the services for the program
18 shall be administered by the board pursuant to Article 4
19 (commencing with Section 10335) of Chapter 2 of Part 2 of
20 Division 2 of the Public Contract Code. However, Section 10425
21 of the Public Contract Code shall not apply to this subdivision.

22 (b) The administering entity shall have expertise and experience
23 in the areas of substance or alcohol abuse in healing arts
24 professionals.

25 (c) The administering entity shall identify and use a statewide
26 treatment resource network that includes treatment and screening
27 programs and support groups and shall establish a process for
28 evaluating the effectiveness of such programs.

29 (d) The administering entity shall provide counseling and
30 support for the physician and surgeon and for the family of any
31 physician and surgeon referred for treatment.

32 (e) The administering entity shall make their services available
33 to all licensed California physicians and surgeons, including those
34 who self-refer to the program.

35 (f) The administering entity shall have a system for immediately
36 reporting a physician and surgeon who is terminated from the
37 program to the board. This system shall ensure absolute
38 confidentiality in the communication to the board. The
39 administering entity shall not provide this information to any other

1 *individual or entity unless authorized by the participating physician*
2 *and surgeon.*

3 *(g) The contract entered into pursuant to this section shall also*
4 *require the administering entity to do the following:*

5 *(1) Provide regular communication to the board, including*
6 *annual reports to the board with program statistics, including, but*
7 *not limited to, the number of participants currently in the program,*
8 *the number of participants referred by the board as a condition*
9 *of probation, the number of participants who have successfully*
10 *completed their agreement period, and the number of participants*
11 *terminated from the program. In making reports, the administering*
12 *entity shall not disclose any personally identifiable information*
13 *relating to any participant.*

14 *(2) Submit to periodic audits and inspections of all operations,*
15 *records, and management related to the program to ensure*
16 *compliance with the requirements of this article and its*
17 *implementing rules and regulations. Any audit conducted pursuant*
18 *to this section shall maintain the confidentiality of all records*
19 *reviewed and information obtained in the course of conducting*
20 *the audit and shall not disclose any information identifying a*
21 *program participant.*

22 *(h) In the event that the board determines the administering*
23 *entity is not in compliance with the requirements of the program*
24 *or contract entered into with the board, the board may terminate*
25 *the contract.*

26 *2340.6. (a) A physician and surgeon shall, as a condition of*
27 *participation in the program, enter into an individual agreement*
28 *with the program and agree to pay expenses related to treatment,*
29 *monitoring, laboratory tests, and other activities specified in the*
30 *participant's written agreement. The agreement shall include all*
31 *of the following:*

32 *(1) A jointly agreed upon plan and mandatory conditions and*
33 *procedures to monitor compliance with the program.*

34 *(2) Compliance with terms and conditions of treatment and*
35 *monitoring.*

36 *(3) Criteria for program completion.*

37 *(4) Criteria for termination of a physician and surgeon*
38 *participant from the program.*

1 (5) Acknowledgment that withdrawal or termination of a
2 physician and surgeon participant from the program shall be
3 reported to the board.

4 (6) Acknowledgment that expenses related to treatment,
5 monitoring, laboratory tests, and other activities specified by the
6 program shall be paid by the physician and surgeon participant.

7 (b) Any agreement entered into pursuant to this section shall
8 not be considered a disciplinary action or order by the board and
9 shall not be disclosed if both of the following apply:

10 (1) The physician and surgeon did not enroll in the program as
11 a condition of probation or as a result of an action by the board.

12 (2) The physician and surgeon is in compliance with the
13 conditions and procedures in the agreement.

14 (c) Any oral or written information reported to the board shall
15 remain confidential and shall not constitute a waiver of any existing
16 evidentiary privileges under any other provision or rule of law.
17 However, confidentiality regarding the physician and surgeon's
18 participation in the program and related records shall not apply
19 if the board has referred a participant as a condition of probation.

20 (d) Nothing in this section prohibits, requires, or otherwise
21 affects the discovery or admissibility of evidence in an action by
22 the board against a physician and surgeon based on acts or
23 omissions within the course and scope of his or her practice.

24 (e) Any information received, developed, or maintained
25 regarding a physician and surgeon in the program shall not be
26 used for any other purposes.

27 (f) Participation in the program shall not be a defense to any
28 disciplinary action that may be taken by the board. This section
29 does not preclude the board from commencing disciplinary action
30 against a physician and surgeon who is terminated unsuccessfully
31 from the program. However, that disciplinary action may not
32 include as evidence any confidential information unless authorized
33 by this section.

34 2340.8. (a) The Physician and Surgeon Health and Wellness
35 Program Account is hereby established within the Contingent Fund
36 of the Medical Board of California. Any fees collected by the board
37 pursuant to subdivision (b) shall be deposited in the Physician and
38 Surgeon Health and Wellness Program Account and shall be
39 available, upon appropriation by the Legislature, for the support
40 of the program.

1 ***(b) The board shall adopt regulations to determine the***
2 ***appropriate fee that a physician and surgeon participating in the***
3 ***program shall provide to the board. The fee amount adopted by***
4 ***the board shall be set at a level sufficient to cover all costs for***
5 ***participating in the program.***

6 ***(c) Subject to appropriation by the Legislature, the board may***
7 ***use moneys from the Contingent Fund of the Medical Board of***
8 ***California to support the initial costs for the board to establish***
9 ***the program under this article, except these moneys shall not be***
10 ***used to cover any costs for individual physician and surgeon***
11 ***participation in the program.***

12 ***2340.10. The Administrative Procedure Act (Chapter 3.5***
13 ***(commencing with Section 11340) of Part 1 of Division 3 of Title***
14 ***2 of the Government Code) shall apply to regulations adopted***
15 ***pursuant to this article.***

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1189
Author: Pan and Jackson
Bill Date: April 26, 2016, Amended
Subject: Autopsies: Licensed Physicians and Surgeons
Sponsor: Union of American Physicians and Dentists (UAPD)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that a forensic autopsy is the practice of medicine and can only be conducted by a licensed physician and surgeon.

BACKGROUND

California law does not define the term “autopsy”, but a 1970 opinion of the California Attorney General states that an autopsy is a “form of postmortem examination in which a dead body is examined and at least partially dissected for the purpose of ascertaining the cause of death, the nature and extent of lesions of disease, or any other abnormalities present.”

The Ventura County District Attorney’s (DA) Office published a report in February 2016 entitled “A Report on the Ventura County Medical Examiner Investigation.” In this report, the Ventura County DA reviews the investigation it conducted on Ventura County’s former Medical Examiner, and discusses the obstacles faced by the DA’s office in pursuing criminal action. In the report, it brings up several grey areas of law related to autopsies and who can perform them. The report states that there is no California law that defines an autopsy and there is no statute that clearly defines that performance of an autopsy is the practice of medicine. The report also states there is a need for legislation to clarify whether the performance of an autopsy is included in the practice of medicine.

Fifty of California’s 58 counties have sheriff-coroner offices, which means that the two offices are consolidated and the sheriff also serves as the coroner. There are sections in the Government Code that authorize the coroner to perform autopsies. There is also a section in the Health and Safety Code that allows an autopsy to be performed by a coroner or other officer authorized by law to perform autopsies. The definition of the practice of medicine in the Medical Practice Act does not specifically address that conducting an autopsy on a dead body constitutes the practice of medicine. The Ventura County DA’s office makes recommendations in the conclusion of its report that the Legislature should consider amending existing law to clarify whether an autopsy is the practice of medicine and to define the term autopsy.

ANALYSIS

This bill would require a forensic autopsy to be considered the practice of medicine and would expressly state that forensic autopsies can only be conducted by a licensed physician and surgeon. This bill would require that the results of an autopsy may only be determined by a licensed physician and surgeon. This bill would define a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined. This bill would permit law enforcement personnel who have completed specified training to be allowed into the autopsy suite at the discretion of the licensed physician and surgeon. This bill would prohibit, if an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved with the care and custody of that individual from being involved with any portion of the forensic autopsy. This bill would require police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to the death that is incident to law enforcement activity to be made available to the licensed physician and surgeon prior to the completion of the investigation of the death. This bill would make conforming changes to other portions of the Government Code that reference autopsies.

According to the authors, a medically trained physician and surgeon is best equipped to determine the cause of death and provide an accurate report. Clarifying that a medically trained professional should be the one who conducts the autopsy also clarifies ambiguities in existing law. The sponsor of this bill believes that elected officials lack the medical expertise necessary to perform an autopsy to the same degree as a licensed physician and surgeon and this bill seeks to add further legitimacy and authority to death investigations in coroner cases.

In reading the Ventura County DA report, and in discussions with Senator Jackson's office, Board staff believes there are grey areas in the law related to autopsies being the practice of medicine and who can perform autopsies. It should be made clear in the law that autopsies are the practice of medicine and can only be performed by licensed physicians and surgeons. This clarification will assist the Board in its enforcement actions and further the Board's mission of consumer protection. For these reasons, Board staff suggests the Board take a support position on this bill.

FISCAL: None

SUPPORT: UAPD (Sponsor)
Consumer Attorneys of California
National Association of Medical Examiners
Three Individuals

OPPOSITION: California Hospital Association (unless amended)
California State Sheriff's Association

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 26, 2016
AMENDED IN SENATE APRIL 13, 2016
AMENDED IN SENATE MARCH 28, 2016

SENATE BILL

No. 1189

Introduced by Senators Pan and Jackson

February 18, 2016

An act to amend Sections 27491.4, 27491.41, 27491.43, 27491.46, 27491.47, and 27520 of, and to add Section 27522 to, the Government Code, relating to autopsies.

LEGISLATIVE COUNSEL'S DIGEST

SB 1189, as amended, Pan. Postmortem examinations or autopsies: forensic pathologists.

Existing law requires a county coroner to inquire into and determine the circumstances, manner, and cause of certain deaths. Existing law either requires or authorizes a county coroner, under certain circumstances, to perform, or cause to be performed, an autopsy on a decedent. Existing law imposes certain requirements on a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains.

Existing law authorizes the board of supervisors of a county to consolidate the duties of certain county offices in one or more of specified combinations, including, but not limited to, sheriff and coroner, district attorney and coroner, and public administrator and coroner. Existing law authorizes the board of supervisors of a county to abolish the office of coroner and provide instead for the office of medical examiner, as specified, and requires the medical examiner to be a

licensed physician and surgeon duly qualified as a specialist in pathology.

This bill would require that a forensic autopsy, as defined, be conducted by a licensed physician and surgeon. The bill would require that the results of a postmortem examination or autopsy, as specified, forensic autopsy and the cause and manner of death be determined by a licensed physician and surgeon who is a forensic pathologist, preferably a diplomat of the American Board of Pathology. surgeon.

~~This bill would also require blood and urine specimens collected from a patient at the time of admission to a hospital, if the patient is admitted under specified circumstances, to be retained until the patient is discharged from the hospital. The bill would require the specimens to be released to the coroner if the patient dies prior to discharge.~~

~~This~~

The bill would require, for health and safety purposes, that all persons in the autopsy suite have current bloodborne pathogen training and personal protective equipment, as specified. The bill would provide that police and other law enforcement personnel who have completed the specified training may be allowed into the autopsy suite at the discretion of the forensic pathologist, but would prohibit law enforcement personnel directly involved with the care and custody of an individual who died incident to due to involvement of law enforcement activity from being involved with any portion of the postmortem examination or being inside the autopsy suite during the performance of the autopsy. The bill would define a postmortem examination for this purpose to be the external examination of the body where no manner or cause of death is determined.

~~This~~

The bill would require specified materials that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity to be made available to the forensic pathologist prior to the completion of the investigation of the death.

The bill would specify that these provisions shall not be construed to limit the practice of an autopsy for educational or research purposes.

By imposing additional duties upon local officials and law enforcement agencies, this bill would create a state-mandated local program.

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

~~This~~

The bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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 27491.4 of the Government Code is
2 amended to read:

3 27491.4. (a) For purposes of inquiry the coroner shall, within
4 24 hours or as soon as feasible thereafter, where the suspected
5 cause of death is sudden infant death syndrome and, in all other
6 cases, the coroner may, in his or her discretion, take possession of
7 the body, which shall include the authority to exhume the body,
8 order it removed to a convenient place, and make or cause to be
9 made a postmortem ~~examination~~ examination, or cause to be made
10 an autopsy thereon, and make or cause to be made an analysis of
11 the stomach, stomach contents, blood, organs, fluids, or tissues of
12 the body. The detailed medical findings resulting from an
13 inspection of the body or autopsy by an examining *licensed*
14 physician *and surgeon* shall be either reduced to writing or
15 permanently preserved on recording discs or other similar recording
16 media, shall include all positive and negative findings pertinent to
17 establishing the cause of death in accordance with medicolegal
18 practice and this, along with the written opinions and conclusions
19 of the examining ~~physician~~, *licensed physician and surgeon*, shall
20 be included in the coroner's record of the death. The coroner shall
21 have the right to retain only those tissues of the body removed at
22 the time of the autopsy as may, in his or her opinion, be necessary
23 or advisable to the inquiry into the case, or for the verification of
24 his or her findings. No person may be present during the
25 performance of a coroner's an autopsy without the express consent
26 of the coroner. *licensed physician and surgeon who is conducting*
27 *the autopsy.*

28 (b) In any case in which the coroner knows, or has reason to
29 believe, that the deceased has made valid provision for the
30 disposition of his or her body or a part or parts thereof for medical

1 or scientific purposes in accordance with Chapter 3.5 (commencing
2 with Section 7150) of Part 1 of Division 7 of the Health and Safety
3 Code, the coroner shall neither perform nor authorize any other
4 person to perform an autopsy on the body unless the coroner has
5 contacted or attempted to contact the physician last in attendance
6 to the deceased. If the physician cannot be contacted, the coroner
7 shall then notify or attempt to notify one of the following of the
8 need for an autopsy to determine the cause of death: (1) the
9 surviving spouse; (2) a surviving child or parent; (3) a surviving
10 brother or sister; (4) any other kin or person who has acquired the
11 right to control the disposition of the remains. Following a period
12 of 24 hours after attempting to contact the physician last in
13 attendance and notifying or attempting to notify one of the
14 responsible parties listed above, the coroner may ~~perform or~~
15 authorize the performance of an autopsy, as otherwise authorized
16 or required by law.

17 (c) Nothing in this section shall be deemed to prohibit the
18 discretion of the coroner to ~~conduct autopsies~~ *cause to be*
19 *conducted an autopsy* upon any victim of sudden, unexpected, or
20 unexplained death or any death known or suspected of resulting
21 from an accident, suicide, or apparent criminal means, or other
22 death, as described in Section 27491.

23 *SEC. 2. Section 27491.41 of the Government Code is amended*
24 *to read:*

25 27491.41. (a) For purposes of this section, “sudden infant
26 death syndrome” means the sudden death of any infant that is
27 unexpected by the history of the infant and where a thorough
28 postmortem examination fails to demonstrate an adequate cause
29 of death.

30 (b) The Legislature finds and declares that sudden infant death
31 syndrome (SIDS) is the leading cause of death for children under
32 age one, striking one out of every 500 children. The Legislature
33 finds and declares that sudden infant death syndrome is a serious
34 problem within the State of California, and that public interest is
35 served by research and study of sudden infant death syndrome,
36 and its potential causes and indications.

37 (c) (1) To facilitate these purposes, the coroner shall, within
38 24 hours, or as soon thereafter as feasible, ~~perform~~ *cause* an
39 autopsy *to be performed* in any case where an infant has died
40 suddenly and unexpectedly.

1 (2) However, if the attending *licensed physician and surgeon*
2 desires to certify that the cause of death is sudden infant death
3 syndrome, an autopsy may be performed at the discretion of the
4 coroner. If the coroner ~~performs~~ *causes an autopsy to be performed*
5 pursuant to this section, he or she shall also certify the cause of
6 death.

7 (d) The autopsy shall be conducted pursuant to a standardized
8 protocol developed by the State Department of Health Services.
9 The protocol is exempt from the procedural requirements pertaining
10 to the adoption of administrative rules and regulations pursuant to
11 Article 5 (commencing with Section 11346) of Chapter 3.5 of Part
12 1 of Division 3 of Title 2 of the Government Code. The protocol
13 shall be developed and approved by July 1, 1990.

14 (e) The protocol shall be followed by all ~~coroners~~ *licensed*
15 *physicians and surgeons* throughout the state when conducting the
16 autopsies required by this section. The coroner shall state on the
17 certificate of death that sudden infant death syndrome was the
18 cause of death when the ~~coroner's~~ *licensed physician and surgeon's*
19 findings are consistent with the definition of sudden infant death
20 syndrome specified in the standardized autopsy protocol. The
21 protocol may include requirements and standards for scene
22 investigations, requirements for specific data, criteria for
23 ascertaining cause of death based on the autopsy, and criteria for
24 any specific tissue sampling, and any other requirements. The
25 protocol may also require that specific tissue samples must be
26 provided to a central tissue repository designated by the State
27 Department of Health Services.

28 (f) The State Department of Health Services shall establish
29 procedures and protocols for access by researchers to any tissues,
30 or other materials or data authorized by this section. Research may
31 be conducted by any individual with a valid scientific interest and
32 prior approval from the State Committee for the Protection of
33 Human Subjects. The tissue samples, the materials, and all data
34 shall be subject to the confidentiality requirements of Section
35 103850 of the Health and Safety Code.

36 (g) The coroner may take tissue samples for research purposes
37 from infants who have died suddenly and unexpectedly without
38 consent of the responsible adult if the tissue removal is not likely
39 to result in any visible disfigurement.

1 (h) A coroner *or licensed physician and surgeon* shall not be
2 liable for damages in a civil action for any act or omission done
3 in compliance with this section.

4 (i) No consent of any person is required prior to undertaking
5 the autopsy required by this section.

6 *SEC. 3. Section 27491.43 of the Government Code is amended*
7 *to read:*

8 27491.43. (a) (1) Notwithstanding any other ~~provision of law,~~
9 except as otherwise provided in this section in any case in which
10 the ~~coroner,~~ *licensed physician and surgeon*, before beginning an
11 autopsy, dissection, or removal of corneal tissue, pituitary glands,
12 or any other organ, tissue, or fluid, has received a certificate of
13 religious belief, executed by the decedent as provided in
14 subdivision (b), that the procedure would be contrary to his or her
15 religious belief, the coroner shall not perform that procedure on
16 the body of the decedent.

17 (2) If, before beginning the procedure, the coroner *or licensed*
18 *physician and surgeon* is informed by a relative or a friend of the
19 decedent that the decedent had executed a certificate of religious
20 belief, the ~~coroner~~ *licensed physician and surgeon* shall not perform
21 the procedure, except as otherwise provided in this section, for 48
22 hours. If the certificate is produced within 48 hours, the case shall
23 be governed by this section. If the certificate is not produced within
24 that time, the case shall be governed by the other provisions of
25 this article.

26 (b) Any person, 18 years of age or older, may execute a
27 certificate of religious belief which shall state in clear and
28 unambiguous language that any postmortem anatomical dissection
29 or that specified procedures would violate the religious convictions
30 of the person. The certificate shall be signed and dated by the
31 person in the presence of at least two witnesses. Each witness shall
32 also sign the certificate and shall print on the certificate his or her
33 name and residence address.

34 (c) Notwithstanding the existence of a certificate, the coroner
35 may at any time ~~perform~~ *cause an autopsy to be performed* or any
36 other procedure if he or she has a reasonable suspicion that the
37 death was caused by the criminal act of another or by a contagious
38 disease constituting a public health hazard.

39 (d) (1) If a certificate is produced, and if subdivision (c) does
40 not apply, the coroner may petition the superior court, without fee,

1 for an order authorizing an autopsy or other procedure or for an
2 order setting aside the certificate as invalid. Notice of the
3 proceeding shall be given to the person who produced the
4 certificate. The proceeding shall have preference over all other
5 cases.

6 (2) The court shall set aside the certificate if it finds that the
7 certificate was not properly executed or that it does not clearly
8 state the decedent's religious objection to the proposed procedure.

9 (3) The court may order an autopsy or other procedure despite
10 a valid certificate if it finds that the cause of death is not evident,
11 and that the interest of the public in determining the cause of death
12 outweighs its interest in permitting the decedent and like persons
13 fully to exercise their religious convictions.

14 (4) Any procedure performed pursuant to paragraph (3) shall
15 be the least intrusive procedure consistent with the order of the
16 court.

17 (5) If the petition is denied, and no stay is granted, the body of
18 the deceased shall immediately be released to the person authorized
19 to control its disposition.

20 (e) In any case in which the circumstances, manner, or cause
21 of death is not determined because of the provisions of this section,
22 the coroner may state on the certificate of death that an autopsy
23 was not conducted because of the provisions of this section.

24 (f) A coroner shall not be liable for damages in a civil action
25 for any act or omission taken in compliance with the provisions
26 of this section.

27 *SEC. 4. Section 27491.46 of the Government Code is amended*
28 *to read:*

29 27491.46. (a) The coroner shall have the right to retain
30 pituitary glands solely for transmission to a university, for use in
31 research or the advancement of medical science, in those cases in
32 which the coroner has *required an autopsy to be performed*~~an~~
33 ~~autopsy~~ pursuant to this chapter, and during a 48-hour period
34 following such autopsy the body has not been claimed and the
35 coroner has not been informed of any relatives of the decedent.

36 (b) In the course of any ~~autopsy performed by the coroner,~~
37 ~~autopsy,~~ the coroner may ~~remove~~ *cause to be removed* the pituitary
38 gland from the body for transmittal to any public agency for use
39 in manufacturing a hormone necessary for the physical growth of
40 persons who are, or may become, hypopituitary dwarfs, if the

1 coroner has no knowledge of objection to the removal and release
2 of the pituitary gland having been made by the decedent or any
3 other person specified in Section 7151.5 of the Health and Safety
4 Code. Neither the coroner nor the medical examiner authorizing
5 the removal of the pituitary gland, nor any hospital, medical center,
6 tissue bank, storage facility, or person acting upon the request,
7 order, or direction of the coroner or medical examiner in the
8 removal of the pituitary gland pursuant to this section, shall incur
9 civil liability for the removal of the pituitary gland in an action
10 brought by any person who did not object prior to the removal of
11 the pituitary gland, nor be subject to criminal prosecution for
12 removal of the pituitary gland pursuant to the authority of this
13 section.

14 Nothing in this subdivision shall supersede the terms of any gift
15 made pursuant to Chapter 3.5 (commencing with Section 7150)
16 of Part 1 of Division 7 of the Health and Safety Code.

17 *SEC. 5. Section 27491.47 of the Government Code is amended*
18 *to read:*

19 27491.47. (a) Notwithstanding any other ~~provision of law~~, the
20 coroner may, in the course of an autopsy, ~~remove and release or~~
21 authorize the removal and release of corneal eye tissue from a
22 body within the coroner's custody, if all of the following conditions
23 are met:

24 (1) The autopsy has otherwise been authorized.

25 (2) The coroner has no knowledge of objection to the removal
26 and release of corneal tissue having been made by the decedent or
27 any other person specified in Section 7151 of the Health and Safety
28 Code and has obtained any one of the following:

29 (A) A dated and signed written consent by the donor or any
30 other person specified in Section 7151 of the Health and Safety
31 Code on a form that clearly indicates the general intended use of
32 the tissue and contains the signature of at least one witness.

33 (B) Proof of the existence of a recorded telephonic consent by
34 the donor or any other person specified in Section 7151 of the
35 Health and Safety Code in the form of an audio recording of the
36 conversation or a transcript of the recorded conversation, which
37 indicates the general intended use of the tissue.

38 (C) A document recording a verbal telephonic consent by the
39 donor or any other person specified in Section 7151 of the Health
40 and Safety Code, witnessed and signed by no fewer than two

1 members of the requesting entity, hospital, eye bank, or
2 procurement organization, memorializing the consenting person's
3 knowledge of and consent to the general intended use of the gift.

4 The form of consent obtained under subparagraph (A), (B), or
5 (C) shall be kept on file by the requesting entity and the official
6 agency for a minimum of three years.

7 (3) The removal of the tissue will not unnecessarily mutilate
8 the body, be accomplished by enucleation, nor interfere with the
9 autopsy.

10 (4) The tissue will be removed by a ~~coroner~~, licensed physician
11 and ~~surgeon~~, *surgeon* or a trained transplant technician.

12 (5) The tissue will be released to a public or nonprofit facility
13 for transplant, therapeutic, or scientific purposes.

14 (b) Neither the coroner nor medical examiner authorizing the
15 removal of the corneal tissue, nor any hospital, medical center,
16 tissue bank, storage facility, or person acting upon the request,
17 order, or direction of the coroner or medical examiner in the
18 removal of corneal tissue pursuant to this section, shall incur civil
19 liability for the removal in an action brought by any person who
20 did not object prior to the removal of the corneal tissue, nor be
21 subject to criminal prosecution for the removal of the corneal tissue
22 pursuant to this section.

23 (c) This section shall not be construed to interfere with the
24 ability of a person to make an anatomical gift pursuant to the
25 Uniform Anatomical Gift Act (Chapter 3.5 (commencing with
26 Section 7150) of Part 1 of Division 7 of the Health and Safety
27 Code).

28 *SEC. 6. Section 27520 of the Government Code is amended to*
29 *read:*

30 27520. (a) The coroner shall ~~perform or~~ cause to be performed
31 an autopsy on a decedent, for which an autopsy has not already
32 been performed, if the surviving spouse requests him *or her* to do
33 so in writing. If there is no surviving spouse, the coroner shall
34 ~~perform the cause an~~ *autopsy to be performed* if requested to do
35 so in writing by a surviving child or parent, or if there is no
36 surviving child or parent, by the next of kin of the deceased.

37 (b) The coroner may ~~perform or~~ cause to be performed an
38 autopsy on a decedent, for which an autopsy has already been
39 performed, if the surviving spouse requests him *or her* to do so in
40 writing. If there is no surviving spouse, the coroner may ~~perform~~

1 ~~the cause an autopsy to be performed~~ if requested to do so in
 2 writing by a surviving child or parent, or if there is no surviving
 3 child or parent, by the next of kin of the deceased.

4 (c) The cost of an autopsy requested pursuant to either
 5 subdivision (a) or (b) shall be borne by the person requesting that
 6 it be performed.

7 SECTION 1.

8 SEC. 7. Section 27522 is added to the Government Code, to
 9 read:

10 27522. (a) *A forensic autopsy shall only be conducted by a*
 11 *licensed physician and surgeon.* The results of a ~~postmortem~~
 12 ~~examination or forensic autopsy and the cause and manner of death~~
 13 shall *only* be determined by a licensed physician and ~~surgeon who~~
 14 is a forensic pathologist, preferably a diplomat of the American
 15 Board of Pathology. *surgeon.*

16 (b) ~~For purposes of this section, a postmortem examination or~~
 17 ~~autopsy includes, but is not limited to, the following items, if~~
 18 ~~physically feasible:~~

19 (1) ~~Procedures described in subdivision (b) of Section 27521.~~

20 (2) ~~An analysis of the blood, vitreous fluid, urine, bile, stomach~~
 21 ~~contents, other tissues or bodily fluids, or organs of the body.~~

22 (3) ~~The examination or removal, or both, of the internal organs~~
 23 ~~of the body.~~

24 (4) ~~The retention of any organs or tissues of the body as part of~~
 25 ~~the investigation of the death.~~

26 (5) ~~Any laboratory analysis, chemical testing, or imaging~~
 27 ~~performed as part of the investigation of the death.~~

28 (e) ~~If a patient is admitted to a hospital with a life-threatening~~
 29 ~~injury, or is under the influence of an intoxicating substance, as~~
 30 ~~determined by the attending physician at the hospital, or was in~~
 31 ~~the custody of a law enforcement agency within 24 hours of~~
 32 ~~admission to the hospital, blood and urine specimens collected~~
 33 ~~from the patient at the time of admission shall be retained until the~~
 34 ~~patient is discharged from the hospital. If the patient dies prior to~~
 35 ~~discharge, the specimens shall be released to the coroner.~~

36 (b) *A forensic autopsy shall be defined as an examination of a*
 37 *body of a decedent to generate medical evidence for which the*
 38 *cause and manner of death is determined.*

1 (c) For purposes of this section, a postmortem examination shall
2 be defined as the external examination of the body where no
3 manner or cause of death is determined.

4 (d) For health and safety purposes, all persons in the autopsy
5 suite shall have current bloodborne pathogen training and personal
6 protective equipment in accordance with the requirements described
7 in Section 5193 of Title 8 of the California Code of Regulations
8 or its successor.

9 (e) (1) Police and other law enforcement personnel who have
10 completed training as described in subdivision (d) may be allowed
11 into the autopsy suite at the discretion of the forensic pathologist.

12 (2) Notwithstanding paragraph (1), if an individual dies ~~incident~~
13 ~~to~~ due to the involvement of law enforcement activity, law
14 enforcement personnel directly involved with the care and custody
15 of that individual shall not be involved with any portion of the
16 postmortem examination, nor allowed inside the autopsy suite
17 during the performance of the autopsy.

18 (f) Any police reports, crime scene or other information, videos,
19 or laboratory tests that are in the possession of law enforcement
20 and are related to a death that is incident to law enforcement
21 activity shall be made available to the forensic pathologist prior
22 to the completion of the investigation of the death.

23 (g) This section shall not be construed to limit the practice of
24 an autopsy for educational or research purposes.

25 ~~SEC. 2.~~

26 SEC. 8. If the Commission on State Mandates determines that
27 this act contains costs mandated by the state, reimbursement to
28 local agencies and school districts for those costs shall be made
29 pursuant to Part 7 (commencing with Section 17500) of Division
30 4 of Title 2 of the Government Code.

AMENDED IN SENATE APRIL 6, 2016

SENATE BILL

No. 1195

Introduced by Senator Hill

February 18, 2016

An act to amend Sections ~~4800 and 4804.5~~ of 109, 116, 153, 307, 313.1, 2708, 4800, 4804.5, 4825.1, 4830, and 4846.5 of, and to add Sections 4826.3, 4826.5, 4826.7, 4848.1, and 4853.7 to, the Business and Professions Code, and to amend Sections 825, 11346.5, 11349, and 11349.1 of the Government Code, relating to ~~healing arts~~, professional regulation, and making an appropriation therefor.

LEGISLATIVE COUNSEL'S DIGEST

SB 1195, as amended, Hill. ~~Veterinary Medical Board: executive officer.~~ Professions and vocations: board actions: competitive impact.

(1) Existing law provides for the licensure and regulation of various professions and vocations by boards within the Department of Consumer Affairs, and authorizes those boards to adopt regulations to enforce the laws pertaining to the profession and vocation for which they have jurisdiction. Existing law makes decisions of any board within the department pertaining to setting standards, conducting examinations, passing candidates, and revoking licenses final, except as specified, and provides that those decisions are not subject to review by the Director of Consumer Affairs. Existing law authorizes the director to audit and review certain inquiries and complaints regarding licensees, including the dismissal of a disciplinary case. Existing law requires the director to annually report to the chairpersons of certain committees of the Legislature information regarding findings from any audit, review, or monitoring and evaluation. Existing law authorizes the director to contract for services of experts and consultants where necessary.

Existing law requires regulations, except those pertaining to examinations and qualifications for licensure and fee changes proposed or promulgated by a board within the department, to comply with certain requirements before the regulation or fee change can take effect, including that the director is required to be notified of the rule or regulation and given 30 days to disapprove the regulation. Existing law prohibits a rule or regulation that is disapproved by the director from having any force or effect, unless the director's disapproval is overridden by a unanimous vote of the members of the board, as specified.

