State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

Full Board & Committee Meetings

July 27-29, 2016

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MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE

Embassy Suites
250 Gateway Blvd.
South San Francisco, CA 94080

July 27 - 29, 2016

Wednesday, July 27, 2016

- **3:00 pm – 5:30 pm** **Panel A (Room: Golden Gate)**
  (*Members: Wright (Chair), Lewis, Bishop, Feinstein, Hawkins, Warmoth, Yip)*

Thursday, July 28, 2016

- **9:00 am – 12:00 pm** **Panel A (Room: Golden Gate)**
  (*Members: Wright (Chair), Lewis, Bishop, Feinstein, Hawkins, Warmoth, Yip)*

- **9:00 am – 12:00 pm** **Panel B (Room: Sausalito/Tiburon)**
  (Members: Krauss (Chair), Bholat, GnanaDev, Lawson, Levine, Pines, Sutton-Wills)

- **12:00 pm – 1:15 pm** **Lunch Break**

- **1:15 pm – 3:00 pm** **Enforcement Committee (Room: Sausalito/Tiburon)**
  (Members: Yip (Chair), Bholat, Krauss)

- **3:15 pm – 5:30 pm** **Full Board Meeting (Room: Sausalito/Tiburon)**
  (All Members)

Friday, July 29, 2016

- **9:00 a.m. – 2:00 p.m.** **Full Board Meeting (Room: Sausalito/Tiburon)**
  (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.

Embassy Suites
250 Gateway Boulevard
Golden Gate Room
South San Francisco, CA 94080
(650) 589-3400

Wednesday, July 27, 2016
3:00 p.m. to 5:00 p.m.

Thursday, July 28, 2016
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 or technical difficulties.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

Wednesday, July 27, 2016

3:00 p.m. OPEN SESSION

1. Call to order/Roll Call

2. ***CLOSED SESSION**

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

4:00 p.m. OPEN SESSION

3. **Oral Argument on Proposed Decision**

   DAVID, Jaime Cristobal, M.D.

4:45 p.m. CLOSED SESSION – Proposed Decision

   DAVID, Jaime Cristobal, M.D.

4. **OPEN SESSION**

   Recess

****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.

Thursday, July 28, 2016

9:00 a.m. OPEN SESSION

5. Call to order/Roll Call

6. **Oral Argument on Proposed Decision**

   LITWIN, Josh Peter, M.D.

9:45 a.m. *CLOSED SESSION – Proposed Decision

LITWIN, Josh Peter, M.D.

10:30 a.m. OPEN SESSION

7. **Oral Argument on Proposed Decision**

   LOPEZ, Paul Milciades

11:15 a.m. CLOSED SESSION – Proposed Decision

LOPEZ, Paul Milciades

8. **OPEN SESSION**

   Adjournment

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

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

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

MEDICAL BOARD OF CALIFORNIA

PANEL B MEETING AGENDA

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

Dev GnanaDev, M.D.
Kristina Lawson, J.D.
Sharon Levine, M.D.
Denise Pines
Brenda Sutton-Wills, J.D.

Embassy Suites
250 Gateway Boulevard
Sausalito/Tiburon Room
South San Francisco, CA 94080
(650) 589-3400

Thursday, July 28, 2016
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 or technical difficulties.

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

1. Call to Order/Roll Call

2. **Oral Argument on Proposed Decision**

   SHAHAM, Elsagav Sagi, M.D.

9:45 a.m.*CLOSED SESSION – Proposed Decision

SHAHAM, Elsagav Sagi, M.D.

10:15 a.m. OPEN SESSION

3. **Oral Argument on Proposed Decision**

   VAN, Thu-Hoa Victoria

11:00 a.m.*CLOSED SESSION – Proposed Decision

VAN, Thu-Hoa Victoria

4. ***CLOSED SESSION**

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

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.

5. **OPEN SESSION**

Adjournment

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MEDICAL BOARD OF CALIFORNIA

ENFORCEMENT COMMITTEE
MEETING AGENDA

COMMITTEE MEMBERS

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

Embassy Suites San Francisco Airport
250 Gateway Blvd.
South San Francisco, CA 94080

Thursday July 28, 2016
1:15 – 3:00 pm
(or until the conclusion of business)

Sausalito/Tiburon Room

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/Establishment of Quorum

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

3. Approval of Minutes from January 21, 2016 Meeting

4. Enforcement Program Update, including personnel, expert reviewer program, statistics, and enforcement unit updates – Ms. Delp

5. Update on the Demographic Study, including progress and timeline – Ms. Robinson

6. Presentation on the Expert Reviewer Program's Recruitment Plan – Ms. Delp

7. Vertical Enforcement Program Update from Health Quality Investigation Unit – Mr. Chriss and Ms. Nicholls

8. Vertical Enforcement Program Update from Health Quality Enforcement Section – Ms. Castro

9. Presentation on the Probation Unit Timeframes and Actions Taken for Violations of Probation – Ms. Delp and Ms. Houston

10. Future Agenda Items

11. Adjournment

Meeting Information

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

The call-in number for teleconference comments is: (800) 230-1074

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

Agenda Item 3

ENFORCEMENT COMMITTEE MEETING

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

Thursday, January 21, 2016

MINUTES

Agenda Item 1 Call to Order/Roll Call
The Enforcement Committee (Committee) of the Medical Board of California (Board) was called to order by Dr. Yip, Chair. With due notice having been mailed to all interested parties, the meeting was called to order at 12:45 p.m.

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

Other Board Members Present:
Randy Hawkins, M.D.
Sharon Levine, M.D.
Ronald Lewis, M.D.

Staff Present:
Liz Amaral, Deputy Director
Robin Boyd, Staff Services Analyst
Elena Contreraz, Staff Services Analyst
Brian Curtis, Staff Services Manager I
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Dennis Frankenstein, Staff Services Analyst
Virginia Gerard, Associate Governmental Program Analyst
Dayna Hanson, Management Services Technician
Cassandra Hockenson, Public Information Officer II
Chris Jensen, Special Investigator
Kimberly Kirchmeyer, Executive Director
Nicole Kraemer, Staff Services Manager I
Regina Rao, Associate Government Program Analyst
Lois Ranftle, Office Technician
Letitia Robinson, Research Specialist II
Elizabeth Rojas, Staff Services Analyst
Reylina Ruiz, Staff Services Manager

Jennifer Saucedo, Staff Services Analyst
Anita Scuri, Retired Annuitant
Linda Serrano, Associate Governmental Program Analyst
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
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
Robert McKim Bell, Supervising Deputy Attorney General
Gloria Castro, Senior Assistant Attorney General, Department of Justice
Eric Cerlile, Kaiser Permanente
Yvonne Choong, California Medical Association
David Chriss, Chief of Enforcement, Division of Investigation
Zennie Coughlin, Kaiser Permanente
Cassie Davis, Staff Services Analyst
Karen Ehrlich, LM, Midwifery Advisory Council
Julie D'Angelo Fellmeth, Center for Public Interest Law
Rae Greulich, Consumers Union Safe Patient Project
Marian Hollingsworth, Consumers Union Safe Patient Project
Sarah Huchel, Consultant, Senate Business and Professions Committee
Terry Jones, Supervising Deputy Attorney General
Christine Lally, Deputy Director, Department of Consumer Affairs
Lisa McGiffert, Consumers Union Safe Patient Project
Tina Minasian, Consumers Union Safe Patient Project
Michelle Monserrat-Ramos, Consumers Union Safe Patient Project
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unity
Monica Peretto, Investigator, Health Quality Investigation Unit
Arnold Savage, M.D.
Danielle Sullivan, Center for Public Interest Law
Kim Tejada, Investigator, Health Quality Investigation Unit
Cesar Victoria, Department of Consumer Affairs

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments.

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

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

Agenda Item 4 Enforcement Program Update

Ms. Delp spoke about the Expert Reviewer Training scheduled to be held on Saturday, March 19, 2016, at the UC San Diego School of Medicine. Ms. Delp shared the agenda, what would be addressed, and who would be present. She stated that the training would end with a review of a mock case and that attendees would be asked to provide a sample written opinion of a hypothetical case to determine if there was a departure from the standard of care. Ms. Delp advised that Board staff would review the opinions and provide feedback to the attendees. A "Save the Date" announcement regarding the training had been sent out via mail and email, and a formal invitation will be sent out soon. A second training is being considered for the summer in the Los Angeles area.

Agenda Item 5 Update on Demographic Study

Ms. Robinson provided an update on the study being conducted by the California Research Bureau (CRB) regarding the Board demographic study. The CRB met with interested parties from the Black American Political Association of California (BAPAC) and the Golden State Medical Association. The meeting covered items of concern, including the reason for the study. She stated that the CRB may need additional information from the Board and that the report will be released to the public. The report methodology will be finalized and presented to Dr. Krauss for review and approval. Ms. Robinson also stated that the CRB anticipated that it will take two months to finish its analysis and another two months to finalize the report. Updates will be provided accordingly.

Agenda Item 6 Update on the Vertical Enforcement Report

Ms. Robinson spoke about the implementation and goals of vertical enforcement (VE) and noted that the next report is due to the Legislature on March 1, 2016. She said that the data had been hard to get but the final report will be delivered to the Board at the end of February and that a special meeting will need to be held by teleconference.

Ms. Scuri stated that the focus of the report will consist of three primary areas: statistical data, improvements that have taken place since the last report in 2013, and recommendations for statutory changes. She also stated that they have been working with the Attorney General's office to finalize the report.

Agenda Item 7 Investigation and Vertical Enforcement Program Report

Mr. Chriss stated that his current goals are to fill vacancies; continue the staff retention project, which consists of salary increases and field training officer pay; continuing the strategic planning process; completing the combined Division of Investigation (DOI) policy training manual; and developing a division wide training plan. He stated that there are 26 vacant positions but there are 21 people in background for those positions. Interviews have been scheduled to fill the remaining positions.

Ms. Nicholls talked about how the cases for the Board are being prioritized and stated that Business and Professions Code section 2220.05 mandates what the Board's priorities are.

Priority cases are the ones that involve gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients; cases that involve drug or alcohol abuse by a physician involving death or serious bodily injury to a patient; repeated acts of excessive prescribing or prescribing without a good faith exam; repeated acts of clearly excessive recommendations of cannabis to patients without a good faith exam; sexual misconduct with a patient; and practicing medicine while under the influence of drugs or alcohol. Investigative staff went through the entire case load and identified which cases are priority cases and which cases are lower priority. Ms. Nicholls stated thirty two hours a week are spent working on priority cases and one day a week is spent working lower priority cases, which are rotated weekly. She stated staff is very focused on protecting the public and keeping the priority system that has already been established.

Ms. Yaroslavsky asked if the Board will get regular reports regarding the goals and if the Board will be able to monitor them to know it is working.

Ms. Nicholls replied that staff will continue to produce such reports for the Board.

Ms. Yaroslavsky stated that she was concerned because more old cases were showing up.

Ms. Nicholls stated that many of the old cases have to do with staff vacancies and the prioritization of the cases, which means that some of the lower priority cases will be older.

Ms. Castro, talked about VE, stating that there are two issues that are adversely affecting the VE process: staffing investigative positions within the Health Quality Investigation Unit (HQIU) and HQIU's policy for handling administrative investigations as criminal investigations, which takes those matters out of the VE process. She continued saying that one solution to this problem is to assign a second investigator to investigate the administrative investigation. Regarding the parallel investigations Ms. Castro suggested that a conversation should occur between HQIU and the Board to make sure that the priorities match and what to do when they do not match.

Dr. Krauss asked if the expert panel system is adequate.

Ms. Castro said that limitations have a direct impact on what can be done to protect the public, that more training and outreach is needed, and that success depends on the experts.

Dr. Krauss asked if there is an adequate ongoing dialogue between Board staff and the Attorney General's (AG) office, regarding where the deficiencies or weaknesses are so that it can be improved.

Mr. Jones stated that the principal interaction is between HQIU and the medical consultants in the field concerning the selection of physicians as experts. Expanding the pool of experts needs to be at a higher priority, and maybe the Board can use its influence to ask members of the profession to step forward and engage in the expert review process.

Dr. Krauss asked if there is a mechanism in place that will identify where the greatest needs for experts is.

Mr. Jones stated that there is an evaluation that each Deputy Attorney General on a case should complete to provide feedback to the expert, and it is forwarded to the Board. He continued by saying that the real issue comes down to the credibility of the experts on both sides and the most credible expert is determined by a judge.

Ms. Kirchmeyer stated that there are two Associate Governmental Program Analysts in Southern California who are watching for those deficiencies and ads are being placed in the Newsletter regarding what specialties are needed. Recruitment will commence in the hospitals and at the universities after the expert training is complete. Ms. Kirchmeyer stated the Enforcement summary in the packet listed specialties that are needed.

Mr. Chriss stated that there was a meeting with the AG's office, the department, HQIU, and the Board to address the issues of administrative and criminal investigations. He stated that there are less than 100 criminal cases and that he has had ongoing discussions with the AG's office regarding working together to develop guidelines.

Ms. Castro said that it is extremely important for the experts to have the correct education and training, and that the training required needs to be put forth between all the agencies. She finished by saying that while the expert has great technical knowledge, he/she needs to understand the Medical Practice Act or laws.

Ms. Nicholls advised that representatives from all sides participate in expert reviewer training, which includes a medical consultant, a retired Administrative Law Judge, the AG's office, and HQIU, stating that the training is coming from all different aspects.

Dr. Yip spoke about attending the expert witness training two years ago and he will go through the syllabus and training before March with the staff.

Agenda Item 8 Presentation on the Probation Unit's Roles and Functions

Dr. Yip advised that he spent time with the probation unit staff, and spoke about the staff's passion and commitment they share with the Board to carry out the mission of public protection.

Ms. Delp shared the highlights of the organizational structure of the Probation Unit, identified the various positions within the unit, and explained the roles of the positions. She also explained the possible probation terms and conditions that can be imposed, discussed how probation staff monitors compliance with the terms and conditions, reviewed focused areas of improvement efforts within the unit. Ms. Delp continued with conditions found in the Manual Model of Disciplinary Orders and Guidelines stating that there are 23 optional conditions. Ms. Delp offered explanations on several conditions saying that the use of the optional conditions within the orders and stipulated agreements depends on the nature and circumstances of the particular case.

Ms. Delp stated in the Board's last sunset report, it stated that there were 306 positive drug tests. Thirty-three probation violations were reported and 34 petitions to revoke probation were filed. She noted there was a footnote in the sunset report that states the number of positive tests includes those where the licensee had an approved prescription for the substance, which does not constitute a violation of probation.

Ms. Yaroslavsky asked what would be an optimal time lapse between a violation of a condition of probation and when the Board takes some action.

Ms. Delp answered, all probation conditions have specific timelines, some are immediate, which means violations have action started within 24 to 48 hours.

Ms. Kirchmeyer stated that it depends on the violation and the language of the probationary order and explained that getting it set for hearing and completed could take six months to a year.

Ms. Kirchmeyer continued with how First Lab, which does all of the testing, is contacted once a positive test result comes back. They have a panel that they run the test against, then look to see if it is a true positive or an incidental exposure. Once that has been determined, the process of a cease practice order is considered.

Ms. Gerard stated that the lab looks for the threshold for the incidental exposure and the Board staff is setting up procedures so when that threshold is reached the Board can request a blood test to verify levels of specific substances.

Ms. D'Angelo Fellmeth, Center for Public Interest Law, thanked the Board for the detailed review of the Probation Program. She said that she was the public commenter who noted that during 2011-12 there were 306 positive tests yet only 30 petitions to revoke probation were recommended by the Board and filed by the AG's office. She suggested two things: first, it is a probation violation for a doctor not to report to the inspector that he or she has been prescribed a medication that might trigger a positive test and she said that is something that needs focus; second, she would suggest to the Board that actual positive tests should be separated from positive tests due to lawfully prescribed medication. She concluded by saying that she is concerned about the heavy caseloads and the fact that staff caseloads are almost double that of an HQIU investigator. She suggested taking another look at the staffing of the unit to determine whether additional probation inspectors are needed due to the crucial importance of this function.

Ms. Delp stated that those comments are valid and that steps are being taken to hire another manager and another biological fluid analyst. Staff is looking at the workload and assessing assignments, which will probably result in a recommendation for more inspectors.

Ms. Yaroslavsky asked if there is a way to view the outcomes, and said there needs to be some way of validating what is being done based on statistical data provided to the Board.

Ms. Delp said that same concept would be applied in the Complaint Unit, and not just probation. Management's vision is that those statistics will be provided, looking at all the programs.

Dr. Yip stated that more help is needed, but, the fortunate thing is that Board staff is committed and even with a caseload of 35-40 they really do a good job.

Agenda Item 9 Future Agenda

Ms. Yaroslavsky said that she would like to hear information about outreach opportunities for the medical expert reviewer program once the training is complete.

Dr. Yip said the Board was doing outreach before the training too.

Agenda Item 10 Adjournment

There being no further business, the meeting was adjourned at 2:17 p.m.

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

Expert Reviewer Recruitment Plan

Christina Delp
Chief of Enforcement

Current Recruitment Efforts

➢ MBC Newsletter

Interested in becoming an expert reviewer?

If you are actively practicing in California and interested in becoming an expert reviewer (expert), applications are accepted continuously. The Medical Board of California established its Expert Reviewer Program in July 1994 as an impartial and professional means to support the investigation and enforcement functions of the Board. Experts assist the Board by providing reviews and opinions on Board cases and conducting professional competency examinations, medical and psychiatric evaluations.

The Board is currently looking for experts ***in the following specialties***: **addiction medicine with added certification in family medicine or internal medicine or psychiatry, dermatology, family medicine, neurological surgery, neurology, ob/gyn, pathology, pain medicine, pediatric cardiac surgery, plastic surgery, psychiatry, surgery** and **urology**, as well as **midwife reviewers.**

Actively practicing physicians from all other specialties not listed above are also welcome to apply and participate in the review process. Physicians must be board certified, have been practicing their specialty for a minimum of three years after board certification, have no current complaints, no prior discipline, and must be willing to testify in court. Midwives must have an active midwifery practice for the past two years, have no current complaints, no prior discipline, and must be willing to testify in court.

For more information regarding compensation and how to apply, please visit: ***http://www.mbc.ca.gov/Enforcement/Expert_Reviewer/*** or contact the Board's expert program at: ***MBCMedicalExpertProgram@mbc.ca.gov.***

Current Recruitment Efforts

- MBC Website

www.mbc.ca.gov/Default.aspx

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The Medical Board of California

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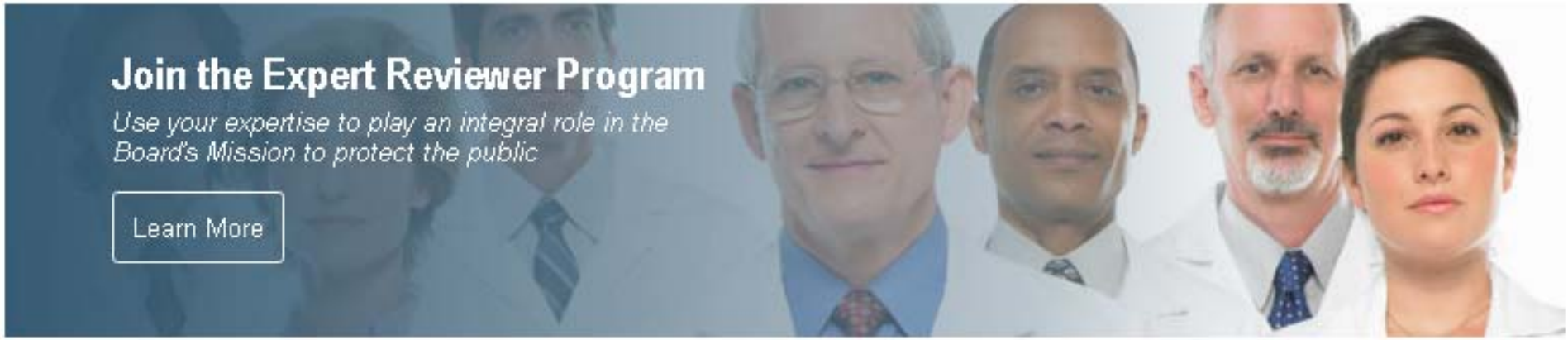
Current Recruitment Efforts

- Via Medical Consultants and Experts

Future Recruitment Plans – Stage 1

Estimated Completion Fall 2016

- MBC Website
  - Add new link from home page (completed)
  - Enhance licensee tab
  - Interchange graphics/quotations (on-going)
  - Track analytics



Future Recruitment Plans – Stage 1

- MBC Newsletter
- Invitation letter from Board President

Future Recruitment Plans – Stage 1

- Create Brochure

The Role of an Expert Reviewer

- Independent and Impartial Reviewer of Facts.
- To provide clinical expertise and testimony regarding complaints a[illegible] the practice of medicine.
- What you are N[illegible] either an advocate for th[illegible]oard or the s[illegible] physician.
- What you ARE: an object[illegible]rev[illegible]er who establishes whethe[illegible]not a departure from the s[illegible]rd of care has occurred.
- You are the Premier Educator.

Responsibilities

- *Fairness*
- *Clarity*
- *Glean relevant medical facts from medical recor[illegible] and array them in chronological ord[illegible]*
- *Apply legal standards [illegible] fac[illegible]*
- *Explain th[illegible]dard [illegible]are, r[illegible]ons fo[illegible] standard, h[illegible]ndar[illegible]ertained*
- *[illegible]ves[illegible]ors and administrative [illegible]al issues of each c[illegible]*
- *Rea[illegible] a conclusion regarding each potential [illegible] of the Medical Practice Act, giving the [illegible]asons for the conclusion*

Medical Board of California

EXPERT REVIEWER PROGRAM
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

Phone: (818) 551-2129/ (818) 539-8314
Fax: (818) 551-2131
E:mbcmedicalexpertprogram@mbc.ca.gov

Minimum requirements to participate in the Expert Reviewer Program:

- Current California medical license in good standing. No prior discipline. No pending accusation. No complaint history within the last three years.
- Current Board certification in one of the 24 [illegible]roved ABMS Boards. The Medical Board also recognizes the American Boards of Facial Plastic & Reconstructive S[illegible] Pain Medicine, Sleep Medicine, [illegible]ne Surgery.
- Minimum of three years of practice in specialty area after board certification.
- Have a current active practice in California (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching at least 40 hours of which is in direct patient care).
- Must be willing to testify

SAMPLE

Future Recruitment Plans – Stage 2

WE'RE LOOKING FOR A FEW GOOD EXPERTS

LOW PAY! **NO BENEFITS!** **BASIC TRAINING!**

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We need people with at least five years experience in their specialty or subspecialty (not including internship and residency), who practice at least 80 hours per month in direct patient care, clinical activity, or teaching which includes at least 40 hours of patient care. Specialty certification by an ABMS or equivalent board, or equivalent/superior qualifications in an "emerging" specialty or subspecialty is required. Peer review experience is recommended but not mandatory. If you want more information about requirements, give us a call.

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The Board receives hundreds of complaints each month from consumers, other health professionals and other governmental agencies. Many of the complaints are closed without any action, but several thousand are reviewed by physicians each year to determine whether there might be law violations. To assure a fair and appropriate review, the Board uses experts in the specialties of the physicians involved. With more than 24 specialties, and dozens of communities statewide, we need a large pool from which to select experts. This also allows us to find reviewers who don't know the subject of the complaint personally, and to avoid overloading our experts with too many cases.

We especially need more experts in: OB/Gyn, Family Practice, Otolaryngology, Plastic Surgery and Surgery, but we still have a need for all specialties.

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If you apply for the Expert Reviewer Program, you will be given a loose-leaf binder containing a variety of fascinating, well-written, Board-approved training materials. We think you will need about six hours to study them. Then we will ask you to attend a two-hour face-to-face session at a Board office to learn more about working with our medical consultants, investigators and attorneys. If you complete these steps, you will be added to our pool of experts, and may be called to advise on a case-by-case basis. That's it!

How Can I Apply?

Send us your CV. Our address is:
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c/o Medical Board of California
1426 Howe Avenue, Suite 100
Sacramento, CA 95825-3236
(916) 263-2677

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Apply now and receive an attractive binder containing everything you need to know to be an MBC Expert Reviewer!

Medical Board of California Action Report
July 1995 Page 8

Estimated Completion Spring 2017

- MBC Newsletter

Future Recruitment Plans – Stage 2

- External newsletters and magazines

"Keep your health care consumers in focus!"
"Become an Expert"

If you want to help, then become a Expert Reviewer…contact us at:
http://www.mbc.ca.gov/Enforcement/Expert_Reviewer/
or email:
MBCMedicalExpertProgram@mbc.ca.gov

Future Recruitment Plans – Stage 2

- Attend hospital staff meetings, specialty board meetings, CME activities, and special conferences

Future Recruitment Plans – Stage 3

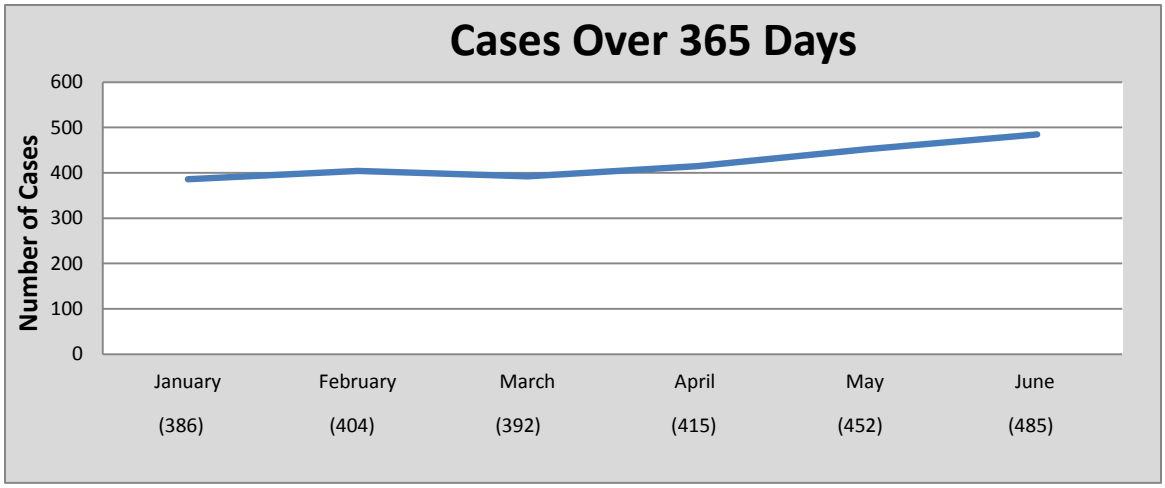
Estimated Completion Fall 2017

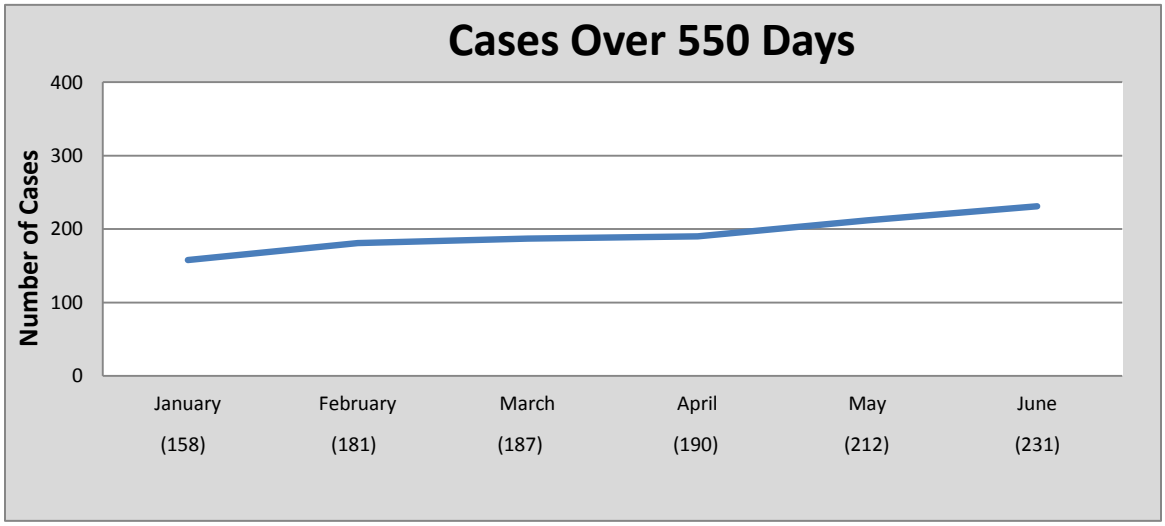
- MBC Webpage
  - Create short (1-3 minute) video

Conclusion

- Comments
- Suggestions
- Questions??

HQIU ACTIVE CASE STATISTICS
JANUARY 2016 – JUNE 2016





This data has been manually calculated and has not been verified by the MBC data integrity analyst.

Violations of Probation

Probation Unit: Disciplinary Actions and Timeframes

Christina Delp, Chief of Enforcement

Susan Houston, Enforcement Program Manager

Presentation Overview

- Manual Model of Disciplinary Terms and Conditions
- Uniform Standards for Substance-Abusing Licensees
- Actions taken when a violation occurs and timeframes for action
- Statistics

Objectives

- Awareness of what actions are taken when a violation occurs
- Timeframes for those actions

Statutory Authorities

- Business and Professions (B&P) Code section 2229
  - Public protection shall be the highest priority
  - Rehabilitation of licensee, restrict the scope of practice, or order restrictions and
  - Offer education, restrictions from practice, or other means, that will remove those deficiencies.
  - Where rehabilitation and protection are inconsistent, public protection shall be paramount.

Statutory Authorities

- Implement the mandates of B&P Code section 2229.
- CCR, Title 16, section 1361 – Manual Model Disciplinary Orders and Disciplinary Guidelines
- CCR, Title 16, section 1361.5 – Uniform Standards for Substance-Abusing Licensees

Manual Model of Disciplinary Guidelines

- 23 – Optional Conditions

11– Standard Conditions

Suspension (optional #4)

- Barred from practicing medicine
- Probation Staff:
  - Drives by and/or call place of employment
  - Over 30-days, retrieves wall certificate and pocket license and notifies DEA

Suspension (optional #4)

Violation:

- Practicing with suspended license

Action/Timeframe:

- Within 24-48 hours referral to the investigative office
- Transmittal to Attorney General's Office (AGO) for Accusation (ACC)/Petition to Revoke (PTR)

Controlled Substances

(optional #5– #8)

- Prohibited or limited from
  - Ordering
  - Prescribing
  - Administering
  - Furnishing
  - Possessing
- Surrender DEA Permit
- Maintain/Access to Records and Inventories

Controlled Substances

(optional #5– #8)

- Probation Staff:
  - Verifies DEA permit/pads were surrendered
  - Notifies DEA of drug limitations
  - Obtains proof from probationer of surrendered or reissued permit
  - Runs CURES reports
  - Reviews logs for compliance and discrepancies with CURES reports

Controlled Substances

(optional #5- #8)

Violation:

- Ordering, dispensing, etc. drugs when prohibited or restricted

Action/Timeframe:

- Within 24-48 hours referral to the investigative office
- Transmittal to AGO for ACC/PTR

Controlled Substances

(optional #5- #8)

Violation:

- Does not provide proof surrender or reissuance of permit (partial restriction)

Action/Timeframe:

- Within 3 business days
  - Non-compliance report/non-compliance letter
  - 5 business days to comply
- Issues citation and fine with order of abatement

Controlled Substances

(optional #5- #8)

Violation:

- Log does not meet criteria

Action/Timeframe:

- Within 3 business days
  - Non-compliance report/non-compliance letter
  - 5 business days to comply
- Issues citation and fine with order of abatement

Controlled Substances

(optional #5– #8)

Violation:

- Log has discrepancies when compared with CURES report

Action/Timeframe:

- Within 7 business days
  - Requests explanation from Probationer
  - Contacts pharmacy for confirmation
  - If confirmed, transmittal to AGO for ACC/PTR
  - No confirmation, referral to the investigative office – transmittal to AGO for ACC/PTR

Abstain from Use–Drugs/Alcohol (optional #9 and #10)

- Refrain from use or possession of controlled drugs, dangerous drugs or drugs that require a prescription

- Refrain from use of products or beverages containing alcohol

Abstain from Use–Drugs/Alcohol (optional #9 and #10)

- Probation Staff:
  - Obtains list of lawfully prescribed medications from probationer
  - Monitors biological fluid testing

Abstain from Use–Drugs/Alcohol (optional #9 and #10)

Violation:

- Confirmed positive biological fluid test for drugs or alcohol

Action/Timeframe:

- Within 24 to 48 hours
  - Requests explanation from probationer and lab
  - Requests certified documents
  - Non-compliance report
  - Issues cease practice order
  - Transmittal to AGO for PTR

Abstain from Use–Drugs/Alcohol (optional #9 and #10)

Violation:

- Does not provide timely notification of lawfully prescribed medication and there are positive tests

Action/Timeframe:

- Within 24–48 hours
- Requests explanation
- Issues cease practice order
- If determined lawfully prescribed/failed to report – lift CPO and issue cite and fine
- If unlawful, transmittal to AGO for ACC/PTR

Biological Fluid Testing

(option #11)

- Submit to random, unannounced, observed biological fluid testing
- Probation Staff:
  - Checks the approved laboratories' database to confirm compliance with call-ins and tests
  - Receives alerts if tests are positive

Biological Fluid Testing
(option #11)

Violation:

- Does not call in daily

Action/Timeframe:

- Within 24-48 hours
  - Requests explanation
- Within 3-5 business days
- Non-compliance report
  - 1st offense: non-compliance letter, alert of cite and fine
  - 2rd offense: issues cite and fine with order of abatement
  - 3rd offense: transmittal to AGO for PTR

Biological Fluid Testing
(option #11)

Violation:

- Does not test when requested

Action/Timeframe:

- Within 24-48 hours
  - Requests explanation
- Within 3-5 working days
  - Non-compliance report
    - 1st offense, issues cite and fine
    - 2nd offense, issues cease practice order, transmittal to AGO for PTR

Required Courses

(options #13 – #17

- Continuing Medical Education
- Prescribing Practices
- Medical Record Keeping
- Professionalism Program (Ethics)
- Professional Boundaries Program

Required Courses

(options #13- #17

Violation:

- Does not enroll within 60 days

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Non-compliance letter -7 business days to comply
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Required Courses

(options #13- #17

Violation:

- Enrolls, but does not complete within timeframe
- Does not complete other components within timeframe
- Untimely submission of proof of completion

Action/Timeframe:

- Within 3-5 business days:
  - Requests explanation
  - Non-compliance report
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR
- Components/Proof: Non-compliance letter with 7 business days to comply; non-compliant - issue cite and fine or PTR

Required Courses

(options #13- #17

Violation:

- Does not complete Boundaries course with within 6-months (condition precedent)

Action/Timeframe:

- Within 24-48 hours
  - Requests explanation
  - Issues cease practice order

Clinical Training Program
(option #18)

- Enroll into a clinical training or educational program that assesses probationer's
  - Physical and mental health
  - Basic clinical and communication skills
  - Medical knowledge, skill, and judgment pertaining to probationer's area of practice in which probationer was found to be deficient

Clinical Training Program
(option #18)

- Probation Staff:
  - Contacts provider to confirm enrollment/participation
  - Reviews program report

Clinical Training Program

(option #18)

Violation:

- Fails to enroll within 60 days, participate or complete within 6 months
- Does not comply with program recommendations

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Confirms non-compliance with provider
  - Non-compliance report
  - Issues cease practice order

Clinical Training Program

(option #18)

Violation:

- Fails clinical training program

Action/Timeframe:

- Within 24-48 hours
  - Non-compliance report
  - Issues cease practice order
  - Transmittal to AGO for PTR

Psychiatric Evaluation
(option #20)

- Undergo psychiatric evaluation and psychological testing, if deemed necessary
- Probation Staff:
  - Selects Board-appointed, Board-certified psychiatrist
  - Reviews report
  - If condition precedent, notifies probationer he/she is safe to practice medicine

Psychiatric Evaluation

(option #20)

Violation:

- Does not undergo evaluation within 30 days
- Does not comply with recommend restrictions/conditions

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Psychotherapy
(option #21)

- Undergo psychotherapy treatment

- Probation Staff:
  - Reviews qualifications/approves candidate
  - Ensures therapist is submitting quarterly reports
  - Reviews reports
  - May recommend probationer undergo psychiatric evaluation

Psychotherapy
(option #21)

Violation:

- Does not submit therapist name for approval to undergo therapy within 60 days

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Non-compliance letter, 7 business day to comply
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Medical Evaluation and Treatment (option #22)

- Undergo medical evaluation and treatment
- Probation Staff:
  - Selects Board-appointed physician
  - Reviews report
  - Approves treating physician of respondent's choice, if recommended
  - Ensures quarterly reports submitted by treating physician
  - Requests treatment records, when necessary
  - If condition precedent, notifies probationer he/she is safe to practice medicine

Medical Evaluation and Treatment (option #22)

Violation:

- Does not have evaluation within 30 days

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Non-compliance letter, 7 business day to comply
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Medical Evaluation and Treatment (option #22)

Violation:

- Does not comply with restrictions/conditions within 15 calendar days of being noticed
- Does not submit for approval, name of treating physician within 30 calendar days of being noticed

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Non-compliance letter, 7 business day to comply
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Medical Evaluation and Treatment (option #22)

Violation:

- Treating physician does not provide quarterly reports to Board

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Non-compliance letter, 7 business day to comply
- Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Monitoring– Practice/Billing

(option #23)

- Independent individual monitors probationer's medical or billing practices
- Probation Staff:
  - Approves monitor of respondent's choice
  - Ensures quarterly reports submitted by monitor

Monitoring– Practice/Billing

(option #23)

Violation:

- Does not submit, for approval, name of monitor within 30 calendar days
- No approved monitor in place within 60 calendar days
- Must ensure monitor submits quarterly reports
- Fails to submit name of replacement monitor (5/15/60 calendar days)

Monitoring- Practice/Billing

(option #23)

Action/Timeframe:

- Within 3-5 business days (30 day)
  - Non-compliance report
  - Non-compliance letter, 7 business day to comply
- Within 24-48 Hours (60 day)
  - Issues cease practice order

Solo Practice Prohibition

(option #24)

- Cannot engage in solo practice of medicine
- Probation Staff:
  - Approves office setting
  - Visits office setting to confirm physician colleague is present
  - Regular communication with colleague at the practice setting

Solo Practice Prohibition

(option #24)

Violation:

- Within 60 days does not secure employment in appropriate practice setting: upon effective date of order and when practice setting changes

Action/Timeframe:

- Within 24-48 hours
  - Non-compliance report
  - Issues cease practice order

Third Party Chaperone

(option #25)

- Chaperone present while consulting, examining or treating patients

- Probation Staff
  - Approves chaperone
  - Reviews log or written notification
  - Contacts patients on log to ensure chaperone is present during visits

Third Party Chaperone

(option #25)

Violation:

- Within 60 days does not secure an approved chaperone: upon effective date of Order or if chaperone resigns or is no longer available

Action/Timeframe:

- Within 24-48 hours
  - Issues cease practice order

Third Party Chaperone

(option #25)

Violation:

- Fails to maintain appropriate log

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Prohibited Practice (option #26)

- Prohibited from practicing, performing, or treating a specific procedure/surgery; or prohibition on specific patient population
- Probation Staff
  - Ensures log is complete
  - Contacts patients on log to ensure probationer is providing notification of prohibited practice to patients

Prohibited Practice (option #26)

Violation:

- Fails to provide notification to patients or maintain adequate log

Action/Timeframe:

- Within 3-5 business days
  - Requests explanation
  - Non-compliance report
  - Issues cite and fine with order of abatement
- Non-compliance, transmittal to AGO for PTR

Manual Model of Disciplinary Guidelines

- 23 – Optional Conditions

11– Standard Conditions

Standard Conditions

- Notification
- Supervision of Physician Assistants
- Quarterly Declarations
- General Probation Requirements
- Non-practice while on probation
- Probation Monitoring Costs

Standard Conditions

- Probation Staff:
  - Ensures compliance within set timeframes
  - Ensures probationer takes clinical training program if period of non-practice exceeds 18 months

Standard Conditions

Violation:

- Does not comply with provisions as written

Action/Timeframe:

- Within 3-5 days
  - Non-compliance report
  - Issues citation and fine with order of abatement
  - Transmittal to AGO for PTR

Uniform Standards for Substance Abusing Licensees

- 5 – Conditions

Major and minor violations

Substance Abusing Licensee

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

Uniform Standards for Substance Abusing Licensees

- 5 – Conditions

Major and minor violations

Substance Abusing Licensee

- Major Violation:
- Fails to undergo clinical diagnostic evaluation
- Commits multiple minor violations of probation
- Treats patient(s) while under the influence of prohibited substance
- Engages in any drug or alcohol related act that violation law or regulation
- Fails to undergo biological fluid testing
- Uses, consumes, ingests, or administers to himself/herself a prohibited substance
- Defrauds or attempts to defraud biological fluid testing
- Fails to comply that impacts public safety

- Action/Timeframes:
- Within 24-48 hours
  - Non-compliance report
    1) Issues cease practice order
    2) Increases frequency of biological fluid testing
    3) Refers for further disciplinary action

Substance Abusing Licensee

- Minor Violation:
- Fails to submit required documentation timely
- Unexcused absence at required meeting
- Fails to contact with worksite monitor
- Fails to comply with terms/conditions that does not impair public safety

- Actions/Timeframes:
- Within 24-48 hours
  - Non-compliance report
    1) Issues cease practice order
    2) Imposes practice limitations
    3) Increases supervision
    4) Increases documentation
    5) Issues cite and fine or warning letter
    6) Undergoes clinical diagnostic evaluation
    7) Takes other action determined

Statistics

	Fiscal Year 14/15	Fiscal Year 15/16
Cease Practice Orders Issued	9	14
PTR/ACC and PTR – Transmitted	20	36
PTR/ACC and PTR – Filed	21	29

Statistics

Physicians on Probation by Case Type	Total
Gross Negligence/Incompetence	162
Inappropriate Prescribing	65
Unlicensed Activity	8
Sexual Misconduct	39
Mental/Physical Illness	21
Self-Abuse of Drugs/Alcohol	85
Fraud	15
Conviction of a Crime	32
Unprofessional Conduct	178
Total	**605**
Probation Type	Total
Applicant	61
Licensee	504
Reinstatement	40
Total	**605**
In State/Out of State	Total
In State	501
Out of State	104
Total	**605**

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Applicant	IN	THREE (3) YEARS	2015	FRAUD
Applicant	IN	THREE (3) YEARS	2015	FRAUD
Applicant	IN	THREE (3) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Applicant	IN	FOUR (4) YEARS	2000	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2010	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	IN	SEVEN (7) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
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Applicant	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	THIRTY-FIVE (35) MONTHS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Applicant	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	TEN (10) YEARS	2008	EXCESSIVE PRESCRIBING

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	THREE (3) YEARS	2010	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2011	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2012	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2012	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2012	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2012	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2013	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2014	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	FOUR (4) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	SIX (6) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	TEN (10) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	TWO (2) YEARS	2015	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	FOUR (4) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	FOUR (4) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2016	EXCESSIVE PRESCRIBING

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	THREE (3) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2016	EXCESSIVE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	1997	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2012	FELONY ARREST/CONVICTION
Licensee	IN	THREE (3) YEARS	2012	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	IN	SEVEN (7) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	IN	SEVEN (7) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	IN	THREE (3) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	IN	THREE (3) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2014	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2014	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2014	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2015	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2016	FELONY ARREST/CONVICTION
Licensee	IN	SEVEN (7) YEARS	2016	FELONY ARREST/CONVICTION
Licensee	IN	THREE (3) YEARS	2016	FELONY ARREST/CONVICTION
Licensee	IN	FIVE (5) YEARS	2011	FRAUD
Licensee	IN	FIVE (5) YEARS	2011	FRAUD
Licensee	IN	FIVE (5) YEARS	2011	FRAUD
Licensee	IN	SEVEN (7) YEARS	2011	FRAUD
Licensee	IN	SIX (6) YEARS	2012	FRAUD
Licensee	IN	TEN (10) YEARS	2012	FRAUD
Licensee	IN	SEVEN (7) YEARS	2013	FRAUD
Licensee	IN	FIVE (5) YEARS	2014	FRAUD
Licensee	IN	SEVEN (7) YEARS	2014	FRAUD
Licensee	IN	SEVEN (7) YEARS	2015	FRAUD
Licensee	IN	TEN (10) YEARS	2015	FRAUD
Licensee	IN	FIVE (5) YEARS	2016	FRAUD
Licensee	IN	SEVEN (7) YEARS	2008	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2011	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2013	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2013	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	SEVEN (7) YEARS	2013	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	THREE (3) YEARS	2013	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2014	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2014	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FOUR (4) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	SEVEN (7) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	TWO (2) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2016	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	TEN (10) YEARS	2016	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	IN	FIVE (5) YEARS	2011	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2012	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2012	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2014	INAPPROPRIATE PRESCRIBING
Licensee	IN	ONE (1) YEAR	2014	INAPPROPRIATE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2014	INAPPROPRIATE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2014	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	SEVEN (7) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	THREE (3) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	TWO (2) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIVE (5) YEARS	2016	INAPPROPRIATE PRESCRIBING
Licensee	IN	FIFTY-NINE (59) MONTHS	2012	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2012	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2012	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FOUR (4) YEARS	2012	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FOUR (4) YEARS	2012	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2014	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2014	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2014	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2014	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	SEVEN (7) YEARS	2014	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2015	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	2016	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FOUR (4) YEARS	2016	MISDEMEANOR ARREST/CONVICTON
Licensee	IN	FIVE (5) YEARS	1989	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	1994	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	1996	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	1997	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	1998	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	1999	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2001	NEGLIGENCE/INCOMPETENCE

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	FIVE (5) YEARS	2001	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Licensee	IN	TEN (10) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2011	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THIRTY-FIVE (35) MONTHS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	IN	EXTENDED THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	SEVEN (7) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FIVE (5) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	FOUR (4) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	THREE (3) YEARS	2016	NEGLIGENCE/INCOMPETENCE
Licensee	IN	EIGHT (8) YEARS	2008	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE-DEATH/SERIOUS INJURY

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	FIVE (5) YEARS	2011	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	SEVEN (7) YEARS	2011	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2012	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FOUR (4) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2013	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2014	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FOUR (4) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	SEVEN (7) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THIRTY-FIVE (35) MONTHS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2015	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	THREE (3) YEARS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	TWO (2) YEARS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	TWO (2) YEARS	2016	NEGLIGENCE-DEATH/SERIOUS INJURY
Licensee	IN	FIVE (5) YEARS	2004	PRACTICE UNDER THE INFLUENCE

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	FIVE (5) YEARS	2013	PRACTICE UNDER THE INFLUENCE
Licensee	IN	THREE (3) YEARS	2014	PRACTICE UNDER THE INFLUENCE
Licensee	IN	THREE (3) YEARS	2014	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	IN	SEVEN (7) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2016	PRACTICE UNDER THE INFLUENCE
Licensee	IN	SEVEN (7) YEARS	2016	PRACTICE UNDER THE INFLUENCE
Licensee	IN	SEVEN (7) YEARS	2016	PRACTICE UNDER THE INFLUENCE
Licensee	IN	FIVE (5) YEARS	2009	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2012	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FOUR (4) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FOUR (4) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FOUR (4) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	THREE (3) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FOUR (4) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FOUR (4) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	TWO (2) YEARS	2015	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	FIVE (5) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	THREE (3) YEARS	2016	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	IN	SEVEN (7) YEARS	1998	SEXUAL MISCONDUCT
Licensee	IN	FIVE (5) YEARS	2011	SEXUAL MISCONDUCT
Licensee	IN	FIVE (5) YEARS	2013	SEXUAL MISCONDUCT
Licensee	IN	FIVE (5) YEARS	2013	SEXUAL MISCONDUCT
Licensee	IN	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT
Licensee	IN	SIX (6) YEARS	2014	SEXUAL MISCONDUCT
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	SEXUAL MISCONDUCT
Licensee	IN	SEVEN (7) YEARS	2006	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2011	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2012	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2012	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2012	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2012	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2013	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2013	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2013	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	THREE (3) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2015	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2015	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2016	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2016	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2016	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	SEVEN (7) YEARS	2016	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	IN	FIVE (5) YEARS	2011	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	FIVE (5) YEARS	2012	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	FIVE (5) YEARS	2014	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	FOUR (4) YEARS	2014	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	SEVEN (7) YEARS	2014	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	THREE (3) YEARS	2015	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	EXTENDED TWO (2) YEARS	2016	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	THREE (3) YEARS	2016	UNLICENSED PRACTICE/ACTIVITY
Licensee	IN	FOUR (4) YEARS	1996	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2001	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2003	UNPROFESSIONAL CONDUCT
Licensee	IN	TEN (10) YEARS	2005	UNPROFESSIONAL CONDUCT
Licensee	IN	INCREASED TO EIGHT (8) YEARS	2009	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2010	UNPROFESSIONAL CONDUCT
Licensee	IN	ONE (1) YEAR	2010	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2010	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2010	UNPROFESSIONAL CONDUCT
Licensee	IN	EIGHT (8) YEARS	2011	UNPROFESSIONAL CONDUCT
Licensee	IN	EXTENDED INDEFINITE	2011	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FOUR (4) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	FOUR (4) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2012	UNPROFESSIONAL CONDUCT
Licensee	IN	EXTENDED ONE (1) YEAR	2013	UNPROFESSIONAL CONDUCT

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	EXTENDED TWO (2) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	TEN (10) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	FOUR (4) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	THIRTY-FIVE (35) MONTHS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	THIRTY-FIVE (35) MONTHS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	TWO (2) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	IN	ADDED THREE (3) CONSECUTIVE YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	SEVEN (7) YEARS	2016	UNPROFESSIONAL CONDUCT

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	THIRTY-FIVE (35) MONTHS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	IN	TWO (2) YEARS	2016	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2011	SEXUAL MISCONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2010	SEXUAL MISCONDUCT DURING TREATMENT
Reinstatement	IN	FIVE (5) YEARS	1995	UNPROFESSIONAL CONDUCT
Reinstatement	IN	TEN (10) YEARS	2006	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2009	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2010	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SIX (6) YEARS	2011	UNPROFESSIONAL CONDUCT
Reinstatement	IN	TEN (10) YEARS	2011	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2012	UNPROFESSIONAL CONDUCT
Reinstatement	IN	TEN (10) YEARS	2012	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SIX (6) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	TEN (10) YEARS	2013	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Reinstatement	IN	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Reinstatement	IN	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2015	IMPAIRMENT-MENTAL OR PHYSICAL
Applicant	OUT	THREE (3) YEARS	1996	UNPROFESSIONAL CONDUCT
Applicant	OUT	FIVE (5) YEARS	2001	UNPROFESSIONAL CONDUCT

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Applicant	OUT	FIVE (5) YEARS	2002	UNPROFESSIONAL CONDUCT
Applicant	OUT	FIVE (5) YEARS	2009	UNPROFESSIONAL CONDUCT
Applicant	OUT	FIVE (5) YEARS	2011	UNPROFESSIONAL CONDUCT
Applicant	OUT	SEVEN (7) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2012	UNPROFESSIONAL CONDUCT
Applicant	OUT	FIVE (5) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2013	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Applicant	OUT	THREE (3) YEARS	2016	UNPROFESSIONAL CONDUCT
Licensee	OUT	THIRTY-FIVE (35) MONTHS	2016	EXCESSIVE PRESCRIBING
Licensee	OUT	FIVE (5) YEARS	2001	FELONY ARREST/CONVICTION
Licensee	OUT	FIVE (5) YEARS	2013	FELONY ARREST/CONVICTION
Licensee	OUT	SEVEN (7) YEARS	2016	FELONY ARREST/CONVICTION
Licensee	OUT	FIVE (5) YEARS	2015	FRAUD
Licensee	OUT	TEN (10) YEARS	2003	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	OUT	SEVEN (7) YEARS	2012	IMPAIRMENT-MENTAL OR PHYSICAL
Licensee	OUT	FIVE (5) YEARS	2015	INAPPROPRIATE PRESCRIBING
Licensee	OUT	FIVE (5) YEARS	2016	INAPPROPRIATE PRESCRIBING
Licensee	OUT	FIVE (5) YEARS	2015	MISDEMEANOR ARREST/CONVICTON
Licensee	OUT	FIVE (5) YEARS	1986	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	1993	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	1993	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	1996	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	1997	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	1997	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	TWO (2) YEARS	1997	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	2000	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	TEN (10) YEARS	2001	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2005	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2006	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2011	NEGLIGENCE/INCOMPETENCE

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	OUT	FIVE (5) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FOUR (4) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	2012	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FOUR (4) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	2013	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	THREE (3) YEARS	2014	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	FIVE (5) YEARS	2015	NEGLIGENCE/INCOMPETENCE
Licensee	OUT	SEVEN (7) YEARS	2014	PRACTICE UNDER THE INFLUENCE
Licensee	OUT	FOUR (4) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	OUT	TEN (10) YEARS	2015	PRACTICE UNDER THE INFLUENCE
Licensee	OUT	FIVE (5) YEARS	2010	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2012	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2012	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2012	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	FIVE (5) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	TEN (10) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	THREE (3) YEARS	2013	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	SEVEN (7) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	THREE (3) YEARS	2014	SELF-ABUSE OF DRUGS/ALCOHOL
Licensee	OUT	SEVEN (7) YEARS	1995	SEXUAL MISCONDUCT
Licensee	OUT	FIVE (5) YEARS	1999	SEXUAL MISCONDUCT
Licensee	OUT	FIVE (5) YEARS	1999	SEXUAL MISCONDUCT
Licensee	OUT	SEVEN (7) YEARS	2014	SEXUAL MISCONDUCT
Licensee	OUT	THREE (3) YEARS	2016	SEXUAL MISCONDUCT
Licensee	OUT	FIVE (5) YEARS	2014	SEXUAL MISCONDUCT DURING TREATMENT
Licensee	OUT	SEVEN (7) YEARS	1984	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	1985	UNPROFESSIONAL CONDUCT
Licensee	OUT	TEN (10) YEARS	1986	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	1988	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	1991	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	1996	UNPROFESSIONAL CONDUCT
Licensee	OUT	THREE (3) YEARS	1996	UNPROFESSIONAL CONDUCT

Physicians on Probation

Applicant / Licensee / Reinstatement	In State / Out Of State	Probation Term	Year Probation Ordered	Case Type
Licensee	OUT	FIVE (5) YEARS	1998	UNPROFESSIONAL CONDUCT
Licensee	OUT	FOUR (4) YEARS	2011	UNPROFESSIONAL CONDUCT
Licensee	OUT	THREE (3) YEARS	2014	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	OUT	SEVEN (7) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	OUT	THIRTY-FIVE (35) MONTHS	2015	UNPROFESSIONAL CONDUCT
Licensee	OUT	THREE (3) YEARS	2015	UNPROFESSIONAL CONDUCT
Licensee	OUT	FIVE (5) YEARS	2016	UNPROFESSIONAL CONDUCT
Reinstatement	OUT	THREE (3) YEARS	1998	NEGLIGENCE/INCOMPETENCE
Reinstatement	OUT	SEVEN (7) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Reinstatement	OUT	TWO (2) YEARS	2002	NEGLIGENCE/INCOMPETENCE
Reinstatement	OUT	TEN (10) YEARS	1993	SEXUAL MISCONDUCT
Reinstatement	OUT	FIVE (5) YEARS	2004	UNPROFESSIONAL CONDUCT
Reinstatement	OUT	FIVE (5) YEARS	2012	UNPROFESSIONAL CONDUCT
Reinstatement	OUT	FIVE (5) YEARS	2014	UNPROFESSIONAL CONDUCT
Reinstatement	OUT	SEVEN (7) YEARS	2016	UNPROFESSIONAL CONDUCT

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.

Embassy Suites San Francisco Airport
250 Gateway Blvd.
South San Francisco, CA 94080

Thursday, July 28, 2016
3:15 p.m. – 5:30 p.m.

Friday, July 29, 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 July 28, 2016

3:15 p.m.

1. Call to Order/Roll Call/Establishment of a Quorum

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 May 5 – 6, 2016 Meeting

4. Presentation on the End of Life Option Act – David R. Grube, M.D., National Medical Director, Compassion and Choices, Former Oregon Medical Board Member

5. President's Report, including notable accomplishments and priorities – Dr. GnanaDev on behalf of Mr. Serrano Sewell

6. Board Member Communications with Interested Parties – Dr. GnanaDev

7. Executive Management Reports – Ms. Kirchmeyer
   A. Administrative Summary, including budget, personnel, and technology updates
   B. Enforcement Program Summary, including personnel, expert reviewer program, statistics, and enforcement unit updates
   C. Licensing Program Summary, including personnel, statistics, and licensing unit updates
   D. Update on the CURES Program, including registration and outreach information
   E. Update on the Health Professions Education Foundation, including information on the Stephen M. Thompson Loan Repayment Program
   F. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children
   G. Update on the Federation of State Medical Boards

8. Discussion on Collaboration with the Osteopathic Medical Board of California, Board of Registered Nursing, Board of Pharmacy, and Physician Assistant Board – Ms. Kirchmeyer

9. Update on the Sunset Review Process – 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 Enforcement Committee – Dr. Yip

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

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

14. Election of Officers

Friday July 29, 2016

9:00 a.m.

15. Call to Order/Roll Call/Establishment of a Quorum

16. 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)]

17. 9:00a.m. REGULATIONS – PUBLIC HEARING – Consideration and Possible Action on Proposed Regulations: Midwife Assistants. Addition of Title 16, Division 13, California Code of Regulations (CCR), Sections 1379.01 through 1379.09 – Ms. Webb

18. Presentation on Medical School Curriculum and Changes – Cathryn L. Nation, MD, Associate Vice President, Division of Health Sciences and Services, University of California, Office of the President

19. Discussion and Possible Action on Legislation/Regulations – Ms. Simoes

A. 2016 Legislation

AB 1244	AB 1977	AB 2216
AB 1306	AB 2024	AB 2744
AB 2745	SB 563	SB 1261
SB 22	SB 1174	SB 1471
SB 482	SB 1177	SB 1478
SB 538	SB 1189	

B. Federal Legislation – S. 2943 – National Defense Authorization Act for 2017, Section 705(d) – Enhancements of Use of Telehealth Services in Military Health System, Location of Care

C. Legislative Items for Future Meeting

D. Status of Regulatory Actions

1. Physician and Surgeon Licensing Examinations Minimum Passing Scores, 16 CCR, section 1328.1
2. Outpatient Surgery Setting Accreditation Agency Standards, 16 CCR, section 1313.4
3. Disclaimers and Explanatory Information Applicable to Internet Postings, 16 CCR, section 1355.35
4. Disciplinary Guidelines, 16 CCR, section 1361
5. Midwife Assistants, 16 CCR, sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09

20. Presentation and Possible Action on the Universidad Iberoamericana (UNIBE) Medical School Application for Recognition – Dr. Nuovo, Dr. Lewis, Mr. Worden and Ms. Dobbs

21. Update from the Application Review and Special Program Committee – Dr. Yip

22. Discussion and Possible Action on Proposed Regulations amending Title 16, Division 13, CCR Sections 1364.10, 1364.11, 1364.13, and 1364.15 related to Citable Offenses, Citation Disclosure, and Citation and Fine Authority for Allied Health Professionals – Ms. Webb

23. Discussion and Possible Action on Proposed Regulations Updating the Manual of Model Disciplinary Orders and Disciplinary Guidelines, amending Title 16, Division 13, CCR Section 1361 – Ms. Webb

24. Update on the Interim Suspension Order (ISO) Study - Ms. Kirchmeyer

25. Update on the Outreach Campaign – Dr. Lewis

26. Discussion on the Process to Revise the Statement on Marijuana for Medical Purposes, Marijuana Recommendations Guidelines, and a Policy on Physician Use of Marijuana – Ms. Kirchmeyer

27. Update on the Improvements and Potential Changes to the Vertical Enforcement Program – Ms. Kirchmeyer

28. Agenda Items for the October 27 – 28, 2016 Meeting in the San Diego Area

29. 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 July 28, 2016 (800) 230-1074

Friday July 29, 2016 (800) 230-1059

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 **16** – 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.

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MEDICAL BOARD OF CALIFORNIA

Agenda Item 3

QUARTERLY BOARD MEETING

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

May 5-6, 2016

MEETING MINUTES

Thursday May 5, 2016

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

Members Present:
David Serrano Sewell, President
Dev GnanaDev, M.D., Vice President
Denise Pines, Secretary
Michelle Bholat, M.D.
Michael Bishop, M.D.
Judge Katherine Feinstein, (ret.)
Randy Hawkins, M.D.
Howard Krauss, M.D.
Kristina Lawson, J.D.
Ronald Lewis, M.D.
Brenda Sutton-Wills, J.D.
David Warmoth
Jamie Wright, J.D.
Felix Yip, M.D.

Members Absent:
Sharon Levine, M.D.

Staff Present:
Liz Amaral, Deputy Director
Regina Armstrong, Inspector
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Kimberly Kirchmeyer, Executive Director
Dino Pierini, Business Services Officer
Anne Potter, Staff Services Manager I
Regina Rao, Associate Government Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel

Curt Worden, Chief of Licensing

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
Genevieve Clavreul
Elizabeth Costello, Investigator, Health Quality Investigation Unit
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Louis Galiano, Videographer, Department of Consumer Affairs
Bridgette Gramme, Center for Public Interest Law
Marianne Hollingsworth, Consumers Union, Safe Patient Project
Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
Bernard Lim, Investigator, Health Quality Investigation Unit
Lisa McGiffert, Consumers Union, Safe Patient Project
Michelle Monserratt-Ramos, Consumers Union, Safe Patient Project
Barbara Yaroslavsky, Prior Board Member
Natalie Zellmer, Supervising Investigator I, Health Quality Investigation Unit

Agenda Item 1 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on May 5, 2016, at 3:35 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

No public comments were heard.

Agenda Item 3 Approval of Minutes from the January 22, 2016 and February 26, 2016 Meetings

Dr. Hawkins made a motion to approve both the January 22, 2016 and February 26, 2016 meeting minutes as written; s/Dr. Lewis. Motion carried. 10-1-3. (Absent – Bishop) (Abstain - GnanaDev, Sutton-Wills and Warmoth).

Agenda Item 4 President's Report

Mr. Serrano Sewell introduced and welcomed Ms. Sutton-Wills and Mr. Warmoth to the Board. The ceremonial swearing in was administered for both Ms. Sutton-Wills and Mr. Warmoth.

Mr. Serrano Sewell announced the 2016 Legislative Day was scheduled for Wednesday, May 11, 2016. He stated the intent was for Board Members to meet with several Senate and Assembly Members to educate them on the Board's role and function. Those Members would also be asked to use their social media websites to get information regarding the Board out to their constituents.

Mr. Serrano Sewell noted that since the last Board Meeting he had had several meetings on issues related to the Board. He had a phone meeting with the Chair of the Board of Podiatric Medicine, as well as with Senator Hill. He stated he also had several calls with Board staff on issues before the Board.

Mr. Serrano Sewell referred the Members to pages BRD 4B-1 and 4B-2 in their packets, where they found an updated Committee roster. He noted that with several new Members, he and Ms. Kirchmeyer would be reaching out to the Members for new committee appointments soon. He announced that there are appointments needed for the Enforcement Committee, the Application and Special Programs Review Committee, and a public member is needed for the Special Faculty Permit Review Committee as well as for the Prescribing Task Force. He stated if any Members were interested in one of these appointments, or would like to change Committees, to let him or Ms. Kirchmeyer know.

Michelle Monserratt-Ramos, Consumer's Union Safe Patient Project, stated the ratio of public members to the physician members was only one public member to five physicians on the Board's Executive Committee, zero public members to three physician members on the Board's Enforcement Committee and only two public members to four physician members on the Board's Public Outreach, Education and Wellness Committee. She stated these ratios had gotten worse since the last Committee Roster was distributed in October 2015. She noted that it was clear that the intention of the Legislature that public members be much more heavily represented in deliberations of the Board, as the law requires that seven of the fifteen members be public members. She recommended the Board set a policy to establish a practice that all Committees of the Medical Board reflect a balance similar to what is required by the Legislature for the full Board. Ms. Monserratt-Ramos urged the Board to revisit its Committee compositions with the aim of having them reflect the nearly 50/50 physician/public member split of the Board itself.

Agenda Item 5 Board Member Communications with Interested Parties

Ms. Wright stated she attended the 35th annual gala for Delta Sigma Theta and had met the new Dean of Charles Drew Medical University. She had a discussion regarding the Board, public outreach and their path of growth for the University.

Dr. Krauss stated he had been an invited speaker at the Annual Federation of State Medical Boards (FSMB) meeting that was held in San Diego, April 27-30, 2016. He stated he spoke on physician recommendations for marijuana and physician use of marijuana.

Dr. GnanaDev stated he also attended the FSMB meeting and welcomed the FSMB and its attendees to California, who was the host of this year's annual meeting. He also noted that he is an active member of the California Medical Association (CMA) and is involved in various activities, but keeps the Board business separate from CMA's business.

Agenda Item 6 Discussion and Possible Action on 2017 Proposed Board Meeting Dates

Ms. Kirchmeyer referred the Members to page BRD 6-1 in their packets that contained the proposed 2017 meeting dates and locations. Ms. Kirchmeyer stated these dates would allow the

appropriate amount of time between meetings and would also work with other meetings that are scheduled throughout the year, such as the 2017 Annual FSMB meeting.

Ms. Wright made a motion to approve the 2017 proposed meeting dates and locations as submitted in the Board packet; s/Dr. Lewis. Motion carried, 13-0. (Bishop absent).

Agenda Item 7 Executive Management Reports

Ms. Kirchmeyer stated she would not be going over the reports in detail unless Members had any questions, but would bring a few items to their attention. She referred the Members to pages BRD 7A-4, that showed the Board's fund condition. Ms. Kirchmeyer noted that, at this time, the Board's fund reserve was projected to be at 3.8 months at the end of the current fiscal year and below the mandate in fiscal year 17/18. She then noted that the Board's Budget Change Proposals (BCP) to hire additional staff in the Central Complaint Unit (CCU) and to increase the Board's expert reviewer funding were approved by both the Senate and Assembly Budget Committees. Once the budget bill makes it out of both of those Committees and the Governor signs it, one additional staff will be hired in the Enforcement Unit. Ms. Kirchmeyer noted that as stated at the last meeting, the other two additional BCPs going through the process is the augmentation for the Attorney General's (AG) office due to Senate Bill (SB) 467 and the change due to the transition of the Registered Dispensing Opticians Program to the Board of Optometry.

Ms. Kirchmeyer noted that the Board continues to monitor the CURES registration process and notify physicians that they must be registered by July 1, 2016. The Board had placed information on the website including tutorials, frequently asked questions, and helpful tips. She noted the Board had recently been asked to assist in sending out a survey to physicians to get feedback on how the CURES 2.0 system was working for them, as well as what type of problems they may be experiencing. She stated the survey should go out in the fall, and that it is part of the study on opioids via a grant given to the California Department of Public Health (CDPH). The Department of Justice (DOJ) was also awarded a grant to study the issues with opioid use, including the use of CURES. She noted the DOJ wants to use the survey information to determine if changes are needed to the system.

Ms. Kirchmeyer then referred the Members to page BRD 7E-1. She stated that with the elimination of the Board Members from the Health Professions Education Foundation (Foundation), Ms. Kirchmeyer asked the executive director of the Foundation to provide a written report for the Boards update. This will ensure the Board stays informed about the activities of the Foundation.

Ms. Kirchmeyer stated that in regard to the issue of overprescribing of psychotropic medication to foster children, the Members can find a written update on page BRD 7A-3. She noted that the Board recently had an exit interview with the Bureau of State Audits (BSA) regarding its audit on this issue. She noted that while the audit focused on the Department of Health Care Services, the Department of Social Services, and the counties, a portion of it also reviewed the Board and the work the Board is doing on the issue. She stated the BSA report is scheduled to be released sometime in the Summer. There is also a bill related to this issue that Ms. Simoes will be discussing during the legislative agenda item.

Ms. Kirchmeyer noted that staff has been meeting with the Business, Consumer Services, and Housing Agency, who is taking the lead on ensuring the End of Life Option Act is fully implemented by June 9, 2016, when the law takes effect. The Board has developed a webpage specifically on this issue that will be released upon approval of CDPH's website. She noted the Board had met with some experts in this area and there would be a presentation on this issue at the Board's July meeting.

Ms. Kirchmeyer then gave an update on the opioid misuse and overdose prevention workgroup led by the CDPH. She noted the Board had been a part of this workgroup for almost two years and while a lot of collaboration had been done by this workgroup, the workgroup had now identified some priorities and are developing different taskforces that would be working in different areas on this issue. Ms. Kirchmeyer noted she is excited about the work that is going to be put into these task forces. She stated she would bring task force updates to the Board, once they have met.

Ms. Kirchmeyer ended her report by reminding all Members to turn in their travel expense claims as soon as possible as the end of the fiscal year was approaching and the cutoff date for submission is June 1, 2016.

Yvonne Choong, California Medical Association, raised an issue with regard to the Enforcement Program summary. She stated in the expert reviewer program part of the report, it was stated the Board was seeking expert reviewers in a variety of expert areas. Ms. Choong noted the CMA would like to urge the Board to consider allowing osteopathic physicians to serve as expert reviewers when appropriate in specialties where recruitment has been an issue. She asked Board staff to discuss this with legal counsel to see if it would impact the Board's enforcement cases.

Agenda Item 8 Update on the Federation of State Medical Boards

Ms. Kirchmeyer stated the FSMB annual meeting took place in San Diego on April 28-30, 2016. She noted that on BRD 8-1, Members would find the agenda for that meeting. She noted there were several great speakers, including Dr. Krauss, who spoke on legal and legislative challenges of changing the medical marijuana landscape. Ms. Kirchmeyer stated she was quite impressed with the opening presentation by the United States Surgeon General. Though the focus of his presentation had been on overprescribing of opioids, he also discussed stress and physician burnout. Dr. Murthy talked about what was being done at the federal level on both of these issues. Ms. Kirchmeyer stated there were several different educational sessions. She sees the physician burnout issue as being one of the leading issues at the FSMB within the next year. She stated the FSMB would also be taking a look at physician compounding among other topics.

Ms. Kirchmeyer noted that Dr. GnanaDev, Dr. Lewis, Ms. Delp and Mr. Worden also attended the meeting. She then asked the Members who attended if they had any additional comments about the meeting.

Dr. GnanaDev began by thanking Ms. Kirchmeyer for writing his opening speech for him, which included the top 10 odd laws in California. He stated the meeting started and ended on a great note.

Dr. Krauss stated this was only his second time attending the FSMB meeting, and feels it was a great opportunity to meet medical board colleagues from all over the country and to discuss how each state was facing identical circumstances in many cases and to look at different solutions. He then encouraged the other Members to look at next year's FSMB meeting dates and try to make the time to attend.

Dr. Krauss then noted that Ms. Kirchmeyer was sought after for her opinions and is very well respected, which made him proud to be a member of the Board.

Dr. Lewis noted that the highlight of the FSMB meeting for him was the networking with the western region boards. Ms. Kirchmeyer presented the highlights of what the Board was doing and stated that approximately 50% of the questions asked were directed to Ms. Kirchmeyer for response and for her opinion on different issues happening in the different states. This also made him proud to have our Board's Executive Director's opinion sought out in that meeting.

Agenda Item 9 Update, Presentation, and Possible Action on the Sunset Review Process/New Sunset Issues

Ms. Kirchmeyer began by explaining that 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. She noted the sunset review process begins by the Committees sending out a questionnaire to the Board requesting completion by the following November or December. The 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. Ms. Kirchmeyer stated the questionnaire also discusses current issues, which could include the implementation of the Uniform Standards, the Consumer Protection Enforcement Initiative regulations, BreEZe, and any other issues the Committees would like the Board to address. Ms. Kirchmeyer then stated that 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. She added 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.

Ms. Kirchmeyer continued by noting that the Board's last sunset review report was completed in 2012 and the hearing was held in 2013. She noted the background paper that was provided to the Board contained 39 issues where the Board had to provide responses, however, she said it is important to note that 20 of the issues were issues identified by the Board in its sunset review report. Ms. Kirchmeyer added that these 39 issues can be found in pages BRD 9-21 through BRD 9-27 of the board packet. She noted these pages provide a listing of the 39 issues for the Board during the last sunset review process. She added almost all of the issues had been addressed and completed, with the exception of issue number 4. She stated 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. She added Board staff would be working with Committee staff to determine how to proceed on these matters.

Ms. Kirchmeyer then moved on to the part of the sunset review process where the Board would be bringing up new issues that had been raised to or by the Board and any recommended solutions to these

issues where the Committees may be of assistance. She noted that board staff had identified several issues that should be placed in this section of the report. In addition, a few issues had been raised at Board meetings by Board Members. Ms. Kirchmeyer requested the Members review each of these issues to determine if Board staff should include the issues in the sunset review report. The issues that have been identified are as follows:

- **Expiration date of licenses:** Ms. Kirchmeyer stated that 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. She said 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). Ms. Kirchmeyer noted legislation had 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 BreEZe system. In addition, she added, proration would result in additional time for licensure based upon these business process changes. Therefore, staff would be requesting that the expiration date be two years from the month of issuance instead of the birth month. She stated 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:** Ms. Kirchmeyer stated the Board had requested discussion on the issue of increasing 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. She noted there had been extensive discussion by the Board and an interested parties meeting regarding this issue.

- **Data Collection for Outpatient Surgery Settings (OSS):** Ms. Kirchmeyer stated that 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 CDPH is required to report aggregate utilization and patient encounter data to the Office of Statewide Health, Planning and Development (OSHPD). She noted, however, most OSSs are required to be accredited instead of licensed, and there is no requirement to for them report data to OSHPD. Ms. Kirchmeyer stated this had resulted in a serious deficiency of OSS data for accredited OSSs. She added 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, and the Board agreed to work with interested parties to determine what specific information was actually needed for the Board and for trend analysis. She announced the Board had an interested parties meeting scheduled for May 26, 2016, to discuss this issue.

- **Amendments to Adverse Event Reporting for OSSs:** Ms. Kirchmeyer stated that 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. She noted that OSSs are different from hospitals and the reporting requirements should be tailored to an OSS and not a hospital.

- **Posting of Information Related to a Probationary License:** Ms. Kirchmeyer stated that **c**urrently 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. She noted 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:** Ms. Kirchmeyer stated that 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. She added 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. She stated this "805.01 report" should be received prior to the filing of an "805 report." Ms. Kirchmeyer added the statistics over the past several years, since the bill was implemented, indicated that entities were not providing these reports. She noted that 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. She stated the Board believes entities are not submitting 805.01 reports as required. She noted 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 could 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:** Ms. Kirchmeyer noted 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:** Ms. Kirchmeyer stated 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:** Ms. Kirchmeyer noted that up 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. She noted in return for this support, individuals agreed to provide direct patient care in an underserved area of California for three years. On January 1, 2016, the Board's participation on HPEF ended. She stated 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:** Lastly, Ms. Kirchmeyer noted that 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 American Board of Medical Specialties (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. She added that 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. So, for an ABMS specialty board to become recognized, it takes years and involves 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 had 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. Ms. Kirchmeyer stated the Board and the law had 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.

Ms. Kirchmeyer then recommended Board Members determine if any additional issues should be brought forward in the report.

Dr. Lewis asked if while staff was meeting with Legislators over the years, were they getting a sense of issues that might come up, or might be hot issues that perhaps staff could begin working on ahead of getting the questions.

Ms. Kirchmeyer stated she believes the Enforcement timelines will be an issue for the Board, along with the Vertical Enforcement model. She feels that there will be specific questions with regard to both of those.

Dr. GnanaDev asked Ms. Kirchmeyer if she had heard anything about whether the Interstate Licensure Compact may be brought into the sunset review.

Ms. Kirchmeyer stated she had not heard anything as of yet, but it could come up since there are now 23 states that have either adopted the Interstate Licensure Compact or are in the process of adopting it. She felt that as more and more states adopt it, there would be a push by some interested parties for California to adopt it, as well.

Dr. Hawkins asked if the Board really wanted to add certain issues as new issues and whether that brings undue attention to the Board.

Ms. Kirchmeyer stated that when staff looked at these new issues, they were determined to be important to the Board and to consumer protection and this is the perfect time to get legislative changes made, if needed.

Mr. Serrano Sewell felt the language on the signs in physician’s offices should be added to the new issues list. He stated the new language should refer consumer questions to either a phone number or website and be a neutral, factual statement.

Dr. Lewis made a motion to approve the new issues shown in the packet and also to include the issue of the new language for the sign posted in offices; s/Ms. Wright.