This bill would instead authorize the director, upon his or her own initiative, and require the director, upon the request of a consumer or licensee, to review a decision or other action, except as specified, of a board within the department to determine whether it unreasonably restrains trade and to approve, disapprove, or modify the board decision or action, as specified. The bill would require the director to post on the department's Internet Web site his or her final written decision and the reasons for the decision within 90 days from receipt of the request of a consumer or licensee. The bill would, commencing on March 1, 2017, require the director to annually report to the chairs of specified committees of the Legislature information regarding the director's disapprovals, modifications, or findings from any audit, review, or monitoring and evaluation. The bill would authorize the director to seek, designate, employ, or contract for the services of independent antitrust experts for purposes of reviewing board actions for unreasonable restraints on trade. The bill would also require the director to review and approve any regulation promulgated by a board within the department, as specified. The bill would authorize the director to modify any regulation as a condition of approval, and to disapprove a regulation because it would have an impermissible anticompetitive effect. The bill would prohibit any rule or regulation from having any force or effect if the director does not approve the regulation because it has an impermissible anticompetitive effect.

(2) Existing law, until January 1, 2018, provides for the licensure and regulation of registered nurses by the Board of Registered Nursing, which is within the Department of Consumer Affairs, and requires the board to appoint an executive officer who is a nurse currently licensed by the board.

This bill would instead prohibit the executive officer from being a licensee of the board.

~~The~~

(3) *The Veterinary Medicine Practice Act provides for the licensure and registration of veterinarians and registered veterinary technicians and the regulation of the practice of veterinary medicine by the Veterinary Medical Board, which is within the Department of Consumer Affairs, and authorizes the board to appoint an executive officer, as specified. Existing law repeals the provisions establishing the board and authorizing the board to appoint an executive officer as of January 1, 2017. That act exempts certain persons from the requirements of the act, including a veterinarian employed by the University of California or the Western University of Health Sciences while engaged in the performance of specified duties. That act requires all premises where veterinary medicine, dentistry, and surgery is being practiced to register with the board. That act requires all fees collected on behalf of the board to be deposited into the Veterinary Medical Board Contingent Fund, which continuously appropriates fees deposited into the fund. That act makes a violation of any provision of the act punishable as a misdemeanor.*

This bill would extend the operation of the board and the authorization of the board to appoint an executive officer to January 1, 2021. *The bill would authorize a veterinarian and registered veterinary technician who is under the direct supervision of a veterinarian with a current and active license to compound a drug for anesthesia, the prevention, cure, or relief of a wound, fracture, bodily injury, or disease of an animal in a premises currently and actively registered with the board, as specified. The bill would authorize the California State Board of Pharmacy and the board to ensure compliance with these requirements. The bill would instead require veterinarians engaged in the practice of veterinary medicine employed by the University of California or by the Western University of Health Sciences while engaged in the performance of specified duties to be licensed as a veterinarian in the state or hold a university license issued by the board. The bill would require an applicant for a university license to meet certain requirements, including that the applicant passes a specified exam. The bill would also prohibit a premise registration that is not renewed within 5 years after its expiration from being renewed, restored, reissued, or reinstated; however, the bill would authorize a new premise registration to be issued to an applicant if no fact, circumstance, or condition exists that would justify the revocation or suspension of the registration if the registration was issued and if specified fees are paid. By requiring*

additional persons to be licensed and pay certain fees that would go into a continuously appropriated fund, this bill would make an appropriation. By requiring additional persons to be licensed under the act that were previously exempt, this bill would expand the definition of an existing crime and would, therefore, result in a state-mandated local program.

(4) Existing law, except as provided, requires a public entity to pay any judgment or any compromise or settlement of a claim or action against an employee or former employee of the public entity if the employee or former employee requests the public entity to defend him or her against any claim or action against him or her for an injury arising out of an act or omission occurring within the scope of his or her employment as an employee of the public entity, the request is made in writing not less than 10 days before the day of trial, and the employee or former employee reasonably cooperates in good faith in the defense of the claim or action.

This bill would require a public entity to pay a judgment or settlement for treble damage antitrust awards against a member of a regulatory board for an act or omission occurring within the scope of his or her employment as a member of a regulatory board.

(5) The Administrative Procedure Act governs the procedure for the adoption, amendment, or repeal of regulations by state agencies and for the review of those regulatory actions by the Office of Administrative Law. That act requires the review by the office to follow certain standards, including, among others, necessity, as defined. That act requires an agency proposing to adopt, amend, or repeal a regulation to prepare a notice to the public that includes specified information, including reference to the authority under which the regulation is proposed.

This bill would add competitive impact, as defined, as an additional standard for the office to follow when reviewing regulatory actions of a state board on which a controlling number of decisionmakers are active market participants in the market that the board regulates, and requires the office to, among other things, consider whether the anticompetitive effects of the proposed regulation are clearly outweighed by the public policy merits. The bill would authorize the office to designate, employ, or contract for the services of independent antitrust or applicable economic experts when reviewing proposed regulations for competitive impact. The bill would require state boards on which a controlling number of decisionmakers are active market participants

in the market that the board regulates, when preparing the public notice, to additionally include a statement that the agency has evaluated the impact of the regulation on competition and that the effect of the regulation is within a clearly articulated and affirmatively expressed state law or policy.

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

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

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

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

1 SECTION 1. Section 109 of the Business and Professions Code
2 is amended to read:

3 ~~109. (a) The decisions of any of the boards comprising the~~
4 ~~department with respect to setting standards, conducting~~
5 ~~examinations, passing candidates, and revoking licenses, are not~~
6 ~~subject to review by the director, but are final within the limits~~
7 ~~provided by this code which are applicable to the particular board,~~
8 ~~except as provided in this section.~~

9 ~~(b)~~

10 109. (a) The director may initiate an investigation of any
11 allegations of misconduct in the preparation, administration, or
12 scoring of an examination which is administered by a board, or in
13 the review of qualifications which are a part of the licensing process
14 of any board. A request for investigation shall be made by the
15 director to the Division of Investigation through the chief of the
16 division or to any law enforcement agency in the jurisdiction where
17 the alleged misconduct occurred.

18 ~~(c)~~

19 (b) (1) The director may intervene in any matter of any board
20 where an investigation by the Division of Investigation discloses
21 probable cause to believe that the conduct or activity of a board,
22 or its members or employees constitutes a violation of criminal
23 law.

24 ~~The~~

1 (2) ~~The term “intervene,” as used in paragraph (c) of this section~~
2 (1) may include, but is not limited to, an application for a
3 restraining order or injunctive relief as specified in Section 123.5,
4 or a referral or request for criminal prosecution. For purposes of
5 this section, the director shall be deemed to have standing under
6 Section 123.5 and shall seek representation of the Attorney
7 General, or other appropriate counsel in the event of a conflict in
8 pursuing that action.

9 (c) *The director may, upon his or her own initiative, and shall,*
10 *upon request by a consumer or licensee, review any board decision*
11 *or other action to determine whether it unreasonably restrains*
12 *trade. Such a review shall proceed as follows:*

13 (1) *The director shall assess whether the action or decision*
14 *reflects a clearly articulated and affirmatively expressed state law.*
15 *If the director determines that the action or decision does not*
16 *reflect a clearly articulated and affirmatively expressed state law,*
17 *the director shall disapprove the board action or decision and it*
18 *shall not go into effect.*

19 (2) *If the action or decision is a reflection of clearly articulated*
20 *and affirmatively expressed state law, the director shall assess*
21 *whether the action or decision was the result of the board’s*
22 *exercise of ministerial or discretionary judgment. If the director*
23 *finds no exercise of discretionary judgment, but merely the direct*
24 *application of statutory or constitutional provisions, the director*
25 *shall close the investigation and review of the board action or*
26 *decision.*

27 (3) *If the director concludes under paragraph (2) that the board*
28 *exercised discretionary judgment, the director shall review the*
29 *board action or decision as follows:*

30 (A) *The director shall conduct a full review of the board action*
31 *or decision using all relevant facts, data, market conditions, public*
32 *comment, studies, or other documentary evidence pertaining to*
33 *the market impacted by the board’s action or decision and*
34 *determine whether the anticompetitive effects of the action or*
35 *decision are clearly outweighed by the benefit to the public. The*
36 *director may seek, designate, employ, or contract for the services*
37 *of independent antitrust or economic experts pursuant to Section*
38 *307. These experts shall not be active participants in the market*
39 *affected by the board action or decision.*

1 (B) If the board action or decision was not previously subject
2 to a public comment period, the director shall release the subject
3 matter of his or her investigation for a 30-day public comment
4 period and shall consider all comments received.

5 (C) If the director determines that the action or decision furthers
6 the public protection mission of the board and the impact on
7 competition is justified, the director may approve the action or
8 decision.

9 (D) If the director determines that the action furthers the public
10 protection mission of the board and the impact on competition is
11 justified, the director may approve the action or decision. If the
12 director finds the action or decision does not further the public
13 protection mission of the board or finds that the action or decision
14 is not justified, the director shall either refuse to approve it or
15 shall modify the action or decision to ensure that any restraints
16 of trade are related to, and advance, clearly articulated state law
17 or public policy.

18 (4) The director shall issue, and post on the department's
19 Internet Web site, his or her final written decision approving,
20 modifying, or disapproving the action or decision with an
21 explanation of the reasons and rationale behind the director's
22 decision within 90 days from receipt of the request from a
23 consumer or licensee. Notwithstanding any other law, the decision
24 of the director shall be final, except if the state or federal
25 constitution requires an appeal of the director's decision.

26 (d) The review set forth in paragraph (3) of subdivision (c) shall
27 not apply when an individual seeks review of disciplinary or other
28 action pertaining solely to that individual.

29 (e) The director shall report to the Chairs of the Senate Business,
30 Professions, and Economic Development Committee and the
31 Assembly Business and Professions Committee annually,
32 commencing March 1, 2017, regarding his or her disapprovals,
33 modifications, or findings from any audit, review, or monitoring
34 and evaluation conducted pursuant to this section. That report
35 shall be submitted in compliance with Section 9795 of the
36 Government Code.

37 (f) If the director has already reviewed a board action or
38 decision pursuant to this section or Section 313.1, the director
39 shall not review that action or decision again.

1 (g) *This section shall not be construed to affect, impede, or*
2 *delay any disciplinary actions of any board.*

3 *SEC. 2. Section 116 of the Business and Professions Code is*
4 *amended to read:*

5 116. (a) The director may audit and review, upon his or her
6 own initiative, or upon the request of a consumer or licensee,
7 inquiries and complaints regarding licensees, dismissals of
8 disciplinary cases, the opening, conduct, or closure of
9 investigations, informal conferences, and discipline short of formal
10 accusation by ~~the Medical Board of California, the allied health~~
11 ~~professional boards, and the California Board of Podiatric~~
12 ~~Medicine. The director may make recommendations for changes~~
13 ~~to the disciplinary system to the appropriate board, the Legislature,~~
14 ~~or both.~~ *any board or bureau within the department.*

15 (b) The director shall report to the ~~Chairpersons~~ *Chairs* of the
16 ~~Senate Business and Professions~~ *Business, Professions, and*
17 *Economic Development* Committee and the ~~Assembly Health~~
18 *Business and Professions* Committee annually, commencing March
19 1, ~~1995,~~ 2017, regarding his or her findings from any audit, review,
20 or monitoring and evaluation conducted pursuant to this section.
21 *This report shall be submitted in compliance with Section 9795 of*
22 *the Government Code.*

23 *SEC. 3. Section 153 of the Business and Professions Code is*
24 *amended to read:*

25 153. The director may investigate the work of the several
26 boards in his department and may obtain a copy of all records and
27 full and complete data in all official matters in possession of the
28 boards, their members, officers, or ~~employees, other than~~
29 ~~examination questions prior to submission to applicants at~~
30 ~~scheduled examinations.~~ *employees.*

31 *SEC. 4. Section 307 of the Business and Professions Code is*
32 *amended to read:*

33 307. The director may contract for the services of experts and
34 consultants where necessary to carry out ~~the provisions of this~~
35 chapter and may provide compensation and reimbursement of
36 expenses for ~~such~~ *those* experts and consultants in accordance with
37 state law.

38 *SEC. 5. Section 313.1 of the Business and Professions Code*
39 *is amended to read:*

1 313.1. (a) Notwithstanding any other ~~provision~~ of law to the
2 contrary, no rule or ~~regulation, except those relating to~~
3 ~~examinations and qualifications for licensure, regulation~~ and no
4 fee change proposed or promulgated by any of the boards,
5 commissions, or committees within the department, shall take
6 effect pending compliance with this section.

7 (b) The director shall be formally notified of and shall ~~be~~
8 ~~provided a full opportunity to review, in accordance with the~~
9 requirements of Article 5 (commencing with Section 11346) of
10 Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government
11 Code, *the requirements in subdivision (c) of Section 109*, and this
12 section, all of the following:

13 (1) All notices of proposed action, any modifications and
14 supplements thereto, and the text of proposed regulations.

15 (2) Any notices of sufficiently related changes to regulations
16 previously noticed to the public, and the text of proposed
17 regulations showing modifications to the text.

18 (3) Final rulemaking records.

19 (4) *All relevant facts, data, public comments, market conditions,*
20 *studies, or other documentary evidence pertaining to the market*
21 *impacted by the proposed regulation. This information shall be*
22 *included in the written decision of the director required under*
23 *paragraph (4) of subdivision (c) of Section 109.*

24 (c) The submission of all notices and final rulemaking records
25 to the director and the ~~completion of the director's review,~~
26 *approval*, as authorized by this section, shall be a precondition to
27 the filing of any rule or regulation with the Office of Administrative
28 Law. The Office of Administrative Law shall have no jurisdiction
29 to review a rule or regulation subject to this section until after the
30 ~~completion of the director's review and only then if the director~~
31 ~~has not disapproved it.~~ *approval*. The filing of any document with
32 the Office of Administrative Law shall be accompanied by a
33 certification that the board, commission, or committee has complied
34 with the requirements of this section.

35 (d) Following the receipt of any final rulemaking record subject
36 to subdivision (a), the director shall have the authority for a period
37 of 30 days to *approve a proposed rule or regulation or disapprove*
38 *a proposed rule or regulation on the ground that it is injurious to*
39 *the public health, safety, or ~~welfare.~~ welfare, or has an*
40 *impermissible anticompetitive effect. The director may modify a*

1 rule or regulation as a condition of approval. Any modifications
2 to regulations by the director shall be subject to a 30-day public
3 comment period before the director issues a final decision
4 regarding the modified regulation. If the director does not approve
5 the rule or regulation within the 30-day period, the rule or
6 regulation shall not be submitted to the Office of Administrative
7 Law and the rule or regulation shall have no effect.

8 (e) Final rulemaking records shall be filed with the director
9 within the one-year notice period specified in Section 11346.4 of
10 the Government Code. If necessary for compliance with this
11 section, the one-year notice period may be extended, as specified
12 by this subdivision.

13 (1) In the event that the one-year notice period lapses during
14 the director's 30-day review period, or within 60 days following
15 the notice of the director's disapproval, it may be extended for a
16 maximum of 90 days.

17 (2) If the director approves the final rulemaking record or
18 declines to take action on it within 30 days, record, the board,
19 commission, or committee shall have five days from the receipt
20 of the record from the director within which to file it with the
21 Office of Administrative Law.

22 (3) If the director disapproves a rule or regulation, it shall have
23 no force or effect unless, within 60 days of the notice of
24 disapproval, (A) the disapproval is overridden by a unanimous
25 vote of the members of the board, commission, or committee, and
26 (B) the board, commission, or committee files the final rulemaking
27 record with the Office of Administrative Law in compliance with
28 this section and the procedures required by Chapter 3.5
29 (commencing with Section 11340) of Part 1 of Division 3 of Title
30 2 of the Government Code. *This paragraph shall not apply to any*
31 *decision disapproved by the director under subdivision (c) of*
32 *Section 109.*

33 (f) ~~Nothing in this~~ This section shall *not* be construed to prohibit
34 the director from affirmatively approving a proposed rule,
35 regulation, or fee change at any time within the 30-day period after
36 it has been submitted to him or her, in which event it shall become
37 effective upon compliance with this section and the procedures
38 required by Chapter 3.5 (commencing with Section 11340) of Part
39 1 of Division 3 of Title 2 of the Government Code.

1 *SEC. 6. Section 2708 of the Business and Professions Code is*
2 *amended to read:*

3 2708. (a) The board shall appoint an executive officer who
4 shall perform the duties delegated by the board and who shall be
5 responsible to it for the accomplishment of those duties.

6 (b) The executive officer shall *not* be a ~~nurse currently licensed~~
7 *licensee* under this chapter and shall possess other qualifications
8 as determined by the board.

9 (c) The executive officer shall not be a member of the board.

10 (d) This section shall remain in effect only until January 1, 2018,
11 and as of that date is repealed, unless a later enacted statute, that
12 is enacted before January 1, 2018, deletes or extends that date.

13 ~~SECTION 1.~~

14 *SEC. 7. Section 4800 of the Business and Professions Code is*
15 *amended to read:*

16 4800. (a) There is in the Department of Consumer Affairs a
17 Veterinary Medical Board in which the administration of this
18 chapter is vested. The board consists of the following members:

19 (1) Four licensed veterinarians.

20 (2) One registered veterinary technician.

21 (3) Three public members.

22 (b) This section shall remain in effect only until January 1, 2021,
23 and as of that date is repealed.

24 (c) Notwithstanding any other law, the repeal of this section
25 renders the board subject to review by the appropriate policy
26 committees of the Legislature. However, the review of the board
27 shall be limited to those issues identified by the appropriate policy
28 committees of the Legislature and shall not involve the preparation
29 or submission of a sunset review document or evaluative
30 questionnaire.

31 ~~SEC. 2.~~

32 *SEC. 8. Section 4804.5 of the Business and Professions Code*
33 *is amended to read:*

34 4804.5. (a) The board may appoint a person exempt from civil
35 service who shall be designated as an executive officer and who
36 shall exercise the powers and perform the duties delegated by the
37 board and vested in him or her by this chapter.

38 (b) This section shall remain in effect only until January 1, 2021,
39 and as of that date is repealed.

1 *SEC. 9. Section 4825.1 of the Business and Professions Code*
2 *is amended to read:*

3 4825.1. These definitions shall govern the construction of this
4 chapter as it applies to veterinary medicine.

5 (a) “Diagnosis” means the act or process of identifying or
6 determining the health status of an animal through examination
7 and the opinion derived from that examination.

8 (b) “Animal” means any member of the animal kingdom other
9 than humans, and includes fowl, fish, and reptiles, wild or
10 domestic, whether living or dead.

11 (c) “Food animal” means any animal that is raised for the
12 production of an edible product intended for consumption by
13 humans. The edible product includes, but is not limited to, milk,
14 meat, and eggs. Food animal includes, but is not limited to, cattle
15 (beef or dairy), swine, sheep, poultry, fish, and amphibian species.

16 (d) “Livestock” includes all animals, poultry, aquatic and
17 amphibian species that are raised, kept, or used for profit. It does
18 not include those species that are usually kept as pets such as dogs,
19 cats, and pet birds, or companion animals, including equines.

20 (e) “*Compounding*,” for the purposes of veterinary medicine,
21 shall have the same meaning given in Section 1735 of Title 16 of
22 the California Code of Regulations, except that every reference
23 therein to “pharmacy” and “pharmacist” shall be replaced with
24 “veterinary premises” and “veterinarian,” and except that only
25 a licensed veterinarian or a licensed registered veterinarian
26 technician under direct supervision of a veterinarian may perform
27 compounding and shall not delegate to or supervise any part of
28 the performance of compounding by any other person.

29 *SEC. 10. Section 4826.3 is added to the Business and*
30 *Professions Code, to read:*

31 4826.3. (a) *Notwithstanding Section 4051, a veterinarian or*
32 *registered veterinarian technician under the direct supervision of*
33 *a veterinarian with a current and active license may compound a*
34 *drug for anesthesia, the prevention, cure, or relief of a wound,*
35 *fracture, bodily injury, or disease of an animal in a premises*
36 *currently and actively registered with the board and only under*
37 *the following conditions:*

38 (1) *Where there is no FDA-approved animal or human drug*
39 *that can be used as labeled or in an appropriate extralabel manner*

1 *to properly treat the disease, symptom, or condition for which the*
2 *drug is being prescribed.*

3 *(2) Where the compounded drug is not available from a*
4 *compounding pharmacy, outsourcing facility, or other*
5 *compounding supplier in a dosage form and concentration to*
6 *appropriately treat the disease, symptom, or condition for which*
7 *the drug is being prescribed.*

8 *(3) Where the need and prescription for the compounded*
9 *medication has arisen within an established*
10 *veterinarian-client-patient relationship as a means to treat a*
11 *specific occurrence of a disease, symptom, or condition observed*
12 *and diagnosed by the veterinarian in a specific animal that*
13 *threatens the health of the animal or will cause suffering or death*
14 *if left untreated.*

15 *(4) Where the quantity compounded does not exceed a quantity*
16 *demonstrably needed to treat a patient with which the veterinarian*
17 *has a current veterinarian-client-patient relationship.*

18 *(5) Except as specified in subdivision (c), where the compound*
19 *is prepared only with commercially available FDA-approved*
20 *animal or human drugs as active ingredients.*

21 *(b) A compounded veterinary drug may be prepared from an*
22 *FDA-approved animal or human drug for extralabel use only when*
23 *there is no approved animal or human drug that, when used as*
24 *labeled or in an appropriate extralabel manner will, in the*
25 *available dosage form and concentration, treat the disease,*
26 *symptom, or condition. Compounding from an approved human*
27 *drug for use in food-producing animals is not permitted if an*
28 *approved animal drug can be used for compounding.*

29 *(c) A compounded veterinary drug may be prepared from bulk*
30 *drug substances only when:*

31 *(1) The drug is compounded and dispensed by the veterinarian*
32 *to treat an individually identified animal patient under his or her*
33 *care.*

34 *(2) The drug is not intended for use in food-producing animals.*

35 *(3) If the drug contains a bulk drug substance that is a*
36 *component of any marketed FDA-approved animal or human drug,*
37 *there is a change between the compounded drug and the*
38 *comparable marketed drug made for an individually identified*
39 *animal patient that produces a clinical difference for that*
40 *individually identified animal patient, as determined by the*

1 veterinarian prescribing the compounded drug for his or her
2 patient.

3 (4) There are no FDA-approved animal or human drugs that
4 can be used as labeled or in an appropriate extralabel manner to
5 properly treat the disease, symptom, or condition for which the
6 drug is being prescribed.

7 (5) All bulk drug substances used in compounding are
8 manufactured by an establishment registered under Section 360
9 of Title 21 of the United States Code and are accompanied by a
10 valid certificate of analysis.

11 (6) The drug is not sold or transferred by the veterinarian
12 compounding the drug, except that the veterinarian shall be
13 permitted to administer the drug to a patient under his or her care
14 or dispense it to the owner or caretaker of an animal under his or
15 her care.

16 (7) Within 15 days of becoming aware of any product defect or
17 serious adverse event associated with any drug compounded by
18 the veterinarian from bulk drug substances, the veterinarian shall
19 report it to the federal Food and Drug Administration on Form
20 FDA 1932a.

21 (8) In addition to any other requirements, the label of any
22 veterinary drug compounded from bulk drug substances shall
23 indicate the species of the intended animal patient, the name of
24 the animal patient, and the name of the owner or caretaker of the
25 patient.

26 (d) Each compounded veterinary drug preparation shall meet
27 the labeling requirements of Section 4076 and Sections 1707.5
28 and 1735.4 of Title 16 of the California Code of Regulations, except
29 that every reference therein to “pharmacy” and “pharmacist”
30 shall be replaced by “veterinary premises” and “veterinarian,”
31 and any reference to “patient” shall be understood to refer to the
32 animal patient. In addition, each label on a compounded veterinary
33 drug preparation shall include withdrawal and holding times, if
34 needed, and the disease, symptom, or condition for which the drug
35 is being prescribed. Any compounded veterinary drug preparation
36 that is intended to be sterile, including for injection, administration
37 into the eye, or inhalation, shall in addition meet the labeling
38 requirements of Section 1751.2 of Title 16 of the California Code
39 of Regulations, except that every reference therein to “pharmacy”
40 and “pharmacist” shall be replaced by “veterinary premises” and

1 “veterinarian,” and any reference to “patient” shall be understood
2 to refer to the animal patient.

3 (e) Any veterinarian, registered veterinarian technician who is
4 under the direct supervision of a veterinarian, and veterinary
5 premises engaged in compounding shall meet the compounding
6 requirements for pharmacies and pharmacists stated by the
7 provisions of Article 4.5 (commencing with Section 1735) of Title
8 16 of the California Code of Regulations, except that every
9 reference therein to “pharmacy” and “pharmacist” shall be
10 replaced by “veterinary premises” and “veterinarian,” and any
11 reference to “patient” shall be understood to refer to the animal
12 patient:

13 (1) Section 1735.1 of Title 16 of the California Code of
14 Regulations.

15 (2) Subdivisions (d),(e), (f), (g), (h), (i), (j), (k), and (l) of Section
16 1735.2 of Title 16 of the California Code of Regulations.

17 (3) Section 1735.3 of Title 16 of the California Code of
18 Regulations, except that only a licensed veterinarian or registered
19 veterinarian technician may perform compounding and shall not
20 delegate to or supervise any part of the performance of
21 compounding by any other person.

22 (4) Section 1735.4 of Title 16 of the California Code of
23 Regulations.

24 (5) Section 1735.5 of Title 16 of the California Code of
25 Regulations.

26 (6) Section 1735.6 of Title 16 of the California Code of
27 Regulations.

28 (7) Section 1735.7 of Title 16 of the California Code of
29 Regulations.

30 (8) Section 1735.8 of Title 16 of the California Code of
31 Regulations.

32 (f) Any veterinarian, registered veterinarian technician under
33 the direct supervision of a veterinarian, and veterinary premises
34 engaged in sterile compounding shall meet the sterile compounding
35 requirements for pharmacies and pharmacists under Article 7
36 (commencing with Section 1751) of Title 16 of the California Code
37 of Regulations, except that every reference therein to “pharmacy”
38 and “pharmacist” shall be replaced by “veterinary premises” and
39 “veterinarian,” and any reference to “patient” shall be understood
40 to refer to the animal patient.

1 (g) *The California State Board of Pharmacy shall have authority*
2 *with the board to ensure compliance with this section and shall*
3 *have the right to inspect any veterinary premises engaged in*
4 *compounding, along with or separate from the board, to ensure*
5 *compliance with this section. The board is specifically charged*
6 *with enforcing this section with regard to its licensees.*

7 *SEC. 11. Section 4826.5 is added to the Business and*
8 *Professions Code, to read:*

9 *4826.5. Failure by a licensed veterinarian, registered*
10 *veterinarian technician, or veterinary premises to comply with the*
11 *provisions of this article shall be deemed unprofessional conduct*
12 *and constitute grounds for discipline.*

13 *SEC. 12. Section 4826.7 is added to the Business and*
14 *Professions Code, to read:*

15 *4826.7. The board may adopt regulations to implement the*
16 *provisions of this article.*

17 *SEC. 13. Section 4830 of the Business and Professions Code*
18 *is amended to read:*

19 4830. (a) This chapter does not apply to:

20 (1) Veterinarians while serving in any armed branch of the
21 military service of the United States or the United States
22 Department of Agriculture while actually engaged and employed
23 in their official capacity.

24 (2) Regularly licensed veterinarians in actual consultation from
25 other states.

26 (3) Regularly licensed veterinarians actually called from other
27 states to attend cases in this state, but who do not open an office
28 or appoint a place to do business within this state.

29 ~~(4) Veterinarians employed by the University of California~~
30 ~~while engaged in the performance of duties in connection with the~~
31 ~~College of Agriculture, the Agricultural Experiment Station, the~~
32 ~~School of Veterinary Medicine, or the agricultural extension work~~
33 ~~of the university or employed by the Western University of Health~~
34 ~~Sciences while engaged in the performance of duties in connection~~
35 ~~with the College of Veterinary Medicine or the agricultural~~
36 ~~extension work of the university.~~

37 ~~(5)~~

38 (4) Students in the School of Veterinary Medicine of the
39 University of California or the College of Veterinary Medicine of
40 the Western University of Health Sciences who participate in

1 diagnosis and treatment as part of their educational experience,
2 including those in off-campus educational programs under the
3 direct supervision of a licensed veterinarian in good standing, as
4 defined in paragraph (1) of subdivision (b) of Section 4848,
5 appointed by the University of California, Davis, or the Western
6 University of Health Sciences.

7 ~~(6)~~

8 (5) A veterinarian who is employed by the Meat and Poultry
9 Inspection Branch of the California Department of Food and
10 Agriculture while actually engaged and employed in his or her
11 official capacity. A person exempt under this paragraph shall not
12 otherwise engage in the practice of veterinary medicine unless he
13 or she is issued a license by the board.

14 ~~(7)~~

15 (6) Unlicensed personnel employed by the Department of Food
16 and Agriculture or the United States Department of Agriculture
17 when in the course of their duties they are directed by a veterinarian
18 supervisor to conduct an examination, obtain biological specimens,
19 apply biological tests, or administer medications or biological
20 products as part of government disease or condition monitoring,
21 investigation, control, or eradication activities.

22 (b) (1) For purposes of paragraph (3) of subdivision (a), a
23 regularly licensed veterinarian in good standing who is called from
24 another state by a law enforcement agency or animal control
25 agency, as defined in Section 31606 of the Food and Agricultural
26 Code, to attend to cases that are a part of an investigation of an
27 alleged violation of federal or state animal fighting or animal
28 cruelty laws within a single geographic location shall be exempt
29 from the licensing requirements of this chapter if the law
30 enforcement agency or animal control agency determines that it
31 is necessary to call the veterinarian in order for the agency or
32 officer to conduct the investigation in a timely, efficient, and
33 effective manner. In determining whether it is necessary to call a
34 veterinarian from another state, consideration shall be given to the
35 availability of veterinarians in this state to attend to these cases.
36 An agency, department, or officer that calls a veterinarian pursuant
37 to this subdivision shall notify the board of the investigation.

38 (2) Notwithstanding any other provision of this chapter, a
39 regularly licensed veterinarian in good standing who is called from
40 another state to attend to cases that are a part of an investigation

1 described in paragraph (1) may provide veterinary medical care
2 for animals that are affected by the investigation with a temporary
3 shelter facility, and the temporary shelter facility shall be exempt
4 from the registration requirement of Section 4853 if all of the
5 following conditions are met:

6 (A) The temporary shelter facility is established only for the
7 purpose of the investigation.

8 (B) The temporary shelter facility provides veterinary medical
9 care, shelter, food, and water only to animals that are affected by
10 the investigation.

11 (C) The temporary shelter facility complies with Section 4854.

12 (D) The temporary shelter facility exists for not more than 60
13 days, unless the law enforcement agency or animal control agency
14 determines that a longer period of time is necessary to complete
15 the investigation.

16 (E) Within 30 calendar days upon completion of the provision
17 of veterinary health care services at a temporary shelter facility
18 established pursuant to this section, the veterinarian called from
19 another state by a law enforcement agency or animal control agency
20 to attend to a case shall file a report with the board. The report
21 shall contain the date, place, type, and general description of the
22 care provided, along with a listing of the veterinary health care
23 practitioners who participated in providing that care.

24 (c) For purposes of paragraph (3) of subdivision (a), the board
25 may inspect temporary facilities established pursuant to this
26 section.

27 *SEC. 14. Section 4846.5 of the Business and Professions Code*
28 *is amended to read:*

29 4846.5. (a) Except as provided in this section, the board shall
30 issue renewal licenses only to those applicants that have completed
31 a minimum of 36 hours of continuing education in the preceding
32 two years.

33 (b) (1) Notwithstanding any other law, continuing education
34 hours shall be earned by attending courses relevant to veterinary
35 medicine and sponsored or cosponsored by any of the following:

36 (A) American Veterinary Medical Association (AVMA)
37 accredited veterinary medical colleges.

38 (B) Accredited colleges or universities offering programs
39 relevant to veterinary medicine.

40 (C) The American Veterinary Medical Association.

1 (D) American Veterinary Medical Association recognized
2 specialty or affiliated allied groups.

3 (E) American Veterinary Medical Association’s affiliated state
4 veterinary medical associations.

5 (F) Nonprofit annual conferences established in conjunction
6 with state veterinary medical associations.

7 (G) Educational organizations affiliated with the American
8 Veterinary Medical Association or its state affiliated veterinary
9 medical associations.

10 (H) Local veterinary medical associations affiliated with the
11 California Veterinary Medical Association.

12 (I) Federal, state, or local government agencies.

13 (J) Providers accredited by the Accreditation Council for
14 Continuing Medical Education (ACCME) or approved by the
15 American Medical Association (AMA), providers recognized by
16 the American Dental Association Continuing Education
17 Recognition Program (ADA CERP), and AMA or ADA affiliated
18 state, local, and specialty organizations.

19 (2) Continuing education credits shall be granted to those
20 veterinarians taking self-study courses, which may include, but
21 are not limited to, reading journals, viewing video recordings, or
22 listening to audio recordings. The taking of these courses shall be
23 limited to no more than six hours biennially.

24 (3) The board may approve other continuing veterinary medical
25 education providers not specified in paragraph (1).

26 (A) The board has the authority to recognize national continuing
27 education approval bodies for the purpose of approving continuing
28 education providers not specified in paragraph (1).

29 (B) Applicants seeking continuing education provider approval
30 shall have the option of applying to the board or to a
31 board-recognized national approval body.

32 (4) For good cause, the board may adopt an order specifying,
33 on a prospective basis, that a provider of continuing veterinary
34 medical education authorized pursuant to paragraph (1) or (3) is
35 no longer an acceptable provider.

36 (5) Continuing education hours earned by attending courses
37 sponsored or cosponsored by those entities listed in paragraph (1)
38 between January 1, 2000, and January 1, 2001, shall be credited
39 toward a veterinarian’s continuing education requirement under
40 this section.

1 (c) Every person renewing his or her license issued pursuant to
2 Section 4846.4, or any person applying for relicensure or for
3 reinstatement of his or her license to active status, shall submit
4 proof of compliance with this section to the board certifying that
5 he or she is in compliance with this section. Any false statement
6 submitted pursuant to this section shall be a violation subject to
7 Section 4831.

8 (d) This section shall not apply to a veterinarian's first license
9 renewal. This section shall apply only to second and subsequent
10 license renewals granted on or after January 1, 2002.

11 (e) The board shall have the right to audit the records of all
12 applicants to verify the completion of the continuing education
13 requirement. Applicants shall maintain records of completion of
14 required continuing education coursework for a period of four
15 years and shall make these records available to the board for
16 auditing purposes upon request. If the board, during this audit,
17 questions whether any course reported by the veterinarian satisfies
18 the continuing education requirement, the veterinarian shall provide
19 information to the board concerning the content of the course; the
20 name of its sponsor and cosponsor, if any; and specify the specific
21 curricula that was of benefit to the veterinarian.

22 (f) A veterinarian desiring an inactive license or to restore an
23 inactive license under Section 701 shall submit an application on
24 a form provided by the board. In order to restore an inactive license
25 to active status, the veterinarian shall have completed a minimum
26 of 36 hours of continuing education within the last two years
27 preceding application. The inactive license status of a veterinarian
28 shall not deprive the board of its authority to institute or continue
29 a disciplinary action against a licensee.

30 (g) Knowing misrepresentation of compliance with this article
31 by a veterinarian constitutes unprofessional conduct and grounds
32 for disciplinary action or for the issuance of a citation and the
33 imposition of a civil penalty pursuant to Section 4883.

34 (h) The board, in its discretion, may exempt from the continuing
35 education requirement any veterinarian who for reasons of health,
36 military service, or undue hardship cannot meet those requirements.
37 Applications for waivers shall be submitted on a form provided
38 by the board.

39 (i) The administration of this section may be funded through
40 professional license and continuing education provider fees. The

1 fees related to the administration of this section shall not exceed
2 the costs of administering the corresponding provisions of this
3 section.

4 (j) For those continuing education providers not listed in
5 paragraph (1) of subdivision (b), the board or its recognized
6 national approval agent shall establish criteria by which a provider
7 of continuing education shall be approved. The board shall initially
8 review and approve these criteria and may review the criteria as
9 needed. The board or its recognized agent shall monitor, maintain,
10 and manage related records and data. The board may impose an
11 application fee, not to exceed two hundred dollars (\$200)
12 biennially, for continuing education providers not listed in
13 paragraph (1) of subdivision (b).

14 (k) (1) ~~On or after~~ Beginning January 1, 2018, a licensed
15 veterinarian who renews his or her license shall complete a
16 minimum of one credit hour of continuing education on the
17 judicious use of medically important antimicrobial drugs every
18 four years as part of his or her continuing education requirements.

19 (2) For purposes of this subdivision, “medically important
20 antimicrobial drug” means an antimicrobial drug listed in Appendix
21 A of the federal Food and Drug Administration’s Guidance for
22 Industry #152, including critically important, highly important,
23 and important antimicrobial drugs, as that appendix may be
24 amended.

25 *SEC. 15. Section 4848.1 is added to the Business and*
26 *Professions Code, to read:*

27 *4848.1. (a) A veterinarian engaged in the practice of veterinary*
28 *medicine, as defined in Section 4826, employed by the University*
29 *of California while engaged in the performance of duties in*
30 *connection with the School of Veterinary Medicine or employed*
31 *by the Western University of Health Sciences while engaged in the*
32 *performance of duties in connection with the College of Veterinary*
33 *Medicine shall be licensed in California or shall hold a university*
34 *license issued by the board.*

35 *(b) An applicant is eligible to hold a university license if all of*
36 *the following are satisfied:*

37 *(1) The applicant is currently employed by the University of*
38 *California or Western University of Health Sciences as defined in*
39 *subdivision (a).*

1 (2) *Passes an examination concerning the statutes and*
2 *regulations of the Veterinary Medicine Practice Act, administered*
3 *by the board, pursuant to subparagraph (C) of paragraph (2) of*
4 *subdivision (a) of Section 4848.*

5 (3) *Successfully completes the approved educational curriculum*
6 *described in paragraph (5) of subdivision (b) of Section 4848 on*
7 *regionally specific and important diseases and conditions.*

8 (c) *A university license:*

9 (1) *Shall be numbered as described in Section 4847.*

10 (2) *Shall cease to be valid upon termination of employment by*
11 *the University of California or by the Western University of Health*
12 *Sciences.*

13 (3) *Shall be subject to the license renewal provisions in Section*
14 *4846.4.*

15 (4) *Shall be subject to denial, revocation, or suspension pursuant*
16 *to Sections 4875 and 4883.*

17 (d) *An individual who holds a University License is exempt from*
18 *satisfying the license renewal requirements of Section 4846.5.*

19 SEC. 16. *Section 4853.7 is added to the Business and*
20 *Professions Code, to read:*

21 4853.7. *A premise registration that is not renewed within five*
22 *years after its expiration may not be renewed and shall not be*
23 *restored, reissued, or reinstated thereafter. However, an*
24 *application for a new premise registration may be submitted and*
25 *obtained if both of the following conditions are met:*

26 (a) *No fact, circumstance, or condition exists that, if the premise*
27 *registration was issued, would justify its revocation or suspension.*

28 (b) *All of the fees that would be required for the initial premise*
29 *registration are paid at the time of application.*

30 SEC. 17. *Section 825 of the Government Code is amended to*
31 *read:*

32 825. (a) *Except as otherwise provided in this section, if an*
33 *employee or former employee of a public entity requests the public*
34 *entity to defend him or her against any claim or action against him*
35 *or her for an injury arising out of an act or omission occurring*
36 *within the scope of his or her employment as an employee of the*
37 *public entity and the request is made in writing not less than 10*
38 *days before the day of trial, and the employee or former employee*
39 *reasonably cooperates in good faith in the defense of the claim or*
40 *action, the public entity shall pay any judgment based thereon or*

1 any compromise or settlement of the claim or action to which the
2 public entity has agreed.

3 If the public entity conducts the defense of an employee or
4 former employee against any claim or action with his or her
5 reasonable good-faith cooperation, the public entity shall pay any
6 judgment based thereon or any compromise or settlement of the
7 claim or action to which the public entity has agreed. However,
8 where the public entity conducted the defense pursuant to an
9 agreement with the employee or former employee reserving the
10 rights of the public entity not to pay the judgment, compromise,
11 or settlement until it is established that the injury arose out of an
12 act or omission occurring within the scope of his or her
13 employment as an employee of the public entity, the public entity
14 is required to pay the judgment, compromise, or settlement only
15 if it is established that the injury arose out of an act or omission
16 occurring in the scope of his or her employment as an employee
17 of the public entity.

18 Nothing in this section authorizes a public entity to pay that part
19 of a claim or judgment that is for punitive or exemplary damages.

20 (b) Notwithstanding subdivision (a) or any other provision of
21 law, a public entity is authorized to pay that part of a judgment
22 that is for punitive or exemplary damages if the governing body
23 of that public entity, acting in its sole discretion except in cases
24 involving an entity of the state government, finds all of the
25 following:

26 (1) The judgment is based on an act or omission of an employee
27 or former employee acting within the course and scope of his or
28 her employment as an employee of the public entity.

29 (2) At the time of the act giving rise to the liability, the employee
30 or former employee acted, or failed to act, in good faith, without
31 actual malice and in the apparent best interests of the public entity.

32 (3) Payment of the claim or judgment would be in the best
33 interests of the public entity.

34 As used in this subdivision with respect to an entity of state
35 government, “a decision of the governing body” means the
36 approval of the Legislature for payment of that part of a judgment
37 that is for punitive damages or exemplary damages, upon
38 recommendation of the appointing power of the employee or
39 former employee, based upon the finding by the Legislature and
40 the appointing authority of the existence of the three conditions

1 for payment of a punitive or exemplary damages claim. The
2 provisions of subdivision (a) of Section 965.6 shall apply to the
3 payment of any claim pursuant to this subdivision.

4 The discovery of the assets of a public entity and the introduction
5 of evidence of the assets of a public entity shall not be permitted
6 in an action in which it is alleged that a public employee is liable
7 for punitive or exemplary damages.

8 The possibility that a public entity may pay that part of a
9 judgment that is for punitive damages shall not be disclosed in any
10 trial in which it is alleged that a public employee is liable for
11 punitive or exemplary damages, and that disclosure shall be
12 grounds for a mistrial.

13 (c) Except as provided in subdivision (d), if the provisions of
14 this section are in conflict with the provisions of a memorandum
15 of understanding reached pursuant to Chapter 10 (commencing
16 with Section 3500) of Division 4 of Title 1, the memorandum of
17 understanding shall be controlling without further legislative action,
18 except that if those provisions of a memorandum of understanding
19 require the expenditure of funds, the provisions shall not become
20 effective unless approved by the Legislature in the annual Budget
21 Act.

22 (d) The subject of payment of punitive damages pursuant to this
23 section or any other provision of law shall not be a subject of meet
24 and confer under the provisions of Chapter 10 (commencing with
25 Section 3500) of Division 4 of Title 1, or pursuant to any other
26 law or authority.

27 (e) Nothing in this section shall affect the provisions of Section
28 818 prohibiting the award of punitive damages against a public
29 entity. This section shall not be construed as a waiver of a public
30 entity's immunity from liability for punitive damages under Section
31 1981, 1983, or 1985 of Title 42 of the United States Code.

32 (f) (1) Except as provided in paragraph (2), a public entity shall
33 not pay a judgment, compromise, or settlement arising from a
34 claim or action against an elected official, if the claim or action is
35 based on conduct by the elected official by way of tortiously
36 intervening or attempting to intervene in, or by way of tortiously
37 influencing or attempting to influence the outcome of, any judicial
38 action or proceeding for the benefit of a particular party by
39 contacting the trial judge or any commissioner, court-appointed
40 arbitrator, court-appointed mediator, or court-appointed special

1 referee assigned to the matter, or the court clerk, bailiff, or marshal
2 after an action has been filed, unless he or she was counsel of
3 record acting lawfully within the scope of his or her employment
4 on behalf of that party. Notwithstanding Section 825.6, if a public
5 entity conducted the defense of an elected official against such a
6 claim or action and the elected official is found liable by the trier
7 of fact, the court shall order the elected official to pay to the public
8 entity the cost of that defense.

9 (2) If an elected official is held liable for monetary damages in
10 the action, the plaintiff shall first seek recovery of the judgment
11 against the assets of the elected official. If the elected official's
12 assets are insufficient to satisfy the total judgment, as determined
13 by the court, the public entity may pay the deficiency if the public
14 entity is authorized by law to pay that judgment.

15 (3) To the extent the public entity pays any portion of the
16 judgment or is entitled to reimbursement of defense costs pursuant
17 to paragraph (1), the public entity shall pursue all available
18 creditor's remedies against the elected official, including
19 garnishment, until that party has fully reimbursed the public entity.

20 (4) This subdivision shall not apply to any criminal or civil
21 enforcement action brought in the name of the people of the State
22 of California by an elected district attorney, city attorney, or
23 attorney general.

24 (g) *Notwithstanding subdivision (a), a public entity shall pay*
25 *for a judgment or settlement for treble damage antitrust awards*
26 *against a member of a regulatory board for an act or omission*
27 *occurring within the scope of his or her employment as a member*
28 *of a regulatory board.*

29 *SEC. 18. Section 11346.5 of the Government Code is amended*
30 *to read:*

31 11346.5. (a) The notice of proposed adoption, amendment, or
32 repeal of a regulation shall include the following:

33 (1) A statement of the time, place, and nature of proceedings
34 for adoption, amendment, or repeal of the regulation.

35 (2) Reference to the authority under which the regulation is
36 proposed and a reference to the particular code sections or other
37 provisions of law that are being implemented, interpreted, or made
38 specific.

1 (3) An informative digest drafted in plain English in a format
2 similar to the Legislative Counsel’s digest on legislative bills. The
3 informative digest shall include the following:

4 (A) A concise and clear summary of existing laws and
5 regulations, if any, related directly to the proposed action and of
6 the effect of the proposed action.

7 (B) If the proposed action differs substantially from an existing
8 comparable federal regulation or statute, a brief description of the
9 significant differences and the full citation of the federal regulations
10 or statutes.

11 (C) A policy statement overview explaining the broad objectives
12 of the regulation and the specific benefits anticipated by the
13 proposed adoption, amendment, or repeal of a regulation, including,
14 to the extent applicable, nonmonetary benefits such as the
15 protection of public health and safety, worker safety, or the
16 environment, the prevention of discrimination, the promotion of
17 fairness or social equity, and the increase in openness and
18 transparency in business and government, among other things.

19 (D) An evaluation of whether the proposed regulation is
20 inconsistent or incompatible with existing state regulations.

21 (4) Any other matters as are prescribed by statute applicable to
22 the specific state agency or to any specific regulation or class of
23 regulations.

24 (5) A determination as to whether the regulation imposes a
25 mandate on local agencies or school districts and, if so, whether
26 the mandate requires state reimbursement pursuant to Part 7
27 (commencing with Section 17500) of Division 4.

28 (6) An estimate, prepared in accordance with instructions
29 adopted by the Department of Finance, of the cost or savings to
30 any state agency, the cost to any local agency or school district
31 that is required to be reimbursed under Part 7 (commencing with
32 Section 17500) of Division 4, other nondiscretionary cost or
33 savings imposed on local agencies, and the cost or savings in
34 federal funding to the state.

35 For purposes of this paragraph, “cost or savings” means
36 additional costs or savings, both direct and indirect, that a public
37 agency necessarily incurs in reasonable compliance with
38 regulations.

39 (7) If a state agency, in proposing to adopt, amend, or repeal
40 any administrative regulation, makes an initial determination that

1 the action may have a significant, statewide adverse economic
2 impact directly affecting business, including the ability of
3 California businesses to compete with businesses in other states,
4 it shall include the following information in the notice of proposed
5 action:

6 (A) Identification of the types of businesses that would be
7 affected.

8 (B) A description of the projected reporting, recordkeeping, and
9 other compliance requirements that would result from the proposed
10 action.

11 (C) The following statement: “The (name of agency) has made
12 an initial determination that the (adoption/amendment/repeal) of
13 this regulation may have a significant, statewide adverse economic
14 impact directly affecting business, including the ability of
15 California businesses to compete with businesses in other states.
16 The (name of agency) (has/has not) considered proposed
17 alternatives that would lessen any adverse economic impact on
18 business and invites you to submit proposals. Submissions may
19 include the following considerations:

20 (i) The establishment of differing compliance or reporting
21 requirements or timetables that take into account the resources
22 available to businesses.

23 (ii) Consolidation or simplification of compliance and reporting
24 requirements for businesses.

25 (iii) The use of performance standards rather than prescriptive
26 standards.

27 (iv) Exemption or partial exemption from the regulatory
28 requirements for businesses.”

29 (8) If a state agency, in adopting, amending, or repealing any
30 administrative regulation, makes an initial determination that the
31 action will not have a significant, statewide adverse economic
32 impact directly affecting business, including the ability of
33 California businesses to compete with businesses in other states,
34 it shall make a declaration to that effect in the notice of proposed
35 action. In making this declaration, the agency shall provide in the
36 record facts, evidence, documents, testimony, or other evidence
37 upon which the agency relies to support its initial determination.

38 An agency’s initial determination and declaration that a proposed
39 adoption, amendment, or repeal of a regulation may have or will
40 not have a significant, adverse impact on businesses, including the

1 ability of California businesses to compete with businesses in other
2 states, shall not be grounds for the office to refuse to publish the
3 notice of proposed action.

4 (9) A description of all cost impacts, known to the agency at
5 the time the notice of proposed action is submitted to the office,
6 that a representative private person or business would necessarily
7 incur in reasonable compliance with the proposed action.

8 If no cost impacts are known to the agency, it shall state the
9 following:

10 “The agency is not aware of any cost impacts that a
11 representative private person or business would necessarily incur
12 in reasonable compliance with the proposed action.”

13 (10) A statement of the results of the economic impact
14 assessment required by subdivision (b) of Section 11346.3 or the
15 standardized regulatory impact analysis if required by subdivision
16 (c) of Section 11346.3, a summary of any comments submitted to
17 the agency pursuant to subdivision (f) of Section 11346.3 and the
18 agency’s response to those comments.

19 (11) The finding prescribed by subdivision (d) of Section
20 11346.3, if required.

21 (12) (A) A statement that the action would have a significant
22 effect on housing costs, if a state agency, in adopting, amending,
23 or repealing any administrative regulation, makes an initial
24 determination that the action would have that effect.

25 (B) The agency officer designated in paragraph ~~(14)~~ (15) shall
26 make available to the public, upon request, the agency’s evaluation,
27 if any, of the effect of the proposed regulatory action on housing
28 costs.

29 (C) The statement described in subparagraph (A) shall also
30 include the estimated costs of compliance and potential benefits
31 of a building standard, if any, that were included in the initial
32 statement of reasons.

33 (D) For purposes of model codes adopted pursuant to Section
34 18928 of the Health and Safety Code, the agency shall comply
35 with the requirements of this paragraph only if an interested party
36 has made a request to the agency to examine a specific section for
37 purposes of estimating the costs of compliance and potential
38 benefits for that section, as described in Section 11346.2.

39 (13) *If the regulatory action is submitted by a state board on*
40 *which a controlling number of decisionmakers are active market*

1 *participants in the market the board regulates, a statement that*
2 *the adopting agency has evaluated the impact of the proposed*
3 *regulation on competition, and that the proposed regulation*
4 *further a clearly articulated and affirmatively expressed state law*
5 *to restrain competition.*

6 ~~(13)~~

7 (14) A statement that the adopting agency must determine that
8 no reasonable alternative considered by the agency or that has
9 otherwise been identified and brought to the attention of the agency
10 would be more effective in carrying out the purpose for which the
11 action is proposed, would be as effective and less burdensome to
12 affected private persons than the proposed action, or would be
13 more cost effective to affected private persons and equally effective
14 in implementing the statutory policy or other provision of law. For
15 a major regulation, as defined by Section 11342.548, proposed on
16 or after November 1, 2013, the statement shall be based, in part,
17 upon the standardized regulatory impact analysis of the proposed
18 regulation, as required by Section 11346.3, as well as upon the
19 benefits of the proposed regulation identified pursuant to
20 subparagraph (C) of paragraph (3).

21 ~~(14)~~

22 (15) The name and telephone number of the agency
23 representative and designated backup contact person to whom
24 inquiries concerning the proposed administrative action may be
25 directed.

26 ~~(15)~~

27 (16) The date by which comments submitted in writing must
28 be received to present statements, arguments, or contentions in
29 writing relating to the proposed action in order for them to be
30 considered by the state agency before it adopts, amends, or repeals
31 a regulation.

32 ~~(16)~~

33 (17) Reference to the fact that the agency proposing the action
34 has prepared a statement of the reasons for the proposed action,
35 has available all the information upon which its proposal is based,
36 and has available the express terms of the proposed action, pursuant
37 to subdivision (b).

38 ~~(17)~~

39 (18) A statement that if a public hearing is not scheduled, any
40 interested person or his or her duly authorized representative may

1 request, no later than 15 days prior to the close of the written
2 comment period, a public hearing pursuant to Section 11346.8.

3 ~~(18)~~

4 (19) A statement indicating that the full text of a regulation
5 changed pursuant to Section 11346.8 will be available for at least
6 15 days prior to the date on which the agency adopts, amends, or
7 repeals the resulting regulation.

8 ~~(19)~~

9 (20) A statement explaining how to obtain a copy of the final
10 statement of reasons once it has been prepared pursuant to
11 subdivision (a) of Section 11346.9.

12 ~~(20)~~

13 (21) If the agency maintains an Internet Web site or other similar
14 forum for the electronic publication or distribution of written
15 material, a statement explaining how materials published or
16 distributed through that forum can be accessed.

17 ~~(21)~~

18 (22) If the proposed regulation is subject to Section 11346.6, a
19 statement that the agency shall provide, upon request, a description
20 of the proposed changes included in the proposed action, in the
21 manner provided by Section 11346.6, to accommodate a person
22 with a visual or other disability for which effective communication
23 is required under state or federal law and that providing the
24 description of proposed changes may require extending the period
25 of public comment for the proposed action.

26 (b) The agency representative designated in paragraph~~(14)~~ (15)
27 of subdivision (a) shall make available to the public upon request
28 the express terms of the proposed action. The representative shall
29 also make available to the public upon request the location of
30 public records, including reports, documentation, and other
31 materials, related to the proposed action. If the representative
32 receives an inquiry regarding the proposed action that the
33 representative cannot answer, the representative shall refer the
34 inquiry to another person in the agency for a prompt response.

35 (c) This section shall not be construed in any manner that results
36 in the invalidation of a regulation because of the alleged inadequacy
37 of the notice content or the summary or cost estimates, or the
38 alleged inadequacy or inaccuracy of the housing cost estimates, if
39 there has been substantial compliance with those requirements.

1 *SEC. 19. Section 11349 of the Government Code is amended*
2 *to read:*

3 11349. The following definitions govern the interpretation of
4 this chapter:

5 (a) “Necessity” means the record of the rulemaking proceeding
6 demonstrates by substantial evidence the need for a regulation to
7 effectuate the purpose of the statute, court decision, or other
8 provision of law that the regulation implements, interprets, or
9 makes specific, taking into account the totality of the record. For
10 purposes of this standard, evidence includes, but is not limited to,
11 facts, studies, and expert opinion.

12 (b) “Authority” means the provision of law which permits or
13 obligates the agency to adopt, amend, or repeal a regulation.

14 (c) “Clarity” means written or displayed so that the meaning of
15 regulations will be easily understood by those persons directly
16 affected by them.

17 (d) “Consistency” means being in harmony with, and not in
18 conflict with or contradictory to, existing statutes, court decisions,
19 or other provisions of law.

20 (e) “Reference” means the statute, court decision, or other
21 provision of law which the agency implements, interprets, or makes
22 specific by adopting, amending, or repealing a regulation.

23 (f) “Nonduplication” means that a regulation does not serve the
24 same purpose as a state or federal statute or another regulation.
25 This standard requires that an agency proposing to amend or adopt
26 a regulation must identify any state or federal statute or regulation
27 which is overlapped or duplicated by the proposed regulation and
28 justify any overlap or duplication. This standard is not intended
29 to prohibit state agencies from printing relevant portions of
30 enabling legislation in regulations when the duplication is necessary
31 to satisfy the clarity standard in paragraph (3) of subdivision (a)
32 of Section 11349.1. This standard is intended to prevent the
33 indiscriminate incorporation of statutory language in a regulation.

34 (g) “Competitive impact” means that the record of the
35 rulemaking proceeding or other documentation demonstrates that
36 the regulation is authorized by a clearly articulated and
37 affirmatively expressed state law, that the regulation furthers the
38 public protection mission of the state agency, and that the impact
39 on competition is justified in light of the applicable regulatory
40 rationale for the regulation.

1 *SEC. 20. Section 11349.1 of the Government Code is amended*
2 *to read:*

3 11349.1. (a) The office shall review all regulations adopted,
4 amended, or repealed pursuant to the procedure specified in Article
5 5 (commencing with Section 11346) and submitted to it for
6 publication in the California Code of Regulations Supplement and
7 for transmittal to the Secretary of State and make determinations
8 using all of the following standards:

9 (1) Necessity.

10 (2) Authority.

11 (3) Clarity.

12 (4) Consistency.

13 (5) Reference.

14 (6) Nonduplication.

15 (7) *For those regulations submitted by a state board on which*
16 *a controlling number of decisionmakers are active market*
17 *participants in the market the board regulates, the office shall*
18 *review for competitive impact.*

19 In reviewing regulations pursuant to this section, the office shall
20 restrict its review to the regulation and the record of the rulemaking
21 ~~proceeding~~, *except as directed in subdivision (h)*. The office shall
22 approve the regulation or order of repeal if it complies with the
23 standards set forth in this section and with this chapter.

24 (b) In reviewing proposed regulations for the criteria in
25 subdivision (a), the office may consider the clarity of the proposed
26 regulation in the context of related regulations already in existence.

27 (c) The office shall adopt regulations governing the procedures
28 it uses in reviewing regulations submitted to it. The regulations
29 shall provide for an orderly review and shall specify the methods,
30 standards, presumptions, and principles the office uses, and the
31 limitations it observes, in reviewing regulations to establish
32 compliance with the standards specified in subdivision (a). The
33 regulations adopted by the office shall ensure that it does not
34 substitute its judgment for that of the rulemaking agency as
35 expressed in the substantive content of adopted regulations.

36 (d) The office shall return any regulation subject to this chapter
37 to the adopting agency if any of the following occur:

38 (1) The adopting agency has not prepared the estimate required
39 by paragraph (6) of subdivision (a) of Section 11346.5 and has not

1 included the data used and calculations made and the summary
2 report of the estimate in the file of the rulemaking.

3 (2) The agency has not complied with Section 11346.3.
4 “Noncompliance” means that the agency failed to complete the
5 economic impact assessment or standardized regulatory impact
6 analysis required by Section 11346.3 or failed to include the
7 assessment or analysis in the file of the rulemaking proceeding as
8 required by Section 11347.3.

9 (3) The adopting agency has prepared the estimate required by
10 paragraph (6) of subdivision (a) of Section 11346.5, the estimate
11 indicates that the regulation will result in a cost to local agencies
12 or school districts that is required to be reimbursed under Part 7
13 (commencing with Section 17500) of Division 4, and the adopting
14 agency fails to do any of the following:

15 (A) Cite an item in the Budget Act for the fiscal year in which
16 the regulation will go into effect as the source from which the
17 Controller may pay the claims of local agencies or school districts.

18 (B) Cite an accompanying bill appropriating funds as the source
19 from which the Controller may pay the claims of local agencies
20 or school districts.

21 (C) Attach a letter or other documentation from the Department
22 of Finance which states that the Department of Finance has
23 approved a request by the agency that funds be included in the
24 Budget Bill for the next following fiscal year to reimburse local
25 agencies or school districts for the costs mandated by the
26 regulation.

27 (D) Attach a letter or other documentation from the Department
28 of Finance which states that the Department of Finance has
29 authorized the augmentation of the amount available for
30 expenditure under the agency’s appropriation in the Budget Act
31 which is for reimbursement pursuant to Part 7 (commencing with
32 Section 17500) of Division 4 to local agencies or school districts
33 from the unencumbered balances of other appropriations in the
34 Budget Act and that this augmentation is sufficient to reimburse
35 local agencies or school districts for their costs mandated by the
36 regulation.

37 (4) The proposed regulation conflicts with an existing state
38 regulation and the agency has not identified the manner in which
39 the conflict may be resolved.

1 (5) The agency did not make the alternatives determination as
2 required by paragraph (4) of subdivision (a) of Section 11346.9.

3 (6) *The office decides that the record of the rulemaking*
4 *proceeding or other documentation for the proposed regulation*
5 *does not demonstrate that the regulation is authorized by a clearly*
6 *articulated and affirmatively expressed state law, that the*
7 *regulation does not further the public protection mission of the*
8 *state agency, or that the impact on competition is not justified in*
9 *light of the applicable regulatory rationale for the regulation.*

10 (e) The office shall notify the Department of Finance of all
11 regulations returned pursuant to subdivision (d).

12 (f) The office shall return a rulemaking file to the submitting
13 agency if the file does not comply with subdivisions (a) and (b)
14 of Section 11347.3. Within three state working days of the receipt
15 of a rulemaking file, the office shall notify the submitting agency
16 of any deficiency identified. If no notice of deficiency is mailed
17 to the adopting agency within that time, a rulemaking file shall be
18 deemed submitted as of the date of its original receipt by the office.
19 A rulemaking file shall not be deemed submitted until each
20 deficiency identified under this subdivision has been corrected.

21 (g) Notwithstanding any other law, return of the regulation to
22 the adopting agency by the office pursuant to this section is the
23 exclusive remedy for a failure to comply with subdivision (c) of
24 Section 11346.3 or paragraph (10) of subdivision (a) of Section
25 11346.5.

26 (h) *The office may designate, employ, or contract for the services*
27 *of independent antitrust or applicable economic experts when*
28 *reviewing proposed regulations for competitive impact. When*
29 *reviewing a regulation for competitive impact, the office shall do*
30 *all of the following:*

31 (1) *If the Director of Consumer Affairs issued a written decision*
32 *pursuant to subdivision (c) of Section 109 of the Business and*
33 *Professions Code, the office shall review and consider the decision*
34 *and all supporting documentation in the rulemaking file.*

35 (2) *Consider whether the anticompetitive effects of the proposed*
36 *regulation are clearly outweighed by the public policy merits.*

37 (3) *Provide a written opinion setting forth the office's findings*
38 *and substantive conclusions under paragraph (2), including, but*
39 *not limited to, whether rejection or modification of the proposed*
40 *regulation is necessary to ensure that restraints of trade are related*

1 *to and advance the public policy underlying the applicable*
2 *regulatory rationale.*

3 *SEC. 21. No reimbursement is required by this act pursuant*
4 *to Section 6 of Article XIII B of the California Constitution because*
5 *the only costs that may be incurred by a local agency or school*
6 *district will be incurred because this act creates a new crime or*
7 *infraction, eliminates a crime or infraction, or changes the penalty*
8 *for a crime or infraction, within the meaning of Section 17556 of*
9 *the Government Code, or changes the definition of a crime within*
10 *the meaning of Section 6 of Article XIII B of the California*
11 *Constitution.*

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1261
Author: Stone
Bill Date: February 18, 2016, Introduced
Subject: Physicians and Surgeons: Licensure Exemption
Sponsor: California Primary Care Association (CPCA)

DESCRIPTION OF CURRENT LEGISLATION:

This bill would authorize physicians licensed in another state to work in California free clinics for up to 60 days a year, as specified.

BACKGROUND

This bill is modeled after existing law, AB 2699 (Bass, Chapter 270, Statutes of 2010). This bill provided a framework whereby healing arts boards are authorized to adopt regulations under which a health care practitioner licensed and in good standing in another state, district or territory of the United States may, under specified conditions, provide health care services for a limited time in California (up to 10 days) without obtaining California licensure. These professional services only can be provided at free health care events sponsored by certain entities. The Medical Board of California (Board) opposed this bill because it believed that only physicians licensed in California should be allowed to practice medicine in California in order to ensure the highest quality medical care is being provided to individuals in California.