Lisa McGiffert, Consumers Union Safe Patient Project, welcomed the new Members. She stated there were a few things that they would like to see added to the sunset review report. She stated they support the Board's plan to get OSSs that are owned by physicians to report to OSHPD, regarding information about the procedures they are doing. She noted the adverse events that occur in OSSs, should be posted on the Board's website, and if there is legislative approval to do this, then it should be added to the sunset review report. She stated the accreditors are now required to look into the background of the ownership interest to see if they have had accreditation issues in the past. Consumer's Union believes they should also be required to look into the physician owner's background, as well. Ms. McGiffert noted Consumers Union would like to see the signs posted in physician offices be updated and changed with more information for the consumers. She added there are also some issues with the Board's statute of limitations, stating it is a confusing law and consumers do not know when the time limits are for filing a complaint. Lastly, she noted they appreciate the Board's opinions on the 805.01 reports.

Motion carried unanimously.

Agenda Item 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 welcomed the new Members, thanked them for their service and stated she and Director Kidane are looking forward to working with them.

Ms. Lally announced that after eight years of service with the Department of Consumer Affairs (DCA), Tracy Rhine, Chief Deputy Director, had accepted a new job and was leaving the DCA.

Ms. Lally stated the DCA was in the process of developing a new training specifically for new executive officers (EO) and growing the next generation of EOs. The DCA would be sending out a survey to all current EOs, as well as Board Members, to assess current training needs for these EOs and hoped that everyone would participate in that survey.

Ms. Lally noted the DCA's SOLID team would start facilitating "brown bag" gatherings for their EOs to develop networking and training opportunities for the DCA's EOs.

Ms. Lally then discussed SB 1195 (Hill), stating this bill was amended on April 6, 2016, to include a number of provisions that address the anti-trust issues presented by the *(North Carolina Board of Dental Examiners (NCBDE) vs. the Federal Trade Commission (FTC)* U.S. Supreme Court decision that came out last February. One of the most significant amendments that would affect the DCA boards, is that it grants the DCA Director expanded authority over regulations to ensure they are not anti-competitive. Currently, the DCA Director can only disapprove regulations that could injure the health, safety, and welfare of the public. Ms. Lally stated if the EO or any Members have any questions about this bill or any other legislation, DCA has a legislative Director, Ms. Melinda McClain, who is always available to assist.

Next, Ms. Lally provided an update on the BreEZe system. She noted the Board is continuing to see a substantial amount of applications submitted online. She stated that at the end of March, the Board received approximately 8500 applications online, which represents about 63% of the total application volume for that period. She noted that renewals make up the vast majority of online applications received. There were approximately 7700 renewals received at the end of March, and 99% of them were approved the same day.

Ms. Lally stated that of the 18 programs on BreEZe they are approaching a milestone of about 200 million dollars processed via the online BreEZe portal, which makes up over half of the money processed in BreEZe.

Ms. Lally noted that DCA had launched the 2nd release of BreEZe in January 2016. This release included seven boards and one bureau to the BreEZe system, which now makes 18 programs of the DCA's 40 on the system. Since January, DCA and the BreEZe vendor had dramatically increased the number of system changes that are regularly deployed through maintenance updates. She stated the maintenance updates occur every 6-7 weeks, with the next update scheduled for June 2016, which would include approximately 250 changes.

Ms. Lally stated that specific to the Board, since January of this year, the Board had put forward and enacted 57 changes and/or enhancements. As of the end of April, the Board had a total of 159 outstanding defects and/or enhancements pending for the BreEZe system. She noted that some of these requests are older requests and DCA's IT and the Board's executive director are reviewing those requests to prioritize those that are still necessary.

Ms. Lally then announced a new pilot program that DCA and the Board are working on together to develop. It is a reporting tool that would eventually be used by all DCA boards and bureaus. This reporting tool has been named the Quality Business Intelligence Reporting Tool aka QBIRT. This tool would be linked to all of the data that is in the BreEZe system, and its objective is to provide Board staff greater flexibility to build and modify data reports as it puts the data directly in the hands of Board staff. Currently, DCA has received positive feedback from the four programs in the pilot program. She thanked the Board staff for the valuable feedback and input on key areas that they provided to enhance the tool's effectiveness. Ms. Lally stated this tool is scheduled for department wide rollout in fall of this year.

Lastly, Ms. Lally noted DCA and the Board are also working together to enhance the BreEZe verify a license main page by making the page more user friendly. They are currently developing surveys and focus groups to get feedback on how to help enhance the webpage. The surveys will go out late summer and the DCA will work with the Board's executive director to gather the appropriate stakeholders to be included in the focus groups.

Ms. Lally ended by thanking the Board's staff and executive director for always making themselves available when DCA needs some assistance with IT matters. She stated their assistance is very much appreciated.

Dr. GnanaDev thanked Ms. Lally for her report and agreed that BreEZe is getting better on the licensing functions, but requested that the same efforts be put toward the enforcement functions.

Dr. Yip agreed with Dr. GnanaDev and stated that hopefully the new QBIRT tool will assist in the enforcement data being extracted for reports.

Agenda Item 11 Update, Discussion and Possible Action on Recommendations from the Public Outreach, Education and Wellness Committee

Dr. Lewis stated the first agenda item discussed at the Committee meeting was an update on the public outreach plan. After the Committee meeting in January, he had the opportunity to work with staff to set due dates and priorities for all of the outreach activities.

Dr. Lewis noted that staff had already completed some of the activities in the outreach plan. One of those completed activities included a message encouraging state employees, vendors and contractors to check up on their physicians' licenses, which will appear on all warrants issued by the State Controller's Office during the period of June 1 through June 30, 2016. Dr. Lewis stated the message will reach approximately 440,000 individuals. In addition, an article with information about the Board and a link to the Board's website was included in the California State Teachers Retirement System (CalSTRS) and the California State Retiree's Organization's (CalSRO) April newsletter and will again be in its spring and summer 2016 newsletters. He stated the target number of these groups is 934,000 individuals.

Dr. Lewis noted that Board staff had reached out to a number of other organizations, such as city and county entities, unions, AARP and others. He stated staff was working on a website tutorial on how to look up a physician, which should be completed by the next Board meeting in July 2016. He stated staff was also working on Public Service Announcements (PSA) that could be provided to various media organizations and other interested parties, which should be completed by September 2016.

Dr. Lewis said the staff had also updated the Committee on the status of the Public Affairs' strategic plan activities. He announced that the Committee had discussions on possible enhancements to the Board's website after reviewing the Consumer Reports' survey on the ranking of the medical and osteopathic boards that was done in 2015. Dr. Lewis noted that the Committee heard recommendations from staff and others that will be put into place.

Mr. Serrano Sewell thanked Dr. Lewis and staff for getting so much done in a short amount of time and stated there is always more work to do, but that this effort is off to a very good and positive start.

Agenda Item 12 Update on the Physician Assistant Board

Dr. Bishop stated the last Physician Assistant Board (PAB) Meeting was in April 2016. At that meeting, they introduced a new Member, Miriam Valencia, J.D. to the PAB. Ms. Valencia replaced Ms. Gomez-Vidal. Ms. Valencia is the Regional Government Affairs Manager for Out Front Media, formerly CBS Outdoor. Dr. Bishop stated Ms. Valencia is a member of the Valley Industry and Commerce Association, Los Angeles County Business Federation and Los Angeles World Affairs Council. Ms. Valencia's term expires January 1, 2019, and she was warmly welcomed to the PAB.

Dr. Bishop then noted the Senate Committee on Business Professions and Economic Development and Assembly Committee on Business and Professions completed their sunset

oversight review of the PAB on March 9, 2016. He stated in preparation of the oversight hearing, staff of the Committees developed a background paper that summarized the contents of the Board's sunset report. The paper also reviewed the PAB's prior sunset report to see if they had implemented prior Committee recommendations. He noted that the paper also addressed current sunset issues. Committee staff identified 10 issues for the PAB. He stated that out of those 10 issues, Committee staff identified four issues which were discussed by the PAB's president, vice president and executive officer at the hearing. Dr. Bishop stated it was noted by Committee staff that since its last review, the PAB has shown a commitment to improve its overall efficiency and effectiveness and has worked cooperatively with the Legislature and Committees to bring about necessary changes. He noted it was recommended by the Legislature that the PAB continue to regulate physician assistants. He stated AB 2193 had been introduced, which would extend the Sunset date for the Board for four years.

Dr. Bishop then stated PAB staff is working with the BreEZe team to update the online version of the physician assistant application. He noted that with this update, applicants will no longer be required to send in a paper application when they apply online. This change will take place in May. Currently online applicants must also submit a complete hard copy of their application, so this change will make applying more efficient and user friendly and allow the Board to more quickly process applications. He stated the PAB is also working on a BreEZe system change that would allow licensees to change their addresses online. This change will take place in June 2016. He noted this enhancement would make it more convenient for licensees to update their addresses with the PAB, however, licensees would still have the option to request address changes in writing or via the website.

Dr. Bishop moved on to four regulations he felt needed to be brought to the MBC's attention. The first being a regulatory proposal for the PAB's disciplinary guidelines to include the uniform standards for substance abusing health care licensees, which were approved by the Office of Administrative Law (OAL) on April 11, 2016. He stated this regulation would be effective on July 1, 2016.

Dr. Bishop stated the next regulation, which was discussed at the PAB's last meeting raised questions about the current criminal conviction disclosure requirements. He noted that members raised concerns about whether the $300.00 trigger for reporting infractions was too low and whether the PAB might be receiving too many disclosures for convictions, such as minor traffic violations, unrelated to the practice of physician assistants. He said the PAB voted to request the staff bring language to the next PAB meeting showing the proposed changes discussed at the meeting for possible initiation of a rulemaking file to amend current regulations.

Dr. Bishop noted the third regulation was in regard to the PAB's requirements for the Physician Assistant Specialty programs. The PAB voted to create a sub-committee to look at physician assistant specialty programs and consider applications for approval.

Lastly, Dr. Bishop stated the PAB discussed the widespread practice of the use of electronic signatures in patient records and other documents utilized in the medical environment. He noted it was recognized that electronic signatures allow for the more efficient use by the medical practitioners, thus improving patient care. He said the PAB voted to request staff to bring language to the next PAB meeting showing proposed changes that would include the use of electronic signatures and the delegations of a service agreement for possible initiation of the rulemaking process to amend current regulations.

Dr. Bishop ended his report by thanking the executive director and staff for their continued assistance and support of the PAB.

Mr. Serrano Sewell then presented Ms. Yaroslavsky with a resolution from Senator Allen and a plaque from the Board in honor of her 13 years of dedicated service to the Board from 2003 to 2016. He stated that Ms. Yaroslavsky had served and led virtually every standing committee of the Board. He stated that beyond the service to the Board, the 13 years represent her focused commitment to the Board's mandate, which is consumer protection. Mr. Serrano Sewell noted that the Board has come a long way in the past 13 years, and much of that was due to the dedicated service and leadership of Ms. Yaroslavsky.

Several additional Members thanked Ms. Yaroslavsky for her leadership, humanity, compassion and passion she has shown through her 13 years of service on the Board and stated she will be missed both on a professional level as well as a personal level.

Ms. Yaroslavsky thanked each of the Board Members for being part of the community and wished them all the best. She stated she is always available to assist in any way and encouraged the Members to take this job seriously, as what they do is very important, not just for them, but for the people they will never see, and the voices they will never hear. She stated they are making a difference in the quality of life of everyone who lives in the State of California.

Several comments from the public were received thanking Ms. Yaroslavsky for her dedication and service.

Mr. Serrano Sewell adjourned the meeting at 5:40 p.m.

Friday, May 6, 2016

Members Present:
David Serrano Sewell, President
Dev GnanaDev, M.D., Vice 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.
Brenda Sutton-Wills, J.D.
David Warmoth
Jamie Wright, J.D.
Felix Yip, M.D.
Staff Present:
Liz Amaral, Deputy Director

Regina Armstrong, Inspector
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Kimberly Kirchmeyer, Executive Director
Dino Pierini, Business Services Officer
Anne Potter, Staff Services Manager I
Regina Rao, Associate Government Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Members of the Audience:
Sejad Afahan, Midwestern University
Teresa Anderson, California Academy of Physician Assistants
Carmen Balber, Consumer Watchdog
Claudia Brigalia, Licensed Midwife
Ricardo Castillo, Attorney General's Office
Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
Yvonne Choong, California Medical Association
David Chriss, Chief, Health Quality Investigation Unit
Zennie Coughlin, Kaiser Permanente
Julie D'Angelo Fellmeth, Center for Public Interest Law
Christopher Figueroa, Investigator, Health Quality Investigation Unit
Louis Galiano, Videographer, Department of Consumer Affairs
Cristina Gejmundo, Midwestern University
Jon Genens, Investigator, Health Quality Investigation Unit
Bridgette Gramme, Center for Public Interest Law
Ed Hollingsworth
Marianne Hollingsworth, Consumers Union, Safe Patient Project
Lisa McGiffert, Consumer' Union, Safe Patient Project
Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
Michelle Monserratt-Ramos, Consumers Union, Safe Patient Project
Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit
Phuong Pham, Midwestern University
Robert Pulido, Supervising Investigator II, Health Quality Investigation Unit
Randy Schuntz, Midwestern University
Michael Schwartz, Ventura County District Attorney
Carrie Sparrevohn, Licensed Midwife, Midwifery Advisory Counsel
Tracy Tu, Investigator, Health Quality Investigation Unit

Agenda Item 13 Call to Order/Roll Call

Mr. Serrano Sewell called the meeting of the Medical Board of California (Board) to order on May 6 2016 at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 14 Public Comments on Items not on the Agenda

No public comments were heard.

Agenda Item 15 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes referred the Members to their Legislative Packet and stated they should have received an updated tracker list and one updated bill analysis. She noted that the bills in blue are either 2-year bills or the Board had already taken positions on them, so they will not be discussed. She noted the bills in pink are the Board sponsored bills, so those would be discussed first. She then stated the bills in green will require discussion and a position. She made note that the bill that Ms. Lally had mentioned, SB 1195 (Hill), had been introduced and addressed the FTC issue. This bill would grant authority to the Director of DCA to review a decision or other action of a board within DCA to determine whether it unreasonably restrains trade and to approve, disapprove, or modify the board decision or action, as specified. It would also add an additional standard for the Office of Administrative Law to follow when reviewing regulatory actions of state boards. She stated the Board does not need to take a position on this bill, but there is a copy of the bill in the legislative packet for review.

Ms. Simoes then noted the next Legislative Day was scheduled for May 11, 2016, and staff had set up meetings with 15 Legislators. She will bring an update back at the next Board meeting.

AB 2745 (Hill) Ms. Simoes began with the Board's sponsored clean-up bill, AB 2745 (Hill). She noted this bill passed out of Assembly Business & Professions Committee with no "no" votes and passed out of the Assembly on consent.

SB 1039 (Hill) Ms. Simoes stated the Board of Podiatric Medicine (BPM) is its own board and is completely separate from this Board. She noted that for more than the past two decades, the BPM has been issuing its own podiatric licenses, separate and apart from the Board. She said 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. She stated this bill will remove references to the Board in the BPC sections that regulate the BPM. The bill will make it clear that the BPM is its own board that performs its own licensing functions.

Ms. Simoes stated 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 (B&P) and they agreed that the changes needed to be made and this language was amended into this clean-up bill authored by Senator Hill. Ms. Simoes stated this bill had passed Senate B&P and was in Senate Appropriations.

SB 1478 (Sen. B&P) Ms. Simoes noted the bill was the health omnibus bill. The provisions pertaining to the Board deleted some outdated sections of law that are related to the Board. This bill passed Assembly B&P and was in Senate Appropriations.

SB 1033 (Hill) Ms. Simoes noted this is the bill that 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 licensees' probation, the length of the probation and the end date, and all practice restrictions placed

on the license on any Board documents informing the public of probation orders and probationary licenses, including, but not limited to, the Board's Newsletter. She added this summary information is also required to be posted on the BreEZe licensee profile for each licensee subject to probation.

Ms. Simoes stated 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.

Ms. Simoes noted 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; or
- Restricting the licensee totally or partially from prescribing controlled substances.

Ms. Simoes added 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.

She noted 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.

Ms. Simoes added the 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.

Ms. Simoes then went over the fiscal impact of this bill. Staff believes that 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. She stated that 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. Based on that, the Board's additional cost would likely be $1 million dollars. She noted that one amendment that is being discussed to help cover this fiscal impact is to allow cost recovery for physicians on probation, which would mean that if the Board puts a physician on probation, prosecution costs could be recovered from the physician. She noted that currently, cost recovery is not an option.

Ms. Simoes continued by saying the probationary status of a physician is public information and available on the Board's website, and that 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. She stated tha,t again, in these situations, the patient may not have the opportunity to make an informed decision.

In addition, Ms. Simoes stated that 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.

Dr. Krauss stated he has several concerns. The first being the burden that will be placed on the Board; not just in terms of increased cost, but in terms of being overwhelmed and having the capacity to work through all of the hearings. He noted that if the Board cannot do its job, many cases would be dropped, which offers a greater harm to consumers than requiring the few hundred physicians who are on probation to notify their patients. He stated he is also concerned about the practical implication of a physician instituting this in their practice. Dr. Krauss stated he felt that with the time involved in not only informing the patient, but discussing the circumstances with the patient, it would likely jeopardize the ability of the physician to stay in practice.

Dr. Krauss stated he found it ironic that this bill is in the State Legislature, and there is no state in the Union that has this requirement. However, Consumer Reports stated that California's website is already the best in terms of access to information regarding misbehavior of a physician (compared to every other state). Yet, California has somehow become a target state for this type of legislation.

Dr. GnanaDev voiced his concerns about patients who are going into surgery and not meeting some of the surgical team until ten minutes before they actually go into the surgery room. He stated that type of information being shared at that time could be detrimental to the patient. He stated he agrees with the staff recommendation of neutral if amended.

Ms. Monserratt-Ramos, Consumers Union, Safe Patient Project, urged the Board to support this legislation as they feel it is the most effective way to keep patients safe and to achieve the Board's policy that all California consumers should know the background, training, certification, and history of disciplinary actions of any healthcare provider they consider seeing. She stated this bill does not represent the same proposal that the Board turned down in October. She noted this bill requires physicians who are on probation for serious issues to inform their patients, to provide a simplified method of disclosure, and to include a similar requirement for other primary healthcare practitioners.

Ms. Balber, Consumer Watchdog, urged the Board to reconsider their position on this bill. She feels that physicians with the most serious disciplinary actions should have to tell their patients at the point of care, as opposed to the Board putting time and funds into an outreach program to put the burden on the consumer.

Ms. Choong, California Medical Association, encouraged the Board to approve the staff recommended amendments, however, she urged the Board take an oppose unless amended position as it should be

made clear that the Board is not neutral, but opposed without the amendments. She also noted that the staff fiscal analysis suggested cases that would result in a stipulated settlement of more than three years would still be stipulated under this bill. She noted that they disagree with this assessment due to the practical impact of the bill's requirement on a physician's practice would be equivalent to a suspension, which will give physicians much less incentive to settle regardless of the length of probation. She noted that they believe the fiscal impact would be much higher than stated by staff.

Ms. Gramme, Center for Public Interest Law, stated they strongly support SB 1033 for the reasons that Consumers Union stated, but also because the Board's probation unit is charged with monitoring physicians on probation and detecting any violations of probation so that the Board can take appropriate action. She stated the probation unit is now comprised of non-sworn probation inspectors with double the case loads of peace officers who investigate the Board's cases. She stated that within the past several years, the probation unit has been unable to keep up with the extremely large caseload. She stated they have seen many petitions to revoke probation documenting probation violations going back a year or more. These petitions had not been filed promptly and the probationary physicians had been able to continue to practice. She stated that for all of these reasons, they urge the Board to support SB 1033.

Dr. Lewis made a motion to take a neutral, if amended to exempt certain situations and to include all health care providers, position on this bill; s/Ms. Wright.

Dr. Bishop stated he is concerned about the fact that the longer it takes the Board to resolve a case, the longer that physician has no monitoring. He stated he feels the Board needs to think about the risk/benefit of a neutral position.

Motion carried, 13-2 (Krauss, Sutton-Wills)

AB 1977 (Wood) Ms. Simoes stated this bill would establish an Opioid Abuse Task Force (Task Force) to develop recommendations regarding the abuse and misuse of opioids. She noted 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 and address specified issue areas.

Ms. Simoes added 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.

Ms. Simoes noted 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. She stated Board staff believes 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 the bill is signed into law to ensure the discussions are in line with the Board's Guidelines.

Dr. Levine made a motion to support this bill; s/Dr. Lewis.

Dr. GnanaDev stated this is currently the biggest issue for public safety. He feels the Board needs to do whatever it takes to resolve this issue.

Dr. Levine stated that so much work has been done already in trying to get control of this issue. She noted the Centers for Disease Control recently released guidelines and there was a lot of work by the Board's Prescribing Task Force. She feels there is plenty of work already done for the new Task Force to call upon to develop recommendations on this issue.

Motion carried unanimously.

AB 2024 (Wood) - Ms. Simoes stated 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 judgment 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.

Ms. Simoes noted 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. Ms. Simoes added 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 judgment of a physician.

Dr. Bishop made a motion for the Board to take a neutral position on this bill; s/Dr. Lewis.

Dr. Krauss stated he agreed with taking a neutral position, and reminded everyone that not every state has a corporate bar on the practice of medicine. He feels the Board needs to carefully evaluate any law that changes the ban as a potential for trouble. He noted his main concern is always to assure the physician's primary interest is the care of the patient and not serving the interest of an employer.

Motion carried unanimously.

AB 2216 (Bonta) – Ms. Simoes stated this bill would establish the Teaching Health Center (THC) Primary Care Graduate Medical Education Fund (Fund) in the State Treasury and would require the Director of 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. She added 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.

Ms. Simoes noted this bill would increase funding for residency programs in California, which would help promote the Board's mission of increasing access to care for consumers.

Dr. GnanaDev made a motion for the Board to take a support position on this bill; s/Dr. Lewis.

Dr. GnanaDev stated that the Board should do whatever it takes to increase graduate medical education, since most of the positions are concentrated on the east coast. He noted there are so few in California, so this bill is very important.

Dr. Krauss reminded the Board that California is doing a good job in terms of increasing the number of medical school seats, however, statistical analysis shows that the greatest probability of the site of the residents' practice is not where they went to medical school, but where the residency was done. That usually means that many of the California medical school graduates must leave California for residency and then do not return.

Dr. Lewis stated he believes the bigger issue is the lack of funding for these programs from the federal government.

Motion carried unanimously.

AB 2507 (Gordon) Ms. Simoes stated 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. She noted this bill would prohibit health care providers from requiring the use of telehealth when it is not appropriate. Ms. Simoes added this bill would specify that a patient shall not be precluded from receiving in-person health care delivery services.

Ms. Simoes added 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.

Ms. Simoes stated Board staff believes the changes this bill would make to existing telehealth law would not have a negative impact on consumer protection and may increase access to care.

Dr. Bholat made a motion for the Board to take a support position on this bill; s/Dr. Lewis.

Dr. Levine stated after looking at the language of the bill, she believes this bill just adds video and telephone, it does not expand protections that were in the prior bill that was passed in telehealth.

Ms. Kirchmeyer added that any complaint that was received would be looked at from the standard of care perspective no matter what type of communication was used for the patient.

Motion carried unanimously.

AB 2592 (Cooper) Ms. Simoes stated this bill would require CDPH to establish a pilot program, if funding is available, to award grants to combat opioid abuse through the safe prescribing of opioids. CDPH would determine the amount of grants to award to individual pharmacies that choose to participate in the program. She added that 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. She noted that 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. Ms. Simoes stated a patient would not receive the medicine locking closure package unless he or she consents either orally or in writing. She added this bill would define a medicine locking closure package as a locking closure container, unlocked only with a user-generated code, that only allows the person with the prescription to access the medicine. Ms. Simoes noted the medicine locking closure package includes, but is not limited to, an amber prescription container combined with a resettable alphanumerical 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. She added 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.

Ms. Simoes stated 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.

Dr. Lewis made a motion for the Board to support this bill; s/Dr. Krauss.

Dr. Levine recommended that language be included in the bill to say this pilot program be constructed with matched controls with a scientific approach so that CDPH can determine if it actually made a difference in the opioid misuse issue.

Ms. Sparrevohn, Licensed Midwife, stated the only target audience she sees for this are people who have an opioid prescription and an opioid abuser in the home. She feels that the number of people who opt into this are very small.

Dr. Bishop stated that unless it is a device that is bolted down or bullet proof, he feels that anyone who wanted to get into the prescription bottle bad enough, would be able to get into it someway.

Motion carried with the understanding that Dr. Levine's comments be passed on to the author, 8-3 (Feinstein, Lawson, Yip) -4 Abstain (Bishop, GnanaDev, Levine, Wright).

AB 2606 (Grove) Ms. Simoes stated 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 that issued the credential, license, or permit, including the Board. She stated 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. She added that once the Board receives this information, it would still go through the Board's normal complaint and investigation process, which is confidential**.** Ms. Simoes noted this bill was recently amended, but the amendments were minor and do not impact the Board's analysis.

Dr. GnanaDev made a motion for the Board to support this bill; s/Dr. Levine. Motion carried unanimously.

AB 2744 (Gordon) Ms. Simoes stated the 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. She stated 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. She added this bill would specify that it does not apply to basic health care services or essential health benefits and this bill would require the entity that provides the advertising to demonstrate that the licensee consented in writing to the requirements of the bill.

Ms. Simoes noted that 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.

Dr. Lewis made a motion for the Board to take a neutral position.

Motion carried, 9-2 (Feinstein, Sutton-Wills) -4 Abstain (GnanaDev, Lawson, Warmoth, Wright).

SB 22 (Roth, Cannella , and Galgiani) Ms. Simoes stated this bill was substantially amended since the last Board Meeting. She noted this bill would continuously appropriate $300 million from the General Fund (over a three-year period) to the OSHPD for the purpose of funding new and existing graduate medical education physician residency positions, and support training faculty, pursuant to the Song-Brown Health Care Workforce Training Act. This bill would increase funding for residency programs in California, which would 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.

Dr. GnanaDev made a motion for the Board to support this bill; s/Dr. Krauss. Motion carried unanimously.

SB 482 (Lara) Ms. Simoes stated the bill would require all prescribers issuing Schedules II and III drugs to access and consult the CURES database before prescribing a Schedule II or III controlled substance under specified conditions. She added 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.

She stated the 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.

Ms. Simoes noted this bill would specify that it is not operative until the Department of Justice (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.

Ms. Simoes added that the 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. She added 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.

Ms. Kirchmeyer stated there was a public comment that was received and was handed out to each of the Members for review.

Ms. Choong, CMA, stated SB 482 was amended to expand the exemptions from the blanket duty to consult in the previous version of the bill and they agree that the previous language failed to take into consideration the many situations in which a duty to consult would not be reasonable. However, she stated, the exemptions as drafted are problematic. She noted, for example, the language provides an exemption for checking when the prescription is prescribed for surgery in a licensed facility. They agree that a mandatory consultation is not reasonable when a prescription is for surgery, however, the language excludes surgery performed in an OSS. She added the language attempts to provide an exemption for administration in patient settings, which makes sense, but the mechanism for doing it is flawed. Ms. Choong noted they feel there should be a third party that certifies the database is ready for statewide use. Ms. Choong also stated that CMA strongly cautions the Board against supporting this bill based on a conceptual idea without attention to the details.

Ms. Balber, Consumer Watchdog, stated the AG's office has been at the Board meetings several times to update the Board on how CURES is functioning and are extremely pleased with the way it is working. She stated she understands that CMA has been strongly opposed to the mandatory use of CURES for several years now and claiming technical difficulties is one way for them to object to mandatory use. She stated that the biggest complaint she is hearing about CURES is physicians not understanding how to go through the registration system to get signed up. She stated the Consumer Watchdog urges the Board to hold its support position.

Ms. D'Angelo Fellmeth, Center for Public Interest Law, stated that in states that have required the use of a Prescription Drug Monitoring Program (PDMP), "Doctor shopping" has dropped tremendously, which is what is needed in California, and she urged the Board to hold its support position on this bill.

Dr. GnanaDev stated he agreed with some of CMA's concerns in regard to the settings. However, he also stated he is a strong supporter of PDMP. He noted that the answer is to have a PDMP with appropriate exemptions in facility settings.

Dr. Yip stated he feels this burden should be shared by the hospitals and OSSs. He thinks that when they give the physician the printout of the medication, they should also be required to include a history of prescribed medications for the patient.

Dr. Bishop asked who all has the authority to access CURES.

Ms. Kirchmeyer stated that anyone who is authorized to dispense, prescribe or administer controlled substances. As long as the person has a DEA and a license they can access CURES.

Dr. Bishop stated that he would like to see an amendment where a designated individual, such as a designated RN, be able to assist by obtaining a CURES report. This would be very important for a busy practice or Emergency Department.

Ms. Kirchmeyer stated that when CURES 2.0 was released, it included a way to designate someone to request the CURES information, but the physician has to be the one to print it out.

Dr. Krauss noted he speaks in favor of support. He understands the concerns being heard today, and feels there will always be a need for some exemption. He stated that he would be disappointed to

imagine that after the time and effort being put into creating the CURES system, these would be road blocks put up in requiring its use.

Dr. GnanaDev clarified that with a physician's delegate they can access the CURES system and request the information for the physician, however, the actual information is sent directly to the physician and not the requestor, as it is HIPPA protected.

Dr. Krauss made a motion for the Board to support this bill with technical assistance to define what "inaccessible" means; s/Dr. Lewis. Motion carried unanimously.

SB 1174 (McGuire) Ms. Kirchmeyer stated 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. She noted that 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.

Ms. Kirchmeyer stated 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. She added this bill would specify that the data provided to the Board shall include a breakdown by population, as specified.

Ms. Kirchmeyer noted 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. Ms. Kirchmeyer noted that anecdotally, the Board does not receive complaints regarding overprescribing of psychotropic medications to foster children. The data 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 existing data use agreement (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.

Dr. Lewis made a motion for the Board to support this bill with needed amendments including a sunset date and clearly identifying what data will be received; s/Dr. Krauss.

Dr. GnanaDev noted that his concern is that this is a huge problem in institutions with DSS and the Board is addressing peripheral issues rather than the real issue, which is getting support for these kids with mental health issues.

Judge Feinstein expressed her concerns about this bill not addressing enough of the problem. She stated this is a county issue and in many areas, these kids are not being prescribed medication by licensed, board certified child psychiatrists. She stated the important thing is to have what is being done reviewed by someone who is an expert and can assess the situation.

Ms. Kirchmeyer stated Judge Feinstein is correct. This bill does not solve the problem and it is just one small portion of a much larger issue. Ms. Kirchmeyer noted that this at least makes sure that the Board gets the data so it can be reviewed. Staff has discussed this issue with all entities involved including the Senator's office numerous times, letting them know that the thing that would make the biggest impact is anyone who witnesses what appears to be inappropriate prescribing should report it the Board immediately.

Ms. Sparrevohn stated she is concerned about there only being one physician in certain rural areas and this bill may discourage that physician to not want to see foster children.

Ms. Balber stated that Consumer Watchdog supports this bill. She noted the legislature passed three similar bills last year that requires more information and oversight by the county and state level, but this bill goes specifically to accountability.

Motion carried, 13-0-2 Abstain (Feinstein and Levine).

SB 1177 (Galgiani) Ms. Simoes stated this bill would authorize establishment of a physician and surgeon health and wellness program (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. Ms. Simoes noted the PHWP shall aid a physician with substance abuse issues impacting his or her ability to practice medicine.

She noted the bill states 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 for Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Section 315.

Ms. Simoes stated 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. She noted 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. Ms. Simoes added 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. Ms. Simoes stated 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 specified requirements.

Ms. Simoes stated if the Board determined the administering entity was 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.

Ms. Simoes noted 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.

Ms. Simoes added 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.

Ms. Simoes added 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. She stated 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.

Ms. Simoes stated 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. She added 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. She stated 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. Ms. Simoes noted that currently, the bill 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, and in fact this amendment has already been drafted.

Ms. D'Angelo Fellmeth stated that several areas of this bill are not consistent with the Uniform Standards that the Board voted on and put into place. In other parts of the bill, it sets forth standards and requirements that are also not consistent with the Uniform Standards nor are they consistent with the regulations that implement the Uniform Standards. She stated if this bill should pass as is, it will trump the Board's Uniform Standards which is unacceptable. She also stated the bill should require the Board to establish a standing committee that meets in public to discuss participants.

Ms. Balber agreed with everything that Ms. Fellmeth said, and added the bill specifically stated the program would be required to notify the Board if a physician withdraws or is terminated from the program, whereas the Uniform Standards required reporting to the Board on any failure to comply, which includes a failed drug test. She felt this is one of the key inconsistencies that the Board needed to be absolute that the bill corrects.

Ms. Monserratt-Ramos stated Consumers Union, Safe Patient Project opposes this bill. It does not conform with the Uniform Standards and there is no need to create a program that may undermine the oversight responsibility of the Board. She stated if physicians have the right to engage in substance abuse, then their patients have a right to know about it. She stated they also agree with Ms. Fellmeth's request to have the Board create a standing committee of the Board, both public and physician members, to have oversight over the program to ensure the Uniform Standards are met.

Ms. Choong, California Medical Association, stated they are sponsors of this bill, and support the staff recommendation to the Board to support this bill. She noted they appreciated the Board's assistance in working with them and the stakeholders to create and meet all of the principles of the bill. She reiterated that this is not a diversion program, but a program to address a gap in early identification and intervention for physicians in crisis who are suffering from these types of issues.

Dr. Krauss stated his concern is that in the absence of a health and wellness program, physicians tend to hide their depression and their substance abuse issues, and he stated he does not know any other state that does not have some sort of physician health and wellness program. He stated the bill is certainly appropriate and needed, and if flaws are detected along the way, the Board may need to have regulations to address those.

Dr. Lewis made a motion for the Board to support this bill; s/Dr. Krauss.

Dr. Bishop asked Ms. Simoes to bring the concerns that were brought up by all parties during the discussion today to the author's attention.

Ms. Simoes stated she is still working with the author and would be sure to mention them.

Dr. Bholat recommended adding a subcommittee as discussed.

Mr. Serrano Sewell stated that once the bill is passed and signed, it is recommended the Board set up a standing subcommittee on this issue.

Motion carried unanimously.

SB 1189 (Pan and Jackson) Ms. Simoes stated 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. She noted 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, along with other provisions. Ms. Simoes added 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 reviewed the investigation it conducted on Ventura County's former Medical Examiner (ME), and discussed the obstacles faced by the DA's office in pursuing criminal action. She stated also in the report, it brought

up several grey areas of law related to autopsies and who can perform them. The report stated 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 stated there is a need for legislation to clarify whether the performance of an autopsy is included in the practice of medicine.

Ms. Simoes stated after 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. She stated this clarification will assist the Board in its enforcement actions and further the Board's mission of consumer protection.

Dr. Lewis made a motion for the Board to support this bill; s/Dr. GnanaDev.

Mr. Schwartz, Ventura County District Attorney's Office, stated the report that was referenced by staff could be found on their website and refers to a complaint they received in regard to an administrator who was opening up bodies, manipulating organs, and taking samples, although he had no medical training, while the ME was on vacation. This ME had been communicating with the administrator via email, and when the ME returned from vacation, he signed off on the death certificates for bodies he had never seen. Mr. Schwartz felt the law should reflect that autopsies must be done by a physician only and not by staff.

Judge Feinstein stated that Ventura County is not the only county that has suffered adversely from situations like this and sheriffs are not trained in medicine and not qualified to perform autopsies.

Motion carried unanimously.

For SB 1261 (Stone), Ms. Simoes stated Members were given an updated copy of this bill as it was substantially amended and now would allow out-of-state physicians who are licensed in California to have license and renewal fees waived if they certify to the board that the sole purpose of their license is to provide voluntary, unpaid service.

Dr. Lewis made a motion for the Board to take a neutral position on this bill; s/Judge Feinstein. Motion carried unanimously.

SB 1471 (Hernandez), Ms. Simoes stated that under current law, revenue from fines and penalties levied on health plans is deposited in the Managed Care Administrative Fines and Penalties Fund (MCAFPF) . She noted that existing law requires fines and penalties collected up to $1 million to be deposited into the Medically Underserved Account for Physicians (MUAP) in the HPEF for purposes of the Steven M. Thompson Loan Repayment Program (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. Ms. Simoes stated that this bill starting January 1, 2017, and annually, thereafter, any amount over the first two million, including accrued interest isto be transferred to the HPEF for the STLRP program. She stated 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.

Ms. Simoes added 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.

Dr. Lewis made a motion for the Board to support this bill; s/Dr. Yip. Motion carried unanimously.

Ms. Simoes then moved to item 15C, stating the regulation matrix is included in the Board packets and she can answer any questions.

Agenda Item 16 Update, Discussion and Possible Action on Recommendations from the Licensing Committee

Dr. Bishop stated that Mr. Worden had given a great presentation regarding minimum requirements for Board recognized accredited postgraduate training. The presentation focused on the possible need to increase the minimum requirements for postgraduate training. He noted since the way medical education was taught in the 1980s, it is very different than the way it is being taught today, not to mention the mass expansion in knowledge and skills necessary to be a functioning physician. He stated Mr. Worden explained the pros and cons of increasing the minimum requirements. He noted if the minimum requirements were increased, there would be a need for a training license. Mr. Worden discussed in general terms what a training license would allow a resident to do and when a training license would be issued. Dr. Bishop stated that Mr. Worden would be sending a Power Point presentation out for review by some of the UC Associate Deans for Graduate Medical Education (GME) for input and will then provide the Power Point to designated institutional officers to present at a monthly GME Program Director meeting to obtain input for Board staff to help identify issues and the lead time it would take to implement any needed changes. He noted the increase in the minimum requirement may eliminate the need for Board staff to review international medical schools and instead use the list of medical schools in the World Directory of Medical Schools. That directory had been developed through a partnership between the World Federation for Medical Education and the Foundation for Advancement of International Medical Education and Research.

Mr. Worden also gave a presentation on special faculty permits (SFP) that included some historical background, the number of SFPs that have been issued since the start of the program, along with the number of current permits. He stated Board staff had sent out a survey to medical schools regarding the need and asked if any medical schools had any need and/or recommended changes that should be considered by the Board. Mr. Worden presented the results of the survey.
Dr. Bishop noted that Mr. Worden had also given a presentation on the current Special Programs that the Board approves pursuant to the Business and Professions Code and California Code of Regulations sections.

Dr. Levine congratulated Mr. Worden for his terrific work as she feels there is nothing more important to protecting consumers than looking at raising the bar for getting a license to practice medicine in California.

Agenda Item 17 Discussion and Possible Action on Universidad de Guadalajara Application for Recognition

Mr. Worden asked the Board for approval for the Universidad de Guadalajara (UAG) School of Medicine's international program. Staff requested the Board recognize UAG's four-year curriculum and deem it to be in compliance with BPC 2089 and 2089.5 and CCR, Title 16,

Division 13, Section 1314.1. He noted the prepared reports could be found on pages BRD 17-1 and BRD 17-2 in the Board packets.

Dr. Lewis made a motion for the Board to accept UAG's application for recognition; s/Dr. Krauss.

Marianne Hollingsworth expressed her personal concern about the Board accepting UAG's application. She stated she had been working on a list of egregious offenses by physicians in California along with other interested parties, and has noticed that UAG showed up frequently as the medical school that some of the physicians have attended, and some of the most frequently cited disciplines were for sexual misconduct. She suggested that in order for UAG to receive recognition, they mandate a class on ethics and boundaries.

Mr. Boreman stated he was grateful to work with Mr. Worden and staff as they did a wonderful job through a difficult review process. He stated the Board had been very fair and balanced in their approach.

Motion carried unanimously.

Agenda Item 18 Discussion and Possible Action on Proposed Regulations for Midwife Assistants, adding Title 16, Division 13, CCR sections 1379.01 through 1379.09

Ms. Webb referred the Members to tab 18 in their Board packet. She stated that effective January 1, 2016, SB 408 created BPC section 2516.5, which formally allows licensed midwives, and certified nurse midwives to use midwife assistants in their practices. She stated midwife assistants are unlicensed individuals who must meet specific requirements pursuant to BPC section 2069, which deals with medical assistants. They also must meet other requirements established by the Board through the regulatory process. She noted the Board staff had held an interested parties meeting to receive input on drafting the proposed regulations. These draft regulations were presented to the Midwifery Advisory Council (MAC) on March 10, 2016, where additional input was received.

Ms. Webb stated staff was requesting authorization from the Board to initiate the rulemaking process and to formally notice the proposed language for public comment and a hearing to be set at a future Board meeting. Ms. Webb noted that the regulations address the qualifications to be a midwife assistant, who can supervise, what type of technical assistance they can provide, training by licensed midwives and certified nurse midwives, and any schools the Board anticipates will develop to fill this need.

Ms. Brigalia, Licensed Midwife, stated that currently, they are only allowed to use students from an approved school or other licensed midwives as assistants. She noted that assistants are needed and what this bill would allow is for midwives to have an assistant that is not another licensed midwife, which would make midwives more available for other needs.

Dr. Lewis made a motion to approve authorization to initiate the rulemaking process and to notice the approved language for public comment and to have a hearing scheduled at the Board's next meeting; s/Judge Feinstein. Motion carried unanimously.

Agenda Item 19 Update, Discussion and Possible Action on Recommendations from the Midwifery Advisory Council Meeting

Ms. Sparrevohn, MAC Chair, began by thanking the Board for voting to approve the authorization to initiate the rulemaking process for the proposed midwife assistant regulations. She stated her full report could be found in the Board packets under tab 19. She did, however, comment on the action by the MAC at their March 10, 2016, meeting where Dr. Anne Marie Adams was recommended for the vacant physician position on the MAC. She noted that Dr. Adams had already attended several MAC meetings and interested parties meetings that pertain to Licensed Midwives and her participation, comments and suggestions had been well received. She also brings a unique skill set and insight as a physician who is actively practicing in home birth settings and attending peer review with licensed midwives.

Ms. Sparrevohn then asked for approval of the following agenda items for the next MAC meeting.

- Task Force Update:
  - Update on Revisions to Licensed Midwife Annual Report (LMAR)
- Update on continuing regulatory efforts required by 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

Dr. Krauss made a motion to approve the requested agenda items for the next MAC meeting; s/Dr. Levine. Motion carried unanimously.

Agenda Item 20 Discussion and Possible Action on Midwifery Advisory Council Appointments

Mr. Worden asked for Board approval to appoint Dr. Anne Marie Adams to the vacant physician member position on the MAC. He also asked for Board approval to appoint Jocelyn Dugan to the vacant public member position. He then stated staff recommended that if at the August 18, 2016 MAC meeting, they vote to recommend a licensed midwife to the vacant midwife position, the candidate be permitted to sit on the MAC at the meeting pending Board approval at the Board's October 2016 meeting.

Dr. Lewis made a motion to approve Ms. Dugan for the vacant public member position, and to approve Dr. Adams to the vacant physician member position to the MAC and included in the motion the approval to allow the licensed midwife position to sit on the MAC at the August MAC meeting prior to the Board's approval; s/Mr. Warmoth. Motion carried unanimously.

Agenda Item 21 Investigation and Vertical Enforcement Program Report

Mr. Chriss, Chief of DCA's Division of Investigation (DOI), and Ms. Nicholls, Deputy Chief, provided an update on the Health Quality Investigation Unit (HQIU). Mr. Chriss stated it was asserted at the last Board meeting that HQIU vacancies were adversely effecting Vertical

Enforcement (VE). He stated they had been analyzing the root cause of investigator vacancies and determined there are two main factors, pay and the VE system itself. He continued stating in regard to the pay issue, a retention pay proposal for HQIU investigators had been prepared by DOI. It was hopeful that it would be addressed in the collective bargaining process, which is currently taking place. In February 2016, HQIU had sent out a confidential survey via Survey Monkey to sworn investigators to solicit feedback on the VE program and to get suggestions on improvements to the program. He stated the feedback report had been shared with Ms. Kirchmeyer and Ms. Delp and he would be working with the Board and the AG's Office to discuss improvements to the program to maximize efficiencies and to reduce vacancies.

Mr. Chriss stated they had taken active steps to assist with the workload. He noted they had initiated an emergency pilot project to fill six special investigator assistant positions statewide. He noted these positions did not require full peace officer backgrounds and are vital to assisting with investigator tasks, such as obtaining court records, medical records and releases, servicing subpoenas, and providing support for sworn investigator staff. These positions could also identify and develop great potential candidates for sworn peace officer positions. Mr. Chriss stated they had also contacted recently retired investigators to re-hire them as retired annuitants. He noted that supervisors were also carrying an active caseload to assist in the backlog. Overtime had been approved for existing investigators to help manage the larger caseload.

Mr. Chriss noted they had streamlined the background process to identify any potential issues that disqualify candidates up front, so the focus can be put on the backgrounds that would result in successful hires. He stated they were actively filling vacancies and had upcoming investigator interviews scheduled for several offices.

He stated the HQIU staff had worked with the Board and the AG's Office in developing a new case disposition procedure to streamline the process and to improve processing times once the investigation is complete. He noted that collaboration was successful and the new procedure went into effect on May 3, 2016.

Mr. Chriss stated that it was also reported at the last Board meeting by the AG's Office that the majority of the criminal cases referred do not result in filings. He noted that this information was not correct. He stated that during the FY 15/16, 26 cases for criminal prosecution were referred for prosecution. He stated 15 of them had been filed, 2 had been rejected and 9 were still pending final decisions by the district attorney. For FY 14/15, 40 criminal cases were filed and 23 were rejected. He noted that on March 4, 2016, a complete list of all active criminal cases for their 12 field offices was sent to Ms. Castro. He stated there were only 110 cases on that list that involved licensees, and 11 of them were physician cases, while 6 others were allied health cases. The remaining 93 cases were unlicensed individuals and not under the purview of the AG's Office and have no licensing component. Those 17 cases represent only 1.3% of the total case load. He noted that for full transparency purposes, they will be providing the AG's Office with full and complete spreadsheets of all active cases to avoid confusion moving forward. Mr. Chriss added that the transfer of investigators to the HQIU did not increase criminal referrals when compared to prior years.

Mr. Chriss stated that additionally, they had worked with the Board and the AG's Office to develop parallel prosecution guidelines to ensure that public protection is achieved in cases that are criminal. He noted that meetings to develop these guidelines had begun in December 2015. One of the key functions of this process was to have dual referrals made to the District

Attorney's (DA) Office and the AG's Office simultaneously. The AG's Office would be reviewing that case for filing an accusation and would recommend any additional evidence needed to pursue the administrative case and monitor any statute or issues. When the case is received in the field office, the AG's Office would continue to review all incoming cases and help identify those cases that might necessitate interim suspension orders.

Mr. Chriss noted that the HQIU staff had participated in the Board's recent expert reviewer training in San Diego on March 19, 2016. They are continuing to assist in this valuable project and are working with Board staff to determine future training dates for the Los Angeles and Northern California area. He stated they have two joint training sessions scheduled with the AG's Office regarding 805 investigations. These trainings are a collaborative effort that would lead to statewide consistency in investigative methods and evidence collection. He added a cloud based information sharing system had been implemented in April 2016. This system will allow HQIU to share data with the AG's Office. All information will be scanned and uploaded to the cloud for assigned attorneys to review and provide feedback. This system will help eliminate communication gaps for document review.

Ms. Chriss stated that ongoing meetings had been established with Ms. Kirchmeyer and Ms. Delp regarding important HQIU issues as they develop.

Ms. Chriss stated that the HQIU investigators are their most important resource. Their cases are very serious and complex and the investigative staff are very educated, very experienced and skilled at working these types of cases. He noted staff had persevered despite shortages and system challenges. They are true professionals and he stated he is very proud of them and also proud to be their Chief.

Ms. Nicholls gave a brief update on the interviews that they had or that are currently scheduled. She noted that she is personally sitting on all of the interview panels, since these positions are so critical and a vital part of reducing their vacancies. There were interviews in several different district offices and they still had more to come. She noted they are very aggressively trying to get people interviewed and positions filled with qualified candidates.

Dr. Levine asked if the HQIU had put any retention strategies in place for current staff.

Ms. Nicholls stated there was a retention plan submitted as part of the proposal asking for an increase in investigator pay. In addition, they completed the survey to help identify things that are causing job dissatisfaction. She noted they will be working aggressively with Ms. Kirchmeyer and Ms. Castro to make improvements to encourage the current staff to stay with the unit.

Dr. Levine added that she was thinking more in terms of non-monetary strategies.

Ms. Nicholls stated they are developing a continuous improvement team that will be comprised of a handful of investigators from each area and one of the team's first projects is discussing a retention recognition system for those who stay with the unit. This team will be developing ways, other than monetarily, to help recognize those staff. She stated she hoped to have some updates on this team's ideas, at future Board meetings.

Dr. Bholat asked Mr. Chriss what their recruitment process is in the sense of how they advertise the position to make it inviting for applicants.

Mr. Chriss stated it is advertised as a peace officer position and he noted that the knowledge base and education that are part of the minimum qualifications tend to attract the folks that are passionate about that type of work, and they also emphasize the training that is given with these types of positions. He noted there had been some pay issues, but felt pretty optimistic about many of the ways they are working on improving the recruitment process.

Judge Feinstein asked if there is an estimate of the number of cases that are pending for either referral for prosecution or are already in simultaneous criminal prosecution.

Mr. Chriss stated that for criminal prosecution, it would be approximately two percent of their cases. He noted some cases are so egregious on the front end that they would need criminal prosecution, which is one reason he is pleased to have the parallel prosecution policy in place.

Ms. Kirchmeyer stated this situation had not gone unnoticed by the Board. The Board still has four and one half positions that are non-sworn positions that they will be filling to expand that unit. They would be given some of the less complex cases from the HQIU.

Ms. Castro stated that she, her management team, her DAGs, and the lead prosecutors are very happy with the leadership since Mr. Chriss has stepped into that role.

Ms. Castro then stated that as of her last report at the previous Board meeting, regarding the criminal investigations, all of the issues that she had raised had been resolved to her satisfaction and all of her concerns had been addressed.

Ms. Castro noted that she was pleased to see that several of her favorite investigators are still with the HQIU, as they are very elite investigators who have a very technical background, and she is not surprised that they are being sought out by other agencies that want those skills in their offices. She reiterated that she was quite pleased with the HQIU and its leadership.

Ms. Castro stated she meets with Ms. Kirchmeyer and Ms. Delp to continue to discuss data reconciliation efforts and any efficiencies that can be put into place at the Complaint Investigation Office as well as the probation unit at Ms. Kirchmeyer's office.

Agenda Item 22 Update from the Attorney General's Office

Ms. Castro thanked the Board for providing a letter to one of their most elite Supervising Deputy Attorney Generals (SDAG), Jose Guerrero, who recently retired. She stated that it meant a lot to her and her staff to have Ms. Kirchmeyer join them at the retirement gathering.

She then announced that after 30 years of service, Vivian Hara, who was previously an SDAG in the San Francisco office, has retired. Ms. Castro stated it was very difficult to lose two really qualified folks. She announced that she had two new DAGs, Brian Bill and Nicholas Schultz who joined their Los Angeles office.

Dr. GnanaDev stated that he is anxious to see the pending case numbers go down.

Ms. Castro stated she felt with the three newest important initiatives of data sharing, efficiencies in the case disposition process, and other efficiencies in the Complaint Investigation Office, this will occur.

Agenda Item 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 section 1364.10, 1364.11, 1364.13, and 1364.15

Ms. Webb stated Board staff is looking to amend the citation and fine regulations in several ways. The first would be to add licensed midwives and polysomnographic technologists, technicians and trainees as individuals that Board staff can cite and fine. She stated staff would like to also add certain code sections to the regulations where if the licensee or registrant violates them, they could be cited and fined.

Ms. Webb noted that under CCR section 1364.13, staff would like to add licensed midwives along with the polysomnographic positions to address unlicensed practice situations. Also under CCR section 1364.15, she stated that because of a change in statute, any citations are kept on the website for three years, rather than five years, so the regulations need to be amended to reflect that statutory change. Ms. Webb then noted she had one suggestion for a change to section 1364.11, that would also apply to 1364.13. At the end of the section it currently reads "the sanction authorized under this section shall be separate from, and in addition to, any other civil or criminal remedies…", she suggested changing it to read, "the sanction authorized under this section shall be separate from, and in addition to any other administrative, civil or criminal remedies…"

Dr. GnanaDev made a motion to authorize staff to move forward with the rulemaking process to notice the language with the suggested amendments or public comment and to set the matter for hearing at a future Board meeting; s/Dr. Krauss. Motion carried unanimously.

Agenda Item 24 Discussion and Possible Action on Proposed Regulations on Requirements for Physicians on Probation, amending Title 16, Division 13, CCR section 1358

Ms. Webb stated this is a regulation that had outdated language in it and staff recommended an amendment be made by striking the word "division" and replacing it with the word "Board" and also by correcting the title of the Board's probation unit. The regulation currently states the title as the "Probation Surveillance Compliance Program," and its title is the "Probation Program." She noted the Board no longer has the "investigative personnel" that is currently referenced. She stated the current regulation has it referenced as "the probationer needs to be compliant with biological fluid testing" yet another reminder should be added that they are expected to be compliant with each term and condition in the order placing the physician on probation.
Dr. Lewis made a motion to authorize staff to move forward with the rulemaking process, to notice the language for public comment and to set the matter for hearing at a future Board meeting; s/Dr. GnanaDev. Motion carried unanimously.

Agenda Item 25 Agenda Items for the July 2016 Meeting in the San Francisco Area

Mr. Serrano Sewell stated there should be an End of Life Option Act (ELOA) presentation, the regulatory hearings, elections of officers, and an update on the ISO project.

Dr. GnanaDev requested that Board staff start looking into Board collaboration with the Nursing Board, the Medical Board and the Pharmacy Board. He felt that a lot could get accomplished if all the boards worked together more often.

Dr. Krauss stated that at the FSMB meeting, they adopted two policies with respect to marijuana and he requested these two policies be discussed at the next Board meeting.

Dr. Krauss also suggested that in light of having new Board Members, he would like to have an informational report on what is involved in oversight and verification of the terms of probation.

Ms. Wright suggested an update on the demographic study.

Dr. Levine suggested having a narrative of the changes to the VE and what the outcome of those changes/improvements will be.

Dr. Bholat requested a presentation on the training in medical schools/residencies regarding ethical conduct.

Ms. Choong, CMA, stated, pursuant to Government Code Section 11425.60 and procedures that the Board has adopted, they are suggesting that the Board consider and designate a certain decision as precedential. The decision in the Gary Igor Reyzin case dated March 22, 2015, be designated as precedential, as it contains significant legal and policy determinations of general applications that are likely to recur. She stated a written request would be provided to the Board to explain the reasons why they feel the decision should be designated as precedential.

Mr. Serrano Sewell thanked the Members for being there and the audience for attending, and also thanked Board staff for their work.

Agenda Item 26 Adjournment

Mr. Serrano Sewell adjourned the meeting at 12:35 PM.

_____ _____
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

July 28, 2016

compassion & choices

Care and Choice at the End of Life

DAVID R. GRUBE MD

NATIONAL MEDICAL DIRECTOR

COMPASSION AND CHOICES

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Goals

- Overview of **Medical Aid in Dying**
- Review ORS 127.8
- Review CA EOLO Act (ABX2 – 15)
- Compare the two State Laws
- Discuss the experience of the Oregon Health Authority and the Oregon Medical Board
- Consider future implications for MBC
- Q&A

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Sources

- Personal Experience
- State Epidemiologist – Oregon Health Authority
  - Katrina Hedberg MD
- Oregon Medical Board
  - Joseph Thaler MD – Medical Director
  - Kathleen Haley JD – Executive Director
- National Death With Dignity Center
  - George Eighmey JD - President

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"my hats…."

DRG – Personal Experience

Rural Family Practice (Philomath, OR - 38 years)

- DWD: ~ 30 patients (~ 15 Attending ; ~ 15 Consulting)

Oregon Medical Board (7 years)

(2 years as Chair / Interim *Pro Tem* Med. Dir.)

C&C National Medical Director (2 years)

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THE ART OF MEDICINE

To cure sometimes,

to relieve often,

to comfort always…

HIPPOCRATES

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End of Life Care:
What is the Licensee's role?

- To **Care** for the patient
- To **Teach** the patient/family
- To **Respect** the wishes of the patient
- To **Comfort** and **Alleviate** Suffering

compassion & choices

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End of life options:

- Full treatment
- Decline (some or all) treatments
  - Unwanted medical care
- Hospice/Palliative Care
- VSED ("*terminal fasting*")
- Terminal Sedation (in hospice)
- Medical Aid in Dying

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Not an EOL option….

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*The **Art** and **Science** of Medicine include:*

- Patient Autonomy
- Shared Medical Decision Making
- Professionalism
  - (Integrity *vs* Personal Beliefs)

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Medical Aid in Dying - USA

- Oregon – (referendum) 1997
- Washington – (referendum) 2009
- Montana (Supreme Court) 2009
- Vermont – (leg. vote) 2013
- California – (leg. Vote) 2016

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EOLO Act in California:
Patient Requests for Information

- ~ 250,000 deaths each year in California
  - ~ 34,000/yr in Oregon
- ~ 3,500 requests for information each year about Death with Dignity in OR
- Projection ?: **30,000-50,000/yr in CA**

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Oregon: Death with Dignity
(ORS 127.8)
California: End of Life Option Act
(ABX – 15)

- Laws are very similar
- Oregon has 18 years of data and experience
- California - ???

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THE OREGON EXPERIENCE 1997-2016

Death with Dignity

ORS 127.800-897

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ORS 127.800 – .897 "Death With Dignity:" caveats…

- Dignity is defined by the dying patient. (Dignity is <u>not</u> defined by the doctor, the hospice nurse, legislators, ethicists, medical boards, etc.)
- A person with a terminal illness may have a dignified death in many ways:
  - Choosing all or some treatments
  - Choosing no treatments
  - Choosing to have control of the "timing" of death

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ORS 127 .800 - .897

Death With Dignity Act (DWD)

An adult who is **capable**, is a **resident** of Oregon, and has been determined by the attending physician and consulting physician to be suffering from a **terminal disease**, and who has **voluntarily** expressed his or her wish to die, may make a written request for medication for the purpose of ending his or her life in a humane and dignified manner in accordance with ORS 127.800 - 127.897.

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ORS 127
Physician Components

- Two physicians
  - #1: Attending
  - #2: Consulting
    - Referral if psychiatric diagnosis uncovered
    - Both must affirm patient eligibility

(Not PA / NP / DC / ND)

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Attending Physician Responsibilities

- Two oral requests from patient
  (not necessarily in person)
  - At least **15** days apart
- Written request (after both doctor's eval.)
  - Signed by two witnesses
- Prescription may not be written until 48 hours <u>after</u> second oral request

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Physician Responsibilities

- Inform patient of feasible alternatives:
  - Hospice Care / Palliative Care / Pain Control
- Must request (but may not require) patient notify next of kin of Rx request

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Physician Responsibilities

- Both Prescribing and Consulting Physicians must complete Dept. of Human Services' (DHS) forms
- Prescribing Physician must inform DHS only if prescription is written
- Pharmacy must be informed of medication's intended use (1999)
- Follow-up form w/in 10 days of patient's death (rev. 2010)

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Statistics

(ORE. PUBLIC HEALTH DIV. ANNUAL REPORT 2/2016)

- 2015:
  - 218 DWDA prescriptions written
  - 132 DWDA deaths (61%)
  - (2014 = 155 / 105) (67%)
- Since 1997:
  - 1,545 DWDA prescriptions written
  - 991 DWDA deaths (64%)

(38.6/10,000 deaths)

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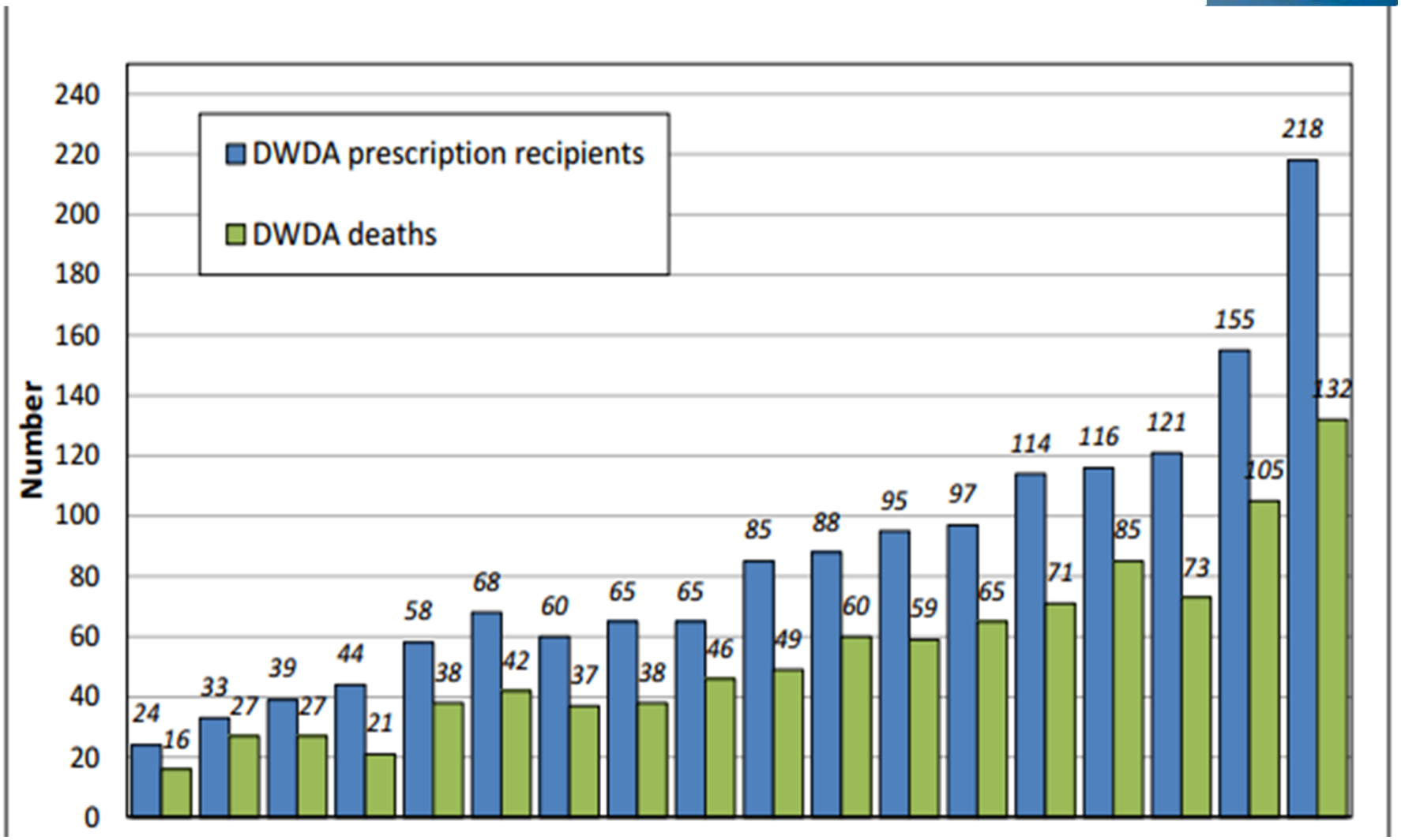

DWDA prescription recipients and deaths by year, Oregon, 1998-2016

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2015 - OR DWD

- 218 prescriptions by 106 physicians
  - 1 – 27 prescriptions
  - 5 referrals for mental health evaluation
- 92.2% in hospice
- 90% died at home
- 99% had health insurance

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Since 2010, Follow-up Questionnaire: to determine circumstances at death

- Only when physician or nurse present
- Voluntary
- Time to death (5 min – 34 hours)
- 2015 data: 27 cases
  - 14 physician
  - 13 nurse

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The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals

(March 1998; 4th Revision December 2008)

https://www.ohsu.edu/xd/education/continuing-education/center-for-ethics/ethics-outreach/upload/Oregon-Death-with-Dignity-Act-Guidebook.pdf

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The Oregon Death with Dignity Act: A Guidebook for Health Care Professionals

Chapter 12
Responding to Professional Non-Compliance

Guidelines

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Guidelines

- **12.1 -** Health professionals **must report** to the appropriate licensing and certifying board professionals who engage in medical **incompetence or unprofessional** conduct.
- **12.2 -** If there is a concern about the **conduct of a professional in another health care discipline**, there is an ethical obligation to act. There may be a requirement for institutional or professional board reporting.

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Guidelines - 2

- **12.3 -** If a health professional has **questions** about the appropriateness of a practice relative to comfort care or participation in the Oregon Death with Dignity Act, he/she should consult the staff of the appropriate licensing board for guidance.

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Guidelines - 3

- **12.4 -** Physicians and other health care providers with prescriptive authority need to ensure that patients receive sufficient dosages of appropriate medications for the relief of pain and suffering. The Oregon Medical Board encourages physicians to employ skillful and compassionate pain control for dying patients. The Oregon Medical Board investigates allegations of **under prescribing** for pain in the same manner as **over-prescribing**.

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Guidelines - 4

- **12.5 -** Licensees should not report another professional to the licensing board simply because the other professional has cooperated with the request for a prescription under the Oregon Act. The Oregon Medical Board does not consider **good faith compliance** with the Oregon Act unprofessional conduct.

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Oregon Health Authority

- Types of concerns
  - ‘Pure paperwork’ (vast majority)
    - Investigate and have Licensee correct
    - Refer to OMB if non-compliance
  - Possible violation of ORS 127.8
    - Refer to OMB
  - Approximately 2/year
  - No increase over last ten years in spite of increase in DWD cases

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Oregon Medical Board

- Review all OHA referrals
- "*Letter of Concern*" to Licensee if *apropos*
  - 1 - 2 per year
- Med. Dir. may request information/charts (rare)
- Open investigation for cases with concerns
  - No cases opened in last five years (more?)
- **<u>No disciplinary actions by OMB in 18 years of ORS 127.8</u>**

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EOLO Act – CA (vs.) DWD Act – OR

- Residency (specific*)
- Attending Physician
  - Responsible for checklists
  - **Must see patient alone**
- Consulting Physician
  - "Independent" (*sic*)
- 48 Hour Attestation Form
- Language Interpreter (forms)
- Death Certificate ?
  (10 YEAR SUNSET)

- Residency (non-specific**)
- Attending Physician
  - Forms
- Consulting Physician
  - Forms
- Prescription
  - Not electronic or FAX
- Death Certificate
  - Cannot list DWD

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California EOLO Act

- 443.5 (a) Before prescribing an aid-in-dying drug, the attending physician shall do … the following:
- …Confirm that the individual is making an informed decision … by discussing with him or her … the feasible alternatives or additional treatment options including, but not limited to, … **hospice care, (and) palliative care** ...

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California EOLO Act

- 443.5 (cont'd)
- (5) Counsel the qualified individual about the importance of … the following:
- (A) Having another person present when he or she ingests the aid-in-dying drug prescribed ….
- (B) Not ingesting the aid-in-dying drug in a public place.
- (C) Notifying the next of kin of his or her request for an aid-in-dying drug. (A qualified individual who declines or is unable to notify next of kin shall not have his or her request denied for that reason).
- (D) **Participating in a hospice program.**
- (E) Maintaining the aid-in-dying drug in a safe … location

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443.14. … a person shall not be subject to civil, criminal, administrative, employment, or contractual liability or professional disciplinary action for participating in good faith compliance with this part, including an individual who is present when a qualified individual self-administers the prescribed aid-in-dying drug.

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Attending Physician – Definitions:

- Oregon: "Attending physician" means the physician who has primary responsibility for the care of the patient and treatment of the patient's terminal disease.
- California: “Attending physician” means the physician who has primary responsibility for the health care of an individual and treatment of the individual’s terminal disease.

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Consultant – Definition

- Oregon: "Consulting physician" means a physician who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding the patient's disease.
- California: “Consulting physician” means a physician who is **independent** from the attending physician and who is qualified by specialty or experience to make a professional diagnosis and prognosis regarding an individual’s terminal disease.

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Attestation Form (CA only)

Within 48 hours prior to the individual self-administering the aid-in-dying drug, the individual shall complete the final attestation form. ….. the completed form shall be delivered by the individual's health care provider, family member, or other representative to the attending physician to be included in the patient's medical record.

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Barriers for Citizens
(Social Justice)

- LACK OF EDUCATION (of both citizens and licensees)
- OR: process cannot often, in reality, be completed in 15 days; median time for DWD is 48 days
- OR: some communities (Roseburg) have no licensees who participate
- Medical providers opposed to the law have provided patients with misinformation or delayed the patient from starting the process until it is too late

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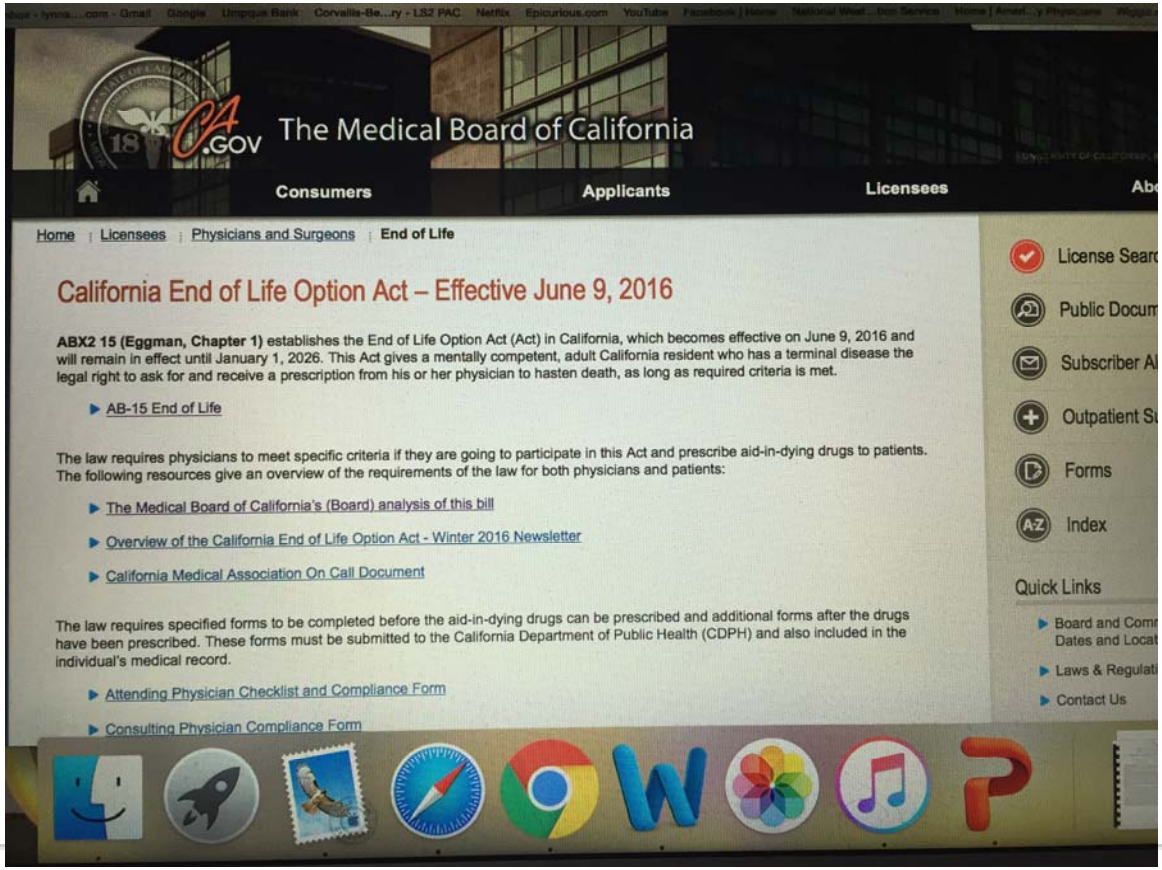
Medical Board of California



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What might be the MBC potential concerns

- The ***intent of the law***, and how to deal with Licensee's who violate it
- "Pure paper" complaints – what to do?
  - e.g. "Attestation Form"
- Dealing with complaints
  - Legitimate and non-legitimate
- Responding to opponents

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Endoflifeoption.org

- Website includes:
  - A policy library for navigating health systems across the state **(FIND CARE)**
  - Videos and fact sheets for physicians, pharmacists, and patients
  - Information in both English and Spanish

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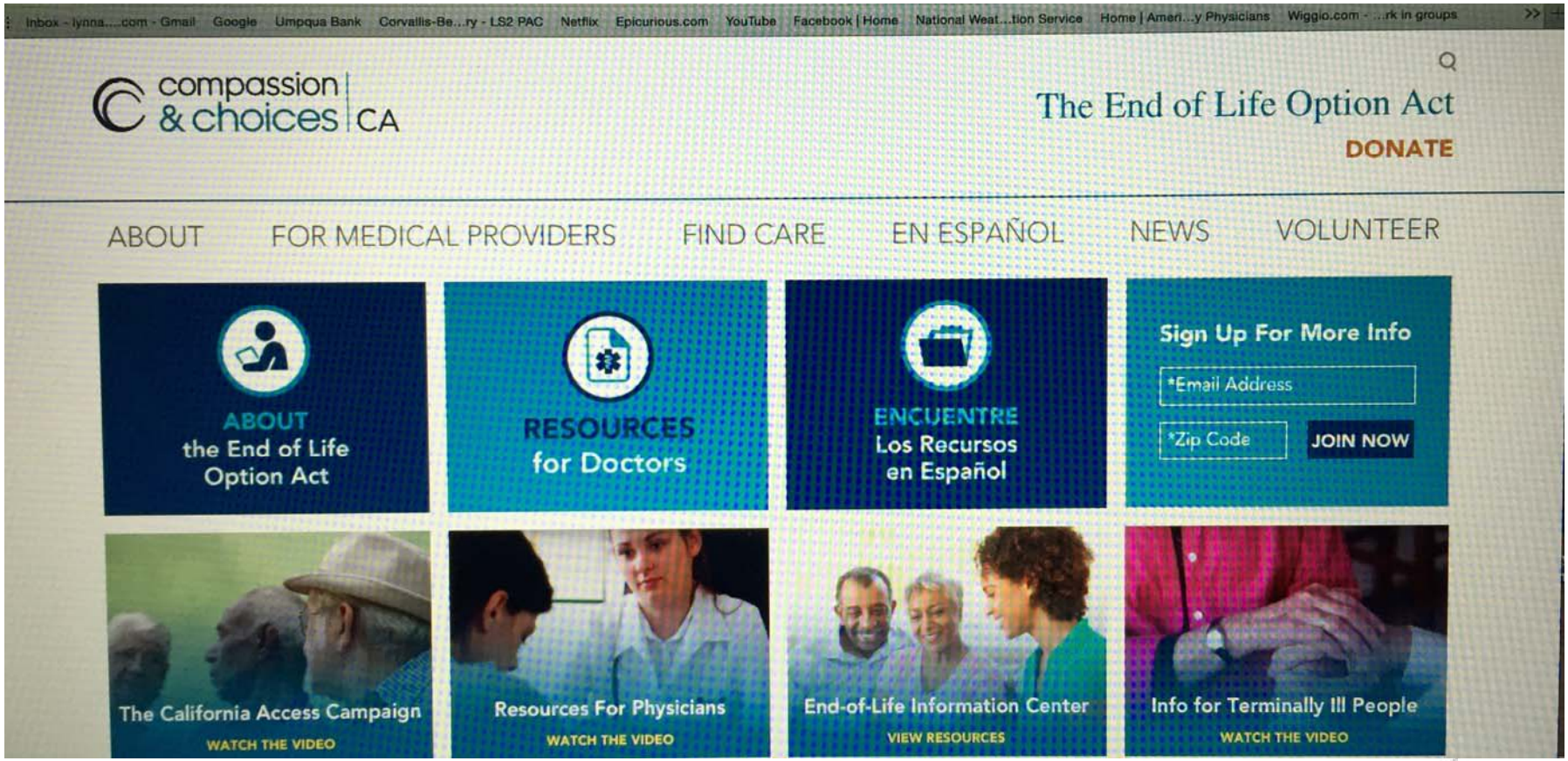
www.endoflifeoption.org



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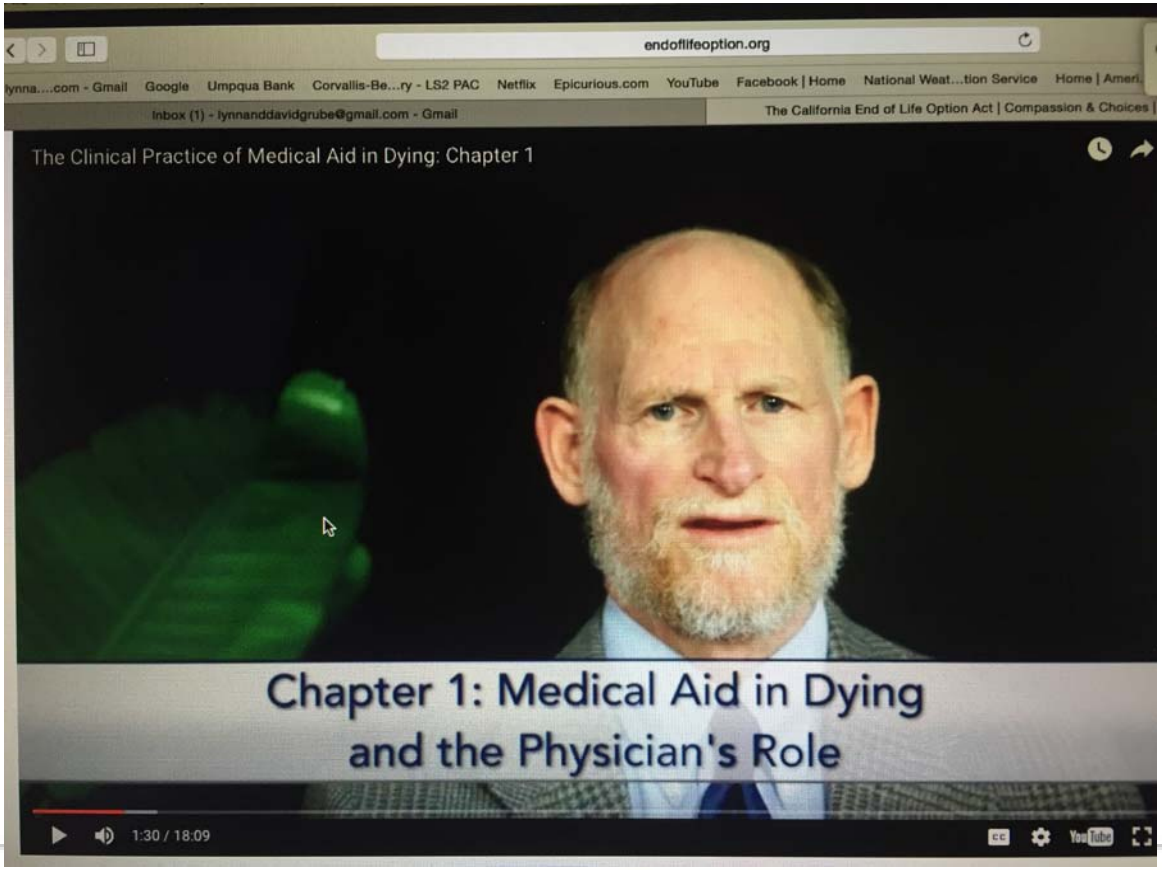
Chapter 1



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Chapter 2

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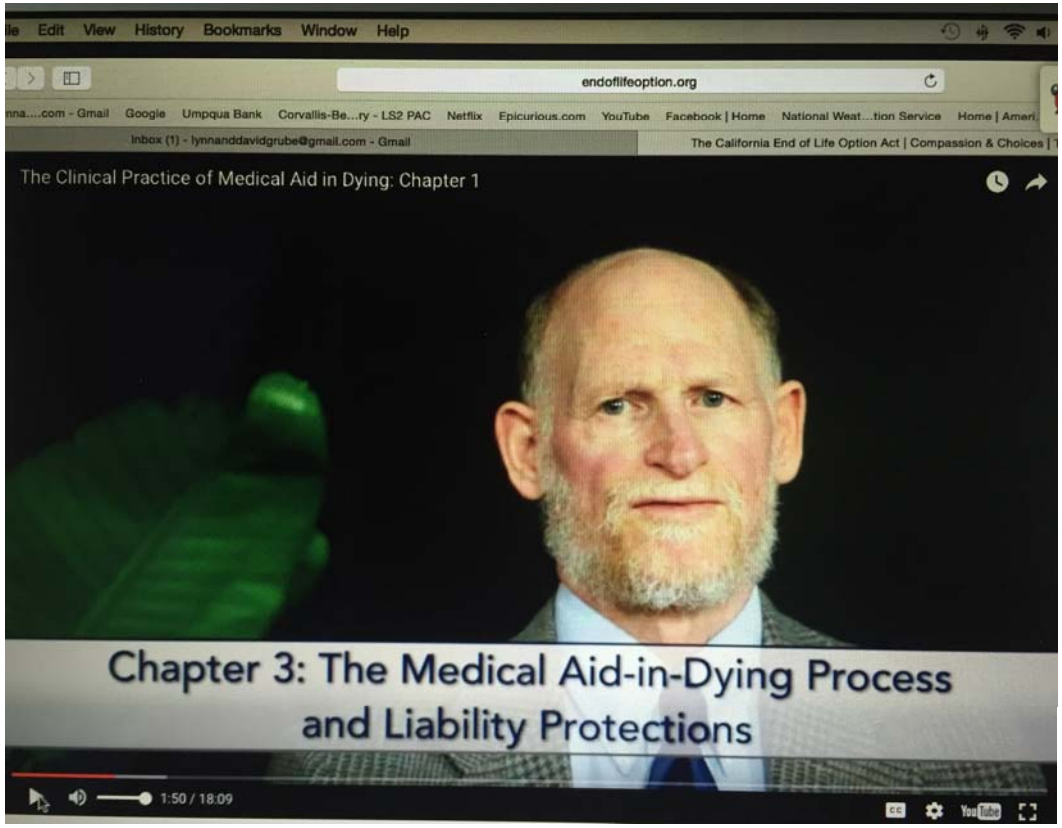
Chapter 3



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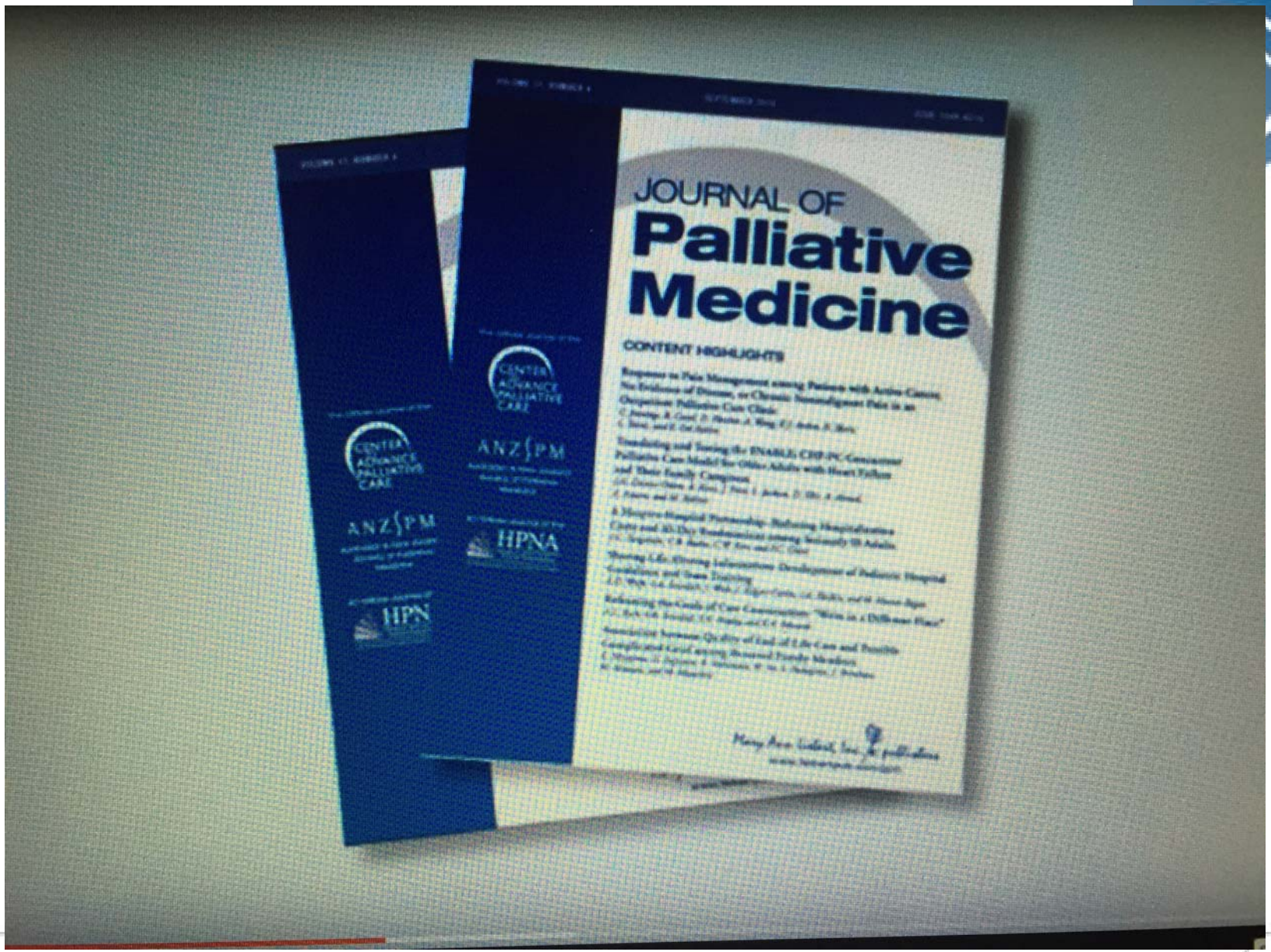

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JOURNAL OF PALLIATIVE MEDICINE
Volume 18, Number X, 2015
DOI: 10.1089/jpm.2015.0092

Clinical Criteria for Physician Aid in Dying

David Orentlicher, MD, JD,[1] Thaddeus Mason Pope, JD, PhD,[2] and Ben A. Rich, JD, PhD[3];
Physician Aid-in-Dying Clinical Criteria Committee

1) How to respond to a patient's request for medical aid in dying
2) How to assess patient decision making capacity
3) How to address other significant issues

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Conclusions (OR)

- Medical aid in dying is not commonly used
- There are barriers and the law is not necessarily easy to navigate
- The OMB has not uncovered licensees who have violated the intent of the law
- The unexpected consequences are good:
  - Improved end of life care, no “slippery slope,” no abuse of disabled, poor, etc.

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One does not ask of one who suffers: What is your country and what is your religion?

One merely says: You suffer, this is enough for me: you belong to me and I shall help you.

LOUIS PASTEUR MD 1886

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Resources: Compassion and Choices

- www.endoflifeoption.org
- YouTube:

  The Clinical Practice of Medical Aid in Dying (all six chapters)
- Doc2Doc **1-800-247-7241**
- California Hotline **1-800-893-4548**

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BOARD PRESIDENT'S REPORT

DATE REPORT ISSUED: July 12, 2016
ATTENTION: Members, Medical Board of California (Board)
SUBJECT: President's Report – Thank you!

Dear Members,

As my term as Board President comes to a close, this report is an opportunity to reflect on the good work we have done, my priorities, and to share a few thoughts on the work ahead.

First, I want to thank each of you for allowing me to serve as President and Vice President. It has been an honor. Our state is fortunate to have this Board at this moment, comprised of citizens with the highest degree of talent, ethics, dedication to its consumer protection mission, and respect for the public.

Notable Accomplishments

We have done much to be proud of, but I want to highlight a few accomplishments:

- Implementing the Uniform Standards for Substance-Abusing Licensees.
- Drafting the Board's *Guidelines for Prescribing Controlled Substances for Pain* to guide physicians on the prescribing of opioids; it is a model used by others.
- Sponsoring pro-consumer legislation, such as:
    - Public disclosure laws so that disciplinary documents with significant discipline remain on the Board's website as long as the documents are public, rather than ten years as previously required.
    - Enhancing the laws for outpatient surgery settings, including requiring peer review of all physicians in these settings.
- "Legislative Days" in Sacramento. For two years, Board members and staff have met directly with key Legislators to hear their concerns, discuss the Board's function, and to answer questions. It has been a great success.
- Taking a proactive (and judicious) role in the complaint process, moving from a purely complaint driven stance, especially as it relates to opioid prescribing.
- Investigating unnecessary psychotropic medication prescribing to foster care children by executing a data use agreement with the Department of Health Care Services and the California Department of Social Services to obtain physicians' prescribing information, an action noted by the Legislature.

Priorities

As Board President, I sought to focus on three items. And, through the hard work of the Board and staff, we have made positive progress.

Interim Suspension Orders (ISO)
The length of time to issue an ISO is too long and there are too few ISOs being granted. We heard about this issue at a Board meeting. It is my understanding that a forthcoming report will indicate that the number of ISOs has more than doubled in the past fiscal year and that the length of time from the receipt of the complaint to the issuance of the ISO has significantly decreased.

Physician Health Program

Over the years, numerous bills on this issue have been introduced and failed. In my view, something needed to be done.

After meetings with interested parties, the Board adopted a set of guiding principles that such a program would have to meet to gain the Board's support. The Board provided the guidance to the public and the Legislature for a physician health program.

Public Outreach

The final area that I really felt needed to be discussed and developed was the Board's outreach program to increase awareness of the Board and its website.

The Board's Public Outreach, Education, and Wellness Committee has done a great job and we made great progress. I know the Members will be proud of the work done to date.

On a related issue, while Board President, the important issue of patient notification by a physician on probation was brought to the Board's attention.

Although the Board denied the petition regarding this issue, I established a Patient Notification Task Force (Task Force) to look into the issues. After the Task Force's first meeting, Senate Bill 1033 (Hill), which would have required physicians to notify their patients that they were on probation, was introduced. The Task Force did not meet while the issue was being addressed through the legislative process. However, this bill did not proceed.

During discussions at the Task Force and during the Board meetings, several alternatives and ideas originating from this proposal were brought forward. Clearly, the work of the Task Force is not complete.

Because this is such an important issue to the Board and the public, I have assigned (in consultation with Ms. Kirchmeyer) those issues to the appropriate Board Committees, rather than continue with a separate Task Force. By doing so, we will get more input from the Members. Mrs. Kirchmeyer will discuss Committee assignments under her report.

I wish the Board and staff the best and continued success.

Sincerely,

David Serrano Sewell
Board President

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 12, 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 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, staffing, and retention concerns.
- 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 attends monthly meetings with the California Department of Public Health (CDPH) 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 has met with numerous legislative offices, with both Members and their staff, to provide updates, discuss pending legislation, and provide education on the Board's functions.
- Board Members and Staff met with Legislative Members and their staff during the Board's 2nd Annual Legislative Day.
- Board staff has had several meetings with DCA executive staff and interested parties on the implementation of Business and Profession Code section 853, which is the Licensed Physicians and Dentists from Mexico Pilot Program. In addition, staff met with the Governor's Office staff regarding this program and its funding and implementation.
- Board staff, DOJ-CURES staff, and CDPH staff have been meeting to discuss the joint survey that will be sent out to all physicians with an expiration date of November 30, 2016. This survey will ask questions regarding the CURES program, physician's usage of the system, and suggestions for improvement.
- Board staff had a teleconference with CDPH staff and several County Health Officers regarding the medical exemption for vaccinations and the Board's enforcement process.
- Board staff had a teleconference with the Centers for Disease Control and Prevention (CDC) to discuss the CDC Guideline for Prescribing Opioids for Chronic Pain and its dissemination. Part of the discussion was the differences between CDC Guidelines and the Board's Guidelines for prescribing controlled substances for pain, and how the CDC and Board need to work together on the opioid epidemic.
- Board staff met with staff from the Senate Business, Professions, and Economic Development Committee and interested parties to discuss proposed legislation for data reporting by outpatient surgery settings.
- Board staff provided a presentation to the California Medical Assistants Association regarding their scope of practice.
- 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 met with interested parties regarding the End of Life Option Act and the definition of an "attending physician."
- Board staff met with staff from the Ventura County Environmental Health Division regarding scarification and the Medical Practice Act.
- Board staff gave a presentation to the American Academy of Psychiatry and Law on the Board's enforcement process.
- Board staff met with the California Research Bureau to receive an update on the demographic study.
- 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 continues to meet with representatives from the CDPH, 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 160.6 permanent full-time positions (in addition to temporary staff). The Board is at a 5% vacancy rate which equates to 8 vacant positions. This is .6% higher than the vacancy rate that was provided in the last Administrative Summary, which was 4.4%.

Budget Update

The Board's budget documents are attached, beginning on page BRD 7A-5 and continuing to page BRD 7A-17. BRD 7A-5 contains an excerpt of the budget that was signed by the Governor, which specifically identifies the Board's budget for FY 16-17. Included in the FY 16-17 budget are four budget change proposals (BCP) that were approved. The first BCP is to add one Associate Governmental Program Analyst to the Board's Central Complaint Unit to assist with the duties associated with adverse event reports received from outpatient surgery settings and the workload associated with the processing of this report. The funding for this position is $113,000 for FY 16-16 and $105,000 in ongoing fiscal years. The second BCP will add $206,000 to the Board's expert reviewer line item due to the need for additional funding. The third and fourth BCPs were submitted by the DCA and were for $577,000 for the AG's office due to SB 467,which required reporting to the Legislature by the AG's office, and a $39,000 decrease in the budget due to the movement of the Registered Dispensing Optician Program to the Board of Optometry.

The Board's fund condition on page BRD 7A-6 identifies the Board's fund reserve at 3.6 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-7 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 May 31, 2016 can be found on page BRD 7A-8. Pages BRD 7A-9 to 7A-13 show the budget report, specifically for licensing, enforcement, the HQIU, and the AG expenditures. Page BRD 7A-17 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. Requests designed to streamline the physician and surgeon renewal process for licensees renewing online and Board staff processing deficiencies are pending an investigative analysis (Resource/Cost Estimate) from the vendor before a final vote by the BreEZe Change Control Board. Currently, staff is working on requests to redesign the physician and surgeon postgraduate training authorization letter and initial applications based on the modifications to the paper applications recently finalized by licensing staff. These improvements will make these online functions more user-friendly to applicants and licensees as well as make deficiency processing and resolution clearer to the applicants and licensees and more efficient for Board staff.

Controlled Substance Utilization Review and Evaluation System (CURES) Update

During the month leading up to July 1, 2016, the Board worked with the DOJ to identify all physicians who had registered in CURES and then sent weekly reminders, via email, to all licensees who were not registered. In addition, the Board sent out subscriber's list notices and Tweets. The Board also put a countdown on the Board's home page, which counted down the minutes to July 1, 2016.

The Board is currently working with the DOJ to identify physicians who have a DEA registration but have not registered in the CURES system. The Board will send out notices to those who have not registered via email (for those who have an email on file with the Board). For those that do not have an email, the Board may be sending them a postcard notification.

The Board continues to receive calls from physicians who are trying to register for CURES and have been unable to do so. During the week leading up to July 1, 2016, numerous phone calls were received. Board staff assisted physicians in the registration process when possible, or referred them to DOJ for additional assistance.

The Board is working on a FAQ to go into the Summer Newsletter to assist physicians on understanding CURES and what information is available. The Board will use the questions it has received through telephone calls to the Board and via webmaster to put the FAQs together.

Patient Notification Task Force

As stated by Mr. Serrano Sewell in the President's Report (BRD 5-2), the alternatives and ideas from the Patient Notification Task Force will be assigned to the appropriate Board Committee. There were four main topics that came from the Task Force discussion.

The first two are the need for the Board to ensure the public is aware of the Board and to have a website that provides as much information as legally available for the public via a user-friendly system. This issue is currently being discussed and directed by the Public Outreach, Education, and Wellness Committee and the Department of Consumer Affairs (DCA) and Board staff. As previously indicated, the outreach campaign is moving forward and has made significant strides in reaching the public about the Board and the necessity to check the website for information regarding a physician. The DCA, with assistance from Board staff, is working to develop a new license lookup system that will be more user friendly and will provide the information in a manner that is easier for the public to access.

The third issue that was raised is the need for more information on the signage required pursuant to Business and Professions Code section 138. This sign, pursuant to this section of law, informs patients that the physician is licensed and regulated by the Board and provides contact information for the Board. However, it does not include any additional information, such as directing individuals to file a complaint or to check the website to

look up the physician's license status. As determined by the Board staff, in order for the Board to require more information be placed on the sign, this would require a legislative change. Therefore, the Board requested this issue be brought up in the Board's Sunset Review report as an issue where the legislature could assist the Board with new legislation for consumer protection.

Finally, the Board discussed the current terms and conditions in the Board's disciplinary guidelines and the possibility of a condition to require physicians to have to notify their patients that they are on probation. If the Board were to list the notification requirement as an optional condition, the Board could review the circumstances of the case, and in those cases where it is believed such notification would be in the interest of consumer protection, could require such notification. Certain circumstances, such as multiple probations, could be reasons to require such a notification. It would be the Board's ultimate decision as to whether the physician would be required to provide such a notification. The Board understands what a serious issue this is and wants to give it a full discussion to determine the mechanics of how such a notification may be implemented without unintended consequences. This issue will be assigned to the Board's Enforcement Committee, which will discuss and consider all options and consequences to determine how regulations could be promulgated.

Board of Pharmacy

On pages BRD 7A-18 to 7A-19 is an update from the Board of Pharmacy's Executive Officer. The Board and the Board of Pharmacy are continuing their collaboration on issues of mutual interest and will continue to provide reports at each other's board meetings.

Item		Amount
Provisions:		
1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.		
1111-001-0755—For support of Medical Board of California, payable from the Licensed Midwifery Fund....		14,000
Schedule:		
(1) 1150038-Licensed Midwifery Program.....	14,000	
Provisions:		
1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.		
1111-001-0757—For support of California Architects Board, payable from the California Architects Board-Landscape Architects Fund.....		1,014,000
Schedule:		
(1) 1105020-Landscape Architects Technical Committee.....	1,015,000	
(2) Reimbursements to 1105020-Landscape Architects Technical Committee.....	−1,000	
Provisions:		
1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.		
1111-001-0758—For support of Medical Board of California, payable from the Contingent Fund of the Medical Board of California.....		63,216,000
Schedule:		
(1) 1150019-Medical Board of California—Support.....	64,438,000	
(2) 1150013-Medical Board of California—Distributed.....	−838,000	
(3) Reimbursements to 1150019-Medical Board of California—Support....	−384,000	
Provisions:		
1. The amount appropriated in this item may include revenues derived from the assessment of fines and penalties imposed as specified in Section 13332.18 of the Government Code.		
1111-001-0759—For support of Physical Therapy Board of California, payable from the Physical Therapy Fund.....		5,224,000

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	$ 28,087	$ 19,185	$ 15,194	$ 5,978
Prior Year Adjustment	$ 515	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 28,666	$ 28,087	$ 19,185	$ 15,194	$ 5,978
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	$ 81,356	$ 78,487	$ 70,458	$ 59,242
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1110 Program Expenditures (State Operations)	$ 55,090	$ 59,661	$ 59,865	$ 61,132	$ 61,132
2015-16 and Ongoing Approved Costs					
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)
Anticipated Future Costs					
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)	$ 4	$ -	$ -	$ -	$ -
8880 Financial Information System for California (State Operations)	$ 48	$ 107	$ 77	$ -	$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	$ 55,142	$ 62,171	$ 63,293	$ 64,480	$ 64,480
Unscheduled Reimbursements		$ 900	$ 900	$ 900	$ 900
FUND BALANCE					
Reserve for economic uncertainties	$ 28,087	$ 19,185	$ 15,194	$ 5,978	$ (5,238)
Months in Reserve	5.4	3.6	2.8	1.1	-1.1

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	$ 28,087	$ 19,185	$ 15,194	$ 3,978
Prior Year Adjustment	$ 515	$ -	$ -	$ -	$ -
Adjusted Beginning Balance	$ 28,666	$ 28,087	$ 19,185	$ 15,194	$ 3,978
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, TRANSFERS AND OTHER ADJUSTMENTS	$ 54,563	$ 53,269	$ 53,302	$ 53,264	$ 53,264
TOTAL RESOURCES	$ 83,229	$ 81,356	$ 72,487	$ 68,458	$ 57,242
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1110 Program Expenditures (State Operations)	$ 55,090	$ 59,661	$ 59,865	$ 61,132	$ 61,132
2015-16 and Ongoing Approved Costs					
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)
Anticipated Future Costs					
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)	$ 4	$ -	$ -	$ -	$ -
8880 Financial Information System for California (State Operations)	$ 48	$ 107	$ 77	$ -	$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	$ 55,142	$ 62,171	$ 63,293	$ 64,480	$ 64,480
Unscheduled Reimbursements		$ 900	$ 900	$ 900	$ 900
FUND BALANCE					
Reserve for economic uncertainties	$ 28,087	$ 19,185	$ 9,194	$ 3,978	$ (7,238)
Months in Reserve	5.4	3.6	1.7	0.7	-1.5

NOTES:

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

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report
(As of May 31, 2016)
(92% 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	7,864,399	83.3	1,582,165
Board Members	31,500	66,900	212.4	(35,400)
Temp Help	755,880	140,482	18.6	615,398
BL 12-03 Blanket	0	570,693	0.0	(570,693)
Overtime	44,441	96,200	216.5	(51,759)
Staff Benefits	5,213,036	4,413,012	84.7	800,024
TOTALS, PERS SERVICES	15,491,421	13,151,687	84.9	2,339,734
OPERATING EXP & EQUIP				
Fingerprint Reports	333,448	324,545	97.3	8,903
General Expense	204,206	264,363	129.5	(60,157)
Printing	194,755	240,027	123.2	(45,272)
Communications	106,190	107,159	100.9	(969)
Postage	149,511	83,323	55.7	66,188
Insurance	2,053	8,056	392.4	(6,003)
Travel In-State	130,298	153,097	117.5	(22,799)
Travel Out-of-State	0	6,420	0.0	(6,420)
Training	54,895	11,834	21.6	43,061
Facilities Operation (Rent)	928,140	1,083,533	116.7	(155,393)
Consult/Prof Services	1,317,088	1,154,833	87.7	162,255
Departmental Prorata	6,473,849	6,473,849	100.0	0
HQIU	16,871,000	12,149,009	72.0	4,721,991
Consolidated Data Center	650,230	116,881	18.0	533,349
Data Processing	117,492	240,467	204.7	(122,975)
Central Admin Svcs (Statewide Prorata)	2,912,000	2,912,000	100.0	0
Major Equipment	8,500	0	0.0	8,500
Other Items of Expense	0	0	0.0	0
Vehicle Operations	31,925	20,754	65.0	11,171
Attorney General Services	13,347,280	11,964,322	89.6	1,382,958
Office of Administrative Hearings	1,750,080	870,020	49.7	880,060
Evidence/Witness	1,893,439	1,423,708	75.2	469,731
Court Reporter Services	225,000	189,974	84.4	35,026
Minor Equipment	35,200	54,302	154.3	(19,102)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	47,736,579	39,852,476	83.5	7,884,103
TOTALS, EXPENDITURES	63,228,000	53,004,163	83.8	10,223,837
Scheduled Reimbursements	(384,000)	(362,508)	94.4	(21,492)
Distributed Costs	(780,000)	(436,000)	55.9	(344,000)
TOTAL, STATE OPERATIONS	62,064,000	52,205,655	84.1	9,858,345
Unscheduled Reimbursements*	0	(1,776,140)		
		50,429,514		

** no authority to spend*

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Licensing
(As of May 31, 2016)
(92% 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	2,328,815	86.3	369,360
Board Members	0	0	0.0	0
Temp Help	48,396	18,543	38.3	29,853
BL 12-03 Blanket	0	58,053	0.0	(58,053)
Overtime	21,716	44,311	204.0	(22,595)
Staff Benefits	1,404,032	1,360,180	96.9	43,852
TOTALS, PERS SERVICES	4,172,319	3,809,902	91.3	362,417
OPERATING EXP & EQUIP				
Fingerprint Reports	333,448	323,547	97.0	9,901
General Expense	22,381	23,103	103.2	(722)
Printing	92,627	96,628	104.3	(4,001)
Communications	19,647	18,401	93.7	1,246
Postage	72,495	44,009	60.7	28,486
Insurance	0	0	0.0	0
Travel In-State	17,179	17,912	104.3	(733)
Travel Out-of-State	0	5,080	0.0	(5,080)
Training	18,207	495	2.7	17,712
Facilities Operation (Rent)	269,758	355,000	131.6	(85,242)
Consult/Prof Services	794,091	1,038,484	130.8	(244,393)
Departmental Prorata	2,147,167	2,147,167	100.0	0
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	965,816	100.0	0
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	29,959	102.6	(770)
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	5,073,583	105.8	(279,700)
TOTALS, EXPENDITURES	8,966,202	8,883,485	99.1	82,717
Scheduled Reimbursements	(384,000)	(362,508)	94.4	(21,492)
Distributed Costs	(31,131)	(16,337)	52.5	(14,794)
TOTAL, STATE OPERATIONS	8,551,071	8,504,640	99.5	46,431
Unscheduled Reimbursements*	0	(20)		
		8,504,620		

** no authority to spend*

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report - Enforcement
(As of May 31, 2016)
(92% 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	2,210,130	85.9	363,977
Board Members	0	0	0.0	0
Temp Help	608,589	2,059	0.3	606,530
BL 12-03 Blanket	0	489,441	0.0	(489,441)
Overtime	10,281	28,001	272.4	(17,720)
Staff Benefits	1,619,426	1,315,865	81.3	303,561
TOTALS, PERS SERVICES	4,812,403	4,045,496	84.1	766,907
OPERATING EXP & EQUIP				
Fingerprint Reports	0	978	0.0	(978)
General Expense	69,470	90,210	129.9	(20,740)
Printing	43,898	56,802	129.4	(12,904)
Communications	40,015	38,344	95.8	1,671
Postage	74,371	37,227	50.1	37,144
Insurance	0	0	0.0	0
Travel In-State	39,017	53,228	136.4	(14,211)
Travel Out-of-State	0	874	0.0	(874)
Training	15,087	5,184	34.4	9,903
Facilities Operation (Rent)	294,072	312,620	106.3	(18,548)
Consult/Prof Services	479,560	113,154	23.6	366,406
Departmental Prorata	1,779,197	1,779,197	100.0	0
HQIU	16,871,000	12,149,009	72.0	4,721,991
Consolidated Data Center	0	60	0.0	(60)
Data Processing	15,045	22,059	146.6	(7,014)
Central Admin Svcs (Statewide Prorata)	800,300	800,300	100.0	0
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	11,934,363	89.6	1,383,728
Office of Administrative Hearings	1,750,080	870,020	49.7	880,060
Evidence/Witness	1,736,958	1,331,236	76.6	405,722
Court Reporter Services	224,750	189,974	84.5	34,776
Minor Equipment	4,863	4,359	89.6	504
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	37,555,774	29,789,198	79.3	7,766,576
TOTALS, EXPENDITURES	42,368,177	33,834,694	79.9	8,533,483
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	(744,054)	(414,591)	55.7	(329,463)
TOTAL, STATE OPERATIONS	41,624,123	33,420,103	80.3	8,204,020
Unscheduled Reimbursements*	0	(250,399)		
		33,169,704		

** no authority to spend*

Health Quality Investigation Unit (HQIU)
Fiscal Year 2015-16
Budget Expenditure Report
(As of May 31, 2016)
(92% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,177,000	6,031,942	73.8	2,145,058
Temp Help	1,074,000	1,325,009	123.4	(251,009)
Overtime	6,000	28,070	467.8	(22,070)
Staff Benefits	4,644,000	3,588,240	77.3	1,055,760
BL 12-03 Blanket	0	7,397	0.0	(7,397)
TOTALS, PERS SERVICES	**13,901,000**	**10,980,657**	**79.0**	**2,920,343**
OPERATING EXP & EQUIP				
General Expense	214,000	266,535	124.5	(52,535)
Printing	69,000	55,663	80.7	13,337
Communications	172,000	106,489	61.9	65,511
Postage	36,000	25,630	71.2	10,370
Insurance	38,000	45,099	118.7	(7,099)
Travel In-State	222,000	126,181	56.8	95,819
Travel Out-of-State	7,000	0	0.0	7,000
Training	27,000	20,423	75.6	6,577
Facilities Operation (Rent)	1,574,000	1,517,509	96.4	56,491
Consult/Prof Services	91,000	57,857	63.6	33,143
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	202,551	1350.3	(187,551)
Data Processing	0	58,642	0.0	(58,642)
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	90,815	324.3	(155,938)
Vehicle Operations	216,000	183,938	85.2	216,000
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	37,823	0.0	(37,823)
Court Reporter Services	0	388,934	0.0	(388,934)
Minor Equipment	8,000	148,531	1856.6	(140,531)
Special Items of Expense	0	180	0.0	(180)
TOTALS, OE&E	**2,916,000**	**3,332,799**	**114**	**(325,984)**
TOTALS, EXPENDITURES	16,817,000	14,313,456	85.1	2,503,544
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	0	0	0.0	0
NET TOTAL, EXPENDITURES	**16,817,000**	**14,313,456**	**85.1**	**2,503,544**
Unscheduled Reimbursements*	0	0	0.0	0

** no authority to spend*

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 2015-16
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
Page 1 of 2

		Number of Hours	Rate	Amount
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			$0.00
				$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			$2,773.85
				$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			$7,132.90
				$1,088,017.65
October	Attorney Services	6094.00	$170.00	$1,035,980.00
	Paralegal Services	352.75	$120.00	$42,330.00
	Auditor/Analyst Services	213.25	$99.00	$21,111.75
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$399.94
				$1,099,821.69
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			$2,729.50
				$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			$8,075.75
				$984,544.25

Total July-Dec =	**$6,221,956.19**
FY 2015-16 Budget =	**$13,318,091.00**

MEDICAL BOARD OF CALIFORNIA
ATTORNEY GENERAL EXPENDITURES - FY 2015-16
DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)
page 2 of 2

		Number of Hours	Rate	Amount
January	Attorney Services	5498.25	$170.00	$934,702.50
	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			$1,735.60
				$1,002,162.10
February	Attorney Services	6321.25	$170.00	$1,074,612.50
	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			$2,936.12
				$1,144,282.87
March	Attorney Services	7077.50	$170.00	$1,203,175.00
	Paralegal Services	274.00	$120.00	$32,880.00
	Auditor/Analyst Services	220.00	$99.00	$21,780.00
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$1,824.70
				$1,259,659.70
April	Attorney Services	6468.00	$170.00	$1,099,560.00
	Paralegal Services	316.25	$120.00	$37,950.00
	Auditor/Analyst Services	212.75	$99.00	$21,062.25
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$1,992.72
				$1,160,564.97
May	Attorney Services	6361.25	$170.00	$1,081,412.50
	Paralegal Services	322.25	$120.00	$38,670.00
	Auditor/Analyst Services	235.25	$99.00	$23,289.75
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$2,365.15
				$1,145,737.40
June	Attorney Services	0.00	$170.00	$0.00
	Paralegal Services	0.00	$120.00	$0.00
	Auditor/Analyst Services	0.00	$99.00	$0.00
	Special Agent	0.00	$120.00	$0.00
	Cost of Suit			$0.00
				$0.00

FYTD Total = $11,934,363.23
FY 2015-16 Budget = $13,318,091.00

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	0	100		550
Criminal Cost Recovery	451	4,851	7,581	1,100	1,400	2,400	3,188	4,607	551	4,789	551		31,469
Probation Monitoring	74,221	54,139	42,860	44,930	62,069	102,916	359,823	222,613	91,728	64,230	68,510		1,188,039
Exam	9,593	5,778	1,922	16,948	5,721	11,506	10,926	16,650	6,225	10,617	8,165		104,051
Cite/Fine	0	0	0	0	0	0	2,500	700	5,000	2,850	1,050		12,100
MONTHLY TOTAL	84,315	64,818	52,413	63,028	69,190	116,922	376,437	244,620	103,604	82,486	78,376	0	1,336,209
FYTD TOTAL	84,315	149,133	201,546	264,574	333,764	450,686	827,123	1,071,743	1,175,347	1,257,833	1,336,209	1,336,209	

excel:enfreceiptsmonthlyprofile.xls.revised 6/13/2016

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

MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 12/13								
$ Budgeted	2,132,008	39,300,606	525,515	6,399,247	1,570,587	3,754,162	2,239,391	55,921,516
$ Spent *	1,762,058	37,058,493	672,700	5,770,689	1,671,010	3,001,574	720,484	50,657,008 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 13/14								
$ Budgeted	2,304,466	40,127,776	716,147	8,386,914	1,833,855	3,363,720	2,281,227	59,014,105
$ Spent*	1,427,599	40,148,898	879,418	6,023,718	1,650,434	3,166,541	1,424,973	54,721,581 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 14/15								
$ Budgeted	1,909,018	45,230,270		6,502,878	1,576,586	3,154,922	2,065,009	60,438,683
$ Spent*	1,517,922	40,108,425		8,845,645	1,413,056	2,745,722	2,276,725	56,907,495 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1
FY 15/16								
$ Budgeted **	2,000,070	41,624,123		8,551,071	2,312,598	3,969,970	3,606,168	62,064,000
$ Spent thru 5/31*	1,865,750	33,420,103		8,504,640	2,175,943	3,068,116	3,171,103	52,205,655 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1

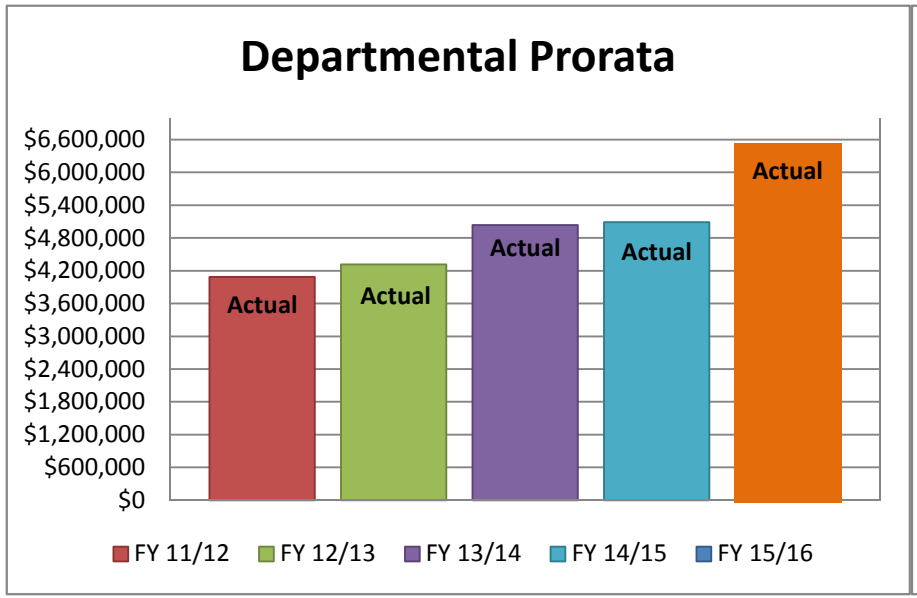
** net expenditures (excludes unscheduled reimbursements)*

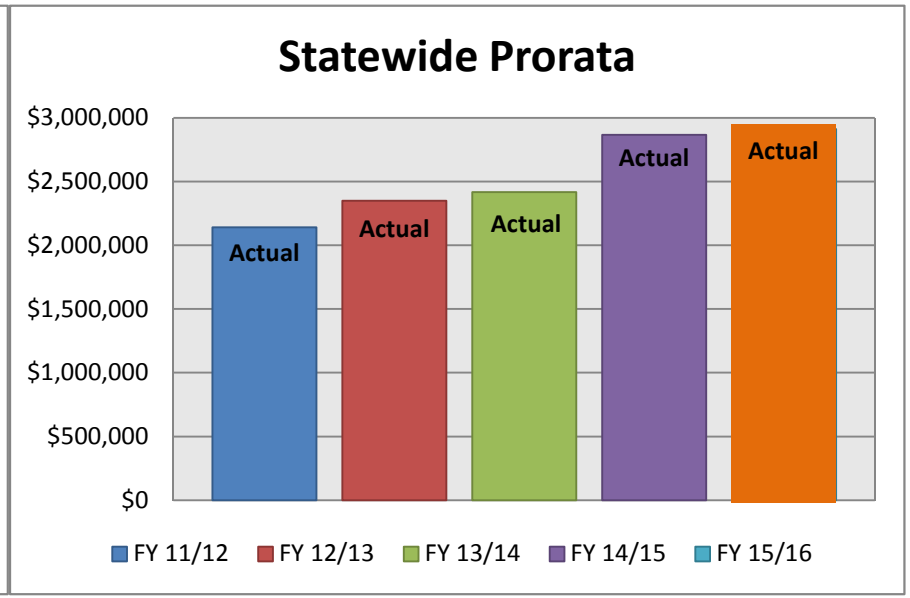
*** Budgeted does not include pending current year budget adjustments.*

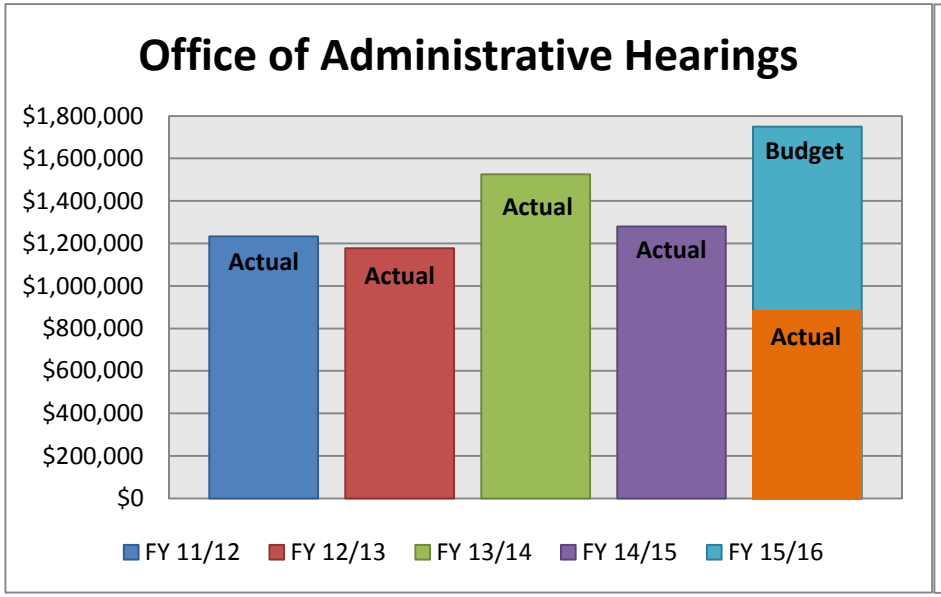
6/27/2016

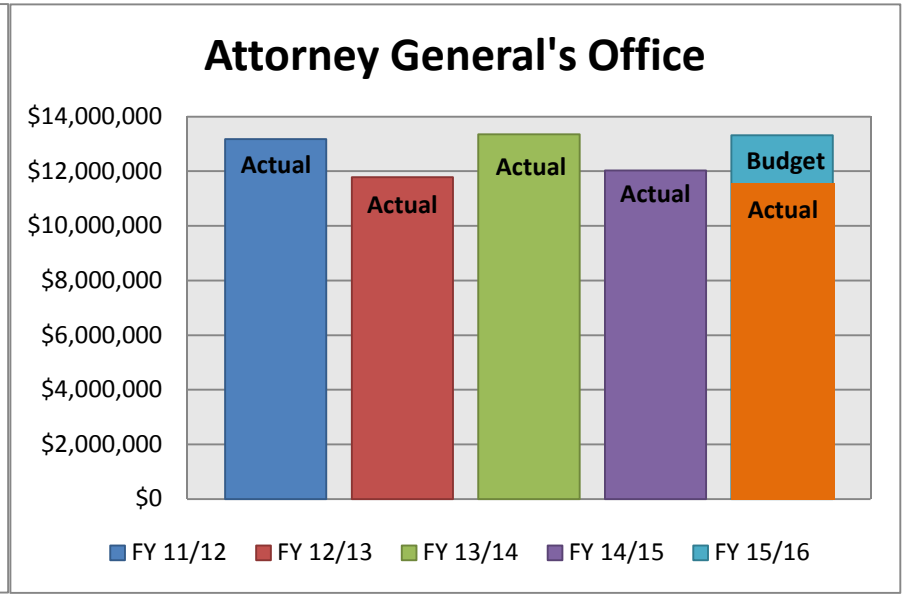
Budget Overview by Program.xlsx

External Agencies' Spending









FY 15/16 actual expenditures through 5/31/16

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

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BHOLAT - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total-Dr. Bholat	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**
DR. BISHOP - Per diem	$ 800	$ 600	$ 700	$ 600	$ 400	$ 700	$ 800	$ 400	$ 500	$ -	$ -	$ -	$ 5,500
Travel	$ 880	$ -	$ -	$ 54	$ -	$ -	$ 892	$ -	$ -	$ -	$ 575	$ -	$ 2,401
Total-Dr. Bishop	$ 1,680	$ 600	$ 700	$ 654	$ 400	$ 700	$ 1,692	$ 400	$ 500	$ -	$ 575	$ -	**$ 7,901**
JUDGE FEINSTEIN - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500	$ 1,100	$ 1,100	$ -	$ 2,700
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total-Judge Feinstein	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 500	$ 1,100	$ 1,100	$ -	**$ 2,700**
DR. GNANADEV - Per diem	$ 1,000	$ 1,000	$ 1,000	$ 1,200	$ 700	$ 900	$ 700	$ 1,100	$ 600	$ 500	$ -	$ -	$ 8,700
Travel	$ 962	$ -	$ -	$ 610	$ 480	$ -	$ -	$ -	$ -	$ 1,334	$ -	$ -	$ 3,387
Total-Dr. Gnanadev	$ 1,962	$ 1,000	$ 1,000	$ 1,810	$ 1,180	$ 900	$ 700	$ 1,100	$ 600	$ 1,834	$ -	$ -	**$ 12,087**
DR. HAWKINS - Per diem	$ 1,700	$ 1,000	$ 1,800	$ 1,500	$ 1,000	$ 1,700	$ 2,000	$ 1,800	$ 1,500	$ 1,500	$ 2,100	$ -	$ 17,600
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total-Dr. Hawkins	$ 1,700	$ 1,000	$ 1,800	$ 1,500	$ 1,000	$ 1,700	$ 2,000	$ 1,800	$ 1,500	$ 1,500	$ 2,100	$ -	**$ 17,600**
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	$ 600	$ 900	$ 700	$ -	$ 4,000
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total-Ms. Lawson	$ -	$ -	$ -	$ -	$ -	$ 300	$ 1,000	$ 500	$ 600	$ 900	$ 700	$ -	**$ 4,000**
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	$ 400	$ 1,100	$ 1,300	$ -	$ 9,700
Travel	$ 751	$ -	$ -	$ 657	$ -	$ 659	$ 612	$ 939	$ -	$ 1,411	$ 1,057	$ -	$ 6,087
Total-Dr. Lewis	$ 1,751	$ 700	$ 800	$ 1,757	$ 400	$ 1,359	$ 1,712	$ 2,039	$ 400	$ 2,511	$ 2,357	$ -	**$ 15,787**
MS. PINES - Per diem	$ 1,300	$ 1,100	$ 1,100	$ 1,400	$ 900	$ 800	$ 1,200	$ 800	$ 1,100	$ 1,000	$ 1,200	$ -	$ 11,900
Travel	$ 729	$ -	$ -	$ 615	$ -	$ -	$ 825	$ -	$ -	$ -	$ 611	$ -	$ 2,780
Total-Ms. Pines	$ 2,029	$ 1,100	$ 1,100	$ 2,015	$ 900	$ 800	$ 2,025	$ 800	$ -	$ -	$ -	$ -	**$ 14,680**
MS. SCHIPSKE - Per diem	$ 1,000	$ 500	$ 700	$ 1,100	$ 200	$ 800	$ 500	$ 800	$ 900	$ 100	$ -	$ -	$ 6,600
Travel	$ -	$ -	$ -	$ 579	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 579
Total-Ms. Schipske	$ 1,000	$ 500	$ 700	$ 1,679	$ 200	$ 800	$ 500	$ 800	$ -	$ -	$ -	$ -	**$ 7,179**
MR. SERRANO SEWELL- Per diem	$ 600	$ 600	$ 600	$ 600	$ 500	$ 500	$ 600	$ 500	$ 300	$ -	$ -	$ -	$ 4,800
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ 266	$ -	$ -	$ -	$ 605	$ -	$ 872
Total-Mr. Serrano Sewell	$ 600	$ 600	$ 600	$ 600	$ 500	$ 500	$ 866	$ 500	$ -	$ -	$ -	$ -	**$ 5,672**
MS. SUTTON-WILLS - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,400	$ 1,500	$ -	$ 2,900
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 541	$ 66	$ -	$ 607
Total-Ms. Sutton-Wills	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 3,507**
MR. WARMOTH - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 600	$ 1,000	$ 800	$ -	$ 2,400
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 1,159	$ -	$ 1,089	$ -	$ 2,248
Total-Mr. Warmoth	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ 4,648**
MS. WRIGHT - Per diem	$ 1,500	$ 1,300	$ 1,600	$ 1,300	$ 1,000	$ 800	$ 1,200	$ 1,000	$ 400	$ 800	$ 400	$ -	$ 11,300
Travel	$ 922	$ -	$ -	$ 541	$ -	$ -	$ 637	$ -	$ -	$ -	$ -	$ -	$ 2,100
Total-Ms. Wright	$ 2,422	$ 1,300	$ 1,600	$ 1,841	$ 1,000	$ 800	$ 1,837	$ 1,000	$ -	$ -	$ -	$ -	**$ 13,400**
MS. YAROSLAVSKY - Per diem	$ -	$ 1,300	$ 1,000	$ 1,400	$ -	$ 1,200	$ 1,400	$ 800	$ -	$ -	$ -	$ -	$ 7,100
Travel	$ 924	$ -	$ -	$ 608	$ -	$ 482	$ 866	$ -	$ -	$ -	$ -	$ -	$ 2,880
Total-Ms. Yaroslavsky	$ 924	$ 1,300	$ 1,000	$ 2,008	$ -	$ 1,682	$ 2,266	$ 800	$ -	$ -	$ -	$ -	**$ 9,980**
DR. YIP - Per diem	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Travel	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Total-Dr. Yip	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	**$ -**

As of: 6/27/16

TOTAL PER DIEM BUDGETED	$ 31,500
TOTAL PER DIEM	$ 98,800
TOTAL TRAVEL	$ 25,336
TOTAL	**$ 124,136**

California State Board of Pharmacy
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www.pharmacy.ca.gov

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

July 13, 2016

To: Members, Medical Board of California

From: Board of Pharmacy
Virginia Herold, Executive Officer

Subject: Update on Activities

It is my pleasure to resume information sharing activity reports between the Medical Board and Board of Pharmacy. The board also looks forward to resuming an active collaboration between our boards in the coming months.

1. Sunset Review: The board is undergoing the sunset review process this year. A four-year extension in our sunset date to 2021 is currently proposed in SB 1193. The bill is currently in the Assembly Appropriations Committee.

2. Implementation of State-Developed Protocols for Pharmacists: The board has fully promulgated the regulations creating protocols for pharmacists to provide specific services to patients. We again thank the Medical Board for its collaboration and approval of the three state protocols put in place since early 2015:
   - Provision of Naloxone
   - Nicotine Replacement Products
   - Self-Administered Hormonal Contraception

3. Compounding and Sterile Compounding: The board has completed work on a major overhaul of compounding and sterile compounding regulations for pharmacies. The rulemaking file for these expanded requirements is currently undergoing review by the Business, Consumer Services and Housing Agency, and we hope to have these requirements in effect January 1, 2017. Work is underway in educating our licensees about the requirements, and developing a process for hospitals and other health systems that plan to develop structural modifications to comply with requirements in the regulations.

   On the horizon are two additional elements that will trigger modified regulations in this area in the next few years: Major changes in United States Pharmacopoeia (USP) section 797, which is the FDA's main component for regulating compounding in pharmacies, and USP section 800 which deals with hazardous drugs. These will be long-term projects for us.

4. Licensure of Outsourcing Facilities: The board is also seeking statutory authorization for a new licensure category for a new form of compounder, the outsourcing facility. Outsourcing facilities were created in late 2013 by the federal Drug Quality Security Act, and perform large-scale compounding services more similar to those of drug manufacturers than to that of pharmacies. The board hopes to be able to issue permits for California and out of state outsourcing facilities in January 2017. The primary purchasers of these compounded products are hospitals.

5. Prescription Drug Abuse: The board's Prescription Drug Abuse Subcommittee completed its work last summer, and ongoing activities involving CURES implementation, public and licensee education and enforcement initiatives are now being performed by the board's Enforcement and Compounding Committee and the Communication and Public Education Committee.

   The board performed aggressive outreach to pharmacists to ensure registration of pharmacists in CURES by July 1, including two mailings to pharmacists who were not seemingly registered in CURES. Pharmacists who are registered to access CURES are using the system: according to data provided by the DOJ in June, "dispensers" accessed CURES reports 377,000 times in the prior month.

Thank you for this opportunity to provide a Pharmacy Board update to the Medical Board. It has been my pleasure to share this information.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 8, 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:
There are currently 1082 active experts in the Board's expert database. 171 experts were utilized to review 256 cases from January 1 through June 30, 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
- Colon and Rectal Surgery
- Dermatology
- Family Medicine
- Midwife Reviewer
- Neurological Surgery
- Neurology
- OB/Gyn
- Pathology
- Pain Medicine
- Pediatric Cardiac Surgery
- Pediatric Pulmonology
- Plastic Surgery
- Psychiatry (general and addiction)
- Surgery
- Urology
- Vascular Surgery

The Expert Reviewer Program analysts have begun to devote time to recruiting new experts into the program, to include but not limited to, recruiting individuals that work in the aforementioned specialty fields of medicine. A recruitment plan was developed, and the plan will be presented at the July Board Meeting during the Enforcement Committee Meeting.

The analysts have also begun efforts to finalize the details for the next two Expert Reviewer trainings. Training at the University of California, San Francisco (UCSF) will take place on Saturday, October 8, 2016. Training in Southern California is tentatively scheduled to take place on either October 15 or November 5, 2016. Staff has been working to secure a location to hold the training at either the University of California, Los Angeles (UCLA) or University of Southern California (USC). Staff will send "save the date" invites to all existing experts by August 1, 2016.

Central Complaint Unit (CCU):
The CCU has shown a steady improvement following the restructure and reorganization of the unit. In this last quarter of fiscal year 2015/2016, CCU management and staff were able to focus all efforts on reducing initiation and case processing timeframes.

CCU intake staff was able to maintain their average of 15-days to initiate a complaint. While still five days over the timeframe mandated by Business and Professions Code section 129(b), management expects this requirement will be met and maintained, by next quarter following the hiring of the additional MST that will be assigned to initiate complaints.

The average time to process a complaint is currently 146 days, down 16-days from the average of 162 days reported in the third quarter. Heading into the new fiscal year, management has already begun to identify ways to improve the overall processing timeframes. For example, an unnecessary system activity code was eliminated from the case initiation process and supervisors have been meeting with each staff person to monitor pending complaints to ensure timely completion of the workload.

The CCU has three vacant positions: a Management Services Technician (MST), a Limited Term Staff Services Analyst (SSA), and an Associate Governmental Program Analyst (AGPA). The MST recruitment has been completed and this individual is scheduled to report to work on July 18, 2016. The SSA and AGPA positions have been advertised and interviews for these positions will be conducted by the end of July.

Discipline Coordination Unit (DCU):
Staff in the Discipline Coordination Unit continues to focus their efforts on restoring public disclosure documents to the Board's website to ensure compliance with Assembly Bill 1886. Since the last Enforcement Summary provided at the May 2016 Board Meeting, a retired annuitant (RA) and two student assistants were hired to help finalize the project and are making good progress. With the RA and students on board, staff that was redirected to assist with this assignment has returned to their regular duties.

The Discipline Coordination Unit has two vacant positions: a SSA and an AGPA. Both positions have been advertised and management anticipates interviews will be conducted mid-August.

Complaint Investigation Office (CIO):
The CIO non-sworn Special Investigators continue to monitor a case load of approximately 55 cases. Since the last Enforcement Summary provided at the May 2016 Board meeting, CIO has closed 54 cases and has transmitted 16 cases to the Attorney General's Office – 8 criminal conviction cases, 4 Petitions for Reinstatement of licensure, 4 Petitions for Early Termination/Modification of probation. Management is evaluating case procedures with the goal of reducing overall processing timeframes.

The Petitions for Modification and/or Early Termination of Probation requests were redirected back to the Probation Unit effective June 1, 2016, now that Probation filled its vacant analyst position. The Complaint Investigation Office is fully staffed.

Probation Unit:
Effective July 1, 2016, the Probation Unit implemented two new Performance Measures (PM): PM07 and PM08. PMs are statistical data that is reported to the Department of Consumer Affairs (DCA) and is intended to capture how long it takes staff to complete workload activities. PM07 and PM08 are specific to

probation. PM07 will capture the timeframe of when a probation Inspector is assigned a case to when the Inspector makes the initial telephone call to the probationer to set up the face-to-face intake interview.

PM08 will capture the timeframe of when a probation Inspector confirms/supports with evidence that a violation of a term and condition of probation may have occurred, to when management has provided approval for appropriate action to be taken for the violation of probation.

Management continues to review Probation Unit policies and procedures to ensure optimal efficiency of the unit. For fiscal year 15/16, the number of Cease Practice Orders (CPO), Petitions to Revoke Probation (PTR), and Accusations/Petitions to Revoke Probation have increased since fiscal year 14/15 and demonstrates the good efforts of staff to action when a violation of probation occurs.

	Fiscal Year 14/15	Fiscal Year 15/16
Cease Practice Orders Issued	9	14
PTR/Accusation and PTR - Transmitted	20	36
PTR/Accusation and PTR - Filed	21	29

The Probation Unit has two vacant Inspector positions. A tentative job offer was made to fill one Inspector position and this individual's employment date is pending the results of the candidate's fingerprint and health evaluation clearances. Management is reviewing the applications received for the other Inspector position and anticipates conducting interviews at the beginning of August. The Probation North Unit hired an AGPA in May 2016, and this analyst is assigned to monitor 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 Public Reprimand. In addition, two Inspector Supervisors have been out on extended leave since the beginning of the year and their anticipated return is unknown; for the time being, the Probation Managers have resumed the responsibilities carried out by the supervisors.

Medical Board of California
Expert Reviewer Program Report

July 1, 2016

SPECIALTY	**Number of Cases reviewed by Experts** January 1 through June 30, 2016	**Number of Experts and how often Utilized** from January 1 through June 30, 2016	**Active List Experts** 1,082 ↑
ADDICTION	4	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	11 ↑
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes)	1	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	79 ↓
COLON & RECTAL SURGERY (CRS)	5	2 EXPERTS 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	2
COMPLEMENTARY/ALTERNATIVE MEDICINE **2 WERE COMPANION CASES (SAME SUBJECT)*	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 CASE REVIEWED BY 2 EXPERTS	5	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	45 ↑
FAMILY (FM) * - 5 CASES, BUT 4 CASES WERE COMPANION CASES ** - 8 CASES REVIEWS & 3 PREPARATION FOR HEARING	50	22 EXPERTS 11 LIST EXPERTS REVIEWED 1 CASE EACH 4 LIST EXPERTS REVIEWED 2 CASES 4 LIST EXPERTS REVIEWED 3 CASES 1 LIST EXPERT REVIEWED 4 CASES 1 LIST EXPERT REVIEWED 5 CASES * 1 LIST EXPERT REVIEWED 11 CASES **	60 ↓
HAND SURGERY			12
HOSPICE & PALLIATIVE MEDICINE			14
INTERNAL (General Internal Med) 1 CASE REVIEWED BY 2 EXPERTS	40	30 EXPERTS 21 LIST EXPERTS REVIEWED 1 CASE EACH 7 LIST EXPERTS REVIEWED 2 CASES EACH 2 LIST EXPERTS REVIEWED 3 CASES EACH	154 ↑
Cardiovascular Disease (Cv)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	32
Endocrinology, Diabetes and Metabolism (EDM)	1	1 EXPERT 1 LIST EXPERT	6
Gastroenterology (Ge)	4	4 EXPERT 4 LIST EXPERT REVIEWED 1 CASE EACH	19
Infectious Disease (Inf)			8

Medical Board of California
Expert Reviewer Program Report

July 1, 2016

SPECIALTY	**Number of Cases reviewed by Experts** January 1 through June 30, 2016	**Number of Experts and how often Utilized** from January 1 through June 30, 2016	**Active List Experts** 1,082 ↑
Medical Oncology (Onc)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	11
Nephrology (Nep)	2	2 EXPERTS 2 LIST EXPERT	11
Pulmonary Disease (Pul)			16
Rheumatology (Rhu)			6
MIDWIFE REVIEWER	2	1 EXPERT 1 LIST EXPERT REVIEWED 2 CASES	4
NEUROLOGICAL SURGERY (NS)	3	3 EXPERTS 3 LIST EXPERTS	10
NEUROLOGY (N)	6	6 EXPERTS 6 LIST EXPERTS REVIEWED 1 CASE EACH	20
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			3
NUCLEAR MEDICINE (NuM)			4
OBSTETRICS & GYNECOLOGY (ObG) 1 CASE REVIEWED BY 2 EXPERTS	16	12 EXPERTS 9 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES	68 ↑
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	30
OTOLARYNGOLOGY (Oto)			18
PAIN MEDICINE (PM)	20	12 EXPERTS 7 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH 3 LIST EXPERTS REVIEWED 3 CASES EACH	26 ↓
PATHOLOGY (Path)	2	2 EXPERTS 2 LIST EXPERTS	11↓

Medical Board of California
Expert Reviewer Program Report

July 1, 2016

SPECIALTY	**Number of Cases reviewed by Experts** January 1 through June 30, 2016	**Number of Experts and how often Utilized** from January 1 through June 30, 2016	**Active List Experts** 1,082 ↑
PEDIATRICS (Ped)	4	4 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EACH	47
Pediatric Cardiology (Cd)	1	1 EXPERT 1 LIST EXPERT	5
Pediatric Emergency Medicine (PEM)			3
Pediatric Endocrinology (En)			1
Pediatric Gastroenterology (Ge)			5
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)			11
PLASTIC SURGERY (PIS) *2 CASE REVIEWED BY 2 EXPERTS*	16	10 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH 3 LIST EXPERTS REVIEWED 3 CASES EACH	43 ↑
PSYCHIATRY (Psyc) *4 CASES REVIEWED BY 2 EXPERTS* *6 cases = * Expert '1' is 4 mental exams, 1 case review and 1 supplemental work. Expert '2' is 3 mental exams, 3 case reviews and 1 testimony work* *7 cases = **Expert performed 4 mental exams, 2 case reviews and 1 supplemental work.* *8 cases = *** Expert performed 6 mental exams and 2 case reviews*	62	33 EXPERTS 21 LIST EXPERTS REVIEWED 1 CASE EACH 4 LIST EXPERTS REVIEWED 2 CASES EACH 3 LIST EXPERTS REVIEWED 3 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 6 CASES EACH* 1 LIST EXPERT REVIEWED 7 CASES** 1 LIST EXPERT REVIEWED 8 CASES***	70 ↑
RADIOLOGY (Rad)	4	3 EXPERT 2 LIST EXPERTS REVIEWED 2 CASES EACH 1 LIST EXPERT REVIEWED 2 CASES	29
Radiation Oncology (Rad RO)			5
SLEEP MEDICINE (S)			7
SURGERY (S)	10	6 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH 4 LIST EXPERTS REVIEWED 2 CASES EACH	27

Medical Board of California
Expert Reviewer Program Report

July 1, 2016

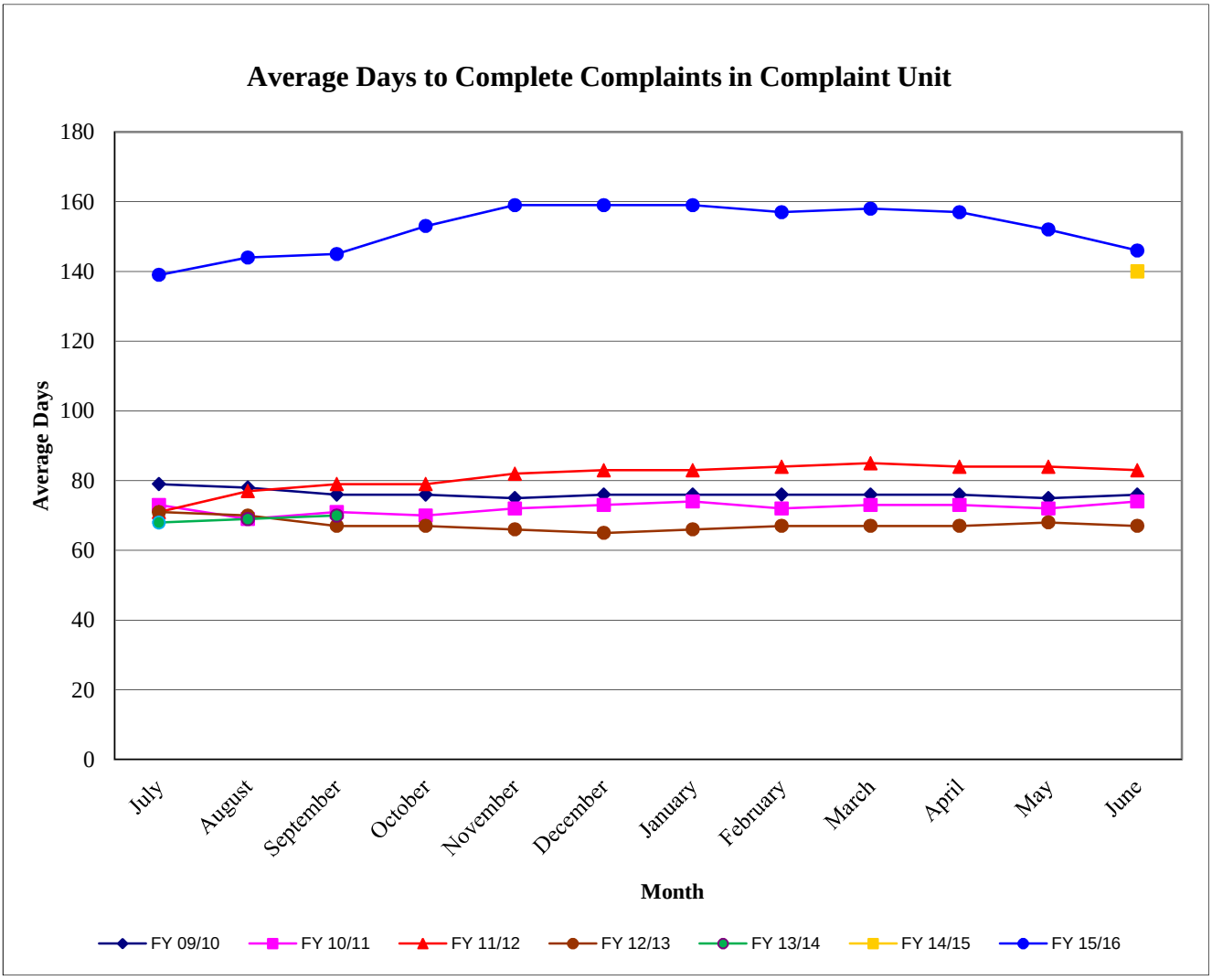
SPECIALTY	**Number of Cases reviewed by Experts** January 1 through June 30, 2016	**Number of Experts and how often Utilized** from January 1 through June 30, 2016	**Active List Experts** 1,082 ↑
Pediatric Surgery (PdS)	1	1 EXPERT 1 LIST EXPERT	2
Vascular Surgery (VascS)	3	2 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6
THORACIC SURGERY (TS)			9
Pediatric Cardiothoracic Surgery	1	1 EXPERT 1 OFF-LIST EXPERT	0
(*MEDICAL) TOXICOLOGY*			7
UROLOGY (U)	5	4 EXPERT 3 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERTS REVIEWED 2 CASES	12 ↓

TOTAL CASES REVIEWED (Jan. - June 2016)	**256**
TOTAL EXPERTS UTILIZED (Jan. - June 2016)	**171**
TOTAL ACTIVE LIST EXPERTS (7/1/2016)	**1082**

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

Medical Board of California Enforcement Program
Average Days to Complete Complaint in Complaint Unit

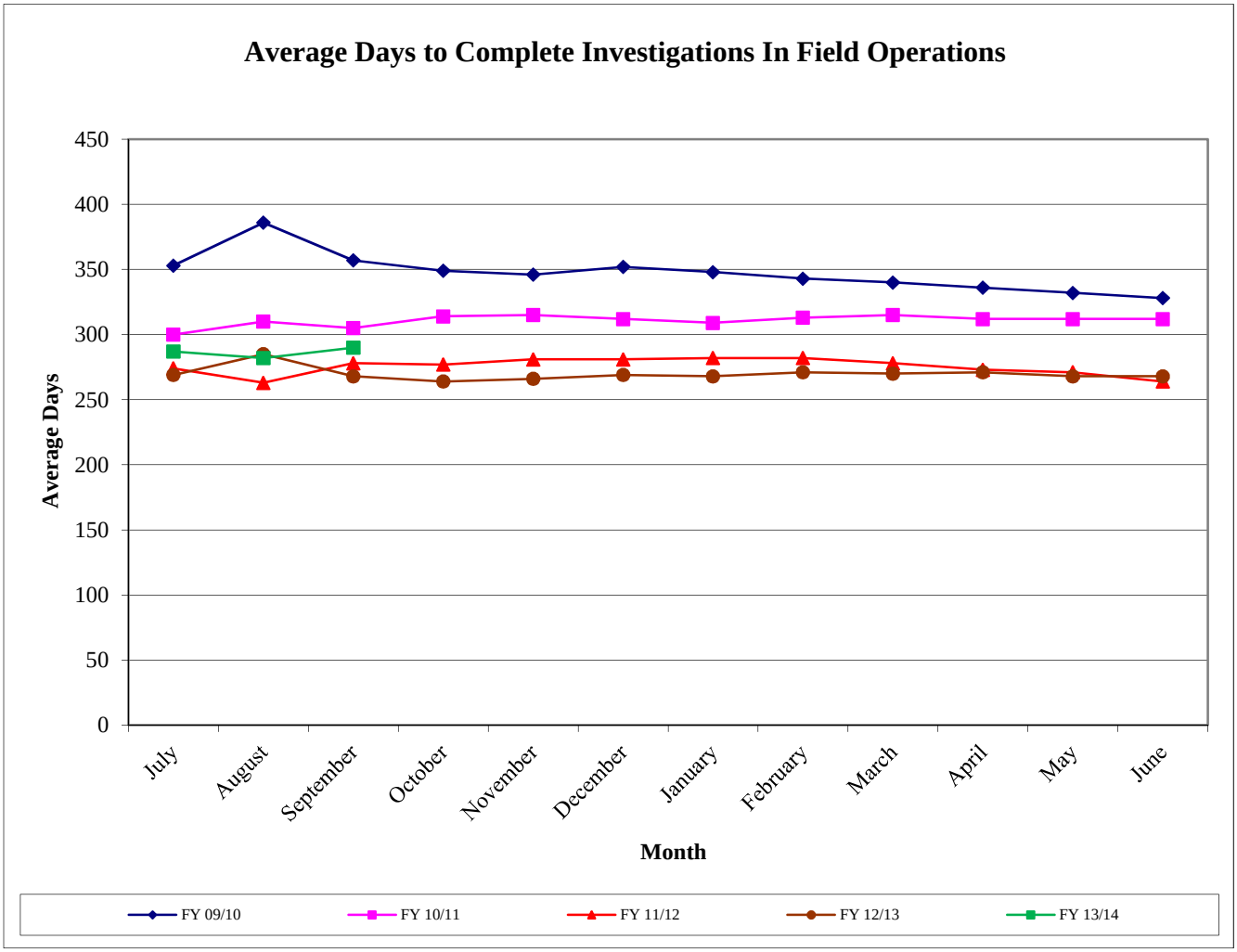
Month	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
July	79	73	71	71	68		139
August	78	69	77	70	69		144
September	76	71	79	67	70		145
October	76	70	79	67			153
November	75	72	82	66			159
December	76	73	83	65			159
January	76	74	83	66			159
February	76	72	84	67			157
March	76	73	85	67			158
April	76	73	84	67			157
May	75	72	84	68			152
June	76	74	83	67		140	146



Average Days to Complete Complaints in Complaint Unit includes complaints resolved by Complaint Unit and Complaint Unit processing days for cases completed at field investigation.

Medical Board of California Enforcement Program
Average Days to Complete Investigations in Field Operations

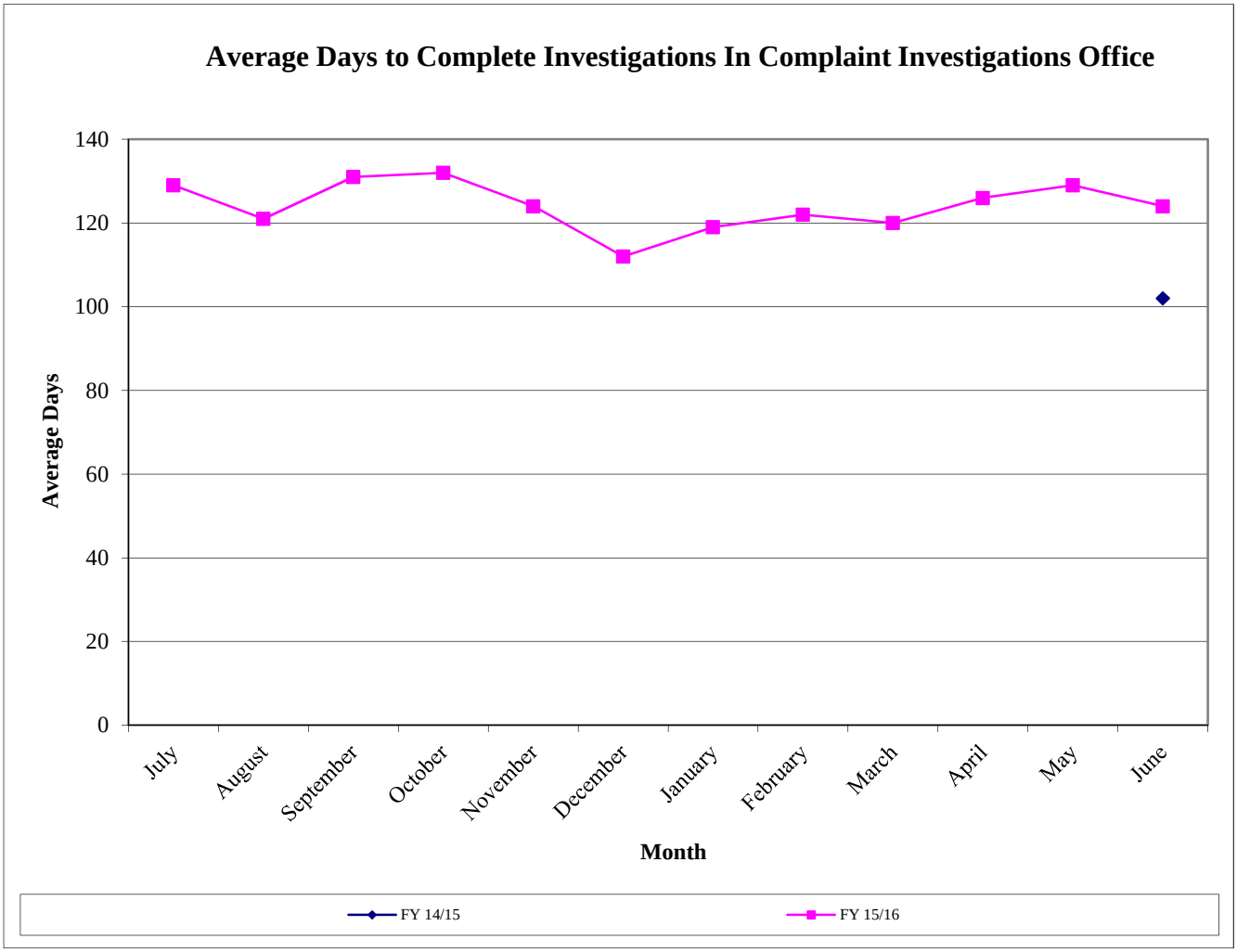
Month	Fiscal Year FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14
July	353	300	274	269	287
August	386	310	263	285	282
September	357	305	278	268	290
October	349	314	277	264	
November	346	315	281	266	
December	352	312	281	269	
January	348	309	282	268	
February	343	313	282	271	
March	340	315	278	270	
April	336	312	273	271	
May	332	312	271	268	
June	328	312	264	268	



Investigation processing days are from the date case was sent to field investigation by Complaint Unit until closure or referral (does not include Complaint Unit processing days for complaints completed at field investigation).