ANALYSIS

This bill would allow a physician who offers or provides health care services at a free clinic to be exempt from the requirement to be licensed as a physician in California. This bill would define free clinic as a clinic operated by a tax-exempt, nonprofit corporation supported in whole or in part by voluntary donations, bequests, gifts, grants, government funds or contributions. In a free clinic there can be no charges directly to the patient. This bill would define a physician as any person, licensed or certified in good standing in another state, district, or territory of the United States who offers or provides health care services for which he or she is licensed or certified.

This bill would require the physician, prior to providing services at a free clinic, to do the following:

- Obtain authorization from the Board to participate in a free clinic after submitting to the Board a copy of his or her valid license or certificate from each state where he or she holds licensure or certification and photographic identification. The Board would be required to notify the free clinic, within 20 calendar days of receiving a request for authorization, whether that request is approved or denied.

- The physician must not have committed any act or been convicted of a crime constituting grounds for denial of licensure and must be in good standing in each state where he or she is licensed. The physician must have had the appropriate education and experience to participate in a free clinic, as determined by the Board. The physician must agree to comply with all applicable practice requirements, which will be adopted by the Board through regulations.
- The physician must submit to the Board, on a form prescribed by the Board, a request for authorization to practice without a license and pay a fee in an amount determined by the Board through regulations.
- The physician can provide services to uninsured or underinsured individuals, which means the individual does not have health care coverage, or if they have health care coverage, the coverage is not adequate to obtain the health care services offered by the physician. The services must be provided on a voluntary basis for a total of 60 days in a calendar year. The free clinic must be enrolled in the Medi-Cal program. The services must be provided without charge to the patient.

This bill would allow the Board to deny a physician authorization to practice without a license if the physician fails to comply with the requirements in this bill or for any act that would be grounds for denial of an application for licensure.

This bill would require a free clinic enrolled in the Medi-Cal Program, seeking to provide or arrange for the provision of health care services using an out of state physician, to register with the Board by completing a registration form that includes the following:

- The name of the free clinic.
- The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the free clinic.
- The address and telephone numbers of the free clinic's principal office and each individual listed in the bullet above.
- Any additional information required by the Board.

The registration form information must also be provided to the county health department of the county in which the health care services will be provided. The free clinic would be required to notify the Board and the county health department in writing of any change to the information submitted. The free clinic would be required to file a report with the Board and the county health department within 15 calendar days of the provision of health care services. The report must include the date, place, type, and general description of the care provided, along with a listing of the physicians who participated in providing that care. This bill would require the free clinic to maintain a list of physicians associated with the provision of health care services allowed under this bill, along with other specified information. This bill would prohibit a contract of liability insurance issued, amended or renewed in California on or after January 1, 2017 from excluding coverage of a physician or a free clinic that provides, or arranges for, the provision of health care services.

This bill would allow the Board to terminate authorization for a physician to provide

health care services for failure to comply with the law, as specified, and provides for an appeals process for the physician.

This bill would essentially expand the number of out-of-state physicians that can practice in California without obtaining a California physician and surgeon license.. Right now this is allowed only at sponsored health care events and only for up to 10 days. This bill would expand existing law and allow physicians licensed in other states to work at any free clinic enrolled in the Medi-Cal program and would allow these physicians to work up to 60 days per calendar year. The framework for this bill already exists, however, this is a significant expansion. Physicians treating patients in California should all be held to the same standards, in order to ensure that the highest quality medical care is being provided in California. The author's office does not know exactly how many free clinics there are in California, but the Board believes it will be a significant expansion.

The Board's primary mission is consumer protection, and physicians practicing in California should all be subject to the same laws and regulations when caring for patients in California. It should not matter where that care is being provided and to whom that care is being provided. For these reasons, Board staff suggests that the Board take an oppose position on this bill.

FISCAL: This bill is a significant expansion of current law what would result in increased workload. The Board anticipates it would need one position at the staff services analyst level to handle the increased workload and ensure that the registrants meet the requirements of law and have the correct documentation. The Board will also need to amend existing regulations. This would result in a cost of \$124,000 for the first year and \$111,000 in ongoing costs.

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Oppose

Introduced by Senator StoneFebruary 18, 2016

An act to add Section 902 to the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1261, as introduced, Stone. Physicians and surgeons: licensure exemption.

Existing law provides for the licensure and regulation of various healing arts practitioners by boards within the Department of Consumer Affairs. Existing law provides an exemption from these requirements for a health care practitioner licensed in another state who offers or provides health care for which he or she is licensed during a state of emergency, as defined, and upon request of the Director of the Emergency Medical Services Authority, as specified.

Existing law provides, until January 1, 2018, an exemption from the licensure and regulation requirements for a health care practitioner, as defined, licensed or certified in good standing in another state or states, who offers or provides health care services for which he or she is licensed or certified through a sponsored event, as defined, (1) to uninsured or underinsured persons, (2) on a short-term voluntary basis, (3) in association with a sponsoring entity that registers with the applicable healing arts board, as defined, and provides specified information to the county health department of the county in which the health care services will be provided, and (4) without charge to the recipient or a 3rd party on behalf of the recipient, as specified. Existing law also requires an exempt health care practitioner to obtain prior authorization to provide these services from the applicable licensing

board, as defined, and to satisfy other specified requirements, including payment of a fee as determined by the applicable licensing board.

This bill would provide an exemption similar to that sponsored event exemption to be administered by the Medical Board of California, applicable only to a physician, defined as a person licensed or certified in good standing in another jurisdiction of the United States, who offers or provides health care services for which he or she is licensed or certified, and who engages in acts that are subject to licensure or regulation under the Medical Practice Act. That exemption would be for health care services that are provided through free clinics, as defined, rather than through sponsored events. Such a physician would be authorized to volunteer for up to 60 days in a calendar year, which need not be consecutive.

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

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

1 SECTION 1. Section 902 is added to the Business and
2 Professions Code, to read:

3 902. (a) For purposes of this section, the following definitions
4 apply:

5 (1) “Board” means the Medical Board of California.

6 (2) “Free clinic” has the same meaning as defined in Section
7 1204 of the Health and Safety Code.

8 (3) “Physician” means any person, licensed or certified in good
9 standing in another state, district, or territory of the United States
10 who offers or provides health care services for which he or she is
11 licensed or certified and who engages in acts that are subject to
12 licensure or regulation under Chapter 5 (commencing with Section
13 2000).

14 (4) “Uninsured or underinsured person” means a person who
15 does not have health care coverage, including private coverage or
16 coverage through a program funded in whole or in part by a
17 governmental entity, or a person who has health care coverage,
18 but the coverage is not adequate to obtain those health care services
19 offered by the physician under this section.

20 (b) A physician who offers or provides health care services at
21 a free clinic is exempt from the requirement for licensure under

1 Chapter 5 (commencing with Section 2000) if all of the following
2 requirements are met:

3 (1) Prior to providing those services, he or she does all of the
4 following:

5 (A) Obtains authorization from the board to participate in a free
6 clinic after submitting to the board a copy of his or her valid license
7 or certificate from each state in which he or she holds licensure or
8 certification and a photographic identification issued by one of the
9 states in which he or she holds licensure or certification. The board
10 shall notify the free clinic, within 20 calendar days of receiving a
11 request for authorization, whether that request is approved or
12 denied.

13 (B) Satisfies the following requirements:

14 (i) The physician has not committed any act or been convicted
15 of a crime constituting grounds for denial of licensure or
16 registration under Section 480 and is in good standing in each state
17 in which he or she holds licensure or certification.

18 (ii) The physician has the appropriate education and experience
19 to participate in a free clinic, as determined by the board.

20 (iii) The physician shall agree to comply with all applicable
21 practice requirements set forth in this division and the regulations
22 adopted pursuant to this division.

23 (C) Submits to the board, on a form prescribed by the board, a
24 request for authorization to practice without a license, and pays a
25 fee, in an amount determined by the board by regulation, which
26 shall be available, upon appropriation, to cover the cost of
27 developing the authorization process and processing the request.

28 (2) The services are provided under all of the following
29 circumstances:

30 (A) To uninsured or underinsured persons.

31 (B) On voluntary basis, for a total of days not to exceed 60 days
32 in a calendar year. The 60 days need not be consecutive.

33 (C) In association with a free clinic enrolled in the Medi-Cal
34 program that complies with subdivision (d).

35 (D) Without charge to the recipient or to a third party on behalf
36 of the recipient.

37 (c) The board may deny a physician authorization to practice
38 without a license if the physician fails to comply with this section
39 or for any act that would be grounds for denial of an application
40 for licensure.

- 1 (d) A free clinic enrolled in the Medi-Cal program seeking to
2 provide, or arrange for the provision of, health care services under
3 this section shall do both of the following:
- 4 (1) Register with the board by completing a registration form
5 that shall include all of the following:
- 6 (A) The name of the free clinic.
7 (B) The name of the principal individual or individuals who are
8 the officers or organizational officials responsible for the operation
9 of the free clinic.
10 (C) The address, including street, city, ZIP Code, and county,
11 of the free clinic's principal office and each individual listed
12 pursuant to subparagraph (B).
13 (D) The telephone number for the principal office of the free
14 clinic and each individual listed pursuant to subparagraph (B).
15 (E) Any additional information required by the board.
- 16 (2) Provide the information listed in paragraph (1) to the county
17 health department of the county in which the health care services
18 will be provided, along with any additional information that may
19 be required by that department.
- 20 (e) The free clinic shall notify the board and the county health
21 department described in paragraph (2) of subdivision (d) in writing
22 of any change to the information required under subdivision (d)
23 within 30 calendar days of the change.
- 24 (f) Within 15 calendar days of the provision of health care
25 services pursuant to this section, the free clinic shall file a report
26 with the board and the county health department of the county in
27 which the health care services were provided. This report shall
28 contain the date, place, type, and general description of the care
29 provided, along with a listing of the physicians who participated
30 in providing that care.
- 31 (g) The free clinic shall maintain a list of physicians associated
32 with the provision of health care services under this section. The
33 free clinic shall maintain a copy of each physician's current license
34 or certification and shall require each physician to attest in writing
35 that his or her license or certificate is not suspended or revoked
36 pursuant to disciplinary proceedings in any jurisdiction. The free
37 clinic shall maintain these records for a period of at least five years
38 following the provision of health care services under this section
39 and shall, upon request, furnish those records to the board or any
40 county health department.

1 (h) A contract of liability insurance issued, amended, or renewed
2 in this state on or after January 1, 2017, shall not exclude coverage
3 of a physician or a free clinic that provides, or arranges for the
4 provision of, health care services under this section, provided that
5 the practitioner or free clinic complies with this section.

6 (i) Subdivision (b) shall not be construed to authorize a physician
7 to render care outside the scope of practice authorized by his or
8 her license or certificate or this division.

9 (j) (1) The board may terminate authorization for a physician
10 to provide health care services pursuant to this section for failure
11 to comply with this section, any applicable practice requirement
12 set forth in this division, any regulations adopted pursuant to this
13 division, or for any act that would be grounds for discipline if done
14 by a licensee of the board.

15 (2) The board shall provide both the free clinic and the physician
16 with a written notice of termination including the basis for that
17 termination. The physician may, within 30 days after the date of
18 the receipt of notice of termination, file a written appeal to the
19 board. The appeal shall include any documentation the physician
20 wishes to present to the board.

21 (3) A physician whose authorization to provide health care
22 services pursuant to this section has been terminated shall not
23 provide health care services pursuant to this section unless and
24 until a subsequent request for authorization has been approved by
25 the board. A physician who provides health care services in
26 violation of this paragraph shall be deemed to be practicing health
27 care in violation of Chapter 5 (commencing with Section 2000),
28 and be subject to any applicable administrative, civil, or criminal
29 fines, penalties, and other sanctions provided in this division.

30 (k) The provisions of this section are severable. If any provision
31 of this section or its application is held invalid, that invalidity shall
32 not affect other provisions or applications that can be given effect
33 without the invalid provision or application.

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1471
Author: Hernandez
Bill Date: April 21, 2016, Amended
Subject: Health Professions Development: Loan Repayment
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would transfer specified moneys from the Managed Care Administrative Fines and Penalties Fund (MCAFPF) to the Medically Underserved Account for Physicians (MUAP) in the Health Professions Education Fund (HPEF) for use by the Steven M. Thompson Loan Repayment Program (STLRP).

BACKGROUND

The STLRP was created in 2002 via legislation which was co-sponsored by the Medical Board of California (Board). The STLRP encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans (up to \$105,000) in exchange for a minimum three years of service. In 2006, the administration of STLRP was transitioned from the Board to the Health Professions Education Foundation (HPEF). Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health professions' students and recent graduates, these programs are funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, and corporations, as well as through a surcharge on the renewal fees of various health professionals, including a \$25 fee paid by physicians and surgeons.

ANALYSIS

Under current law, revenue from fines and penalties levied on health plans is deposited in the MCAFPF. Existing law requires fines and penalties collected up to \$1 million to be deposited in to the MUAP in the HPEF for purposes of the STLRP. Existing law requires any amount over the first \$1 million to be transferred to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature by the Major Risk Medical Insurance Program (MRMIP).

This bill would require, beginning January 1, 2017 and annually thereafter, any amount over the first \$2 million, including accrued interest, to be transferred to the HPEF for the STLRP program. This bill would allow one-half of these moneys to be prioritized to fund repayment of loans for those physicians who are trained in, and practice, psychiatry, as specified. This bill would also make other conforming changes and delete references to

inoperative programs.

According to the author, the STLRP was created in response to the physician shortage problem in underserved areas, but funding for this program has been unpredictable and insufficient, with demand exceeding available funding every year. Currently up to 20% of the available funding for the STLRP may be awarded to program applicants from specialties outside of the primary care specialties, including psychiatry, but is annually disbursed among other specialties. This bill would provide much needed funding for the STLRP to assist with loan repayment for physicians who agree to practice in medically underserved areas of the state, as well as prioritize new funds for those who are trained in, and practice, psychiatry. This bill would promote the Board's mission of access to care and Board staff suggests that the Board take a support position on this bill.

FISCAL: None

SUPPORT: None on file

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE APRIL 21, 2016

AMENDED IN SENATE APRIL 14, 2016

SENATE BILL

No. 1471

Introduced by Senator Hernandez

February 19, 2016

An act to amend Sections 1341.45, 128551, and 128552 ~~of, and to add Section 128555.5 to,~~ of the Health and Safety Code, relating to health professions development.

LEGISLATIVE COUNSEL'S DIGEST

SB 1471, as amended, Hernandez. Health professions development: loan repayment.

Existing law establishes the Steven M. Thompson Physician Corps Loan Repayment Program in the California Physician Corps Program within the Health Professions Education Foundation, which provides financial incentives, including repayment of educational loans, to a physician and surgeon who practices in a medically underserved area, ~~as defined~~ *defined, and who is trained in, and practices, in certain practice settings or primary specialties, as defined*. Existing law authorizes the selection committee to fill up to 20% of the available positions with program applicants from specialties outside of the primary specialties, including psychiatry. Existing law establishes the Medically Underserved Account for Physicians, a continuously appropriated account, within the Health Professions Education Fund that is managed by the Health Professions Education Foundation and the Office of Statewide Health Planning and Development, to primarily provide funding for the ongoing operations of the Steven M. Thompson Physician Corps Loan Repayment Program.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and imposes certain requirements on health care service plans. Existing law imposes various fines and administrative penalties on health care service plans for certain violations of the act, which are deposited into the Managed Care Administrative Fines and Penalties Fund. Existing law requires the first \$1,000,000 in the fund to be transferred each year to the Medically Underserved Account for Physicians and to be used, upon appropriation by the Legislature, for purposes of the Steven M. Thompson Physician Corps Loan Repayment Program. Existing law requires all remaining funds to be transferred each year to the Major Risk Medical Insurance Fund and to be used, upon appropriation by the Legislature, for purposes of the Major Risk Medical Insurance Program.

~~This bill would expand the eligibility for loan repayment funds under the Steven M. Thompson Physician Corps Loan Repayment Program to include those physicians providing psychiatric services. The bill would provide that continuously appropriated funds deposited into the Medically Underserved Account for Physicians shall not be made available under the Steven M. Thompson Physician Corps Loan Repayment Program to fund the repayment of loans for those physicians providing psychiatric services or those physicians whose primary specialty is psychiatry, as specified.~~

The bill would instead require, after the first \$1,000,000 is transferred from the Managed Care Administrative Fines and Penalties Fund to the Medically Underserved Account for Physicians, \$1,000,000 to be transferred each year to the Major Risk Medical Insurance Fund to be used, upon appropriation by the Legislature, for the Major Risk Medical Insurance Program. The bill would require any amount remaining over the amounts transferred to the Medically Underserved Account for Physicians and the Major Risk Medical Insurance Fund to be transferred each year to the Medically Underserved Account for Physicians to be used, upon appropriation by the Legislature, for the Steven M. Thompson Physician Corps Loan Repayment Program, and provide that one-half of these moneys ~~are to be used~~ *may be prioritized* to fund the repayment of loans for those ~~physicians providing psychiatric services or those physicians whose primary specialty is psychiatry~~ *program applicants who are trained in, and practice, psychiatry*, under the Steven M. Thompson Physician Corps Loan Repayment Program.

The bill would also delete a reference to an obsolete program and make other technical, nonsubstantive changes.

Vote: majority. Appropriation: no. Fiscal committee: yes.

State-mandated local program: no.

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

1 SECTION 1. Section 1341.45 of the Health and Safety Code
2 is amended to read:

3 1341.45. (a) There is hereby created in the State Treasury the
4 Managed Care Administrative Fines and Penalties Fund.

5 (b) The fines and administrative penalties collected pursuant to
6 this chapter, on and after September 30, 2008, shall be deposited
7 into the Managed Care Administrative Fines and Penalties Fund.

8 (c) The fines and administrative penalties deposited into the
9 Managed Care Administrative Fines and Penalties Fund shall be
10 transferred by the department, annually, as follows:

11 (1) The first one million dollars (\$1,000,000) shall be transferred
12 to the Medically Underserved Account for Physicians within the
13 Health Professions Education Fund and shall, upon appropriation
14 by the Legislature, be used for the purposes of the Steven M.
15 Thompson Physician Corps Loan Repayment Program, as specified
16 in Article 5 (commencing with Section 128550) of Chapter 5 of
17 Part 3 of Division 107 and, notwithstanding Section 128555, shall
18 not be used to provide funding for the Physician Volunteer
19 Program.

20 (2) Until January 1, 2017, any amount over the first one million
21 dollars (\$1,000,000), including accrued interest, in the fund shall
22 be transferred to the Major Risk Medical Insurance Fund continued
23 pursuant to Section 15893 of the Welfare and Institutions Code
24 and shall, upon appropriation by the Legislature, be used for the
25 Major Risk Medical Insurance Program for the purposes specified
26 in Section 15894 of the Welfare and Institutions Code.

27 (3) On and after January 1, 2017, and annually thereafter, the
28 second one million dollars (\$1,000,000) shall be transferred to the
29 Major Risk Medical Insurance Fund continued pursuant to Section
30 15893 of the Welfare and Institutions Code and shall, upon
31 appropriation by the Legislature, be used for the Major Risk
32 Medical Insurance Program for the purposes specified in Section
33 15894 of the Welfare and Institutions Code.

1 (4) (A) On and after January 1, 2017 any amount over the first
2 two million dollars (\$2,000,000), including accrued interest, in the
3 fund shall be transferred to the Medically Underserved Account
4 for Physicians within the Health Professions Education Fund and
5 shall, upon appropriation by the Legislature, and subject to
6 subparagraph (B), be used for the purposes of the Steven M.
7 Thompson Physician Corps Loan Repayment Program, as specified
8 in Article 5 (commencing with Section 128550) of Chapter 5 of
9 Part 3 of Division 107 and, notwithstanding Section 128555, shall
10 not be used to provide funding for the Physician Volunteer
11 Program.

12 (B) ~~One-half~~ *Up to one-half* of the moneys deposited into the
13 Medically Underserved Account for Physicians within the Health
14 Professions Education Fund under this paragraph ~~shall, upon~~
15 ~~appropriation by the Legislature, be used~~ *may be prioritized* to
16 fund the repayment of ~~loans~~ *loans pursuant to paragraph (2) of*
17 *subdivision (d) of Section 128553* for those ~~physicians providing~~
18 ~~psychiatric services or those physicians whose primary specialty~~
19 ~~is psychiatry~~ *program applicants who are trained in, and practice,*
20 *psychiatry*, under the Steven M. Thompson Physician Corps Loan
21 Repayment Program, ~~as specified in Article~~ *Program (Article 5*
22 *commencing with Section 128550) of Chapter 5 of Part 3 of*
23 ~~Division 107. 107).~~

24 (d) Notwithstanding subdivision (b) of Section 1356 and Section
25 1356.1, the fines and administrative penalties authorized pursuant
26 to this chapter shall not be used to reduce the assessments imposed
27 on health care service plans pursuant to Section 1356.

28 SEC. 2. Section 128551 of the Health and Safety Code is
29 amended to read:

30 128551. (a) It is the intent of this article that the Health
31 Professions Education Foundation and the office provide the
32 ongoing program management of the two programs identified in
33 subdivision (b) of Section 128550 as a part of the California
34 Physician Corps Program.

35 (b) For purposes of subdivision (a), the foundation shall consult
36 with the Medical Board of California, Office of Statewide Health
37 Planning and Development, and shall establish and consult with
38 an advisory committee of not more than seven members, that shall
39 include two members recommended by the California Medical
40 Association and may include other members of the medical

1 community, including ethnic representatives, medical schools,
2 health advocates representing ethnic communities, primary care
3 clinics, public hospitals, and health systems, statewide agencies
4 administering state and federally funded programs targeting
5 underserved communities, and members of the public with
6 expertise in health care issues.

7 SEC. 3. Section 128552 of the Health and Safety Code is
8 amended to read:

9 128552. For purposes of this article, the following definitions
10 shall apply:

11 (a) “Account” means the Medically Underserved Account for
12 Physicians established within the Health Professions Education
13 Fund pursuant to this article.

14 (b) “Foundation” means the Health Professions Education
15 Foundation.

16 (c) “Fund” means the Health Professions Education Fund.

17 (d) “Medi-Cal threshold languages” means primary languages
18 spoken by limited-English-proficient (LEP) population groups
19 meeting a numeric threshold of 3,000, eligible LEP Medi-Cal
20 beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP
21 beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal
22 beneficiaries residing in two contiguous ZIP Codes.

23 (e) “Medically underserved area” means an area defined as a
24 health professional shortage area in Part 5 (commencing with
25 Section 5.1) of Subchapter A of Chapter 1 of Title 42 of the Code
26 of Federal Regulations or an area of the state where unmet priority
27 needs for physicians exist as determined by the California
28 Healthcare Workforce Policy Commission pursuant to Section
29 128225.

30 (f) “Medically underserved population” means the Medi-Cal
31 program and uninsured populations.

32 (g) “Office” means the Office of Statewide Health Planning and
33 Development (OSHPD).

34 (h) “Physician Volunteer Program” means the Physician
35 Volunteer Registry Program established by the Medical Board of
36 California.

37 (i) “Practice setting,” for the purposes of this article only, means
38 either of the following:

39 (1) A community clinic as defined in subdivision (a) of Section
40 1204 and subdivision (c) of Section 1206, a clinic owned or

1 operated by a public hospital and health system, or a clinic owned
 2 and operated by a hospital that maintains the primary contract with
 3 a county government to fulfill the county’s role pursuant to Section
 4 17000 of the Welfare and Institutions Code, which is located in a
 5 medically underserved area and at least 50 percent of whose
 6 patients are from a medically underserved population.

7 (2) A physician owned and operated medical practice setting
 8 that provides primary care ~~or psychiatric services~~ located in a
 9 medically underserved area and has a minimum of 50 percent of
 10 patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries
 11 of another publicly funded program that serves patients who earn
 12 less than 250 percent of the federal poverty level.

13 (j) “Primary specialty” means family practice, internal medicine,
 14 pediatrics, ~~psychiatry~~, or obstetrics/gynecology.

15 (k) “Program” means the Steven M. Thompson Physician Corps
 16 Loan Repayment Program.

17 (l) “Selection committee” means a minimum three-member
 18 committee of the board, that includes a member that was appointed
 19 by the Medical Board of California.

20 ~~SEC. 4. Section 128555.5 is added to the Health and Safety~~
 21 ~~Code, to read:~~

22 ~~128555.5. Notwithstanding subdivision (e) of Section 128555,~~
 23 ~~funds deposited into the Medically Underserved Account for~~
 24 ~~Physicians shall not be made available to fund the repayment of~~
 25 ~~loans under the Steven M. Thompson Physician Corps Loan~~
 26 ~~Repayment Program for those physicians providing psychiatric~~
 27 ~~services or those physicians whose primary specialty is psychiatry,~~
 28 ~~except as provided in subparagraph (B) of paragraph (4) of~~
 29 ~~subdivision (e) of Section 1341.45.~~

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1478
Author: Senate Business, Professions and Economic Development Committee
Bill Date: March 10, 2016, Introduced
Subject: Healing Arts
Sponsor: Author and affected healing arts boards
Position: Support provisions related to the Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill is the vehicle by which omnibus legislation has been carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). This bill would delete outdated sections of the BPC that are related to the Board.

ANALYSIS

- This bill would delete BPC Section 2029 that requires the Board to keep copies of complaints for 10 years. The Board already has its own record retention schedule and BPC Section 2227.5 only requires the Board to keep complaints for seven years or until the statute of limitations has expired, whichever is shorter. BPC Section 2230.5 sets forth the statute of limitations for filing an accusation, which is three years from the date the Board finds out about the event or seven years from the date of the event, whichever occurs first. Both of these section of law make BPC 2029 inapplicable.
- This bill would delete the Task Force created in BPC Section 852, as it no longer exists.
- This bill would also delete Sections 2380-2392 of the BPC, which create the Bureau of Medical Statistics in the Board. The Bureau of Medical Statistics does not exist, so this change is code clean up only.

These changes will remove outdated and inapplicable sections from the BPC and the Board is pleased to sponsor/support these provisions in SB 1478.

FISCAL: None

SUPPORT: Medical Board of California

OPPOSITION: None on File

Introduced by Committee on Business, Professions and Economic Development (Senators Hill (Chair), Bates, Berryhill, Block, Galgiani, Hernandez, Jackson, Mendoza, and Wieckowski)

March 10, 2016

An act to amend Sections 1632, 1634.1, 2467, 4980.36, 4980.37, 4980.43, 4980.78, 4980.79, 4992.05, 4996.18, 4996.23, 4999.12, 4999.40, 4999.47, 4999.52, 4999.60, 4999.61, and 4999.120 of, to add Sections 4980.09 and 4999.12.5 to, to repeal Sections 852, 2029, 4980.40.5, and 4999.54 of, and to repeal Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, as introduced, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of healing arts professions and vocations by boards within the Department of Consumer Affairs.

(1) Existing law establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the task force to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency, identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices and assess the need for voluntary certification standards and examinations for cultural and linguistic competency.

This bill would delete those provisions.

(2) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. Existing law requires

each applicant to, among other things, successfully complete the Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

This bill would instead require the applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(3) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law requires the board to keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint, as provided.

This bill would delete that requirement.

Existing law creates the Bureau of Medical Statistics within the board. Under existing law, the purpose of the bureau is to provide the board with statistical information necessary to carry out their functions of licensing, medical education, medical quality, and enforcement.

This bill would abolish that bureau.

(4) Under existing law, the California Board of Podiatric Medicine is responsible for the certification and regulation of the practice of podiatric medicine. Existing law requires the board to annually elect one of its members to act as president and vice president.

This bill would instead require the board to elect from its members a president, a vice president, and a secretary.

(5) The Board of Behavioral Sciences is responsible for administering, among others, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

(A) Existing law, the Licensed Marriage and Family Therapist Act, provides for the regulation of the practice of marriage and family therapy by the Board of Behavioral Sciences. A violation of the act is a crime. Existing law requires the licensure of marriage and family therapists and the registration of marriage and family therapist interns. Under existing law, an “intern” is defined as an unlicensed person who has earned his or her master’s or doctoral degree qualifying him or her for licensure and is registered with the board. Existing law prohibits the abbreviation “MFTI” from being used in an advertisement unless the title “marriage and family therapist registered intern” appears in the advertisement.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the regulation of the practice of professional clinical

counseling by the Board of Behavioral Sciences. Existing law requires the licensure of professional clinical counselors and the registration of professional clinical counselor interns. Under existing law, an “intern” is defined as an unlicensed person who meets specified requirements for registration and is registered with the board.

This bill, commencing January 1, 2018, would provide that certain specified titles using the term “intern” or any reference to the term “intern” in those acts shall be deemed to be a reference to an “associate,” as specified. Because this bill would change the definition of a crime, it would impose a state-mandated local program.

(B) The Licensed Marriage and Family Therapist Act generally requires specified applicants for licensure and registration to meet certain educational degree requirements, including having obtained that degree from a school, college, or university that, among other things, is accredited by a regional accrediting agency recognized by the United States Department of Education.

This bill would authorize that accreditation to be by a regional or national institutional accrediting agency recognized by the United States Department of Education.

Under the Licensed Marriage and Family Therapist Act, a specified doctoral or master’s degree approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, is considered by the Board of Behavioral Sciences to meet the specified licensure and registration requirements if the degree is conferred on or before July 1, 2010. As an alternative, existing law requires the Board of Behavioral Sciences to accept those doctoral or master's degrees as equivalent degrees if those degrees are conferred by educational institutions accredited by specified associations.

This bill would delete those provisions.

(C) Under the Licensed Marriage and Family Therapist Act, an applicant for licensure is required to complete experience related to the practice of marriage and family therapy under the supervision of a supervisor. Existing law requires applicants, trainees who are unlicensed persons enrolled in an educational program to qualify for licensure, and interns who are unlicensed persons who have completed an educational program and is registered with the board to be at all times under the supervision of a supervisor. Existing law requires interns and trainees to only gain supervised experience as an employee or volunteer and prohibits experience from being gained as an independent contractor. Similarly, the Licensed Professional Clinical Counselor Act requires

clinical counselor trainees, interns, and applicants to perform services only as an employee or as a volunteer. The Licensed Professional Clinical Counselor Act prohibits gaining mental health experience by interns or trainees as an independent contractor.

The Clinical Social Worker Practice Act requires applicants to complete supervised experience related to the practice of clinical social work.

This bill would prohibit these persons from being employed as independent contractors and from gaining experience for work performed as an independent contractor reported on a specified tax form.

(D) The Licensed Professional Clinical Counselor Act defines the term “accredited” for the purposes of the act to mean a school, college, or university accredited by the Western Association of Schools and Colleges, or its equivalent regional accrediting association. The act requires each educational institution preparing applicants to qualify for licensure to notify each of its students in writing that its degree program is designed to meet specified examination eligibility or registration requirements and to certify to the Board of Behavioral Sciences that it has provided that notice.

This bill would re-define “accredited” to mean a school, college, or university accredited by a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The bill would additionally require an applicant for registration or licensure to submit to the Board of Behavioral Sciences a certification from the applicant’s educational institution specifying that the curriculum and coursework complies with those examination eligibility or registration requirements.

(6) This bill would additionally delete various obsolete provisions, make conforming changes, and make other nonsubstantive changes.