Medical Board of California Enforcement Program
Average Days to Complete Investigations in Complaint Investigations Office

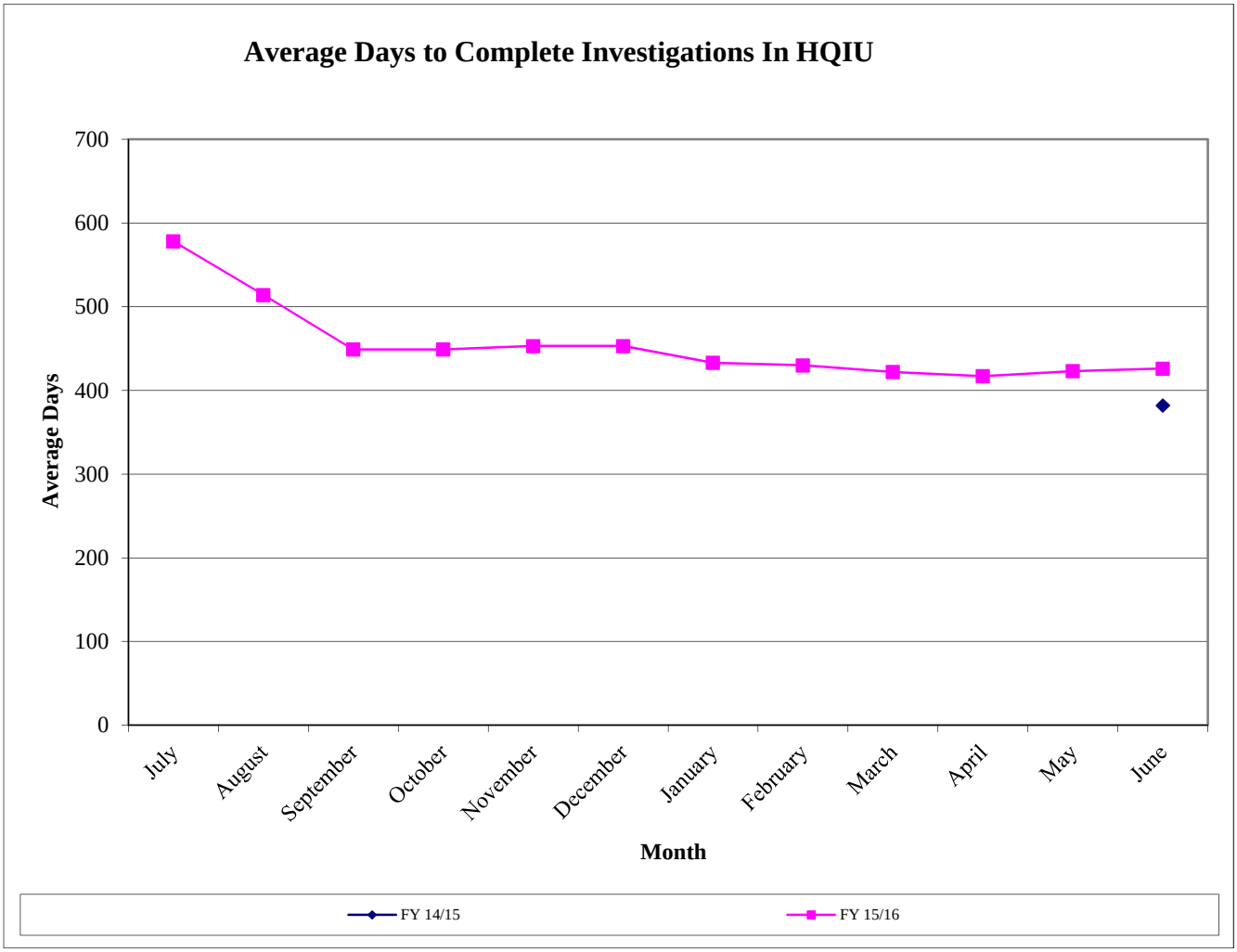
Month	Fiscal Year FY 14/15	FY 15/16
July		129
August		121
September		131
October		132
November		124
December		112
January		119
February		122
March		120
April		126
May		129
June	102	124



Investigation processing days are from the date case was assigned to Complaint Investigation Office (CIO) Investigator by Complaint Unit until closure or referral (does not include Complaint Unit processing days for complaints completed at CIO).

Medical Board of California Enforcement Program
Average Days to Complete Investigations in HQIU

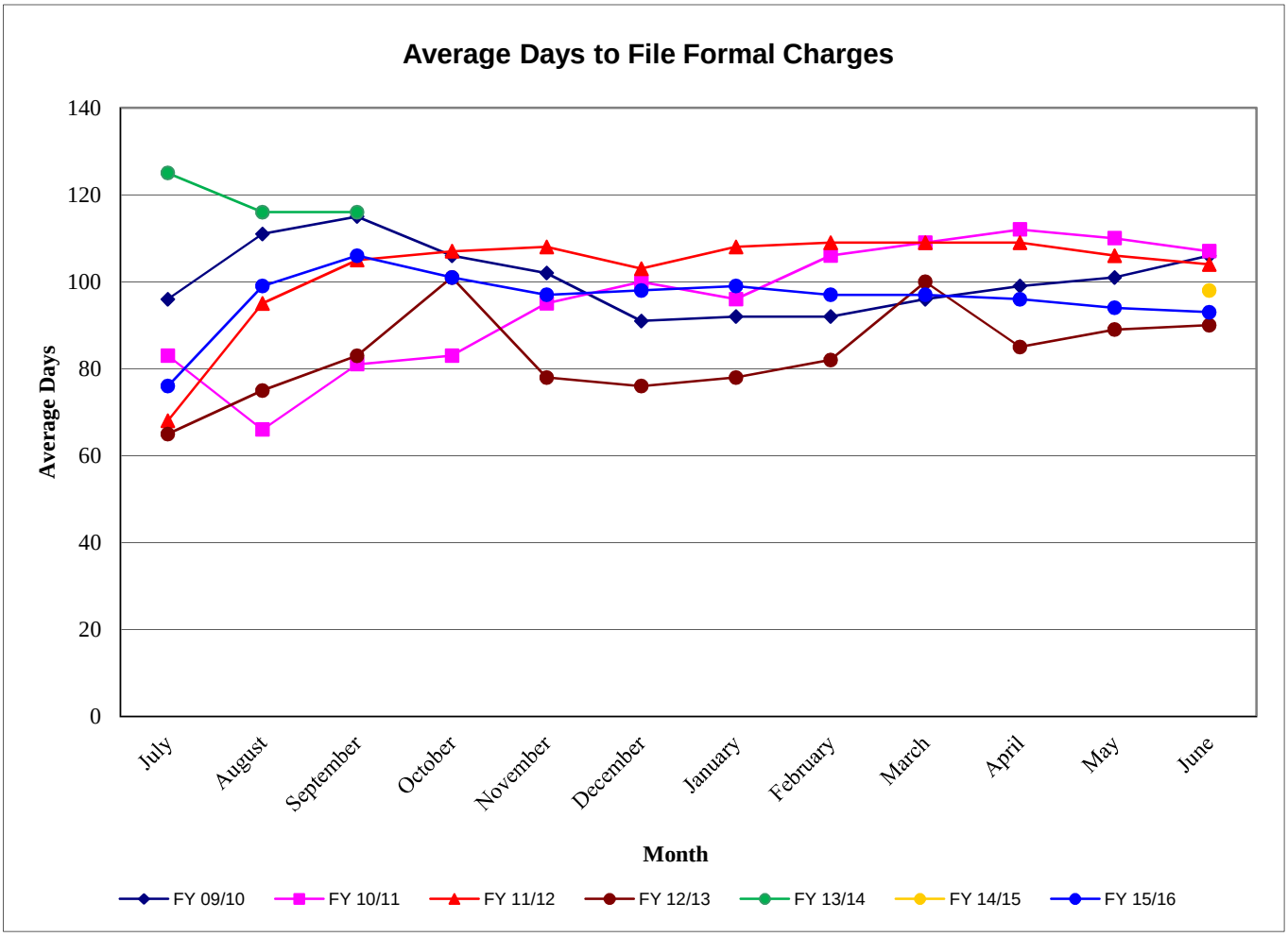
Month	Fiscal Year FY 14/15	FY 15/16
July		578
August		514
September		449
October		449
November		453
December		453
January		433
February		430
March		422
April		417
May		423
June	382	426



Investigation processing days are from the date case was assigned to HQIU investigator by Complaint Unit until closure or referral (does not include Complaint Unit processing days for complaints completed at HQIU).

Medical Board of California Enforcement Program
Average Days to File Administrative Charges Prepared by the Office of the Attorney General

Month	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
July	96	83	68	65	125		76
August	111	66	95	75	116		99
September	115	81	105	83	116		106
October	106	83	107	101			101
November	102	95	108	78			97
December	91	100	103	76			98
January	92	96	108	78			99
February	92	106	109	82			97
March	96	109	109	100			97
April	99	112	109	85			96
May	101	110	106	89			94
June	106	107	104	90		98	93



Average Days to File Formal Charges are the days from the date the case is referred to the AG's Office until formal charges are filed.

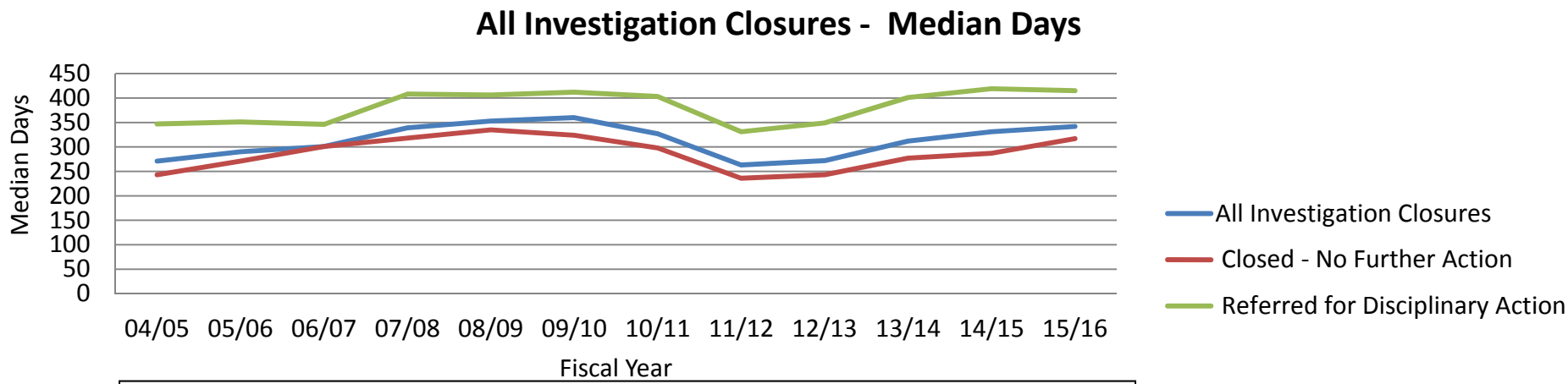
ENFORCEMENT TIMEFRAMES

FISCAL YEARS	2007 - 2008		2008- 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013		2013 - 2014		2014 - 2015[1]		2015 - 2016[1]	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN
COMPLAINT PROCESSING	61	49	75	63	76	63	74	77	83	64	67	54	67	43	140	113	146	119
INVESTIGATION PROCESSING - MBC-CIO															102	57	124	52
INVESTIGATION PROCESSING - HQIU															382	352	426	367
INVESTIGATION PROCESSING - ALL	324	272	349	309	328	292	312	283	264	225	268	245	245	205				
TOTAL MBC & HQIU																		
DAYS	385	321	424	372	404	355	386	360	347	289	335	299	312	248	228	150	230	155
YEARS	1.05	0.88	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79	0.92	0.82	0.85	0.68	0.62	0.41	0.63	0.42
AG PREP FOR ACC/PTR/ACC&PTR/SOI	121	58	103	63	106	66	107	72	104	78	90	75	110	86	98	68	93	67
POST ACCUSATION/PTR/SOI	471	324	381	311	368	312	417	324	396	350	435	366	443	402	459	392	453	378
ACCUSATION DECLINED BY AG															44	23	56	31
TOTAL AG																		
DAYS	592	382	484	374	474	378	524	396	500	428	525	441	553	488	473	413	479	393
YEARS	1.62	1.05	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.17	1.44	1.21	1.52	1.34	1.30	1.13	1.31	1.08
TOTAL MBC & AG																		
DAYS	977	703	908	746	878	733	910	756	847	717	860	740	865	736	956	927	967	919
YEARS	2.68	1.93	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.96	2.36	2.03	2.37	2.02	2.62	2.54	2.65	2.52

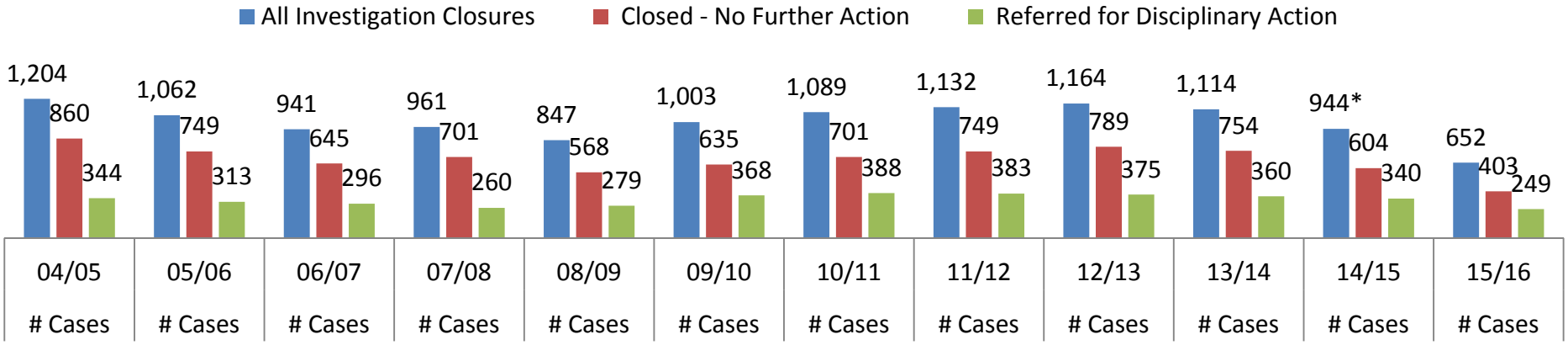
Years calculated using 365 days per year

[1] "Total" Days prior to FY 14-15 were the averages per unit added together. Beginning in FY 14-15, reports were run that show true averages for the Total timeframes.

Vertical Enforcement/Prosecution Cases - Median Days



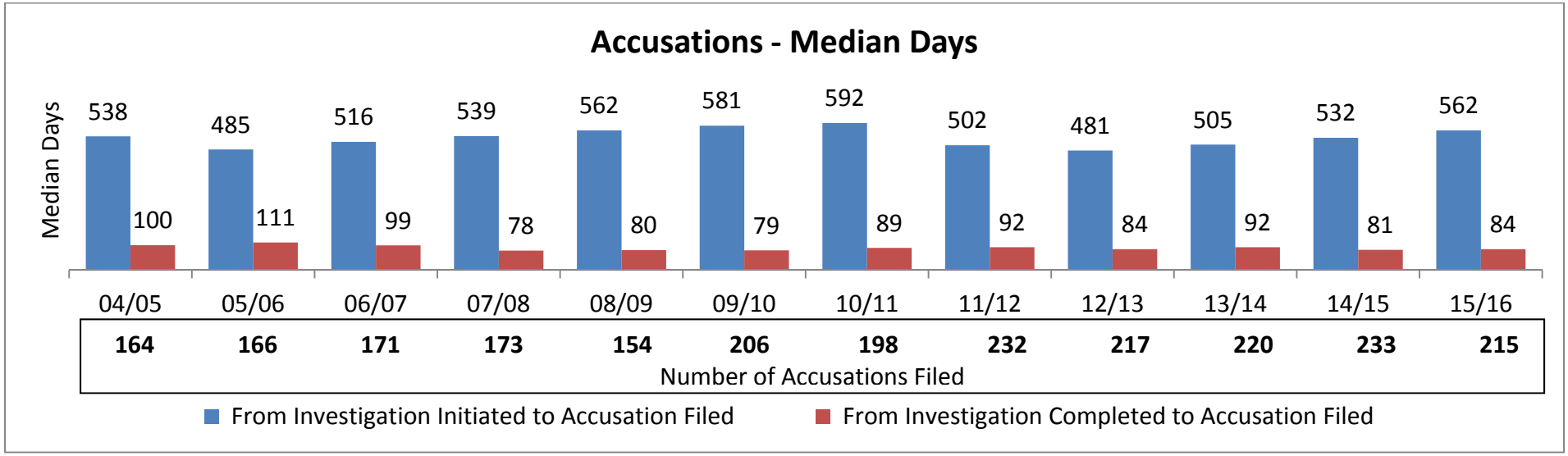
Median days - From the date the case was assigned to the Investigator/Deputy Attorney General to closure or referral to the Attorney General's Office for prosecution.

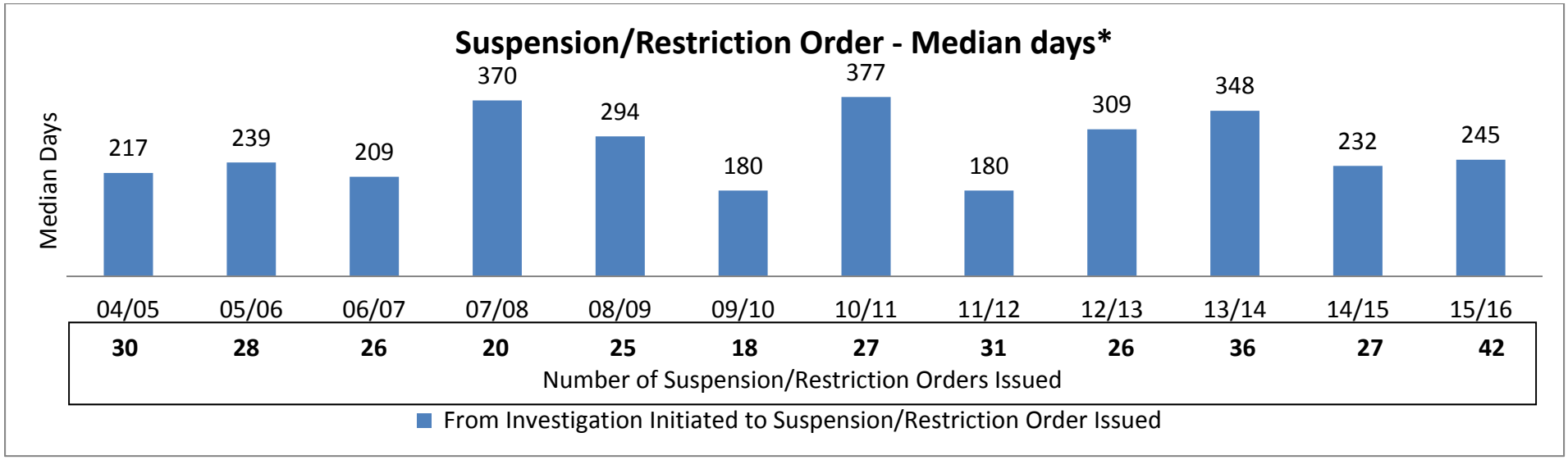


* This decrease is due to the Board initiating, in July 2014, a complaint investigation office of non-sworn special investigators who began investigating cases that would have been sent to HQIU.

The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

Vertical Enforcement/Prosecution Cases - Median Days

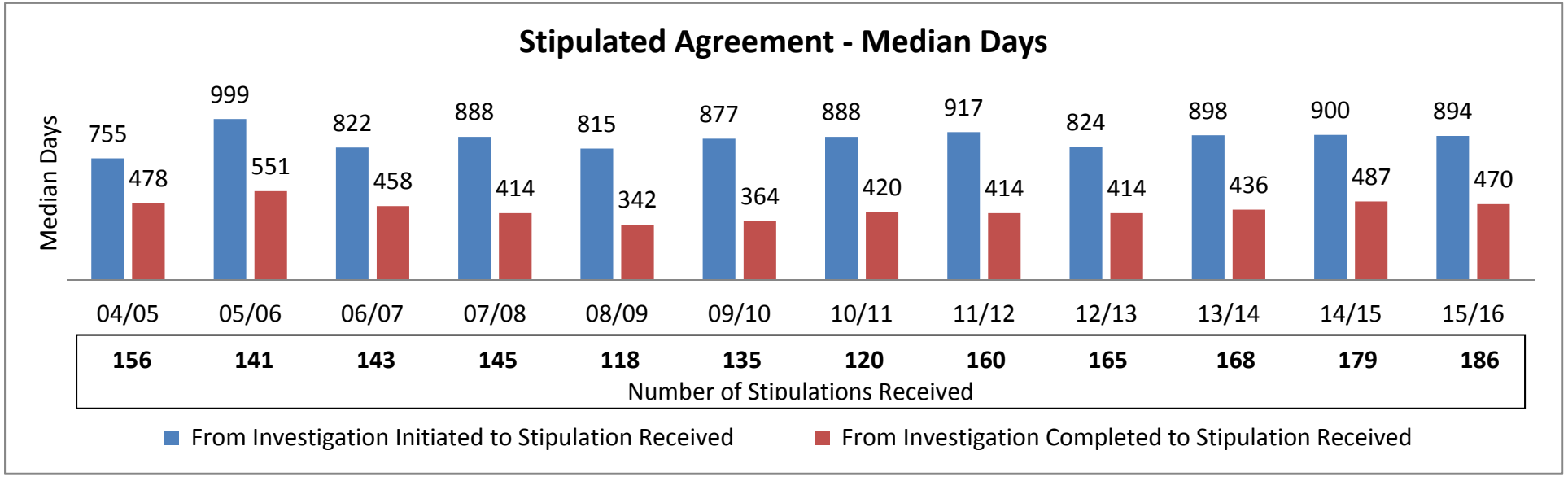


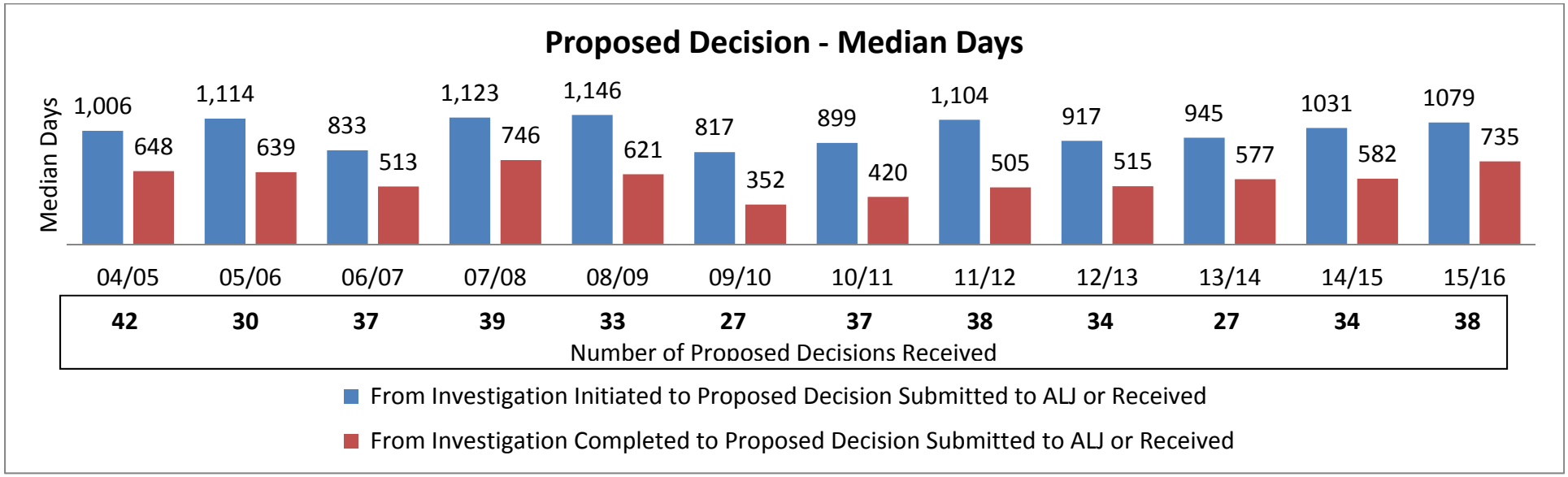


* This data includes: interim suspension orders, Penal Code section 23 restrictions, stipulated agreements to restrictions/suspension, and temporary restraining orders. It does not include out-of-state suspension orders, automatic suspension orders, or orders to cease practice while on probation.

The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

Vertical Enforcement/Prosecution Cases - Median Days





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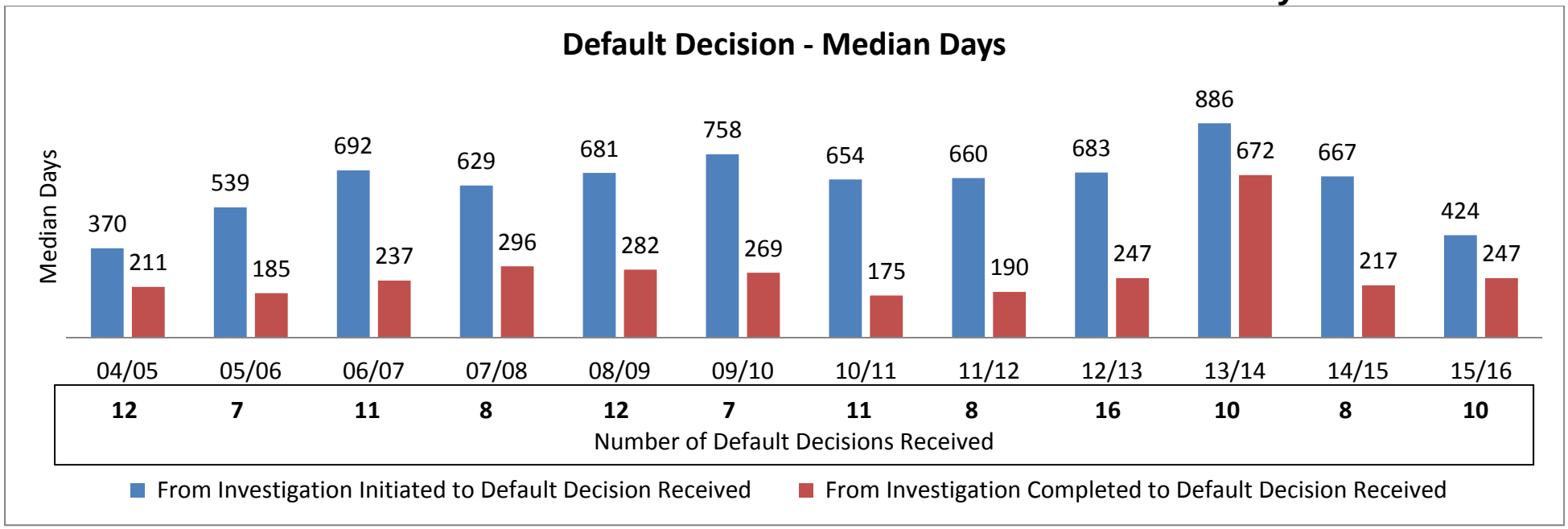
Vertical Enforcement/Prosecution Cases - Median Days



The graph above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: July 12, 2016
ATTENTION: Members, Medical Board of California (Board)
SUBJECT: Licensing Program Summary
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:
The Licensing Program staffing level during the fourth quarter was low due to staff being out of the office for unplanned leaves, and scheduled vacations. However, staff continued to work hard in the third 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:
- Office Technician (Cashiering)
- Staff Services Analyst (IMG P&S Application Review)
- Associate Governmental Program Analyst (Senior Review)

Staff in training:
- 5 - Management Services Technicians (US/CAN P&S Application Review)
- 2 - Staff Services Analysts (IMG P&S Application Review)
- 1 - Staff Services Manager I

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 BreEZe system. The statistics that have been provided have been obtained from the call center phone system, tracked manually, or from the BreEZe system.

Notable statistics include:
- Consumer Information Unit telephone calls answered: 19,385
  - 266 less calls answered than the previous quarter
- Consumer Information Unit telephone calls abandoned: 8,395
  - 2,390 more abandon calls than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 8,498
  - 2,788 more call back requests than the previous quarter

Note: The phone system was down for several hours one day and another day several call center staff were out unexpectedly.

- P&S applications initial review completed: 2,165
  - 263 more applications reviewed than the previous quarter
- P&S licenses issued: 1,938
  - 222 more licenses issued than the previous quarter
- P&S applications received in FY 2015-16: 7,763
  - 913 more than FY 2014-15

- P&S licenses issued in FY 2015-16: 6,316
  - 443 more than FY 2014-15

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 6 weeks out of the 13 weeks in the fourth quarter of FY 2015-16. 11 days was the highest number of days over the initial review goal.

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 significant workload for the Board. The Board received one new Self-Assessment Report and there are currently seven Self-Assessment Reports that are pending. Board staff conducted the site visit at Universidad Iberoamericana School of Medicine (UNIBE) in May and June 2016. UNIBE representative(s) plan to attend the Board meeting to be available to the Members during the Board's consideration of UNIBE's request for recognition.

SPECIALTY BOARD APPLICATIONS:
The Board has one pending application from a 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:

April 6:	Mercy Merced: 6 residents
	Kaweah Delta (Visalia): 35 residents
April 7:	UCSF Fresno: 45 residents
April 19:	Kaiser Ontario: 15 residents
April 20:	UCLA: 50 residents
April 27:	Children's Hospital Oakland: 45 residents

The Board does not conduct license fairs in May or June.

Resident Orientation:

June 15:	St Mary's SF: 40 residents
June 17:	UCSF Day 1: 150 residents
June 20:	UCI Day 1: 125 residents
June 21:	UCLA Day 1: 150 residents
June 22:	UCR: 40 residents
June 27:	Loma Linda Day 1: 150 residents
	California Hospital (LA): 8 residents
June 30:	UCSF Day 2: 100 residents

Licensing Program Report

WORKLOAD REPORT
as of June 30, 2016

Agenda Item 7C
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CONSUMER INFORMATION UNIT FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Total Calls Answered	**77,532**	19,692	18,804	19,651	19,385
Calls Requesting Call Back	**32,727**	12,788	5,731	5,710	8,498
Calls Abandoned	**27,687**	8,913	4,374	6,005	8,395
Address Changes Completed	**4,363**	1,438	950	969	1,006

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	**7,763**	2,262	1,732	2,094	1,675
Initial Reviews Completed	**7,687**	1,645	1,975	1,902	2,165
Total Pending	**N/A**				
Reviewed	**N/A**				
Not Reviewed	**N/A**				
(SR2s Pending)	**N/A**	35	38	51	53
Licenses Issued	**6,316**	1,237	1,425	1,716	1,938
Renewals Issued	**66,778**	17,123	16,237	16,712	16,706

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

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

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	**29**	7	8	10	4
PG/Medical Knowledge	**61**	16	23	16	6
Convictions	**41**	17	8	11	5
Other	**128**	31	32	31	34

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 June 30, 2016** | **Agenda Item 7C 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	122
Pending Self-Assessment Reports (included above)	**N/A**	7	7	7	7
New Self-Assessment Reports Received	**1**	0	0	0	1
New Unrecognized Schools Received	**45**	13	13	7	12
School Recognized Pursuant to CCR 1314(a)(1)	**29**	6	4	8	11
School Recognized Pursuant to CCR 1314(a)(2)	**0**	0	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	**N/A**	114	123	122	124

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	0
Applications Pending	**N/A**	0	1	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	0
RP Licenses Issued	**9**	3	1	4	1

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

Licensing Program Report

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LICENSED MIDWIVES FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Applications Received	**26**	5	4	12	5
Applications Pending	**N/A**	2	3	1	2
Applications Withdrawn	**1**	1	0	0	0
Licenses Issued	**29**	8	3	14	4
Licenses Renewed	**170**	37	43	50	40

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	**1289**	375	295	318	301
P&S - FNP Issued	**1,243**	324	268	337	314
P&S - FNP Pending	**N/A**	N/A	N/A	N/A	N/A
P&S - FNP Renewed	**5,104**	1,337	1,121	1,357	1,289
Podiatric FNP Received	**18**	6	7	1	4
Podiatric FNP Issued	**26**	6	9	6	5
Podiatric FNP Pending	**N/A**	N/A	N/A	N/A	N/A
Podiatric FNP Renewed	**156**	36	35	44	41

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

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POLYSOMNOGRAPHY FY 15/16					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Trainee					
Applications Received	**5**	N/A	N/A	N/A	5
Registrations Issued	**7**	N/A	N/A	N/A	7
Registrations Renewed	**1**	N/A	N/A	N/A	1
Technician					
Applications Received	**5**	N/A	N/A	N/A	5
Registrations Issued	**7**	N/A	N/A	N/A	7
Registrations Renewed	**5**	N/A	N/A	N/A	5
Technologist					
Applications Received	**11**	N/A	N/A	N/A	11
Registrations Issued	**12**	N/A	N/A	N/A	12
Registrations Renewed	**11**	N/A	N/A	N/A	11

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 June 30, 2016** | **Agenda Item 7C 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	7	13	12	5	7	14	11	8	4	14	6	11	9	17	9	7	10	0	0	0	0
2112	1	1	0	1	1	1	0	0	0	1	0	0	0	0	0	1	1	1	1	2	0	0	0	0
2113	6	6	12	7	4	4	8	8	5	10	4	5	18	10	10	9	15	11	19	21	0	0	0	0
2168	0	2	0	1	0	2	0	0	2	0	1	0	2	2	2	2	0	2	1	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	0	0	1	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

Licensing Program Report

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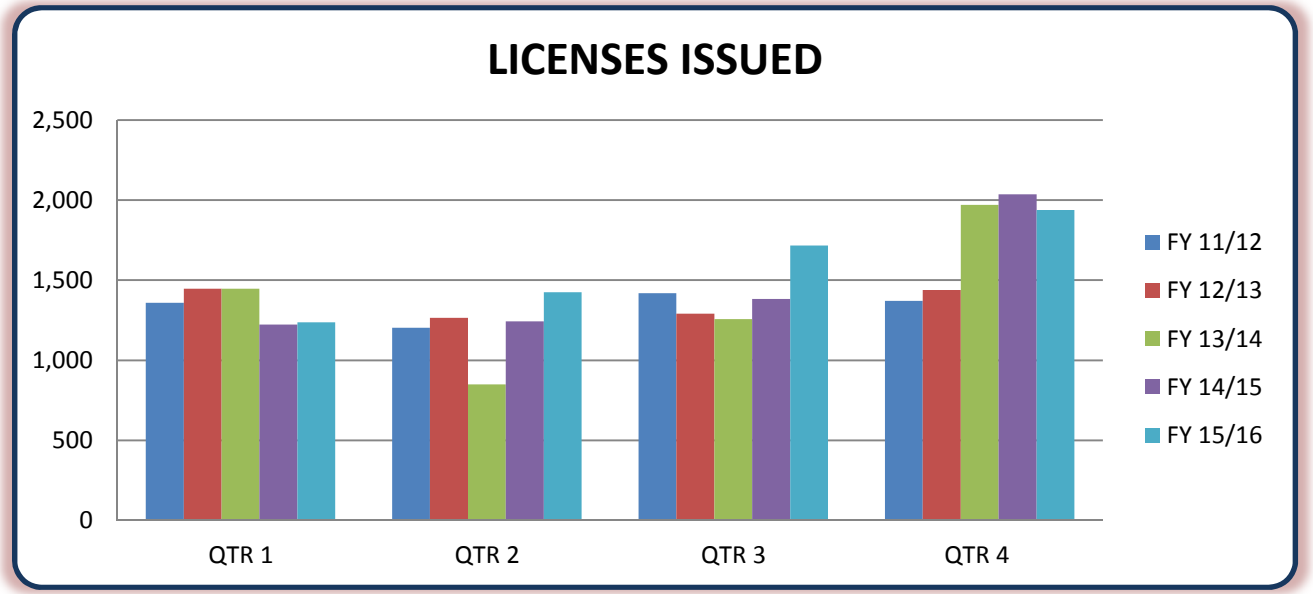
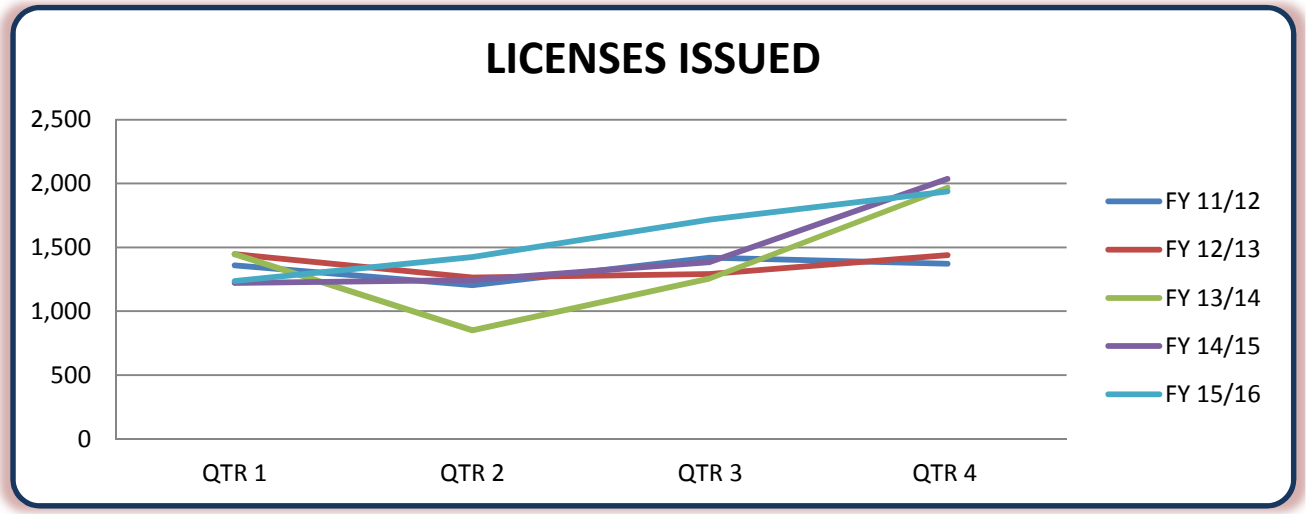
Fiscal Year 2015-2016

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	1,938	***6,316***
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***





Licensing Program Report

WORKLOAD REPORT
as of June 30, 2016

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Fiscal Year 2015-2016

*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED Five Fiscal Year History					
Fiscal Year	**QTR 1**	**QTR 2**	**QTR 3**	**QTR 4**	**TOTAL**
FY 15/16	2,262	1,732	2,094	1,675	**7,763**
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***

Fiscal Year - 2015/2016

Strategic Plan Goal 5: Organizational Effectiveness Objective 5.1: Licensing Applications to be Reviewed Within 45 Days					
	FY 15/16	**Q1**	**Q2**	**Q3**	**Q4**
Number of Weeks 45 Day Initial Review Goal Not Met	**38**	10	9	13	6
Number of Weeks	**52**	13	13	13	13
Highest # of Days Goal Exceeded	**N/A**	19	23	13	11

Fiscal Year - 2014/2015

Strategic Plan Goal 5: Organizational Effectiveness Objective 5.1: Licensing Applications to be Reviewed Within 45 Days					
	FY 14/15	**Q1**	**Q2**	**Q3**	**Q4**
Number of Weeks 45 Day Initial Review Goal Not Met	**17**	0	3	9	5
Number of Weeks	**52**	13	13	13	13
Highest # of Days Goal Exceeded	**N/A**	0	10	12	12

HEALTH PROFESSIONS EDUCATION FOUNDATION
Giving Golden Opportunities

Health Professions Education Foundation (HPEF)
Update for California Medical Board
July 11, 2016

Steven M. Thompson Physician Corps Loan Repayment Program (STLRP)
The Steven M. Thompson Physician Corps Loan Repayment Program was created in 2003 to increase the accessibility to healthcare and promote the longevity of primary care physicians in medically underserved areas of California. Physicians and surgeons can receive up to $105,000 in exchange for providing direct patient care in a medically underserved area for a minimum of three years.

Based on the number of applicants and the amount of funds available each year, the process of selecting recipients continues to be competitive. To date, STLRP has awarded more than $46.5 million for 471 awards. Table 1 shows a summary of the applicants to the program since its inception. Please see the STLRP Annual Report covering the period of July 2014 through November 2015 to the Legislature at http://oshpd.ca.gov/documents/HPEF/Publications/2016-STLRP-Report-to-Legislature.pdf.

- Fiscal Year (FY) 2015-16 Cycle ended June 30, 2016.
  - 39 physicians were awarded with funds from The California Endowment (TCE).
  - 24 applicants were awarded from the licensure fees and the Managed Care Penalties Fund allocations.

Table 1: Summary of Applicants, 2003-2015

Cycle	Applicants	Awarded STLRP	Awarded Hybrid STLRP/SLRP	Amount Awarded	Matching Award from SLRP
2015	187	63	0	$6,030,141	$0
2014	230	107	0	$10,324,863	$0
2013	157	109	0	$10,720,800	$0
2012	87	30	0	$2,377,957	$0
2011	185	15	61	$4,121,688	$2,826,164
2010	63	29	0	$2,809,821	$0
2009	66	16	0	$1,510,027	$0
2008	40	5	0	$250,000	$0
2007	52	12	0	$989,000	$0
2006	63	21	0	$1,686,810	$0
2005	57	19	0	$1,700,493	$0
2004	77	16	0	$1,310,178	$0
2003	96	29	0	$2,691,764	$0
Total	**2411**	**471**	**61**	**$46,523,542**	**$2,826,164**

HPEF Scholarship and Loan Repayment Programs

- The FY 2015-16 application cycles for HPEF's other programs ended on June 30, 2016. There are six scholarship programs and seven loan repayment programs, including STLRP. A total of 1,961 applicants were awarded from the following 12 programs:
    - The two Mental Health programs awarded 1,580 applicants.
    - The two Allied Health programs awarded 44 applicants.
    - The two Advanced Practice Healthcare programs awarded 64 applicants.
    - The six Nursing programs awarded 238 applicants.

Other Pertinent News

- HPEF application cycle dates for FY 2016-17 are as follows:
    - HPEF's six loan repayment programs will open their cycles on August 1, 2016.
    - STLRP's cycle will open December 1, 2016.
    - The six scholarship programs will open January 2017.

- On June 27, 2016, the Governor signed the California State Budget for FY 2016-17, which began on July 1, 2016. The Office of Statewide Health Planning and Development's (OSHPD) budget includes:
    - A one-time augmentation of $1.5 million from the County Medical Service Program to support HPEF's Allied Healthcare Loan Repayment Program.

Outreach

- HPEF staff and Board members are visiting campuses, conferences, and workshops the next few months to get the word out for all HPEF programs. In addition to events, HPEF posts daily updates on Facebook and Twitter. HPEF also hosts webinars, application workshops, and conference calls for potential applicants.

    - Events where HPEF provides outreach to physicians and future physicians:

Table 2: Calendar Year 2016 Events and Outreach	
Event Name	**Location**
Mt. San Antonio College 10th Annual Health Professions Conference	Walnut
CareerMD Career Fair	San Francisco
National Medical Association Conference	Los Angeles
California Primary Care Association – Webinar Presentation	Sacramento
CareerMD Career Fair	Los Angeles
Network of Ethnic Physicians Organization Conference	Newport Beach
Osteopathic Board Meeting – Presentation	Vallejo
CareerMD Career Fair	Palo Alto
14th UC Davis Pre-Health Professions National Conference/Presentation	UC Davis

Event Name	Location
CareerMD Career Fair	Orange County
California Primary Care Association Conference	Long Beach
CareerMD Career Fair	Fresno
CareerMD Career Fair	San Diego

Steven M. Thompson Physician Corps Loan Repayment Program

Annual Report to the Legislature
April 2016

Prepared by the Health Professions Education Foundation

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Executive Summary

The Health Professions Education Foundation (HPEF) is a nonprofit 501(c)(3) public benefit corporation housed within the Office of Statewide Health Planning and Development (OSHPD). Pursuant to Health and Safety Code Section 128330-128370, HPEF is required to submit an annual report to the California State Legislature documenting the performance of the Steven M. Thompson Physician Corps Loan Repayment Program (STLRP). The report is to include: 1) the number of STLRP program participants, 2) name and location of all practice settings with program participants, 3) amount expended for the program, 4) annual performance reviews by the practice settings, and 5) the program participants and the status of the Physician Volunteer Program. As the Physician Volunteer Program is not currently administered by HPEF, an update on this program is not included in this report.

This report covers the period of July 1, 2014 through November 30, 2015, for the purpose of including the second year of The California Endowment's (TCE) three-year $21.4 million total grant for STLRP. This report also includes data on STLRP recipients awarded during this period that were funded by The Medical Board of California and Osteopathic Medical Board of California licensure fees, and the Managed Care Administrative Fines and Penalties Fund, which is administered by the Department of Managed Health Care.

From July 1, 2014 through November 30, 2015, HPEF administered two application cycles. The first cycle was from October 6, 2014 to November 30, 2014 and the second cycle was from May 18, 2015 to June 26, 2015. A total of 230 STLRP applications were received and 107 recipients were awarded a total of $10.3 million during this period.

Program Authority

STLRP guidelines are in California Health and Safety Code Section 128550-128558 and the California Code of Regulations, Title 22, sections 97931.01-97931.06. In June 2015, the administration of STLRP was transferred from The Medical Board of California to HPEF.

Program Background

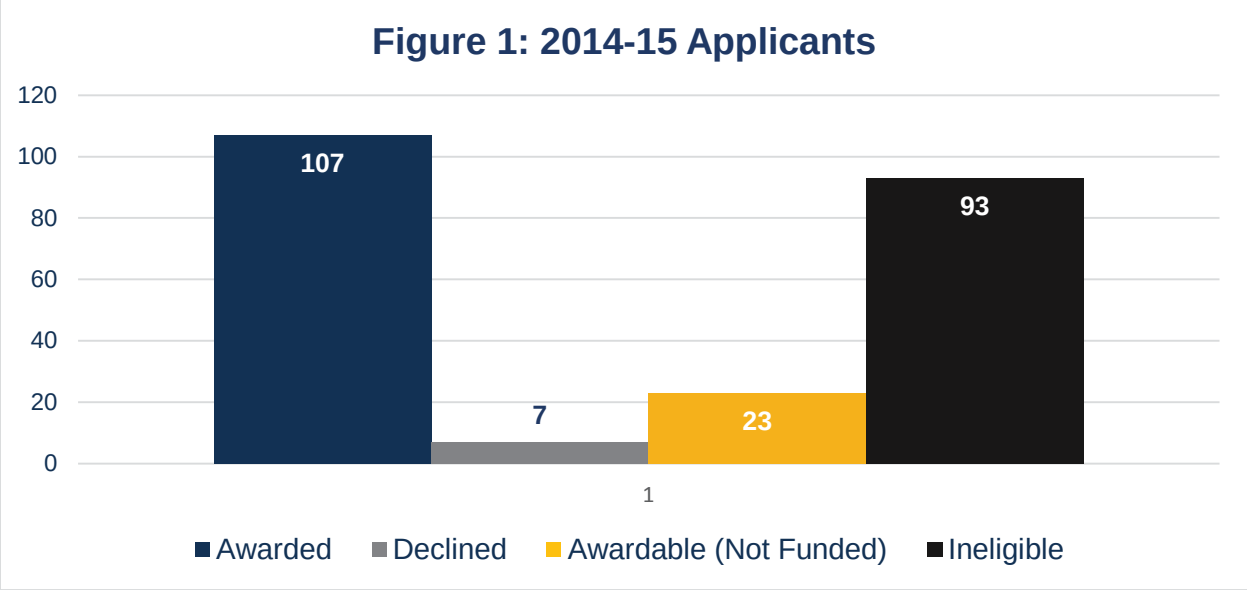
STLRP was established in 2003 to increase access to healthcare and promote the retention of primary care physicians in medically underserved areas[1] (MUAs) of California. The program is counseled by an Advisory Committee of seven members, with 2 members recommended by the California Medical Association. Physicians and surgeons can receive up to $105,000 in exchange for providing direct patient care in a MUA for a minimum of three years.

Since its inception, STLRP has received 1,172 applications. This program has awarded and monitored the progress of 475 physicians providing direct patient care in 45 of California's 58 counties. Over this period of time, the program has awarded more than $41 million. Consistent with the intent of the program, 80 percent of the total recipients are certified in a primary care specialty.

[1] "Medically underserved area" means an area defined as a health professional shortage area in Part 5 of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

Section 1: Participants

From July 1, 2014 to November 30, 2015, HPEF received 230 STLRP applications representing 30 counties and more than $45 million of applicant educational debt. As displayed in Figure 1, 107 applicants were awarded, seven awards were declined due to change in employment, practice site, and required number of hours, 23 were eligible but did not receive an award due to a limit on awarded applicants with outside specialties, and 93 were not eligible due to practice setting or part-time employment.



The number of applicants for this cycle increased by 68 percent over the previous year due to HPEF's increased participation in outreach events, stakeholder partnerships, and expanded use of social media. Accordingly, the number of ineligible applicants also increased. HPEF reviews and modifies the application process on a yearly basis to ensure clarity of program requirements. HPEF will continue to improve how eligibility criteria is communicated to potential applicants through outreach and marketing with the goal of reducing the number of ineligible applicants.

STLRP applicants are awarded based on their practice setting, medical specialty, and ability to meet the cultural and linguistic needs of the patients they serve. All recipients must serve in a MUA where more than 50 percent of its patients are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program serving patients who earn less than 250 percent of the federal poverty level. Applicants are reviewed by the STLRP Selection Committee, which is required to have a minimum of three members, including a member appointed by The Medical Board of California. The Selection Committee is required to award at least 65 percent of available funds to primary care physicians who have completed a three-year postgraduate residency in the areas of family practice, internal medicine, pediatrics, or obstetrics and gynecology. Up to 15 percent of the total funds are dedicated to loan assistance for physicians and surgeons who practice in geriatric care settings, and up to 20 percent of funds may be awarded for other specialties.

Furthermore, priority consideration is given to the applicants best suited to meet the cultural and linguistic needs of patients, as determined by meeting one or more of the following criteria:

- Speaks a Medi-Cal threshold language.
- Comes from an economically disadvantaged background.
- Has significant training in culturally and linguistically appropriate service delivery.
- Has three years of experience working in a medically underserved area or with a medically underserved population.
- Has obtained a license to practice medicine in any state of the United States or Canada within the last 15 years.

Table 1 illustrates a listing of postgraduate training for the recipients.

Table 1: Specialty Certifications Held by Recipients

American Board of Medical Specialties Certifications	# of Recipients
Family Physician	48
Internist	5
Obstetrician/Gynecologist	9
Pediatrician	29
Psychiatrist	13
Other: Child Neurology	1
Other: Gastroenterology and Hepatology	1
Other: Physical Medicine and Rehabilitation	1
Total	**107**

Section 2: Practice Settings

The STLRP Advisory Committee selects the most qualified applicants practicing in settings that meet program requirements. All settings are located in MUAs, and at least 50 percent of their patients are from the Medi-Cal Program and uninsured populations. The Committee also considers if applicants work in the areas of California with the greatest need to ensure a geographic distribution of awards. Northern California, the Bay Area, the Central Valley, the Central Coast, Southern California, and the Inland Empire are the geographic regions represented within Appendix A and B, detailing the distribution of recipients by practice setting and county.

Fifty of the 107 recipients worked in a federally designated Health Professional Shortage Area (areas deficient in primary care, dental care, or mental health providers); 44 recipients worked in a Primary Care Shortage Area (areas with shortages of family physicians, nurse practitioners, and physicians assistants), as determined by the California Healthcare Workforce Policy Commission; 67 of the physicians came from an economically disadvantaged background; and 88 spoke at least one of the Medi-Cal threshold languages.

HPEF utilized TCE grant funding to fund primary care physicians providing direct patient care in TCE Building Healthy Community counties, which included: Alameda, Contra Costa, Fresno,

Kern, Los Angeles, Merced, Monterey, Orange, Riverside, Sacramento, and San Diego. HPEF also funded physicians in four Central Valley counties: Madera, San Joaquin, Stanislaus, and Tulare.

Section 3: Expenditures

Funds for STLRP during this period were allocated from The Medical Board of California and the Osteopathic Medical Board of California through a $25 licensure fee surcharge fund, the Managed Care Administrative Fines and Penalties Fund, and a three-year grant from TCE, which was received in 2013. Licensure fees totaled $2.6 million dollars, funding from the Managed Care Administrative Fines and Penalties Fund totaled $1.7 million, and TCE provided $6 million. Funding from all sources for this report period was $10.3 million.

Section 4: Performance

As of November 30, 2015, HPEF continued to monitor 233 active STLRP participants for compliance according to the program's statutory and regulatory guidelines. Twenty-seven recipient contracts will end in June 2016 with another 115 contracts ending in June 2017. Each recipient is contractually obligated to work full-time providing direct patient care for a minimum of three years in a MUA. Every six months, HPEF requests a signed statement from the recipient's employer or practice site to verify employment and eligibility for continued program participation and award payments.

Upon the completion of each year of service, HPEF issues a portion of the recipient's total award for the repayment of their educational debt. A payment of 24 percent of the total award is made upon completing one year, 33 percent upon completing two years, and 43 percent upon completing the third and final year.

At the completion of the recipient's service obligation, HPEF sends a post-program survey to evaluate the effectiveness of the program. Survey data is shared with the HPEF Board of Trustees and OSHPD to develop and improve future outreach, application, and award processes.

Appendix A: Employment County, Practice Settings, Award Amounts, and Specialties

#	County	Practice Setting	Award Amount ($)
		Family Practice	
1	Alameda	La Clinica de la Raza	105,000
2	Alameda	Lifelong Medical Care	98,887
3	Contra Costa	Lifelong Medical Care	49,230
4	Contra Costa	West County Health Center/Contra Costa Regional Medical Center	98,887
5	Fresno	Central California Faculty Medical Group	105,000
6	Fresno	Central California Faculty Medical Group	105,000
7	Humboldt	Mad River Community Hospital	105,000
8	Los Angeles	The Children's Clinic	105,000
9	Los Angeles	South Central Family Health Center	71,385
10	Los Angeles	Los Angeles County, MLK Jr. Multi-Service Ambulatory Care Center	105,000
11	Los Angeles	AltaMed Medical Group	105,000
12	Los Angeles	AltaMed Medical and Dental Group	105,000
13	Los Angeles	AltaMed	105,000
14	Los Angeles	Saban Community Clinic	105,000
15	Los Angeles	Los Angeles County DHS Hubert H. Humphrey Comprehensive Health Center	105,000
16	Los Angeles	The Children's Clinic	98,887
17	Los Angeles	The Children's Clinic of Long Beach	59,119
18	Los Angeles	East Valley Community Health Clinic	98,887
19	Los Angeles	Eisner Pediatric and Family Center	98,887
20	Los Angeles	Northeast Valley Health Corporation	98,887
21	Los Angeles	Grand Medical Associates	98,887
22	Los Angeles	Los Angeles Christian Health Centers	98,887
23	Los Angeles	Comprehensive Community Health Center	98,887
24	Los Angeles	Venice Family Clinic	59,314
25	Madera	Madera Family & Pediatrics Medical Group	98,887
26	Merced	Golden Valley Health Clinic	105,000
27	Merced	MFA Medical Group, Inc. - Hilmar Family Medical Center	98,887
28	Monterey	Salud Para La Gente	56,495
29	Orange	AltaMed Health Services	105,000
30	Orange	Nhan Hoa Comprehensive Health Care Clinic	105,000
31	Orange	Nhan Hoa Clinic	98,887
32	Orange	AltaMed	98,887
33	Orange	AltaMed	55,039
34	Orange	Serve The People, Inc.	98,887
35	Sacramento	UC Davis	105,000
36	San Diego	San Ysidro Health Center	105,000

#	County	Practice Setting	Award Amount ($)
37	San Diego	San Ysidro Health Center	105,000
38	San Diego	San Ysidro Health Center	98,887
39	San Diego	San Ysidro Health Center	98,887
40	San Diego	Imperial Beach Health Center-Nestor	98,887
41	San Diego	Family Health Centers of San Diego	98,887
42	San Diego	Imperial Beach Community Clinic	98,887
43	Santa Cruz	Santa Cruz County	105,000
44	Ventura	Fillmore Medical Clinic	105,000
45	Ventura	Conejo Valley Family Care Center	105,000
46	Ventura	Family Health Center of Moorpark	105,000
47	Ventura	Moorpark Family Medical Clinic	105,000
48	Ventura	Clinicas Del Camino Real	105,000
		48 Family Practice Physicians awarded	Total: $4,644,435
Internal Medicine			
49	Alameda	Highland Hosptial Adult Medicine Clinic	105,000
50	Los Angeles	AltaMed	98,887
51	Los Angeles	Highland Hospital Adult Medicine Clinic	98,887
52	Madera	Camarena Health	75,167
53	San Diego	Family Health Centers of San Diego	105,000
		5 Internists awarded	Total: $482,941
Obstetrics/Gynecology			
54	Los Angeles	Northeast Community Clinic	98,887
55	Sacramento	Camellia Women's Health	98,887
56	San Diego	Family Health Centers of San Diego	98,887
57	San Diego	San Ysidro Health Center	98,887
58	San Luis Obispo	Community Health Center	105,000
59	Santa Cruz	Salud Para La Gente	105,000
60	Tulare	Living Water Clinic	98,887
61	Ventura	Clinicas Del Camino Real	105,000
62	Ventura	Clinicas Del Camino Real, Inc.	105,000
		9 Obstetricians/Gynecologists awarded	Total: $914,435
Pediatrics			
63	Alameda	Asian Health Services	98,887
64	Fresno	Valley Health Team, Inc.	98,887
65	Kern	Clinica Sierra Vista	105,000
66	Los Angeles	Children's Hospital Los Angeles	105,000
67	Los Angeles	East Valley Community Health Center	105,000
68	Los Angeles	Children's Hospital Los Angeles Medical Group - AltaMed Clinic	88,508
69	Los Angeles	Children's Hospital Los Angeles	105,000
70	Los Angeles	Clinica Monsenor Oscar A Romero	98,887
71	Los Angeles	Serra Medical Clinic	98,887
72	Los Angeles	Venice Family Clinic	98,887

#	County	Practice Setting	Award Amount ($)
73	Madera	Specialty Medical Group	98,887
74	Madera	Valley Children's Specialty Medical Group	98,887
75	Madera	Specialty Medical Group	98,887
76	Madera	Specialty Medical Group, Central California	98,887
77	Madera	Specialty Medical Group	49,749
78	Monterey	Soledad Medical Clinic	36,994
79	Orange	Friends of Family Health Center	98,887
80	Riverside	Borrego Community Health Foundation	105,000
81	Riverside	Community Health Service Inc.	98,887
82	Riverside	Borrego Community Health Foundation	98,887
83	Riverside	Borrego Health	94,329
84	Riverside	Borrego Health	98,887
85	Sacramento	WellSpace Health	98,887
86	San Diego	La Maestra Comunity Health Centers	42,495
87	San Diego	North County Health Services	98,887
88	Santa Clara	Santa Clara Valley Medical Center - Tully Clinic	105,000
89	Shasta	Shasta Community Health Center	105,000
90	Tulare	Tulare Community Health Clinic	105,000
91	Ventura	Ventura County Medical Center, Sierra Vista Family Medical Clinic	105,000
		29 Pediatricians awarded	Total: $2,740,380
		Psychiatry	
92	Alameda	TRUST Clinic, Healthcare for the Homeless	105,000
93	Humboldt	Humboldt Mental Health	105,000
94	Los Angeles	Los Angeles County Department of Mental Health/ Edelman Mental Health	52,027
95	Los Angeles	Olive View-UCLA Medical Center	45,669
96	Napa	California Department of State Hospitals	105,000
97	Napa	Department of State Hospitals-Napa State Hospital	105,000
98	Riverside	Riverside County Department of Mental Health	105,000
99	San Bernardino	Department of State Hospitals Patton State Hospital	105,000
100	San Diego	San Diego American Indian Health Center	105,000
101	San Diego	Family Health Centers of San Diego	105,000
102	Santa Clara	Santa Clara County/East Valley Federally Qualified Health Center	105,000
103	Santa Clara	Santa Clara County	105,000
104	Ventura	Ventura County Behavioral Health, Oxnard Adult	79,976
		13 Psychiatrists awarded	Total: $1,227,672

#	County	Practice Setting	Award Amount ($)
Other			
105	Fresno	Adventist Health Selma	105,000
106	San Diego	Department of Child Neurology UCSD/ Rady Children's Hospital	105,000
107	Ventura	Centers For Family Health	105,000
		3 Other physicians awarded	Total: $315,000
		107 Total Physicians awarded	**Total: $10,324,863**

Appendix B: Map of Recipients by County of Employment

STLRP Recipients by County of Employment July 1, 2014 to November 30, 2015

Alameda	5	San Bernardino	1
Contra Costa	2	San Diego	15
Fresno	4	San Luis Obispo	1
Humboldt	2	Santa Clara	3
Kern	1	Santa Cruz	2
Los Angeles	29	Shasta	1
Madera	7	Tulare	2
Merced	2	Ventura	10
Monterey	2		
Napa	2		
Orange	7		
Riverside	6		
Sacramento	3		

Total Recipients = 107

*STLRP is available to applicants in all of California's 58 counties serving in MUAs.

Edmund G. Brown Jr.

Governor

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Health Professions Education Foundation

[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, but not limited to:
   - 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. Is the board's fund continuously appropriated? If yes, please cite the statute outlining this continuous appropriation.
9. Describe the board's current reserve level, spending, and if a statutory reserve level exists.
10. 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 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	FY 2016/17	FY 2017/18
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						

11. 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?

12. 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 2012/13		FY 2013/14		FY 2014/15		FY 2015/16	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	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.

13. Describe the amount the board has contributed to the BreEZe program. What are the anticipated BreEZe costs the board has received from DCA?

14. 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 2012/13 Revenue	FY 2013/14 Revenue	FY 2014/15 Revenue	FY 2015/16 Revenue	% of Total Revenue

15. Describe Budget Change Proposals (BCPs) submitted by the board in the past four fiscal years.

Table 5. Budget Change Proposals (BCPs)

BCP ID #	Fiscal	Description of	Personnel Services	OE&E

	Year	Purpose of BCP	# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved

Staffing Issues

16. Describe any board staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.
17. 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

18. What are the board's performance targets/expectations for its licensing[2] program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
19. 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?
20. 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 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
[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				

[2] The term "license" in this document includes a license certificate or registration.

	Out-of-Country				
	Delinquent				

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 2013/14	(Exam)					-	-	-	-	-	-
	(License)					-	-	-	-	-	-
	(Renewal)			n/a		-	-	-	-	-	-
FY 2014/15	(Exam)										
	(License)										
	(Renewal)			n/a							
FY 2015/16	(Exam)										
	(License)										
	(Renewal)			n/a							

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data

	FY 2013/14	FY 2014/15	FY 2015/16
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.

21. 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?
22. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.
23. 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?
24. 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 2012/13	# of 1st Time Candidates			
	Pass %			
FY 2013/14	# of 1st Time Candidates			
	Pass %			
FY 2014/15	# of 1st Time Candidates			
	Pass %			
FY 2015/16	# of 1st 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 2012/13	# of 1st Time Candidates			
	Pass %			
FY 2013/14	# of 1st Time Candidates			
	Pass %			
FY 2014/15	# of 1st Time Candidates			
	Pass %			
FY 2015/16	# of 1st time Candidates			
	Pass %			
	Date of Last OA			
	Name of OA Developer			
	Target OA Date			

25. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required? Are examinations offered in a language other than English?
26. What are pass rates for first time vs. retakes in the past 4 fiscal years? *(Refer to Table 8: Examination Data)* Are pass rates collected for examinations offered in a language other than English?
27. 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?
28. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

School approvals

29. 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?
30. How many schools are approved by the board? How often are approved schools reviewed? Can the board remove its approval of a school?
31. What are the board's legal requirements regarding approval of international schools?

Continuing Education/Competency Requirements

32. 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

33. 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?

34. 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 2013/14	FY 2014/15	FY 2015/16
COMPLAINT			
Intake			
Received			
Closed			
Referred to INV			
Average Time to Close			
Pending (close of FY)			
Source of Complaint			
Public			
Licensee/Professional Groups			
Governmental Agencies			
Other			
Conviction / Arrest			
CONV Received			
CONV Closed			
Average Time to Close			
CONV Pending (close of FY)			
LICENSE DENIAL			
License Applications Denied			
SOIs Filed			
SOIs Withdrawn			
SOIs Dismissed			
SOIs Declined			
Average Days SOI			
ACCUSATION			
Accusations Filed			

Accusations Withdrawn			
Accusations Dismissed			
Accusations Declined			
Average Days Accusations			
Pending (close of FY)			

Table 9b. Enforcement Statistics (continued)			
	FY 2013/14	FY 2014/15	FY 2015/16
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions			
Stipulations			
Average Days to Complete			
AG Cases Initiated			
AG Cases Pending (close of FY)			
Disciplinary Outcomes			
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 2013/14	FY 2014/15	FY 2015/16
INVESTIGATION			
All Investigations			
First Assigned			
Closed			
Average days to close			
Pending (close of FY)			
Desk Investigations			
Closed			
Average days to close			
Pending (close of FY)			
Non-Sworn Investigation			
Closed			
Average days to close			
Pending (close of FY)			
Sworn Investigation			
Closed			
Average days to close			
Pending (close of FY)			
COMPLIANCE ACTION			
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			
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 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	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						

35. What do overall statistics show as to increases or decreases in disciplinary action since last review?
36. 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.
37. 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?
    a. What is the dollar threshold for settlement reports received by the board?
    b. What is the average dollar amount of settlements reported to the board?
38. Describe settlements the board, and Office of the Attorney General on behalf of the board, enter into with licensees.
    a. What is the number of cases, pre-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?
    b. What is the number of cases, post-accusation, that the board settled for the past four years, compared to the number that resulted in a hearing?
    c. What is the overall percentage of cases for the past four years that have been settled rather than resulted in a hearing?
39. 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?
40. Describe the board's efforts to address unlicensed activity and the underground economy.

Cite and Fine

41. 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?
42. How is cite and fine used? What types of violations are the basis for citation and fine?
43. 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?
44. What are the 5 most common violations for which citations are issued?
45. What is average fine pre- and post- appeal?
46. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Cost Recovery and Restitution

47. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.
48. How many and how much is ordered by the board for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.
49. Are there cases for which the board does not seek cost recovery? Why?
50. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.
51. 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 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
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 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Amount Ordered				
Amount Collected				

Section 6 – Public Information Policies

52. 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?

53. 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?
54. Does the board establish an annual meeting calendar, and post it on the board's web site?
55. 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)?
56. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?
57. What methods are used by the board to provide consumer outreach and education?

Section 7 – Online Practice Issues

58. 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

59. What actions has the board taken in terms of workforce development?
60. Describe any assessment the board has conducted on the impact of licensing delays.
61. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.
62. Describe any barriers to licensure and/or employment the board believes exist.
63. Provide any workforce development data collected by the board, such as:
    a. Workforce shortages
    b. Successful training programs.

Section 9 – Current Issues

64. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?
65. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?
66. Describe how the board is participating in development of BreEZe and any other secondary IT issues affecting the board.

a. Is the board utilizing BreEZe? What Release was the board included in? What is the status of the board's change requests?
b. If the board is not utilizing BreEZe, what is the board's plan for future IT needs? What discussions has the board had with DCA about IT needs and options? What is the board's understanding of Release 3 boards? Is the board currently using a bridge or workaround system?

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 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 and the overall costs of the program compared with its successes.

Diversion Evaluation Committees (DEC) (for BRN and Osteo 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 DECs?
11. How many DEC recommendations have been rejected by the board in the past four fiscal years (broken down by year)?

Chapter 4. Selection of Officers & Committees

Officers of the Board
(B&P Code Section 2012)

The Board shall select a President, Vice President, and Secretary from its Members.

Election of Officers
(Board Policy)

The Board shall elect the officers at the first meeting of the fiscal year. Officers shall serve a term of one year beginning the next meeting day. All officers may be elected on one motion or ballot as a slate of officers unless more than one Board Member is running per office. An officer may be re-elected and serve for more than one term.

Panel Members
(B&P Code section 2008)

A Panel of the Board shall at no time be composed of less than four Members and the number of public Members assigned shall not exceed the number of licensed physician and surgeon Members assigned to the Panel. The Board President shall not be a member of any Panel if a full complement of the Board has been appointed (15 Members). The Board usually is comprised of two panels, however, if there is an insufficient number of Members, there may only be one Panel.

Election of Panel Members
(B&P Code section 2008)

Each Panel shall annually, at the last meeting of the calendar year, elect a Chair and a Vice Chair.

Officer Vacancies
(Board Policy)

If an office becomes vacant during the year, an election shall be held at the next meeting. If the office of the President becomes vacant, the Vice President shall assume the office of the President. Elected officers then shall serve the remainder of the term.

Committee Appointments
(Board Policy)

The Board President shall establish Committees, whether standing or special, as he or she deems necessary. The composition of the Committees and the appointment of the Members shall be determined by the Board President in consultation with the Vice President, Secretary, and the Executive Director. Committees may include the appointment of non-Board Members.

Attendance at Committee Meetings
(Government Code section 11120 et seq.)

Board Members are encouraged to attend a meeting of a Committee of which he or she is not a member. Board Members who are not Members of the Committee that is meeting cannot vote during the Committee meeting and may participate only as observers if a majority of the Board is present at a Committee meeting.

Duties of the Officers

The following matrix delineates the duties of the Board officers, Committee Chairs, and Panel officers.

Roles of Board Officers/Committee Chairs/Panel Officers

President

- Spokesperson for the Medical Board (including but not limited to) – may attend legislative hearings and testify on behalf of the Board, may attend meetings with stakeholders and Legislators on behalf of Board, may talk to the media on behalf of the Board, and signs letters on behalf of the Board
- Meets and communicates with the Executive Director on a regular basis
- Communicates with other Board Members for Board business
- Authors a president's message in every quarterly newsletter
- Approves Board Meeting agendas
- Chairs and facilitates Board Meetings
- Chairs the Executive Committee
- Signs specified full board enforcement approval orders
- Signs the minutes for each of the Board's quarterly Board Meetings
- Represents the Board at Federation of State Medical Boards meetings and other such meetings

Vice President

- Is the Back-up for the duties above in the President's absence.
- Is a member of Executive Committee

Secretary

- Signs the minutes for each of the Board's quarterly Board Meetings
- Is a member of Executive Committee

Past President

- Is responsible for mentoring and imparting knowledge to the new Board President
- May attend meetings and legislative hearings to provide historical background information, as needed
- Is a member of Executive Committee

Committee Chair

- Approves the Committee Agendas
- Chairs and facilitates Committee Meetings

Panel Officers

- Chair – Chairs and facilitates Panel Meetings
- Chair – Signs orders for Panel decisions
- Vice Chair – Acts as Chair when Chair is absent

TITLE 16. MEDICAL BOARD OF CALIFORNIA

NOTICE IS HEREBY GIVEN that the Medical Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held at the Embassy Suites San Francisco Airport – South San Francisco, 250 Gateway Blvd., South San Francisco, CA 94080, at 9:00 a.m., on July 29, 2016.

Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office no later than 5:00 p.m. on July 19, 2016, or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018 and 2516.5 of the Business and Professions Code, and to implement, interpret or make specific section 2516.5 of said Code, the Board is considering adding Sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST

A. Informative Digest

Currently, Business and Professions Code (BPC) section 2516.5 provides for the definition of a midwife assistant, as well as a description of some of the duties a midwife assistant may perform. This statute became effective on January 1, 2016, and there are currently no implementing regulations in the California Code of Regulations (CCR) regarding midwife assistants, their training, nor certification.

This rulemaking proposes to add Title 16, Division 13, Chapter 3, Article 6, CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 to further define BPC section 2516.5 regarding the minimum requirements for midwife assistants, their training, and certification.

These new proposed regulations will do the following:

Section 1379.01 specifies who may supervise midwife assistants.

Section 1379.02 specifies each midwife assistant shall have a Neonatal

Resuscitation Certification from the American Academy of Pediatrics.

Section 1379.03 specifies each midwife assistant shall maintain certification in basic life support from the American Heart Association or the American Safety and Health Institute.

Section 1379.04 specifies each midwife assistant shall have received training in Center for Disease Control "Guidelines for Infection Control in Health Care Personnel" and must demonstrate to the supervisor that he or she understands infection control.

Section 1379.05 specifies the minimum training a midwife assistant shall complete.

Section 1379.06 specifies how midwife assistant training shall be administered.

Section 1379.07 specifies the minimum requirements certifying organizations for midwife assistant training must meet to receive Board approval.

Section 1379.08 specifies the changes that Board approved certification agencies must report to the Board, and timeframes for reporting the changes to the Board.

Section 1379.09 – specifies process times for the Board to review an application from a certification organization.

B. Policy Statement Overview/Anticipated Benefits of Proposal

The proposed CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 will further define BPC section 2516.5 that created midwife assistants in statute, and will further define the minimum training requirements for midwife assistants, the minimum requirements for the administration of training, and the requirements for approved certifying organizations, thereby furthering the Board's mission of consumer protection by ensuring that midwife assistants have the proper training and supervision.

C. Consistency and Compatibility with Existing State Regulations

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

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

Business Impact:

The board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action.

Effect on Housing Costs:

None

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulation would not adversely affect small businesses, since the proposed CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 will further define BPC section 2516.5 that created midwife assistants in statute, and allows for recognition of new education programs and certifying organizations.

RESULTS OF ECONOMIC IMPACT ASSESSMENT/ANALYSIS:

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

- It is not likely to eliminate jobs within the State of California. It is likely to create jobs for midwife assistants, instructors, and employees of certifying organizations. This initial determination is based on the fact that prior to January 2016, midwife assistants were not permitted by statute or regulation. Under BPC section 2516.5, midwife assistants are now permitted under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations, and create new job opportunities in the state.

- It is not likely to eliminate existing businesses within the State of California. In fact, existing businesses may expand to meet demand for this new position. This

initial determination is based on the fact that prior to January 2016, midwife assistants were not authorized by statute or regulation. Under BPC section 2516.5, midwife assistants are now allowed under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations. It is likely that educational programs and certifying organizations will expand to fill the need to train and certify midwife assistants.

- It will likely result in the expansion of businesses currently doing business within the State of California. This initial determination is based on the fact that prior to January 2016, midwife assistants were not authorized by statute or regulation. Under BPC section 2516.5, midwife assistants are now allowed under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations. It is likely that educational programs and certifying organizations already familiar with medical assistant requirements will expand to fill the need to train and certify midwife assistants.

- It will benefit the health and welfare of California residents, because the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations to further consumer protection.

- It will have a positive impact on worker safety, because the proposed regulations will set forth minimum requirements for midwife assistants, which include infection control.

- It will not have an impact on the state's environment, because the regulations will simply set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations.

CONSIDERATION OF ALTERNATIVES

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

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

INITIAL STATEMENT OF REASONS AND INFORMATION

The Board has prepared an Initial Statement of Reasons for the proposed action and all the information upon which the proposal is based is available upon request.

TEXT OF PROPOSAL

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

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

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

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

CONTACT PERSON

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

Name:	Curtis Worden
Address:	Medical Board of California 2005 Evergreen St., Ste. 1200 Sacramento, CA 95815
Telephone No.:	(916) 274-2986
Fax No.:	(916) 263-2387
E-Mail Address:	regulations@mbc.ca.gov

The backup contact person is:

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

Website Access Materials regarding this proposal can be found at http://www.mbc.ca.gov/About_Us/Laws/Proposed_Regulations.

MEDICAL BOARD OF CALIFORNIA
MIDWIFE ASSISTANTS
Specific Language of Proposed Changes

Legend

Underlined text: Indicates new proposed language.

Add Sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09, Article 6, of Chapter 3, Division 13, of Title 16 of the California Code of Regulations to read as follows:

§ 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.

Note: Authority cited: Sections 2018 and 2516.5, Business and Professions code. Reference: Sections 2069 and 2516.5, Business and Professions Code.

MEDICAL BOARD OF BOARD

INITIAL STATEMENT OF REASONS

Hearing Date: July 29, 2016

Subject Matter of Proposed Regulations: Midwife Assistants

Section(s) Affected: Division 13, Title 16, Chapter 3, Article 6, California Code of Regulations (CCR) add sections: 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09.

Specific Purpose of each adoption, amendment, or repeal:

1. Problem Being Addressed:

   The Legislature adopted Business and Professions Code (BPC) section 2516.5 to permit licensed midwives and certified nurse-midwives to use midwife assistants in their practices. BPC section 2516.5 sets forth some minimum requirements for midwife assistants, references standards for medical assistants established by the Board pursuant to BPC section 2069, and indicates under subsection (a)(1) that the "midwife assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training." The section, however, does not specify such details as what the training entails, who can conduct the training, and who can certify that a midwife assistant meets the minimum requirements. These details have been left to the Medical Board of California (Board) to establish via regulations. Additionally, subsection (b)(4) authorizes midwife assistants to "[p]erform additional midwife technical support services under regulations and standards established by the board."