(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 852 of the Business and Professions Code
2 is repealed.
3 ~~852. (a) The Task Force on Culturally and Linguistically~~
4 ~~Competent Physicians and Dentists is hereby created and shall~~
5 ~~consist of the following members:~~
6 ~~(1) The State Director of Health Services and the Director of~~
7 ~~Consumer Affairs, who shall serve as cochairs of the task force.~~
8 ~~(2) The Executive Director of the Medical Board of California.~~
9 ~~(3) The Executive Director of the Dental Board of California.~~
10 ~~(4) One member appointed by the Senate Committee on Rules.~~
11 ~~(5) One member appointed by the Speaker of the Assembly.~~
12 ~~(b) Additional task force members shall be appointed by the~~
13 ~~Director of Consumer Affairs, in consultation with the State~~
14 ~~Director of Health Services, as follows:~~
15 ~~(1) Representatives of organizations that advocate on behalf of~~
16 ~~California licensed physicians and dentists.~~
17 ~~(2) California licensed physicians and dentists that provide~~
18 ~~health services to members of language and ethnic minority groups.~~
19 ~~(3) Representatives of organizations that advocate on behalf of,~~
20 ~~or provide health services to, members of language and ethnic~~
21 ~~minority groups.~~
22 ~~(4) Representatives of entities that offer continuing education~~
23 ~~for physicians and dentists.~~
24 ~~(5) Representatives of California's medical and dental schools.~~
25 ~~(6) Individuals with experience in developing, implementing,~~
26 ~~monitoring, and evaluating cultural and linguistic programs.~~
27 ~~(c) The duties of the task force shall include the following:~~
28 ~~(1) Developing recommendations for a continuing education~~
29 ~~program that includes language proficiency standards of foreign~~
30 ~~language to be acquired to meet linguistic competency.~~
31 ~~(2) Identifying the key cultural elements necessary to meet~~
32 ~~cultural competency by physicians, dentists, and their offices.~~
33 ~~(3) Assessing the need for voluntary certification standards and~~
34 ~~examinations for cultural and linguistic competency.~~
35 ~~(d) The task force shall hold hearings and convene meetings to~~
36 ~~obtain input from persons belonging to language and ethnic~~
37 ~~minority groups to determine their needs and preferences for having~~
38 ~~culturally competent medical providers. These hearings and~~

1 meetings shall be convened in communities that have large
2 populations of language and ethnic minority groups.

3 (e) ~~The task force shall report its findings to the Legislature and~~
4 ~~appropriate licensing boards within two years after creation of the~~
5 ~~task force.~~

6 (f) ~~The Medical Board of California and the Dental Board of~~
7 ~~California shall pay the state administrative costs of implementing~~
8 ~~this section.~~

9 (g) ~~Nothing in this section shall be construed to require~~
10 ~~mandatory continuing education of physicians and dentists.~~

11 SEC. 2. Section 1632 of the Business and Professions Code is
12 amended to read:

13 1632. (a) The board shall require each applicant to successfully
14 complete the ~~Part I and Part II written examinations~~ *written*
15 *examination* of the National Board Dental Examination of the Joint
16 Commission on National Dental Examinations.

17 (b) The board shall require each applicant to successfully
18 complete an examination in California law and ethics developed
19 and administered by the board. The board shall provide a separate
20 application for this examination. The board shall ensure that the
21 law and ethics examination reflects current law and regulations,
22 and ensure that the examinations are randomized. Applicants shall
23 submit this application and required fee to the board in order to
24 take this examination. In addition to the aforementioned
25 application, the only other requirement for taking this examination
26 shall be certification from the dean of the qualifying dental school
27 attended by the applicant that the applicant has graduated, or will
28 graduate, or is expected to graduate. Applicants who submit
29 completed applications and certification from the dean at least 15
30 days prior to a scheduled examination shall be scheduled to take
31 the examination. Successful results of the examination shall, as
32 established by board regulation, remain valid for two years from
33 the date that the applicant is notified of having passed the
34 examination.

35 (c) Except as otherwise provided in Section 1632.5, the board
36 shall require each applicant to have taken and received a passing
37 score on one of the following:

38 (1) A portfolio examination of the applicant's competence to
39 enter the practice of dentistry. This examination shall be conducted
40 while the applicant is enrolled in a dental school program at a

1 board-approved school located in California. This examination
2 shall utilize uniform standards of clinical experiences and
3 competencies, as approved by the board pursuant to Section 1632.1.
4 The applicant shall pass a final assessment of the submitted
5 portfolio at the end of his or her dental school program. Before
6 any portfolio assessment may be submitted to the board, the
7 applicant shall remit the required fee to the board to be deposited
8 into the State Dentistry Fund, and a letter of good standing signed
9 by the dean of his or her dental school or his or her delegate stating
10 that the applicant has graduated or will graduate with no pending
11 ethical issues.

12 (A) The portfolio examination shall not be conducted until the
13 board adopts regulations to carry out this paragraph. The board
14 shall post notice on its Internet Web site when these regulations
15 have been adopted.

16 (B) The board shall also provide written notice to the Legislature
17 and the Legislative Counsel when these regulations have been
18 adopted.

19 (2) A clinical and written examination administered by the
20 Western Regional Examining Board, which board shall determine
21 the passing score for that examination.

22 (d) Notwithstanding subdivision (b) of Section 1628, the board
23 is authorized to do either of the following:

24 (1) Approve an application for examination from, and to
25 examine an applicant who is enrolled in, but has not yet graduated
26 from, a reputable dental school approved by the board.

27 (2) Accept the results of an examination described in paragraph
28 (2) of subdivision (c) submitted by an applicant who was enrolled
29 in, but had not graduated from, a reputable dental school approved
30 by the board at the time the examination was administered.

31 In either case, the board shall require the dean of that school or
32 his or her delegate to furnish satisfactory proof that the applicant
33 will graduate within one year of the date the examination was
34 administered or as provided in paragraph (1) of subdivision (c).

35 SEC. 3. Section 1634.1 of the Business and Professions Code
36 is amended to read:

37 1634.1. Notwithstanding Section 1634, the board may grant a
38 license to practice dentistry to an applicant who submits all of the
39 following to the board:

1 (a) A completed application form and all fees required by the
2 board.

3 (b) Satisfactory evidence of having graduated from a dental
4 school approved by the board or by the Commission on Dental
5 Accreditation of the American Dental Association.

6 (c) Satisfactory evidence of having completed a clinically based
7 advanced education program in general dentistry or an advanced
8 education program in general practice residency that is, at
9 minimum, one year in duration and is accredited by either the
10 Commission on Dental Accreditation of the American Dental
11 Association or a national accrediting body approved by the board.
12 The advanced education program shall include a certification of
13 clinical residency program completion approved by the board, to
14 be completed upon the resident’s successful completion of the
15 program in order to evaluate his or her competence to practice
16 dentistry in the state.

17 (d) Satisfactory evidence of having successfully completed the
18 ~~written examinations~~ *examination* of the National Board Dental
19 Examination of the Joint Commission on National Dental
20 Examinations.

21 (e) Satisfactory evidence of having successfully completed an
22 examination in California law and ethics.

23 (f) Proof that the applicant has not failed the examination for
24 licensure to practice dentistry under this chapter within five years
25 prior to the date of his or her application for a license under this
26 chapter.

27 SEC. 4. Section 2029 of the Business and Professions Code is
28 repealed.

29 ~~2029. The board shall keep a copy of a complaint it receives
30 regarding the poor quality of care rendered by a licensee for 10
31 years from the date the board receives the complaint. For retrieval
32 purposes, these complaints shall be filed by the licensee’s name
33 and license number.~~

34 SEC. 5. Article 16 (commencing with Section 2380) of Chapter
35 5 of Division 2 of the Business and Professions Code is repealed.

36 SEC. 6. Section 2467 of the Business and Professions Code is
37 amended to read:

38 2467. (a) The board may convene from time to time as it deems
39 necessary.

1 (b) Four members of the board constitute a quorum for the
2 transaction of business at any meeting.

3 (c) It shall require the affirmative vote of a majority of those
4 members present at a meeting, those members constituting at least
5 a quorum, to pass any motion, resolution, or measure.

6 (d) The board shall ~~annually elect one of~~ *from* its members ~~to~~
7 ~~act as president and a member to act as a president, a vice-president~~
8 *president, and a secretary* who shall hold their respective positions
9 at the pleasure of the board. The president may call meetings of
10 the board and any duly appointed committee at a specified time
11 and place.

12 SEC. 7. Section 4980.09 is added to the Business and
13 Professions Code, to read:

14 4980.09. (a) The title “marriage and family therapist intern”
15 or “marriage and family therapist registered intern” is hereby
16 renamed “associate marriage and family therapist” or “registered
17 associate marriage and family therapist,” respectively. Any
18 reference in statute or regulation to a “marriage and family therapist
19 intern” or “marriage and family therapist registered intern” shall
20 be deemed a reference to an “associate marriage and family
21 therapist” or “registered associate marriage and family therapist.”

22 (b) Nothing in this section shall be construed to expand or
23 constrict the scope of practice of a person licensed or registered
24 pursuant to this chapter.

25 (c) This section shall become operative January 1, 2018.

26 SEC. 8. Section 4980.36 of the Business and Professions Code
27 is amended to read:

28 4980.36. (a) This section shall apply to the following:

29 (1) Applicants for licensure or registration who begin graduate
30 study before August 1, 2012, and do not complete that study on
31 or before December 31, 2018.

32 (2) Applicants for licensure or registration who begin graduate
33 study before August 1, 2012, and who graduate from a degree
34 program that meets the requirements of this section.

35 (3) Applicants for licensure or registration who begin graduate
36 study on or after August 1, 2012.

37 (b) To qualify for a license or registration, applicants shall
38 possess a doctoral or master’s degree meeting the requirements of
39 this section in marriage, family, and child counseling, marriage
40 and family therapy, couple and family therapy, psychology, clinical

1 psychology, counseling psychology, or counseling with an
2 emphasis in either marriage, family, and child counseling or
3 marriage and family therapy, obtained from a school, college, or
4 university approved by the Bureau for Private Postsecondary
5 Education, or accredited by either the Commission on Accreditation
6 for Marriage and Family Therapy Education, or a regional *or*
7 *national institutional* accrediting agency that is recognized by the
8 United States Department of Education. The board has the authority
9 to make the final determination as to whether a degree meets all
10 requirements, including, but not limited to, course requirements,
11 regardless of accreditation or approval.

12 (c) A doctoral or master's degree program that qualifies for
13 licensure or registration shall do the following:

14 (1) Integrate all of the following throughout its curriculum:

15 (A) Marriage and family therapy principles.

16 (B) The principles of mental health recovery-oriented care and
17 methods of service delivery in recovery-oriented practice
18 environments, among others.

19 (C) An understanding of various cultures and the social and
20 psychological implications of socioeconomic position, and an
21 understanding of how poverty and social stress impact an
22 individual's mental health and recovery.

23 (2) Allow for innovation and individuality in the education of
24 marriage and family therapists.

25 (3) Encourage students to develop the personal qualities that
26 are intimately related to effective practice, including, but not
27 limited to, integrity, sensitivity, flexibility, insight, compassion,
28 and personal presence.

29 (4) Permit an emphasis or specialization that may address any
30 one or more of the unique and complex array of human problems,
31 symptoms, and needs of Californians served by marriage and
32 family therapists.

33 (5) Provide students with the opportunity to meet with various
34 consumers and family members of consumers of mental health
35 services to enhance understanding of their experience of mental
36 illness, treatment, and recovery.

37 (d) The degree described in subdivision (b) shall contain no less
38 than 60 semester or 90 quarter units of instruction that includes,
39 but is not limited to, the following requirements:

40 (1) Both of the following:

1 (A) No less than 12 semester or 18 quarter units of coursework
2 in theories, principles, and methods of a variety of
3 psychotherapeutic orientations directly related to marriage and
4 family therapy and marital and family systems approaches to
5 treatment and how these theories can be applied therapeutically
6 with individuals, couples, families, adults, including elder adults,
7 children, adolescents, and groups to improve, restore, or maintain
8 healthy relationships.

9 (B) Practicum that involves direct client contact, as follows:

10 (i) A minimum of six semester or nine quarter units of practicum
11 in a supervised clinical placement that provides supervised
12 fieldwork experience.

13 (ii) A minimum of 150 hours of face-to-face experience
14 counseling individuals, couples, families, or groups.

15 (iii) A student must be enrolled in a practicum course while
16 counseling clients, except as specified in subdivision (c) of Section
17 4980.42.

18 (iv) The practicum shall provide training in all of the following
19 areas:

20 (I) Applied use of theory and psychotherapeutic techniques.

21 (II) Assessment, diagnosis, and prognosis.

22 (III) Treatment of individuals and premarital, couple, family,
23 and child relationships, including trauma and abuse, dysfunctions,
24 healthy functioning, health promotion, illness prevention, and
25 working with families.

26 (IV) Professional writing, including documentation of services,
27 treatment plans, and progress notes.

28 (V) How to connect people with resources that deliver the
29 quality of services and support needed in the community.

30 (v) Educational institutions are encouraged to design the
31 practicum required by this subparagraph to include marriage and
32 family therapy experience in low income and multicultural mental
33 health settings.

34 (vi) In addition to the 150 hours required in clause (ii), 75 hours
35 of either of the following, or a combination thereof:

36 (I) Client centered advocacy, as defined in Section 4980.03.

37 (II) Face-to-face experience counseling individuals, couples,
38 families, or groups.

39 (2) Instruction in all of the following:

- 1 (A) Diagnosis, assessment, prognosis, and treatment of mental
2 disorders, including severe mental disorders, evidence-based
3 practices, psychological testing, psychopharmacology, and
4 promising mental health practices that are evaluated in peer
5 reviewed literature.
- 6 (B) Developmental issues from infancy to old age, including
7 instruction in all of the following areas:
- 8 (i) The effects of developmental issues on individuals, couples,
9 and family relationships.
- 10 (ii) The psychological, psychotherapeutic, and health
11 implications of developmental issues and their effects.
- 12 (iii) Aging and its biological, social, cognitive, and
13 psychological aspects. This coursework shall include instruction
14 on the assessment and reporting of, as well as treatment related
15 to, elder and dependent adult abuse and neglect.
- 16 (iv) A variety of cultural understandings of human development.
- 17 (v) The understanding of human behavior within the social
18 context of socioeconomic status and other contextual issues
19 affecting social position.
- 20 (vi) The understanding of human behavior within the social
21 context of a representative variety of the cultures found within
22 California.
- 23 (vii) The understanding of the impact that personal and social
24 insecurity, social stress, low educational levels, inadequate housing,
25 and malnutrition have on human development.
- 26 (C) The broad range of matters and life events that may arise
27 within marriage and family relationships and within a variety of
28 California cultures, including instruction in all of the following:
- 29 (i) A minimum of seven contact hours of training or coursework
30 in child abuse assessment and reporting as specified in Section 28,
31 and any regulations promulgated thereunder.
- 32 (ii) Spousal or partner abuse assessment, detection, intervention
33 strategies, and same gender abuse dynamics.
- 34 (iii) Cultural factors relevant to abuse of partners and family
35 members.
- 36 (iv) Childbirth, child rearing, parenting, and stepparenting.
- 37 (v) Marriage, divorce, and blended families.
- 38 (vi) Long-term care.
- 39 (vii) End of life and grief.
- 40 (viii) Poverty and deprivation.

- 1 (ix) Financial and social stress.
- 2 (x) Effects of trauma.
- 3 (xi) The psychological, psychotherapeutic, community, and
- 4 health implications of the matters and life events described in
- 5 clauses (i) to (x), inclusive.
- 6 (D) Cultural competency and sensitivity, including a familiarity
- 7 with the racial, cultural, linguistic, and ethnic backgrounds of
- 8 persons living in California.
- 9 (E) Multicultural development and cross-cultural interaction,
- 10 including experiences of race, ethnicity, class, spirituality, sexual
- 11 orientation, gender, and disability, and their incorporation into the
- 12 psychotherapeutic process.
- 13 (F) The effects of socioeconomic status on treatment and
- 14 available resources.
- 15 (G) Resilience, including the personal and community qualities
- 16 that enable persons to cope with adversity, trauma, tragedy, threats,
- 17 or other stresses.
- 18 (H) Human sexuality, including the study of physiological,
- 19 psychological, and social cultural variables associated with sexual
- 20 behavior and gender identity, and the assessment and treatment of
- 21 psychosexual dysfunction.
- 22 (I) Substance use disorders, co-occurring disorders, and
- 23 addiction, including, but not limited to, instruction in all of the
- 24 following:
 - 25 (i) The definition of substance use disorders, co-occurring
 - 26 disorders, and addiction. For purposes of this subparagraph,
 - 27 “co-occurring disorders” means a mental illness and substance
 - 28 abuse diagnosis occurring simultaneously in an individual.
 - 29 (ii) Medical aspects of substance use disorders and co-occurring
 - 30 disorders.
 - 31 (iii) The effects of psychoactive drug use.
 - 32 (iv) Current theories of the etiology of substance abuse and
 - 33 addiction.
 - 34 (v) The role of persons and systems that support or compound
 - 35 substance abuse and addiction.
 - 36 (vi) Major approaches to identification, evaluation, and treatment
 - 37 of substance use disorders, co-occurring disorders, and addiction,
 - 38 including, but not limited to, best practices.
 - 39 (vii) Legal aspects of substance abuse.

- 1 (viii) Populations at risk with regard to substance use disorders
2 and co-occurring disorders.
- 3 (ix) Community resources offering screening, assessment,
4 treatment, and followup for the affected person and family.
- 5 (x) Recognition of substance use disorders, co-occurring
6 disorders, and addiction, and appropriate referral.
- 7 (xi) The prevention of substance use disorders and addiction.
- 8 (J) California law and professional ethics for marriage and
9 family therapists, including instruction in all of the following areas
10 of study:
- 11 (i) Contemporary professional ethics and statutory, regulatory,
12 and decisional laws that delineate the scope of practice of marriage
13 and family therapy.
- 14 (ii) The therapeutic, clinical, and practical considerations
15 involved in the legal and ethical practice of marriage and family
16 therapy, including, but not limited to, family law.
- 17 (iii) The current legal patterns and trends in the mental health
18 professions.
- 19 (iv) The psychotherapist-patient privilege, confidentiality, the
20 patient dangerous to self or others, and the treatment of minors
21 with and without parental consent.
- 22 (v) A recognition and exploration of the relationship between
23 a practitioner's sense of self and human values and his or her
24 professional behavior and ethics.
- 25 (vi) Differences in legal and ethical standards for different types
26 of work settings.
- 27 (vii) Licensing law and licensing process.
- 28 (e) The degree described in subdivision (b) shall, in addition to
29 meeting the requirements of subdivision (d), include instruction
30 in case management, systems of care for the severely mentally ill,
31 public and private services and supports available for the severely
32 mentally ill, community resources for persons with mental illness
33 and for victims of abuse, disaster and trauma response, advocacy
34 for the severely mentally ill, and collaborative treatment. This
35 instruction may be provided either in credit level coursework or
36 through extension programs offered by the degree-granting
37 institution.
- 38 (f) The changes made to law by this section are intended to
39 improve the educational qualifications for licensure in order to
40 better prepare future licentiates for practice, and are not intended

1 to expand or restrict the scope of practice for marriage and family
2 therapists.

3 SEC. 9. Section 4980.37 of the Business and Professions Code
4 is amended to read:

5 4980.37. (a) This section shall apply to applicants for licensure
6 or registration who begin graduate study before August 1, 2012,
7 and complete that study on or before December 31, 2018. Those
8 applicants may alternatively qualify under paragraph (2) of
9 subdivision (a) of Section 4980.36.

10 (b) To qualify for a license or registration, applicants shall
11 possess a doctor's or master's degree in marriage, family, and child
12 counseling, marriage and family therapy, couple and family
13 therapy, psychology, clinical psychology, counseling psychology,
14 or counseling with an emphasis in either marriage, family, and
15 child counseling or marriage and family therapy, obtained from a
16 school, college, or university accredited by a regional *or national*
17 *institutional* accrediting agency that is recognized by the United
18 States Department of Education or approved by the Bureau for
19 Private Postsecondary Education. The board has the authority to
20 make the final determination as to whether a degree meets all
21 requirements, including, but not limited to, course requirements,
22 regardless of accreditation or approval. In order to qualify for
23 licensure pursuant to this section, a doctor's or master's degree
24 program shall be a single, integrated program primarily designed
25 to train marriage and family therapists and shall contain no less
26 than 48 semester or 72 quarter units of instruction. This instruction
27 shall include no less than 12 semester units or 18 quarter units of
28 coursework in the areas of marriage, family, and child counseling,
29 and marital and family systems approaches to treatment. The
30 coursework shall include all of the following areas:

31 (1) The salient theories of a variety of psychotherapeutic
32 orientations directly related to marriage and family therapy, and
33 marital and family systems approaches to treatment.

34 (2) Theories of marriage and family therapy and how they can
35 be utilized in order to intervene therapeutically with couples,
36 families, adults, children, and groups.

37 (3) Developmental issues and life events from infancy to old
38 age and their effect on individuals, couples, and family
39 relationships. This may include coursework that focuses on specific
40 family life events and the psychological, psychotherapeutic, and

1 health implications that arise within couples and families,
2 including, but not limited to, childbirth, child rearing, childhood,
3 adolescence, adulthood, marriage, divorce, blended families,
4 stepparenting, abuse and neglect of older and dependent adults,
5 and geropsychology.

6 (4) A variety of approaches to the treatment of children.

7 The board shall, by regulation, set forth the subjects of instruction
8 required in this subdivision.

9 (c) (1) In addition to the 12 semester or 18 quarter units of
10 coursework specified in subdivision (b), the doctor's or master's
11 degree program shall contain not less than six semester or nine
12 quarter units of supervised practicum in applied psychotherapeutic
13 technique, assessments, diagnosis, prognosis, and treatment of
14 premarital, couple, family, and child relationships, including
15 dysfunctions, healthy functioning, health promotion, and illness
16 prevention, in a supervised clinical placement that provides
17 supervised fieldwork experience within the scope of practice of a
18 marriage and family therapist.

19 (2) For applicants who enrolled in a degree program on or after
20 January 1, 1995, the practicum shall include a minimum of 150
21 hours of face-to-face experience counseling individuals, couples,
22 families, or groups.

23 (3) The practicum hours shall be considered as part of the 48
24 semester or 72 quarter unit requirement.

25 (d) As an alternative to meeting the qualifications specified in
26 subdivision (b), the board shall accept as equivalent degrees those
27 master's or doctor's degrees granted by educational institutions
28 whose degree program is approved by the Commission on
29 Accreditation for Marriage and Family Therapy Education.

30 (e) In order to provide an integrated course of study and
31 appropriate professional training, while allowing for innovation
32 and individuality in the education of marriage and family therapists,
33 a degree program that meets the educational qualifications for
34 licensure or registration under this section shall do all of the
35 following:

36 (1) Provide an integrated course of study that trains students
37 generally in the diagnosis, assessment, prognosis, and treatment
38 of mental disorders.

39 (2) Prepare students to be familiar with the broad range of
40 matters that may arise within marriage and family relationships.

1 (3) Train students specifically in the application of marriage
2 and family relationship counseling principles and methods.

3 (4) Encourage students to develop those personal qualities that
4 are intimately related to the counseling situation such as integrity,
5 sensitivity, flexibility, insight, compassion, and personal presence.

6 (5) Teach students a variety of effective psychotherapeutic
7 techniques and modalities that may be utilized to improve, restore,
8 or maintain healthy individual, couple, and family relationships.

9 (6) Permit an emphasis or specialization that may address any
10 one or more of the unique and complex array of human problems,
11 symptoms, and needs of Californians served by marriage and
12 family therapists.

13 (7) Prepare students to be familiar with cross-cultural mores
14 and values, including a familiarity with the wide range of racial
15 and ethnic backgrounds common among California's population,
16 including, but not limited to, Blacks, Hispanics, Asians, and Native
17 Americans.

18 (f) Educational institutions are encouraged to design the
19 practicum required by this section to include marriage and family
20 therapy experience in low income and multicultural mental health
21 settings.

22 (g) This section shall remain in effect only until January 1, 2019,
23 and as of that date is repealed, unless a later enacted statute, that
24 is enacted before January 1, 2019, deletes or extends that date.

25 SEC. 10. Section 4980.40.5 of the Business and Professions
26 Code is repealed.

27 ~~4980.40.5. (a) A doctoral or master's degree in marriage,~~
28 ~~family, and child counseling, marital and family therapy, couple~~
29 ~~and family therapy, psychology, clinical psychology, counseling~~
30 ~~psychology, or counseling with an emphasis in either marriage,~~
31 ~~family, and child counseling, or marriage and family therapy,~~
32 ~~obtained from a school, college, or university approved by the~~
33 ~~Bureau for Private Postsecondary Education as of June 30, 2007,~~
34 ~~shall be considered by the board to meet the requirements necessary~~
35 ~~for licensure as a marriage and family therapist and for registration~~
36 ~~as a marriage and family therapist intern provided that the degree~~
37 ~~is conferred on or before July 1, 2010.~~

38 ~~(b) As an alternative to meeting the qualifications specified in~~
39 ~~subdivision (a) of Section 4980.40, the board shall accept as~~
40 ~~equivalent degrees those doctoral or master's degrees that otherwise~~

1 ~~meet the requirements of this chapter and are conferred by~~
2 ~~educational institutions accredited by any of the following~~
3 ~~associations:~~

4 ~~(1) Northwest Commission on Colleges and Universities.~~

5 ~~(2) Middle States Association of Colleges and Secondary~~
6 ~~Schools.~~

7 ~~(3) New England Association of Schools and Colleges.~~

8 ~~(4) North Central Association of Colleges and Secondary~~
9 ~~Schools.~~

10 ~~(5) Southern Association of Colleges and Schools.~~

11 SEC. 11. Section 4980.43 of the Business and Professions
12 Code is amended to read:

13 4980.43. (a) To qualify for licensure as specified in Section
14 4980.40, each applicant shall complete experience related to the
15 practice of marriage and family therapy under a supervisor who
16 meets the qualifications set forth in Section 4980.03. The
17 experience shall comply with the following:

18 (1) A minimum of 3,000 hours of supervised experience
19 completed during a period of at least 104 weeks.

20 (2) A maximum of 40 hours in any seven consecutive days.

21 (3) A minimum of 1,700 hours obtained after the qualifying
22 master's or doctoral degree was awarded.

23 (4) A maximum of 1,300 hours obtained prior to the award date
24 of the qualifying master's or doctoral degree.

25 (5) A maximum of 750 hours of counseling and direct supervisor
26 contact prior to the award date of the qualifying master's or
27 doctoral degree.

28 (6) No hours of experience may be gained prior to completing
29 either 12 semester units or 18 quarter units of graduate instruction.

30 (7) No hours of experience may be gained more than six years
31 prior to the date the application for examination eligibility was
32 filed, except that up to 500 hours of clinical experience gained in
33 the supervised practicum required by subdivision (c) of Section
34 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d)
35 of Section 4980.36 shall be exempt from this six-year requirement.

36 (8) A minimum of 1,750 hours of direct counseling with
37 individuals, groups, couples, or families, that includes not less than
38 500 total hours of experience in diagnosing and treating couples,
39 families, and children.

1 (9) A maximum of 1,250 hours of nonclinical practice,
2 consisting of direct supervisor contact, administering and
3 evaluating psychological tests, writing clinical reports, writing
4 progress or process notes, client centered advocacy, and workshops,
5 seminars, training sessions, or conferences directly related to
6 marriage and family therapy that have been approved by the
7 applicant's supervisor.

8 (10) It is anticipated and encouraged that hours of experience
9 will include working with elders and dependent adults who have
10 physical or mental limitations that restrict their ability to carry out
11 normal activities or protect their rights.

12 This subdivision shall only apply to hours gained on and after
13 January 1, 2010.

14 (b) An individual who submits an application for examination
15 eligibility between January 1, 2016, and December 31, 2020, may
16 alternatively qualify under the experience requirements that were
17 in place on January 1, 2015.

18 (c) All applicants, trainees, and registrants shall be at all times
19 under the supervision of a supervisor who shall be responsible for
20 ensuring that the extent, kind, and quality of counseling performed
21 is consistent with the training and experience of the person being
22 supervised, and who shall be responsible to the board for
23 compliance with all laws, rules, and regulations governing the
24 practice of marriage and family therapy. Supervised experience
25 shall be gained by an intern or trainee only as an employee or as
26 a volunteer. The requirements of this chapter regarding gaining
27 hours of experience and supervision are applicable equally to
28 employees and volunteers. ~~Experience shall not be gained by an~~
29 ~~intern or trainee as an independent contractor. Associates and~~
30 ~~trainees shall not be employed as independent contractors, and~~
31 ~~shall not gain experience for work performed as an independent~~
32 ~~contractor, reported on an IRS Form 1099, or both.~~

33 (1) If employed, an intern shall provide the board with copies
34 of the corresponding W-2 tax forms for each year of experience
35 claimed upon application for licensure.

36 (2) If volunteering, an intern shall provide the board with a letter
37 from his or her employer verifying the intern's employment as a
38 volunteer upon application for licensure.

39 (d) Except for experience gained by attending workshops,
40 seminars, training sessions, or conferences as described in

1 paragraph (9) of subdivision (a), supervision shall include at least
2 one hour of direct supervisor contact in each week for which
3 experience is credited in each work setting, as specified:

4 (1) A trainee shall receive an average of at least one hour of
5 direct supervisor contact for every five hours of client contact in
6 each setting. No more than six hours of supervision, whether
7 individual or group, shall be credited during any single week.

8 (2) An individual supervised after being granted a qualifying
9 degree shall receive at least one additional hour of direct supervisor
10 contact for every week in which more than 10 hours of client
11 contact is gained in each setting. No more than six hours of
12 supervision, whether individual or group, shall be credited during
13 any single week.

14 (3) For purposes of this section, “one hour of direct supervisor
15 contact” means one hour per week of face-to-face contact on an
16 individual basis or two hours per week of face-to-face contact in
17 a group.

18 (4) Direct supervisor contact shall occur within the same week
19 as the hours claimed.

20 (5) Direct supervisor contact provided in a group shall be
21 provided in a group of not more than eight supervisees and in
22 segments lasting no less than one continuous hour.

23 (6) Notwithstanding paragraph (3), an intern working in a
24 governmental entity, a school, a college, or a university, or an
25 institution that is both nonprofit and charitable may obtain the
26 required weekly direct supervisor contact via two-way, real-time
27 videoconferencing. The supervisor shall be responsible for ensuring
28 that client confidentiality is upheld.

29 (7) All experience gained by a trainee shall be monitored by the
30 supervisor as specified by regulation.

31 (8) The six hours of supervision that may be credited during
32 any single week pursuant to paragraphs (1) and (2) shall apply to
33 supervision hours gained on or after January 1, 2009.

34 (e) (1) A trainee may be credited with supervised experience
35 completed in any setting that meets all of the following:

36 (A) Lawfully and regularly provides mental health counseling
37 or psychotherapy.

38 (B) Provides oversight to ensure that the trainee’s work at the
39 setting meets the experience and supervision requirements set forth

1 in this chapter and is within the scope of practice for the profession
2 as defined in Section 4980.02.

3 (C) Is not a private practice owned by a licensed marriage and
4 family therapist, a licensed professional clinical counselor, a
5 licensed psychologist, a licensed clinical social worker, a licensed
6 physician and surgeon, or a professional corporation of any of
7 those licensed professions.

8 (2) Experience may be gained by the trainee solely as part of
9 the position for which the trainee volunteers or is employed.

10 (f) (1) An intern may be credited with supervised experience
11 completed in any setting that meets both of the following:

12 (A) Lawfully and regularly provides mental health counseling
13 or psychotherapy.

14 (B) Provides oversight to ensure that the intern's work at the
15 setting meets the experience and supervision requirements set forth
16 in this chapter and is within the scope of practice for the profession
17 as defined in Section 4980.02.

18 (2) An applicant shall not be employed or volunteer in a private
19 practice, as defined in subparagraph (C) of paragraph (1) of
20 subdivision (e), until registered as an intern.

21 (3) While an intern may be either a paid employee or a
22 volunteer, employers are encouraged to provide fair remuneration
23 to interns.

24 (4) Except for periods of time during a supervisor's vacation or
25 sick leave, an intern who is employed or volunteering in private
26 practice shall be under the direct supervision of a licensee that has
27 satisfied subdivision (g) of Section 4980.03. The supervising
28 licensee shall either be employed by and practice at the same site
29 as the intern's employer, or shall be an owner or shareholder of
30 the private practice. Alternative supervision may be arranged during
31 a supervisor's vacation or sick leave if the supervision meets the
32 requirements of this section.

33 (5) Experience may be gained by the intern solely as part of the
34 position for which the intern volunteers or is employed.

35 (g) Except as provided in subdivision (h), all persons shall
36 register with the board as an intern to be credited for postdegree
37 hours of supervised experience gained toward licensure.

38 (h) Postdegree hours of experience shall be credited toward
39 licensure so long as the applicant applies for the intern registration
40 within 90 days of the granting of the qualifying master's or doctoral

1 degree and is thereafter granted the intern registration by the board.
2 An applicant shall not be employed or volunteer in a private
3 practice until registered as an intern by the board.

4 (i) Trainees, interns, and applicants shall not receive any
5 remuneration from patients or clients, and shall only be paid by
6 their employers.

7 (j) Trainees, interns, and applicants shall only perform services
8 at the place where their employers regularly conduct business,
9 which may include performing services at other locations, so long
10 as the services are performed under the direction and control of
11 their employer and supervisor, and in compliance with the laws
12 and regulations pertaining to supervision. For purposes of
13 paragraph (3) of subdivision (a) of Section 2290.5, interns and
14 trainees working under licensed supervision, consistent with
15 subdivision (c), may provide services via telehealth within the
16 scope authorized by this chapter and in accordance with any
17 regulations governing the use of telehealth promulgated by the
18 board. Trainees and interns shall have no proprietary interest in
19 their employers' businesses and shall not lease or rent space, pay
20 for furnishings, equipment, or supplies, or in any other way pay
21 for the obligations of their employers.

22 (k) Trainees, interns, or applicants who provide volunteered
23 services or other services, and who receive no more than a total,
24 from all work settings, of five hundred dollars (\$500) per month
25 as reimbursement for expenses actually incurred by those trainees,
26 interns, or applicants for services rendered in any lawful work
27 setting other than a private practice shall be considered employees
28 and not independent contractors. The board may audit applicants
29 who receive reimbursement for expenses, and the applicants shall
30 have the burden of demonstrating that the payments received were
31 for reimbursement of expenses actually incurred.

32 (l) Each educational institution preparing applicants for licensure
33 pursuant to this chapter shall consider requiring, and shall
34 encourage, its students to undergo individual, marital or conjoint,
35 family, or group counseling or psychotherapy, as appropriate. Each
36 supervisor shall consider, advise, and encourage his or her interns
37 and trainees regarding the advisability of undertaking individual,
38 marital or conjoint, family, or group counseling or psychotherapy,
39 as appropriate. Insofar as it is deemed appropriate and is desired
40 by the applicant, the educational institution and supervisors are

1 encouraged to assist the applicant in locating that counseling or
2 psychotherapy at a reasonable cost.

3 SEC. 12. Section 4980.78 of the Business and Professions
4 Code is amended to read:

5 4980.78. (a) This section applies to persons who apply for
6 licensure or registration on or after January 1, 2016, and who do
7 not hold a license as described in Section 4980.72.

8 (b) For purposes of Section 4980.74, education is substantially
9 equivalent if all of the following requirements are met:

10 (1) The degree is obtained from a school, college, or university
11 accredited by ~~an~~ *a regional or national institutional* accrediting
12 agency that is recognized by the United States Department of
13 Education and consists of, at a minimum, the following:

14 (A) (i) For an applicant who obtained his or her degree within
15 the timeline prescribed by subdivision (a) of Section 4980.36, the
16 degree shall contain no less than 60 semester or 90 quarter units
17 of instruction.

18 (ii) Up to 12 semester or 18 quarter units of instruction may be
19 remediated, if missing from the degree. The remediation may occur
20 while the applicant is registered as an intern.

21 (B) For an applicant who obtained his or her degree within the
22 timeline prescribed by subdivision (a) of Section 4980.37, the
23 degree shall contain no less than 48 semester units or 72 quarter
24 units of instruction.

25 (C) Six semester or nine quarter units of practicum, including,
26 but not limited to, a minimum of 150 hours of face-to-face
27 counseling, and an additional 75 hours of either face-to-face
28 counseling or client-centered advocacy, or a combination of
29 face-to-face counseling and client-centered advocacy.

30 (D) Twelve semester or 18 quarter units in the areas of marriage,
31 family, and child counseling and marital and family systems
32 approaches to treatment, as specified in subparagraph (A) of
33 paragraph (1) of subdivision (d) of Section 4980.36.

34 (2) The applicant shall complete coursework in California law
35 and ethics as follows:

36 (A) An applicant who completed a course in law and
37 professional ethics for marriage and family therapists as specified
38 in paragraph (7) of subdivision (a) of Section 4980.81, that did not
39 contain instruction in California law and ethics, shall complete an
40 18-hour course in California law and professional ethics. The

1 content of the course shall include, but not be limited to,
2 advertising, scope of practice, scope of competence, treatment of
3 minors, confidentiality, dangerous patients, psychotherapist-patient
4 privilege, recordkeeping, patient access to records, state and federal
5 laws relating to confidentiality of patient health information, dual
6 relationships, child abuse, elder and dependent adult abuse, online
7 therapy, insurance reimbursement, civil liability, disciplinary
8 actions and unprofessional conduct, ethics complaints and ethical
9 standards, termination of therapy, standards of care, relevant family
10 law, therapist disclosures to patients, differences in legal and ethical
11 standards in different types of work settings, and licensing law
12 and licensing process. This coursework shall be completed prior
13 to registration as an intern.

14 (B) An applicant who has not completed a course in law and
15 professional ethics for marriage and family therapists as specified
16 in paragraph (7) of subdivision (a) of Section 4980.81 shall
17 complete this required coursework. The coursework shall contain
18 content specific to California law and ethics. This coursework shall
19 be completed prior to registration as an intern.

20 (3) The applicant completes the educational requirements
21 specified in Section 4980.81 not already completed in his or her
22 education. The coursework may be from an accredited school,
23 college, or university as specified in paragraph (1), from an
24 educational institution approved by the Bureau for Private
25 Postsecondary Education, or from a continuing education provider
26 that is acceptable to the board as defined in Section 4980.54.
27 Undergraduate courses shall not satisfy this requirement.

28 (4) The applicant completes the following coursework not
29 already completed in his or her education from an accredited
30 school, college, or university as specified in paragraph (1) from
31 an educational institution approved by the Bureau for Private
32 Postsecondary Education, or from a continuing education provider
33 that is acceptable to the board as defined in Section 4980.54.
34 Undergraduate courses shall not satisfy this requirement.

35 (A) At least three semester units, or 45 hours, of instruction
36 regarding the principles of mental health recovery-oriented care
37 and methods of service delivery in recovery-oriented practice
38 environments, including structured meetings with various
39 consumers and family members of consumers of mental health

1 services to enhance understanding of their experience of mental
2 illness, treatment, and recovery.

3 (B) At least one semester unit, or 15 hours, of instruction that
4 includes an understanding of various California cultures and the
5 social and psychological implications of socioeconomic position.

6 (5) An applicant may complete any units and course content
7 requirements required under paragraphs (3) and (4) not already
8 completed in his or her education while registered as an intern,
9 unless otherwise specified.

10 (6) The applicant's degree title need not be identical to that
11 required by subdivision (b) of Section 4980.36.

12 SEC. 13. Section 4980.79 of the Business and Professions
13 Code is amended to read:

14 4980.79. (a) This section applies to persons who apply for
15 licensure or registration on or after January 1, 2016, and who hold
16 a license as described in Section 4980.72.

17 (b) For purposes of Section 4980.72, education is substantially
18 equivalent if all of the following requirements are met:

19 (1) The degree is obtained from a school, college, or university
20 accredited by ~~an~~ *a regional or national institutional* accrediting
21 agency recognized by the United States Department of Education
22 and consists of, at a minimum, the following:

23 (A) (i) For an applicant who obtained his or her degree within
24 the timeline prescribed by subdivision (a) of Section 4980.36, the
25 degree shall contain no less than 60 semester or 90 quarter units
26 of instruction.

27 (ii) Up to 12 semester or 18 quarter units of instruction may be
28 remediated, if missing from the degree. The remediation may occur
29 while the applicant is registered as an intern.

30 (B) For an applicant who obtained his or her degree within the
31 timeline prescribed by subdivision (a) of Section 4980.37, the
32 degree shall contain no less than 48 semester or 72 quarter units
33 of instruction.

34 (C) Six semester or nine quarter units of practicum, including,
35 but not limited to, a minimum of 150 hours of face-to-face
36 counseling, and an additional 75 hours of either face-to-face
37 counseling or client-centered advocacy, or a combination of
38 face-to-face counseling and client-centered advocacy.

1 (i) An out-of-state applicant who has been licensed for at least
2 two years in clinical practice, as verified by the board, is exempt
3 from this requirement.

4 (ii) An out-of-state applicant who has been licensed for less
5 than two years in clinical practice, as verified by the board, who
6 does not meet the practicum requirement, shall remediate it by
7 obtaining 150 hours of face-to-face counseling, and an additional
8 75 hours of either face-to-face counseling or client-centered
9 advocacy, or a combination of face-to-face counseling and
10 client-centered advocacy. These hours are in addition to the 3,000
11 hours of experience required by this chapter, and shall be gained
12 while registered as an intern.

13 (D) Twelve semester or 18 quarter units in the areas of marriage,
14 family, and child counseling and marital and family systems
15 approaches to treatment, as specified in subparagraph (A) of
16 paragraph (1) of subdivision (d) of Section 4980.36.

17 (2) An applicant shall complete coursework in California law
18 and ethics as follows:

19 (A) An applicant who completed a course in law and
20 professional ethics for marriage and family therapists as specified
21 in paragraph (7) of subdivision (a) of Section 4980.81 that did not
22 include instruction in California law and ethics, shall complete an
23 18-hour course in California law and professional ethics. The
24 content of the course shall include, but not be limited to,
25 advertising, scope of practice, scope of competence, treatment of
26 minors, confidentiality, dangerous patients, psychotherapist-patient
27 privilege, recordkeeping, patient access to records, state and federal
28 laws relating to confidentiality of patient health information, dual
29 relationships, child abuse, elder and dependent adult abuse, online
30 therapy, insurance reimbursement, civil liability, disciplinary
31 actions and unprofessional conduct, ethics complaints and ethical
32 standards, termination of therapy, standards of care, relevant family
33 law, therapist disclosures to patients, differences in legal and ethical
34 standards in different types of work settings, and licensing law
35 and licensing process. This coursework shall be completed prior
36 to registration as an intern.

37 (B) An applicant who has not completed a course in law and
38 professional ethics for marriage and family therapists as specified
39 in paragraph (7) of subdivision (a) of Section 4980.81 shall
40 complete this required coursework. The coursework shall include

1 content specific to California law and ethics. An applicant shall
2 complete this coursework prior to registration as an intern.

3 (3) The applicant completes the educational requirements
4 specified in Section 4980.81 not already completed in his or her
5 education. The coursework may be from an accredited school,
6 college, or university as specified in paragraph (1), from an
7 educational institution approved by the Bureau for Private
8 Postsecondary Education, or from a continuing education provider
9 that is acceptable to the board as defined in Section 4980.54.
10 Undergraduate coursework shall not satisfy this requirement.

11 (4) The applicant completes the following coursework not
12 already completed in his or her education from an accredited
13 school, college, or university as specified in paragraph (1) above,
14 from an educational institution approved by the Bureau for Private
15 Postsecondary Education, or from a continuing education provider
16 that is acceptable to the board as defined in Section 4980.54.
17 Undergraduate coursework shall not satisfy this requirement.

18 (A) At least three semester units, or 45 hours, of instruction
19 pertaining to the principles of mental health recovery-oriented care
20 and methods of service delivery in recovery-oriented practice
21 environments, including structured meetings with various
22 consumers and family members of consumers of mental health
23 services to enhance understanding of their experience of mental
24 illness, treatment, and recovery.

25 (B) At least one semester unit, or 15 hours, of instruction that
26 includes an understanding of various California cultures and the
27 social and psychological implications of socioeconomic position.

28 (5) An applicant's degree title need not be identical to that
29 required by subdivision (b) of Section 4980.36.

30 (6) An applicant may complete any units and course content
31 requirements required under paragraphs (3) and (4) not already
32 completed in his or her education while registered as an intern,
33 unless otherwise specified.

34 SEC. 14. Section 4992.05 of the Business and Professions
35 Code is amended to read:

36 4992.05. (a) Effective January 1, 2016, an applicant for
37 licensure as a clinical social worker shall pass the following two
38 examinations as prescribed by the board:

39 (1) A California law and ethics examination.

40 (2) A clinical examination.

1 (b) Upon registration with the board, an associate *clinical* social
2 worker registrant shall, within the first year of registration, take
3 an examination on California law and ethics.

4 (c) A registrant may take the clinical examination only upon
5 meeting all of the following requirements:

6 (1) Completion of all education requirements.

7 (2) Passage of the California law and ethics examination.

8 (3) Completion of all required supervised work experience.

9 (d) This section shall become operative on January 1, 2016.

10 SEC. 15. Section 4996.18 of the Business and Professions
11 Code is amended to read:

12 4996.18. (a) A person who wishes to be credited with
13 experience toward licensure requirements shall register with the
14 board as an associate clinical social worker prior to obtaining that
15 experience. The application shall be made on a form prescribed
16 by the board.

17 (b) An applicant for registration shall satisfy the following
18 requirements:

19 (1) Possess a master's degree from an accredited school or
20 department of social work.

21 (2) Have committed no crimes or acts constituting grounds for
22 denial of licensure under Section 480.

23 (3) Commencing January 1, 2014, have completed training or
24 coursework, which may be embedded within more than one course,
25 in California law and professional ethics for clinical social workers,
26 including instruction in all of the following areas of study:

27 (A) Contemporary professional ethics and statutes, regulations,
28 and court decisions that delineate the scope of practice of clinical
29 social work.

30 (B) The therapeutic, clinical, and practical considerations
31 involved in the legal and ethical practice of clinical social work,
32 including, but not limited to, family law.

33 (C) The current legal patterns and trends in the mental health
34 professions.

35 (D) The psychotherapist-patient privilege, confidentiality,
36 dangerous patients, and the treatment of minors with and without
37 parental consent.

38 (E) A recognition and exploration of the relationship between
39 a practitioner's sense of self and human values, and his or her
40 professional behavior and ethics.

1 (F) Differences in legal and ethical standards for different types
2 of work settings.

3 (G) Licensing law and process.

4 (c) An applicant who possesses a master's degree from a school
5 or department of social work that is a candidate for accreditation
6 by the Commission on Accreditation of the Council on Social
7 Work Education shall be eligible, and shall be required, to register
8 as an associate clinical social worker in order to gain experience
9 toward licensure if the applicant has not committed any crimes or
10 acts that constitute grounds for denial of licensure under Section
11 480. That applicant shall not, however, be eligible ~~for~~ *to take the*
12 *clinical* examination until the school or department of social work
13 has received accreditation by the Commission on Accreditation
14 of the Council on Social Work Education.

15 (d) All applicants and registrants shall be at all times under the
16 supervision of a supervisor who shall be responsible for ensuring
17 that the extent, kind, and quality of counseling performed is
18 consistent with the training and experience of the person being
19 supervised, and who shall be responsible to the board for
20 compliance with all laws, rules, and regulations governing the
21 practice of clinical social work.

22 (e) Any experience obtained under the supervision of a spouse
23 or relative by blood or marriage shall not be credited toward the
24 required hours of supervised experience. Any experience obtained
25 under the supervision of a supervisor with whom the applicant has
26 a personal relationship that undermines the authority or
27 effectiveness of the supervision shall not be credited toward the
28 required hours of supervised experience.

29 (f) An applicant who possesses a master's degree from an
30 accredited school or department of social work shall be able to
31 apply experience the applicant obtained during the time the
32 accredited school or department was in candidacy status by the
33 Commission on Accreditation of the Council on Social Work
34 Education toward the licensure requirements, if the experience
35 meets the requirements of Section 4996.23. This subdivision shall
36 apply retroactively to persons who possess a master's degree from
37 an accredited school or department of social work and who
38 obtained experience during the time the accredited school or
39 department was in candidacy status by the Commission on
40 Accreditation of the Council on Social Work Education.

1 (g) An applicant for registration or licensure trained in an
 2 educational institution outside the United States shall demonstrate
 3 to the satisfaction of the board that he or she possesses a master’s
 4 of social work degree that is equivalent to a master’s degree issued
 5 from a school or department of social work that is accredited by
 6 the Commission on Accreditation of the Council on Social Work
 7 Education. These applicants shall provide the board with a
 8 comprehensive evaluation of the degree and shall provide any
 9 other documentation the board deems necessary. The board has
 10 the authority to make the final determination as to whether a degree
 11 meets all requirements, including, but not limited to, course
 12 requirements regardless of evaluation or accreditation.

13 (h) A registrant shall not provide clinical social work services
 14 to the public for a fee, monetary or otherwise, except as an
 15 employee.

16 (i) A registrant shall inform each client or patient prior to
 17 performing any professional services that he or she is unlicensed
 18 and is under the supervision of a licensed professional.

19 SEC. 16. Section 4996.23 of the Business and Professions
 20 Code is amended to read:

21 4996.23. (a) To qualify for licensure as specified in Section
 22 4996.2, each applicant shall complete 3,200 hours of post-master’s
 23 degree supervised experience related to the practice of clinical
 24 social work. The experience shall comply with the following:

25 (1) At least 1,700 hours shall be gained under the supervision
 26 of a licensed clinical social worker. The remaining required
 27 supervised experience may be gained under the supervision of a
 28 licensed mental health professional acceptable to the board as
 29 defined by a regulation adopted by the board.

30 (2) A minimum of 2,000 hours in clinical psychosocial
 31 diagnosis, assessment, and treatment, including psychotherapy or
 32 counseling.

33 (3) A maximum of 1,200 hours in client centered advocacy,
 34 consultation, evaluation, research, direct supervisor contact, and
 35 workshops, seminars, training sessions, or conferences directly
 36 related to clinical social work that have been approved by the
 37 applicant’s supervisor.

38 (4) Of the 2,000 clinical hours required in paragraph (2), no less
 39 than 750 hours shall be face-to-face individual or group

1 psychotherapy provided to clients in the context of clinical social
2 work services.

3 (5) A minimum of two years of supervised experience is required
4 to be obtained over a period of not less than 104 weeks and shall
5 have been gained within the six years immediately preceding the
6 date on which the application for licensure was filed.

7 (6) Experience shall not be credited for more than 40 hours in
8 any week.

9 (b) An individual who submits an application for examination
10 eligibility between January 1, 2016, and December 31, 2020, may
11 alternatively qualify under the experience requirements that were
12 in place on January 1, 2015.

13 (c) “Supervision” means responsibility for, and control of, the
14 quality of clinical social work services being provided.
15 Consultation or peer discussion shall not be considered to be
16 supervision.

17 (d) (1) Prior to the commencement of supervision, a supervisor
18 shall comply with all requirements enumerated in Section 1870 of
19 Title 16 of the California Code of Regulations and shall sign under
20 penalty of perjury the “Responsibility Statement for Supervisors
21 of an Associate Clinical Social Worker” form.

22 (2) Supervised experience shall include at least one hour of
23 direct supervisor contact for a minimum of 104 weeks. For
24 purposes of this subdivision, “one hour of direct supervisor contact”
25 means one hour per week of face-to-face contact on an individual
26 basis or two hours of face-to-face contact in a group conducted
27 within the same week as the hours claimed.

28 (3) An associate shall receive at least one additional hour of
29 direct supervisor contact for every week in which more than 10
30 hours of face-to-face psychotherapy is performed in each setting
31 in which experience is gained. No more than six hours of
32 supervision, whether individual or group, shall be credited during
33 any single week.

34 (4) Supervision shall include at least one hour of direct
35 supervisor contact during each week for which experience is gained
36 in each work setting. Supervision is not required for experience
37 gained attending workshops, seminars, training sessions, or
38 conferences as described in paragraph (3) of subdivision (a).

1 (5) The six hours of supervision that may be credited during
2 any single week pursuant to paragraph (3) shall apply only to
3 supervision hours gained on or after January 1, 2010.

4 (6) Group supervision shall be provided in a group of not more
5 than eight supervisees and shall be provided in segments lasting
6 no less than one continuous hour.

7 (7) Of the 104 weeks of required supervision, 52 weeks shall
8 be individual supervision, and of the 52 weeks of required
9 individual supervision, not less than 13 weeks shall be supervised
10 by a licensed clinical social worker.

11 (8) Notwithstanding paragraph (2), an associate clinical social
12 worker working for a governmental entity, school, college, or
13 university, or an institution that is both a nonprofit and charitable
14 institution, may obtain the required weekly direct supervisor
15 contact via live two-way videoconferencing. The supervisor shall
16 be responsible for ensuring that client confidentiality is preserved.

17 (e) The supervisor and the associate shall develop a supervisory
18 plan that describes the goals and objectives of supervision. These
19 goals shall include the ongoing assessment of strengths and
20 limitations and the assurance of practice in accordance with the
21 laws and regulations. The associate shall submit to the board the
22 initial original supervisory plan upon application for licensure.

23 (f) Experience shall only be gained in a setting that meets both
24 of the following:

25 (1) Lawfully and regularly provides clinical social work, mental
26 health counseling, or psychotherapy.

27 (2) Provides oversight to ensure that the associate's work at the
28 setting meets the experience and supervision requirements set forth
29 in this chapter and is within the scope of practice for the profession
30 as defined in Section 4996.9.

31 (g) Experience shall not be gained until the applicant has been
32 registered as an associate clinical social worker.

33 (h) Employment in a private practice as defined in subdivision
34 (i) shall not commence until the applicant has been registered as
35 an associate clinical social worker.

36 (i) A private practice setting is a setting that is owned by a
37 licensed clinical social worker, a licensed marriage and family
38 therapist, a licensed psychologist, a licensed professional clinical
39 counselor, a licensed physician and surgeon, or a professional
40 corporation of any of those licensed professions.

1 (j) Associates shall not be employed as independent contractors,
2 and shall not gain experience for work performed as an
3 independent contractor, reported on an IRS Form 1099, or both.

4 ~~(j)~~

5 (k) If volunteering, the associate shall provide the board with a
6 letter from his or her employer verifying his or her voluntary status
7 upon application for licensure.

8 ~~(k)~~

9 (l) If employed, the associate shall provide the board with copies
10 of his or her W-2 tax forms for each year of experience claimed
11 upon application for licensure.

12 ~~(l)~~

13 (m) While an associate may be either a paid employee or
14 volunteer, employers are encouraged to provide fair remuneration
15 to associates.

16 ~~(m)~~

17 (n) An associate shall not do the following:

18 (1) Receive any remuneration from patients or clients and shall
19 only be paid by his or her employer.

20 (2) Have any proprietary interest in the employer's business.

21 (3) Lease or rent space, pay for furnishings, equipment, or
22 supplies, or in any other way pay for the obligations of his or her
23 employer.

24 ~~(n)~~

25 (o) An associate, whether employed or volunteering, may obtain
26 supervision from a person not employed by the associate's
27 employer if that person has signed a written agreement with the
28 employer to take supervisory responsibility for the associate's
29 social work services.

30 ~~(o)~~

31 (p) Notwithstanding any other provision of law, associates and
32 applicants for examination shall receive a minimum of one hour
33 of supervision per week for each setting in which he or she is
34 working.

35 SEC. 17. Section 4999.12 of the Business and Professions
36 Code is amended to read:

37 4999.12. For purposes of this chapter, the following terms have
38 the following meanings:

39 (a) "Board" means the Board of Behavioral Sciences.

1 (b) “Accredited” means a school, college, or university
2 accredited by the ~~Western Association of Schools and Colleges,~~
3 ~~or its equivalent regional accrediting association.~~ *a regional or*
4 *national institutional accrediting agency that is recognized by the*
5 *United States Department of Education.*

6 (c) “Approved” means a school, college, or university that
7 possessed unconditional approval by the Bureau for Private
8 Postsecondary Education at the time of the applicant’s graduation
9 from the school, college, or university.

10 (d) “Applicant” means an unlicensed person who has completed
11 a master’s or doctoral degree program, as specified in Section
12 4999.32 or 4999.33, as applicable, and whose application for
13 registration as an intern is pending or who has applied for
14 examination eligibility, or an unlicensed person who has completed
15 the requirements for licensure specified in this chapter and is no
16 longer registered with the board as an intern.

17 (e) “Licensed professional clinical counselor” or “LPCC” means
18 a person licensed under this chapter to practice professional clinical
19 counseling, as defined in Section 4999.20.

20 (f) “Intern” means an unlicensed person who meets the
21 requirements of Section 4999.42 and is registered with the board.

22 (g) “Clinical counselor trainee” means an unlicensed person
23 who is currently enrolled in a master’s or doctoral degree program,
24 as specified in Section 4999.32 or 4999.33, as applicable, that is
25 designed to qualify him or her for licensure under this chapter, and
26 who has completed no less than 12 semester units or 18 quarter
27 units of coursework in any qualifying degree program.

28 (h) “Approved supervisor” means an individual who meets the
29 following requirements:

30 (1) Has documented two years of clinical experience as a
31 licensed professional clinical counselor, licensed marriage and
32 family therapist, licensed clinical psychologist, licensed clinical
33 social worker, or licensed physician and surgeon who is certified
34 in psychiatry by the American Board of Psychiatry and Neurology.

35 (2) Has received professional training in supervision.

36 (3) Has not provided therapeutic services to the clinical
37 counselor trainee or intern.

38 (4) Has a current and valid license that is not under suspension
39 or probation.

1 (i) “Client centered advocacy” includes, but is not limited to,
2 researching, identifying, and accessing resources, or other activities,
3 related to obtaining or providing services and supports for clients
4 or groups of clients receiving psychotherapy or counseling services.

5 (j) “Advertising” or “advertise” includes, but is not limited to,
6 the issuance of any card, sign, or device to any person, or the
7 causing, permitting, or allowing of any sign or marking on, or in,
8 any building or structure, or in any newspaper or magazine or in
9 any directory, or any printed matter whatsoever, with or without
10 any limiting qualification. It also includes business solicitations
11 communicated by radio or television broadcasting. Signs within
12 church buildings or notices in church bulletins mailed to a
13 congregation shall not be construed as advertising within the
14 meaning of this chapter.

15 (k) “Referral” means evaluating and identifying the needs of a
16 client to determine whether it is advisable to refer the client to
17 other specialists, informing the client of that judgment, and
18 communicating that determination as requested or deemed
19 appropriate to referral sources.

20 (l) “Research” means a systematic effort to collect, analyze, and
21 interpret quantitative and qualitative data that describes how social
22 characteristics, behavior, emotion, cognitions, disabilities, mental
23 disorders, and interpersonal transactions among individuals and
24 organizations interact.

25 (m) “Supervision” includes the following:

26 (1) Ensuring that the extent, kind, and quality of counseling
27 performed is consistent with the education, training, and experience
28 of the person being supervised.

29 (2) Reviewing client or patient records, monitoring and
30 evaluating assessment, diagnosis, and treatment decisions of the
31 clinical counselor trainee.

32 (3) Monitoring and evaluating the ability of the intern or clinical
33 counselor trainee to provide services to the particular clientele at
34 the site or sites where he or she will be practicing.

35 (4) Ensuring compliance with laws and regulations governing
36 the practice of licensed professional clinical counseling.

37 (5) That amount of direct observation, or review of audio or
38 videotapes of counseling or therapy, as deemed appropriate by the
39 supervisor.

1 SEC. 18. Section 4999.12.5 is added to the Business and
2 Professions Code, to read:

3 4999.12.5. (a) The title “professional clinical counselor intern”
4 or “professional clinical counselor registered intern” is hereby
5 renamed “associate professional clinical counselor” or “registered
6 associate professional clinical counselor,” respectively. Any
7 reference in any statute or regulation to a “professional clinical
8 counselor intern” or “professional clinical counselor registered
9 intern” shall be deemed a reference to an “associate professional
10 clinical counselor” or “registered associate professional clinical
11 counselor.”

12 (b) Nothing in this section shall be construed to expand or
13 constrict the scope of practice of a person licensed or registered
14 pursuant to this chapter.

15 (c) This section shall become operative January 1, 2018.

16 SEC. 19. Section 4999.40 of the Business and Professions
17 Code is amended to read:

18 4999.40. (a) Each educational institution preparing applicants
19 to qualify for licensure shall notify each of its students by means
20 of its public documents or otherwise in writing that its degree
21 program is designed to meet the requirements of Section 4999.32
22 or 4999.33 and shall certify to the board that it has so notified its
23 students.

24 (b) *An applicant for registration or licensure shall submit to*
25 *the board a certification by the applicant’s educational institution*
26 *that the institution’s required curriculum for graduation and any*
27 *associated coursework completed by the applicant does one of the*
28 *following:*

29 (1) *Meets all of the requirements set forth in Section 4999.32.*

30 (2) *Meets all of the requirements set forth in Section 4999.33.*

31 ~~(b)~~

32 (c) An applicant trained at an educational institution outside the
33 United States shall demonstrate to the satisfaction of the board
34 that he or she possesses a qualifying degree that is equivalent to a
35 degree earned from an institution of higher education that is
36 accredited or approved. These applicants shall provide the board
37 with a comprehensive evaluation of the degree performed by a
38 foreign credential evaluation service that is a member of the
39 National Association of Credential Evaluation Services and shall
40 provide any other documentation the board deems necessary.

1 SEC. 20. Section 4999.47 of the Business and Professions
2 Code is amended to read:

3 4999.47. (a) Clinical counselor trainees, interns, and applicants
4 shall perform services only as an employee or as a volunteer.

5 The requirements of this chapter regarding gaining hours of
6 clinical mental health experience and supervision are applicable
7 equally to employees and volunteers. ~~Experience shall not be~~
8 ~~gained by interns or trainees as an independent contractor.~~
9 *Associates and trainees shall not be employed as independent*
10 *contractors, and shall not gain experience for work performed as*
11 *an independent contractor, reported on an IRS Form 1099, or*
12 *both.*

13 (1) If employed, a clinical counselor intern shall provide the
14 board with copies of the corresponding W-2 tax forms for each
15 year of experience claimed upon application for licensure as a
16 professional clinical counselor.

17 (2) If volunteering, a clinical counselor intern shall provide the
18 board with a letter from his or her employer verifying the intern's
19 employment as a volunteer upon application for licensure as a
20 professional clinical counselor.

21 (b) Clinical counselor trainees, interns, and applicants shall not
22 receive any remuneration from patients or clients, and shall only
23 be paid by their employers.

24 (c) While an intern may be either a paid employee or a volunteer,
25 employers are encouraged to provide fair remuneration.

26 (d) Clinical counselor trainees, interns, and applicants who
27 provide voluntary services or other services, and who receive no
28 more than a total, from all work settings, of five hundred dollars
29 (\$500) per month as reimbursement for expenses actually incurred
30 by those clinical counselor trainees, interns, and applicants for
31 services rendered in any lawful work setting other than a private
32 practice shall be considered an employee and not an independent
33 contractor.

34 (e) The board may audit an intern or applicant who receives
35 reimbursement for expenses and the intern or applicant shall have
36 the burden of demonstrating that the payments received were for
37 reimbursement of expenses actually incurred.

38 (f) Clinical counselor trainees, interns, and applicants shall only
39 perform services at the place where their employer regularly
40 conducts business and services, which may include other locations,

1 as long as the services are performed under the direction and
2 control of the employer and supervisor in compliance with the
3 laws and regulations pertaining to supervision. Clinical counselor
4 trainees, interns, and applicants shall have no proprietary interest
5 in the employer's business.