   Accordingly, the purpose of this proposed rulemaking is to further define BPC section 2516.5 to make specific the requirements for midwife assistants, the administration of training of midwife assistants, and the requirements for certifying organizations. These regulations are necessary for consumer protection to ensure that midwife assistants have the proper training and supervision.

2. Anticipated Benefits from this Regulatory Action:

   This proposed rulemaking will further define BPC section 2516.5 to make specific the requirements for midwife assistants, the administration of training of midwife assistants, and the requirements for certifying organizations. The minimum requirements set forth in the proposed regulations are necessary to further the Board's mission of consumer protection by ensuring that midwife assistants have the proper training and supervision.

3. Specific Purpose of Each Proposed New Section:

Section 1379.01 specifies that licensed midwives and certified nurse midwives may supervise midwife assistants and authorize midwife assistants to perform the services referenced in BPC section 2516.5(b)(1). This section further indicates that the supervising licensed midwife or certified nurse midwife is responsible for the patient's treatment and care. This section is necessary for consumer protection to ensure proper supervision of midwife assistants, to provide a limit on the types of services midwife assistants may be authorized to perform, and to clearly state that the supervising licensed midwife or certified nurse midwife is responsible for the care and treatment of his or her patient.

Section 1379.02 specifies each midwife assistant shall have a Neonatal Resuscitation Certification from the American Academy of Pediatrics. This section is necessary for consumer protection to ensure that midwife assistants are properly trained in neonatal resuscitation by a reputable agency.

Section 1379.03 specifies each midwife assistant shall maintain certification in basic life support from the American Heart Association or the American Safety and Health Institute. This section is necessary for consumer protection to ensure that midwife assistants are properly trained in basic life support by a reputable agency.

Section 1379.04 specifies each midwife assistant shall have received training in Center for Disease Control "Guidelines for Infection Control in Health Care Personnel" and must demonstrate to the supervisor that he or she understands infection control. This section is necessary for consumer protection to ensure that midwife assistants are properly trained in infection control using guidelines from a reputable agency. This section is modelled after the Board's regulations for medical assistants pursuant to 16 CCR section 1366.4.

Section 1379.05 specifies the minimum training a midwife assistant shall complete. This section is necessary for consumer protection to ensure that midwife assistants have met a minimum level of didactic and hands-on training, and demonstrate satisfactory performance of tasks they will be authorized to do, before they begin performing the services with patients. This section is modelled after the Board's statutes and regulations for medical assistants pursuant to BPC sections 2069 and 2070, and 16 CCR section 1366.1, as directed by BPC section 2516.5(a)(1) and (b)(2).

Section 1379.06 specifies how midwife assistant training shall be administered and certified. This section is necessary for consumer protection to ensure that training of midwife assistants is administered and certified by a licensed midwife or certified nurse midwife, or by an appropriate secondary, postsecondary, or adult education program. This section is modelled after the Board's regulations for medical assistants relating to the administration of training pursuant to 16 CCR section 1366.3, as generally directed by BPC section 2516.5(a)(1) (stating, the midwife assistant is a person who "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.”).

Section 1379.07 specifies the minimum requirements certifying organizations for midwife assistant training must meet to receive Board approval. This section is necessary for consumer protection to ensure that certifying organizations meet minimum standards in requirements for training and competence of midwife assistants before they will grant them certification or recertification. This section is modelled after the Board’s regulations for approved certifying organizations for medical assistants pursuant to 16 CCR section 1366.31, as generally directed by BPC section 2516.5(a)(1) (stating, the midwife assistant is a person who “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.” Further, section 2516.5(a)(1) references “certificates,” so the Board is defining minimum requirements for certifying organizations based on requirements for medical assistants consistent with the statute.).

Section 1379.08 specifies changes Board approved certification agencies must report to the Board and timeframes for reporting the changes to the Board. This section is necessary for consumer protection to ensure that certifying organizations keep the Board informed of changes to their standards, so that the Board may ensure the organizations continue to the meet the minimum requirements set forth in proposed section 1379.07. This section also indicates that the certifying organizations are subject to review every five years by the Board to ensure compliance with the standards. This section is modelled after the Board’s regulations regarding certifying organizations for medical assistants pursuant to 16 CCR section 1366.32, as generally directed by BPC section 2516.5(a)(1) (stating, the midwife assistant is a person who “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.” Further, section 2516.5(a)(1) references “certificates,” so the Board is defining minimum requirements for certifying organizations based on requirements for medical assistants consistent with the statute.).

Section 1379.09 – specifies process times for the Board to review an application from a certifying organization. This section is necessary to ensure that applications from certifying organizations are processed in a timely fashion by the Board. This will help to foster access to certified midwife assistants in an efficient manner. This section is modelled after the Board’s regulations for approved certifying organizations for medical assistants pursuant to 16 CCR section 1366.33.

Factual Basis/Rationale

BPC section 2516.5 became effective on January 1, 2016, permitting licensed midwives and certified nurse-midwives to use midwife assistants in their practices. BPC section 2516.5 sets forth some minimum requirements for midwife assistants, references standards for medical assistants established by the Board pursuant to BPC section

2069, and indicates under subsection (a)(1) that the "midwife assistant shall be issued a certificate by the training institution or instructor indicating satisfactory completion of the required training." The section, however, does not specify such details as what the training entails, who can conduct the training, and who can certify that a midwife assistant meets the minimum requirements. Additionally, subsection (b)(4) authorizes midwife assistants to "[p]erform additional midwife technical support services under regulations and standards established by the board."

The responsibility for making BPC section 2516.5 more specific lies with the Board through this rulemaking process.

Underlying Data

The Board held an interested parties meeting on February 3, 2016, to get input on drafting the proposed regulations for midwife assistants. On March 10, 2016, the proposed draft midwife assistants regulations were presented to the Midwifery Advisory Council (MAC) for discussion, and were approved with amendments for presentation to the Board.

Staff prepared a report for the May 6, 2016 Medical Board of California meeting (agenda item 18) regarding the need to add CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09.

At the May 6, 2016 Board meeting, the Board adopted a motion directing staff to begin the regulatory process to add CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 to further define BPC section 2516.5 to provide clarification regarding the training requirements and scope of practice for midwife assistants.

Business Impact

The addition of CCR sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09 will not have a significant adverse economic impact on businesses. This initial determination is based on the fact that these regulations will likely have a positive economic impact for the state, since licensed midwives and certified nurse midwives will now be permitted to hire midwife assistants meeting the qualifications as set forth in these proposed regulations and pursuant to BPC section 2516.5.

Economic Impact Assessment

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

- It is likely to create jobs for midwife assistants, instructors, and employees of certifying organizations. It is not likely to eliminate jobs within the State of California. This initial determination is based on the fact that prior to January 2016, midwife assistants were not permitted by statute or regulation. Under BPC

section 2516.5, midwife assistants are now permitted under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations, and create new job opportunities in the state.

- It is not likely to create or eliminate existing businesses within the State of California, however, existing businesses may expand to meet demand for this new position. This initial determination is based on the fact that prior to January 2016, midwife assistants were not authorized by statute or regulation. Under BPC section 2516.5, midwife assistants are now allowed under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations. It is likely that educational programs and certifying organizations will expand to fill the need to train and certify midwife assistants, but the number of individuals interested in becoming midwife assistants is not expected to be great enough to anticipate the creation of new businesses.

- It will likely result in the expansion of businesses currently doing business within the State of California. This initial determination is based on the fact that prior to January 2016, midwife assistants were not authorized by statute or regulation. Under BPC section 2516.5, midwife assistants are now allowed under the law, and the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations. It is likely that educational programs and certifying organizations already familiar with medical assistant requirements will expand to fill the need to train and certify midwife assistants.

- It will benefit the health and welfare of California residents, because the regulations will set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations to further consumer protection.

- It will have a positive impact on worker safety, because the proposed regulations will set forth minimum requirements for midwife assistants, which include infection control.

- It will not have an impact on the state's environment, because the regulations will simply set forth minimum requirements for midwife assistants, instructors, educational programs, and certifying organizations.

Specific Technologies or Equipment

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

Consideration of Alternatives

No reasonable alternative to the regulatory proposal would be either more effective in

carrying out the purpose for which the action is proposed or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the law being implemented or made specific.

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

1. Do not proceed with the rulemaking to add the sections identified. This alternative was rejected because BPC section 2516.5 needs to be made more specific to support the Board's mission of consumer protection by identifying the minimum requirements for midwife assistant training, the minimum requirements for instructors and training programs, and the minimum requirements for certifying organizations.

2. Adopt the proposed regulatory amendments. This alternative was determined to be the most appropriate, because it supports the Board's mission of consumer protection by identifying the minimum requirements for midwife assistant training, the minimum requirements for instructors and training programs, and the minimum requirements for certifying organizations.

Medical Education in California

An Overview of Recent Activities

Cathryn L. Nation, MD
Associate Vice President – Health Sciences
University of California, Office of the President
July 29, 2016

Medical Education in California

- California has a relatively small medical education system when compared to the size of its population and geography.
- On a per capita basis, California has a statewide medical school enrollment that is the third lowest in the nation (18.4 students per 100,000 population, by contrast to a median of 30.3).
- There are approximately 7,000 students enrolled in California's now 12 medical schools.

Public and Private Medical Schools

Public (MD Granting)
UC Davis
UC Irvine
UC Los Angeles
UC Riverside
UC San Diego
UC San Francisco

Private (MD Granting)
Loma Linda University
University of Southern California
Stanford University
California Northstate University*

Private (DO Granting)
Touro University
Western University of Health Sciences

**First accredited for-profit allopathic medical school in the U.S.*

UC Medical Schools

- The University of California system plays a major role in medical education.
- UC trains more than 3,000 medical students at its six Schools of Medicine and approximately 5,000 medical residents and fellows, or nearly half of the state's total.
- Medical students and residents, together make up roughly two-thirds of all UC health sciences students.

The National GME Accrediting Body

- The Accreditation Council for Graduate Medical Education (ACGME) is responsible for the accreditation of GME programs throughout the U.S.
- 27 ACGME-accredited specialty programs that lead to initial board eligibility and certification.
- Roughly 100 accredited subspecialty programs recognized by the ACGME.

CA GME Programs: By the Numbers

There are 878 ACGME-accredited residency training programs in California.

- 375 Specialty Programs (8,800 Residents)
- 503 Subspecialty Programs (2,100 Fellows)

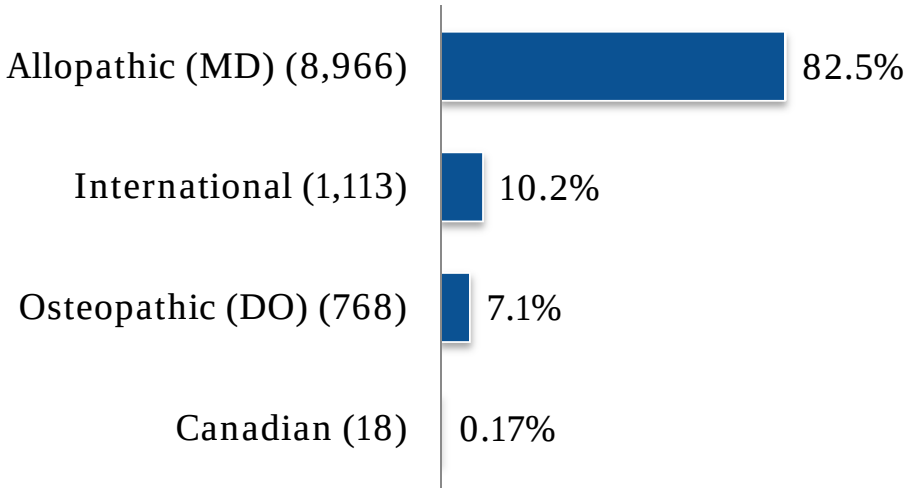
These programs are run by 84 different sponsoring institutions.

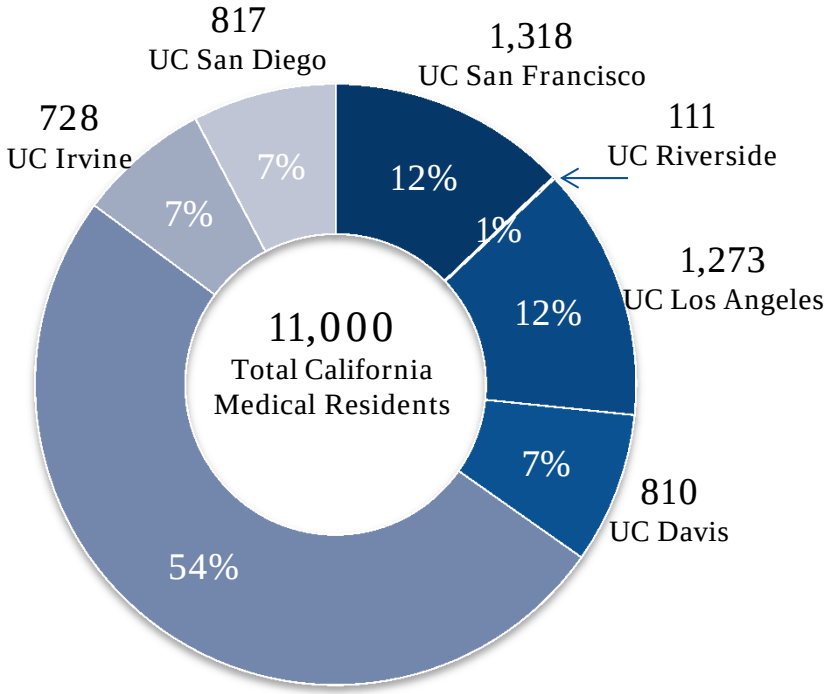
Major sponsors of GME include:

- UC medical schools/medical centers
- Private CA medical schools/medical centers
- Kaiser Permanente
- Children's Hospitals
- Community-Based Programs

Medical Residents in California, 2015-16

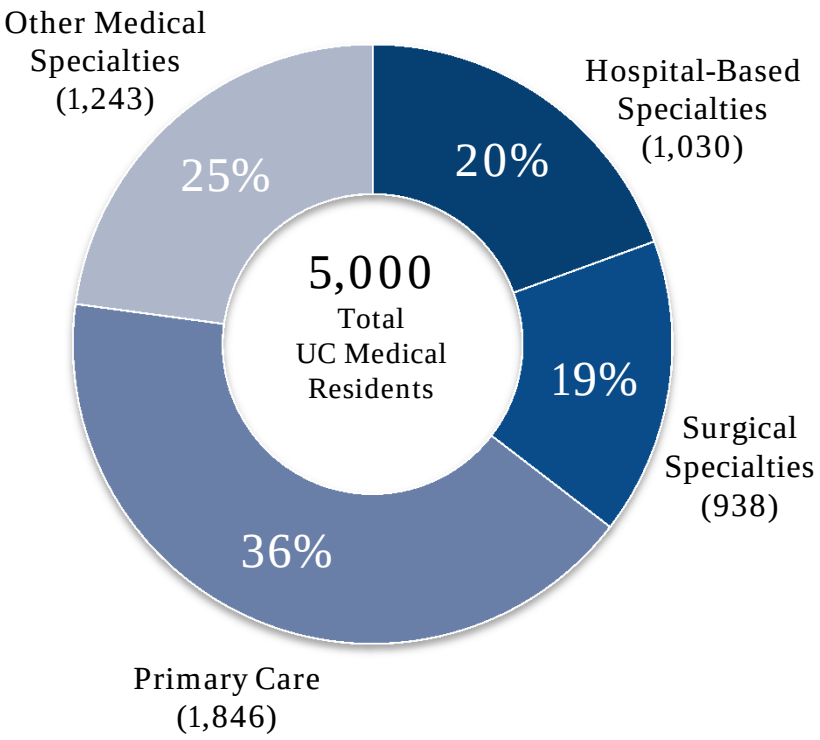
There are nearly 11,000 medical residents and fellows enrolled in California's residency training programs.





UC GME Enrollment for 2015-16

There are roughly 5,000 residents enrolled in UC-sponsored residency and affiliated family medicine programs – or nearly half of California's total.



Return on Investment for California

- California ranks first in the nation with the highest retention rates:
  - Percent of physicians retained in state from GME (69.8%)
  - Percent of physicians retained in state from undergraduate medical education (62.7%)
  - Percent of physicians retained in state from public UME (i.e., graduated from UC) (68.3%)

Challenges for GME

- Fiscal
- Workforce
- Access to GME training
- Resident well-being

Recent UC Medical Education Initiatives

- UC Davis:
  - Innovative educational tracks that supplement the core curriculum:
    - Accelerated Competency-Based Education in Primary Care (ACE-PC)
    - Valley PRIME program with UC Merced and UCSF Fresno
    - Transforming Education and Community Health in Medical School (TEACH-MS)
- UC Irvine:
  - Integrated, Technology-Enhanced, Activity-Coordinated, Humanistic (iTEACH) pre-clerkship curriculum
- UC Los Angeles:
  - Pathways Program
  - Dean's Leadership in Health and Science Scholarship

Recent UC Medical Education Initiatives

- UC Riverside:
  - Establishment of a new UC School of Medicine, which received provisional accreditation in June 2015 and has enrolled a total of 150 students in the first three years of medical school. UCR will welcome 60 new medical students this fall.
- UC San Diego:
  - New global health and clinical research academic tracks
  - Integrated curriculum emphasizing how basic science applies to clinical medicine
- UC San Francisco:
  - Bridges Curriculum – a new curriculum integrating the student into a healthcare team and emphasizing team-based training to address health disparities

Recent UC GME Initiatives

- Some increases in total UC GME positions (but with no federal or state support).
- Development of GME programs for UC Riverside in partnership with regional, county and community hospitals.
- Co-sponsorship of legislation in 2012, AB 155 (Mitchell) to support the UCLA International Medical Graduate Pilot Program.

Ethics Training and Discipline

- UC is dedicated to training ethical, professional physicians.
- Programs use a variety of tools to assess, educate and evaluate applicants, students and residents including:
  - Admissions processes that considers information from letters of recommendation and uses the interview to ask questions about ethical challenges and strategies
  - Professionalism and ethics curricula
  - Grading based on specific and observable performance-based attitudes
  - Continuous assessment by peers and supervisors, including 360 reviews

Ethics Training and Discipline

- When ethical lapses are reported or flagged, programs use disciplinary committees to evaluate and recommend remediation or other penalties.
- In the event of significant ethical lapses or failure to complete remediation, students and residents can be dismissed.

Looking Forward

- Increasing focus on health care quality and outcomes
- Increasing emphasis on institutional accountability
- Expanding use of health technologies
- Advancements in tele-health
- Development of new models of care
- Potential new funding for GME as part of a possible ballot initiative in 2016

UC GME Financing

- UC received roughly $100,000 in GME payments for each position – $208 million in FY 2013.
- Total costs to train a resident averages nearly $150,000 annually.
- With few exceptions, Medicare caps (established by Congress in 1997) have not changed.
  - Medicare-funded slots for UC residents: 2,151
  - UC Slots over the Medicare cap: 377
  - Over-the-cap costs to UC: approximately $31 million

State of California
Business, Consumer Services and Housing Agency

MEDICAL BOARD OF CALIFORNIA

July 28-29, 2016

Board Meeting

Legislative Packet

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MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
July 14, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1244	Gray	Worker's Compensation: Providers	Sen. Approps	Reco: Support	6/22/16
AB 1306	Burke	Certified Nurse-Midwives: Scope of Practice	Sen. Approps	Oppose Unless Amended	6/20/16
AB 1977	Wood & Waldron	Opioid Abuse Task Force	Sen. Approps	Support	4/13/16
AB 2024	Wood	Critical Access Hospitals: Employment	Sen. Approps	Neutral	6/9/16
AB 2216	Bonta	Primary Care Residency Programs: Grant Program	Sen. Approps	Support	5/27/16
AB 2744	Gordon	Healing Arts: Referrals	Sen. Approps	Neutral	6/16/16
AB 2745	Holden	Healing Arts: Licensing and Certification	Sen. Approps	Sponsor/Support	4/25/16
SB 22	Roth, Cannella & Galgiani	Residency Training: Funding	Assembly	Support	2/29/16
SB 482	Lara	Controlled Substances: CURES Database	Asm. Approps – Suspense	Support	6/21/16
SB 538	Hueso	Naturopathic Doctors	Asm. Approps	Oppose	6/29/16
SB 563	Pan	Workers' Compensation: Utilization Review	Asm. Approps	Support	6/23/16
SB 1174	McGuire	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications	Asm. Approps	Support if Amended	6/22/16
SB 1177	Galgiani	Physician and Suregon Health and Wellness Program	Asm. Approps	Support	6/23/16
SB 1189	Pan & Jackson	Postmortem Examinations or Autopsies	Asm. Approps	Support	6/22/16

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
July 14, 2016

SB 1261	Stone	Physicians and Surgeons: Licensure Exemption	Asm. Approps	Neutral	5/3/16
SB 1471	Hernandez	Health Professions Development: Loan Repayment	Asm. Approps. - Suspense	Reco: Support	4/21/16
SB 1478	Sen. B&P	Health Omnibus	Assembly	Sponsor/Support MBC Provisions	

Pink – Sponsored Bill, Green – For Discussion , Blue – No Discussion Needed

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1244
Author: Gray
Bill Date: June 22, 2016, Amended
Subject: Workers' Compensation: Providers: Suspension
Sponsor: Author

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify the circumstances in which a medical provider must be suspended from participating in the workers' compensation system. This bill would also ensure that the appropriate licensing board is notified of the suspension and provide for communication between various state agencies.

BACKGROUND

The workers' compensation system in California provides benefits to an employee who suffers from an injury or illness that arises out of, and in the course of employment, irrespective of fault. This system requires all employers to secure payment of benefits by either securing the consent of the Department of Industrial Relations to self-insure or by securing insurance against liability from an insurance company authorized by the state. 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.

Existing law requires the director of the Department of Health Care Services (DHCS) to suspend any or all payments to a medical service provider if there is a credible allegation of fraud against the Medi-Cal system or if a provider has been convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of medical services.

ANALYSIS

This bill would require the administrative director (AD) of the Division of Workers' Compensation (DWC) to suspend medical service providers from participating in any capacity in the workers' compensation system if the provider is:

- Convicted of a felony;
- Convicted of a misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system;
- Convicted of a misdemeanor involving fraud or abuse of any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service;
- Suspended from the federal Medicare or Medicaid programs due to fraud or abuse; or
- Lost or surrendered a license, certificate, or approval to provide health care.

This bill would require the AD to provide written notice to the medical provider who has been identified as eligible for suspension. This bill would require the DWC to hold a hearing on the suspension of a medical provider within 30 days of a request. Such a request would stay any suspension of a medical provider. If, during the hearing, the AD finds that the medical provider is eligible for suspension due to the reasons listed above, the AD must suspend the medical provider immediately. Upon suspension, the AD must notify the relevant licensing, certification, or registration board, including the Medical Board. This bill would also require the director of DHCS to notify the AD of the DWC if a medical provider is added to the Suspended or Ineligible Provider List (this notification from DHCS is already required to be provided to the Medical Board).

This bill seeks to combat workers' compensation fraud by changing the incentives facing medical providers in the California workers' compensation system. Specifically, this bill would create a suspension process for medical providers who commit serious crimes or are involved in fraudulent activity that is modeled after the suspension process for Medi-Cal, including requiring notification to the appropriate licensing board. This bill will ensure that the Medical Board is notified when a physician is suspended by the DWC, which will help to ensure consumer protection. This bill will also provide for communication between the DWC and DHCS, which will also help to protect consumers. For these reasons, Board staff is suggesting that the Board support this bill.

FISCAL: None to the Board

SUPPORT: Association of California Insurance Companies; California Chamber of Commerce; California Conference Board of the Amalgamated Transit Union; California Conference of Machinists; California Professional Firefighters; California State Association of Counties; California Teamsters Public Affairs Council; Engineers & scientists of CA, IFPTE Local 20, AFL-CIO; International Longshore & Warehouse Union; Professional & Technical Engineers, IFPTE Local 21, AFL-CIO; UNITE-HERE, AFL-CIO; Utility Workers Union of America, AFL-CIO

OPPOSITION: None on file

POSITION: Recommendation: Support

AMENDED IN SENATE JUNE 22, 2016

AMENDED IN SENATE MAY 10, 2016

AMENDED IN ASSEMBLY JANUARY 26, 2016

AMENDED IN ASSEMBLY JANUARY 4, 2016

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1244

Introduced by Assembly Member Gray

February 27, 2015

An act *to amend Section 139.2 of, and* to add Section ~~5307.15 to~~ *139.21 to,* the Labor Code, and to amend Section 14123 of the Welfare and Institutions Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1244, as amended, Gray. Workers' compensation: providers: ~~suspension and revocation.~~ *suspension.*

Under existing law, the Director of Health Care Services is authorized, for purposes of administering the Medi-Cal program, to suspend a provider of service from further participation under the program for specified reasons, including conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Existing law requires the director, upon receipt of written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, to promptly suspend the practitioner from participation in the Medi-Cal program.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury.

Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees and requires the administrative director to contract with individual physicians or an independent medical review organization to perform medical provider network independent medical reviews. Existing law also requires the administrative director to appoint qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues. *Existing law requires the administrative director to terminate from the list of medical evaluators a physician who has been subject to disciplinary action by the relevant licensing board or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice.*

~~This bill would require the Director of Health Care Services to notify the administrative director of a suspension imposed pursuant to the above provisions and would require the administrative director, upon that notification, to promptly suspend the physician or practitioner from participating in the workers' compensation system in any capacity, including, but not limited to, participation as a qualified medical examiner, a treating provider in a medical provider network, or an independent medical reviewer. The bill would require the administrative director to adopt regulations establishing criteria for revocation of a suspended physician's or practitioner's participation in the workers' compensation system, subject to specified notice and hearing requirements.~~

This bill would require the administrative director to *promptly suspend any physician or practitioner from participating in the workers' compensation system in any capacity when the individual or entity meets specified criteria, including when that individual has been convicted of a felony or any one of specified misdemeanors involving fraud or abuse, when that individual's license, certificate, or approval to provide health care has been surrendered or revoked, or when that individual or entity has been suspended, due to fraud or abuse, from participation*

in the Medicare or Medicaid programs. The bill would require the administrative director to adopt regulations for suspending a physician's or practitioner's participation in the workers' compensation system pursuant to these provisions, as specified, and would require the administrative director to furnish to the physician or practitioner written notice of the right to a hearing regarding the suspension and the procedure to follow to request that hearing. If a physician is a qualified medical examiner, and the department finds that the physician meets the criteria for suspension pursuant to these provisions, the bill would require the administrative director to terminate the physician from the list of medical evaluators. The bill would also require the administrative director to notify the appropriate state licensing entity of a physician's or practitioner's suspension ~~or revocation~~ and to update relevant provider databases of qualified medical evaluators and medical provider networks. The bill would prohibit *a provider of services from submitting or pursuing* claims for payment for services or supplies provided by a ~~provider~~ *physician or practitioner* whose participation in the workers' compensation system has been ~~suspended or revoked, except under specified circumstances.~~ *suspended, unless that claim for payment has been reduced to final judgment or the services or supplies are unrelated to a violation of the laws governing workers' compensation.*

The bill would also require the Director of Health Care Services to notify the administrative director of a suspension of a physician from participation in the Medi-Cal program imposed pursuant to the provisions described above authorizing the director to suspend a provider of services from participation.

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

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

~~SECTION 1. Section 5307.15 is added to the Labor Code, to read:~~

~~5307.15. (a) (1) Whenever the administrative director receives written notification from the Director of Health Care Services pursuant to Section 14123 of the Welfare and Institutions Code that a physician or other individual practitioner has been suspended from participation in the Medi-Cal program, the administrative director shall promptly suspend the physician or practitioner from participating in the workers' compensation system in any capacity,~~

~~including, but not limited to, participation as a qualified medical examiner, a treating provider in a medical provider network, or a medical provider network independent medical reviewer.~~

~~(2) The administrative director also shall exercise due diligence to identify physicians and practitioners who have been suspended as described in subdivision (a) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.~~

~~(b) (1) The administrative director shall adopt regulations establishing criteria for revocation of a suspended physician's or practitioner's participation in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).~~

~~(2) The administrative director shall serve the physician or practitioner with written notice of the specific basis for revocation of his or her participation in the workers' compensation system and shall set a hearing within 30 days of the date of service on the physician or practitioner. The hearing proceedings shall be conducted pursuant to Chapter 4 (commencing with Section 11370) of Part 1 of Division 3 of Title 2 of the Government Code.~~

~~(c) The administrative director shall promptly notify the physician's or practitioner's state licensing, certifying, or registering authority of a suspension or revocation imposed pursuant to this section and shall update the department's qualified medical evaluator and medical provider network databases, as appropriate.~~

~~(d) A provider of services, whether an individual, clinic, group, corporation, or other association, may not submit a claim for payment to a payor for any services or supplies provided by a physician or practitioner whose participation in the workers' compensation has been suspended or revoked pursuant to this section. This subdivision does not apply with respect to services or supplies provided prior to the date of the suspension or revocation.~~

SECTION 1. Section 139.2 of the Labor Code is amended to read:

139.2. (a) The administrative director shall appoint qualified medical evaluators in each of the respective specialties as required

for the evaluation of medical-legal issues. The appointments shall be for two-year terms.

(b) The administrative director shall appoint or reappoint as a qualified medical evaluator a physician, as defined in Section 3209.3, who is licensed to practice in this state and who demonstrates that he or she meets the requirements in paragraphs (1), (2), (6), and (7), and, if the physician is a medical doctor, doctor of osteopathy, doctor of chiropractic, or a psychologist, that he or she also meets the applicable requirements in paragraph (3), (4), or (5).

(1) Prior to his or her appointment as a qualified medical evaluator, passes an examination written and administered by the administrative director for the purpose of demonstrating competence in evaluating medical-legal issues in the workers' compensation system. Physicians shall not be required to pass an additional examination as a condition of reappointment. A physician seeking appointment as a qualified medical evaluator on or after January 1, 2001, shall also complete prior to appointment, a course on disability evaluation report writing approved by the administrative director. The administrative director shall specify the curriculum to be covered by disability evaluation report writing courses, which shall include, but is not limited to, 12 or more hours of instruction.

(2) Devotes at least one-third of total practice time to providing direct medical treatment, or has served as an agreed medical evaluator on eight or more occasions in the 12 months prior to applying to be appointed as a qualified medical evaluator.

(3) Is a medical doctor or doctor of osteopathy and meets one of the following requirements:

(A) Is board certified in a specialty by a board recognized by the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California.

(B) Has successfully completed a residency training program accredited by the Accreditation Council for Graduate Medical Education or the osteopathic equivalent.

(C) Was an active qualified medical evaluator on June 30, 2000.

(D) Has qualifications that the administrative director and either the Medical Board of California or the Osteopathic Medical Board of California, as appropriate, both deem to be equivalent to board certification in a specialty.

(4) Is a doctor of chiropractic and has been certified in California workers' compensation evaluation by a provider recognized by the administrative director. The certification program shall include instruction on disability evaluation report writing that meets the standards set forth in paragraph (1).

(5) Is a psychologist and meets one of the following requirements:

(A) Is board certified in clinical psychology by a board recognized by the administrative director.

(B) Holds a doctoral degree in psychology, or a doctoral degree deemed equivalent for licensure by the Board of Psychology pursuant to Section 2914 of the Business and Professions Code, from a university or professional school recognized by the administrative director and has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders.

(C) Has not less than five years' postdoctoral experience in the diagnosis and treatment of emotional and mental disorders, and has served as an agreed medical evaluator on eight or more occasions prior to January 1, 1990.

(6) Does not have a conflict of interest as determined under the regulations adopted by the administrative director pursuant to subdivision (o).

(7) Meets any additional medical or professional standards adopted pursuant to paragraph (6) of subdivision (j).

(c) The administrative director shall adopt standards for appointment of physicians who are retired or who hold teaching positions who are exceptionally well qualified to serve as a qualified medical evaluator even though they do not otherwise qualify under paragraph (2) of subdivision (b). A physician whose full-time practice is limited to the forensic evaluation of disability shall not be appointed as a qualified medical evaluator under this subdivision.

(d) The qualified medical evaluator, upon request, shall be reappointed if he or she meets the qualifications of subdivision (b) and meets all of the following criteria:

(1) Is in compliance with all applicable regulations and evaluation guidelines adopted by the administrative director.

(2) Has not had more than five of his or her evaluations that were considered by a workers' compensation administrative law

judge at a contested hearing rejected by the workers' compensation administrative law judge or the appeals board pursuant to this section during the most recent two-year period during which the physician served as a qualified medical evaluator. If the workers' compensation administrative law judge or the appeals board rejects the qualified medical evaluator's report on the basis that it fails to meet the minimum standards for those reports established by the administrative director or the appeals board, the workers' compensation administrative law judge or the appeals board, as the case may be, shall make a specific finding to that effect, and shall give notice to the medical evaluator and to the administrative director. Any rejection shall not be counted as one of the five qualifying rejections until the specific finding has become final and time for appeal has expired.

(3) Has completed within the previous 24 months at least 12 hours of continuing education in impairment evaluation or workers' compensation-related medical dispute evaluation approved by the administrative director.

(4) Has not been terminated, suspended, placed on probation, or otherwise disciplined by the administrative director during his or her most recent term as a qualified medical evaluator.

If the evaluator does not meet any one of these criteria, the administrative director may in his or her discretion reappoint or deny reappointment according to regulations adopted by the administrative director. A physician who does not currently meet the requirements for initial appointment or who has been terminated under subdivision (e) because his or her license has been revoked or terminated by the licensing authority shall not be reappointed.

(e) The administrative director may, in his or her discretion, suspend or terminate a qualified medical evaluator during his or her term of appointment without a hearing as provided under subdivision (k) or (*l*) whenever either of the following conditions occurs:

(1) The evaluator's license to practice in California has been suspended by the relevant licensing authority so as to preclude practice, or has been revoked or terminated by the licensing authority.

(2) The evaluator has failed to timely pay the fee required by the administrative director pursuant to subdivision (n).

(f) The administrative director shall furnish a physician, upon request, with a written statement of its reasons for termination of, or for denying appointment or reappointment as, a qualified medical evaluator. Upon receipt of a specific response to the statement of reasons, the administrative director shall review his or her decision not to appoint or reappoint the physician or to terminate the physician and shall notify the physician of its final decision within 60 days after receipt of the physician's response.

(g) The administrative director shall establish agreements with qualified medical evaluators to ensure the expeditious evaluation of cases assigned to them for comprehensive medical evaluations.

(h) (1) When requested by an employee or employer pursuant to Section 4062.1, the medical director appointed pursuant to Section 122 shall assign three-member panels of qualified medical evaluators within five working days after receiving a request for a panel. Preference in assigning panels shall be given to cases in which the employee is not represented. If a panel is not assigned within 20 working days, the employee shall have the right to obtain a medical evaluation from any qualified medical evaluator of his or her choice within a reasonable geographic area. The medical director shall use a random selection method for assigning panels of qualified medical evaluators. The medical director shall select evaluators who are specialists of the type requested by the employee. The medical director shall advise the employee that he or she should consult with his or her treating physician prior to deciding which type of specialist to request.

(2) The administrative director shall promulgate a form that shall notify the employee of the physicians selected for his or her panel after a request has been made pursuant to Section 4062.1 or 4062.2. The form shall include, for each physician on the panel, the physician's name, address, telephone number, specialty, number of years in practice, and a brief description of his or her education and training, and shall advise the employee that he or she is entitled to receive transportation expenses and temporary disability for each day necessary for the examination. The form shall also state in a clear and conspicuous location and type: "You have the right to consult with an information and assistance officer at no cost to you prior to selecting the doctor to prepare your evaluation, or you may consult with an attorney. If your claim eventually goes to court, the workers' compensation administrative law judge will

consider the evaluation prepared by the doctor you select to decide your claim."

(3) When compiling the list of evaluators from which to select randomly, the medical director shall include all qualified medical evaluators who meet all of the following criteria:

(A) He or she does not have a conflict of interest in the case, as defined by regulations adopted pursuant to subdivision (o).

(B) He or she is certified by the administrative director to evaluate in an appropriate specialty and at locations within the general geographic area of the employee's residence. An evaluator shall not conduct qualified medical evaluations at more than 10 locations.

(C) He or she has not been suspended or terminated as a qualified medical evaluator for failure to pay the fee required by the administrative director pursuant to subdivision (n) or for any other reason.

(4) When the medical director determines that an employee has requested an evaluation by a type of specialist that is appropriate for the employee's injury, but there are not enough qualified medical evaluators of that type within the general geographic area of the employee's residence to establish a three-member panel, the medical director shall include sufficient qualified medical evaluators from other geographic areas and the employer shall pay all necessary travel costs incurred in the event the employee selects an evaluator from another geographic area.

(i) The medical director appointed pursuant to Section 122 shall continuously review the quality of comprehensive medical evaluations and reports prepared by agreed and qualified medical evaluators and the timeliness with which evaluation reports are prepared and submitted. The review shall include, but not be limited to, a review of a random sample of reports submitted to the division, and a review of all reports alleged to be inaccurate or incomplete by a party to a case for which the evaluation was prepared. The medical director shall submit to the administrative director an annual report summarizing the results of the continuous review of medical evaluations and reports prepared by agreed and qualified medical evaluators and make recommendations for the improvement of the system of medical evaluations and determinations.

(j) After public hearing pursuant to Section 5307.3, the administrative director shall adopt regulations concerning the following issues:

(1) (A) Standards governing the timeframes within which medical evaluations shall be prepared and submitted by agreed and qualified medical evaluators. Except as provided in this subdivision, the timeframe for initial medical evaluations to be prepared and submitted shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure. The administrative director shall develop regulations governing the provision of extensions of the 30-day period in both of the following cases:

(i) When the evaluator has not received test results or consulting physician's evaluations in time to meet the 30-day deadline.

(ii) To extend the 30-day period by not more than 15 days when the failure to meet the 30-day deadline was for good cause.

(B) For purposes of subparagraph (A), "good cause" means any of the following:

(i) Medical emergencies of the evaluator or evaluator's family.

(ii) Death in the evaluator's family.

(iii) Natural disasters or other community catastrophes that interrupt the operation of the evaluator's business.

(C) The administrative director shall develop timeframes governing availability of qualified medical evaluators for unrepresented employees under Section 4062.1. These timeframes shall give the employee the right to the addition of a new evaluator to his or her panel, selected at random, for each evaluator not available to see the employee within a specified period of time, but shall also permit the employee to waive this right for a specified period of time thereafter.

(2) Procedures to be followed by all physicians in evaluating the existence and extent of permanent impairment and limitations resulting from an injury in a manner consistent with Sections 4660 and 4660.1.

(3) Procedures governing the determination of any disputed medical treatment issues in a manner consistent with Section 5307.27.

(4) Procedures to be used in determining the compensability of psychiatric injury. The procedures shall be in accordance with Section 3208.3 and shall require that the diagnosis of a mental

disorder be expressed using the terminology and criteria of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, Third Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(5) Guidelines for the range of time normally required to perform the following:

(A) A medical-legal evaluation that has not been defined and valued pursuant to Section 5307.6. The guidelines shall establish minimum times for patient contact in the conduct of the evaluations, and shall be consistent with regulations adopted pursuant to Section 5307.6.

(B) Any treatment procedures that have not been defined and valued pursuant to Section 5307.1.

(C) Any other evaluation procedure requested by the Insurance Commissioner, or deemed appropriate by the administrative director.

(6) Any additional medical or professional standards that a medical evaluator shall meet as a condition of appointment, reappointment, or maintenance in the status of a medical evaluator.

(k) Except as provided in this subdivision, the administrative director may, in his or her discretion, suspend or terminate the privilege of a physician to serve as a qualified medical evaluator if the administrative director, after hearing pursuant to subdivision (*l*), determines, based on substantial evidence, that a qualified medical evaluator:

(1) Has violated any material statutory or administrative duty.

(2) Has failed to follow the medical procedures or qualifications established pursuant to paragraph (2), (3), (4), or (5) of subdivision (j).

(3) Has failed to comply with the timeframe standards established pursuant to subdivision (j).

(4) Has failed to meet the requirements of subdivision (b) or (c).

(5) Has prepared medical-legal evaluations that fail to meet the minimum standards for those reports established by the administrative director or the appeals board.

(6) Has made material misrepresentations or false statements in an application for appointment or reappointment as a qualified medical evaluator.

A hearing shall not be required prior to the suspension or termination of a physician's privilege to serve as a qualified medical evaluator when the physician has done either of the following:

(A) Failed to timely pay the fee required pursuant to subdivision (n).

(B) Had his or her license to practice in California suspended by the relevant licensing authority so as to preclude practice, or had the license revoked or terminated by the licensing authority.

(*l*) The administrative director shall cite the qualified medical evaluator for a violation listed in subdivision (k) and shall set a hearing on the alleged violation within 30 days of service of the citation on the qualified medical evaluator. In addition to the authority to terminate or suspend the qualified medical evaluator upon finding a violation listed in subdivision (k), the administrative director may, in his or her discretion, place a qualified medical evaluator on probation subject to appropriate conditions, including ordering continuing education or training. The administrative director shall report to the appropriate licensing board the name of any qualified medical evaluator who is disciplined pursuant to this subdivision.

(m) The administrative director shall terminate from the list of medical evaluators any physician ~~where~~ *whose* licensure has been terminated by the relevant licensing board, or who has been convicted of a misdemeanor or felony related to the conduct of his or her medical practice, or of a crime of moral turpitude. The administrative director shall suspend or terminate as a medical evaluator any physician who has been suspended or placed on probation by the relevant licensing board. *The administrative director shall terminate as a medical evaluator any physician who is a person described in paragraph (3) of subdivision (b) of Section 139.21*. If a physician is suspended or terminated as a qualified medical evaluator under this subdivision, a report prepared by the physician that is not complete, signed, and furnished to one or more of the parties prior to the date of conviction or action of the licensing board, whichever is earlier, shall not be admissible in any proceeding before the appeals board nor shall there be any

liability for payment for the report and any expense incurred by the physician in connection with the report.

(n) A qualified medical evaluator shall pay a fee, as determined by the administrative director, for appointment or reappointment. These fees shall be based on a sliding scale as established by the administrative director. All revenues from fees paid under this subdivision shall be deposited into the Workers' Compensation Administration Revolving Fund and are available for expenditure upon appropriation by the Legislature, and shall not be used by any other department or agency or for any purpose other than administration of the programs of the Division of Workers' Compensation related to the provision of medical treatment to injured employees.

(o) An evaluator shall not request or accept any compensation or other thing of value from any source that does or could create a conflict with his or her duties as an evaluator under this code. The administrative director, after consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt regulations to implement this subdivision.

SEC. 2. Section 139.21 is added to the Labor Code, immediately following Section 139.2, to read:

139.21. (a) (1) The administrative director shall promptly suspend any physician or practitioner from participating in the workers' compensation system in any capacity when the individual or entity meets any of the following criteria:

(A) The individual has been convicted of a felony.

(B) The individual has been convicted of a misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system.

(C) The individual has been convicted of a misdemeanor involving fraud or abuse of any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(D) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(E) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians and practitioners who have been suspended as described in subdivision (a) by accessing the quarterly updates to

the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp.

(b) (1) The administrative director shall adopt regulations for suspending a physician's or practitioner's participation in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician or practitioner written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the department is required to suspend the physician or practitioner pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician or practitioner requests a hearing and, in that hearing, the physician or practitioner provides proof that paragraph (1) of subdivision (a) is not applicable. The physician or practitioner may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the department finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician or practitioner.

(3) If a physician is a qualified medical examiner, and the department finds, in accordance with the notice and hearing requirements of this section, that paragraph (1) of subdivision (a) is applicable to that physician, the physician shall be terminated from the list of medical evaluators pursuant to subdivision (m) of Section 139.2.

(c) The administrative director shall promptly notify the physician's or practitioner's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the department's qualified medical evaluator and medical provider network databases, as appropriate.

(d) A provider of services, whether an individual, clinic, group, corporation, or other association, may not submit a claim for payment to, or pursue a claim for payment from, a payor for any services or supplies provided by a physician or practitioner whose participation in the workers' compensation system has been

suspended pursuant to this section, unless that claim for payment has been reduced to final judgment or the services or supplies are unrelated to a violation of the laws governing workers' compensation.

~~SEC. 2.~~

SEC. 3. Section 14123 of the Welfare and Institutions Code is amended to read:

14123. Participation in the Medi-Cal program by a provider of service is subject to suspension in order to protect the health of the recipients and the funds appropriated to carry out this chapter.

(a) (1) The director may suspend a provider of service from further participation under the Medi-Cal program for violation of any provision of this chapter or Chapter 8 (commencing with Section 14200) or any rule or regulation promulgated by the director pursuant to those chapters. The suspension may be for an indefinite or specified period of time and with or without conditions, or may be imposed with the operation of the suspension stayed or probation granted. The director shall suspend a provider of service for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

(2) If the provider of service is a clinic, group, corporation, or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization, of a crime described in paragraph (1) shall result in the suspension of that organization and the individual convicted if the director believes that suspension would be in the best interest of the Medi-Cal program. If the provider of services is a political subdivision of the state or other government agency, the conviction of the person in charge of the facility of a crime described in paragraph (1) may result in the suspension of that facility. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(3) After conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, the director, if he or she believes that suspension would be in the best

interests of the Medi-Cal program, may order the suspension of a provider of service. When the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence irrespective of any subsequent order under Section 1203.4 of the Penal Code allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment, the director shall order the suspension of a provider of service. The suspension shall not take effect earlier than the date of the director's order. Suspension following a conviction is not subject to the proceedings required in subdivision (c). However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision.

(4) If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement to the Medi-Cal program after the conviction is reversed. Notwithstanding Section ~~14126.6,~~ *14124.6,* the application for reinstatement shall not be subject to the one-year waiting period for the filing of a reinstatement petition pursuant to Section 11522 of the Government Code.

(b) Whenever the director receives written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or medicaid programs, the director shall promptly suspend the practitioner from participation in the Medi-Cal program and notify the Administrative Director of the Division of Workers' Compensation of the suspension, in accordance with paragraph (2) of subdivision (e). This automatic suspension is not subject to the proceedings required in subdivision (c). No payment from state or federal funds may be made for any item or service rendered by the practitioner during the period of suspension.

(c) The proceedings for suspension shall be conducted pursuant to Section 100171 of the Health and Safety Code. The director may temporarily suspend any provider of service prior to any hearing when in his or her opinion that action is necessary to

protect the public welfare or the interests of the Medi-Cal program. The director shall notify the provider of service of the temporary suspension and the effective date thereof and at the same time serve the provider with an accusation. The accusation and all proceedings thereafter shall be in accordance with Section 100171 of the Health and Safety Code. Upon receipt of a notice of defense by the provider, the director shall set the matter for hearing within 30 days after receipt of the notice. The temporary suspension shall remain in effect until such time as the hearing is completed and the director has made a final determination on the merits. The temporary suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. This subdivision does not apply where the suspension of a provider is based upon the conviction of any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare program. In those instances, suspension shall be automatic.

(d) (1) The suspension by the director of any provider of service shall preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program, except for services or supplies provided prior to the suspension. No clinic, group, corporation, or other association which is a provider of service shall submit claims for payment to the Medi-Cal program for any services or supplies provided by a person within the organization who has been suspended or revoked by the director, except for services or supplies provided prior to the suspension.

(2) If the provisions of this chapter, Chapter 8 (commencing with Section 14200), or the regulations promulgated by the director are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the organization who is responsible for the violation.

(e) (1) Notice of the suspension shall be sent by the director to the provider's state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

(2) At the same time notice is provided pursuant to paragraph (1), the director shall provide written notification of the suspension

to the Administrative Director of the Division of Workers' Compensation, for purposes of Section ~~5307.15~~ *139.21* of the Labor Code.

(f) In addition to the bases for suspension contained in subdivisions (a) and (b), the director may suspend a provider of service from further participation under the Medi-Cal dental program for the provision of services that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. The suspension shall be subject to the requirements contained in subdivisions (a) to (e), inclusive.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1306
Author: Burke
Bill Date: June 30, 2016, Amended
Subject: Certified Nurse Midwives: Scope of Practice
Sponsor: California Nurse Midwives Association
Current Position: Oppose Unless Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would remove the physician supervision requirement for certified nurse midwives (CNMs) working in specified settings, would increase educational requirements, and would establish a Nurse-Midwifery Advisory Committee within the Board of Registered Nursing (BRN), among other changes.

BACKGROUND:

CNMs are registered nurses with a certificate to practice midwifery, who have acquired additional training in the field of obstetrics and are certified by the American College of Nurse Midwives. Like licensed midwives (LMs), CNMS can practice in homes, birth centers and clinics; however, CNMs can also practice in hospital settings. In 2012, CNMs attended approximately 8.5 percent of all births in California, the majority of these births took place in a hospital, and the remainder took place in free-standing birthing centers. It is estimated that ninety percent of CNM attended births take place in a hospital setting. CNMs are required to practice under the supervision of a physician; California is one of six states that require physician supervision of CNMs.

Existing law authorizes a CNM, under physician supervision, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care for the mother, and immediate care for the newborn. Existing law authorizes a CNM to furnish and order drugs or devices incidental to the provision of family planning services, routine health care or perinatal care, and care rendered consistently with the CNM's education, and in accordance with standardized procedures and protocols with the supervising physician. Existing law also authorizes a CNM to perform and repair episiotomies and repair first-degree and second degree lacerations of the perineum in a licensed acute care hospital and licensed alternate birth center, if performed pursuant to protocols developed and approved by the supervising physician.

AB 1308 (Bonilla, Chapter 665) was signed into law in 2013 and removed the physician supervision requirement for LMs. There were specific requirements on what type of patients LMs can accept, which are those that meet the criteria for normal pregnancy and

childbirth, as specified. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM must refer that client to a physician trained in obstetrics and gynecology for examination; the LM can only accept the client if the physician examines the client and determines that the risk factors are not likely to significantly affect the course of pregnancy and childbirth. AB 1308 also allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to the practice of midwifery and consistent with the LMs' scope of practice. AB 1308 was very narrow on what services could be provided and what patients an LM could accept. It also included other provisions related to hospital transfers and education program requirements.

ANALYSIS

This bill would subject CNMs to the anti-kickback and referral prohibitions in Business and Professions Code Section 650.01 and the exemptions in 650.02 and would add an exemption for a referral to a licensed alternative birth center or nationally accredited alternative birth center.

This bill would require a CNM applicant to provide evidence of current advanced level national certification by a certifying body that meets standards established and approved by the BRN.

This bill would require the BRN to create and appoint a Nurse-Midwifery Advisory Committee (Committee), similar to the Medical Board of California's (Board) Midwifery Advisory Council (MAC), which would consist of CNMs in good standing with experience in hospital settings, alternative birth center settings, and home settings; a nurse-midwife educator, as specified; a consumer of midwifery care; and at least two qualified physicians, including an obstetrician that has experience working with nurse-midwives. The Committee membership must consist of a majority of CNMs who shall make recommendations to BRN on all matters related to nurse-midwifery practice, education, and other matters specified by BRN, and would require the Committee to meet regularly, but at least twice a year.

This bill would authorize a CNM to manage a full range of primary gynecological and obstetric care services for women from adolescence to beyond menopause, consistent with the Core Competencies for Basic Midwifery Practice promulgated by the American College of Nurse-Midwives, as approved by BRN. These services include, but are not limited to: primary health care; gynecologic and family planning services; preconception care; care during pregnancy, childbirth, and postpartum period; immediate care of the newborn; and treatment of male partners for sexually transmitted infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.

This bill would allow a CNM to practice without physician supervision in the following settings:

- A licensed clinic.

- A licensed health facility (this includes a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, etc.).
- A county medical facility.
- A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.
- A licensed alternative birth center or a nationally accredited alternative birth center.
- A nursing corporation.
- A home setting.

This bill would allow a CNM to be employed in these settings; however the entity shall not interfere with, control, or otherwise direct the professional judgment of a CNM.

This bill would only allow a CNM to attend normal and low-risk pregnancy and childbirth in the home setting when all of the following conditions apply:

- There is an absence of all of the following:
    - Any preexisting maternal disease or condition creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.
    - Disease arising from or during the pregnancy creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.
    - Prior caesarean delivery.
- There is a singleton fetus.
- There is cephalic presentation at the onset of labor.
- The gestational age of the fetus is greater than 37 0/7 weeks and less than 42 0/7 completed weeks of pregnancy at the onset of labor.
- Labor is spontaneous or induced in an outpatient setting.

If a potential CNM client meets all of the above conditions, but has had a prior caesarean delivery, and the woman still desires to be a client of the CNM, the CNM shall provide the woman with a referral for an examination by a physician trained in obstetrics and gynecology. A CNM may assist the woman in pregnancy and childbirth only if an examination by a physician trained in obstetrics and gynecology is obtained and, based upon review of the client's medical file, the CNM determines that the risk factors presented by the woman's condition do not increase the woman's risk beyond that of a normal, low-risk pregnancy and birth. A CNM may continue care of the client during a reasonable interval between the referral and the initial appointment with the physician.

This bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the

client and the resources of the medical personnel available in the setting of care. This bill would provide that the practice of nurse-midwifery emphasizes informed consent, preventive care and early detection and referral of a complication to a physician. This bill would require CNMs working in a hospital setting to collaboratively care for women with more complex health needs.

This bill would require a CNM to be subject to all credentialing and quality standards held by the facility in which he or she practices. This bill would require the peer review body to include CNMs as part of the peer review body that reviews CNMS. This bill would require the peer review body of that facility to impose standards that assure quality and patient safety and these standards must be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

This bill would delete requirements in existing law that drugs or devices must be furnished or ordered by a CNM in accordance with standardized procedures and protocols. This bill would require CNMs to only furnish Schedule II controlled substances in a nonhospital setting during labor and delivery and only after a consultation with a physician. This bill would authorize a CMN to: furnish and order drugs or devices in connection with care rendered in a home; directly procure supplies and devices; order, obtain, and administer drugs and diagnostic tests; order laboratory and diagnostic testing; and receive reports that are necessary to his or her practice as a CNM and that are consistent with nurse-midwifery education preparation.

This bill would authorize a CNM to perform and repair episiotomies and to repair first degree and second degree lacerations of the perineum in a nationally accredited birth center or in a patient's home, as specified, and would delete all requirements that those procedures be performed pursuant to protocols developed and approved by a supervising physician.

This bill would state that a consultative relationship between a CNM and a physician shall not, by itself, provide the basis for finding a physician liable for any act or omission of the CNM.

This bill has been significantly amended and the amendments address the concerns previously raised by the Board. This bill now would require two physician members on the Committee, is very restricted on what types of patients a CNM can accept, and requires a physician examination for patients that have had a prior caesarean delivery. Although the CNM is allowed to make the determination regarding the risk factors for patients that have had a prior caesarean delivery, the CNM is still held to the standard of care and subject to discipline if that standard is not met. Although this bill does not include a ban on the corporate practice of medicine for CNMs, the type of settings where CNMs are allowed to work without physician supervision are limited, and for the most part they are licensed facilities overseen by the California Department of Public Health. Although this bill now includes parameters on independent CNM practice, this bill does expand the scope of a CNM to include primary health care as part of the gynecological and obstetric care services that a CNM can provide. If the

reference to primary health care is removed, Board staff believes this bill has the necessary protections in place to ensure consumer protection. As such, Board staff is recommending that the Board change its position from oppose unless amended to neutral if amended.

FISCAL: None to the Board

SUPPORT: California Nurse Midwives Association (Sponsor); Association of Healthcare Districts; and AARP

7/1/15 Version

American Association of Birth Centers; American College of Nurse-Midwives; American Nurses Association/California; Beach Cities Midwifery & Women's Health Care; Beachside Birth Center; Black Women for Wellness; California Association of Midwives; California Association of Nurse Anesthetists; Center on Reproductive Rights and Justice at the University of California, Berkley School of Law; County of Santa Cruz Board of Supervisors; Inland Midwife Service; Maternal and Child Health Access; South Coast Midwifery & Women's Healthcare, Inc.; United Nurses Associations of California/Union of Health Care Professionals; and numerous individuals

OPPOSITION: Adventist Health; California Association for Nurse Practitioners; California Hospital Association; and Sutter Health

7/1/15 Version

California Association of Clinical Nurse Specialists; Ceders-Sinai; Coalinga Regional Medical Center; Community Hospital of the Monterey Peninsula; El Camino Hospital; Henry Mayo Newhall Hospital; Lodi Health; Loma Linda University Health; Lompoc Valley Medical Center; Mammoth Hospital; Medical Board of California; Natividad Medical Center; Ridgecrest Regional Hospital; San Antonio Regional Hospital; San Benito Health Care District; San Gorgonio Memorial Hospital; Sharp Healthcare; St. Helena Hospital Napa Valley; Sutter Health; and Watsonville Community Hospital

POSITION: Recommendation: Neutral if Amended

AMENDED IN SENATE JUNE 30, 2016

AMENDED IN SENATE JUNE 20, 2016

AMENDED IN SENATE JULY 1, 2015

AMENDED IN ASSEMBLY MAY 28, 2015

CALIFORNIA LEGISLATURE—2015–16 REGULAR SESSION

ASSEMBLY BILL No. 1306

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

February 27, 2015

An act to amend Sections *510,* 650.01, 650.02, 2725.1, 2746.2, 2746.5, 2746.51, 2746.52, 4061, 4076, and 4170 of, and to add Section 2746.6 to, the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

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

(1) Existing law, the Nursing Practice Act, provides for the licensure and regulation of the practice of nursing by the Board of Registered Nursing and authorizes the board to issue a certificate to practice nurse-midwifery to a person who meets educational standards established by the board or the equivalent of those educational standards. The act makes the violation of any of its provisions a misdemeanor punishable upon conviction by imprisonment in the county jail for not less than 10 days nor more than one year, or by a fine of not less than $20 nor more than $1,000, or by both that fine and imprisonment.

This bill would additionally require an applicant for a certificate to practice nurse-midwifery to provide evidence of current advanced level

national certification by a certifying body that meets standards established and approved by the board. The bill would also require the board to create and appoint a Nurse-Midwifery Advisory Committee consisting of certified nurse-midwives in good standing with experience in hospital settings, alternative birth settings, and home settings, a nurse-midwife educator, as specified, 2 qualified physicians, and a consumer of midwifery care. ~~This~~ *The* bill would require the committee to consist of a majority of certified nurse-midwives and would require the committee to make recommendations to the board on all matters related to nurse-midwifery practice, education, disciplinary actions, standards of care, and other matters specified by the board, and would require the committee to meet regularly, but at least twice a year. ~~This bill would prohibit corporations and other artificial legal entities from having professional rights, privileges, or powers under the act, except as specified. The bill would authorize specified entities to employ a certified nurse-midwife and charge for professional services rendered by that certified nurse-midwife, as provided.~~

(2) The act authorizes a certified nurse-midwife, under the supervision of a licensed physician and surgeon, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother, and immediate care for the newborn, and provides that the practice of nurse-midwifery constitutes the furthering or undertaking by a certified person, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, to assist a woman in childbirth so long as progress meets criteria accepted as normal.

This bill would delete those provisions and would instead authorize a certified nurse-midwife to manage a full range of gynecological and obstetric care services for women from adolescence beyond menopause, as provided. The bill would authorize a certified nurse-midwife to practice *under that gynecological and obstetric care services authorization without supervision of a physician and surgeon* in certain settings, including, but not limited to, a home setting, as specified. ~~This~~ *The bill would prohibit entities described in those specified settings from interfering with, controlling, or otherwise directing the professional judgment of such a certified nurse-midwife, as specified. The* bill would declare that the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the client and the resources of the medical personnel available in the setting of care, and would provide that the practice of

nurse-midwifery emphasizes informed consent, preventive care, and early detection and referral of complications to a physician and surgeon.

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

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

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

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

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

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

(6) Existing law provides prescribed protection against retaliation for health care practitioners who advocate for appropriate health care for their patients. Existing law defines "health care practitioner" for those purposes to mean a person who engages in acts that are the subject of licensure or regulation under specific law or initiative act and who is either a licentiate, as defined, a party to a contract with a payer whose decision, policy, or practice is subject to such advocacy, or an individual designated in a contract with a payer whose decision, policy, or practice is subject to such advocacy, where the individual is granted the right to appeal denials of payment or authorization for treatment under the contract.

This bill would expand that protection against retaliation to certified nurse-midwives.

~~(6)~~

(7) Existing law prohibits a licensee, as defined, from referring a person for laboratory, diagnostic, nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or entity that receives the referral, and makes a violation of that prohibition punishable as a misdemeanor. Under existing law, the Medical Board of California is required to review the facts and circumstances of any conviction for violating the prohibition, and to take appropriate disciplinary action if the licensee has committed unprofessional conduct. Existing law provides that, among other exceptions, this prohibition does not apply to a licensee who refers a person to a health facility if specified conditions are met.

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

~~(7)~~

(8) 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 510 of the Business and Professions Code*
2 *is amended to read:*
3 510. (a) The purpose of this section is to provide protection
4 against retaliation for health care practitioners who advocate for
5 appropriate health care for their patients pursuant to Wickline v.
6 State of California 192 Cal. App. 3d 1630.
7 (b) It is the public policy of the State of California that a health
8 care practitioner be encouraged to advocate for appropriate health
9 care for his or her patients. For purposes of this section, "to
10 advocate for appropriate health care" means to appeal a payer's
11 decision to deny payment for a service pursuant to the reasonable
12 grievance or appeal procedure established by a medical group,
13 independent practice association, preferred provider organization,
14 foundation, hospital medical staff and governing body, or payer,
15 or to protest a decision, policy, or practice that the health care
16 practitioner, consistent with that degree of learning and skill
17 ordinarily possessed by reputable health care practitioners with
18 the same license or certification and practicing according to the
19 applicable legal standard of care, reasonably believes impairs the
20 health care practitioner's ability to provide appropriate health care
21 to his or her patients.
22 (c) The application and rendering by any individual, partnership,
23 corporation, or other organization of a decision to terminate an
24 employment or other contractual relationship with or otherwise
25 penalize a health care practitioner principally for advocating for
26 appropriate health care consistent with that degree of learning and
27 skill ordinarily possessed by reputable health care practitioners
28 with the same license or certification and practicing according to
29 the applicable legal standard of care violates the public policy of
30 this state.

(d) This section shall not be construed to prohibit a payer from making a determination not to pay for a particular medical treatment or service, or the services of a type of health care practitioner, or to prohibit a medical group, independent practice association, preferred provider organization, foundation, hospital medical staff, hospital governing body acting pursuant to Section 809.05, or payer from enforcing reasonable peer review or utilization review protocols or determining whether a health care practitioner has complied with those protocols.

(e) (1) Except as provided in paragraph (2), appropriate health care in a hospital licensed pursuant to Section 1250 of the Health and Safety Code shall be defined by the appropriate hospital committee and approved by the hospital medical staff and the governing body, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care.

(2) To the extent the issue is under the jurisdiction of the medical staff and its committees, appropriate health care in a hospital licensed pursuant to Section 1250 of the Health and Safety Code shall be defined by the hospital medical staff and approved by the governing body, consistent with that degree of learning and skill ordinarily possessed by reputable health care practitioners with the same license or certification and practicing according to the applicable legal standard of care.

(f) Nothing in this section shall be construed to prohibit the governing body of a hospital from taking disciplinary actions against a health care practitioner as authorized by Sections 809.05, 809.4, and 809.5.

(g) Nothing in this section shall be construed to prohibit the appropriate licensing authority from taking disciplinary actions against a health care practitioner.

(h) For purposes of this section, “health care practitioner” means *either* a person who is described in subdivision (f) of Section 900 and who is either (1) a licentiate as defined in Section 805, or (2) a party to a contract with a payer whose decision, policy, or practice is subject to the advocacy described in subdivision (b), or (3) an individual designated in a contract with a payer whose decision, policy, or practice is subject to the advocacy described in subdivision (b), where the individual is granted the right to appeal

denials of payment or authorization for treatment under the ~~contract.~~ *contract, or a person who is described in Section 2746.2.*

(i) Nothing in this section shall be construed to revise or expand the scope of practice of any health care practitioner, or to revise or expand the types of health care practitioners who are authorized to obtain medical staff privileges or to submit claims for reimbursement to payers.

(j) The protections afforded health care practitioners by this section shall be in addition to the protections available under any other law of this state.

~~SECTION 1.~~

SEC. 2. Section 650.01 of the Business and Professions Code is amended to read:

650.01. (a) Notwithstanding Section 650, or any other law, it is unlawful for a licensee to refer a person for laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services if the licensee or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 650.02, the following shall apply:

(1) "Diagnostic imaging" includes, but is not limited to, all X-ray, computed axial tomography, magnetic resonance imaging nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) A "financial interest" includes, but is not limited to, any type of ownership interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the licensee refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect financial relationship between a licensee and the referral recipient including, but not limited to, an arrangement whereby a licensee has an ownership interest in an entity that leases property to the referral recipient. Any financial interest transferred by a licensee to any person or entity or otherwise established in any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the licensee. For

purposes of this paragraph, "direct or indirect payment" shall not include a royalty or consulting fee received by a physician and surgeon who has completed a recognized residency training program in orthopedics from a manufacturer or distributor as a result of his or her research and development of medical devices and techniques for that manufacturer or distributor. For purposes of this paragraph, "consulting fees" means those fees paid by the manufacturer or distributor to a physician and surgeon who has completed a recognized residency training program in orthopedics only for his or her ongoing services in making refinements to his or her medical devices or techniques marketed or distributed by the manufacturer or distributor, if the manufacturer or distributor does not own or control the facility to which the physician is referring the patient. A "financial interest" shall not include the receipt of capitation payments or other fixed amounts that are prepaid in exchange for a promise of a licensee to provide specified health care services to specified beneficiaries. A "financial interest" shall not include the receipt of remuneration by a medical director of a hospice, as defined in Section 1746 of the Health and Safety Code, for specified services if the arrangement is set out in writing, and specifies all services to be provided by the medical director, the term of the arrangement is for at least one year, and the compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between parties.

(3) For the purposes of this section, "immediate family" includes the spouse and children of the licensee, the parents of the licensee, and the spouses of the children of the licensee.

(4) "Licensee" means a physician as defined in Section 3209.3 of the Labor Code, and a certified nurse-midwife as defined in Article 2.5 (commencing with Section 2746) of Chapter 6 of Division 2 of the Business and Professions Code.

(5) "Licensee's office" means either of the following:

(A) An office of a licensee in solo practice.

(B) An office in which services or goods are personally provided by the licensee or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall

be licensed or certified when licensure or certification is required by law.

(6) "Office of a group practice" means an office or offices in which two or more licensees are legally organized as a partnership, professional corporation, or not-for-profit corporation, licensed pursuant to subdivision (a) of Section 1204 of the Health and Safety Code, for which all of the following apply:

(A) Each licensee who is a member of the group provides substantially the full range of services that the licensee routinely provides, including medical care, consultation, diagnosis, or treatment through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the licensees who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, except in the case of a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(d) No claim for payment shall be presented by an entity to any individual, third party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) No insurer, self-insurer, or other payer shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(f) A licensee who refers a person to, or seeks consultation from, an organization in which the licensee has a financial interest, other than as prohibited by subdivision (a), shall disclose the financial interest to the patient, or the parent or legal guardian of the patient, in writing, at the time of the referral or request for consultation.

(1) If a referral, billing, or other solicitation is between one or more licensees who contract with a multispecialty clinic pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code or who conduct their practice as members of the same professional corporation or partnership, and the services are rendered on the same physical premises, or under the same professional corporation or partnership name, the requirements of this subdivision may be met by posting a conspicuous disclosure statement at the registration area or by providing a patient with a written disclosure statement.

(2) If a licensee is under contract with the Department of Corrections or the California Youth Authority, and the patient is an inmate or parolee of either respective department, the requirements of this subdivision shall be satisfied by disclosing financial interests to either the Department of Corrections or the California Youth Authority.

(g) A violation of subdivision (a) shall be a misdemeanor. In the case of a licensee who is a physician, the Medical Board of California shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. In the case of a licensee who is a certified nurse-midwife, the Board of Registered Nursing shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), or (e) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California, the Board of Registered Nursing, or other appropriate governmental agency.

(h) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(i) This section shall become operative on January 1, 1995.

~~SEC. 2.~~

SEC. 3. Section 650.02 of the Business and Professions Code is amended to read:

650.02. The prohibition of Section 650.01 shall not apply to or restrict any of the following:

(a) A licensee may refer a patient for a good or service otherwise prohibited by subdivision (a) of Section 650.01 if the licensee's regular practice is located where there is no alternative provider of the service within either 25 miles or 40 minutes traveling time, via the shortest route on a paved road. If an alternative provider commences furnishing the good or service for which a patient was referred pursuant to this subdivision, the licensee shall cease referrals under this subdivision within six months of the time at which the licensee knew or should have known that the alternative provider is furnishing the good or service. A licensee who refers to or seeks consultation from an organization in which the licensee has a financial interest under this subdivision shall disclose this interest to the patient or the patient's parents or legal guardian in writing at the time of referral.

(b) A licensee, when the licensee or his or her immediate family has one or more of the following arrangements with another licensee, a person, or an entity, is not prohibited from referring a patient to the licensee, person, or entity because of the arrangement:

(1) A loan between a licensee and the recipient of the referral, if the loan has commercially reasonable terms, bears interest at the prime rate or a higher rate that does not constitute usury, is adequately secured, and the loan terms are not affected by either party's referral of any person or the volume of services provided by either party.

(2) A lease of space or equipment between a licensee and the recipient of the referral, if the lease is written, has commercially reasonable terms, has a fixed periodic rent payment, has a term of one year or more, and the lease payments are not affected by either party's referral of any person or the volume of services provided by either party.

(3) Ownership of corporate investment securities, including shares, bonds, or other debt instruments that may be purchased on terms generally available to the public and that are traded on a licensed securities exchange or NASDAQ, do not base profit distributions or other transfers of value on the licensee's referral

of persons to the corporation, do not have a separate class or accounting for any persons or for any licensees who may refer persons to the corporation, and are in a corporation that had, at the end of the corporation's most recent fiscal year, or on average during the previous three fiscal years, stockholder equity exceeding seventy-five million dollars ($75,000,000).

(4) Ownership of shares in a regulated investment company as defined in Section 851(a) of the federal Internal Revenue Code, if the company had, at the end of the company's most recent fiscal year, or on average during the previous three fiscal years, total assets exceeding seventy-five million dollars ($75,000,000).

(5) A one-time sale or transfer of a practice or property or other financial interest between a licensee and the recipient of the referral if the sale or transfer is for commercially reasonable terms and the consideration is not affected by either party's referral of any person or the volume of services provided by either party.

(6) A personal services arrangement between a licensee or an immediate family member of the licensee and the recipient of the referral if the arrangement meets all of the following requirements:

(A) It is set out in writing and is signed by the parties.

(B) It specifies all of the services to be provided by the licensee or an immediate family member of the licensee.

(C) The aggregate services contracted for do not exceed those that are reasonable and necessary for the legitimate business purposes of the arrangement.

(D) A person who is referred by a licensee or an immediate family member of the licensee is informed in writing of the personal services arrangement that includes information on where a person may go to file a complaint against the licensee or the immediate family member of the licensee.

(E) The term of the arrangement is for at least one year.

(F) The compensation to be paid over the term of the arrangement is set in advance, does not exceed fair market value, and is not determined in a manner that takes into account the volume or value of any referrals or other business generated between the parties.

(G) The services to be performed under the arrangement do not involve the counseling or promotion of a business arrangement or other activity that violates any state or federal law.

(c) (1) A licensee may refer a person to a health facility, as defined in Section 1250 of the Health and Safety Code, a licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or to any facility, or nationally accredited alternative birth center, owned or leased by a health facility, if the recipient of the referral does not compensate the licensee for the patient referral, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b).

(2) Nothing shall preclude this subdivision from applying to a licensee solely because the licensee has an ownership or leasehold interest in an entire health facility or an entity that owns or leases an entire health facility.

(3) A licensee may refer a person to a health facility for any service classified as an emergency under subdivision (a) or (b) of Section 1317.1 of the Health and Safety Code.

(4) A licensee may refer a person to any organization that owns or leases a health facility licensed pursuant to subdivision (a), (b), or (f) of Section 1250 of the Health and Safety Code if the licensee is not compensated for the patient referral, the licensee does not receive any payment from the recipient of the referral that is based or determined on the number or value of any patient referrals, and any equipment lease arrangement between the licensee and the referral recipient complies with the requirements of paragraph (2) of subdivision (b). For purposes of this paragraph, the ownership may be through stock or membership, and may be represented by a parent holding company that solely owns or controls both the health facility organization and the affiliated organization.

(d) A licensee may refer a person to a nonprofit corporation that provides physician services pursuant to subdivision (*l*) of Section 1206 of the Health and Safety Code if the nonprofit corporation is controlled through membership by one or more health facilities or health facility systems and the amount of compensation or other transfer of funds from the health facility or nonprofit corporation to the licensee is fixed annually, except for adjustments caused by physicians joining or leaving the groups during the year, and is not based on the number of persons utilizing goods or services specified in Section 650.01.

(e) A licensee compensated or employed by a university may refer a person for a physician service, to any facility owned or operated by the university, or to another licensee employed by the university, provided that the facility or university does not compensate the referring licensee for the patient referral. In the case of a facility that is totally or partially owned by an entity other than the university, but that is staffed by university physicians, those physicians may not refer patients to the facility if the facility compensates the referring physicians for those referrals.

(f) The prohibition of Section 650.01 shall not apply to any service for a specific patient that is performed within, or goods that are supplied by, a licensee's office, or the office of a group practice. Further, the provisions of Section 650.01 shall not alter, limit, or expand a licensee's ability to deliver, or to direct or supervise the delivery of, in-office goods or services according to the laws, rules, and regulations governing his or her scope of practice.

(g) The prohibition of Section 650.01 shall not apply to cardiac rehabilitation services provided by a licensee or by a suitably trained individual under the direct or general supervision of a licensee, if the services are provided to patients meeting the criteria for Medicare reimbursement for the services.

(h) The prohibition of Section 650.01 shall not apply if a licensee is in the office of a group practice and refers a person for services or goods specified in Section 650.01 to a multispecialty clinic, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code.

(i) The prohibition of Section 650.01 shall not apply to health care services provided to an enrollee of a health care service plan licensed pursuant to the Knox-Keene Health Care Service Plan Act of 1975 (Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code).

(j) The prohibition of Section 650.01 shall not apply to a request by a pathologist for clinical diagnostic laboratory tests and pathological examination services, a request by a radiologist for diagnostic radiology services, or a request by a radiation oncologist for radiation therapy if those services are furnished by, or under the supervision of, the pathologist, radiologist, or radiation oncologist pursuant to a consultation requested by another physician.

(k) This section shall not apply to referrals for services that are described in and covered by Sections 139.3 and 139.31 of the Labor Code.

(*l*) This section shall become operative on January 1, 1995.

~~SEC. 3.~~

SEC. 4. Section 2725.1 of the Business and Professions Code is amended to read:

2725.1. (a) Notwithstanding any other law, a registered nurse may dispense drugs or devices upon an order by a licensed physician and surgeon or an order by a certified nurse-midwife, nurse practitioner, or physician assistant issued pursuant to Section 2746.51, 2836.1, or 3502.1, respectively, if the registered nurse is functioning within a licensed primary care clinic as defined in subdivision (a) of Section 1204 of, or within a clinic as defined in subdivision (b), (c), (h), or (j) of Section 1206 of, the Health and Safety Code.

(b) No clinic shall employ a registered nurse to perform dispensing duties exclusively. No registered nurse shall dispense drugs in a pharmacy, keep a pharmacy, open shop, or drugstore for the retailing of drugs or poisons. No registered nurse shall compound drugs. Dispensing of drugs by a registered nurse, except a certified nurse-midwife who functions pursuant to Section 2746.51 or a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, shall not include substances included in the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code). Nothing in this section shall exempt a clinic from the provisions of Article 13 (commencing with Section 4180) of Chapter 9.

(c) This section shall not be construed to limit any other authority granted to a certified nurse-midwife pursuant to Article 2.5 (commencing with Section 2746), to a nurse practitioner pursuant to Article 8 (commencing with Section 2834), or to a physician assistant pursuant to Chapter 7.7 (commencing with Section 3500).

(d) This section shall not be construed to affect the sites or types of health care facilities at which drugs or devices are authorized to be dispensed pursuant to Chapter 9 (commencing with Section 4000).

~~SEC. 4.~~

SEC. 5. Section 2746.2 of the Business and Professions Code is amended to read:

2746.2. (a) Each applicant shall show by evidence satisfactory to the board that he or she has met the educational standards established by the board or has at least the equivalent thereof, including evidence of current advanced level national certification by a certifying body that meets standards established and approved by the board.

(b) The board shall create and appoint a Nurse-Midwifery Advisory Committee consisting of certified nurse-midwives in good standing with experience in hospital settings, alternative birth center settings, and home settings, a nurse-midwife educator who has demonstrated familiarity with educational standards in the delivery of maternal-child health care, a consumer of midwifery care, and at least two qualified physicians, including an obstetrician that has experience working with nurse-midwives. The committee membership shall consist of a majority of certified nurse-midwives and shall make recommendations to the board on all matters related to nurse-midwifery practice, education, and other matters as specified by the board. The committee shall meet regularly, but at least twice a year.

~~(c) Corporations and other artificial legal entities shall have no professional rights, privileges, or powers. However, the Board of Registered Nursing may in its discretion, after such investigation and review of such documentary evidence as it may require, and under regulations adopted by it, grant approval of the employment of licensees on a salary basis by licensed charitable institutions, foundations, or clinics, if no charge for professional services rendered patients is made by any such institution, foundation, or clinic.~~

~~(d) Notwithstanding subdivision (c), the following entities may employ a certified nurse-midwife and charge for professional services rendered by a certified nurse-midwife; however, the entity shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife:~~

~~(1) A clinic operated under subdivision (h) or (p) of Section 1206 of the Health and Safety Code.~~

~~(2) A hospital owned and operated by a health care district pursuant to Division 23 (commencing with Section 32000) of the Health and Safety Code.~~

~~(3) A clinic operated primarily for the purpose of medical education or nursing education by a public or private nonprofit university medical school, which is approved by the Medical Board or the Osteopathic Medical Board of California, provided the certified nurse-midwife holds an academic appointment on the faculty of the university, including, but not limited to, the University of California medical schools and hospitals.~~

~~(4) A licensed alternative birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited alternative birth center owned or operated by a nursing corporation, as defined in Section 2775 of the Business and Professions Code.~~

~~(5) A health facility described in Section 1250 of the Health and Safety Code if the certified-nurse midwife is practicing under the supervision of a physician and surgeon.~~

~~(6) A clinic operated under subdivision (a) of Section 1204 of the Health and Safety code.~~

~~(e) As used in this section, supervision shall not be construed to require the physical presence of a supervising physician and surgeon. A facility described in paragraphs (1) to (4), inclusive, of subdivision (d) that employs a certified-nurse midwife shall not require supervision by a physician and surgeon of the certified-nurse midwife.~~

~~SEC. 5.~~

SEC. 6. Section 2746.5 of the Business and Professions Code is amended to read:

2746.5. (a) The certificate to practice nurse-midwifery authorizes the holder to manage a full range of primary gynecological and obstetric care services for women from adolescence to beyond menopause, consistent with the Core Competencies for Basic Midwifery practice promulgated by the American College of Nurse-Midwives, or its successor national professional organization, as approved by the board. These services include, but are not limited to, primary health care, gynecologic and family planning services, preconception care, care during pregnancy, childbirth, and the postpartum period, immediate care of the newborn, and treatment of male partners for sexually

transmitted infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services, as indicated.

(b) A certified nurse-midwife may practice *under this section without supervision of a physician and surgeon* in the following settings:

(1) A licensed clinic as described in Chapter 1 (commencing with Section 1200) of Division 2 of the Health and Safety Code.

(2) A facility as described in Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(3) A facility as described in Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(4) A medical group practice, including a professional medical corporation, a medical partnership, a medical foundation exempt from licensure pursuant to Section 1206 of the Health and Safety Code, or another lawfully organized group of physicians that delivers, furnishes, or otherwise arranges for or provides health care services.

(5) A licensed alternative birth center, as described in Section 1204 of the Health and Safety Code, or nationally accredited birth center.

(6) A nursing corporation, as defined in Section 2775 of the Business and Professions Code.

(7) A home setting.

(A) Except as provided in subparagraph (B), a certified nurse-midwife shall only attend during normal, low-risk pregnancy and childbirth in the home setting when all of the following conditions apply:

(i) There is the absence of all of the following:

(I) Any preexisting maternal disease or condition creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.

(II) Disease arising from or during the pregnancy creating risks beyond that of a normal, low-risk pregnancy or birth, as defined in the American College of Nurse-Midwives' standard-setting documents and any future changes to those documents.

(III) Prior caesarean delivery.

(ii) There is a singleton fetus.

(iii) There is cephalic presentation at the onset of labor.

(iv) The gestational age of the fetus is greater than 370/7 weeks and less than 420/7 completed weeks of pregnancy at the onset of labor.

(v) Labor is spontaneous or induced in an outpatient setting.

(B) If a potential certified nurse-midwife client meets the conditions specified in subclauses (I) and (II) of clause (i) and clauses (ii) to (v), inclusive, of subparagraph (A), but fails to meet the condition specified in subclause (III) of clause (i) of subparagraph (A), and the woman still desires to be a client of the certified nurse-midwife, the certified nurse-midwife shall provide the woman with a referral for an examination by a physician and surgeon trained in obstetrics and gynecology. A certified nurse-midwife may assist the woman in pregnancy and childbirth only if an examination by a physician and surgeon trained in obstetrics and gynecology is obtained and, based upon review of the client's medical file, the certified nurse-midwife determines that the risk factors presented by the woman's condition do not increase the woman's risk beyond that of a normal, low-risk pregnancy and birth. The certified nurse-midwife may continue care of the client during a reasonable interval between the referral and the initial appointment with the physician and surgeon.

(c) An entity described in subdivision (b) shall not interfere with, control, or otherwise direct the professional judgment of a certified nurse-midwife functioning pursuant to this section in a manner prohibited by Section 510 or any other law.

~~(c)~~

(d) As used in this chapter, the practice of nurse-midwifery within a health care system provides for consultation, collaboration, or referral as indicated by the health status of the patient and the resources and medical personnel available in the setting of care. The practice of nurse-midwifery care emphasizes informed consent, preventive care, and early detection and referral of complications to physicians and surgeons. While practicing in a hospital setting, the certified nurse-midwife shall collaboratively care for women with more complex health needs.

~~(d)~~

(e) A certified nurse-midwife practicing under subdivision (a) shall be subject to all credentialing and quality standards held by the facility in which he or she practices. The peer review body shall include nurse-midwives as part of the peer review body that

reviews nurse-midwives. The peer review body of that facility shall impose standards that ensure quality and patient safety in their facility. The standards shall be approved by the relevant governing body unless found by a court to be arbitrary and capricious.

~~(e)~~

(f) The practice of nurse-midwifery does not include the assisting of childbirth by any forcible or mechanical means or the performance of a version.

~~(f)~~

(g) A certified nurse-midwife is not authorized to practice medicine and surgery by the provisions of this chapter.

~~(g)~~

(h) Any regulations promulgated by a state department that affect the scope of practice of a certified nurse-midwife shall be developed in consultation with the board and the Nurse-Midwifery Advisory Committee.

~~SEC. 6.~~

SEC. 7. Section 2746.51 of the Business and Professions Code is amended to read:

2746.51. (a) Neither this chapter nor any other law shall be construed to prohibit a certified nurse-midwife from furnishing or ordering drugs or devices, including controlled substances classified in Schedule II, III, IV, or V under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code), when the drugs or devices are furnished or ordered related to the provision of any of the following:

(1) Family planning services, as defined in Section 14503 of the Welfare and Institutions Code.

(2) Routine health care or perinatal care, as defined in subdivision (d) of Section 123485 of the Health and Safety Code.

(3) Care rendered, consistent with the certified nurse-midwife's educational preparation or for which clinical competency has been established and maintained, to persons within a facility specified in subdivision (a), (b), (c), (d), (i), or (j) of Section 1206 of the Health and Safety Code, a clinic as specified in Section 1204 of the Health and Safety Code, a general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code, a licensed birth center as defined in Section 1204.3 of the Health

and Safety Code, or a special hospital specified as a maternity hospital in subdivision (f) of Section 1250 of the Health and Safety Code.

(4) Care rendered in a home pursuant to subdivision (a) of Section 2746.5.

(b) (1) The furnishing or ordering of drugs or devices by a certified nurse-midwife is conditional on the issuance by the board of a number to the applicant who has successfully completed the requirements of paragraph (2). The number shall be included on all transmittals of orders for drugs or devices by the certified nurse-midwife. The board shall maintain a list of the certified nurse-midwives that it has certified pursuant to this paragraph and the number it has issued to each one. The board shall make the list available to the California State Board of Pharmacy upon its request. Every certified nurse-midwife who is authorized pursuant to this section to furnish or issue a drug order for a controlled substance shall register with the United States Drug Enforcement Administration.

(2) The board has certified in accordance with paragraph (1) that the certified nurse-midwife has satisfactorily completed a course in pharmacology covering the drugs or devices to be furnished or ordered under this section. The board shall establish the requirements for satisfactory completion of this paragraph.

(3) Certified nurse-midwives who are certified by the board and hold an active furnishing number, who are currently authorized to furnish Schedule II controlled substances, and who are registered with the United States Drug Enforcement Administration shall provide documentation of continuing education specific to the use of Schedule II controlled substances in settings other than a hospital based on standards developed by the board.

(c) Drugs or devices furnished or ordered by a certified nurse-midwife may include Schedule II controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) when the drugs and devices are furnished or ordered in accordance with requirements referenced in paragraphs (1) to (3), inclusive, of subdivision (b). In a nonhospital setting, a Schedule II controlled substance shall be furnished by a certified nurse-midwife only during labor and delivery and only after a consultation with a physician and surgeon.

(d) Furnishing of drugs or devices by a certified nurse-midwife means the act of making a pharmaceutical agent or agents available to the patient.

(e) "Drug order" or "order" for purposes of this section means an order for medication or for a drug or device that is dispensed to or for an ultimate user, issued by a certified nurse-midwife as an individual practitioner, within the meaning of Section 1306.03 of Title 21 of the Code of Federal Regulations. Notwithstanding any other law, (1) a drug order issued pursuant to this section shall be treated in the same manner as a prescription of a physician; (2) all references to "prescription" in this code and the Health and Safety Code shall include drug orders issued by certified nurse-midwives; and (3) the signature of a certified nurse-midwife on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

(f) A certified nurse-midwife is authorized to directly procure supplies and devices, to order, obtain, and administer drugs and diagnostic tests, to order laboratory and diagnostic testing, and to receive reports that are necessary to his or her practice as a certified nurse-midwife and consistent with nurse-midwifery education preparation.

~~SEC. 7.~~

SEC. 8. Section 2746.52 of the Business and Professions Code is amended to read:

2746.52. (a) Notwithstanding Section 2746.5, the certificate to practice nurse-midwifery authorizes the holder to perform and repair episiotomies, and to repair first-degree and second-degree lacerations of the perineum, in a licensed acute care hospital, as defined in subdivision (a) of Section 1250 of the Health and Safety Code, in a licensed alternate birth center, as defined in paragraph (4) of subdivision (b) of Section 1204 of the Health and Safety Code, or a nationally accredited birth center, and in a home pursuant to paragraph (7) of subdivision (b) of Section 2746.5.

(b) The certified nurse-midwife performing and repairing first-degree and second-degree lacerations of the perineum shall do both of the following:

(1) Ensure that all complications are referred to a physician and surgeon immediately.

(2) Ensure immediate care of patients who are in need of care beyond the scope of practice of the certified nurse-midwife, or provide emergency care for times when a physician and surgeon is not available.

~~SEC. 8.~~

SEC. 9. Section 2746.6 is added to the Business and Professions Code, to read:

2746.6. A consultative relationship between a certified nurse-midwife and a physician and surgeon shall not, by itself, provide the basis for finding a physician and surgeon liable for any act or omission of the certified nurse-midwife.

~~SEC. 9.~~

SEC. 10. Section 4061 of the Business and Professions Code is amended to read:

4061. (a) A manufacturer's sales representative shall not distribute any dangerous drug or dangerous device as a complimentary sample without the written request of a physician, dentist, podiatrist, optometrist, veterinarian, or naturopathic doctor pursuant to Section 3640.7. However, a certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to a protocol described in Section 3502.1, or a naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, may sign for the request and receipt of complimentary samples of a dangerous drug or dangerous device that has been identified in the standardized procedure, protocol, or practice agreement. Standardized procedures, protocols, and practice agreements shall include specific approval by a physician. A review process, consistent with the requirements of Section 2725, 3502.1, or 3640.5, of the complimentary samples requested and received by a nurse practitioner, certified nurse-midwife, physician assistant, or naturopathic doctor, shall be defined within the standardized procedure, protocol, or practice agreement.

(b) Each written request shall contain the names and addresses of the supplier and the requester, the name and quantity of the specific dangerous drug desired, the name of the certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor, if applicable, receiving the samples pursuant

to this section, the date of receipt, and the name and quantity of the dangerous drugs or dangerous devices provided. These records shall be preserved by the supplier with the records required by Section 4059.

(c) Nothing in this section is intended to expand the scope of practice of a certified nurse-midwife, nurse practitioner, physician assistant, or naturopathic doctor.

~~SEC. 10. Section 4076 of the Business and Professions Code is amended to read:~~

~~4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:~~

~~(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.~~

~~(2) The directions for the use of the drug.~~

~~(3) The name of the patient or patients.~~

~~(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.~~

~~(5) The date of issue.~~

~~(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.~~

~~(7) The strength of the drug or drugs dispensed.~~

~~(8) The quantity of the drug or drugs dispensed.~~

~~(9) The expiration date of the effectiveness of the drug dispensed.~~

~~(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.~~

~~(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:~~

~~(i) Prescriptions dispensed by a veterinarian.~~

~~(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.~~

~~(iii) Dispensed medications for which no physical description exists in any commercially available database.~~

~~(B) This paragraph applies to outpatient pharmacies only.~~

~~(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.~~

~~(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.~~

~~(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.~~

~~(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who~~

~~functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.~~

~~(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.~~

SEC. 11. Section 4076 of the Business and Professions Code is amended to read:

4076. (a) A pharmacist shall not dispense any prescription except in a container that meets the requirements of state and federal law and is correctly labeled with all of the following:

(1) Except when the prescriber or the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6 orders otherwise, either the manufacturer's trade name of the drug or the generic name and the name of the manufacturer. Commonly used abbreviations may be used. Preparations containing two or more active ingredients may be identified by the manufacturer's trade name or the commonly used name or the principal active ingredients.

(2) The directions for the use of the drug.

(3) The name of the patient or patients.

(4) The name of the prescriber or, if applicable, the name of the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor

who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(5) The date of issue.

(6) The name and address of the pharmacy, and prescription number or other means of identifying the prescription.

(7) The strength of the drug or drugs dispensed.

(8) The quantity of the drug or drugs dispensed.

(9) The expiration date of the effectiveness of the drug dispensed.

(10) The condition or purpose for which the drug was prescribed if the condition or purpose is indicated on the prescription.

(11) (A) Commencing January 1, 2006, the physical description of the dispensed medication, including its color, shape, and any identification code that appears on the tablets or capsules, except as follows:

(i) Prescriptions dispensed by a veterinarian.

(ii) An exemption from the requirements of this paragraph shall be granted to a new drug for the first 120 days that the drug is on the market and for the 90 days during which the national reference file has no description on file.

(iii) Dispensed medications for which no physical description exists in any commercially available database.

(B) This paragraph applies to outpatient pharmacies only.

(C) The information required by this paragraph may be printed on an auxiliary label that is affixed to the prescription container.

(D) This paragraph shall not become operative if the board, prior to January 1, 2006, adopts regulations that mandate the same labeling requirements set forth in this paragraph.

(b) If a pharmacist dispenses a prescribed drug by means of a unit dose medication system, as defined by administrative regulation, for a patient in a skilled nursing, intermediate care, or other health care facility, the requirements of this section will be satisfied if the unit dose medication system contains the aforementioned information or the information is otherwise readily available at the time of drug administration.

(c) If a pharmacist dispenses a dangerous drug or device in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include on individual unit dose

containers for a specific patient, the name of the certified nurse-midwife who functions pursuant to ~~a standardized procedure or protocol described in~~ Section 2746.51, the nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1 or protocol, the physician assistant who functions pursuant to Section 3502.1, the naturopathic doctor who functions pursuant to a standardized procedure or protocol described in Section 3640.5, or the pharmacist who functions pursuant to a policy, procedure, or protocol pursuant to Section 4052.1, 4052.2, or 4052.6.

(d) If a pharmacist dispenses a prescription drug for use in a facility licensed pursuant to Section 1250 of the Health and Safety Code, it is not necessary to include the information required in paragraph (11) of subdivision (a) when the prescription drug is administered to a patient by a person licensed under the Medical Practice Act (Chapter 5 (commencing with Section 2000)), the Nursing Practice Act (Chapter 6 (commencing with Section 2700)), or the Vocational Nursing Practice Act (Chapter 6.5 (commencing with Section 2840)), who is acting within his or her scope of practice.

(e) A pharmacist shall use professional judgment to provide a patient with directions for use that enhance the patient's understanding of those directions, consistent with the prescriber's instructions.

~~SEC. 11.~~

SEC. 12. Section 4170 of the Business and Professions Code is amended to read:

4170. (a) A prescriber shall not dispense drugs or dangerous devices to patients in his or her office or place of practice unless all of the following conditions are met:

(1) The dangerous drugs or dangerous devices are dispensed to the prescriber's own patient, and the drugs or dangerous devices are not furnished by a nurse or physician attendant.

(2) The dangerous drugs or dangerous devices are necessary in the treatment of the condition for which the prescriber is attending the patient.

(3) The prescriber does not keep a pharmacy, open shop, or drugstore, advertised or otherwise, for the retailing of dangerous drugs, dangerous devices, or poisons.

(4) The prescriber fulfills all of the labeling requirements imposed upon pharmacists by Section 4076, all of the recordkeeping requirements of this chapter, and all of the packaging requirements of good pharmaceutical practice, including the use of childproof containers.

(5) The prescriber does not use a dispensing device unless he or she personally owns the device and the contents of the device, and personally dispenses the dangerous drugs or dangerous devices to the patient packaged, labeled, and recorded in accordance with paragraph (4).

(6) The prescriber, prior to dispensing, offers to give a written prescription to the patient that the patient may elect to have filled by the prescriber or by any pharmacy.

(7) The prescriber provides the patient with written disclosure that the patient has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a pharmacy of the patient's choice.

(8) A certified nurse-midwife who functions pursuant to Section 2746.51, a nurse practitioner who functions pursuant to a standardized procedure described in Section 2836.1, or protocol, a physician assistant who functions pursuant to Section 3502.1, or a naturopathic doctor who functions pursuant to Section 3640.5, may hand to a patient of the supervising physician and surgeon, if applicable, a properly labeled prescription drug prepackaged by a physician and surgeon, a manufacturer as defined in this chapter, or a pharmacist.

(b) The Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Osteopathic Medical Board of California, the Board of Registered Nursing, the Veterinary Medical Board, and the Physician Assistant Committee shall have authority with the California State Board of Pharmacy to ensure compliance with this section, and those boards are specifically charged with the enforcement of this chapter with respect to their respective licensees.

(c) "Prescriber," as used in this section, means a person, who holds a physician's and surgeon's certificate, a license to practice optometry, a license to practice naturopathic medicine, a license to practice dentistry, a license to practice veterinary medicine, or a certificate to practice podiatry, and who is duly registered by the

Medical Board of California, the State Board of Optometry, the Bureau of Naturopathic Medicine, the Dental Board of California, the Veterinary Medical Board, or the Board of Osteopathic Examiners of this state.

~~SEC. 12.~~

SEC. 13. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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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
Position: Support

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. The issues assigned to the Task Force would be helpful to the Board's work as well, and Board staff plans on participating in the Task Force if this bill is signed into law to ensure the discussions are in line with the Board's Guidelines. For these reasons, the Board took a support position on this bill.

FISCAL: None

SUPPORT: California Council of Community Behavioral Health Agencies; California Dental Association; California District Attorneys Association; California Health+Advocates; California State Sheriffs' Association; County Health Executives Association of California; L.A. Care Health Plan; Medical Board of California; and Mental Health America of California

OPPOSITION: California Department of Public Health

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:

SECTION 1. The Legislature finds and declares as follows:

(a) Abuse and misuse of opioids is a serious problem that affects the health, social, and economic welfare of the state.

(b) After alcohol, prescription drugs are the most commonly abused substances by Americans over 12 years of age.

(c) Almost 2,000,000 people in the United States suffer from substance use disorders related to prescription opioid pain relievers.

(d) Nonmedical use of prescription opioid pain relievers can be particularly dangerous when the products are manipulated for snorting, injection, or combination with other drugs.

(e) Deaths involving prescription opioid pain relievers represent the largest proportion of drug overdose deaths, greater than the number of overdose deaths involving heroin or cocaine.

(f) The number of unintentional overdose deaths involving prescription opioid pain relievers has more than quadrupled since 1999.

~~SEC. 2. Section 2241.8 is added to the Business and Professions Code, to read:~~

~~2241.8. (a) (1) No physician and surgeon shall prescribe more than a five-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.~~

~~(2) The initial prescription in paragraph (1) may be for a non-abuse-deterrent opioid analgesic drug product and the five-day supply limitation shall still apply.~~

~~(3) This subdivision does not apply to an opioid prescription for a patient in chronic pain.~~

~~(b) Subdivision (a) shall apply even if the patient has previously been prescribed such an opioid from a different physician and surgeon.~~

~~(c) For the purposes of this section, "opioid analgesic drug product" has the same meaning as defined in Section 1367.217 of the Health and Safety Code.~~

~~SEC. 3. Section 4069 is added to the Business and Professions Code, to read:~~

~~4069. (a) A pharmacist shall inform a patient receiving for the first time an opioid analgesic drug product on proper storage and disposal of the drug. The board shall adopt regulations to implement this section.~~

~~(b) For the purposes of this section, "opioid analgesic drug product" has the same meaning as defined in Section 1367.217 of the Health and Safety Code.~~

~~SEC. 4. Section 1367.217 is added to the Health and Safety Code, immediately following Section 1367.215, to read:~~

~~1367.217. (a) Notwithstanding any other law, an individual or group health care service plan issued, amended, or renewed on or after January 1, that provides coverage for an opioid analgesic drug product shall comply with all of the following:~~

~~(1) The plan shall 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.~~

~~(2) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay for brand name abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to brand name prescription drugs covered under the applicable health care service plan.~~

~~(3) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable health care service plan.~~

~~(4) The plan shall not require an enrollee to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product. This paragraph shall not be construed to prevent a health care service plan from applying utilization review requirements, including prior authorization, to abuse-deterrent opioid analgesic drug products, provided that those requirements are applied to all opioid analgesic drug products with the same type of drug release, immediate or extended. This paragraph shall not be construed to preclude the use of a non-abuse-deterrent opioid for the initial prescription for a five-day supply.~~

~~(b) The following definitions shall apply for purposes of this section:~~

~~(1) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration (FDA) with abuse-deterrence labeling claims indicating its abuse-deterrent properties are expected to deter or reduce its abuse.~~

~~(2) "Cost sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.~~

~~(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and that is indicated by the FDA for the treatment of pain, whether in an immediate release or extended release formulation and whether or not the drug product contains any other drug substance.~~

~~SEC. 5. Section 10123.203 is added to the Insurance Code, to read:~~

~~10123.203. (a) Notwithstanding any other law, an insurer issuing, amending, or renewing a policy of individual or group disability insurance on or after January 1, that provides coverage for an opioid analgesic drug product shall comply with all of the following:~~

~~(1) The insurer shall 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.~~

~~(2) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay for brand name abuse-deterrent opioid analgesic drug products covered~~

~~pursuant to this section shall not exceed the lowest cost-sharing level applied to brand name prescription drugs covered under the applicable policy.~~

~~(3) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay for generic abuse-deterrent opioid analgesic drug products covered pursuant to this section shall not exceed the lowest cost-sharing level applied to generic prescription drugs covered under the applicable policy.~~

~~(4) The insurer shall not require an insured to first use a non-abuse-deterrent opioid analgesic drug product before providing coverage for an abuse-deterrent opioid analgesic drug product. This paragraph shall not be construed to prevent an insurer from applying utilization review requirements, including prior authorization, to abuse-deterrent opioid analgesic drug products, provided that those requirements are applied to all opioid analgesic drug products with the same type of drug release, immediate or extended. This paragraph shall not be construed to preclude the use of a non-abuse deterrent opioid for the initial prescription for a five-day supply.~~

~~(b) The following definitions shall apply for purposes of this section:~~

~~(1) "Abuse-deterrent opioid analgesic drug product" means a brand or generic opioid analgesic drug product approved by the federal Food and Drug Administration (FDA) with abuse-deterrence labeling claims indicating its abuse-deterrent properties are expected to deter or reduce its abuse.~~

~~(2) "Cost sharing" means any coverage limit, copayment, coinsurance, deductible, or other out-of-pocket expense requirement.~~

~~(3) "Opioid analgesic drug product" means a drug product that contains an opioid agonist and that is indicated by the FDA for the treatment of pain, whether in an immediate release or extended release formulation and whether or not the drug product contains any other drug substance.~~

~~SEC. 6. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty~~

~~for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

SEC. 2. Division 10.10 (commencing with Section 11999.30) is added to the Health and Safety Code, to read:

DIVISION 10.10. OPIOID ABUSE TASK FORCE

11999.30. (a) 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, shall convene an Opioid Abuse Task Force. The task force shall 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 the state. The task force shall address all of the following:

(1) Interventions that have been scientifically validated and have demonstrated clinical efficacy.

(2) Interventions that have measurable treatment outcomes.

(3) Collaborative, evidence-based approaches to resolving opioid abuse and misuse that incorporate both the provider and the patient into the solution.

(4) 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.

(5) 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.

(b) On or before December 31, 2017, the task force shall submit a report detailing its findings and recommendations to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, the Senate Committee on Health, and the Assembly Committee on Health.

(c) The task force shall be dissolved and shall cease to exist on June 1, 2018.

(d) A violation of this section is not subject to Section 1390.

11999.31. This division shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2024
Author: Wood
Bill Date: June 9, 2016, Amended
Subject: Critical Access Hospitals: Employment
Sponsor: Author
Position: Neutral

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 Office of Statewide Health Planning and Development (OSHPD), on or before July 1, 2023, to provide a report to the Legislature regarding the impact of CAH's and their ability to recruit and retain physicians.

BACKGROUND:

Current law (commonly referred to as the "Corporate Practice of Medicine" – Business & Professions 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 with only five participating hospitals and six participating physicians. Therefore, 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 OSHPD to provide a report to the Legislature containing data about the impact of CAH's employing physicians and their ability to recruit and retain 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, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: Alliance of Catholic Health Care
Association of California Healthcare Districts
California Hospital Association
California Special Districts Association
SEIU California
Union of American Physicians and Dentists

OPPOSITION: None on file

AMENDED IN SENATE JUNE 9, 2016

AMENDED IN SENATE MAY 23, 2016

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 Obernolte)
(Coauthor: Senator Gaines)

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~~ *or* 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. *Existing law establishes the Office of Statewide Health Planning and Development, which succeeds to and is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development.*

This bill, 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 if the medical staff concur by an affirmative vote that the

professional's employment is in the best interest of the communities served by the hospital and the hospital does not direct or interfere with the professional judgment of a physician and surgeon, as specified. The bill would require the ~~board,~~ *office,* 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 and their ability to recruit and retain physicians and surgeons, 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:

SECTION 1. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed

licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(e) (1) Notwithstanding Section 2400, until January 1, 2024, a federally certified critical access hospital may employ licensees and charge for professional services rendered by those licensees to patients, provided both of the following conditions are met:

(A) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(B) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(2) (A) On or before July 1, 2023, the ~~board~~ *Office of Statewide Health Planning and Development* shall provide a report to the Legislature containing data about the impact of paragraph (1) on federally certified critical access hospitals and their ability to recruit and retain physicians and surgeons between January 1, 2017, and January 1, 2023, inclusive. This report shall be submitted in compliance with Section 9795 of the Government Code.

(B) The requirement for submitting a report imposed under subparagraph (A) is inoperative on July 1, 2027.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2216
Author: Bonta
Bill Date: May 27, 2016, Amended
Subject: Primary Care Residency Programs: Grant Program
Sponsor: California Health+ Advocates
California Primary Care Association (CPCA)
Position: Support

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. This bill would specify that implementation is subject to an appropriation in the Budget Act.

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 Program (THCGME) 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.

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 THC's 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 GME. This bill would specify that implementation is subject to an appropriation in the Budget Act.

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. As such, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: California Health+ Advocates (co-sponsor); CPCA (co-sponsor); AFSCME; Aids Project Los Angeles; Alameda Health Consortium; AltaMed Services Corporation; Ampla Health; Arroyo Vista Family Health Center; Association of California Healthcare Districts; Borrego Health; California Academy of Family Physicians; California Family Health Council; California Nurses Association; California School Employees Association; Clinica Sierra Vista; Clinicas De Salud Del Pueblo, Inc.; Coalition of Orange County Community Health Centers; Community Clinic Association of Los Angeles County; Community Clinic Consortium; County Health Executives Association of California; Community Health Partnership; Family Health Centers of San Diego; Golden Valley Health Centers; Health Alliance of Northern California; Health and Life Organization.; Kheir Center; La Maestra Community Health Centers; Marin Community Clinics; Medical Board of California; Mountain Valleys Health Centers; North Coast Clinics Network; North County Health Services; North East Medical Services; Northeast Valley Health Corporation; Omni Family Health; Open Door Community Health Centers; Operation Samahan; Ravenswood Family Health Center; Redwood Community Health Coalition, SanYsidro Health Center; Shasta Community Health Center; St. John's Well Child and

Family Center; Tiburcio Vasquez Health Center, Inc.; Valley Community Healthcare; West County Health Centers; Western Sierra Medical Clinic; and Westside Family Health Center

OPPOSITION: California Right to Life Committee, Inc.

AMENDED IN ASSEMBLY MAY 27, 2016

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. *The bill would provide that its provisions are subject to an appropriation in the Budget Act for these purposes.*

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

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

SECTION 1. Article 1.5 (commencing with Section 128245) is added to Chapter 4 of Part 3 of Division 107 of the Health and Safety Code, to read:

Article 1.5. Teaching Health Center Primary Care Graduate Medical Education Act of 2016

128245. For purposes of this article, the following terms have the following meanings:

(a) "Director" means the Director of Statewide Health Planning and Development.

(b) "Fund" means the Teaching Health Center Primary Care Graduate Medical Education Fund.

(c) "Office" means the Office of Statewide Health Planning and Development.

(d) "Sustaining grant" means a grant awarded to ensure the continued operation of an accredited teaching health center, whether that accreditation was first awarded pursuant to the process created by this article or the accreditation was awarded prior to the enactment of this article.

(e) "Teaching health center" has the same meaning as defined in Article 1 (commencing with Section 128200).

128246. There is in the State Treasury the Teaching Health Center Primary Care Graduate Medical Education Fund, which fund is hereby created.

128247. (a) Subject to appropriation by the Legislature, the director shall award planning and development grants from the fund to teaching health centers for the purpose of establishing new accredited or expanded primary care residency programs.

(b) Grants awarded under this section shall be for a term of not more than three years and the maximum award to a teaching health center shall not be more than five hundred thousand dollars ($500,000).

(c) A grant awarded pursuant to this section shall be used to cover the costs of establishing or expanding a primary care residency training program described in subdivision (a), including costs associated with curriculum development, recruitment, training, and retention of residents and faculty, accreditation by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA), faculty salaries during the development phase, and technical assistance.

(d) A teaching health center seeking a grant under this section shall submit an application to the office in the format prescribed by the office. The director shall evaluate those applications and award grants based on criteria consistent with a teaching health center's readiness and other factors indicating the likelihood of success at implementing a primary care residency program.

128248. (a) Subject to appropriation by the Legislature, the director shall award sustaining grants from the fund to teaching health centers operating primary care residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME), the American Dental Association (ADA), or the American Osteopathic Association (AOA).

(b) The office shall determine the amount of grants awarded per resident by taking into account the direct and indirect costs of graduate medical education. The amount of grants awarded per resident shall be updated, as appropriate, on an annual basis.

128249. The office shall promulgate emergency regulations to implement this article.

128249.5. Implementation of this article shall be subject to an appropriation in the annual Budget Act for these purposes.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2744
Author: Gordon
Bill Date: June 16, 2016, Amended
Subject: Healing Arts: Referrals
Sponsor: The Internet Association
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, 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 through a third-party advertiser, does not itself recommend, endorse, or otherwise select a licensee. This bill would require the licensee to refund the full purchase price, as determined by the terms of the advertising service agreement, if 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. This bill would specify that a third-party advertiser shall make advertisements available to prospective purchasers for all services of licensees in the applicable geographic region.

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, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: The Internet Association (Sponsor)
Groupon

OPPOSITION: California Medical Association
California Society of Plastic Surgeons

AMENDED IN SENATE JUNE 16, 2016

AMENDED IN SENATE JUNE 6, 2016

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 services through a third-party advertiser does not constitute a referral of patients when the third-party advertiser does not itself

recommend, endorse, or otherwise select a licensee. 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.~~ *purchaser, as specified.* 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. The bill would require a third-party advertiser to make available ~~for purchase services advertised by all licensees~~ *to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser* in the applicable geographic region.

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

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

SECTION 1. Section 650 of the Business and Professions Code is amended to read:

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(*l*)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services,

donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and subsequently amended versions.

(f) "Health care facility" means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) The payment or receipt of consideration for advertising, wherein a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or

otherwise select a licensee. ~~To the extent~~ *If* the licensee determines, after consultation with the purchaser of the service, that the service is not appropriate for the purchaser, the purchaser shall receive a refund of the full purchase ~~price.~~ *price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee.* This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available ~~for purchase services advertised by all licensees~~ *to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser* in the applicable geographic region.

(h) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars ($50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty 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)
AFSCME

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:

SECTION 1. Section 2088 of the Business and Professions Code is amended to read:

2088. (a) An applicant for a physician's and surgeon's license or a physician's and surgeon's licensee who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the appropriate initial or renewal license fee.

(2) Signs an agreement on a form prescribed by the board in which the applicant or licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant or licensee described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 2. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate or postgraduate training authorization letter to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license. The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical practice.

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated,

permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 3. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board

may 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 for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, 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. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine, the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy

is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 4. Section 2441 of the Business and Professions Code is amended to read:

2441. (a) Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of medicine unless and until the licensee pays the current renewal fee and does either of the following:

(1) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely.

(2) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the licensee described in paragraph (2) of subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a ~~disability~~ *disabled status* license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to paragraph (2) of subdivision (a) shall be subject to any sanctions available to the board.

SEC. 5. Section 2519 of the Business and Professions Code is amended to read:

2519. The board may suspend, revoke, or place on probation the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that this use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

(1) Consult with a physician and surgeon.

(2) Refer a client to a physician and surgeon.

(3) Transfer a client to a hospital.

SEC. 6. Section 2520 of the Business and Professions Code is amended to read:

2520. (a) (1) The fee to be paid upon the filing of a license application shall be fixed by the board at not less than seventy-five dollars ($75) nor more than three hundred dollars ($300).

(2) The fee for renewal of the midwife license shall be fixed by the board at not less than fifty dollars ($50) nor more than two hundred dollars ($200).

(3) The delinquency fee for renewal of the midwife license shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars ($25) nor more than fifty dollars ($50).

(4) The fee for the examination shall be the cost of administering the examination to the applicant, as determined by the organization that has entered into a contract with the board for the purposes set forth in subdivision (a) of Section 2512.5. Notwithstanding subdivision (c), that fee may be collected and retained by that organization.

(b) The fee for monitoring a licensee on probation shall be the cost of monitoring, as fixed by the board.

(c) The fees prescribed by this article shall be deposited in the Licensed Midwifery Fund, which is hereby established, and shall be available, upon appropriation, to the board for the purposes of this article.

SEC. 7. Section 2522 is added to the Business and Professions Code, to read:

2522. (a) A person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the license or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from midwives licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license was in good standing, and the petitioner's

rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a license or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 8. Section 2523 is added to the Business and Professions Code, to read:

2523. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the license of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a license pursuant to this section shall be conducted in accordance with chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the

Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words "psychological," "psychologist," "psychology," "psychometrists," "psychometrics," or "psychometry," or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, 2235, and 2529.1

SEC. 10. Section 2529.1 is added to the Business and Professions Code, to read:

2529.1. (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside

the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 11. Section 2529.6 is added to the Business and Professions Code, to read:

2529.6. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with ~~chapter~~ *Chapter* 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 12. Section 3576 of the Business and Professions Code is amended to read:

3576. (a) A registration under this chapter may be denied, suspended, revoked, placed on probation, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate this chapter or any regulation adopted under this chapter.

(b) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all powers granted therein.

SEC. 13. Section 3576.1 is added to the Business and Professions Code, to read:

3576.1. (a) A person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the registration or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a registration surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a registration surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from polysomnographic technologists registered in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a registration or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 14. Section 3576.2 is added to the Business and Professions Code, to read:

3576.2. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with ~~chapter~~ *Chapter* 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 15. Section 3576.3 is added to the Business and Professions Code, to read:

3576.3. (a) The board may suspend or revoke the registration of a polysomnographic technologist, polysomnographic technician, or polysomnographic trainee for unprofessional conduct as described in this section.

(b) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public,

or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(c) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 16. Section 3577 of the Business and Professions Code is amended to read:

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(b) Each person to whom registration is granted under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars ($100).

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred fifty dollars ($150).

(d) The fee for monitoring a ~~licensee~~ *registrant* on probation shall be the cost of monitoring, as fixed by the board.

(e) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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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

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:

SECTION 1. The Legislature finds and declares as follows:

(a) More than $40 million of funding for the training of California's primary care physicians is expiring in 2016.

(b) 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 terrible deficit of primary care physicians in California's underserved communities.

(c) 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.

(d) 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.

(e) More than 32 percent of California's practicing primary care physicians are 60 years of age or older – only four other states have a larger percentage of soon-to-retire physicians.

(f) States with higher ratios of primary care physicians to population have better health outcomes, including decreased mortality from cancer, heart disease, and stroke.

(g) 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.

(h) 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.

SEC. 2. Notwithstanding Section 13340 of the Government Code, there is hereby continuously appropriated from the General Fund the sum of three hundred million dollars ($300,000,000) to the Director of Statewide Health Planning and Development, 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 (Article 1 (commencing with Section 128200) of Chapter 4 of Part 3 of Division 107 of the Health and Safety Code). The moneys shall be expended as follows:

(a) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2016–17 fiscal year.

(b) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2017–18 fiscal year.

(c) The sum of one hundred million dollars ($100,000,000) shall be expended in the 2018–19 fiscal year.

~~SECTION 1. Article 7 (commencing with Section 128590) is added to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, to read:~~

~~Article 7. California Medical Residency Training Program~~

~~128590. As used in this article:~~

~~(a) "Director" means the Director of Statewide Health Planning and Development.~~

~~(b) "Foundation" means the Health Professions Education Foundation.~~

~~(c) "Fund" means the Medical Residency Training Fund.~~

~~(d) "Office" means the Office of Statewide Health Planning and Development.~~

~~(e) "Panel" means the Medical Residency Training Advisory Panel, established pursuant to Section 128591.~~

~~(f) "Primary care" means the medical practice areas of family medicine, general surgery, internal medicine, obstetrics and gynecology, pediatrics, psychiatry, and related specialties and subspecialties as the office deems appropriate.~~

~~(g) "Residency position" means a graduate medical education residency position in the field of primary care.~~

~~128591. (a) (1) There is established within the foundation the Medical Residency Training Advisory Panel.~~

~~(2) The panel shall consist of 13 members. Seven members shall be appointed by the Governor, one member shall be appointed by the Speaker of the Assembly, one member shall be appointed by the Senate Committee on Rules, two members of the Medical Board of California shall be appointed by the Medical Board of California, and two members of the Osteopathic Medical Board of California shall be appointed by the Osteopathic Medical Board of California.~~

~~(3) The members of the panel appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules shall consist of representatives of designated and nondesignated public hospitals, private hospitals, community clinics, public and private health insurance providers, the pharmaceutical industry, associations of health care practitioners, and other appropriate members of health or related professions.~~

~~(4) All persons considered for appointment shall have an interest in increasing the number of medical residencies in the state, an interest in increasing access to health care in underserved areas of California, and the ability and desire to solicit funds for the purposes of this article, as determined by the appointing power.~~

~~(b) The Governor shall appoint the president of the panel from among those members appointed by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California.~~

~~(c) (1) Of the members of the panel first appointed by the Governor, three members shall be appointed to serve a one-year term, three members shall be appointed to serve a two-year term, and one member shall be appointed to serve a three-year term.~~

~~(2) Each member of the panel first appointed by the Speaker of the Assembly and the Senate Committee on Rules shall be appointed to serve a three-year term.~~

~~(3) Each member of the panel appointed by the Medical Board of California and the Osteopathic Medical Board of California shall be appointed to serve a four-year term.~~

~~(4) Upon the expiration of the initial appointments to the panel by the Governor, the Speaker of the Assembly, the Senate Committee on Rules, the Medical Board of California, and the Osteopathic Medical Board of California, each member shall be appointed to serve a four-year term.~~

~~(d) (1) Members of the panel appointed by the Governor, the Speaker of the Assembly, and the Senate Committee on Rules shall serve without compensation, but shall be reimbursed for any actual and necessary expenses incurred in connection with their duties as members of the panel.~~

~~(2) The members appointed by the Medical Board of California and the Osteopathic Medical Board of California shall serve without compensation, but shall be reimbursed by the Medical Board of California and the Osteopathic Medical Board of California, respectively, for any actual and necessary expenses incurred in connection with their duties as members of the panel.~~

~~(e) Notwithstanding any law relating to incompatible activities, no member of the panel shall be considered to be engaged in activities inconsistent and incompatible with his or her duties solely as a result of membership on the Medical Board of California or the Osteopathic Medical Board of California.~~

~~(f) The panel shall be subject to the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of Division 2 of Title 2 of the Corporations Code), except that if there is a conflict with this article and the Nonprofit Public Benefit Corporation Law (Part 2 (commencing with Section 5110) of~~

~~Division 2 of Title 2 of the Corporations Code), this article shall prevail.~~

~~128592. The panel shall do all of the following:~~

~~(a) Solicit and accept funds from business, industry, foundations, and other private or public sources for the purpose of establishing and funding new residency positions in areas of the state described in subdivision (c).~~

~~(b) Encourage public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations to identify and provide locations for the establishment of new residency positions in areas of the state described in subdivision (c). The panel shall solicit proposals for medical residency programs, as described in subdivision (c), and shall provide to the foundation a copy of all proposals it receives.~~

~~(c) Upon the sufficient solicitation of funds and at the panel's discretion, recommend to the foundation the establishment of new residency positions. A recommendation shall include all pertinent information required to enter into the necessary contracts to establish the residency positions. The panel shall only approve and recommend to the foundation proposals that would establish residency positions that will serve in any of the following medical service areas:~~

~~(1) A service area that is designated as a primary care shortage area by the office.~~

~~(2) A service area that is designated as a health professional shortage area for primary care, by either population or geographic designation, by the Health Resources and Services Administration of the United States Department of Health and Human Services.~~

~~(3) A service area that is designated as a medically underserved area or medically underserved population by the Health Resources and Services Administration of the United States Department of Health and Human Services.~~

~~(d) Upon foundation approval of a recommendation, deposit into the fund necessary moneys required to establish and fund the residency position.~~

~~(e) Recommend to the director that a portion of the funds solicited from the private sector be used for the administrative requirements of the panel and the foundation.~~

~~(f) Prepare and submit an annual report to the Legislature documenting the amount of money solicited, the amount of money deposited by the panel into the fund, the recommendations for the location and fields of practice of residency positions, total expenditures for the year, and prospective fundraising goals.~~

~~128593. The foundation shall do all of the following:~~

~~(a) Provide technical and staff support to the panel in meeting all of its responsibilities.~~

~~(b) Upon receipt of a recommendation made by the panel pursuant to subdivision (c) of Section 128592, approve the recommendation if the recommendation fulfills the requirements of subdivision (c) of Section 128592 and the recommendation fulfills the goals of this article. Upon sufficient funds being available, an approval shall be sent to the office for implementation pursuant to Section 128594.~~

~~128594. The office shall do all of the following:~~

~~(a) Establish a uniform process by which the panel may solicit proposals from public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations that train primary care residents. The office shall require that the proposals contain all necessary and pertinent information, including, but not limited to, all of the following:~~

~~(1) The location of the proposed residency position.~~

~~(2) The medical practice area of the proposed residency position.~~

~~(3) Information that demonstrates the area's need for the proposed residency position and for additional primary care practitioners.~~

~~(4) The amount of funding required to establish and operate the residency position.~~

~~(b) Enter into contracts with public and private sector institutions, including hospitals, colleges, universities, community clinics, and other health agencies and organizations in order to fund and establish residency positions at, or in association with, these institutions.~~

~~(c) Ensure that the residency position has been, or will be, approved by the Accreditation Council for Graduate Medical Education.~~

~~(d) Provide all of the following information to the panel and the foundation as requested:~~

~~(1) The areas of the state that are deficient in primary care services.~~

~~(2) The areas of the state that have the highest number of Medi-Cal enrollees and persons eligible to enroll in Medi-Cal, by proportion of population.~~

~~(3) Other information relevant to assist the panel and the foundation in making recommendations on possible locations for new residency positions.~~

~~(e) Monitor the residencies established pursuant to this article.~~

~~(f) (1) Prepare and submit an annual report to the panel, the foundation, and the Legislature documenting the amount of money contributed to the fund by the panel, the amount of money expended from the fund, the purposes of those expenditures, the number and location of residency positions established and funded, and recommendations for the location of future residency positions.~~

~~(2) The report pursuant to paragraph (1) shall be made to the Legislature pursuant to Section 9795 of the Government Code.~~

~~128595. (a) The Medical Residency Training Fund is hereby created within the State Treasury.~~

~~(b) The primary purpose of the fund is to allocate funding for new residency positions throughout the state. Money in the fund shall also be used to pay for the cost of administering the goals of the panel and the foundation as established by this article, and for any other purpose authorized by this article.~~

~~(c) The level of expenditure by the office for the administrative support of the panel and the foundation is subject to review and approval annually through the state budget process.~~

~~(d) In addition to funds raised by the panel, the office and the foundation may solicit and accept public and private donations to be deposited into the fund. All money in the fund is continuously appropriated to the office for the purposes of this article. The office shall manage this fund prudently in accordance with applicable laws.~~

~~128596. Any regulations the office adopts to implement this article shall be adopted as emergency regulations in accordance with Section 11346.1 of the Government Code, except that the regulations shall be exempt from the requirements of subdivisions (e), (f), and (g) of that section. The regulations shall be deemed to be emergency regulations for the purposes of Section 11346.1 of the Government Code.~~

~~128597. Notwithstanding any other law, the office may exempt from public disclosure any document in the possession of the office that pertains to a donation made pursuant to this article if the donor has requested anonymity.~~

~~128598. (a) The Governor may include in the annual budget proposal an amount, as he or she deems reasonable, to be appropriated to the office to be used as provided in this article.~~

~~(b) If the Legislature appropriates money for purposes of this article, the money shall be appropriated to the office, which shall hold the money for distribution to the fund.~~

~~(c) Funds appropriated to the office shall be paid into the fund, upon request of the panel, in an amount matching the amount deposited into the fund by the panel or by the foundation and office pursuant to subdivision (d) of Section 128595 for the purposes of this article. Any money that was appropriated to the office and that has not been distributed to the fund at the end of each fiscal year shall be returned to the General Fund.~~

~~SEC. 2. The Legislature finds and declares that Section 1 of this act, which adds Article 7 (commencing with Section 128590) to Chapter 5 of Part 3 of Division 107 of the Health and Safety Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:~~

~~The need to protect individual privacy of donations made by a donor to fund new medical residency positions in underserved areas of the state outweighs the interest in the public disclosure of that information.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 482
Author: Lara
Bill Date: June 21, 2016, Amended
Subject: Controlled Substances: CURES Database
Sponsor: Consumer Attorneys of California and California Narcotics Officers
Current Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require all prescribers issuing Schedules II, III or IV drugs to access and consult the CURES database before prescribing a Schedule II, III or IV 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 licensees who prescribe and dispense, 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 a 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 to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment. This bill would require a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. This bill would define "first time" to mean the initial occurrence in which a health care practitioner intends to prescribe, order, administer, furnish or dispense a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to that patient.

This bill would specify that a prescriber, pharmacist, or any person acting on their behalf, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, or inaccurate information submitted to, or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

This bill would specify that the requirement to consult the CURES database does not apply to a health care practitioner in any of the following circumstances:

- If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered or dispensed to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities:
    - A licensed clinic
    - An outpatient setting
    - A health facility
    - A county medical facility
- When a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a seven-day supply .
- If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient as part of the patient's treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a non-refillable five-day supply and is in a licensed clinic, an outpatient setting, a health facility, a county medical facility or a place of practice.
- If a health care practitioner prescribes, orders, administers, furnishes or dispenses a controlled substance to a patient currently receiving hospice care.
- If all of the following circumstances are satisfied:

    - It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.
    - Another health care practitioner or designee authorized to access CURES is not reasonably available.
    - The quantity of controlled substance does not exceed a non-refillable five-day supply.

- If the CURES database is not operational, as determined by DOJ, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the failure that is reasonably within his or her control.
- If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of the health care practitioner.
- If the CURES database cannot be accessed because of exceptional circumstances, as demonstrated by a health care practitioner.

This bill would specify if CURES is not consulted by the health care practitioner because one of the above exemptions applies, the practitioner shall document the reason he or she did not consult CURES in the patient's medical record.

This bill would specify that if a health care practitioner knowingly fails to consult the CURES database, he or she shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

This bill would specify that it does not create a private cause of action against a health care practitioner and does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

This bill would specify that is not operative until six months after 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 would also ensure that the CURES system will have the capacity to handle this workload before the bill becomes operative.

However, this bill was amended and now includes one very broad exemption, which weakens the requirements in this bill. In addition, this bill would make it very hard for the Board to take any administrative action for physicians who do not comply with the requirements of this bill. For these reasons, Board staff is suggesting that the

Board change its position to support if amended, with the amendments being to remove the broad exemption and to make changes to the provisions related to when the Board can take action and what type of action can be taken for physicians that do not comply.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Consumer Attorneys of California and California Narcotics Officers' Association (co-sponsors); American Insurance Association; California Chamber of Commerce; California Teamsters Public Affairs Council; Center for Public Interest Law; Consumer Watchdog; National Alliance on Mental Illness; and ShatterProof

OPPOSITION: California Medical Association

POSITION: Recommendation: Support if Amended

AMENDED IN ASSEMBLY JUNE 21, 2016

AMENDED IN ASSEMBLY JUNE 6, 2016

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 amend Section 11165.1 of, and 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 a health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the

first time and at least ~~annually~~ *once every 4 months* thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, furnishing, or dispensing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would exempt a health care practitioner from this requirement if it is not reasonably possible for him or her to access the information in the CURES database in a timely manner, another health care practitioner or designee authorized to access the CURES database is not reasonably available, and the quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

The bill would provide that a health care practitioner who knowingly fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use.

The bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, or inaccurate information submitted, to or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

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 11165.1 of the Health and Safety Code
2 is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

(i) Materially falsifying an application for a subscriber.

(ii) Failure to maintain effective controls for access to the patient activity report.

(iii) Suspended or revoked federal DEA registration.

(iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.

(v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or

Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, or inaccurate information submitted to, or reported by, the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

SEC. 2. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) (1) (A) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense a controlled substance shall consult the CURES database to review a patient's

controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least ~~annually~~ *once every four months* thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, furnish, or dispense a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before he or she prescribes, orders, administers, furnishes, or dispenses a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered or dispensed to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) When a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a ~~10-day~~ *seven-day* supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient as part of the patient's treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, furnishes, or dispenses a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, furnished, or dispensed does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If the CURES database cannot be accessed because of exceptional circumstances, as demonstrated by a health care practitioner.

(d) (1) A health care practitioner who knowingly fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 538
Author: Hueso
Bill Date: June 29, 2016, Amended
Subject: Naturopathic Doctors
Sponsor: California Naturopathic Doctor Association
Position: Oppose

DESCRIPTION OF CURRENT LEGISLATION:

This bill would expand the scope of practice for a naturopathic doctor (ND) and would allow an ND to prescribe certain drugs without physician supervision.

BACKGROUND:

NDs can currently prescribe natural and synthetic hormones, epinephrine, vitamins, minerals, and amino acids, independent of physician supervision. California NDs complete 72 pharmacology course hours as part of their schooling and are required to complete a minimum of 20 hours of pharmacotherapeutic training every two years as part of their 60 hour continuing education requirement. NDs attend four year, graduate-level accredited naturopathic medical schools and take a national, standardized licensing examination. NDs perform at least 1500 hours of clinical rotations at mostly clinics and private doctors' offices during their education program. There are over 500 ND licenses that have been issued to date in California.

Current law allows an ND to furnish or order legend drugs and Schedule III-V drugs in accordance with standardized procedures or protocols developed by the ND and his or her supervising physician. Current law authorizes an ND to provide repair and care incidental to superficial lacerations and abrasions, except suturing, and permits an ND to remove foreign bodies located in the superficial tissues. A physician may supervise up to four NDs at a time.

ANALYSIS:

This bill has been amended and significantly narrowed. This bill would expand the scope of an ND, as follows:

- Authorize an ND to order diagnostic imaging studies consistent with the practice of naturopathic medicine (instead of only those determined appropriate by the Naturopathic Medicine Committee (NMC)).
- Clarify that an ND may order, provide, or furnish devices consistent with the naturopathic training, as determined by NMC.
- Authorize an ND to prescribe, administer, or order Schedule V and unclassified drugs labeled "for prescription only", except chemotherapeutics, without physician

supervision.

- Require an ND to be subject to peer review reporting provisions.

This bill expands the scope of practice of an ND and would allow an ND to prescribe specified drugs without physician supervision. Although NDs may be well qualified to practice naturopathic medicine that utilizes natural medicine and treatments in a natural approach, NDs do not receive the education and training in naturopathic education programs to safely prescribe without physician supervision. Physician supervision helps to ensure that the patient care provided by an ND includes physician involvement and oversight.

The Board's primary mission is consumer protection. The Board took an oppose position on this bill previously because it believed that expanding the scope of practice for an ND could compromise patient care and consumer protection. Although this bill has been narrowed, it still allows NDs to prescribe Schedule V and legend drugs without physician supervision.

FISCAL: None

SUPPORT: California Naturopathic Doctor Association (Sponsor); AARP; Akasha Center for Integrative Medicine; American Association of Naturopathic Physicians; Arizona Naturopathic Medical Association; Bastyr University; California Chiropractic Association; California Naturopathic Clinic; California Naturopathic Medicine Committee; Center for Health Santa Cruz; Endocrinology Association of Naturopathic Physicians; Integrative Medicine for the Underserved; National College of Natural Medicine; Naturopathic Academy of Primary Care Physicians; Paracelsus Natural Family Health Center; Pediatric Association of Naturopathic Physicians; Santa Cruz Naturopathic Medical Center; Southwest College of Naturopathic Medicine and Health Statistics; Stengler Center for Integrative Medicine; The Oncology Association of Naturopathic Physicians; Washington Association of Naturopathic Physicians; Women's View Medical Group, Inc.; and 1,155 individuals

OPPOSITION: California Academy of Family Physicians; California Chapter of the American College of Cardiology; California Chapter of the American College of Emergency Physicians; California Orthopaedic Association; California Society of Anesthesiologists; California Society of Dermatology and Dermatologic Surgery; California Society of Plastic Surgeons; Medical Board of California; and Osteopathic Physicians and Surgeons of California

AMENDED IN ASSEMBLY JUNE 29, 2016

AMENDED IN ASSEMBLY AUGUST 17, 2015

AMENDED IN ASSEMBLY JULY 7, 2015

AMENDED IN SENATE APRIL 16, 2015

AMENDED IN SENATE APRIL 6, 2015

SENATE BILL No. 538

Introduced by Senator ~~Block~~ *Hueso*
~~(Coauthor: Senator Hueso)~~
(Principal coauthor: Senator Block)
(Coauthor: Senator Stone)
(Coauthor: Assembly Member Nazarian)

February 26, 2015

An act to amend Sections 3640 and 3640.5 of the Business and Professions Code, relating to naturopathic doctors.

LEGISLATIVE COUNSEL'S DIGEST

SB 538, as amended, ~~Block~~ *Hueso*. Naturopathic doctors.

(1) Existing law, the Naturopathic Doctors Act, provides for the licensure and regulation of naturopathic doctors by the Naturopathic Medicine Committee in the Osteopathic Medical Board of California. Existing law authorizes a naturopathic doctor to perform certain tasks, including physical and laboratory examinations for diagnostic purposes and to order diagnostic imaging studies, consistent with naturopathic training as determined by the committee. Under the act, a naturopathic doctor is authorized to dispense, administer, order, prescribe, furnish, or perform certain things, including health education and health counseling.

This bill would, instead, authorize a naturopathic doctor to perform certain tasks, consistent with the practice of naturopathic medicine, and would additionally authorize a naturopathic doctor to dispense, administer, order, prescribe, provide, or furnish devices and durable medical equipment consistent with the naturopathic training as determined by the committee.

(2) Existing law, the California Uniform Controlled Substances Act, classifies controlled substances into 5 designated schedules, with the most restrictive limitations generally placed on controlled substances classified in Schedule I, and the least restrictive limitation generally placed on controlled substances classified in Schedule V.

Existing law states that nothing in the Naturopathic Doctors Act or any other law shall be construed to prohibit a naturopathic doctor from furnishing or ordering drugs when, among other requirements, the naturopathic doctor is functioning pursuant to standardized procedure, as defined, or protocol developed and approved, as specified, and the Naturopathic Medicine Committee has certified that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be furnished or ordered. Existing law requires that the furnishing or ordering of drugs by a naturopathic doctor occur under the supervision of a physician and surgeon. Existing law also authorizes a naturopathic doctor to furnish or order controlled substances classified in Schedule III, IV, or V of the California Uniform Controlled Substances Act, but limits this authorization to those drugs agreed upon by the naturopathic doctor and physician and surgeon as specified in the standardized procedure. Existing law further requires that drugs classified in Schedule III be furnished or ordered in accordance with a patient-specific protocol approved by the treating or supervising physician.

This bill would instead provide that, except as specified, nothing in the provisions governing naturopathic doctors or any other law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs and would make a conforming change to the scope of the certification duties of the Naturopathic Medicine Committee. The bill would delete certain provisions described above restricting the authority of naturopathic doctors to furnish or order drugs, including the requirements that the naturopathic doctor function pursuant to a standardized procedure, or furnish or order drugs under the supervision of a physician and surgeon for Schedule V controlled substances and for any drug approved by the federal Food

and Drug Administration and labeled "for prescription only," except chemotherapeutics, that is not classified.

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

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

SECTION 1. Section 3640 of the Business and Professions Code is amended to read:

3640. (a) A naturopathic doctor may order and perform physical and laboratory examinations for diagnostic purposes, including, but not limited to, phlebotomy, clinical laboratory tests, speculum examinations, orificial examinations, and physiological function tests.

(b) A naturopathic doctor may order diagnostic imaging studies, including X-ray, ultrasound, mammogram, bone densitometry, and others, consistent with the practice of naturopathic medicine, but shall refer the studies to an appropriately licensed health care professional to conduct the study and interpret the results.

(c) A naturopathic doctor may dispense, administer, order, prescribe, provide, furnish, or perform the following:

(1) Food, extracts of food, nutraceuticals, vitamins, amino acids, minerals, enzymes, botanicals and their extracts, botanical medicines, homeopathic medicines, all dietary supplements and nonprescription drugs as defined by the Federal Food, Drug, and Cosmetic Act, consistent with the routes of administration identified in subdivision (d).

(2) Hot or cold hydrotherapy; naturopathic physical medicine inclusive of the manual use of massage, stretching, resistance, or joint play examination but exclusive of small amplitude movement at or beyond the end range of normal joint motion; electromagnetic energy; colon hydrotherapy; and therapeutic exercise.

(3) Devices, including, but not limited to, therapeutic devices, barrier contraception, and durable medical equipment consistent with the naturopathic training as determined by the committee.

(4) Health education and health counseling.

(5) Repair and care incidental to superficial lacerations and abrasions, except suturing.

(6) Removal of foreign bodies located in the superficial tissues.

(d) A naturopathic doctor may utilize routes of administration that include oral, nasal, auricular, ocular, rectal, vaginal, transdermal, intradermal, subcutaneous, intravenous, and intramuscular.

(e) The committee may establish regulations regarding ocular or intravenous routes of administration that are consistent with the education and training of a naturopathic doctor.

(f) This section shall not exempt a naturopathic doctor from meeting applicable licensure requirements for the performance of clinical laboratory tests, including the requirements imposed under Chapter 3 (commencing with Section 1200).

SEC. 2. Section 3640.5 of the Business and Professions Code is amended to read:

3640.5. (a) Except as set forth in this section, nothing in this chapter or any other ~~provision of~~ law shall be construed to prohibit a naturopathic doctor from administering, furnishing, ordering, or prescribing drugs when functioning pursuant to this section.

(b) Schedule III and Schedule IV controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) shall be administered, furnished, ordered, and prescribed by a naturopathic doctor in accordance with standardized procedures or protocols developed by the naturopathic doctor and his or her supervising physician and surgeon.

(c) The naturopathic doctor shall function pursuant to a standardized procedure, as defined by paragraphs (1) and (2) of subdivision (c) of Section 2725, or protocol. The standardized procedure or protocol shall be developed and approved by the supervising physician and surgeon, the naturopathic doctor, and, where applicable, the facility administrator or his or her designee.

(d) The standardized procedure or protocol covering the administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs shall specify which naturopathic doctors may administer, furnish, order, or prescribe Schedule III and Schedule IV drugs, which Schedule III through Schedule IV drugs may be administered, furnished, ordered, or prescribed and under what circumstances, the extent of physician and surgeon supervision, the method of periodic review of the naturopathic doctor's competence, including peer review, which shall be subject

to the reporting requirement in Section 805, and review of the provisions of the standardized procedure.

(e) The administering, furnishing, ordering, or prescribing of Schedule III and Schedule IV drugs by a naturopathic doctor shall occur under physician and surgeon supervision. Physician and surgeon supervision shall not be construed to require the physical presence of the physician, but does include all of the following:

(1) Collaboration on the development of the standardized procedure.

(2) Approval of the standardized procedure.

(3) Availability by telephonic contact at the time of patient examination by the naturopathic doctor.

(f) When Schedule III controlled substances, as defined in Section 11056 of the Health and Safety Code, are administered, furnished, ordered, or prescribed by a naturopathic doctor, the controlled substances shall be administered, furnished, ordered, or prescribed in accordance with a patient-specific protocol approved by the treating or supervising physician. A copy of the section of the naturopathic doctor's standardized procedure or protocol relating to controlled substances shall be provided, upon request, to a licensed pharmacist who dispenses drugs when there is uncertainty about the naturopathic doctor furnishing the order.

(g) For purposes of this section, a physician and surgeon shall not supervise more than four naturopathic doctors at one time.

(h) Notwithstanding subdivision (c), drugs administered, furnished, ordered, or prescribed by a naturopathic doctor without the supervision of a physician and surgeon shall include Schedule V controlled substances under the California Uniform Controlled Substances Act (Division 10 (commencing with Section 11000) of the Health and Safety Code) and any drug approved by the federal Food and Drug Administration and labeled "for prescription only" or words of similar import, except chemotherapeutics, that is not classified.

(i) The committee shall certify that the naturopathic doctor has satisfactorily completed adequate coursework in pharmacology covering the drugs to be administered, furnished, ordered, or prescribed under this section. The committee shall establish the requirements for satisfactory completion of this subdivision.

(j) Use of the term "furnishing" in this section, in health facilities defined in subdivisions (b), (c), (d), (e), and (i) of Section 1250 of

the Health and Safety Code, shall include both of the following for Schedule III through Schedule IV controlled substances.

(1) Ordering a drug in accordance with the standardized procedure.

(2) Transmitting an order of a supervising physician and surgeon.

(k) For purposes of this section, “drug order” or “order” means an order for medication which is dispensed to or for an ultimate user, issued by a naturopathic doctor as an individual practitioner, within the meaning of Section 1306.02 of Title 21 of the Code of Federal Regulations.

(*l*) Notwithstanding any other law, all of the following shall apply:

(1) A Schedule III through Schedule IV drug order issued pursuant to this section shall be treated in the same manner as a prescription of the supervising physician.

(2) All references to prescription in this code and the Health and Safety Code shall include drug orders issued by naturopathic doctors.

(3) The signature of a naturopathic doctor on a drug order issued in accordance with this section shall be deemed to be the signature of a prescriber for purposes of this code and the Health and Safety Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 563
Author: Pan
Bill Date: June 23, 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 (AD) 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. This bill would prohibit an insurer or third-party administrator from referring a claim for review to a UR organization in which it has a financial

interest, unless that interest is disclosed to the employer. This bill would provide that any information obtained by the AD relating to these contracts is not subject to disclosure pursuant to the Public Records Act.

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)
Medical Board of California

OPPOSITION: None on file

AMENDED IN ASSEMBLY JUNE 23, 2016

AMENDED IN ASSEMBLY JUNE 15, 2016

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 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 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 authorize the administrative director 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. The bill would make any information disclosed to the administrative director confidential and not subject to public disclosure, except as specified.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

Vote: majority. Appropriation: no. Fiscal committee: 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
21 of the utilization process, shall be filed with the administrative

director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, delay, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, delays, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) (1) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify, delay, or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(2) (A) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician under this section.

(B) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer with prior written disclosure of both of the following:

(i) The entity conducting the utilization review services.

(ii) The insurer or third-party administrator's financial interest in the entity.

(3) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule,

or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government ~~Code) unless the division can demonstrate that the information was in the public domain at the time it was disclosed or has entered the public domain through no fault of the division.~~ *Code)*. Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, delay, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify, delay, or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, delay, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the

information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, delay, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, delay, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification, delay, or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical

care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify, delay, or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny or delay a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify

the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify, delay, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The

administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

SEC. 2. The Legislature finds and declares that Section 1 of this act, which amends Section 4610 of the Labor Code, imposes a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitations on the people's rights of access set forth in this act are necessary to protect the privacy and integrity of information submitted to the Administrative Director of the Division of Workers' Compensation pursuant to paragraph (3) of subdivision (e) of Section 4610 of the Labor Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1174
Author: McGuire
Bill Date: June 22, 2016, Amended
Subject: Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications
Sponsor: National Center for Youth Law
Current Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill would add to the Medical Board of California's (Board) 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 at the time the Chair of the Senate Business, Professions and Economic Development Committee. 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 followed, 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 obtained this information in June and the Board's expert is currently reviewing this 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 pursuant to a data-sharing agreement 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. The data shall be provided for each prescriber with a pattern of prescribing that includes one or more of the following:

- Prescriptions for any class of psychotropic medication for a child who is five years of age or younger.
- Prescriptions for concurrent administration of two or more antipsychotic medications that exceed 60 days.
- Prescriptions for concurrent administration of three or more psychotropic medications exceeding 60 days.
- Prescriptions for a dosage that exceeds the amount recommended for children.

The following information shall be included for each prescriber that meets the above-mentioned prescribing patterns:

- Prescriber name, specialty, location and contact information.
- The child's gender and year of birth.
- A list of the psychotropic medications prescribed, diagnosis, and the medication start and end date.
- Unit of each medication, quantity of medication, the day's supply, and the prescription fill date.
- The child's weight.

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; and
- A minor adjudged a ward of the court who has been removed from the physical custody of the parent and placed into foster care.

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 an annual report on the results of the data analysis to the Legislature, DHCS and DSS. This bill would require the Board, DHCS and DSS to consult and revise the data methodology every three years, if determined to be necessary.

This bill would require DHCS to disseminate guidelines on an annual basis via email to any prescriber who meets the data requirement threshold for prescribing psychotropic medications to children and adolescents pursuant to this bill.

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.

This bill will further the Board's mission of consumer protection for a very vulnerable population. The Board currently has a support if amended position on this bill. Amendments were taken that 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; these amendments were requested by the Board. Amendments were also taken to ensure the Board will receive the additional data recently requested by the Board's expert pediatric psychiatrist, which were also requested by the Board. The Board did request an amendment to include a sunset date for receiving the data. The author and sponsor instead included language to allow the Board to revise the data methodology every three years, if needed. This will allow the Board to revise the data being collected, but does not include an actual sunset date. The Board will need to decide if this language is sufficient to address the Board's concern. If it is, the Board's position should change to support.

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); Advokids; Bay Area Youth Center; Children Now; Children's Partnership; Consumer Watchdog; John Burton Foundation; Medical Board of California (if amended); and Pacific Juvenile Defender Center

OPPOSITION: California Academy of Child and Adolescent Psychiatry

AMENDED IN ASSEMBLY JUNE 22, 2016

AMENDED IN ASSEMBLY JUNE 15, 2016

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: 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~~ *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 ~~Medical Board of California~~ *board* to conduct on a quarterly basis an analysis of data regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services *for specified children and minors placed in foster care* using data provided by the State Department of Health Care Services and the State Department of Social Services, as prescribed. The bill would require that the data concerning psychotropic medications and related services be shared pursuant to a data-sharing agreement and would require that, every 3 years, the ~~Medical Board of California,~~ *board,* the State Department of Health Care Services, and the State Department of Social Services consult and revise the methodology, if determined to be necessary. Commencing July 1, 2017, the bill would require the ~~Medical Board of California~~ *board* to report annually 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~~ *board* to review the data in order to determine if any potential violations of law or 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 ~~Medical Board of California to disseminate guidelines for the prescribing of psychotropic medications to children and adolescents on an annual basis to any prescriber who has been flagged for review.~~ *State Department of Health Care Services to disseminate guidelines on an annual basis via email to any prescriber who meets one or more of specified prescribing patterns, such as prescribing any class of psychotropic medication for a child who is 5 years of age or younger, or prescribing a dosage that exceeds the amount recommended for children.* 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:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated 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.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 2. Section 2245 is added to the Business and Professions Code, to read:

2245. (a) The Medical Board of California on a quarterly basis shall review the data provided pursuant to Section 14028 of the Welfare and Institutions Code by the State Department of Health Care Services and the State Department of Social Services in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, shall conduct an investigation.

(b) The ~~Medical Board of California shall disseminate guidelines for the prescribing of psychotropic medications to children and adolescents on an annual basis to any prescriber who has been flagged for review.~~ *State Department of Health Care Services shall disseminate guidelines on an annual basis via email to any prescriber who meets the data requirement threshold for prescribing psychotropic medications to children and adolescents established in subdivision (c) of Section 14028 of the Welfare and Institutions Code.*

(c) If, after an investigation, the Medical Board of California concludes that there was a violation of law, the board shall take disciplinary action, as appropriate, as authorized by Section 2227.

(d) If, after an investigation, the Medical Board of California concludes that there was excessive prescribing of psychotropic medications inconsistent with the standard of care, the board shall take action, as appropriate, as authorized by Section 2227.

(e) (1) Notwithstanding Section 10231.5 of the Government Code, commencing July 1, 2017, the Medical Board of California shall report annually to the Legislature, the State Department of Health Care Services, and the State Department of Social Services

the results of the analysis of data described in Section 14028 of the Welfare and Institutions Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

SEC. 3. Section 14028 is added to the Welfare and Institutions Code, to read:

14028. (a) The Medical Board of California shall conduct on a quarterly basis an analysis of Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services *for individuals described in subparagraphs (B) and (C) of paragraph (1) of subdivision (b)* using data provided quarterly by the department in collaboration with the State Department of Social Services that shall include, but is not limited to, the child welfare psychotropic medication measures and the Healthcare Effectiveness Data and Information Set measures related to psychotropic medications. The data concerning psychotropic medications and related services shall be shared pursuant to a data-sharing agreement that meets the requirements of all applicable state and federal laws and regulations. Every three years, the Medical Board of California, the State Department of Health Care Services, and the State Department of Social Services shall consult and revise the methodology, if determined to be necessary.

(b) (1) The data provided to the Medical Board of California pursuant to subdivision (a) shall include a breakdown by population of all of the following:

(A) Children prescribed psychotropic medications in managed care and fee-for-service settings.

(B) Children adjudged as dependent children under Section 300 and placed in foster care.

(C) A minor adjudged a ward of the court under Section 601 or 602 who has been removed from the physical custody of the parent and placed into foster care.

~~(D) Children with developmental disabilities, as described in Section 4512.~~

(2) The data provided to the medical board as described in paragraph (1) shall include total rate and age stratifications that include the following:

(A) Birth to five years of age, inclusive.

(B) Six to 11 years of age, inclusive.

(C) Twelve to 17 years of age, inclusive.

(c) (1) The data provided to the Medical Board of California pursuant to subdivision (a) shall include the information listed in paragraph (2) for each prescriber with a pattern of prescribing that includes one or more of the following:

(A) Prescriptions for any class of psychotropic medication for a child who is five years of age or younger.

(B) Prescriptions for concurrent administration of two or more antipsychotic medications that exceed 60 days.

(C) Prescriptions for concurrent administration of three or more psychotropic medications exceeding 60 days.

(D) Prescriptions for a dosage that exceeds the amount recommended for children.

(2) The following information shall be included for each prescriber described in paragraph (1):

(A) Prescriber name, specialty, location, and contact information.

(B) The child's gender and year of birth.

(C) A list of the psychotropic medications prescribed, diagnosis, and the medication start and end date.

(D) Unit of each medication, quantity of each medication, the day's supply, and the prescription fill date.

(E) The child's weight.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1177
Author: Galgiani
Bill Date: June 23, 2016, Amended
Subject: Physician and Surgeon Health and Wellness Program
Sponsor: California Medical Association (CMA)
Position: Support

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 does not have a restriction on his or her practice related to those substance abuse issues. If an investigation occurs after the physician has enrolled in the PHWP, the Board may inquire whether the physician is enrolled in the PHWP.
- Comply with the Uniform Standards for Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Business and Professions Code 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 process for procuring the services for the PHWP shall be administered by the Board. 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 from the program to the Board, including but not limited to, a physician who withdraws or is terminated. 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 to the Board if both of the following apply:

- The physician did not enroll in the PHWP as a condition of probation or as a result of an action by the Board.
- The physician 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 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, including any administrative costs incurred by the Board to administer 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. Board staff believes that the PHWP proposed by this bill aligns with the Board-approved elements and the Board has taken a support position on this bill. Pursuant to a legal review of points raised by the opposition, a clarifying amendment may be needed in Business and Professions Code Section 2340.6 (c) to make it clear that confidentiality shall not apply if a physician is not in compliance with the conditions and procedures in the agreement. This technical amendment will ensure that the bill is in compliance with the Uniform Standards. Board staff can work with the author's office and committee staff to ensure this technical amendment is made.

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.

The Board would need one staff position at the Associate Governmental Program Analyst level to set up the PHWP and then coordinate with the third-party vendor to implement the PHWP.

SUPPORT: CMA (Sponsor); California American College of Emergency

Physicians; California Academy of Family Physicians; California Health Advocates; California Hospital Association; California Society of Addiction Medicine; Drug Policy Alliance; Medical Board of California; Union of American Physicians and Dentists; and Western Occupational and Environmental Medical Association

OPPOSITION: Center for Public Interest Law
Consumer Attorneys of California
Consumers' Union Safe Patient Project
One Individual

AMENDED IN ASSEMBLY JUNE 23, 2016

AMENDED IN SENATE JUNE 1, 2016

AMENDED IN SENATE MAY 4, 2016

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 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, substance abuse, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with a private ~~third-party~~ *3rd-party* independent administering entity meeting certain requirements. The bill would require program participants to enter into an individual agreement 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 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:

SECTION 1. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Physician and Surgeon Health and Wellness Program

2340. (a) The board may 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, substance abuse to ensure that the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. The program, if established, shall aid a physician and surgeon with substance abuse issues impacting his or her ability to practice medicine.

(b) For the purposes of this article, "program" shall mean the Physician and Surgeon Health and Wellness Program.

(c) If the board establishes a program, the program shall meet the requirements of this article.

2340.2. If the board establishes a program, the program shall do all of the following:

(a) Provide for the education of all licensed physicians and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.

(b) Offer assistance to a physician and surgeon in identifying substance abuse problems.

(c) Evaluate the extent of substance abuse problems and refer the physician and surgeon to the appropriate treatment by executing a written agreement with a physician and surgeon participant.

(d) Provide for the confidential participation by a physician and surgeon with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. *If an investigation of a physician and surgeon occurs after the physician and surgeon has enrolled in the program, the board may inquire of the program whether the physician and surgeon is enrolled in the program.*

(e) 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.