6 (g) Each educational institution preparing applicants for
7 licensure pursuant to this chapter shall consider requiring, and
8 shall encourage, its students to undergo individual, marital or
9 conjoint, family, or group counseling or psychotherapy, as
10 appropriate. Each supervisor shall consider, advise, and encourage
11 his or her interns and clinical counselor trainees regarding the
12 advisability of undertaking individual, marital or conjoint, family,
13 or group counseling or psychotherapy, as appropriate. Insofar as
14 it is deemed appropriate and is desired by the applicant, the
15 educational institution and supervisors are encouraged to assist
16 the applicant in locating that counseling or psychotherapy at a
17 reasonable cost.

18 SEC. 21. Section 4999.52 of the Business and Professions
19 Code is amended to read:

20 4999.52. (a) ~~Except as provided in Section 4999.54, every~~
21 *Every* applicant for a license as a professional clinical counselor
22 shall be examined by the board. The board shall examine the
23 candidate with regard to his or her knowledge and professional
24 skills and his or her judgment in the utilization of appropriate
25 techniques and methods.

26 (b) The examinations shall be given at least twice a year at a
27 time and place and under supervision as the board may determine.

28 (c) The board shall not deny any applicant who has submitted
29 a complete application for examination admission to the licensure
30 examinations required by this section if the applicant meets the
31 educational and experience requirements of this chapter, and has
32 not committed any acts or engaged in any conduct that would
33 constitute grounds to deny licensure.

34 (d) The board shall not deny any applicant whose application
35 for licensure is complete admission to the examinations specified
36 by paragraph (2) of subdivision (a) of Section 4999.53, nor shall
37 the board postpone or delay this examination for any applicant or
38 delay informing the candidate of the results of this examination,
39 solely upon the receipt by the board of a complaint alleging acts
40 or conduct that would constitute grounds to deny licensure.

1 (e) If an applicant for the examination specified by paragraph
2 (2) of subdivision (a) of Section 4999.53, who has passed the
3 California law and ethics examination, is the subject of a complaint
4 or is under board investigation for acts or conduct that, if proven
5 to be true, would constitute grounds for the board to deny licensure,
6 the board shall permit the applicant to take this examination, but
7 may notify the applicant that licensure will not be granted pending
8 completion of the investigation.

9 (f) Notwithstanding Section 135, the board may deny any
10 applicant who has previously failed either the California law and
11 ethics examination, or the examination specified by paragraph (2)
12 of subdivision (a) of Section 4999.53, permission to retake either
13 examination pending completion of the investigation of any
14 complaints against the applicant.

15 (g) Nothing in this section shall prohibit the board from denying
16 an applicant admission to any examination, withholding the results,
17 or refusing to issue a license to any applicant when an accusation
18 or statement of issues has been filed against the applicant pursuant
19 to Section 11503 or 11504 of the Government Code, respectively,
20 or the application has been denied in accordance with subdivision
21 (b) of Section 485.

22 (h) Notwithstanding any other provision of law, the board may
23 destroy all examination materials two years following the date of
24 an examination.

25 (i) On and after January 1, 2016, the examination specified by
26 paragraph (2) of subdivision (a) of Section 4999.53 shall be passed
27 within seven years of an applicant's initial attempt.

28 (j) A passing score on the clinical examination shall be accepted
29 by the board for a period of seven years from the date the
30 examination was taken.

31 (k) No applicant shall be eligible to participate in the
32 examination specified by paragraph (2) of subdivision (a) of
33 Section 4999.53, if he or she fails to obtain a passing score on this
34 examination within seven years from his or her initial attempt. If
35 the applicant fails to obtain a passing score within seven years of
36 initial attempt, he or she shall obtain a passing score on the current
37 version of the California law and ethics examination in order to
38 be eligible to retake this examination.

39 (l) This section shall become operative on January 1, 2016.

1 SEC. 22. Section 4999.54 of the Business and Professions
2 Code is repealed.

3 ~~4999.54. (a) Notwithstanding Section 4999.50, the board may~~
4 ~~issue a license to any person who submits an application for a~~
5 ~~license between January 1, 2011, and December 31, 2011, provided~~
6 ~~that all documentation is submitted within 12 months of the board's~~
7 ~~evaluation of the application, and provided he or she meets one of~~
8 ~~the following sets of criteria:~~

9 (1) ~~He or she meets all of the following requirements:~~

10 (A) ~~Has a master's or doctoral degree from a school, college,~~
11 ~~or university as specified in Section 4999.32, that is counseling or~~
12 ~~psychotherapy in content. If the person's degree does not include~~
13 ~~all the graduate coursework in all nine core content areas as~~
14 ~~required by paragraph (1) of subdivision (c) of Section 4999.32,~~
15 ~~a person shall provide documentation that he or she has completed~~
16 ~~the required coursework prior to licensure pursuant to this chapter.~~
17 ~~Except as specified in clause (ii), a qualifying degree must include~~
18 ~~the supervised practicum or field study experience as required in~~
19 ~~paragraph (3) of subdivision (c) of Section 4999.32.~~

20 (i) ~~A counselor educator whose degree contains at least seven~~
21 ~~of the nine required core content areas shall be given credit for~~
22 ~~coursework not contained in the degree if the counselor educator~~
23 ~~provides documentation that he or she has taught the equivalent~~
24 ~~of the required core content areas in a graduate program in~~
25 ~~counseling or a related area.~~

26 (ii) ~~Degrees issued prior to 1996 shall include a minimum of~~
27 ~~30 semester units or 45 quarter units and at least six of the nine~~
28 ~~required core content areas specified in paragraph (1) of subdivision~~
29 ~~(c) of Section 4999.32 and three semester units or four and one-half~~
30 ~~quarter units of supervised practicum or field study experience.~~
31 ~~The total number of units shall be no less than 48 semester units~~
32 ~~or 72 quarter units.~~

33 (iii) ~~Degrees issued in 1996 and after shall include a minimum~~
34 ~~of 48 semester units or 72 quarter units and at least seven of the~~
35 ~~nine core content areas specified in paragraph (1) of subdivision~~
36 ~~(c) of Section 4999.32.~~

37 (B) ~~Has completed all of the coursework or training specified~~
38 ~~in subdivision (c) of Section 4999.32.~~

39 (C) ~~Has at least two years, full-time or the equivalent, of~~
40 ~~postdegree counseling experience, that includes at least 1,700 hours~~

1 of experience in a clinical setting supervised by a licensed marriage
2 and family therapist, a licensed clinical social worker, a licensed
3 psychologist, a licensed physician and surgeon specializing in
4 psychiatry, a professional clinical counselor or a person who is
5 licensed in another state to independently practice professional
6 clinical counseling, as defined in Section 4999.20, or a master's
7 level counselor or therapist who is certified by a national certifying
8 or registering organization, including, but not limited to, the
9 National Board for Certified Counselors or the Commission on
10 Rehabilitation Counselor Certification.

11 (D) Has a passing score on the following examinations:

12 (i) ~~The National Counselor Examination for Licensure and~~
13 ~~Certification or the Certified Rehabilitation Counselor~~
14 ~~Examination.~~

15 (ii) ~~The National Clinical Mental Health Counselor Examination.~~

16 (iii) ~~A California jurisprudence and ethics examination, when~~
17 ~~developed by the board.~~

18 (2) ~~Is currently licensed as a marriage and family therapist in~~
19 ~~the State of California, meets the coursework requirements~~
20 ~~described in subparagraph (A) of paragraph (1), and passes the~~
21 ~~examination described in subdivision (b).~~

22 (3) ~~Is currently licensed as a clinical social worker in the State~~
23 ~~of California, meets the coursework requirements described in~~
24 ~~subparagraph (A) of paragraph (1), and passes the examination~~
25 ~~described in subdivision (b).~~

26 (b) (1) ~~The board and the Office of Professional Examination~~
27 ~~Services shall jointly develop an examination on the differences,~~
28 ~~if any differences exist, between the following:~~

29 (A) ~~The practice of professional clinical counseling and the~~
30 ~~practice of marriage and family therapy.~~

31 (B) ~~The practice of professional clinical counseling and the~~
32 ~~practice of clinical social work.~~

33 (2) ~~If the board, in consultation with the Office of Professional~~
34 ~~Examination Services, determines that an examination is necessary~~
35 ~~pursuant to this subdivision, an applicant described in paragraphs~~
36 ~~(2) and (3) of subdivision (a) shall pass the examination as a~~
37 ~~condition of licensure.~~

38 (e) ~~Nothing in this section shall be construed to expand or~~
39 ~~constrict the scope of practice of professional clinical counseling,~~
40 ~~as defined in Section 4999.20.~~

1 SEC. 23. Section 4999.60 of the Business and Professions
2 Code is amended to read:

3 4999.60. (a) This section applies to persons who are licensed
4 outside of California and apply for examination eligibility on or
5 after January 1, 2016.

6 (b) The board may issue a license to a person who, at the time
7 of submitting an application for a license pursuant to this chapter,
8 holds a valid license as a professional clinical counselor, or other
9 counseling license that allows the applicant to independently
10 provide clinical mental health services, in another jurisdiction of
11 the United States, if all of the following conditions are satisfied:

12 (1) The applicant's education is substantially equivalent, as
13 defined in Section 4999.63.

14 (2) The applicant complies with subdivision-~~(b)~~ (c) of Section
15 4999.40, if applicable.

16 (3) The applicant's supervised experience is substantially
17 equivalent to that required for a license under this chapter. The
18 board shall consider hours of experience obtained outside of
19 California during the six-year period immediately preceding the
20 date the applicant initially obtained the license described above.
21 If the applicant has less than 3,000 hours of qualifying supervised
22 experience, time actively licensed as a professional clinical
23 counselor shall be accepted at a rate of 100 hours per month up to
24 a maximum of 1,200 hours if the applicant's degree meets the
25 practicum requirement described in subparagraph (C) of paragraph
26 (1) of subdivision (b) of Section 4999.63 without exemptions or
27 remediation.

28 (4) The applicant passes the examinations required to obtain a
29 license under this chapter. An applicant who obtained his or her
30 license or registration under another jurisdiction may apply for
31 licensure with the board without taking the clinical examination
32 if both of the following conditions are met:

33 (A) The applicant obtained a passing score on the licensing
34 examination set forth in regulation as accepted by the board.

35 (B) The applicant's license or registration in that jurisdiction is
36 in good standing at the time of his or her application and is not
37 revoked, suspended, surrendered, denied, or otherwise restricted
38 or encumbered.

39 SEC. 24. Section 4999.61 of the Business and Professions
40 Code is amended to read:

1 4999.61. (a) This section applies to persons who apply for
2 examination eligibility or registration on or after January 1, 2016,
3 and who do not hold a license as described in Section 4999.60.

4 (b) The board shall accept education gained while residing
5 outside of California for purposes of satisfying licensure or
6 registration requirements if the education is substantially
7 equivalent, as defined in Section 4999.62, and the applicant
8 complies with subdivision ~~(b)~~ (c) of Section 4999.40, if applicable.

9 (c) The board shall accept experience gained outside of
10 California for purposes of satisfying licensure or registration
11 requirements if the experience is substantially equivalent to that
12 required by this chapter.

13 SEC. 25. Section 4999.120 of the Business and Professions
14 Code is amended to read:

15 4999.120. The board shall assess fees for the application for
16 and the issuance and renewal of licenses and for the registration
17 of interns to cover administrative and operating expenses of the
18 board related to this chapter. Fees assessed pursuant to this section
19 shall not exceed the following:

20 (a) The fee for the application for examination eligibility shall
21 be up to two hundred fifty dollars (\$250).

22 (b) The fee for the application for intern registration shall be up
23 to one hundred fifty dollars (\$150).

24 (c) The fee for the application for licensure shall be up to one
25 hundred eighty dollars (\$180).

26 (d) The fee for the board-administered clinical examination, if
27 the board chooses to adopt this examination in regulations, shall
28 be up to two hundred fifty dollars (\$250).

29 (e) The fee for the law and ethics examination shall be up to
30 one hundred fifty dollars (\$150).

31 ~~(f) The fee for the examination described in subdivision (b) of~~
32 ~~Section 4999.54 shall be up to one hundred dollars (\$100).~~

33 ~~(g)~~

34 (f) The fee for the issuance of a license shall be up to two
35 hundred fifty dollars (\$250).

36 ~~(h)~~

37 (g) The fee for annual renewal of an intern registration shall be
38 up to one hundred fifty dollars (\$150).

39 (i)

1 (h) The fee for two-year renewal of licenses shall be up to two
2 hundred fifty dollars (\$250).

3 ~~(j)~~

4 (i) The fee for issuance of a retired license shall be forty dollars
5 (\$40).

6 ~~(k)~~

7 (j) The fee for rescoring an examination shall be twenty dollars
8 (\$20).

9 ~~(t)~~

10 (k) The fee for issuance of a replacement license or registration
11 shall be twenty dollars (\$20).

12 ~~(m)~~

13 (l) The fee for issuance of a certificate or letter of good standing
14 shall be twenty-five dollars (\$25).

15 SEC. 26. No reimbursement is required by this act pursuant to
16 Section 6 of Article XIII B of the California Constitution because
17 the only costs that may be incurred by a local agency or school
18 district will be incurred because this act creates a new crime or
19 infraction, eliminates a crime or infraction, or changes the penalty
20 for a crime or infraction, within the meaning of Section 17556 of
21 the Government Code, or changes the definition of a crime within
22 the meaning of Section 6 of Article XIII B of the California
23 Constitution.

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MBC TRACKER II BILLS**4/27/2016**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 12	Cooley	State Government: Administrative Regulations: Review	Sen. Approps	08/19/15
AB 26	Jones-Sawyer	Medical Cannabis	Sen. B&P	01/25/16
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Sen. Health	03/28/16
AB 73	Waldron	Patient Access to Prescribed Antiretroviral Drugs for HIV/AIDS	Sen. Health	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 366	Bonta	Medi-Cal: Annual Access Monitoring Report	Sen. Approps	07/07/15
AB 419	Kim	Go BIZ: Regulations	Sen. B&P	05/04/15
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	Senate	01/21/16
AB 533	Bonta	Health Care Coverage: Out-of-Network Coverage	Assembly	09/04/15
AB 572	Gaines	Diabetes Prevention: Treatment	Sen. Approps	07/02/15
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 741	Williams	Mental Health: Community Care Facilities	Sen. Human Svcs	05/04/15
AB 766	Ridley-Thomas	Public School Health Center Support Program	Sen. Approps	04/27/15
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	Sen. Approps	04/12/16
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	Sen. Health	01/13/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Sen. PE&R	
AB 923	Steinorth	Respiratory Care Practitioners	Sen. B&P	01/04/16
AB 1001	Maienschein	Child Abuse: Reporting	Sen. Human Svcs	01/14/16
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Sen. Gov. Org.	02/08/16

MBC TRACKER II BILLS

4/27/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1067	Gipson	Foster Children: Rights	Sen. Human Svcs	01/14/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Sen. Approps	07/01/15
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 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	Sen. Approps	07/16/15
AB 1300	Ridley-Thomas	Mental Health: Involuntary Commitment	Sen. Health	03/15/16
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Sen. Health	01/13/16
AB 1575	Bonta	Medical Cannabis	Asm. Approps	04/25/16
AB 1639	Maienschein	Pupil Health: Sudden Cardiac Arrest Prevention Act	Assembly	04/07/16
AB 1644	Bonta	School-Based Early Mental Health Intervention and Prevention	Asm. Approps	04/14/16
AB 1648	Wilk	State Publications: Distribution	Asm. Approps	03/15/16
AB 1668	Calderon	Investigational Drugs, Biological Products, and Devices	Asm. Approps	03/07/16
AB 1696	Holden	Medi-Cal: Tobacco Cessation Services	Asm. Approps	03/28/16
AB 1703	Santiago	Inmates: Medical Treatment	Senate	
AB 1748	Mayes	Pupils: Pupil Health: Opioid Antagonist	Asm. Approps	04/25/16
AB 1763	Gipson	Health Care Coverage: Colorectal Cancer: Screening and Testing	Asm. Approps	
AB 1774	Bonilla	Clinical Laboratories: Licensure	Asm. Approps	04/25/16
AB 1795	Atkins	Health Care Programs: Cancer	Asm. Approps	03/28/16
AB 1805	Melendez	Elder and Dependent Adult Abuse	Assembly	
AB 1823	Bonilla	California Cancer Clinical Trials Program	Asm. Approps	04/12/16
AB 1827	Kim	Emergency Medical Services: Mobile Field Hospitals	Asm. Health	03/16/16
AB 1831	Low	Health Care Coverage: Prescription Drugs: Refills	Asm. Approps	
AB 1836	Maienschein	Mental Health: Conservatorship Hearings	Asm. Approps	03/31/16
AB 1852	Lackey	State Contracts: Contract Requirements	Assembly	
AB 1864	Cooley	Inquests: Sudden Unexplained Death in Childhood	Asm. Approps	03/17/16

MBC TRACKER II BILLS**4/27/2016**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1868	Wagner	Regulations: Legislative Notice	Asm. Approps	
AB 1887	Low	State Government: Discrimination: Travel	Asm. Approps	04/07/16
AB 1939	Patterson	Licensing Requirements	Asm. Approps	04/12/16
AB 1949	Baker	Department of Consumer Affairs	Assembly	
AB 1954	Burke	Health Care Coverage: Reproductive Health Care Services	Asm. Approps	04/25/16
AB 1983	Lackey	Excluded Employees: Shift Seniority	Asm. Approps	
AB 2048	Gray	National Health Service Corps State Loan Repayment Program	Asm. Approps	04/07/16
AB 2083	Chu	Interagency Child Death Review	Asm. 3rd Reading	
AB 2084	Wood	Medi-Cal: Comprehensive Medication Management	Asm. Approps	
AB 2086	Cooley	Workers' Compensation: Neuropsychologists	Assembly	03/30/16
AB 2115	Wood	Health Care Coverage: Disclosures	Asm. Approps	04/20/16
AB 2119	Chu	Medical Information: Disclosure: Medical Examiners and Forensic Pathologists	Asm. Priv. &CP	
AB 2174	Jones	Ken Maddy California Cancer Registry	Asm. Approps	03/18/16
AB 2193	Salas	California Board of Podiatric Medicine: Physician Assistant Board: Extension	Sen. Approps	04/05/16
AB 2209	Bonilla	Health Care Coverage: Clinical Pathways	Asm. Approps	04/26/16
AB 2235	Thurmond	Board of Dentistry: Pediatric Anesthesia: Committee	Assembly	04/11/16
AB 2311	Brown	Emergency Services: Sign Language Interpreters	Asm. Approps	03/16/16
AB 2317	Mullin	California State University: Doctor of Audiology Degrees	Asm. Approps	
AB 2345	Ridley-Thomas	Commission on Health Care Cost Review	Asm. Approps	04/18/16
AB 2372	Burke	Health Care Coverage: HIV Specialists	Asm. Approps	04/25/16
AB 2394	Garcia, E.	Medi-Cal: Non-Medical Transportation	Asm. Approps	03/28/16
AB 2399	Nazarian	Pregnancy: Umbilical Cord Blood: Blood Testing	Asm. Approps	03/28/16

MBC TRACKER II BILLS**4/27/2016**

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2400	Nazarian	Prescription Drug Coverage: Prior Authorization and External Review	Asm. Approps	04/06/16
AB 2404	Cooley	Public Employees' Retirement System: Optional Settlements	Asm. Approps	04/12/16
AB 2407	Chavez	Workers' Compensation	Asm. Insurance	
AB 2421	Jones	Professions and Vocations	Assembly	
AB 2422	Jones	Medical Board of California (SPOT)	Assembly	
AB 2424	Gomez	Community-Based Health Improvement and Innovation Fund	Asm. Approps	04/06/16
AB 2436	Hernandez, R.	Health Care Coverage: Disclosures: Drug Pricing	Assembly	04/06/16
AB 2503	Obernalte	Workers' Compensation: Utilization Review	Asm. Insurance	04/19/16
AB 2512	Grove	Task Force on California Women Veterans Health	Asm. Approps	04/06/16
AB 2531	Burke	Reproductive Health and Research	Asm. 3rd Reading	
AB 2611	Low	The California Public Records Act: Exemptions	Asm. Approps	04/14/16
AB 2640	Gipson	Public Health: HIV	Asm. Approps	04/21/16
AB 2688	Gordon	Privacy: Commercial Health Monitoring Programs	Asm. Priv. &CP	04/11/16
AB 2696	Gaines, B.	Diabetes Prevention and Management	Asm. Approps	04/18/16
AB 2703	Linder	Medical Confidentiality: Authorizations	Asm. Health	03/18/16
AB 2737	Bonta	Nonprovider Health Care Districts	Asm. Approps	04/11/16
AB 2752	Nazarian	Health Care Coverage: Continuity of Care	Asm. Approps	04/26/16
AB 2843	Chau	Public Records: Employee Contact Information	Asm. Approps	03/18/16
AB 2853	Gatto	Public Records	Asm. Approps	04/13/16
AB 2859	Low	Professions and Vocations: Retired Category: Licenses	Asm. Approps	
Ab 2883	Ins. Comm.	Workers' Compensation: Utilization Review	Asm. Approps	03/29/16
ACA 3	Gallagher	Public Employees' Retirement	Asm. PER&SS	
ACR 131	Patterson	Professions and Vocations: Licensing Fees: Equity	Asm. Approps	
SB 3	Leno	Minimum Wage: Adjustment	Chaptered, #4	

MBC TRACKER II BILLS**4/27/2016**

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 10	Lara	Health Care Coverage: Immigration Status	Asm. Health	04/13/16
SB 24	Hill	California Public Employees' Pension Reform Act	Assembly	01/05/16
SB 139	Galgiani	Controlled Substances	Assembly	08/18/15
SB 190	Beall	Health Care Coverage: Acquired Brain Injury	Sen. Health	04/06/15
SB 253	Monning	Juveniles: Psychotropic Medication	Asm. Inactive File	08/31/15
SB 275	Hernandez	Health Facility Data	Asm. Health	
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 447	Allen	Medi-Cal: Clinics: Enrollment Applications	Asm. Approps	08/24/15
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.	Assembly	01/26/16
SB 573	Pan	Statewide Open Data Portal	Asm. Approps	07/09/15
SB 614	Leno	Medi-Cal: Mental Health Services	Asm. Inactive File	08/31/15
SB 780	Mendoza	Psychiatric Technicians and Assistants	Asm. PER&SS	
SB 914	Mendoza	Workers' Compensation: Medical Provider Networks	Assembly	01/26/16
SB 923	Hernandez	Health Care Coverage: Cost Sharing Changes	Sen. 3rd Reading	01/28/16
SB 932	Hernandez	Health Care Mergers, Acquisitions, and Collaborations	Sen. Approps	04/26/16
SB 938	Jackson	Conservatorships: Psychotropic Drugs	Sen. Approps	03/15/16
SB 950	Nielsen	Excluded Employees: Arbitration	Sen. Approps	03/31/16
SB 960	Hernandez	Medi-Cal Telehealth: Reproductive Health Care	Sen. Approps	04/26/16
SB 999	Pavley	Health Insurance: Contraceptives: Annual Supply	Sen. Approps	04/18/16
SB 1002	Monning	End of Life Option Act: Telephone Number	Sen. Approps	04/05/16
SB 1010	Hernandez	Health Care: Prescription Drug Costs	Sen. Approps	03/30/16
SB 1034	Mitchell	Health Care Coverage: Autism	Sen. Approps	04/26/16
SB 1058	Pan	State Employment: Supervisors	Sen. Approps	04/04/16

MBC TRACKER II BILLS**4/27/2016**

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1090	Mitchell	Sexually Transmitted Diseases: Outreach and Screening Services	Sen. Approps	04/12/16
SB 1095	Pan	Newborn Screening Program	Sen. Approps	
SB 1135	Monning	Health Care Coverage: Notice of Timely Access to Care	Sen. Approps	03/30/16
SB 1139	Lara	Health Professionals: Medical Residency Programs: Undocumented Immigrants	Sen. Approps	04/19/16
SB 1140	Moorlach	Legislature: Operation of Statutes	Sen. Gov. Org.	
SB 1155	Morrell	Professions and Vocations: Licenses: Military Service	Sen. Approps	03/28/16
SB 1159	Hernandez	California Health Care Cost and Quality Database	Sen. Approps	03/28/16
SB 1160	Mendoza	Workers' Compensation: Utilization Review	Sen. Approps	04/06/16
SB 1184	Cannella	Health Care: Workforce Training Programs	Senate	
SB 1220	McGuire	Child Welfare Services: Case Plans: Behavioral Health Services	Sen. Approps	04/06/16
SB 1229	Jackson	Home-Generated Pharmaceutical Waste: Secure Drug Take-Back Bins	Assembly	04/19/16
SB 1334	Stone	Crime Reporting: Health Practitioners: Reports	Sen. Approps	04/19/16
SB 1348	Cannella	Licensure Applications: Military Experience	Sen. Approps	
SB 1448	Glazer	Department of Consumer Affairs	Senate	
SB 1466	Mitchell	Early and Periodic Screening, Diagnosis, and Treatment Program	Sen. Approps	04/14/16
SCR 117	Pan	Palliative Care	Sen. Approps	
SR 17	Jackson	Relative to California Health Care Decisions Day	Sen. Adopted	03/16/15
SR 55	Bates	Relative to Drug Facts Week	Sen. Adopted	
SR 71	Berryhill	Relative to Organ Donation	Sen. Adopted	

**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***
Physician and Surgeon Licensing Examinations Minimum Passing Scores	Staff finishing the file to submit to DCA for final review, before submitting to OAL	5/8/15	6/5/15	7/31/15	7/31/15			
Outpatient Surgery Setting Accreditation Agency Standards	Staff finishing the file to submit to DCA for final review, before submitting to OAL	5/8/15	6/5/15	7/31/15	7/31/15			
Disclaimers and Explanatory Information Applicable to Internet Postings	Sent to DCA for final review 4/12/16	5/8/15	6/5/15	7/31/15	10/30/15	4/12/16		
Disciplinary Guidelines	Staff finishing the file to submit to DCA for final review, before submitting to OAL	7/25/14 7/31/15	9/4/15	10/30/15	10/30/15			

Prepared by Kevin A. Schunke
Updated on April 12, 2016
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: April 21, 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, recognize the Universidad Autonoma de Guadalajara School of Medicine, International Program (UAG) four-year curriculum and deem it to be in substantial compliance with the requirements of Business and Professions Code sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1.

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 program 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.

At the January 22, 2016 Board meeting, the Board reviewed the UAG International Program's proposed four-year curriculum. The Board requested additional information regarding the clinical rotations at UAG's affiliated hospitals in Mexico, the oversight of UAG students in clinical rotations, and the oversight of the hospitals where the UAG students are receiving clinical clerkships.

UAG has provided the Board with additional information regarding UAG's oversight of the students and hospitals during the clinical rotation clerkships. Board staff and Medical Consultant Dr. Nuovo have reviewed UAG's policy and procedures regarding student expectations and evaluations during clinical clerkship rotations, and reviewed actual student evaluations and UAG's hospital site visits evaluations. UAG visits sites and evaluates the affiliated hospitals twice a year. Based upon the additional information provided by UAG, UAG has demonstrated the necessary oversight to ensure the quality of the clinical clerkship rotations completed in the UAG affiliated hospitals in Mexico and the necessary oversight of the students who are completing clinical clerkships in those hospitals.

The report prepared by Dr. Nuovo has been included for review (pages BRD 17 – 2).

MEMO

April 21, 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, from a response by the School to additional questions posed after review of the Self-Assessment Report and from additional information provided to Curt Worden.

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.
3. Additional materials provided from the School to Curt Worden.

Recommendations:

After review of all of the information provided by UAG, I feel that the School is in substantial compliance with the required statutes and regulations to justify recognition. The additional materials provided demonstrate compliance with the prior concerns that were stated in my January 12, 2016 memo. Specifically, I 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." Further, I feel that the materials provided by the School demonstrate sufficient oversight in the quality of the clinical rotations available to the students.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 15, 2016
 ATTENTION: Members, Medical Board of California
 SUBJECT: Midwife Assistants Regulations
 STAFF CONTACT: Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

After review and consideration of the attached proposed midwife assistant regulatory language, make a motion to direct staff to proceed with preparing the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory language and schedule a hearing on the rulemaking to add Title 16, Division 13, Chapter 3, Article 6, California Code of Regulations (CCR), sections 1379.01 through 1379.09. The new regulation would further define California Business and Professions Code (BPC) section 2516.5 regarding midwife assistants.

BACKGROUND AND ANALYSIS:

Senate Bill (SB) 408, Morrell, was signed by Governor Brown and filed with the Secretary of State on September 8, 2015, with an effective date of January 1, 2016. SB 408 created BPC section 2516.5 regarding midwife assistants. Midwife assistants are unlicensed individuals (similar to a medical assistant) who must meet specific requirements pursuant to BPC section 2069 and any other requirements established by regulations adopted by the Board to assist licensed midwives or certified nurse-midwives.

On February 3, 2016, the Board held an interested parties meeting to draft proposed regulations for midwife assistants. The Board received input from the interested parties.

Staff prepared the draft language for the midwife assistants proposed regulations based upon the information received at the February 3, 2016 interested parties meeting.

On March 10, 2016, the proposed draft midwife assistants regulations were presented to the Midwifery Advisory Council (MAC). Additional input was received and the MAC approved the proposed draft regulations with edits to be presented to the Board at the May 6, 2016 Board meeting.

STAFF RECOMMENDATION:

Staff recommends the Board authorize staff to proceed with preparing the necessary regulatory documents to submit to OAL to formally notice proposed CCR sections 1379.01 through 1379.09 and schedule a regulatory hearing at a future Board meeting. The suggested language is identified with underlined text below. BPC section 2516.5 is attached (**Attachment A**) for reference.

PROPOSED REGULATION LANGUAGE:

California Code of Regulations
Title 16. Professional and Vocational Regulations
Division 13. Medical Board of California
Chapter 3. Affiliated Healing Arts
Article 6. Midwife Assistants

§ 1379.01 Licensed Midwife Supervisor

The supervising licensed midwife or certified nurse midwife authorizes the midwife assistant to perform the services referenced in section 2516.5(b)(1) of the code, and shall be responsible for the patient's treatment and care.

§ 1379.02 Certification in Neonatal Resuscitation

Each midwife assistant shall maintain current certification in Neonatal Resuscitation. Certification shall be obtained from the American Academy of Pediatrics.

§ 1379.03 Certification in Basic Life Support

Each midwife assistant shall maintain current certification in Basic Life Support. Certification shall be obtained from the American Heart Association or the American Safety and Health Institute.

§ 1379.04 Training in Infection Control

Each midwife assistant shall receive training in the Center for Disease Control "Guidelines for Infection Control in Health Care Personnel" and shall demonstrate to the satisfaction of the supervising licensed midwife or instructor that he or she understands the purposes and techniques of infection control.

§ 1379.05 Training to Perform Services

In order to perform the services of a midwife assistant, the individual shall have completed the minimum training as prescribed herein pursuant to subsections (a), (b), (c), and (i). In order to place a device used for auscultation of fetal heart tones during labor, administer medications by intramuscular, subcutaneous, or intradermal injection, perform skin tests, or perform venipuncture or skin puncture for the purpose of withdrawing blood, a midwife assistant shall have completed the minimum training prescribed herein for the service to be performed pursuant to subsections (d), (e), (f), (g), (h) and (i). Training shall be for the duration required for the midwife assistant to demonstrate to the supervising instructor, supervising licensed midwife, or certified nurse midwife, as referenced in section 2516.5(a)(1) of the code, proficiency in the procedures to be performed as authorized by section 2516.5(b) of the code, where applicable, but shall include no less than:

- (a) Five (5) clock hours of midwifery didactic training.
- (b) Two (2) clock hours of training in administering oxygen by inhalation.
- (c) Ten (10) clock hours of satisfactory demonstration of immediate newborn care.
- (d) Five (5) clock hours and ten (10) demonstrations of satisfactory placement of the device used for auscultation of fetal heart tones during labor or by simulation.
- (e) Ten (10) clock hours of training in administering injections and performing skin tests.
- (f) Ten (10) clock hours of training in venipuncture and skin puncture for the purpose of withdrawing blood.
- (g) Satisfactory performance of ten (10) each of intramuscular, subcutaneous, and intradermal injections.
- (h) Satisfactory performance of ten (10) each of skin tests, venipunctures and skin punctures.
- (i) Training in (a) through (h) above, shall include instruction and demonstration in:
 - (1) pertinent anatomy and physiology appropriate to the procedures;
 - (2) choice of equipment;
 - (3) proper technique including sterile technique;
 - (4) hazards and complications;
 - (5) patient care following treatment or test;
 - (6) emergency procedures;
 - (7) California law and regulations for midwife assistants.