2340.4. (a) If the board establishes a program, the board shall contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the program shall be administered by the board pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, Section 10425 of the Public Contract Code shall not apply to this subdivision.

(b) The administering entity shall have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals.

(c) The administering entity shall identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and shall establish a process for evaluating the effectiveness of such programs.

(d) The administering entity shall provide counseling and support for the physician and surgeon and for the family of any physician and surgeon referred for treatment.

(e) The administering entity shall make their services available to all licensed California physicians and surgeons, including those who self-refer to the program.

(f) The administering entity shall have a system for immediately reporting a physician and ~~surgeon~~ *surgeon, including, but not limited to, a physician and surgeon* who withdraws or is terminated from the ~~program~~ *program,* to the board. This system shall ensure absolute confidentiality in the communication to the board. The administering entity shall not provide this information to any other individual or entity unless authorized by the participating physician and surgeon.

(g) The contract entered into pursuant to this section shall also require the administering entity to do the following:

(1) Provide regular communication to the board, including annual reports to the board with program statistics, including, but not limited to, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of participants who have successfully completed their agreement period, and the number of participants terminated from the program. In making reports, the administering entity shall not disclose any personally identifiable information relating to any participant.

(2) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this article and its implementing rules and regulations. Any audit conducted pursuant to this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information identifying a program participant.

(h) In the event that 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 may terminate the contract.

2340.6. (a) A physician and surgeon shall, as a condition of participation in the program, enter into an individual agreement with the program and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement. The agreement shall include all of the following:

(1) A jointly ~~agreed upon~~ *agreed-upon* plan and mandatory conditions and procedures to monitor compliance with the program.

(2) Compliance with terms and conditions of treatment and monitoring.

(3) Criteria for program completion.

(4) Criteria for termination of a physician and surgeon participant from the program.

(5) Acknowledgment that withdrawal or termination of a physician and surgeon participant from the program shall be reported to the board.

(6) Acknowledgment that expenses related to treatment, monitoring, laboratory tests, and other activities specified by the program shall be paid by the physician and surgeon participant.

(b) Any agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board and shall not be disclosed to the board if both of the following apply:

(1) The physician and surgeon did not enroll in the program as a condition of probation or as a result of an action by the board.

(2) The physician and surgeon is in compliance with the conditions and procedures in the agreement.

(c) Any oral or written information reported to the board shall remain confidential and shall not constitute a waiver of any existing evidentiary privileges under any other provision or rule of law. However, confidentiality regarding the physician and surgeon's participation in the program and related records shall not apply if the board has referred a participant as a condition of probation.

(d) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action by the board against a physician and surgeon based on acts or omissions within the course and scope of his or her practice.

~~(e) Any information received, developed, or maintained regarding a physician and surgeon in the program shall not be used for any other purposes.~~

~~(f)~~

(e) Participation in the program shall not be a defense to any disciplinary action that may be taken by the board. This section does not preclude the board from commencing disciplinary action against a physician and surgeon who is terminated unsuccessfully from the program. However, that disciplinary action may not include as evidence any confidential information unless authorized by this section.

2340.8. (a) The Physician and Surgeon Health and Wellness Program Account is hereby established within the Contingent Fund of the Medical Board of California. Any fees collected by the board pursuant to subdivision (b) shall be deposited in the Physician and Surgeon Health and Wellness Program Account and shall be available, upon appropriation by the Legislature, for the support of the program.

(b) The board shall adopt regulations to determine the appropriate fee that a physician and surgeon participating in the program shall provide to the board. The fee amount adopted by the board shall be set at a level sufficient to cover all costs for participating in the program, including any administrative costs incurred by the board to administer the program.

(c) Subject to appropriation by the Legislature, the board may use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program under this article, except these moneys shall not be used to cover any costs for individual physician and surgeon participation in the program.

~~2340.10. The Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) shall apply to regulations adopted pursuant to this article.~~

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1189
Author: Pan and Jackson
Bill Date: June 22, 2016, Amended
Subject: Autopsies: Licensed Physicians and Surgeons
Sponsor: Union of American Physicians and Dentists (UAPD)
Position Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill would require that a forensic autopsy be conducted by a licensed physician and surgeon and would require that the results of a forensic autopsy can only be determined 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 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 define a postmortem examination to mean the external examination of the body where no manner or cause of death is determined. This bill would require the manner of death to be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

This bill would provide, for health and safety purposes, all persons in the autopsy suite to be informed of the risks presented by blood borne pathogens and they should wear personal protective equipment, as specified. This bill would only allow individuals who are directly involved in the investigation of the death of the decedent in the autopsy suite. 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 shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of an autopsy. This bill would allow individuals in the autopsy suite for educational and research purposes at the discretion of the coroner, and in consultation with the licensed physician and surgeon conducting the 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 forensic pathologist 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 results of an autopsy. Clarifying that a medically trained professional should be the one who conducts the autopsy also clarifies ambiguities in existing law. The sponsors of this bill believe 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 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, the Board has taken a support position on this bill and the recent amendments do not affect the Board's position or the reasons for taking that position.

FISCAL: None

SUPPORT: UAPD (Sponsor)
California District Attorneys Association
California Society of Pathologists
College of American Pathologists
Consumer Attorneys of California
Medical Board of California
National Association of Medical Examiners
Ventura County District Attorney's Office

OPPOSITION: California State Coroner's Association
California State Sheriff's Association

AMENDED IN ASSEMBLY JUNE 22, 2016

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 forensic autopsy ~~and the cause and manner of death~~ be determined by a licensed physician and surgeon. *The bill would require the manner of death to be determined by the coroner or medical examiner of a county. The bill would require, if a licensed physician and surgeon conducts a forensic autopsy, the coroner to consult with the licensed physician and surgeon in the determination of the manner of death.*

The bill would require, for health and safety purposes, that all persons in the autopsy suite ~~have current bloodborne pathogen training~~ *be informed of the risks presented by bloodborne pathogens* and *be informed that they should wear* personal protective equipment, as specified. The bill would ~~provide that police and other law enforcement personnel who have completed the specified training may~~ *require that only individuals who are directly involved in the investigation of the death of the decedent* be allowed into the autopsy suite ~~at the discretion of the forensic pathologist,~~ but *would permit individuals to be in the autopsy suite for educational and research purposes at the discretion of the coroner, in consultation with any licensed physician and surgeon conducting an autopsy. The bill* would prohibit law enforcement personnel directly involved ~~with the care and custody~~ *in the death* of an individual who died 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.

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.

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:

SECTION 1. Section 27491.4 of the Government Code is amended to read:

27491.4. (a) For purposes of inquiry the coroner shall, within 24 hours or as soon as feasible thereafter, where the suspected cause of death is sudden infant death syndrome and, in all other cases, the coroner may, in his or her discretion, take possession of the body, which shall include the authority to exhume the body, order it removed to a convenient place, and make or cause to be made a postmortem examination, or cause to be made an autopsy thereon, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body. The detailed medical findings resulting from an inspection of the body or autopsy by an examining licensed physician and surgeon shall be either reduced to writing or permanently preserved on recording discs or other similar recording media, shall include all positive and negative findings pertinent to establishing the cause of death in accordance with medicolegal practice and this, along with the written opinions and conclusions of the examining licensed physician and surgeon, shall be included in the coroner's record of the death. The coroner shall have the right to retain only those tissues of the body removed at the time of the autopsy as may, in his or her opinion, be necessary or advisable to the inquiry into the case, or for the verification of his or her findings. ~~No person~~ *Only individuals who are directly involved in the investigation of the death of the decedent* may be present during the performance of ~~an autopsy without the express consent of the licensed physician and surgeon who is conducting~~ the autopsy.

(b) In any case in which the coroner knows, or has reason to believe, that the deceased has made valid provision for the disposition of his or her body or a part or parts thereof for medical or scientific purposes in accordance with Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code, the coroner shall neither perform nor authorize any other person to perform an autopsy on the body unless the coroner has contacted or attempted to contact the physician last in attendance to the deceased. If the physician cannot be contacted, the coroner shall then notify or attempt to notify one of the following of the need for an autopsy to determine the cause of death: (1) the surviving spouse; (2) a surviving child or parent; (3) a surviving brother or sister; (4) any other kin or person who has acquired the right to control the disposition of the remains. Following a period of 24 hours after attempting to contact the physician last in attendance and notifying or attempting to notify one of the responsible parties listed above, the coroner may authorize the performance of an autopsy, as otherwise authorized or required by law.

(c) Nothing in this section shall be deemed to prohibit the discretion of the coroner to cause to be conducted an autopsy upon any victim of sudden, unexpected, or unexplained death or any death known or suspected of resulting from an accident, suicide, or apparent criminal means, or other death, as described in Section 27491.

SEC. 2. Section 27491.41 of the Government Code is amended to read:

27491.41. (a) For purposes of this section, “sudden infant death syndrome” means the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.

(b) The Legislature finds and declares that sudden infant death syndrome (SIDS) is the leading cause of death for children under age one, striking one out of every 500 children. The Legislature finds and declares that sudden infant death syndrome is a serious problem within the State of California, and that public interest is served by research and study of sudden infant death syndrome, and its potential causes and indications.

(c) (1) To facilitate these purposes, the coroner shall, within 24 hours, or as soon thereafter as feasible, cause an autopsy to be performed in any case where an infant has died suddenly and unexpectedly.

(2) However, if the attending licensed physician and surgeon desires to certify that the cause of death is sudden infant death syndrome, an autopsy may be performed at the discretion of the coroner. If the coroner causes an autopsy to be performed pursuant to this section, he or she shall also certify the cause of death.

(d) The autopsy shall be conducted pursuant to a standardized protocol developed by the State Department of Health *Care* Services. The protocol is exempt from the procedural requirements pertaining to the adoption of administrative rules and regulations pursuant to Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code. The protocol shall be developed and approved by July 1, 1990.

(e) The protocol shall be followed by all ~~licensed physicians and surgeons~~ *coroners* throughout the state when conducting the autopsies required by this section. The coroner shall state on the certificate of death that sudden infant death syndrome was the cause of death when the ~~licensed physician and surgeon's~~ *coroner's* findings are consistent with the definition of sudden infant death syndrome specified in the standardized autopsy protocol. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, and criteria for any specific tissue sampling, and any other requirements. The protocol may also require that specific tissue samples must be provided to a central tissue repository designated by the State Department of Health *Care* Services.

(f) The State Department of Health *Care* Services shall establish procedures and protocols for access by researchers to any tissues, or other materials or data authorized by this section. Research may be conducted by any individual with a valid scientific interest and prior approval from the State Committee for the Protection of Human Subjects. The tissue samples, the materials, and all data shall be subject to the confidentiality requirements of Section 103850 of the Health and Safety Code.

(g) The coroner may take tissue samples for research purposes from infants who have died suddenly and unexpectedly without

consent of the responsible adult if the tissue removal is not likely to result in any visible disfigurement.

(h) A coroner or licensed physician and surgeon shall not be liable for damages in a civil action for any act or omission done in compliance with this section.

(i) No consent of any person is required prior to undertaking the autopsy required by this section.

SEC. 3. Section 27491.43 of the Government Code is amended to read:

27491.43. (a) (1) Notwithstanding any other law, except as otherwise provided in this ~~section~~ *section,* in any case in which the ~~licensed physician and surgeon,~~ *coroner,* before *the* beginning *of* an autopsy, dissection, or removal of corneal tissue, pituitary glands, or any other organ, tissue, or fluid, has received a certificate of religious belief, executed by the decedent as provided in subdivision (b), that the procedure would be contrary to his or her religious belief, the coroner shall ~~not perform~~ *neither perform, nor order the performance of,* that procedure on the body of the decedent.

(2) If, before beginning the procedure, the coroner ~~or licensed physician and surgeon~~ is informed by a relative or a friend of the decedent that the decedent had executed a certificate of religious belief, the ~~licensed physician and surgeon~~ *coroner* shall not ~~perform the procedure,~~ *order an autopsy to be performed,* except as otherwise provided in this section, for 48 hours. If the certificate is produced within 48 hours, the case shall be governed by this section. If the certificate is not produced within that time, the case shall be governed by the other provisions of this article.

(b) Any person, 18 years of age or older, may execute a certificate of religious belief which shall state in clear and unambiguous language that any postmortem anatomical dissection or that specified procedures would violate the religious convictions of the person. The certificate shall be signed and dated by the person in the presence of at least two witnesses. Each witness shall also sign the certificate and shall print on the certificate his or her name and residence address.

(c) Notwithstanding the existence of a certificate, the coroner may at any time cause an autopsy to be performed or any other procedure if he or she has a reasonable suspicion that the death

was caused by the criminal act of another or by a contagious disease constituting a public health hazard.

(d) (1) If a certificate is produced, and if subdivision (c) does not apply, the coroner may petition the superior court, without fee, for an order authorizing an autopsy or other procedure or for an order setting aside the certificate as invalid. Notice of the proceeding shall be given to the person who produced the certificate. The proceeding shall have preference over all other cases.

(2) The court shall set aside the certificate if it finds that the certificate was not properly executed or that it does not clearly state the decedent's religious objection to the proposed procedure.

(3) The court may order an autopsy or other procedure despite a valid certificate if it finds that the cause of death is not evident, and that the interest of the public in determining the cause of death outweighs its interest in permitting the decedent and like persons fully to exercise their religious convictions.

(4) Any procedure performed pursuant to paragraph (3) shall be the least intrusive procedure consistent with the order of the court.

(5) If the petition is denied, and no stay is granted, the body of the deceased shall immediately be released to the person authorized to control its disposition.

(e) In any case in which the circumstances, manner, or cause of death is not determined because of the provisions of this section, the coroner may state on the certificate of death that an autopsy was not conducted because of the provisions of this section.

(f) A coroner shall not be liable for damages in a civil action for any act or omission taken in compliance with the provisions of this section.

SEC. 4. Section 27491.46 of the Government Code is amended to read:

27491.46. (a) The coroner shall have the right to retain pituitary glands solely for transmission to a university, for use in research or the advancement of medical science, in those cases in which the coroner has required an autopsy to be performed pursuant to this chapter, and during a 48-hour period following such autopsy the body has not been claimed and the coroner has not been informed of any relatives of the decedent.

(b) In the course of any autopsy, the coroner may cause to be removed the pituitary gland from the body for transmittal to any public agency for use in manufacturing a hormone necessary for the physical growth of persons who are, or may become, hypopituitary dwarfs, if the coroner has no knowledge of objection to the removal and release of the pituitary gland having been made by the decedent or any other person specified in Section 7151.5 of the Health and Safety Code. Neither the coroner nor the medical examiner authorizing the removal of the pituitary gland, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of the pituitary gland pursuant to this section, shall incur civil liability for the removal of the pituitary gland in an action brought by any person who did not object prior to the removal of the pituitary gland, nor be subject to criminal prosecution for removal of the pituitary gland pursuant to the authority of this section.

Nothing in this subdivision shall supersede the terms of any gift made pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code.

SEC. 5. Section 27491.47 of the Government Code is amended to read:

27491.47. (a) Notwithstanding any other law, the coroner may, in the course of an autopsy, authorize the removal and release of corneal eye tissue from a body within the coroner's custody, if all of the following conditions are met:

(1) The autopsy has otherwise been authorized.

(2) The coroner has no knowledge of objection to the removal and release of corneal tissue having been made by the decedent or any other person specified in Section 7151 of the Health and Safety Code and has obtained any one of the following:

(A) A dated and signed written consent by the donor or any other person specified in Section 7151 of the Health and Safety Code on a form that clearly indicates the general intended use of the tissue and contains the signature of at least one witness.

(B) Proof of the existence of a recorded telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code in the form of an audio recording of the conversation or a transcript of the recorded conversation, which indicates the general intended use of the tissue.

(C) A document recording a verbal telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code, witnessed and signed by no fewer than two members of the requesting entity, hospital, eye bank, or procurement organization, memorializing the consenting person's knowledge of and consent to the general intended use of the gift.

The form of consent obtained under subparagraph (A), (B), or (C) shall be kept on file by the requesting entity and the official agency for a minimum of three years.

(3) The removal of the tissue will not unnecessarily mutilate the body, be accomplished by enucleation, nor interfere with the autopsy.

(4) The tissue will be removed by a licensed physician and surgeon or a trained transplant technician.

(5) The tissue will be released to a public or nonprofit facility for transplant, therapeutic, or scientific purposes.

(b) Neither the coroner nor medical examiner authorizing the removal of the corneal tissue, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of corneal tissue pursuant to this section, shall incur civil liability for the removal in an action brought by any person who did not object prior to the removal of the corneal tissue, nor be subject to criminal prosecution for the removal of the corneal tissue pursuant to this section.

(c) This section shall not be construed to interfere with the ability of a person to make an anatomical gift pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

SEC. 6. Section 27520 of the Government Code is amended to read:

27520. (a) The coroner shall cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner shall cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(b) The coroner may cause to be performed an autopsy on a decedent, for which an autopsy has already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner may cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(c) The cost of an autopsy requested pursuant to either subdivision (a) or (b) shall be borne by the person requesting that it be performed.

SEC. 7. Section 27522 is added to the Government Code, to read:

27522. (a) A forensic autopsy shall only be conducted by a licensed physician and surgeon. The results of a forensic autopsy shall only be determined by a licensed physician and surgeon.

(b) A forensic autopsy shall be defined as an examination of a body of a decedent to generate medical evidence for which the cause ~~and manner~~ of death is determined.

(c) For purposes of this section, a postmortem examination shall be defined as the external examination of the body where no manner or cause of death is determined.

(d) For purposes of this section, the manner of death shall be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

~~(d)~~

(e) For health and safety purposes, all persons in the autopsy suite shall ~~have current bloodborne pathogen training~~ *be informed of the risks presented by bloodborne pathogens* and *that they should wear* personal protective equipment in accordance with the requirements described in Section 5193 of Title 8 of the California Code of Regulations or its successor.

~~(e)~~

(f) (1) ~~Police and other law enforcement personnel who have completed training as described in subdivision (d) may~~ *Only individuals who are directly involved in the investigation of the death of the decedent shall* be allowed into the autopsy ~~suite at the discretion of the forensic pathologist.~~ *suite.*

(2) ~~Notwithstanding paragraph (1), if~~ *If* an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved ~~with the care and custody~~ *in the death* of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of the autopsy.

(3) Notwithstanding paragraph (1), individuals may be permitted in the autopsy suite for educational and research purposes at the discretion of the coroner and in consultation with any licensed physician and surgeon conducting an autopsy.

~~(f)~~

(g) Any police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity shall be made available to the forensic pathologist prior to the completion of the investigation of the death.

~~(g)~~

(h) This section shall not be construed to limit the practice of an autopsy for educational or research purposes.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1261
Author: Stone
Bill Date: May 3, 2016, Amended
Subject: Physicians and Surgeons: Fee Exemption: Residency
Sponsor: California Primary Care Association (CPCA)
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill was substantially amended and now would only delete the requirement in existing law that a physician and surgeon must reside in California in order to get the license and renewal fees waived for providing volunteer services.

ANALYSIS

Currently, the initial or renewal license fee is waived for a physician and surgeon who resides in California, has a California address of record, and certifies to the Medical Board of California that the initial or renewal license is for the sole purpose of providing voluntary, unpaid service. A voluntary service physician licensee whose initial and/or renewal license fee has been waived pursuant to Business and Professions Code sections 2083 and 2442 must comply with the continuing medical education requirements.

ANALYSIS

This bill would change existing law to allow out-of-state physicians who are licensed in California to have license and renewal fees waived if they certify to the board that the sole purpose of their license is to provide voluntary, unpaid service. This bill may encourage more licensed physicians to provide volunteer services in California. The Board has taken a neutral position on this bill.

FISCAL: Minor and absorbable

SUPPORT: None on file

OPPOSITION: None on file

AMENDED IN SENATE MAY 3, 2016

SENATE BILL No. 1261

Introduced by Senator Stone

February 18, 2016

An act to ~~add Section 902 to~~ *amend Sections 2083 and 2442 of* the Business and Professions Code, relating to healing arts.

LEGISLATIVE COUNSEL'S DIGEST

SB 1261, as amended, Stone. Physicians and surgeons: ~~licensure exemption.~~ *fee exemption: residency.*

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and establishes specific requirements for licensure and renewal. That act generally requires that an application for a certificate be accompanied by the fee required by the act, but requires the waiver of the fee for a physician and surgeon residing in California who certifies to the board that the license is for the sole purpose of providing voluntary, unpaid service. The act establishes a parallel fee waiver requirement for the renewal of a physician and surgeon's certificate.

This bill would remove from those application and renewal fee waiver provisions the requirement that a physician and surgeon reside in California.

~~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:

SECTION 1. Section 2083 of the Business and Professions Code is amended to read:

2083. (a) Except as provided in subdivision (b), each application for a certificate shall be accompanied by the fee required by this chapter and shall be filed with the Division of Licensing.

(b) The license fee shall be waived for a physician and surgeon ~~residing in California~~ who certifies to the Medical Board of California that the issuance of the license ~~or the renewal of the~~

~~license~~ is for the sole purpose of providing voluntary, unpaid service.

SEC. 2. Section 2442 of the Business and Professions Code is amended to read:

2442. The renewal fee shall be waived for a physician and surgeon ~~residing in California~~ who certifies to the Medical Board of California that license renewal is for the sole purpose of providing voluntary, unpaid service.

~~SECTION 1. Section 902 is added to the Business and Professions Code, to read:~~

~~902. (a) For purposes of this section, the following definitions apply:~~

~~(1) "Board" means the Medical Board of California.~~

~~(2) "Free clinic" has the same meaning as defined in Section 1204 of the Health and Safety Code.~~

~~(3) "Physician" means 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 and who engages in acts that are subject to licensure or regulation under Chapter 5 (commencing with Section 2000).~~

~~(4) "Uninsured or underinsured person" means a person who does not have health care coverage, including private coverage or coverage through a program funded in whole or in part by a governmental entity, or a person who has health care coverage, but the coverage is not adequate to obtain those health care services offered by the physician under this section.~~

~~(b) A physician who offers or provides health care services at a free clinic is exempt from the requirement for licensure under Chapter 5 (commencing with Section 2000) if all of the following requirements are met:~~

~~(1) Prior to providing those services, he or she does all of the following:~~

~~(A) Obtains 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 in which he or she holds licensure or certification and a photographic identification issued by one of the states in which he or she holds licensure or certification. The board shall notify the free clinic, within 20 calendar days of receiving a~~

~~request for authorization, whether that request is approved or denied.~~

~~(B) Satisfies the following requirements:~~

~~(i) The physician has not committed any act or been convicted of a crime constituting grounds for denial of licensure or registration under Section 480 and is in good standing in each state in which he or she holds licensure or certification.~~

~~(ii) The physician has the appropriate education and experience to participate in a free clinic, as determined by the board.~~

~~(iii) The physician shall agree to comply with all applicable practice requirements set forth in this division and the regulations adopted pursuant to this division.~~

~~(C) Submits to the board, on a form prescribed by the board, a request for authorization to practice without a license, and pays a fee, in an amount determined by the board by regulation, which shall be available, upon appropriation, to cover the cost of developing the authorization process and processing the request.~~

~~(2) The services are provided under all of the following circumstances:~~

~~(A) To uninsured or underinsured persons.~~

~~(B) On voluntary basis, for a total of days not to exceed 60 days in a calendar year. The 60 days need not be consecutive.~~

~~(C) In association with a free clinic enrolled in the Medi–Cal program that complies with subdivision (d).~~

~~(D) Without charge to the recipient or to a third party on behalf of the recipient.~~

~~(c) The board may deny a physician authorization to practice without a license if the physician fails to comply with this section or for any act that would be grounds for denial of an application for licensure.~~

~~(d) A free clinic enrolled in the Medi–Cal program seeking to provide, or arrange for the provision of, health care services under this section shall do both of the following:~~

~~(1) Register with the board by completing a registration form that shall include all of the following:~~

~~(A) The name of the free clinic.~~

~~(B) The name of the principal individual or individuals who are the officers or organizational officials responsible for the operation of the free clinic.~~

~~(C) The address, including street, city, ZIP Code, and county, of the free clinic's principal office and each individual listed pursuant to subparagraph (B).~~

~~(D) The telephone number for the principal office of the free clinic and each individual listed pursuant to subparagraph (B).~~

~~(E) Any additional information required by the board.~~

~~(2) Provide the information listed in paragraph (1) to the county health department of the county in which the health care services will be provided, along with any additional information that may be required by that department.~~

~~(e) The free clinic shall notify the board and the county health department described in paragraph (2) of subdivision (d) in writing of any change to the information required under subdivision (d) within 30 calendar days of the change.~~

~~(f) Within 15 calendar days of the provision of health care services pursuant to this section, the free clinic shall file a report with the board and the county health department of the county in which the health care services were provided. This report shall contain the date, place, type, and general description of the care provided, along with a listing of the physicians who participated in providing that care.~~

~~(g) The free clinic shall maintain a list of physicians associated with the provision of health care services under this section. The free clinic shall maintain a copy of each physician's current license or certification and shall require each physician to attest in writing that his or her license or certificate is not suspended or revoked pursuant to disciplinary proceedings in any jurisdiction. The free clinic shall maintain these records for a period of at least five years following the provision of health care services under this section and shall, upon request, furnish those records to the board or any county health department.~~

~~(h) A contract of liability insurance issued, amended, or renewed in this state on or after January 1, 2017, shall not exclude coverage of a physician or a free clinic that provides, or arranges for the provision of, health care services under this section, provided that the practitioner or free clinic complies with this section.~~

~~(i) Subdivision (b) shall not be construed to authorize a physician to render care outside the scope of practice authorized by his or her license or certificate or this division.~~

~~(j) (1) The board may terminate authorization for a physician to provide health care services pursuant to this section for failure to comply with this section, any applicable practice requirement set forth in this division, any regulations adopted pursuant to this division, or for any act that would be grounds for discipline if done by a licensee of the board.~~

~~(2) The board shall provide both the free clinic and the physician with a written notice of termination including the basis for that termination. The physician may, within 30 days after the date of the receipt of notice of termination, file a written appeal to the board. The appeal shall include any documentation the physician wishes to present to the board.~~

~~(3) A physician whose authorization to provide health care services pursuant to this section has been terminated shall not provide health care services pursuant to this section unless and until a subsequent request for authorization has been approved by the board. A physician who provides health care services in violation of this paragraph shall be deemed to be practicing health care in violation of Chapter 5 (commencing with Section 2000), and be subject to any applicable administrative, civil, or criminal fines, penalties, and other sanctions provided in this division.~~

~~(k) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.~~

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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
Position: Support

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 the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: Association of California Healthcare Districts
California Association of Marriage and Family Therapists
California Psychiatric Association
County Behavioral Health Directors Association
Medical Board of California

OPPOSITION: None on file

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 specialities, as defined. Existing law authorizes the selection committee to fill up to 20% of the available positions with program applicants from specialities 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:

SECTION 1. Section 1341.45 of the Health and Safety Code is amended to read:

1341.45. (a) There is hereby created in the State Treasury the Managed Care Administrative Fines and Penalties Fund.

(b) The fines and administrative penalties collected pursuant to this chapter, on and after September 30, 2008, shall be deposited into the Managed Care Administrative Fines and Penalties Fund.

(c) The fines and administrative penalties deposited into the Managed Care Administrative Fines and Penalties Fund shall be transferred by the department, annually, as follows:

(1) The first one million dollars ($1,000,000) shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(2) Until January 1, 2017, any amount over the first one million dollars ($1,000,000), including accrued interest, in the fund shall be transferred to the Major Risk Medical Insurance Fund continued pursuant to Section 15893 of the Welfare and Institutions Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(3) On and after January 1, 2017, and annually thereafter, the second one million dollars ($1,000,000) shall be transferred to the Major Risk Medical Insurance Fund continued pursuant to Section 15893 of the Welfare and Institutions Code and shall, upon appropriation by the Legislature, be used for the Major Risk Medical Insurance Program for the purposes specified in Section 15894 of the Welfare and Institutions Code.

(4) (A) On and after January 1, 2017 any amount over the first two million dollars ($2,000,000), including accrued interest, in the fund shall be transferred to the Medically Underserved Account for Physicians within the Health Professions Education Fund and shall, upon appropriation by the Legislature, and subject to subparagraph (B), be used for the purposes of the Steven M. Thompson Physician Corps Loan Repayment Program, as specified in Article 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division 107 and, notwithstanding Section 128555, shall not be used to provide funding for the Physician Volunteer Program.

(B) ~~One-half~~ *Up to one-half* of the moneys deposited into the Medically Underserved Account for Physicians within the Health Professions Education Fund under this paragraph ~~shall, upon appropriation by the Legislature, be used~~ *may be prioritized* to fund the repayment of ~~loans~~ *loans pursuant to paragraph (2) of subdivision (d) of Section 128553* 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, as specified in Article~~ *Program (Article* 5 (commencing with Section 128550) of Chapter 5 of Part 3 of Division ~~107.~~ *107).*

(d) Notwithstanding subdivision (b) of Section 1356 and Section 1356.1, the fines and administrative penalties authorized pursuant to this chapter shall not be used to reduce the assessments imposed on health care service plans pursuant to Section 1356.

SEC. 2. Section 128551 of the Health and Safety Code is amended to read:

128551. (a) It is the intent of this article that the Health Professions Education Foundation and the office provide the ongoing program management of the two programs identified in subdivision (b) of Section 128550 as a part of the California Physician Corps Program.

(b) For purposes of subdivision (a), the foundation shall consult with the Medical Board of California, Office of Statewide Health Planning and Development, and shall establish and consult with an advisory committee of not more than seven members, that shall include two members recommended by the California Medical Association and may include other members of the medical

community, including ethnic representatives, medical schools, health advocates representing ethnic communities, primary care clinics, public hospitals, and health systems, statewide agencies administering state and federally funded programs targeting underserved communities, and members of the public with expertise in health care issues.

SEC. 3. Section 128552 of the Health and Safety Code is amended to read:

128552. For purposes of this article, the following definitions shall apply:

(a) "Account" means the Medically Underserved Account for Physicians established within the Health Professions Education Fund pursuant to this article.

(b) "Foundation" means the Health Professions Education Foundation.

(c) "Fund" means the Health Professions Education Fund.

(d) "Medi-Cal threshold languages" means primary languages spoken by limited-English-proficient (LEP) population groups meeting a numeric threshold of 3,000, eligible LEP Medi-Cal beneficiaries residing in a county, 1,000 Medi-Cal eligible LEP beneficiaries residing in a single ZIP Code, or 1,500 LEP Medi-Cal beneficiaries residing in two contiguous ZIP Codes.

(e) "Medically underserved area" means an area defined as a health professional shortage area in Part 5 (commencing with Section 5.1) of Subchapter A of Chapter 1 of Title 42 of the Code of Federal Regulations or an area of the state where unmet priority needs for physicians exist as determined by the California Healthcare Workforce Policy Commission pursuant to Section 128225.

(f) "Medically underserved population" means the Medi-Cal program and uninsured populations.

(g) "Office" means the Office of Statewide Health Planning and Development (OSHPD).

(h) "Physician Volunteer Program" means the Physician Volunteer Registry Program established by the Medical Board of California.

(i) "Practice setting," for the purposes of this article only, means either of the following:

(1) A community clinic as defined in subdivision (a) of Section 1204 and subdivision (c) of Section 1206, a clinic owned or

operated by a public hospital and health system, or a clinic owned and operated by a hospital that maintains the primary contract with a county government to fulfill the county's role pursuant to Section 17000 of the Welfare and Institutions Code, which is located in a medically underserved area and at least 50 percent of whose patients are from a medically underserved population.

(2) A physician owned and operated medical practice setting that provides primary care ~~or psychiatric services~~ located in a medically underserved area and has a minimum of 50 percent of patients who are uninsured, Medi-Cal beneficiaries, or beneficiaries of another publicly funded program that serves patients who earn less than 250 percent of the federal poverty level.

(j) "Primary specialty" means family practice, internal medicine, pediatrics, ~~psychiatry,~~ or obstetrics/gynecology.

(k) "Program" means the Steven M. Thompson Physician Corps Loan Repayment Program.

(*l*) "Selection committee" means a minimum three-member committee of the board, that includes a member that was appointed by the Medical Board of California.

~~SEC. 4. Section 128555.5 is added to the Health and Safety Code, to read:~~

~~128555.5. Notwithstanding subdivision (e) of Section 128555, funds deposited into the Medically Underserved Account for Physicians shall not be made available to fund the repayment of loans under the Steven M. Thompson Physician Corps Loan Repayment Program for those physicians providing psychiatric services or those physicians whose primary specialty is psychiatry, except as provided in subparagraph (B) of paragraph (4) of subdivision (c) of Section 1341.45.~~

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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 form 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

SENATE BILL No. 1478

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:

SECTION 1. Section 852 of the Business and Professions Code is repealed.

~~852. (a) The Task Force on Culturally and Linguistically Competent Physicians and Dentists is hereby created and shall consist of the following members:~~

~~(1) The State Director of Health Services and the Director of Consumer Affairs, who shall serve as cochairs of the task force.~~

~~(2) The Executive Director of the Medical Board of California.~~

~~(3) The Executive Director of the Dental Board of California.~~

~~(4) One member appointed by the Senate Committee on Rules.~~

~~(5) One member appointed by the Speaker of the Assembly.~~

~~(b) Additional task force members shall be appointed by the Director of Consumer Affairs, in consultation with the State Director of Health Services, as follows:~~

~~(1) Representatives of organizations that advocate on behalf of California licensed physicians and dentists.~~

~~(2) California licensed physicians and dentists that provide health services to members of language and ethnic minority groups.~~

~~(3) Representatives of organizations that advocate on behalf of, or provide health services to, members of language and ethnic minority groups.~~

~~(4) Representatives of entities that offer continuing education for physicians and dentists.~~

~~(5) Representatives of California's medical and dental schools.~~

~~(6) Individuals with experience in developing, implementing, monitoring, and evaluating cultural and linguistic programs.~~

~~(c) The duties of the task force shall include the following:~~

~~(1) Developing recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency.~~

~~(2) Identifying the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices.~~

~~(3) Assessing the need for voluntary certification standards and examinations for cultural and linguistic competency.~~

~~(d) The task force shall hold hearings and convene meetings to obtain input from persons belonging to language and ethnic minority groups to determine their needs and preferences for having culturally competent medical providers. These hearings and~~

~~meetings shall be convened in communities that have large populations of language and ethnic minority groups.~~

~~(e) The task force shall report its findings to the Legislature and appropriate licensing boards within two years after creation of the task force.~~

~~(f) The Medical Board of California and the Dental Board of California shall pay the state administrative costs of implementing this section.~~

~~(g) Nothing in this section shall be construed to require mandatory continuing education of physicians and dentists.~~

SEC. 2. Section 1632 of the Business and Professions Code is amended to read:

1632. (a) The board shall require each applicant to successfully complete the ~~Part I and Part II written examinations~~ *written examination* of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(b) The board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the board. The board shall provide a separate application for this examination. The board shall ensure that the law and ethics examination reflects current law and regulations, and ensure that the examinations are randomized. Applicants shall submit this application and required fee to the board in order to take this examination. In addition to the aforementioned application, the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate. Applicants who submit completed applications and certification from the dean at least 15 days prior to a scheduled examination shall be scheduled to take the examination. Successful results of the examination shall, as established by board regulation, remain valid for two years from the date that the applicant is notified of having passed the examination.

(c) Except as otherwise provided in Section 1632.5, the board shall require each applicant to have taken and received a passing score on one of the following:

(1) A portfolio examination of the applicant's competence to enter the practice of dentistry. This examination shall be conducted while the applicant is enrolled in a dental school program at a

board-approved school located in California. This examination shall utilize uniform standards of clinical experiences and competencies, as approved by the board pursuant to Section 1632.1. The applicant shall pass a final assessment of the submitted portfolio at the end of his or her dental school program. Before any portfolio assessment may be submitted to the board, the applicant shall remit the required fee to the board to be deposited into the State Dentistry Fund, and a letter of good standing signed by the dean of his or her dental school or his or her delegate stating that the applicant has graduated or will graduate with no pending ethical issues.

(A) The portfolio examination shall not be conducted until the board adopts regulations to carry out this paragraph. The board shall post notice on its Internet Web site when these regulations have been adopted.

(B) The board shall also provide written notice to the Legislature and the Legislative Counsel when these regulations have been adopted.

(2) A clinical and written examination administered by the Western Regional Examining Board, which board shall determine the passing score for that examination.

(d) Notwithstanding subdivision (b) of Section 1628, the board is authorized to do either of the following:

(1) Approve an application for examination from, and to examine an applicant who is enrolled in, but has not yet graduated from, a reputable dental school approved by the board.

(2) Accept the results of an examination described in paragraph (2) of subdivision (c) submitted by an applicant who was enrolled in, but had not graduated from, a reputable dental school approved by the board at the time the examination was administered.

In either case, the board shall require the dean of that school or his or her delegate to furnish satisfactory proof that the applicant will graduate within one year of the date the examination was administered or as provided in paragraph (1) of subdivision (c).

SEC. 3. Section 1634.1 of the Business and Professions Code is amended to read:

1634.1. Notwithstanding Section 1634, the board may grant a license to practice dentistry to an applicant who submits all of the following to the board:

(a) A completed application form and all fees required by the board.

(b) Satisfactory evidence of having graduated from a dental school approved by the board or by the Commission on Dental Accreditation of the American Dental Association.

(c) Satisfactory evidence of having completed a clinically based advanced education program in general dentistry or an advanced education program in general practice residency that is, at minimum, one year in duration and is accredited by either the Commission on Dental Accreditation of the American Dental Association or a national accrediting body approved by the board. The advanced education program shall include a certification of clinical residency program completion approved by the board, to be completed upon the resident's successful completion of the program in order to evaluate his or her competence to practice dentistry in the state.

(d) Satisfactory evidence of having successfully completed the written ~~examinations~~ *examination* of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(e) Satisfactory evidence of having successfully completed an examination in California law and ethics.

(f) Proof that the applicant has not failed the examination for licensure to practice dentistry under this chapter within five years prior to the date of his or her application for a license under this chapter.

SEC. 4. Section 2029 of the Business and Professions Code is repealed.

~~2029. The board shall 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. For retrieval purposes, these complaints shall be filed by the licensee's name and license number.~~

SEC. 5. Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of the Business and Professions Code is repealed.

SEC. 6. Section 2467 of the Business and Professions Code is amended to read:

2467. (a) The board may convene from time to time as it deems necessary.

(b) Four members of the board constitute a quorum for the transaction of business at any meeting.

(c) It shall require the affirmative vote of a majority of those members present at a meeting, those members constituting at least a quorum, to pass any motion, resolution, or measure.

(d) The board shall ~~annually~~ elect ~~one of~~ *from* its members ~~to act as president and a member to act as~~ *a president, a* vice ~~president~~ *president, and a secretary* who shall hold their respective positions at the pleasure of the board. The president may call meetings of the board and any duly appointed committee at a specified time and place.

SEC. 7. Section 4980.09 is added to the Business and Professions Code, to read:

4980.09. (a) The title "marriage and family therapist intern" or "marriage and family therapist registered intern" is hereby renamed "associate marriage and family therapist" or "registered associate marriage and family therapist," respectively. Any reference in statute or regulation to a "marriage and family therapist intern" or "marriage and family therapist registered intern" shall be deemed a reference to an "associate marriage and family therapist" or "registered associate marriage and family therapist."

(b) Nothing in this section shall be construed to expand or constrict the scope of practice of a person licensed or registered pursuant to this chapter.

(c) This section shall become operative January 1, 2018.

SEC. 8. Section 4980.36 of the Business and Professions Code is amended to read:

4980.36. (a) This section shall apply to the following:

(1) Applicants for licensure or registration who begin graduate study before August 1, 2012, and do not complete that study on or before December 31, 2018.

(2) Applicants for licensure or registration who begin graduate study before August 1, 2012, and who graduate from a degree program that meets the requirements of this section.

(3) Applicants for licensure or registration who begin graduate study on or after August 1, 2012.

(b) To qualify for a license or registration, applicants shall possess a doctoral or master's degree meeting the requirements of this section in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical

psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education, or accredited by either the Commission on Accreditation for Marriage and Family Therapy Education, or a regional *or national institutional* accrediting agency that is recognized by the United States Department of Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval.

(c) A doctoral or master's degree program that qualifies for licensure or registration shall do the following:

(1) Integrate all of the following throughout its curriculum:

(A) Marriage and family therapy principles.

(B) The principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, among others.

(C) An understanding of various cultures and the social and psychological implications of socioeconomic position, and an understanding of how poverty and social stress impact an individual's mental health and recovery.

(2) Allow for innovation and individuality in the education of marriage and family therapists.

(3) Encourage students to develop the personal qualities that are intimately related to effective practice, including, but not limited to, integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(4) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(5) Provide students with the opportunity to meet with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(d) The degree described in subdivision (b) shall contain no less than 60 semester or 90 quarter units of instruction that includes, but is not limited to, the following requirements:

(1) Both of the following:

(A) No less than 12 semester or 18 quarter units of coursework in theories, principles, and methods of a variety of psychotherapeutic orientations directly related to marriage and family therapy and marital and family systems approaches to treatment and how these theories can be applied therapeutically with individuals, couples, families, adults, including elder adults, children, adolescents, and groups to improve, restore, or maintain healthy relationships.

(B) Practicum that involves direct client contact, as follows:

(i) A minimum of six semester or nine quarter units of practicum in a supervised clinical placement that provides supervised fieldwork experience.

(ii) A minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(iii) A student must be enrolled in a practicum course while counseling clients, except as specified in subdivision (c) of Section 4980.42.

(iv) The practicum shall provide training in all of the following areas:

(I) Applied use of theory and psychotherapeutic techniques.

(II) Assessment, diagnosis, and prognosis.

(III) Treatment of individuals and premarital, couple, family, and child relationships, including trauma and abuse, dysfunctions, healthy functioning, health promotion, illness prevention, and working with families.

(IV) Professional writing, including documentation of services, treatment plans, and progress notes.

(V) How to connect people with resources that deliver the quality of services and support needed in the community.

(v) Educational institutions are encouraged to design the practicum required by this subparagraph to include marriage and family therapy experience in low income and multicultural mental health settings.

(vi) In addition to the 150 hours required in clause (ii), 75 hours of either of the following, or a combination thereof:

(I) Client centered advocacy, as defined in Section 4980.03.

(II) Face-to-face experience counseling individuals, couples, families, or groups.

(2) Instruction in all of the following:

(A) Diagnosis, assessment, prognosis, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer reviewed literature.

(B) Developmental issues from infancy to old age, including instruction in all of the following areas:

(i) The effects of developmental issues on individuals, couples, and family relationships.

(ii) The psychological, psychotherapeutic, and health implications of developmental issues and their effects.

(iii) Aging and its biological, social, cognitive, and psychological aspects. This coursework shall include instruction on the assessment and reporting of, as well as treatment related to, elder and dependent adult abuse and neglect.

(iv) A variety of cultural understandings of human development.

(v) The understanding of human behavior within the social context of socioeconomic status and other contextual issues affecting social position.

(vi) The understanding of human behavior within the social context of a representative variety of the cultures found within California.

(vii) The understanding of the impact that personal and social insecurity, social stress, low educational levels, inadequate housing, and malnutrition have on human development.

(C) The broad range of matters and life events that may arise within marriage and family relationships and within a variety of California cultures, including instruction in all of the following:

(i) A minimum of seven contact hours of training or coursework in child abuse assessment and reporting as specified in Section 28, and any regulations promulgated thereunder.

(ii) Spousal or partner abuse assessment, detection, intervention strategies, and same gender abuse dynamics.

(iii) Cultural factors relevant to abuse of partners and family members.

(iv) Childbirth, child rearing, parenting, and stepparenting.

(v) Marriage, divorce, and blended families.

(vi) Long-term care.

(vii) End of life and grief.

(viii) Poverty and deprivation.

(ix) Financial and social stress.

(x) Effects of trauma.

(xi) The psychological, psychotherapeutic, community, and health implications of the matters and life events described in clauses (i) to (x), inclusive.

(D) Cultural competency and sensitivity, including a familiarity with the racial, cultural, linguistic, and ethnic backgrounds of persons living in California.

(E) Multicultural development and cross-cultural interaction, including experiences of race, ethnicity, class, spirituality, sexual orientation, gender, and disability, and their incorporation into the psychotherapeutic process.

(F) The effects of socioeconomic status on treatment and available resources.

(G) Resilience, including the personal and community qualities that enable persons to cope with adversity, trauma, tragedy, threats, or other stresses.

(H) Human sexuality, including the study of physiological, psychological, and social cultural variables associated with sexual behavior and gender identity, and the assessment and treatment of psychosexual dysfunction.

(I) Substance use disorders, co-occurring disorders, and addiction, including, but not limited to, instruction in all of the following:

(i) The definition of substance use disorders, co-occurring disorders, and addiction. For purposes of this subparagraph, “co-occurring disorders” means a mental illness and substance abuse diagnosis occurring simultaneously in an individual.

(ii) Medical aspects of substance use disorders and co-occurring disorders.

(iii) The effects of psychoactive drug use.

(iv) Current theories of the etiology of substance abuse and addiction.

(v) The role of persons and systems that support or compound substance abuse and addiction.

(vi) Major approaches to identification, evaluation, and treatment of substance use disorders, co-occurring disorders, and addiction, including, but not limited to, best practices.

(vii) Legal aspects of substance abuse.

(viii) Populations at risk with regard to substance use disorders and co-occurring disorders.

(ix) Community resources offering screening, assessment, treatment, and followup for the affected person and family.

(x) Recognition of substance use disorders, co-occurring disorders, and addiction, and appropriate referral.

(xi) The prevention of substance use disorders and addiction.

(J) California law and professional ethics for marriage and family therapists, including instruction in all of the following areas of study:

(i) Contemporary professional ethics and statutory, regulatory, and decisional laws that delineate the scope of practice of marriage and family therapy.

(ii) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of marriage and family therapy, including, but not limited to, family law.

(iii) The current legal patterns and trends in the mental health professions.

(iv) The psychotherapist-patient privilege, confidentiality, the patient dangerous to self or others, and the treatment of minors with and without parental consent.

(v) A recognition and exploration of the relationship between a practitioner's sense of self and human values and his or her professional behavior and ethics.

(vi) Differences in legal and ethical standards for different types of work settings.

(vii) Licensing law and licensing process.

(e) The degree described in subdivision (b) shall, in addition to meeting the requirements of subdivision (d), include instruction in case management, systems of care for the severely mentally ill, public and private services and supports available for the severely mentally ill, community resources for persons with mental illness and for victims of abuse, disaster and trauma response, advocacy for the severely mentally ill, and collaborative treatment. This instruction may be provided either in credit level coursework or through extension programs offered by the degree-granting institution.

(f) The changes made to law by this section are intended to improve the educational qualifications for licensure in order to better prepare future licentiates for practice, and are not intended

to expand or restrict the scope of practice for marriage and family therapists.

SEC. 9. Section 4980.37 of the Business and Professions Code is amended to read:

4980.37. (a) This section shall apply to applicants for licensure or registration who begin graduate study before August 1, 2012, and complete that study on or before December 31, 2018. Those applicants may alternatively qualify under paragraph (2) of subdivision (a) of Section 4980.36.

(b) To qualify for a license or registration, applicants shall possess a doctor's or master's degree in marriage, family, and child counseling, marriage and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or marriage and family therapy, obtained from a school, college, or university accredited by a regional *or national institutional* accrediting agency that is recognized by the United States Department of Education or approved by the Bureau for Private Postsecondary Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this section, a doctor's or master's degree program shall be a single, integrated program primarily designed to train marriage and family therapists and shall contain no less than 48 semester or 72 quarter units of instruction. This instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of marriage, family, and child counseling, and marital and family systems approaches to treatment. The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to marriage and family therapy, and marital and family systems approaches to treatment.

(2) Theories of marriage and family therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.

(3) Developmental issues and life events from infancy to old age and their effect on individuals, couples, and family relationships. This may include coursework that focuses on specific family life events and the psychological, psychotherapeutic, and

health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, abuse and neglect of older and dependent adults, and geropsychology.

(4) A variety of approaches to the treatment of children.

The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

(c) (1) In addition to the 12 semester or 18 quarter units of coursework specified in subdivision (b), the doctor's or master's degree program shall contain not less than six semester or nine quarter units of supervised practicum in applied psychotherapeutic technique, assessments, diagnosis, prognosis, and treatment of premarital, couple, family, and child relationships, including dysfunctions, healthy functioning, health promotion, and illness prevention, in a supervised clinical placement that provides supervised fieldwork experience within the scope of practice of a marriage and family therapist.

(2) For applicants who enrolled in a degree program on or after January 1, 1995, the practicum shall include a minimum of 150 hours of face-to-face experience counseling individuals, couples, families, or groups.

(3) The practicum hours shall be considered as part of the 48 semester or 72 quarter unit requirement.

(d) As an alternative to meeting the qualifications specified in subdivision (b), the board shall accept as equivalent degrees those master's or doctor's degrees granted by educational institutions whose degree program is approved by the Commission on Accreditation for Marriage and Family Therapy Education.

(e) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of marriage and family therapists, a degree program that meets the educational qualifications for licensure or registration under this section shall do all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.

(2) Prepare students to be familiar with the broad range of matters that may arise within marriage and family relationships.

(3) Train students specifically in the application of marriage and family relationship counseling principles and methods.

(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.

(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and family relationships.

(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by marriage and family therapists.

(7) Prepare students to be familiar with cross-cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

(f) Educational institutions are encouraged to design the practicum required by this section to include marriage and family therapy experience in low income and multicultural mental health settings.

(g) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 10. Section 4980.40.5 of the Business and Professions Code is repealed.

~~4980.40.5. (a) A doctoral or master's degree in marriage, family, and child counseling, marital and family therapy, couple and family therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling, or marriage and family therapy, obtained from a school, college, or university approved by the Bureau for Private Postsecondary Education as of June 30, 2007, shall be considered by the board to meet the requirements necessary for licensure as a marriage and family therapist and for registration as a marriage and family therapist intern provided that the degree is conferred on or before July 1, 2010.~~

~~(b) As an alternative to meeting the qualifications specified in subdivision (a) of Section 4980.40, the board shall accept as equivalent degrees those doctoral or master's degrees that otherwise~~

~~meet the requirements of this chapter and are conferred by educational institutions accredited by any of the following associations:~~

~~(1) Northwest Commission on Colleges and Universities.~~

~~(2) Middle States Association of Colleges and Secondary Schools.~~

~~(3) New England Association of Schools and Colleges.~~

~~(4) North Central Association of Colleges and Secondary Schools.~~

~~(5) Southern Association of Colleges and Schools.~~

SEC. 11. Section 4980.43 of the Business and Professions Code is amended to read:

4980.43. (a) To qualify for licensure as specified in Section 4980.40, each applicant shall complete experience related to the practice of marriage and family therapy under a supervisor who meets the qualifications set forth in Section 4980.03. The experience shall comply with the following:

(1) A minimum of 3,000 hours of supervised experience completed during a period of at least 104 weeks.

(2) A maximum of 40 hours in any seven consecutive days.

(3) A minimum of 1,700 hours obtained after the qualifying master's or doctoral degree was awarded.

(4) A maximum of 1,300 hours obtained prior to the award date of the qualifying master's or doctoral degree.

(5) A maximum of 750 hours of counseling and direct supervisor contact prior to the award date of the qualifying master's or doctoral degree.

(6) No hours of experience may be gained prior to completing either 12 semester units or 18 quarter units of graduate instruction.

(7) No hours of experience may be gained more than six years prior to the date the application for examination eligibility was filed, except that up to 500 hours of clinical experience gained in the supervised practicum required by subdivision (c) of Section 4980.37 and subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 shall be exempt from this six-year requirement.

(8) A minimum of 1,750 hours of direct counseling with individuals, groups, couples, or families, that includes not less than 500 total hours of experience in diagnosing and treating couples, families, and children.

(9) A maximum of 1,250 hours of nonclinical practice, consisting of direct supervisor contact, administering and evaluating psychological tests, writing clinical reports, writing progress or process notes, client centered advocacy, and workshops, seminars, training sessions, or conferences directly related to marriage and family therapy that have been approved by the applicant's supervisor.

(10) It is anticipated and encouraged that hours of experience will include working with elders and dependent adults who have physical or mental limitations that restrict their ability to carry out normal activities or protect their rights.

This subdivision shall only apply to hours gained on and after January 1, 2010.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) All applicants, trainees, and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of marriage and family therapy. Supervised experience shall be gained by an intern or trainee only as an employee or as a volunteer. The requirements of this chapter regarding gaining hours of experience and supervision are applicable equally to employees and volunteers. ~~Experience shall not be gained by an intern or trainee as an independent contractor.~~ *Associates and trainees shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.*

(1) If employed, an intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure.

(2) If volunteering, an intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure.

(d) Except for experience gained by attending workshops, seminars, training sessions, or conferences as described in

paragraph (9) of subdivision (a), supervision shall include at least one hour of direct supervisor contact in each week for which experience is credited in each work setting, as specified:

(1) A trainee shall receive an average of at least one hour of direct supervisor contact for every five hours of client contact in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(2) An individual supervised after being granted a qualifying degree shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of client contact is gained in each setting. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(3) For purposes of this section, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours per week of face-to-face contact in a group.

(4) Direct supervisor contact shall occur within the same week as the hours claimed.

(5) Direct supervisor contact provided in a group shall be provided in a group of not more than eight supervisees and in segments lasting no less than one continuous hour.

(6) Notwithstanding paragraph (3), an intern working in a governmental entity, a school, a college, or a university, or an institution that is both nonprofit and charitable may obtain the required weekly direct supervisor contact via two-way, real-time videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is upheld.

(7) All experience gained by a trainee shall be monitored by the supervisor as specified by regulation.

(8) The six hours of supervision that may be credited during any single week pursuant to paragraphs (1) and (2) shall apply to supervision hours gained on or after January 1, 2009.

(e) (1) A trainee may be credited with supervised experience completed in any setting that meets all of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the trainee's work at the setting meets the experience and supervision requirements set forth

in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(C) Is not a private practice owned by a licensed marriage and family therapist, a licensed professional clinical counselor, a licensed psychologist, a licensed clinical social worker, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(2) Experience may be gained by the trainee solely as part of the position for which the trainee volunteers or is employed.

(f) (1) An intern may be credited with supervised experience completed in any setting that meets both of the following:

(A) Lawfully and regularly provides mental health counseling or psychotherapy.

(B) Provides oversight to ensure that the intern's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4980.02.

(2) An applicant shall not be employed or volunteer in a private practice, as defined in subparagraph (C) of paragraph (1) of subdivision (e), until registered as an intern.

(3) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration to interns.

(4) Except for periods of time during a supervisor's vacation or sick leave, an intern who is employed or volunteering in private practice shall be under the direct supervision of a licensee that has satisfied subdivision (g) of Section 4980.03. The supervising licensee shall either be employed by and practice at the same site as the intern's employer, or shall be an owner or shareholder of the private practice. Alternative supervision may be arranged during a supervisor's vacation or sick leave if the supervision meets the requirements of this section.

(5) Experience may be gained by the intern solely as part of the position for which the intern volunteers or is employed.

(g) Except as provided in subdivision (h), all persons shall register with the board as an intern to be credited for postdegree hours of supervised experience gained toward licensure.

(h) Postdegree hours of experience shall be credited toward licensure so long as the applicant applies for the intern registration within 90 days of the granting of the qualifying master's or doctoral

degree and is thereafter granted the intern registration by the board. An applicant shall not be employed or volunteer in a private practice until registered as an intern by the board.

(i) Trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(j) Trainees, interns, and applicants shall only perform services at the place where their employers regularly conduct business, which may include performing services at other locations, so long as the services are performed under the direction and control of their employer and supervisor, and in compliance with the laws and regulations pertaining to supervision. For purposes of paragraph (3) of subdivision (a) of Section 2290.5, interns and trainees working under licensed supervision, consistent with subdivision (c), may provide services via telehealth within the scope authorized by this chapter and in accordance with any regulations governing the use of telehealth promulgated by the board. Trainees and interns shall have no proprietary interest in their employers' businesses and shall not lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of their employers.

(k) Trainees, interns, or applicants who provide volunteered services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those trainees, interns, or applicants for services rendered in any lawful work setting other than a private practice shall be considered employees and not independent contractors. The board may audit applicants who receive reimbursement for expenses, and the applicants shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(*l*) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are

encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 12. Section 4980.78 of the Business and Professions Code is amended to read:

4980.78. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who do not hold a license as described in Section 4980.72.

(b) For purposes of Section 4980.74, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from a school, college, or university accredited by ~~an~~ *a regional or national institutional* accrediting agency that is recognized by the United States Department of Education and consists of, at a minimum, the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.36, the degree shall contain no less than 60 semester or 90 quarter units of instruction.

(ii) Up to 12 semester or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an intern.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.37, the degree shall contain no less than 48 semester units or 72 quarter units of instruction.

(C) Six semester or nine quarter units of practicum, including, but not limited to, a minimum of 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy.

(D) Twelve semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment, as specified in subparagraph (A) of paragraph (1) of subdivision (d) of Section 4980.36.

(2) The applicant shall complete coursework in California law and ethics as follows:

(A) An applicant who completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81, that did not contain instruction in California law and ethics, shall complete an 18-hour course in California law and professional ethics. The

content of the course shall include, but not be limited to, advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and licensing process. This coursework shall be completed prior to registration as an intern.

(B) An applicant who has not completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 shall complete this required coursework. The coursework shall contain content specific to California law and ethics. This coursework shall be completed prior to registration as an intern.

(3) The applicant completes the educational requirements specified in Section 4980.81 not already completed in his or her education. The coursework may be from an accredited school, college, or university as specified in paragraph (1), from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate courses shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited school, college, or university as specified in paragraph (1) from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate courses shall not satisfy this requirement.

(A) At least three semester units, or 45 hours, of instruction regarding the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various consumers and family members of consumers of mental health

services to enhance understanding of their experience of mental illness, treatment, and recovery.

(B) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant may complete any units and course content requirements required under paragraphs (3) and (4) not already completed in his or her education while registered as an intern, unless otherwise specified.

(6) The applicant's degree title need not be identical to that required by subdivision (b) of Section 4980.36.

SEC. 13. Section 4980.79 of the Business and Professions Code is amended to read:

4980.79. (a) This section applies to persons who apply for licensure or registration on or after January 1, 2016, and who hold a license as described in Section 4980.72.

(b) For purposes of Section 4980.72, education is substantially equivalent if all of the following requirements are met:

(1) The degree is obtained from a school, college, or university accredited by ~~an~~ *a regional or national institutional* accrediting agency recognized by the United States Department of Education and consists of, at a minimum, the following:

(A) (i) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.36, the degree shall contain no less than 60 semester or 90 quarter units of instruction.

(ii) Up to 12 semester or 18 quarter units of instruction may be remediated, if missing from the degree. The remediation may occur while the applicant is registered as an intern.

(B) For an applicant who obtained his or her degree within the timeline prescribed by subdivision (a) of Section 4980.37, the degree shall contain no less than 48 semester or 72 quarter units of instruction.

(C) Six semester or nine quarter units of practicum, including, but not limited to, a minimum of 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy.

(i) An out-of-state applicant who has been licensed for at least two years in clinical practice, as verified by the board, is exempt from this requirement.

(ii) An out-of-state applicant who has been licensed for less than two years in clinical practice, as verified by the board, who does not meet the practicum requirement, shall remediate it by obtaining 150 hours of face-to-face counseling, and an additional 75 hours of either face-to-face counseling or client-centered advocacy, or a combination of face-to-face counseling and client-centered advocacy. These hours are in addition to the 3,000 hours of experience required by this chapter, and shall be gained while registered as an intern.

(D) Twelve semester or 18 quarter units in the areas of marriage, family, and child counseling and marital and family systems approaches to treatment, as specified in subparagraph (A) of paragraph (1) of subdivision (d) of Section 4980.36.

(2) An applicant shall complete coursework in California law and ethics as follows:

(A) An applicant who completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 that did not include instruction in California law and ethics, shall complete an 18-hour course in California law and professional ethics. The content of the course shall include, but not be limited to, advertising, scope of practice, scope of competence, treatment of minors, confidentiality, dangerous patients, psychotherapist-patient privilege, recordkeeping, patient access to records, state and federal laws relating to confidentiality of patient health information, dual relationships, child abuse, elder and dependent adult abuse, online therapy, insurance reimbursement, civil liability, disciplinary actions and unprofessional conduct, ethics complaints and ethical standards, termination of therapy, standards of care, relevant family law, therapist disclosures to patients, differences in legal and ethical standards in different types of work settings, and licensing law and licensing process. This coursework shall be completed prior to registration as an intern.

(B) An applicant who has not completed a course in law and professional ethics for marriage and family therapists as specified in paragraph (7) of subdivision (a) of Section 4980.81 shall complete this required coursework. The coursework shall include

content specific to California law and ethics. An applicant shall complete this coursework prior to registration as an intern.

(3) The applicant completes the educational requirements specified in Section 4980.81 not already completed in his or her education. The coursework may be from an accredited school, college, or university as specified in paragraph (1), from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate coursework shall not satisfy this requirement.

(4) The applicant completes the following coursework not already completed in his or her education from an accredited school, college, or university as specified in paragraph (1) above, from an educational institution approved by the Bureau for Private Postsecondary Education, or from a continuing education provider that is acceptable to the board as defined in Section 4980.54. Undergraduate coursework shall not satisfy this requirement.

(A) At least three semester units, or 45 hours, of instruction pertaining to the principles of mental health recovery-oriented care and methods of service delivery in recovery-oriented practice environments, including structured meetings with various consumers and family members of consumers of mental health services to enhance understanding of their experience of mental illness, treatment, and recovery.

(B) At least one semester unit, or 15 hours, of instruction that includes an understanding of various California cultures and the social and psychological implications of socioeconomic position.

(5) An applicant's degree title need not be identical to that required by subdivision (b) of Section 4980.36.

(6) An applicant may complete any units and course content requirements required under paragraphs (3) and (4) not already completed in his or her education while registered as an intern, unless otherwise specified.

SEC. 14. Section 4992.05 of the Business and Professions Code is amended to read:

4992.05. (a) Effective January 1, 2016, an applicant for licensure as a clinical social worker shall pass the following two examinations as prescribed by the board:

(1) A California law and ethics examination.

(2) A clinical examination.

(b) Upon registration with the board, an associate *clinical* social worker registrant shall, within the first year of registration, take an examination on California law and ethics.

(c) A registrant may take the clinical examination only upon meeting all of the following requirements:

(1) Completion of all education requirements.

(2) Passage of the California law and ethics examination.

(3) Completion of all required supervised work experience.

(d) This section shall become operative on January 1, 2016.

SEC. 15. Section 4996.18 of the Business and Professions Code is amended to read:

4996.18. (a) A person who wishes to be credited with experience toward licensure requirements shall register with the board as an associate clinical social worker prior to obtaining that experience. The application shall be made on a form prescribed by the board.

(b) An applicant for registration shall satisfy the following requirements:

(1) Possess a master's degree from an accredited school or department of social work.

(2) Have committed no crimes or acts constituting grounds for denial of licensure under Section 480.

(3) Commencing January 1, 2014, have completed training or coursework, which may be embedded within more than one course, in California law and professional ethics for clinical social workers, including instruction in all of the following areas of study:

(A) Contemporary professional ethics and statutes, regulations, and court decisions that delineate the scope of practice of clinical social work.

(B) The therapeutic, clinical, and practical considerations involved in the legal and ethical practice of clinical social work, including, but not limited to, family law.

(C) The current legal patterns and trends in the mental health professions.

(D) The psychotherapist-patient privilege, confidentiality, dangerous patients, and the treatment of minors with and without parental consent.

(E) A recognition and exploration of the relationship between a practitioner's sense of self and human values, and his or her professional behavior and ethics.

(F) Differences in legal and ethical standards for different types of work settings.

(G) Licensing law and process.

(c) An applicant who possesses a master's degree from a school or department of social work that is a candidate for accreditation by the Commission on Accreditation of the Council on Social Work Education shall be eligible, and shall be required, to register as an associate clinical social worker in order to gain experience toward licensure if the applicant has not committed any crimes or acts that constitute grounds for denial of licensure under Section 480. That applicant shall not, however, be eligible ~~for~~ *to take the clinical* examination until the school or department of social work has received accreditation by the Commission on Accreditation of the Council on Social Work Education.

(d) All applicants and registrants shall be at all times under the supervision of a supervisor who shall be responsible for ensuring that the extent, kind, and quality of counseling performed is consistent with the training and experience of the person being supervised, and who shall be responsible to the board for compliance with all laws, rules, and regulations governing the practice of clinical social work.

(e) Any experience obtained under the supervision of a spouse or relative by blood or marriage shall not be credited toward the required hours of supervised experience. Any experience obtained under the supervision of a supervisor with whom the applicant has a personal relationship that undermines the authority or effectiveness of the supervision shall not be credited toward the required hours of supervised experience.

(f) An applicant who possesses a master's degree from an accredited school or department of social work shall be able to apply experience the applicant obtained during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education toward the licensure requirements, if the experience meets the requirements of Section 4996.23. This subdivision shall apply retroactively to persons who possess a master's degree from an accredited school or department of social work and who obtained experience during the time the accredited school or department was in candidacy status by the Commission on Accreditation of the Council on Social Work Education.

(g) An applicant for registration or licensure trained in an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a master's of social work degree that is equivalent to a master's degree issued from a school or department of social work that is accredited by the Commission on Accreditation of the Council on Social Work Education. These applicants shall provide the board with a comprehensive evaluation of the degree and shall provide any other documentation the board deems necessary. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements regardless of evaluation or accreditation.

(h) A registrant shall not provide clinical social work services to the public for a fee, monetary or otherwise, except as an employee.

(i) A registrant shall inform each client or patient prior to performing any professional services that he or she is unlicensed and is under the supervision of a licensed professional.

SEC. 16. Section 4996.23 of the Business and Professions Code is amended to read:

4996.23. (a) To qualify for licensure as specified in Section 4996.2, each applicant shall complete 3,200 hours of post-master's degree supervised experience related to the practice of clinical social work. The experience shall comply with the following:

(1) At least 1,700 hours shall be gained under the supervision of a licensed clinical social worker. The remaining required supervised experience may be gained under the supervision of a licensed mental health professional acceptable to the board as defined by a regulation adopted by the board.

(2) A minimum of 2,000 hours in clinical psychosocial diagnosis, assessment, and treatment, including psychotherapy or counseling.

(3) A maximum of 1,200 hours in client centered advocacy, consultation, evaluation, research, direct supervisor contact, and workshops, seminars, training sessions, or conferences directly related to clinical social work that have been approved by the applicant's supervisor.

(4) Of the 2,000 clinical hours required in paragraph (2), no less than 750 hours shall be face-to-face individual or group

psychotherapy provided to clients in the context of clinical social work services.

(5) A minimum of two years of supervised experience is required to be obtained over a period of not less than 104 weeks and shall have been gained within the six years immediately preceding the date on which the application for licensure was filed.

(6) Experience shall not be credited for more than 40 hours in any week.

(b) An individual who submits an application for examination eligibility between January 1, 2016, and December 31, 2020, may alternatively qualify under the experience requirements that were in place on January 1, 2015.

(c) "Supervision" means responsibility for, and control of, the quality of clinical social work services being provided. Consultation or peer discussion shall not be considered to be supervision.

(d) (1) Prior to the commencement of supervision, a supervisor shall comply with all requirements enumerated in Section 1870 of Title 16 of the California Code of Regulations and shall sign under penalty of perjury the "Responsibility Statement for Supervisors of an Associate Clinical Social Worker" form.

(2) Supervised experience shall include at least one hour of direct supervisor contact for a minimum of 104 weeks. For purposes of this subdivision, "one hour of direct supervisor contact" means one hour per week of face-to-face contact on an individual basis or two hours of face-to-face contact in a group conducted within the same week as the hours claimed.

(3) An associate shall receive at least one additional hour of direct supervisor contact for every week in which more than 10 hours of face-to-face psychotherapy is performed in each setting in which experience is gained. No more than six hours of supervision, whether individual or group, shall be credited during any single week.

(4) Supervision shall include at least one hour of direct supervisor contact during each week for which experience is gained in each work setting. Supervision is not required for experience gained attending workshops, seminars, training sessions, or conferences as described in paragraph (3) of subdivision (a).

(5) The six hours of supervision that may be credited during any single week pursuant to paragraph (3) shall apply only to supervision hours gained on or after January 1, 2010.

(6) Group supervision shall be provided in a group of not more than eight supervisees and shall be provided in segments lasting no less than one continuous hour.

(7) Of the 104 weeks of required supervision, 52 weeks shall be individual supervision, and of the 52 weeks of required individual supervision, not less than 13 weeks shall be supervised by a licensed clinical social worker.

(8) Notwithstanding paragraph (2), an associate clinical social worker working for a governmental entity, school, college, or university, or an institution that is both a nonprofit and charitable institution, may obtain the required weekly direct supervisor contact via live two-way videoconferencing. The supervisor shall be responsible for ensuring that client confidentiality is preserved.

(e) The supervisor and the associate shall develop a supervisory plan that describes the goals and objectives of supervision. These goals shall include the ongoing assessment of strengths and limitations and the assurance of practice in accordance with the laws and regulations. The associate shall submit to the board the initial original supervisory plan upon application for licensure.

(f) Experience shall only be gained in a setting that meets both of the following:

(1) Lawfully and regularly provides clinical social work, mental health counseling, or psychotherapy.

(2) Provides oversight to ensure that the associate's work at the setting meets the experience and supervision requirements set forth in this chapter and is within the scope of practice for the profession as defined in Section 4996.9.

(g) Experience shall not be gained until the applicant has been registered as an associate clinical social worker.

(h) Employment in a private practice as defined in subdivision (i) shall not commence until the applicant has been registered as an associate clinical social worker.

(i) A private practice setting is a setting that is owned by a licensed clinical social worker, a licensed marriage and family therapist, a licensed psychologist, a licensed professional clinical counselor, a licensed physician and surgeon, or a professional corporation of any of those licensed professions.

(j) Associates shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.

~~(j)~~

(k) If volunteering, the associate shall provide the board with a letter from his or her employer verifying his or her voluntary status upon application for licensure.

~~(k)~~

(l) If employed, the associate shall provide the board with copies of his or her W-2 tax forms for each year of experience claimed upon application for licensure.

~~(l)~~

(m) While an associate may be either a paid employee or volunteer, employers are encouraged to provide fair remuneration to associates.

~~(m)~~

(n) An associate shall not do the following:

(1) Receive any remuneration from patients or clients and shall only be paid by his or her employer.

(2) Have any proprietary interest in the employer's business.

(3) Lease or rent space, pay for furnishings, equipment, or supplies, or in any other way pay for the obligations of his or her employer.

~~(n)~~

(o) An associate, whether employed or volunteering, may obtain supervision from a person not employed by the associate's employer if that person has signed a written agreement with the employer to take supervisory responsibility for the associate's social work services.

~~(o)~~

(p) Notwithstanding any other provision of law, associates and applicants for examination shall receive a minimum of one hour of supervision per week for each setting in which he or she is working.

SEC. 17. Section 4999.12 of the Business and Professions Code is amended to read:

4999.12. For purposes of this chapter, the following terms have the following meanings:

(a) "Board" means the Board of Behavioral Sciences.

(b) "Accredited" means a school, college, or university accredited by ~~the Western Association of Schools and Colleges, or its equivalent regional accrediting association.~~ *a regional or national institutional accrediting agency that is recognized by the United States Department of Education.*

(c) "Approved" means a school, college, or university that possessed unconditional approval by the Bureau for Private Postsecondary Education at the time of the applicant's graduation from the school, college, or university.

(d) "Applicant" means an unlicensed person who has completed a master's or doctoral degree program, as specified in Section 4999.32 or 4999.33, as applicable, and whose application for registration as an intern is pending or who has applied for examination eligibility, or an unlicensed person who has completed the requirements for licensure specified in this chapter and is no longer registered with the board as an intern.

(e) "Licensed professional clinical counselor" or "LPCC" means a person licensed under this chapter to practice professional clinical counseling, as defined in Section 4999.20.

(f) "Intern" means an unlicensed person who meets the requirements of Section 4999.42 and is registered with the board.

(g) "Clinical counselor trainee" means an unlicensed person who is currently enrolled in a master's or doctoral degree program, as specified in Section 4999.32 or 4999.33, as applicable, that is designed to qualify him or her for licensure under this chapter, and who has completed no less than 12 semester units or 18 quarter units of coursework in any qualifying degree program.

(h) "Approved supervisor" means an individual who meets the following requirements:

(1) Has documented two years of clinical experience as a licensed professional clinical counselor, licensed marriage and family therapist, licensed clinical psychologist, licensed clinical social worker, or licensed physician and surgeon who is certified in psychiatry by the American Board of Psychiatry and Neurology.

(2) Has received professional training in supervision.

(3) Has not provided therapeutic services to the clinical counselor trainee or intern.

(4) Has a current and valid license that is not under suspension or probation.

(i) "Client centered advocacy" includes, but is not limited to, researching, identifying, and accessing resources, or other activities, related to obtaining or providing services and supports for clients or groups of clients receiving psychotherapy or counseling services.

(j) "Advertising" or "advertise" includes, but is not limited to, the issuance of any card, sign, or device to any person, or the causing, permitting, or allowing of any sign or marking on, or in, any building or structure, or in any newspaper or magazine or in any directory, or any printed matter whatsoever, with or without any limiting qualification. It also includes business solicitations communicated by radio or television broadcasting. Signs within church buildings or notices in church bulletins mailed to a congregation shall not be construed as advertising within the meaning of this chapter.

(k) "Referral" means evaluating and identifying the needs of a client to determine whether it is advisable to refer the client to other specialists, informing the client of that judgment, and communicating that determination as requested or deemed appropriate to referral sources.

(*l*) "Research" means a systematic effort to collect, analyze, and interpret quantitative and qualitative data that describes how social characteristics, behavior, emotion, cognitions, disabilities, mental disorders, and interpersonal transactions among individuals and organizations interact.

(m) "Supervision" includes the following:

(1) Ensuring that the extent, kind, and quality of counseling performed is consistent with the education, training, and experience of the person being supervised.

(2) Reviewing client or patient records, monitoring and evaluating assessment, diagnosis, and treatment decisions of the clinical counselor trainee.

(3) Monitoring and evaluating the ability of the intern or clinical counselor trainee to provide services to the particular clientele at the site or sites where he or she will be practicing.

(4) Ensuring compliance with laws and regulations governing the practice of licensed professional clinical counseling.

(5) That amount of direct observation, or review of audio or videotapes of counseling or therapy, as deemed appropriate by the supervisor.

SEC. 18. Section 4999.12.5 is added to the Business and Professions Code, to read:

4999.12.5. (a) The title "professional clinical counselor intern" or "professional clinical counselor registered intern" is hereby renamed "associate professional clinical counselor" or "registered associate professional clinical counselor," respectively. Any reference in any statute or regulation to a "professional clinical counselor intern" or "professional clinical counselor registered intern" shall be deemed a reference to an "associate professional clinical counselor" or "registered associate professional clinical counselor."

(b) Nothing in this section shall be construed to expand or constrict the scope of practice of a person licensed or registered pursuant to this chapter.

(c) This section shall become operative January 1, 2018.

SEC. 19. Section 4999.40 of the Business and Professions Code is amended to read:

4999.40. (a) Each educational institution preparing applicants to qualify for licensure shall notify each of its students by means of its public documents or otherwise in writing that its degree program is designed to meet the requirements of Section 4999.32 or 4999.33 and shall certify to the board that it has so notified its students.

(b) An applicant for registration or licensure shall submit to the board a certification by the applicant's educational institution that the institution's required curriculum for graduation and any associated coursework completed by the applicant does one of the following:

(1) Meets all of the requirements set forth in Section 4999.32.

(2) Meets all of the requirements set forth in Section 4999.33.

~~(b)~~

(c) An applicant trained at an educational institution outside the United States shall demonstrate to the satisfaction of the board that he or she possesses a qualifying degree that is equivalent to a degree earned from an institution of higher education that is accredited or approved. These applicants shall provide the board with a comprehensive evaluation of the degree performed by a foreign credential evaluation service that is a member of the National Association of Credential Evaluation Services and shall provide any other documentation the board deems necessary.

SEC. 20. Section 4999.47 of the Business and Professions Code is amended to read:

4999.47. (a) Clinical counselor trainees, interns, and applicants shall perform services only as an employee or as a volunteer.