§ 1379.06 Administration of Training

- (a) Training required in section 1379.05 may be administered in either of these settings:
 - (1) Under a supervising licensed midwife or certified nurse midwife, who shall ascertain the proficiency of the midwife assistant and shall be responsible for determining the content of the training and the proficiency of the midwife assistant; or
 - (2) In a secondary, postsecondary, or adult education program in a public school authorized by the Department of Education, in a community college program provided for in Part 48 of Division 7 of the Education Code, or a postsecondary institution accredited by an accreditation agency recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary Education under sections 94885 and 94887 of the Education Code and any regulations adopted pursuant to those sections. A licensed midwife or certified nurse midwife shall serve as advisor to the midwife assistant training program. The instructor in a public school setting shall possess a valid teaching credential issued by the Commission on Teacher Credentialing. The instructor in a private postsecondary institution shall meet the requirements of section 94885(a)(5) of the Education Code and any regulations adopted pursuant that section.

(b) The supervising licensed midwife or certified nurse midwife, pursuant to subsection (a)(1) or the instructor pursuant to subsection (a)(2) shall certify in writing the place and date such training was administered, the content and duration of the training, and that the midwife assistant was observed by the supervising licensed midwife, certified nurse midwife, or instructor, to demonstrate competence in the performance of each such task or service, and shall sign and date the certification. More than one task or service may be certified in a single document; separate certifications shall be made for subsequent training in additional tasks or services.

§ 1379.07 Approved Certifying Organizations

(a) An organization that certifies midwife assistants may apply to the Board for approval. This application shall include the following information:

(1) Name and address of the applicant;

(2) Applicant's federal employee identification number (FEIN), social security number (SSN), or Individual Taxpayer Identification Number (ITIN);

(3) Name, address and telephone number of a contact person for the applicant;

(4) Name, address and telephone number of the accrediting organization that accredited the applicant;

(5) Name, address and telephone number of the organization that validated the applicant's certifying examination;

(6) Information sufficient to establish that the certifying organization meets the standards set forth in subsection (b).

(b) For purposes of section 1379.06, an organization that certifies midwife assistants shall be approved if it meets all of the following standards:

(1) Is a non-profit, tax-exempt organization;

(2) Requires all applicants for certification to successfully complete a psychometrically valid examination that is secure, is occupationally relevant and tests for the skills and procedures outlined in section 2516.5 of the code;

(3) Has a requirement for certification of a midwife assistant in one or more of the following:

(A) Graduation from a midwife assistant training program accredited by an accreditation agency recognized by the United States Department of Education;

(B) Graduation from a midwife assistant training program in a postsecondary institution accredited by an accreditation agency recognized by the United States Department of Education or an institution approved by the Bureau for Private Postsecondary Education;

(C) A minimum of two (2) years of experience as a practicing midwife assistant within five (5) years immediately preceding the date of examination;

(D) Military training or schooling equivalent to that described in subsections (A) or (B) above;

(E) Employment at the time of certification as an instructor in an accredited midwife assistant program or institution.

(4) Requires its certificate holders to obtain a minimum of 60 hours continuing education related to the practice of midwife assistants over a 5 year period.

§ 1379.08 Report of Changes by Certifying Organization; Review by Board

(a) An approved certifying organization shall notify the Board within thirty (30) days thereafter of any changes related to the standards contained in section 1379.07.

(b) The Board shall review each approved certifying body at least once every five (5) years for compliance with the standards set forth in section 1379.07. The Board may, in its discretion, review any certifying organization that has submitted a notice of changes as required by subsection (a).

§ 1379.09 Permit Processing Times - Approved Certifying Organizations

(a) Within sixty (60) working days of receipt of an application pursuant to section 1379.07 for an approved certifying organization registration, the Board shall inform the applicant in writing whether it is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application. An application is considered complete if it is in compliance with the requirements of section 1379.07.

(b) Within 100 calendar days from the date of filing of a completed application, the Board shall inform the applicant in writing of the decision regarding the application for an approved certifying organization registration.

ATTACHMENT A

BUSINESS AND PROFESSIONS CODE - BPC

DIVISION 2. HEALING ARTS [500 - 4999.129]

(Division 2 enacted by Stats. 1937, Ch. 399.)

CHAPTER 5. Medicine [2000 - 2525.5]

(Chapter 5 repealed and added by Stats. 1980, Ch. 1313, Sec. 2.)

ARTICLE 24. Licensed Midwives [2505 - 2521]

(Article 24 repealed and added by Stats. 1993, Ch. 1280, Sec. 3.)

2516.5.

(a) As used in this section, the following definitions apply:

(1) “Midwife assistant” means a person, who may be unlicensed, who performs basic administrative, clerical, and midwife technical supportive services in accordance with this chapter for a licensed midwife or certified nurse-midwife, is at least 18 years of age, and has had at least the minimum amount of hours of appropriate training pursuant to standards established by the board for a medical assistant pursuant to Section 2069. The midwife assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training. Each employer of the midwife assistant or the midwife assistant shall retain a copy of the certificate as a record.

(2) “Midwife technical supportive services” means simple routine medical tasks and procedures that may be safely performed by a midwife assistant who has limited training and who functions under the supervision of a licensed midwife or certified nurse-midwife.

(3) “Specific authorization” means a specific written order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed on a patient, which shall be placed in the patient’s medical record, or a standing order prepared by the supervising midwife or supervising nurse-midwife authorizing the procedures to be performed. A notation of the standing order shall be placed in the patient’s medical record.

(4) “Supervision” means the supervision of procedures authorized by this section by a licensed midwife or certified nurse-midwife, within his or her scope of practice, who is physically present on the premises during the performance of those procedures.

(b) Notwithstanding any other provision of law, a midwife assistant may do all of the following:

(1) Administer medication only by intradermal, subcutaneous, or intramuscular injections and perform skin tests and additional technical support services upon the specific authorization and supervision of a licensed midwife or certified nurse-midwife. A midwife assistant may also perform all these tasks and services in a clinic licensed in accordance with subdivision (a) of Section 1204 of the Health and Safety Code upon the specific authorization of a licensed midwife or certified nurse-midwife.

(2) Perform venipuncture or skin puncture for the purposes of withdrawing blood upon specific authorization and under the supervision of a licensed midwife or certified nurse-midwife, if the

midwife assistant has met the educational and training requirements for medical assistants as established in Section 2070. Each employer of the assistant shall retain a copy of any related certificates as a record.

(3) Perform the following midwife technical support services:

(A) Administer medications orally, sublingually, topically, or rectally, or by providing a single dose to a patient for immediate self-administration, and administer oxygen at the direction of the supervising licensed midwife or certified nurse-midwife. The licensed midwife or certified nurse-midwife shall verify the correct medication and dosage before the midwife assistant administers medication.

(B) Assist in immediate newborn care when the licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(C) Assist in placement of the device used for auscultation of fetal heart tones when a licensed midwife or certified nurse-midwife is engaged in a concurrent activity that precludes the licensed midwife or certified nurse-midwife from doing so.

(D) Collect by noninvasive techniques and preserve specimens for testing, including, but not limited to, urine.

(E) Assist patients to and from a patient examination room, bed, or bathroom.

(F) Assist patients in activities of daily living, such as assisting with bathing or clothing.

(G) As authorized by the licensed midwife or certified nurse-midwife, provide patient information and instructions.

(H) Collect and record patient data, including height, weight, temperature, pulse, respiration rate, blood pressure, and basic information about the presenting and previous conditions.

(I) Perform simple laboratory and screening tests customarily performed in a medical or midwife office.

(4) Perform additional midwife technical support services under regulations and standards established by the board.

(c) (1) Nothing in this section shall be construed as authorizing the licensure of midwife assistants. Nothing in this section shall be construed as authorizing the administration of local anesthetic agents by a midwife assistant. Nothing in this section shall be construed as authorizing the board to adopt any regulations that violate the prohibitions on diagnosis or treatment in Section 2052.

(2) Nothing in this section shall be construed as authorizing a midwife assistant to perform any clinical laboratory test or examination for which he or she is not authorized under Chapter 3 (commencing with Section 1200).

(d) Notwithstanding any other law, a midwife assistant shall not be employed for inpatient care in a licensed general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(Added by Stats. 2015, Ch. 280, Sec. 1. Effective January 1, 2016.)

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: April 10, 2016
 ATTENTION: Members, Medical Board of California
 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 the Hospital Transfer Form
- Update on midwifery related legislation expected to be introduced or followed this year
- Update on the midwifery program
- Discussion and approval of MAC licensed midwife position that was not filled in March
- Update on progress with midwifery assistant regulations
- Report from the California Association of Licensed Midwives on the new Quality Care Program

BACKGROUND:

The last MAC meeting was held on March 10, 2016. At this meeting, the MAC was updated by Staff regarding recommendations for changes to the Licensed Midwife Annual Report (LMAR). This process continues to be moving forward. The MAC received an update on regulations that will be required pursuant to the passage of Senate Bill (SB) 408 (Morrel) - Midwife Assistants. Kerrie Webb presented proposed regulations. A few edits were received and then the regulations were adopted by the MAC to be sent forward to the full Board. A report, compiled from a survey of licensed midwives (approximately 52 licensed midwives were represented) and presented by Rosanna Davis, President of California Association of Midwives, revealed that the licensed midwives who responded were generally able to secure a consult with a physician when needed. Unfortunately, the respondents to the survey only represent about one eighth of California licensed midwives, so the conclusions drawn may not accurately represent the situation in the entire state.

The MAC reviewed applications from physicians and members of the public for those respective positions on the MAC. Unfortunately, no licensed midwives applied for the Licensed Midwife position and so that order of business was pended until the August meeting.

The MAC is pleased to recommend Dr. Anne Marie Adams for the vacant physician position. Dr. Adams has attended a number of MAC meetings and interested parties meetings that pertain to licensed midwives. Her engagement, comments and suggestions have been well received and well thought out. Additionally, she brings a unique skill set and insight to the MAC as a physician who is actively practicing in home birth settings and attending peer review with licensed midwives.

Medical Board of California
MAC Chair Update
April 10, 2016

The MAC would like to recommend Jocelyn Dugan for the public member position. Ms. Dugan is both a consumer of midwifery home birth services and treasurer of the California Association of Midwives.

The MAC looks forward to working with these two new members.

Once again, the MAC heard updates on the continuing efforts to craft regulations required by AB 1308 (Bonilla, Chapter 665, Statutes of 2013); specifically 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. There continues to be disagreement regarding care for women who have had a prior cesarean. It was asked that staff arrange another interested parties meeting to see if compromise can be had in a structured forum.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 14, 2016
ATTENTION: Members, Medical Board of California (Board)
SUBJECT: Midwifery Advisory Council (MAC) Vacancies
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFF RECOMMENDATION:

Staff recommends the Board approve the MAC's recommendation to appoint Anne Marie Adams, M.D., to the vacant physician member position. Staff also recommends the Board approve the MAC's recommendation to appoint Jocelyn Dugan to the vacant public member position. Staff further recommends that if the MAC at its August 18, 2016 meeting votes to recommend a licensed midwife to the vacant midwife position, the candidate be permitted to sit on the MAC at that meeting pending Board approval at the October 2016 meeting.

EXECUTIVE SUMMARY:

Business and Professions Code Section 2509 states the Board shall create and appoint a Midwifery Advisory Council consisting of licensees of the Board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including, but not limited to, home births. At least one-half of the MAC members shall be California licensed midwives.

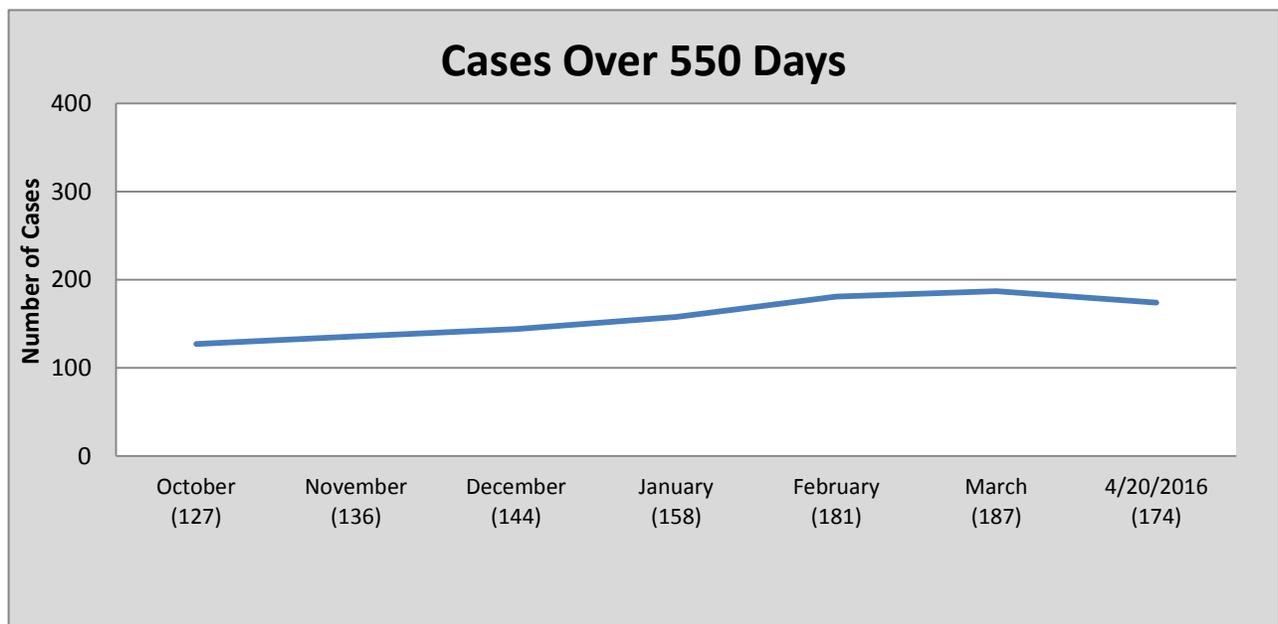
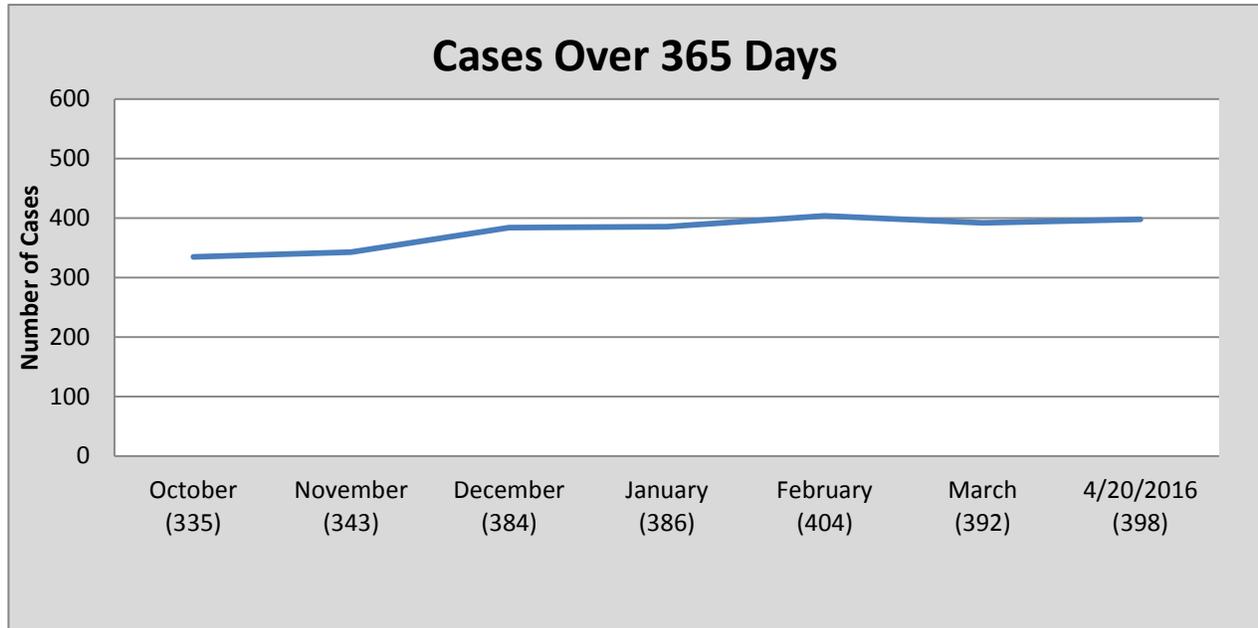
On January 11, 2016, a MAC Member Interest Form was mailed to all California licensed midwives and individuals on the interested parties mailing list for three positions: one licensed midwife, one licensed physician, and one public member positions that are expiring on June 30, 2016. An application was also posted on the Board's website. The deadline for application submissions was February 10, 2016. The Board did not receive any applications for the California licensed midwife position.

The Board received seven applications for the licensed physician member position. Two of the physician applicants were present at the March 10, 2016 MAC meeting and addressed the MAC members regarding their interest to be a MAC member. The MAC members voted to recommend to the full Board Anne Marie Adams, M.D., to the physician member position.

The Board received six applications for the public member position. One of the public member applicants was present and addressed the MAC members regarding her interest to be a MAC member. The MAC members voted to recommend to the full Board Jocelyn Dugan for the vacant public member position.

Staff will send out a MAC Member Interest Form for the vacant licensed midwife position prior to the next MAC meeting on August 18, 2016.

HQIU ACTIVE CASE STATISTICS OCTOBER 2015 - APRIL 20, 2016



This data has been manually calculated and has not been verified by the MBC data integrity analyst.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 21, 2016
ATTENTION: Members, Medical Board of California
SUBJECT: Citation and Fine Authority and Disclosure
STAFF CONTACT: Kerrie Webb, Senior Staff Counsel

RECOMMENDED ACTION:

After review and consideration of the proposed citation and fine regulatory language, make a motion to direct staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend Title 16, Division 13, Chapter 2, Article 6, California Code of Regulations (CCR), sections 1364.10, 1364.11, 1364.13 and 1364.15.

BACKGROUND AND ANALYSIS:Summary of Proposed Amendments to 16 CCR section 1364.10

16 CCR section 1364.10 currently states that a Board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in section 1364.11. Licensed midwives and polysomnographic technologists, technicians, and trainees are not currently covered by the Board's citation and fine regulations, and the Board lacks the authority to issue citations and fines against them where appropriate. These amendments will add licensed midwives and polysomnographic technologists, technicians, and trainees to those to whom a Board can issue a citation. Additionally, the proposed amendments will clarify that citations may be issued for violations of the regulations, as well as the statutes, listed.

Summary of Proposed Amendments to 16 CCR section 1364.11

16 CCR section 1364.11(a) states that a Board official may issue a citation under section 1364.10 for a violation of the provisions listed in this section. Section 1364.11(a) needs to be amended to include the following citation authority:

- B&P section 2234(h), relating to the repeated failure of a certificate holder, in the absence of good cause, to attend and participate in an interview by the board;
- B&P sections 2507, 2508, 2510, 2514, and 2519, relating to licensed midwives;
- B&P sections 3575 and section 3576, relating to polysomnographic technologists, technicians, and trainees;
- B&P section 4172, relating to any prescriber who dispenses drugs and fails to store all drugs to be dispensed in an area that is secure;
- Health and Safety Code section 11165.1(a)(1)(A)(i), requiring health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances to submit an application before July 1, 2016, to the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient maintained in the CURES database; and

- 16 CCR section 1355.4, relating to any licensee that practices medicine and fails to provide proper notice to each patient of the fact that the licensee is licensed and regulated by the Board.

Additionally, this section needs to be reorganized and renumbered so that it is easier for interested parties to locate citable offenses. Also, a section that now falls under the Physical Therapy Board's jurisdiction, B&P section 2630, needs to be stricken. Finally, the proposed amendments clarify that a citation issued under this section is separate from, and in addition to, any other civil or criminal remedies.

Summary of Proposed Amendments to 16 CCR section 1364.13

16 CCR section 1364.13 authorizes a Board official to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon is required under the Medical Practice Act. Amendments to section 1364.13 are needed to authorize a Board official to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a licensed midwife or registration as a polysomnographic technologist, technician, or trainee is required.

Summary of Proposed Amendments to 16 CCR section 1364.15

16 CCR section 1364.15 states every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public and citations that have been resolved by payment of the administrative fine or compliance with the order of abatement shall be purged five (5) years from the date of resolution. However, Assembly Bill 1886 (Eggman), which amended B&P section 2027, effective January 1, 2015, requires citations that have not been resolved or appealed within 30 days to be posted, and, once the citation has been resolved, to only be posted for three (3) years instead of five (5) years. Section 1364.15 needs to be amended to be in compliance with this new legislation.

STAFF RECOMMENDATION:

Staff recommends the Board authorize staff to prepare the necessary regulatory documents to submit to OAL to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend 16 CCR sections 1364.10, 1364.11, 1364.13, and 1364.15. The proposed language is included below for the Board's review. The proposed deletions are identified with ~~strickethrough~~ text, and the proposed additions are identified with underlined text.

PROPOSED REGULATORY LANGUAGE:

§ 1364.10. Citations and Fines.

(a) For purposes of this article, “board official” shall mean the executive director of the board or his or her designee.

(b) A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon, licensed midwife, or polysomnographic technologist, technician, or trainee of the statutes and regulations referred to in Section 1364.11.

(c) A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1364.11. Citable Offenses.

The amount of any fine to be levied by a board official shall take into consideration the factors listed in subdivision (b)(3) of Section 125.9 of the code and shall be within the range set forth below.

(a) In his or her discretion, a board official may issue a citation under Section 1364.10 for a violation of the provisions listed in this section.

- (1) Business and Professions Code Section 119
- (2) Business and Professions Code Section 125
- (3) Business and Professions Code Section 125.6
- (4) Business and Professions Code Section 475(a)(1)
- (5) Business and Professions Code Section 496
- (6) Business and Professions Code Section 650
- (7) Business and Professions Code Section 650.1
- (8) Business and Professions Code Section 654
- (9) Business and Professions Code Section 654.1
- (10) Business and Professions Code Section 654.2
- (11) Business and Professions Code Section 655.5
- (12) Business and Professions Code Section 655.6
- (13) Business and Professions Code Section 702
- (14) Business and Professions Code Section 730
- (15) Business and Professions Code Section 732
- (16) Business and Professions Code Section 802(b)
- (17) Business and Professions Code Section 802.1

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~~(16)~~18 Business and Professions Code Section 810
~~(17)~~19 Business and Professions Code Section 2021
~~(18)~~20 Business and Professions Code Section 2052
~~(19)~~21 Business and Professions Code Section 2054
~~(20)~~22 Business and Professions Code Section 2065
~~(21)~~23 Business and Professions Code Section 2066
~~(22)~~24 Business and Professions Code Section 2072
~~(23)~~25 Business and Professions Code Section 2073
~~(24)~~26 Business and Professions Code Section 2097
~~(25)~~27 Business and Professions Code Section 2168
~~(26)~~28 Business and Professions Code Section 2168.4
~~(27)~~29 Business and Professions Code Section 2216.1
~~(28)~~30 Business and Professions Code Section 2221.1
~~(29)~~31 Business and Professions Code Section 2234(h) ~~only for a violation of one of the following:~~

- ~~(A) Business and Professions Code Section 802(b)~~
- ~~(B) Business and Professions Code Section 802.1~~
- ~~(C) Health and Safety Code Section 102795~~
- ~~(D) Health and Safety Code Section 102800~~
- ~~(E) Health and Safety Code Section 103785~~
- ~~(F) Health and Safety Code Section 109275~~
- ~~(G) Health and Safety Code Section 109277~~
- ~~(H) Health and Safety Code Section 109278~~
- ~~(I) Health and Safety Code Section 109282~~
- ~~(J) Health and Safety Code Section 120250~~
- ~~(K) Health and Safety Code Section 121362~~
- ~~(L) Health and Safety Code Section 121363~~
- ~~(M) Title 17 California Code of Regulations Section 2500~~

~~(30)~~(32) Business and Professions Code Section 2236
~~(31)~~(33) Business and Professions Code Section 2238
~~(32)~~(34) Business and Professions Code Section 2240
~~(33)~~(35) Business and Professions Code Section 2244 (maximum fine \$1000 pursuant to section 2244)
~~(34)~~(36) Business and Professions Code Section 2243
~~(35)~~(37) Business and Professions Code Section 2250
~~(36)~~(38) Business and Professions Code Section 2255
~~(37)~~(39) Business and Professions Code Section 2256
~~(38)~~(40) Business and Professions Code Section 2257
~~(39)~~(41) Business and Professions Code Section 2259
~~(40)~~(42) Business and Professions Code Section 2261
~~(41)~~(43) Business and Professions Code Section 2262
~~(42)~~(44) Business and Professions Code Section 2263
~~(43)~~(45) Business and Professions Code Section 2264
~~(44)~~(46) Business and Professions Code Section 2265
~~(45)~~(47) Business and Professions Code Section 2266
~~(46)~~(48) Business and Professions Code Section 2271

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- ~~(47)~~(49) Business and Professions Code Section 2272
- ~~(48)~~(50) Business and Professions Code Section 2273
- (49)(51) Business and Professions Code Section 2274
- ~~(50)~~(52) Business and Professions Code Section 2285
- ~~(51)~~(53) Business and Professions Code Section 2286
- ~~(52)~~(54) Business and Professions Code Section 2305
- ~~(53)~~(55) Business and Professions Code Section 2400
- ~~(54)~~(56) Business and Professions Code Section 2415
- ~~(55)~~(57) Business and Professions Code Section 2439
- ~~(56)~~(58) Business and Professions Code Section 2440
- ~~(57)~~(59) Business and Professions Code Section 2441
- (60) Business and Professions Code Section 2507
- (61) Business and Professions Code Section 2508
- (62) Business and Professions Code Section 2510
- (63) Business and Professions Code Section 2514
- (64) Business and Professions Code Section 2519
- ~~(58) Business and Professions Code Section 2630~~
- ~~(59)~~(65) Business and Professions Code Section 3516
- (66) Business and Professions Code Section 3575
- (67) Business and Professions Code Section 3576
- ~~(60)~~(68) Business and Professions Code Section 4080
- ~~(61)~~(69) Business and Professions Code Section 4081(a)
- ~~(62)~~(70) Business and Professions Code Section 17500
- ~~(65)~~(71) Civil Code Section 56.10
- ~~(66)~~(72) Health and Safety Code Section 1248.15
- (73) Health and Safety Code Section 11165.1(a)(1)(A)(i)
- (74) Health and Safety Code Section 102795
- (75) Health and Safety Code Section 102800
- (76) Health and Safety Code Section 103785
- (77) Health and Safety Code Section 109275
- (78) Health and Safety Code Section 109277
- (79) Health and Safety Code Section 109278
- (80) Health and Safety Code Section 109282
- (81) Health and Safety Code Section 120250
- (82) Health and Safety Code Section 121362
- (83) Health and Safety Code Section 121363
- ~~(67)~~(84) Health and Safety Code Section 123110(a), (b)
- ~~(68)~~(85) Health and Safety Code Section 123148
- ~~(69)~~(86) Penal Code Section 11166
- ~~(63)~~(87) Title 16 California Code of Regulations Section 1338(c)
- ~~(64)~~(88) Title 16 California Code of Regulations Section 1399.545
- ~~(M)~~(89) Title 17 California Code of Regulations Section 2500

(b) In his or her discretion, a board official may issue a citation under Section 1364.10 to a licensee for a violation of a term or condition contained in the decision placing that licensee on probation.

(c) A citation may include a fine from \$100 to \$2500. However, a citation may include a fine up to \$5,000 if one or more of the following circumstances apply:

(1) The cited person has received two or more prior citations for the same or similar violations;

(2) The citation involves multiple violations that demonstrate a willful disregard for the law.

(d) In his or her discretion, a board official may issue a citation with an order of abatement without levying a fine for the first violation of any provision set forth above.

(e) The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9, 148, 2227, 2228, 2229 and 2234, Business and Professions Code.

§ 1364.13. Citations for Unlicensed Practice.

A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon licensed under Chapter 5 of the code (commencing with section 2000) or as a licensed midwife licensed under Chapter 5 of the code (commencing with section 2505), or registration as a polysomnographic technologist, technician, or trainee registered under Chapter 7.8 (commencing with section 3575) is required. ~~under the Medical Practice Act.~~ Each citation issued shall contain an order of abatement. Where appropriate, a board official shall levy a fine for such unlicensed activity in accordance with subdivision (b)(3) of Section 125.9 of the code. The provisions of Sections 1364.10 and 1364.12 shall apply to the issuance of citations for unlicensed or unregistered activity under this subsection. The sanction authorized under this section shall be separate from and in addition to any other civil or criminal remedies.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code. Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1364.15. Public Disclosure; Record Retention.

Every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public. Citations that have been resolved, by payment of the administrative fine or compliance with the order of abatement, shall be purged ~~five (5)~~ three (3) years from the date of resolution. A citation that has been withdrawn or dismissed shall be purged immediately upon being withdrawn or dismissed.

Note: Authority cited: Sections 125.9, 148, ~~and~~ 2018, and 2027, Business and Professions Code. Reference: Sections 125.9, ~~and~~ 148, and 2027, Business and Professions Code.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: April 20, 2016
 ATTENTION: Members, Medical Board of California
 SUBJECT: Requirements for Physicians on Probation
 STAFF CONTACT: Christina Delp, Chief of Enforcement

RECOMMENDED ACTION:

After review and consideration of the proposed requirements for physicians on probation, make a motion to direct staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend Title 16, Division 13, Chapter 2, Article 3, California Code of Regulations (CCR), section 1358.

BACKGROUND AND ANALYSIS:

The amendments proposed in this rulemaking would remove outdated language referencing the “division” and the “Probation Surveillance Compliance Program” and replace it with references to the “Board” and “Probation Program.” The proposed amendments would also specify that probationers are required to cooperate with all of the terms and conditions of the Order placing them on probation, in addition to referrals for biological fluid testing.

Staff recommends the Board authorize staff to prepare the necessary regulatory documents to submit to OAL to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking. The proposed language for CCR section 1358 is included below for the Board’s review. The proposed amendments are identified by ~~strikethrough~~ for deleted text and underlined text for additions.

PROPOSED REGULATION LANGUAGE:

California Code of Regulations
 Title 16, Division 13, Chapter 2, Article 3

Section 1358 Requirements for Physicians on Probation

Each physician and surgeon who has been placed on probation by the ~~division~~ Board shall be subject to the ~~division's~~ Board's Probation ~~Surveillance Compliance~~ Program and shall be required to fully cooperate with representatives of the ~~division~~ Board and its ~~investigative~~ personnel. Such cooperation shall include, but is not necessarily limited to, compliance with each term and condition in the Order placing the physician and surgeon on probation, and submission to laboratory biological fluid testing for the purpose of determining the existence of alcohol, narcotics, other controlled substances and/or dangerous drugs in his or her system. Such biological fluid tests shall be made at the times and places required by the ~~division~~ Board or its duly authorized representative. Any monetary fees incurred as a result of ~~such laboratory tests~~ a term or condition of probation, or biological fluid testing shall be borne by the physician-probationer.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Sections 2227, 2228, and 2229, Business and Professions Code.