The requirements of this chapter regarding gaining hours of clinical mental health experience and supervision are applicable equally to employees and volunteers. ~~Experience shall not be gained by interns or trainees as an independent contractor.~~ *Associates and trainees shall not be employed as independent contractors, and shall not gain experience for work performed as an independent contractor, reported on an IRS Form 1099, or both.*

(1) If employed, a clinical counselor intern shall provide the board with copies of the corresponding W-2 tax forms for each year of experience claimed upon application for licensure as a professional clinical counselor.

(2) If volunteering, a clinical counselor intern shall provide the board with a letter from his or her employer verifying the intern's employment as a volunteer upon application for licensure as a professional clinical counselor.

(b) Clinical counselor trainees, interns, and applicants shall not receive any remuneration from patients or clients, and shall only be paid by their employers.

(c) While an intern may be either a paid employee or a volunteer, employers are encouraged to provide fair remuneration.

(d) Clinical counselor trainees, interns, and applicants who provide voluntary services or other services, and who receive no more than a total, from all work settings, of five hundred dollars ($500) per month as reimbursement for expenses actually incurred by those clinical counselor trainees, interns, and applicants for services rendered in any lawful work setting other than a private practice shall be considered an employee and not an independent contractor.

(e) The board may audit an intern or applicant who receives reimbursement for expenses and the intern or applicant shall have the burden of demonstrating that the payments received were for reimbursement of expenses actually incurred.

(f) Clinical counselor trainees, interns, and applicants shall only perform services at the place where their employer regularly conducts business and services, which may include other locations,

as long as the services are performed under the direction and control of the employer and supervisor in compliance with the laws and regulations pertaining to supervision. Clinical counselor trainees, interns, and applicants shall have no proprietary interest in the employer's business.

(g) Each educational institution preparing applicants for licensure pursuant to this chapter shall consider requiring, and shall encourage, its students to undergo individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Each supervisor shall consider, advise, and encourage his or her interns and clinical counselor trainees regarding the advisability of undertaking individual, marital or conjoint, family, or group counseling or psychotherapy, as appropriate. Insofar as it is deemed appropriate and is desired by the applicant, the educational institution and supervisors are encouraged to assist the applicant in locating that counseling or psychotherapy at a reasonable cost.

SEC. 21. Section 4999.52 of the Business and Professions Code is amended to read:

4999.52. (a) ~~Except as provided in Section 4999.54, every~~ *Every* applicant for a license as a professional clinical counselor shall be examined by the board. The board shall examine the candidate with regard to his or her knowledge and professional skills and his or her judgment in the utilization of appropriate techniques and methods.

(b) The examinations shall be given at least twice a year at a time and place and under supervision as the board may determine.

(c) The board shall not deny any applicant who has submitted a complete application for examination admission to the licensure examinations required by this section if the applicant meets the educational and experience requirements of this chapter, and has not committed any acts or engaged in any conduct that would constitute grounds to deny licensure.

(d) The board shall not deny any applicant whose application for licensure is complete admission to the examinations specified by paragraph (2) of subdivision (a) of Section 4999.53, nor shall the board postpone or delay this examination for any applicant or delay informing the candidate of the results of this examination, solely upon the receipt by the board of a complaint alleging acts or conduct that would constitute grounds to deny licensure.

(e) If an applicant for the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, who has passed the California law and ethics examination, is the subject of a complaint or is under board investigation for acts or conduct that, if proven to be true, would constitute grounds for the board to deny licensure, the board shall permit the applicant to take this examination, but may notify the applicant that licensure will not be granted pending completion of the investigation.

(f) Notwithstanding Section 135, the board may deny any applicant who has previously failed either the California law and ethics examination, or the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, permission to retake either examination pending completion of the investigation of any complaints against the applicant.

(g) Nothing in this section shall prohibit the board from denying an applicant admission to any examination, withholding the results, or refusing to issue a license to any applicant when an accusation or statement of issues has been filed against the applicant pursuant to Section 11503 or 11504 of the Government Code, respectively, or the application has been denied in accordance with subdivision (b) of Section 485.

(h) Notwithstanding any other provision of law, the board may destroy all examination materials two years following the date of an examination.

(i) On and after January 1, 2016, the examination specified by paragraph (2) of subdivision (a) of Section 4999.53 shall be passed within seven years of an applicant's initial attempt.

(j) A passing score on the clinical examination shall be accepted by the board for a period of seven years from the date the examination was taken.

(k) No applicant shall be eligible to participate in the examination specified by paragraph (2) of subdivision (a) of Section 4999.53, if he or she fails to obtain a passing score on this examination within seven years from his or her initial attempt. If the applicant fails to obtain a passing score within seven years of initial attempt, he or she shall obtain a passing score on the current version of the California law and ethics examination in order to be eligible to retake this examination.

(*l*) This section shall become operative on January 1, 2016.

SEC. 22. Section 4999.54 of the Business and Professions Code is repealed.

~~4999.54. (a) Notwithstanding Section 4999.50, the board may issue a license to any person who submits an application for a license between January 1, 2011, and December 31, 2011, provided that all documentation is submitted within 12 months of the board's evaluation of the application, and provided he or she meets one of the following sets of criteria:~~

~~(1) He or she meets all of the following requirements:~~

~~(A) Has a master's or doctoral degree from a school, college, or university as specified in Section 4999.32, that is counseling or psychotherapy in content. If the person's degree does not include all the graduate coursework in all nine core content areas as required by paragraph (1) of subdivision (c) of Section 4999.32, a person shall provide documentation that he or she has completed the required coursework prior to licensure pursuant to this chapter. Except as specified in clause (ii), a qualifying degree must include the supervised practicum or field study experience as required in paragraph (3) of subdivision (c) of Section 4999.32.~~

~~(i) A counselor educator whose degree contains at least seven of the nine required core content areas shall be given credit for coursework not contained in the degree if the counselor educator provides documentation that he or she has taught the equivalent of the required core content areas in a graduate program in counseling or a related area.~~

~~(ii) Degrees issued prior to 1996 shall include a minimum of 30 semester units or 45 quarter units and at least six of the nine required core content areas specified in paragraph (1) of subdivision (c) of Section 4999.32 and three semester units or four and one-half quarter units of supervised practicum or field study experience. The total number of units shall be no less than 48 semester units or 72 quarter units.~~

~~(iii) Degrees issued in 1996 and after shall include a minimum of 48 semester units or 72 quarter units and at least seven of the nine core content areas specified in paragraph (1) of subdivision (c) of Section 4999.32.~~

~~(B) Has completed all of the coursework or training specified in subdivision (e) of Section 4999.32.~~

~~(C) Has at least two years, full-time or the equivalent, of postdegree counseling experience, that includes at least 1,700 hours~~

~~of experience in a clinical setting supervised by a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, a licensed physician and surgeon specializing in psychiatry, a professional clinical counselor or a person who is licensed in another state to independently practice professional clinical counseling, as defined in Section 4999.20, or a master's level counselor or therapist who is certified by a national certifying or registering organization, including, but not limited to, the National Board for Certified Counselors or the Commission on Rehabilitation Counselor Certification.~~

~~(D) Has a passing score on the following examinations:~~

~~(i) The National Counselor Examination for Licensure and Certification or the Certified Rehabilitation Counselor Examination.~~

~~(ii) The National Clinical Mental Health Counselor Examination.~~

~~(iii) A California jurisprudence and ethics examination, when developed by the board.~~

~~(2) Is currently licensed as a marriage and family therapist in the State of California, meets the coursework requirements described in subparagraph (A) of paragraph (1), and passes the examination described in subdivision (b).~~

~~(3) Is currently licensed as a clinical social worker in the State of California, meets the coursework requirements described in subparagraph (A) of paragraph (1), and passes the examination described in subdivision (b).~~

~~(b) (1) The board and the Office of Professional Examination Services shall jointly develop an examination on the differences, if any differences exist, between the following:~~

~~(A) The practice of professional clinical counseling and the practice of marriage and family therapy.~~

~~(B) The practice of professional clinical counseling and the practice of clinical social work.~~

~~(2) If the board, in consultation with the Office of Professional Examination Services, determines that an examination is necessary pursuant to this subdivision, an applicant described in paragraphs (2) and (3) of subdivision (a) shall pass the examination as a condition of licensure.~~

~~(c) Nothing in this section shall be construed to expand or constrict the scope of practice of professional clinical counseling, as defined in Section 4999.20.~~

SEC. 23. Section 4999.60 of the Business and Professions Code is amended to read:

4999.60. (a) This section applies to persons who are licensed outside of California and apply for examination eligibility on or after January 1, 2016.

(b) The board may issue a license to a person who, at the time of submitting an application for a license pursuant to this chapter, holds a valid license as a professional clinical counselor, or other counseling license that allows the applicant to independently provide clinical mental health services, in another jurisdiction of the United States, if all of the following conditions are satisfied:

(1) The applicant's education is substantially equivalent, as defined in Section 4999.63.

(2) The applicant complies with subdivision ~~(b)~~ *(c)* of Section 4999.40, if applicable.

(3) The applicant's supervised experience is substantially equivalent to that required for a license under this chapter. The board shall consider hours of experience obtained outside of California during the six-year period immediately preceding the date the applicant initially obtained the license described above. If the applicant has less than 3,000 hours of qualifying supervised experience, time actively licensed as a professional clinical counselor shall be accepted at a rate of 100 hours per month up to a maximum of 1,200 hours if the applicant's degree meets the practicum requirement described in subparagraph (C) of paragraph (1) of subdivision (b) of Section 4999.63 without exemptions or remediation.

(4) The applicant passes the examinations required to obtain a license under this chapter. An applicant who obtained his or her license or registration under another jurisdiction may apply for licensure with the board without taking the clinical examination if both of the following conditions are met:

(A) The applicant obtained a passing score on the licensing examination set forth in regulation as accepted by the board.

(B) The applicant's license or registration in that jurisdiction is in good standing at the time of his or her application and is not revoked, suspended, surrendered, denied, or otherwise restricted or encumbered.

SEC. 24. Section 4999.61 of the Business and Professions Code is amended to read:

4999.61. (a) This section applies to persons who apply for examination eligibility or registration on or after January 1, 2016, and who do not hold a license as described in Section 4999.60.

(b) The board shall accept education gained while residing outside of California for purposes of satisfying licensure or registration requirements if the education is substantially equivalent, as defined in Section 4999.62, and the applicant complies with subdivision ~~(b)~~ *(c)* of Section 4999.40, if applicable.

(c) The board shall accept experience gained outside of California for purposes of satisfying licensure or registration requirements if the experience is substantially equivalent to that required by this chapter.

SEC. 25. Section 4999.120 of the Business and Professions Code is amended to read:

4999.120. The board shall assess fees for the application for and the issuance and renewal of licenses and for the registration of interns to cover administrative and operating expenses of the board related to this chapter. Fees assessed pursuant to this section shall not exceed the following:

(a) The fee for the application for examination eligibility shall be up to two hundred fifty dollars ($250).

(b) The fee for the application for intern registration shall be up to one hundred fifty dollars ($150).

(c) The fee for the application for licensure shall be up to one hundred eighty dollars ($180).

(d) The fee for the board-administered clinical examination, if the board chooses to adopt this examination in regulations, shall be up to two hundred fifty dollars ($250).

(e) The fee for the law and ethics examination shall be up to one hundred fifty dollars ($150).

~~(f) The fee for the examination described in subdivision (b) of Section 4999.54 shall be up to one hundred dollars ($100).~~

~~(g)~~

(f) The fee for the issuance of a license shall be up to two hundred fifty dollars ($250).

~~(h)~~

(g) The fee for annual renewal of an intern registration shall be up to one hundred fifty dollars ($150).

~~(i)~~

(h) The fee for two-year renewal of licenses shall be up to two hundred fifty dollars ($250).

~~(j)~~

(i) The fee for issuance of a retired license shall be forty dollars ($40).

~~(k)~~

(j) The fee for rescoring an examination shall be twenty dollars ($20).

~~(l)~~

(k) The fee for issuance of a replacement license or registration shall be twenty dollars ($20).

~~(m)~~

(l) The fee for issuance of a certificate or letter of good standing shall be twenty-five dollars ($25).

SEC. 26. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MBC TRACKER II BILLS
7/12/2016

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. Approps	06/23/16
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Sen. 3rd Reading	03/28/16
AB 72	Bonta	Health Care Coverage: Out-of-Network Coverage	Sen. Approps	06/15/16
AB 83	Gatto	Personal Data	Sen. Inactive File	07/15/15
AB 174	Gray	UC: Medical Education	Sen. Approps	06/01/15
AB 259	Dababneh	Personal Information: Privacy	Sen. Approps	
AB 507	Olsen	DCA: BreEZe System: Annual Report	Sen. B&P	07/09/15
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. Approps	06/16/16
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	Senate	06/21/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Sen. PE&R	
AB 923	Steinorth	Respiratory Care Practitioners	Sen. 3rd Reading	05/31/16
AB 1001	Maienschein	Child Abuse: Reporting	Sen. 3rd Reading	05/11/16
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Asm. Concurrence	05/02/16
AB 1067	Gipson	Foster Children: Rights	Sen. Approps	05/11/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Sen. Approps	07/01/15
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	Senate	06/21/16

MBC TRACKER II BILLS
7/12/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Sen. Approps	06/28/16
AB 1575	Bonta	Medical Cannabis	Sen. Approps	06/22/16
AB 1639	Maienschein	Pupil Health: Sudden Cardiac Arrest Prevention Act	Sen. Approps	06/14/16
AB 1644	Bonta	School-Based Early Mental Health Intervention and Prevention	Sen. Approps	05/27/16
AB 1668	Calderon	Investigational Drugs, Biological Products, and Devices	Sen. Approps	03/07/16
AB 1696	Holden	Medi-Cal: Tobacco Cessation Services	Sen. Approps	06/27/16
AB 1703	Santiago	Inmates: Medical Treatment	Enrollment	
AB 1748	Mayes	Pupils: Pupil Health: Opioid Antagonist	Sen. Approps	06/20/16
AB 1763	Gipson	Health Care Coverage: Colorectal Cancer: Screening and Testing	Sen. Approps	06/27/16
AB 1795	Atkins	Health Care Programs: Cancer	Sen. Approps	05/31/16
AB 1823	Bonilla	California Cancer Clinical Trials Program	Sen. Approps	06/23/16
AB 1827	Kim	Emergency Medical Services: Mobile Field Hospitals	Asm. Health	03/16/16
AB 1831	Low	Health Care Coverage: Prescription Drugs: Refills	Sen. Approps	06/09/16
AB 1836	Maienschein	Mental Health	Sen. Approps	06/15/16
AB 1864	Cooley	Inquests: Sudden Unexplained Death in Childhood	Sen. 3rd Reading	03/17/16
AB 1887	Low	State Government: Discrimination: Travel	Sen. Approps	06/20/16
AB 1954	Burke	Health Care Coverage: Reproductive Health Care Services	Sen. Approps	06/27/16
AB 2004	Bloom	Hearing Aids: Minors	Sen. Approps	05/31/16
AB 2048	Gray	National Health Service Corps State Loan Repayment Program	Sen. Approps	05/27/16
AB 2083	Chu	Interagency Child Death Review	Sen. Approps	06/14/16
AB 2086	Cooley	Workers' Compensation: Neuropsychologists	Sen. Approps	05/16/16
AB 2105	Rodriguez	Workforce Development: Allied Health Professionals	Sen. Approps	06/14/16
AB 2115	Wood	Health Care Coverage: Disclosures	Sen. Approps	05/11/16
AB 2119	Chu	Medical Information: Disclosure: Medical Examiners and Forensic Pathologists	Sen. Approps	06/01/16

MBC TRACKER II BILLS
7/12/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2179	Gipson	Hepatitis C Testing	Sen. Approps	06/22/16
AB 2193	Salas	California Board of Podiatric Medicine: Physician Assistant Board: Extension	Sen. Approps	04/05/16
AB 2235	Thurmond	Board of Dentistry: Pediatric Anesthesia: Committee	Sen. Approps	06/29/16
AB 2311	Brown	Emergency Services	Sen. Approps	05/27/16
AB 2317	Mullin	California State University: Doctor of Audiology Degrees	Sen. 3rd Reading	06/29/16
AB 2325	Bonilla	Ken Maddy California Cancer Registry	Sen. 3rd Reading	06/21/16
AB 2394	Garcia, E.	Medi-Cal: Non-Medical Transportation	Sen. Approps	06/14/16
AB 2404	Cooley	Public Employees' Retirement System: Optional Settlements	Sen. Approps	06/13/16
AB 2424	Gomez	Community-Based Health Improvement and Innovation Fund	Sen. Approps	06/20/16
AB 2503	Obernolte	Workers' Compensation: Utilization Review	Sen. 3rd Reading	04/19/16
AB 2531	Burke	Reproductive Health and Research	Sen. Approps	
AB 2640	Gipson	Public Health: HIV	Sen. Approps	04/21/16
AB 2688	Gordon	Privacy: Commercial Health Monitoring Programs	Sen. 3rd Reading	04/28/16
AB 2696	Gaines, B.	Diabetes Prevention and Management	Enrollment	04/18/16
AB 2737	Bonta	Nonprovider Health Care Districts	Sen. Approps	06/20/16
AB 2828	Chau	Personal Information: Privacy Breach	Sen. Approps	05/27/16
AB 2843	Chau	Public Records: Employee Contact Information	Sen. Approps	06/28/16
AB 2844	Bloom	Public Contracts: Discrimination	Sen. Approps	06/20/16
AB 2853	Gatto	Public Records	Sen. Approps	06/16/16
AB 2859	Low	Professions and Vocations: Retired Category: Licenses	Sen. Approps	06/15/16
Ab 2883	Ins. Comm.	Workers' Compensation: Utilization Review	Sen. Approps	06/28/16
ACA 3	Gallagher	Public Employees' Retirement	Asm. PER&SS	
ACR 131	Patterson	Professions and Vocations: Licensing Fees: Equity	Sen. Approps	06/23/16
SB 3	Leno	Minimum Wage: Adjustment	Chaptered, #4	

MBC TRACKER II BILLS
7/12/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 10	Lara	Health Care Coverage: Immigration Status	Chaptered, #22	05/27/16
SB 24	Hill	California Public Employees' Pension Reform Act	Asm. Approps	01/05/16
SB 139	Galgiani	Controlled Substances	Asm. Approps	06/15/16
SB 253	Monning	Juveniles: Psychotropic Medication	Asm. Inactive File	08/31/15
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 441	Wolk	California Public Records Act: Exemptions	Asm. Approps	06/22/16
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.	Asm. Approps	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. Approps	
SB 914	Mendoza	Workers' Compensation: Medical Provider Networks	Enrollment	01/26/16
SB 923	Hernandez	Health Care Coverage: Cost Sharing Changes	Asm. 3rd Reading	05/31/16
SB 938	Jackson	Conservatorships: Psychotropic Drugs	Asm. Approps	06/29/16
SB 950	Nielsen	Excluded Employees: Arbitration	Asm. Approps	06/29/16
SB 999	Pavley	Health Insurance: Contraceptives: Annual Supply	Asm. Approps	06/20/16
SB 1010	Hernandez	Health Care: Prescription Drug Costs	Asm. Approps	05/31/16
SB 1034	Mitchell	Health Care Coverage: Autism	Asm. Approps	06/30/16
SB 1090	Mitchell	Sexually Transmitted Diseases: Outreach and Screening Services	Asm. Approps	06/01/16
SB 1095	Pan	Newborn Screening Program	Asm. Approps	05/31/16
SB 1135	Monning	Health Care Coverage: Notice of Timely Access to Care	Asm. Approps	06/30/16
SB 1139	Lara	Health Professionals: Medical Residency Programs: Undocumented Immigrants	Asm. Approps	06/21/16

MBC TRACKER II BILLS
7/12/2016

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1155	Morrell	Professions and Vocations: Licenses: Military Service	Asm. Approps	06/23/16
SB 1159	Hernandez	California Health Care Cost and Quality Database	Asm. Approps	06/30/16
SB 1160	Mendoza	Workers' Compensation: Utilization Review	Asm. Approps	06/20/16
SB 1193	Hill	Healing Arts	Asm. Approps	06/21/16
SB 1220	McGuire	Child Welfare Services: Case Plans: Behavioral Health Services	Asm. Approps	04/06/16
SB 1229	Jackson	Home-Generated Pharmaceutical Waste: Secure Drug Take-Back Bins	Asm. 3rd Reading	06/27/16
SB 1348	Cannella	Licensure Applications: Military Experience	Assembly	05/31/16
SB 1466	Mitchell	Early and Periodic Screening, Diagnosis, and Treatment Program	Asm. Approps	05/31/16
SCR 117	Pan	Palliative Care	Assembly	
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	

S. 2943 / National Defense Authorization Act for Fiscal Year 2017

(Recently, the U.S. Senate passed the ***National Defense Authorization Act for Fiscal Year 2017 (S. 2943)***, which includes ***SEC. 705. Enhancement of Use of Telehealth Services in Military Health System, (d) Location of Care***.)

SEC. 705. ENHANCEMENT OF USE OF TELEHEALTH SERVICES IN MILITARY HEALTH SYSTEM.

(a) INCORPORATION OF TELEHEALTH.—

(1) IN GENERAL.—Not later than one year after the date of the enactment of this Act, the Secretary of Defense shall incorporate, throughout the direct care and purchased care components of the military health system, the use of telehealth services, including mobile health applications—

(A) to improve access to primary care, urgent care, behavioral health care, and specialty care;

(B) to perform health assessments;

(C) to provide diagnoses, interventions, and supervision;

(D) to monitor individual health outcomes of covered beneficiaries with chronic diseases or conditions;

(E) to improve communication between health care providers and patients; and

(F) to reduce health care costs for covered beneficiaries and the Department of Defense.

(2) TYPES OF TELEHEALTH SERVICES.—The telehealth services required to be incorporated under paragraph (1) shall include those telehealth services that—

(A) provide real-time interactive communications and remote patient monitoring;

(B) allow covered beneficiaries to schedule appointments and communicate with health care providers; and

(C) allow health care providers, through video conference, telephone or tablet applications, or home health monitoring devices—

(i) to assess and evaluate disease signs and symptoms;

(ii) to diagnose diseases;

(iii) to supervise treatments; and

(iv) to monitor health outcomes.

(b) COVERAGE OF ITEMS OR SERVICES.—An item or service furnished to a covered beneficiary via a telecommunications system shall be covered

under the TRICARE program to the same extent as the item or service would be covered if furnished in the location of the covered beneficiary.

(c) REIMBURSEMENT RATES FOR TELEHEALTH SERVICES.—The Secretary shall develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, including by using reimbursement rates that incentivize the provision of telehealth services.

(d) LOCATION OF CARE.—For purposes of reimbursement, licensure, professional liability, and other purposes relating to the provision of telehealth services under this section, providers of such services shall be considered to be furnishing such services at their location and not at the location of the patient.

(e) REDUCTION OR ELIMINATION OF COPAYMENTS.—The Secretary shall reduce or eliminate, as the Secretary considers appropriate, copayments or cost shares for covered beneficiaries in connection with the receipt of telehealth services under the purchased care component of the TRICARE program.

(f) REPORTS.—

(1) INITIAL REPORT.—

(A) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the full range of telehealth services to be available in the direct care and purchased care components of the military health system and the copayments and cost shares, if any, associated with those services.

(B) REIMBURSEMENT PLAN.—The report required under subparagraph (A) shall include a plan to develop standardized payment methods to reimburse health care providers for telehealth services provided to covered beneficiaries in the purchased care component of the TRICARE program, as required under subsection (c).

(2) FINAL REPORT.—

(A) IN GENERAL.—Not later than three years after the date on which the Secretary begins incorporating, throughout the direct care and purchased care components of the military health system, the use of telehealth services as required under subsection (a), the Secretary shall submit to the Committees on Armed Services of the Senate and the House of Representatives a report describing the impact made by the use of telehealth services, including mobile

health applications, to carry out the actions specified in subparagraphs (A) through (F) of subsection (a)(1).

(B) ELEMENTS.—The report required under subparagraph (A) shall include an assessment of the following:

(i) The satisfaction of covered beneficiaries with telehealth services furnished by the Department of Defense.

(ii) The satisfaction of health care providers in providing telehealth services furnished by the Department.

(iii) The effect of telehealth services furnished by the Department on the following:

(I) The ability of covered beneficiaries to access health care services in the direct care and purchased care components of the military health system.

(II) The frequency of use of telehealth services by covered beneficiaries.

(III) The productivity of health care providers providing care furnished by the Department.

(IV) The reduction, if any, in the use by covered beneficiaries of health care services in military treatment facilities or medical facilities in the private sector.

(V) The number and types of appointments for the receipt of telehealth services furnished by the Department.

(VI) The savings, if any, realized by the Department by furnishing telehealth services to covered beneficiaries.

(g) DEFINITIONS.—In this section, the terms “covered beneficiary” and “TRICARE program” have the meaning given those terms in section 1072 of title 10, United States Code.

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	At Agency for review	5/8/15	6/5/15	7/31/15	7/31/15	5/20/16 to DCA 7/1/16 to Agency		
Outpatient Surgery Setting Accreditation Agency Standards	At Agency for review	5/8/15	6/5/15	7/31/15	7/31/15	5/20/16 to DCA 7/1/16 to Agency		
Disclaimers and Explanatory Information Applicable to Internet Postings	At OAL for final review; submitted 6/6/16	5/8/15	6/5/15	7/31/15	10/30/15	4/12/16 to DCA 5/4/16 to Agency	6/6/16	
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			
Midwife Assistants	Hearing to be held 7/29/16	5/6/16	6/3/16	7/29/16				

Prepared by Kevin A. Schunke
Updated on July 11, 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:	July 12, 2015
ATTENTION:	Medical Board of California
SUBJECT:	Recognition of International Medical School Universidad Iberoamericana School of Medicine
STAFF CONTACT:	Curtis J. Worden, Chief of Licensing

REQUESTED ACTION AND RECOMMENDATION:

After review and discussion recognize Universidad Iberoamericana School of Medicine (UNIBE); deem it to be in substantial compliance with the requirements of California Business and Professions Code Sections 2089 and 2089.5 and Title 16, Division 13, California Code of Regulations, Section 1314.1; and extend recognition to students who matriculate at UNIBE on or after January 1, 2009.

BACKGROUND AND ANALYSIS:

UNIBE is a private, non-profit institution that is fully accredited by the Dominican Republic Ministry of Higher Education. The School of Medicine was one of the first academic programs offered by the university and was founded in 1982. UNIBE also offers 15 undergraduate programs and 30 graduate programs, including but not limited to: law, engineering, education, arts, business and health sciences. This report is focusing on the School of Medicine.

The School of Medicine is a five year program. The first year is a pre-medical year and upon successful completion, the medical students start what UNIBE refers to as:

- First year of basic science
- Second year of basic science
- Third year clinical clerkships
- Fourth year clinical clerkships

UNIBE has approximately 400 faculty who have appropriate credentials from US and European universities. UNIBE has two tracks: Regular Track (taught in Spanish); and International Track (taught in English). The majority of the students are in the Regular Track. In 2013, 253 students were enrolled in the Regular Track and 82 students in the International Track. UNIBE states both tracks require the same curriculum, the same courses, use the same labs and are required to participate in the same research and service learning programs.

UNIBE implemented a “New Educational Model” in 2007, and in 2009 UNIBE required all students to pass a basic science examination in order to progress to the clinical clerkship rotation years.
All third year clinical clerkships are conducted only in the Dominican Republic. Fourth year UNIBE students are eligible for clinical clerkship rotations in some cities in the US, Latin

America, Asia and Europe. UNIBE's July 14, 2015 response to the Board, regarding where the students are doing clinical clerkship rotations, identified only 24 students completed clerkships in the US in the 2013-2014 academic year.

Many of the students in the International Track seek to obtain postgraduate training in Accreditation Council for Graduate Medical Education (ACGME) accredited residency programs. UNIBE requires International Track students to sit for and pass United States Medical Licensing Examinations (USMLE) Step 1, prior to starting clinical clerkships. In addition, International Track students are required to pass USMLE Steps 1, 2 CK and 2 CS in order to graduate.

At the Board's Quarterly Meeting on October 30, 2015, the Board authorized a site visit to UNIBE. The site visit was conducted May 31, 2016 through June 2, 2016. The Board's site visit team consisted of the following team members:

Curtis Worden, Chief of Licensing
Ronald Lewis, M.D., Board Member
Dianne Dobbs, Senior Staff Counsel
James Nuovo, MD, Licensing Medical Consultant

The Board's Licensing Medical Consultant, James Nuovo, M.D., prepared a thorough report of his findings regarding the UNIBE site visit. Dr. Nuovo's report was reviewed by each Member of the site visit team and a draft report was submitted to UNIBE for comment. UNIBE provided the Board with feedback and clarification. Dr. Nuovo's final site visit report has been included for review (pages BRD 20 - 5 through 13). Dr. Nuovo is recommending the Board recognize UNIBE for students who matriculated on or after January 1, 2009.

UNIBE provided the Board with the following additional information regarding UNIBE's policies for evaluating applications for students who are transferring from another medical school.

> The criteria to transfer credits is that courses must be approved with a minimum of 70 points, out of 100, in a medical school accredited by the official agency in the respective country. Since 2010, students can only transfer credits to the Pre-Medical component of the Medical Curriculum. The maximum amount of advanced placement credit that a student can be granted is 8 credits, a maximum of 4 credits for Math, and a maximum of 4 credits for Spanish, due to the Ministry of Higher Education, Science and Technology of the Dominican Republic requirement.
>
> UNIBE does not accept transfer credit from online or distance learning programs. In order to determine academic equivalence with the curriculum, transcripts are submitted to recognized credential evaluation agencies, like World Education Services (WES).
> Currently, students must start the medical component of their program at UNIBE; therefore, no determination for placement in any academic year is necessary.

The Site Visit Team interviewed UNIBE's leadership on May 31, 2016 at the beginning of the site visit and again on June 2, 2016 to inform the UNIBE leadership of the Site Visit Team's preliminary findings and to provide UNIBE's leadership the opportunity to provide additional information or clarification to the Site Visit Team.

The Site Visit Team interviewed 10 UNIBE Basic Science Faulty on May 31, 2016 and 33 UNIBE Core Clinical Faculty on June 1, 2016. In addition, some of the UNIBE Core Clinical Faculty were interviewed again on June 2, 2016 during the site visits to the clinical teaching facilities. Most of the faculty were interviewed in more than one setting and without UNIBE leadership present during the interviews. The exception was during the tour of the medical school and clinical site visits which included to UNIBE leadership members.

The Site Visit Team interviewed 92 UNIBE students during the site visit. The following is a breakdown of the student interviewed by year and Regular Track and International Track:

Information Regarding Students Interviewed by Site Visit Team	First Year	Second Year	Third Year	Fourth Year
Dominican Regular Track	6	6	15	18
Dominican International Track	6	8	19	14
Totals By Year	12	14	34	32
Basic Science Student Totals	26			
Clinical Student Totals	66			
Total Students	92			

Several of these students were interviewed in more than one type of setting:

- At the medical school in groups
- At clinical sites
- During lunch and/or dinner

Most of these interviews were conducted without any of the UNIBE leadership or faculty present. The exception was when the Site Visit Team was at clinical sites. It is important to note

the UNIBE leadership never interfered with the Site Visit Team's interaction with students or faculty on the clinical site visits.

FISCAL CONSIDERATIONS:

In accordance with Business and Professions Code section 2089.5, the costs of conducting a site inspection are borne by the medical school applying for the Board's recognition. These costs include all team members' lodging, air and ground travel costs within the guidelines allowed by the State; the medical consultant's time and daily per diem expense; staff daily per diem expense; and the Board Member's daily per diem expense. Title 16 of the California Code of Regulations section 1314.1(e) required the medical school to submit payment to the Board for the team's estimated travel expenses in advance of the site visit. UNIBE prepaid the estimated cost of the site visit and Board staff is in the process of auditing the final costs of the Site Visit Team. The Board will prepare a request for a refund to the Department of Consumer Affairs of any overpayment if appropriate.

July 12, 2016

To: Members
Medical Board of California

From: Jim Nuovo, MD
Professor & Associate Dean of Graduate Medical Education
UC Davis School of Medicine
4860 Y Street; Suite 2300
Sacramento, CA 95817

Re: Evaluation of the Universidad Iberoamericana School of Medicine (UNIBE) Program

Background

The Medical Board of California (Board) requested a review of the materials provided by the Universidad Iberoamericana School of Medicine (UNIBE) Program. These were submitted in pursuit of a request for the recognition of UNIBE by the Board to enable their students and graduates to participate in clinical clerkships, to enter graduate medical education programs, and to become eligible for licensure to practice medicine in California.

This report is based on my review of the documents initially provided to the Board by UNIBE, from a response by the School to additional questions posed after review of the Self-Assessment Report and the findings of the Site Visit Team.

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 for recognition by the Medical Board of California.

Site Visit Team

The Site Visit Team included:

Curtis J. Worden, MBC Chief of Licensing

Ronald Lewis, MD, MBC Board Member

Dianne Dobbs, DCA Senior Staff Counsel

Jim Nuovo, MD, MBC Licensing Medical Consultant

Site Visit Process

An agenda for the site visit was developed by the team. On May 31, 2016 the Site Visit Team met for 1-hour and 40 minutes with leadership from the School to include: The Dean of the Medical School (Dr. Marcos Nunez), the Academic Director of the Medical School (Dr. Violeta Gonzales), the Director of Curriculum Management (Dr. Elizabeth Peralta), the Administrative Affairs Director (Denisse Morales) and the School Advisor (Dr. Elizabel De Leon). The topics

of discussion for this meeting included the following: Site visit logistics and a presentation by Dr. Nunez.

In his presentation, Dr. Nunez provided an overview of the School, its governance and administration, the educational objectives, admission and promotion standards, curriculum management and educational resources. He also gave the Site Visit Team background information on healthcare concerns in the Dominican Republic.

At this session, Mr. Worden reviewed the intent of the site visit to the School's leadership; specifically, that the Site Visit Team was to perform a comprehensive review of the UNIBE Program as it relates to the requirements of Business and Professions Code Sections 2089 and 2089.5 and California Code of Regulations, Title 16, Division 13, Section 1314.1.

Next, the Site Visit Team met for 20 minutes with other members of the senior leadership of the School to include: the Chancellor (Dr. Julio Castanos), who is also the past Dean of the School of Medicine, the Academic Vice-Chancellor (Dr. Odile Camilo), and the Dean of International Affairs (Dr. Loraine Amell).

Dr. Castanos provided an overview of the UNIBE campus and discussed some of the recent changes that have occurred; particularly with curriculum development and infrastructure support. The most notable change was in 2009 when the School implemented its integrated curriculum as the result of a strategic planning initiative that began in 2006. The Schools' present curriculum is based on these 2009 changes.

The Site Visit Team then met for 1-hour and 30 minutes with faculty who represented the basic science courses; essentially the first two years of the medical school curriculum. The Site Visit Team was provided a template of the entire academic program including the opportunity for a four semester pre-medical curriculum. The focus of our review was to assess the content of the training from the 5th semester (the first year of medical school) through the completion of the 16th semester (the fourth year of medical school).

Regarding the semester system; there are 3 semesters per year, each one of 16 weeks duration.

The Basic Science curriculum begins in the 5th semester and extends through the end of the 10th semester. The content of this curriculum was presented to the team and includes all of the required elements of Business and Professions Code Section 2089. Further discussion with this group included the integrated curriculum, problem-based learning model, academic resources available to the students and how the students' performance was assessed.

The Site Visit Team then met for 1-hour with faculty to discuss the content of the training in physical diagnosis that occurs during the 5th through 10th semesters. The clinical training includes structured experiences in the hospitals and local outpatient clinics as well as the use of the Simulation Center. The Simulation Center includes a variety of physical examination practice models as well as standardized patients. Students also have the opportunity to learn how to use an electronic medical record to prepare notes and to give case presentations.

Finally, the Site Visit Team had a 1-hour lunch with the Basic Science faculty. Each team member had the opportunity for individual discussion with a small group of Basic Science faculty about the School, its curriculum and Institutional resources.

We followed this with a 2-hour and 30 minute tour of the medical school facilities. The tour included visiting classrooms, workrooms, laboratories, the cadaver suite, the library, the student lounge and the Simulation Center. We had the opportunity to have a more in-depth discussion with the faculty who supervise simulation training and cadaver dissection.

After completion of the facilities tour, the Site Visit Team met for 1-hour and 20 minutes with 12 (6 regular track and 6 international track) First Year Basic Science Students (5th – 7th semesters) and afterwards for the same amount of time with 14 (6 Regular Track and 8 International Track) Second Year Basic Science Students (8th – 10th semesters). The content of these discussions included the same content described in our discussions with the Basic Science Faculty. The students from both years also described their preparation for the USMLE Step 1, Step 2 Clinical Knowledge and Step 2 Clinical Skills examinations.

We followed these meetings with a dinner with a mixture of first and second year students. We had the opportunity to have a more in-depth discussion with the students about their backgrounds, their reasons for choosing UNIBE and their professional goals.

The second day of the site visit was focused on the Clinical Sciences. This represented the 3rd and 4th years of medical school (11th – 16th semesters).

The Site Visit Team had a series of 50 minute meetings with faculty from the following clinical services: Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, Psychiatry and Family Medicine. In these meetings we discussed the goals and objectives of the service, the syllabus, how the instructors determine if the students met these educational objectives, how the faculty monitor each student's performance and the faculty's perception of how well the students are prepared when they start their clinical rotations. We also assessed whether the Clinical Sciences curriculum was sufficient to meet the requirements of Business and Professions Code Section 2089.5.

We followed these meetings with a 1-hour lunch with the Clinical Sciences Faculty. Each team member had the opportunity for individual discussion with a small group of Clinical Sciences faculty about the School, its curriculum and Institutional resources.

The Site Visit Team then had a series of 45 minute meetings with groups of students who were currently rotating through each of the clinical services; i.e. Internal Medicine, Pediatrics, Surgery, Obstetrics and Gynecology, Psychiatry and Family Medicine. In these meetings we asked students to describe how they came to be at the UNIBE Program, how they were informed of the goals and objectives of the rotation, the expectations for the clerkship, how performance feedback is given and how they evaluate the rotation and faculty. A total of 66 students were interviewed; 33 were from the Regular Track cohort and 33 were from the International Track cohort.

We followed these meetings with a dinner with a mixture of third and fourth year students. We had the opportunity to have a more in-depth discussion with the students about their backgrounds, their reasons for choosing UNIBE and their professional goals.

The following day the Site Visit Team had a 6-hour tour of the following hospital/clinical facilities.

1. Hospital Escuela Dr. Hazoury Bahles (Inden). This hospital's focus is on the treatment of diabetes and its multi-organ complications. The hospital has 85 beds and provides services for 125,000 patient visits/year. There are 80 physicians on staff.

The Site Visit Team met with UNIBE faculty and students at the facility and toured the following units: the foot care clinic, emergencies services, the eye clinic, pharmacy services, inpatient wards, outpatient clinics, radiology services and student work space.

2. Primary Care Unit Centro Dr. Diaz Pineiro. This outpatient clinic is located in Santo Domingo West. It provides care to a population of 500-700 families. It is staffed by a multidisciplinary team and has activities which includes: health promotion (health educations, vector control, school and occupational health); home visits; family-oriented population health; chronic disease management; immunization programs; coordination of referrals; and emergency care services.

The Site Visit Team met with UNIBE faculty and students at the facility and toured the following units: patient care clinics, pharmacy services and student workspace. The Site Visit Team also had the opportunity to review a brief student presentation on their home assessment project (an ongoing means to map family health status by location).

3. Hospital General De La Plaza De La Salud. This is a large facility that serves over 125,000 patients/year. It has 285 hospital beds and 381 physicians on staff. Services in the facility include the following: internal medicine, surgery, radiology, emergency medicine, family medicine, orthopedics, trauma, dermatology, cardiology, neurology, pulmonary medicine, nephrology, endocrinology, gastroenterology, hematology & oncology and pain medicine.

The Site Visit Team met with UNIBE faculty and students at the facility and toured the above-cited units. We also toured student workrooms, call rooms and conference facilities.

During the site visit, the Team had the opportunity to review additional materials provided by the UNIBE Program. These materials included the following: the organization charts of the school, information regarding governance, additional materials regarding the curriculum, the syllabus for each clinical service, performance data on the medical students, affiliation agreements, background information on the faculty, faculty development structure, faculty research papers, and the final dean's evaluation letter.

The Site Visit Team had a closing meeting with the leadership of the School. This included the following: The Dean of the Medical School (Dr. Marcos Nunez), the Academic Director of the Medical School (Dr. Violeta Gonzalez), the Director of Curriculum Management (Dr. Elizabeth Peralta), the Chancellor (Dr. Julio Castanos), the Academic Vice-Chancellor (Dr. Odile Camilo), the Director of Quality Assurance (Dr. Vhyna Ortega) and the Dean of International Affairs (Dr. Loraine Amell). The Site Visit Team reviewed the findings presented in the "recommendations" section below.

We also used the opportunity to assess when the School made its most substantive changes. We reiterated the previous comments from Dr. Castanos, that the most notable change in the

curriculum occurred in 2009. This change was based on a strategic planning process that was initiated in 2006.

Recommendations

After review of all of the information described above, it is the opinion of the Site Visit Team that the UNIBE Program is 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. The Site Visit Team recommends recognition of the UNIBE Program retroactive to the initiation of the integrated curriculum in 2009, for UNIBE students who matriculated on or after January 1, 2009.

Review

UNIBE has been in existence since 1982. It is described as a private, non-profit institution that is fully accredited by the government of the Dominican Republic Ministry of Higher Education.

The School's mission statement is: "To achieve the development of medical professionals who will be updated with knowledge and have the capacity required to respond to the health needs of society, and promote an integral, human, ethical and innovated approach, developing leadership skills, critical attitude, and a compromise with research and continuous education."

More specifically, they state that the School aims to educate physicians who will:

1. Be able to apply medical knowledge in the prevention, diagnosis and treatment of diseases.

2. Have the analytic tools, through knowledge and the understanding of the principles of health and disease that will allow for the holistic care and treatment of individuals.

3. Respond in an ethical and competent manner to the health and medical needs of the community.

4. Be sensitive, compassionate and socially responsible.

5. Perceive the medical career as a life-long learning experience and be able to understand, design and conduct relevant research.

As a demonstration of their commitment to high academic standards, the School indicates that they will:

1. Attract students of high scholastic performance, serious approach to learning and considerable potential to benefit from and contribute to the stimulating academic environment.

2. Have the Admissions Committee carefully evaluate each applicant's personal qualities such as maturity, responsibility, and leadership abilities as well as their capacity for empathy and judgment. Serious consideration is also given to effective communication and interpersonal skills, community service and a sincere motivation for pursuing a career in medicine.

There are approximately 400 faculty with appropriate credentials from local, US and European universities.

The UNIBE students are eligible for clinical rotations in some cities in the US, Latin America, Asia and Europe.

Students may be enrolled in either the "Spanish-Language Program" (also known as the Regular Track) or the "English-Language Program" (also known as the International Track). The majority of the students are in the Regular Track; e.g. in 2013 there were 253 students in the Regular Track and 82 students in the International Track. The School states there is no difference in the curriculum; "both tracks are required to take the same course, the contents and methodology are the same, they use the same labs and are required to participate in the same research and service learning programs."

Many of the students in the International Track seek residency training positions in the US after graduation. Therefore, the School has required that the International Track students sit for the USMLE examinations before starting their clinical clerkships and must pass Step 2 (CK and CS) in order to graduate.

The following is a detailed assessment of the School based on the aforementioned regulations and on their responses to the Self-Assessment Report and the additional concerns brought by this reviewer.

Business and Professions Code Section 2089

Section 2089 requires the medical curriculum to extend over four years or 32 months of actual instruction. The curriculum at UNIBE is a 5-year program that is comprised on 3 semesters per year (each semester is 16 weeks duration). Therefore, the total amount of training exceeds the requirements of Section 2089; specifically, the number of hours of instruction exceeds the 4,000 hour minimum requirement in Section 2089 (total hours reported = 8,085 which includes 1,650 hours of premedical requirements).

UNIBE does require a minimum of 80% attendance; Professors obtain attendance information at the beginning of each class. At the end of the semester, an attendance report is submitted to the School by each Professor. Students with absences in excess of 20% are not able to sit for the final examination and are required to complete the course in its entirety.

The School's curriculum includes all of the required coursework listed in Section 2089(b). The information provided in the Self-Assessment Report indicates that the goals, objectives and course content are appropriate.

The School provided information on their admissions standards. The Self-Study Report describes these admission requirements which include the following: a National Test Certificate, a High School Certificate, Health Certification and a Police Certification/Background Check. Applications are reviewed by the Admissions Committee which includes: the Academic Vice-Rector, Registrar Officer, Dean of Students, Admissions Director, School of Medicine Director and a School of Medicine Faculty Member.

The School describes a policy on accepting transfer students. The policy is as follows:

"Since 2010, students can only transfer credits to the premedical component of the curriculum. The maximum number of advance placement credit hours allowed is 8." Further, "students must start the medical component of their program at UNIBE. Therefore, no determination for placement is needed."

Business and Professions Code Section 2089.5

The documents provided by UNIBE indicate that the program provides instruction to all of the basic sciences and clinical sciences coursework required in Section 2089.5 at multiple facilities. Based on the information provided, it appears that students do this training at a variety of clinical sites.

The third year clerkships combine hospital rotations with lectures on campus. Therefore, all third year rotations are conducted only in the Dominican Republic.

Item #7 in the July 14, 2015 memo to the Board provides information on the number of sites used in the Dominican Republic for the clerkships in Psychiatry, Internal Medicine, Surgery, Family Medicine, Obstetrics and Gynecology and Pediatrics/Neonatology. This information includes the number of students at each site and whether they are in the Regular Track or the International Track.

In the fourth year, students may complete clinical clerkships at a number of international sites in the US, Puerto Rico, Spain and Portugal; however, the information provided in the July 14, 2015 response letter indicates that very few students (24) have completed clerkships in the US in the 2013-2014 academic year.

As stated, UNIBE is a private non-profit institution that is accredited by the government of the Dominican Republic (Ministry of Higher Education). It is "recognized by the World Health Organization, Tribunal Examinador de Medicaos de Puerto Rico, and Spain's Ministry of Education." The campus is located in Santo Domingo.

The organizational structure of the School includes a Board of Trustees, Rector, Academic Board, Academic Vice-Rector, Deans, School Directors, Academic Coordinators and Department Directors. Resumes of the members of the organizational structure of the School are presented and appear appropriate. There is also a list in the Self-Assessment Report with the names of the Director of the School of Medicine, the Associate Dean for Academic Affairs and

Coordinators for the Basic and Clinical Sciences. Finally, there is a Supervisor of Hospital Rotations.

There is a description of the means by which the School engages in an ongoing review of the program including documentation of the level and extent of its supervision. This is described as the "New Educational Model" which was implemented in 2007. Full implementation of the new curriculum occurred in 2009. There is a description of the evaluation process of each student. The evaluations are done on a regular basis and document completion of all components of the curriculum.

California Code of Regulations, Title 16, Division 13, Section 1314.1

The medical school is a private, non-profit institution that is accredited by the government of the Dominican Republic. Its mission is to: "Develop medical professionals with the most current knowledge and skills required to respond to today's health care necessities in society."

The Self-Assessment Report contains extensive and a clearly defined mission statement and educational/research and service objectives.

The report includes the exact language of "broad expectations" and lists goals and objectives. The report lists the integral role of research in its mission and includes statements of its importance, nature, objectives, processes and evaluation of research in the medical education and practice of the School. The School has developed opportunities for student research as well as funding to support these activities.

The structure and content of the education program provides an adequate foundation in the basic sciences and enables students to learn the fundamental principles of medicine, to acquire critical judgment skills and to use those principles and skills to provide competent medical care. The site visit confirms that the training in the clinical sciences is sufficient.

As required in Section 1314.1, the administration and governance system allows the institution to accomplish its objective, i.e., its statements of the items of knowledge, skills, behavior and attitude that students are expected to learn. The institution's governance gives faculty a formal role in the institution's decision-making process. Students enrolled in the program are not permitted to serve as an instructor, administrator, officer, or director of the School.

UNIBE provided a detailed description of the faculty for each course; and these documents indicate that there are an adequate number for the size of the school. There is a sufficient description of the credentials of the faculty to indicate that they are appropriately qualified to teach their specific curricular content.

There is a clear description of the governing body of UNIBE and a description of the faculty evaluation and development programs.

UNIBE has standards governing the admission requirements. There is a description of the admissions criteria, student selection and promotion processes. This description is consistent

with the institution's mission and objectives. The School's policy on transfer students has been described above.

The description of the policies for Admissions and Promotion are presented in the Self-Study Report. Regarding promotion standards the School states the following:

Since the full implementation of new curriculum in 2009, in order to progress to the clinical years, all students must pass a basic science examination. International Track students must pass USMLE Step 1. In order to graduate, students must have completed all coursework and internship requirements and pass a clinical skills examination. International Track students must pass USMLE Step 2 (CK and CS).

The School provides a description of its Financial Resources in the Self-Assessment Report.

The facilities available to carry out the educational mission, both basic sciences and clinical rotations, are described in this report. They appear to be adequate to achieve the stated educational goals and objectives of the basic science component of the program. The Site Visit Team was able to determine that the clinical facilities including the major hospitals and ambulatory care facilities are adequate to meet the educational objectives of the UNIBE Program.

The School indicates that it is compliant with the requirement to retain student transcripts. They are kept indefinitely.

This completes my report on the UNIBE Program.

Medical Board Site Visit/UNIBE
May 31-June 3, 2016

Acknowledgements

- Site Visit Team:
  - Curt Worden, MBC Chief of Licensing
  - Dianne Dobbs, DCA Senior Staff Counsel
  - Ronald Lewis, MD, MBC Board Member
  - Jim Nuovo, MD, MBC Licensing Medical Consultant

AEROPUERTO INTERNACIONAL DE LAS AM

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UNIBE
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The Medical Board of California Visit

▶ Geography and Cultural Issues

UNIBE
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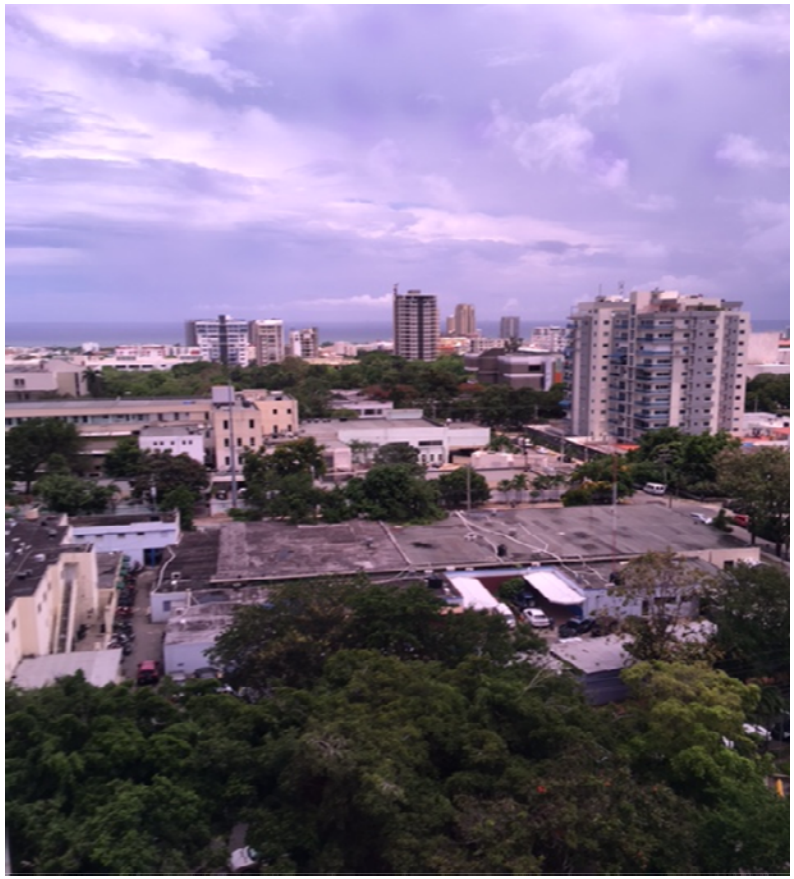

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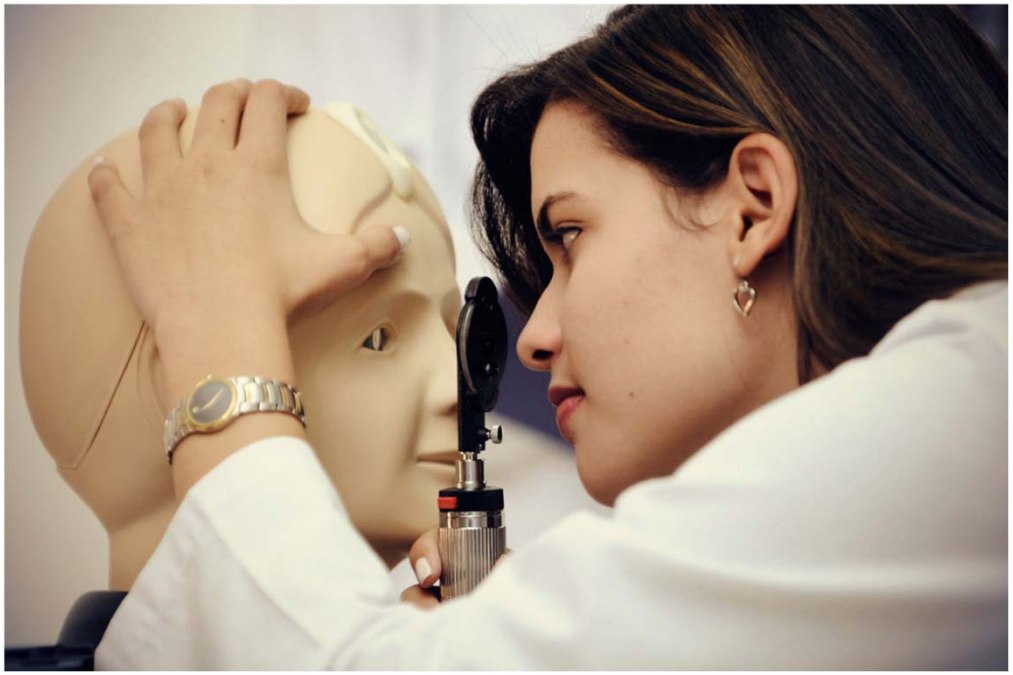

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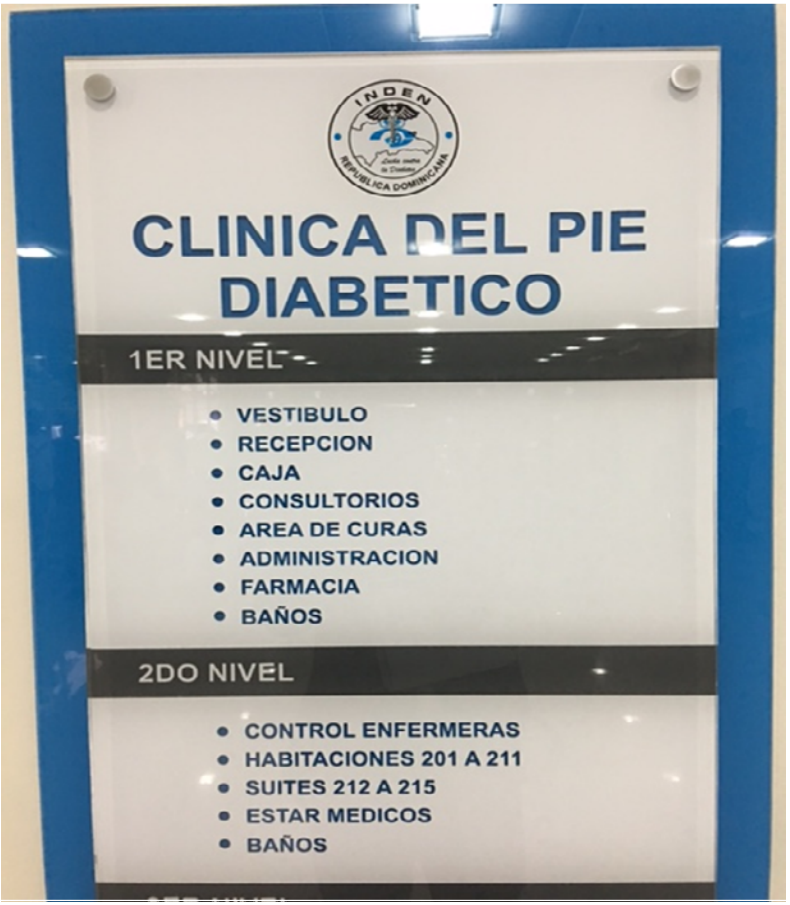
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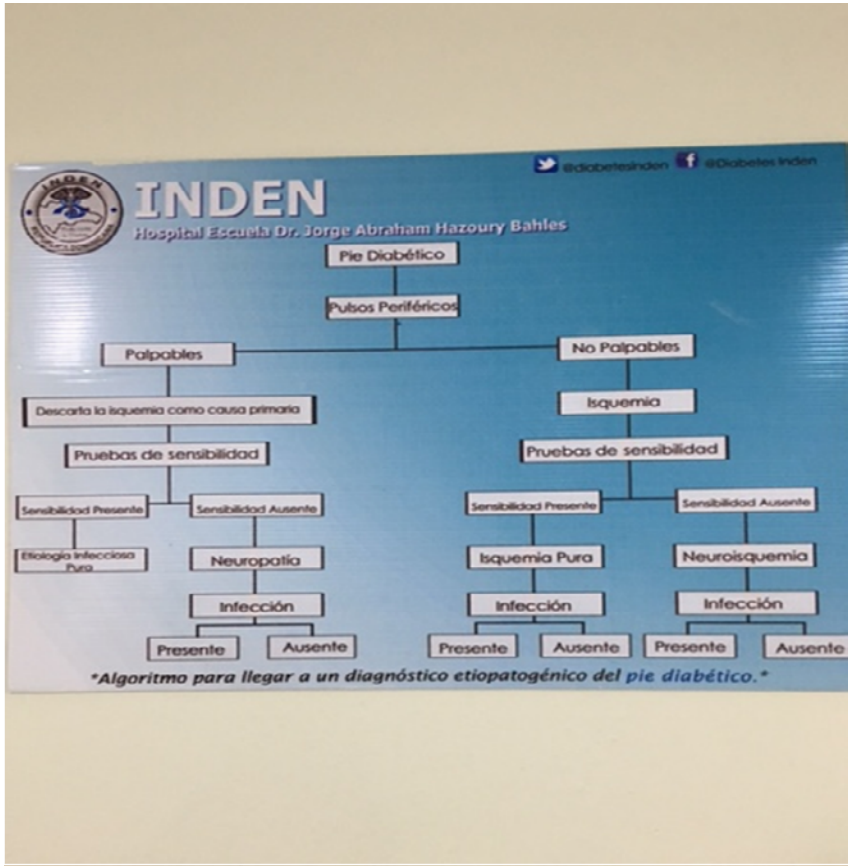
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Sensibilidad Presente
Sensibilidad Ausente
Etiologia Infecciosa Pura
Neuropatía
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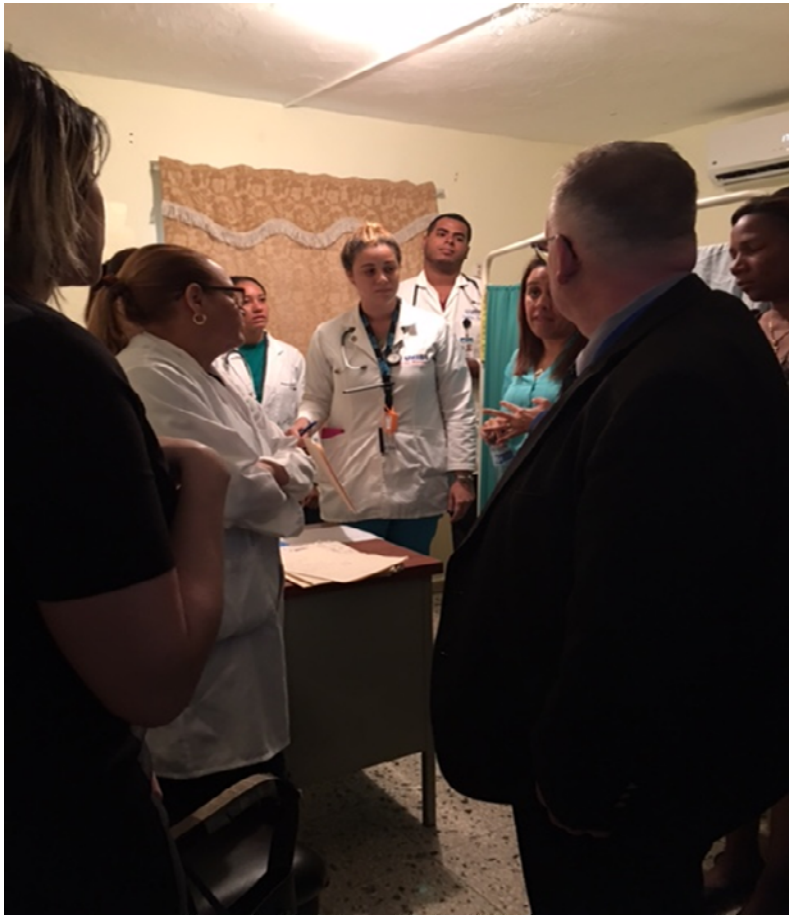
DR. INOCENCIO DIAZ PIÑEYRO



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MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 12, 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 recommended addition to add Health and Safety Code (HSC) section 120370(a) to the citation and fine proposed rulemaking, 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:

At the May 2016 Board Meeting, the Board authorized staff to move forward with amending the Board's citation and fine regulations to, among other things, expand the list of citable offenses. In addition to the changes already approved by the Board, staff is recommending that a violation of HSC section 120370(a) be included as a citable offense.

HSC section 120370(a) relates to a physician providing a parent or guardian of a child a written statement indicating that the physical condition of a child, or the medical circumstances relating to the child, are such that immunization is not considered safe. The written statement may then be filed by the parent or guardian with the governing authority to permit the child to attend school without all of the required vaccinations.

A physician's failure to follow the standard of care when determining whether to prepare a written statement pursuant to HSC section 120370(a) can lead to harm to the child and/or harm to the public's health and safety. Accordingly, staff recommends adding a violation of HSC section 120370(a) as a citable offense.

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, including HSC section 120370(a) as a citable offense, 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 ~~strikethrough~~ text, and the proposed additions are identified with <u>underlined</u> 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

~~(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

~~(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 120370(a)
(83) Health and Safety Code Section 121362
(84) Health and Safety Code Section 121363
~~(67)~~(85) Health and Safety Code Section 123110(a), (b)
~~(68)~~(86) Health and Safety Code Section 123148
~~(69)~~(87) Penal Code Section 11166
~~(63)~~(88) Title 16 California Code of Regulations Section 1338(c)
~~(64)~~(89) Title 16 California Code of Regulations Section 1399.545
~~(M)~~(90) 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 administrative, 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 administrative, 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:	July 12, 2016
ATTENTION:	Members, Medical Board of California
SUBJECT:	Proposed Amendments to Title 16 of the California Code of Regulations section 1361
FROM:	Kerrie Webb, Senior Staff Counsel

REQUESTED ACTION:

After review and consideration of the attached proposed language modifying Title 16 California Code of Regulations (CCR) section 1361 (Attachment A – Only the pertinent pages are attached), make a motion to approve the second modified language, and authorize staff to notice the modified language for a 15-day comment period. If no substantive negative comments are received, authorize the Executive Director to make any non-substantive changes and complete the rulemaking process.

BACKGROUND:

At the July 2015 meeting of the Medical Board of California (Board) Board Members authorized staff to begin the regulatory process to amend 16 CCR section 1361 and the Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines), which are incorporated by reference to section 1361.

The proposed amendments to section 1361 and the Disciplinary Guidelines were noticed for a 45-day comment period, and a hearing was held on October 30, 2015. Two comments were received at the hearing and were accepted and incorporated into the proposed language. The modified language was noticed for a 15-day comment period. No further comments were received from the public. Upon further review, however, staff has identified additional edits to be made as follows:

1) **Change the 12th Edition date from 2015 to 2016:** Since staff is proposing further modifications to the Disciplinary Guidelines, the date of the 12th Edition should be changed to reflect the current year.

2) **Condition 18 – Clinical Competence Assessment Program:** Current language provides in pertinent part: "Respondent shall pay all expenses associated with the clinical training program." This provision was inadvertently left out of this condition, and must be included with a modification to read, "Respondent shall pay all expenses associated with the clinical competence assessment program." Additionally, some minor changes from capitalized letters to lower case are being proposed.

3) **Condition 19 – Written Examination:** Current language refers to a "clinical training program" which the Board is seeking to change with this rulemaking. For consistency, each place referencing "clinical training program" is being amended to state "clinical competence assessment program." Additionally, staff recommends making the following change for consistency between Conditions 18 and 19 under Option 1: Condition Precedent in pertinent part:

> This prohibition shall not bar respondent from participating in a clinical competence assessment program ~~practicing in a clinical training program~~ approved by the Board or its designee. ~~Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.~~

4) **Condition 23 – Monitoring – Practice/Billing:** Current language provides in pertinent part:

> Within 30 calendar days of the effective date of this Decision the respondent shall submit to the Board or its designee for prior approval as a _____[**insert:** practice, billing, or practice and billing] monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified.

The Board noticed the language with modifications as follows, that were not identified by underline for new language. Additionally, the "t" in respondent was underlined in error:

> Within 30 calendar days of the effective date of this Decision, if the respondent is providing direct patient care, the respondent shall submit to the Board or its designee for prior approval as a _____[**insert:** practice, billing, or practice and billing] monitor(s), the name and qualifications of one or more licensed physicians and surgeons whose licenses are valid and in good standing, and who are preferably American Board of Medical Specialties (ABMS) certified.

Staff is seeking permission remove the language that was not properly noticed, and to strike the underline below the "t."

5) **Condition 33 – Non-practice While on Probation: Current language provides** in pertinent part: "Periods of non-practice will not apply to the reduction of the probationary term." This provision was inadvertently left off the noticed language, and must be included.

6) **Recommended Range of Penalties for Violations – Violation of Probation:** Current language refers to a "clinical training program" which the Board is seeking to change with this rulemaking. For consistency, each place referencing "clinical training program" is being amended to state "clinical competence assessment program."

CONCLUSION:

If the Members vote to support these modifications, the rulemaking will be noticed for a 15-day comment period. The Board could authorize the Executive Director to make any non-substantive changes required to complete the rulemaking process if no substantive adverse comments are received.

MEDICAL BOARD OF CALIFORNIA
DISCIPLINARY GUIDELINES

SECOND MODIFIED TEXT

Legend

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

Changes to the originally proposed language are shown by ~~red double strikethrough~~ for deleted test and by red double underline for new text.

Changes to the first modified text are shown by ~~yellow highlighted double strikethrough~~ for deleted test and by yellow highlighted double underline for new text.

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

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

(a) In reaching a decision on a disciplinary action under the Administrative Procedure Act (Government Code section 11400 et seq.), the Medical Board of California shall consider the disciplinary guidelines entitled "Manual of Model Disciplinary Orders and Disciplinary Guidelines" (~~11th Edition/2011~~ 12th Edition/~~2015~~2016) which are hereby incorporated by reference. Deviation from these orders and guidelines, including the standard terms of probation, is appropriate where the Board in its sole discretion determines by adoption of a proposed decision or stipulation that the facts of the particular case warrant such a deviation - for example: the presence of mitigating factors; the age of the case; evidentiary problems.

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

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

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

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

State of California

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

MEDICAL BOARD OF CALIFORNIA

MANUAL OF MODEL DISCIPLINARY ORDERS AND DISCIPLINARY GUIDELINES

~~11~~th 12th Edition
~~2011~~ ~~2015~~2016

STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

State of California
~~State and Consumer Services Agency~~
Business, Consumer Services, and Housing Agency
MEDICAL BOARD OF CALIFORNIA
MANUAL OF MODEL DISCIPLINARY ORDERS
AND DISCIPLINARY GUIDELINES
~~11th~~ 12th Edition
~~2011~~~~2015~~2016
STATE OF CALIFORNIA
MEDICAL BOARD OF CALIFORNIA

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

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

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

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

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

~~**Summary of Changes**~~

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

~~Model Condition Number:~~

~~**5. Controlled Substances – Total Restriction**~~
~~Eliminated the term "good faith" prior examination to reflect amendments made to statute that now requires an "appropriate prior examination and a medical indication" and adds "furnish" to the list of prohibited activities.~~

(Option # 1: Condition Precedent)
Respondent shall not practice medicine until respondent has successfully completed the ~~P~~program and has been so notified by the Board or its designee in writing.

(Option # 2: Condition Subsequent)
If respondent fails to complete the ~~P~~program within the designated time period, respondent shall cease the practice of medicine within three (3) calendar days after being notified by the Board or its designee that respondent failed to complete the ~~P~~program.

18. Clinical Competence Assessment ~~Training~~ Program

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

The ~~P~~program shall consist of a ~~C~~comprehensive ~~A~~assessment ~~program comprised of an two-day assessment~~ of respondent's physical and mental health~~; basic clinical and communication skills common to all clinicians; and medical knowledge, skill and judgment~~ and the six general domains of clinical competence as defined by the Accreditation Council on Graduate Medical Education and American Board of Medical Specialties pertaining to respondent's current or intended area of practice ~~in which respondent was alleged to be deficient, and at minimum, a 40 hour a program of clinical education in the respondent's area of practice in which respondent was alleged to be deficient and~~ . The program shall ~~which~~ take~~s~~ into account data obtained from the pre-assessment, self-report forms and interview, and the Decision(s), Accusation(s), and any other information that the Board or its designee deems relevant. The program shall require respondent's on-site participation for a minimum of 3 ~~to~~ and no more than 5 days as determined by the program for the assessment and clinical education evaluation. Respondent shall pay all expenses associated with the clinical competence assessment program.

At the end of the evaluation, the program will submit a report to ~~Based on respondent's performance and test results in the assessment and clinical education, the Program will advise~~ the Board or its designee which unequivocally states whether the respondent has demonstrated the ability to practice safely and independently. Based on respondent's performance on the ~~C~~clinical ~~C~~competence ~~A~~assessment, the program will advise the Board or its designee of its recommendation(s) for the scope and length of any additional educational or clinical training, evaluation or treatment for any medical condition~~, treatment for any~~ or psychological condition, or anything else affecting respondent's practice of medicine. Respondent shall comply with the ~~P~~program's recommendations.

~~At the completion of any additional educational or clinical training, respondent shall submit to and pass an examination.~~ Determination as to whether respondent successfully completed ~~the examination or successfully completed~~ the clinical competence assessment program is solely within the program's jurisdiction.

[Note: The following language shall be included in this condition unless Option #1 is included: If respondent fails to enroll, participate in, or successfully complete the clinical competence

assessment ~~training~~ program within the designated time period, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. The respondent shall not resume the practice of medicine until enrollment or participation in the outstanding portions of the clinical competence assessment ~~training~~ program have been completed. If the respondent did not successfully complete the clinical competence assessment ~~training~~ program, the respondent shall not resume the practice of medicine until a final decision has been rendered on the accusation and/or a petition to revoke probation. The cessation of practice shall not apply to the reduction of the probationary time period.]

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

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

19. ~~Oral and/or~~ Written Examination

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

Within 60 calendar days of the effective date of this Decision, respondent shall take and pass ~~an oral and/or~~ ~~a written examination, administered by the Board or its designee. The Board or its designee shall designate a subject matter and administer the oral and/or written.~~

~~If the examination is an oral examination, it shall be conducted in accordance with section 2293(a) and (b) of the Code.~~
~~If respondent is required to take and pass a written exam, that examination shall be either~~ the Special Purpose Examination (SPEX) or an equivalent examination as determined by the Board or its designee.

~~If respondent fails the first examination, respondent shall be allowed to take and pass a second examination~~.

Failure to pass the required ~~oral and/or~~ written examination within 180 calendar days after the effective date of this Decision is a violation of probation. Respondent shall pay the costs of all examinations.

[**Note:** The following language shall be included in this condition unless Option #1 is included: If respondent fails to pass the ~~first~~ written examination, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified. Respondent shall not practice medicine until respondent successfully passes the examination, as evidenced by written notice to respondent from the Board or its designee.]

(Option 1: Condition Precedent)
Respondent shall not practice medicine until respondent has passed the required examination and has been so notified by the Board or its designee in writing. This prohibition shall not bar respondent from participating in a clinical competence assessment program ~~practicing in a clinical training program~~ approved by the Board or its designee. ~~Respondent's practice of medicine shall be restricted only to that which is required by the approved training program.~~
Note: The condition precedent option is particularly recommended in cases where respondent has been found to be incompetent, repeatedly negligent, or grossly negligent.

20. Psychiatric Evaluation

Within 30 calendar days of the effective date of this Decision, and on whatever periodic basis thereafter may be required by the Board or its designee, respondent shall undergo and complete a psychiatric evaluation (and psychological testing, if deemed necessary) by a Board-appointed board certified psychiatrist, who shall consider any information provided by the Board or designee and any other information the psychiatrist deems relevant, and shall furnish a written evaluation report to the Board or its designee. Psychiatric evaluations conducted prior to the effective date of the Decision shall not be accepted towards the fulfillment of this requirement. Respondent shall pay the cost of all psychiatric evaluations and psychological testing.

Respondent shall comply with all restrictions or conditions recommended by the evaluating psychiatrist within 15 calendar days after being notified by the Board or its designee.

(Option: Condition Precedent)
Respondent shall not engage in the practice of medicine until notified by the Board or its designee that respondent is mentally fit to practice medicine safely. The period of time that respondent is not practicing medicine shall not be counted toward completion of the term of probation.

21. Psychotherapy

Within 60 calendar days of the effective date of this Decision, respondent shall submit to the Board or its designee for prior approval the name and qualifications of a California-licensed board certified psychiatrist or a licensed psychologist who has a doctoral degree in psychology and at least five years of postgraduate experience in the diagnosis and treatment of emotional and mental disorders. Upon approval, respondent shall undergo and continue psychotherapy treatment, including any modifications to the frequency of psychotherapy, until the Board or its designee deems that no further psychotherapy is necessary.

The psychotherapist shall consider any information provided by the Board or its designee and any other information the psychotherapist deems relevant and shall furnish a written evaluation report to the Board or its designee. Respondent shall cooperate in providing the psychotherapist any information and documents that the psychotherapist may deem pertinent.

Note: This condition is for those cases where the evidence demonstrates that medical illness or disability was a contributing cause of the violations.

23. Monitoring - Practice/Billing

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

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

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

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

The monitor(s) shall submit a quarterly written report to the Board or its designee which includes an evaluation of respondent's performance, indicating whether respondent's practices are within the standard~~s~~ of practice of _____[**insert:** medicine or billing, or both], and whether respondent is practicing medicine safely, billing appropriately or both. It shall be the sole responsibility of respondent to ensure that the monitor submits the quarterly written reports to the Board or its designee within 10 calendar days after the end of the preceding quarter.

If the monitor resigns or is no longer available, respondent shall, within 5 calendar days of such resignation or unavailability, submit to the Board or its designee, for prior approval, the name and qualifications of a replacement monitor who will be assuming that responsibility within 15 calendar days. If respondent fails to obtain approval of a replacement monitor within 60 calendar days of the resignation or unavailability of the monitor, respondent shall receive a notification from the Board or its designee to cease the practice of medicine within three (3) calendar days after being so notified Respondent shall cease the practice of medicine until a replacement monitor is approved and assumes monitoring responsibility.

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

Travel or Residence Outside California
Respondent shall immediately inform the Board or its designee, in writing, of travel to any areas outside the jurisdiction of California which lasts, or is contemplated to last, more than thirty (30) calendar days.

In the event respondent should leave the State of California to reside or to practice respondent shall notify the Board or its designee in writing 30 calendar days prior to the dates of departure and return.

32. Interview with the Board or its Designee

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

33. Non-practice While on Probation

Respondent shall notify the Board or its designee in writing within 15 calendar days of any periods of non-practice lasting more than 30 calendar days and within 15 calendar days of respondent's return to practice. Non-practice is defined as any period of time respondent is not practicing medicine ~~in California~~ as defined in Business and Professions Code sections 2051 and 2052 for at least 40 hours in a calendar month in direct patient care, clinical activity or teaching, or other activity as approved by the Board. If respondent resides in California and is considered to be in non-practice, respondent shall comply with all terms and conditions of probation. All time spent in an intensive training program which has been approved by the Board or its designee shall not be considered non-practice and does not relieve respondent from complying with all the terms and conditions of probation.

In the event respondent's period of non-practice while on probation exceeds 18 calendar months, respondent shall successfully complete the Federation of State Medical Board's Special Purpose Examination, or, at the Board's discretion, a clinical competence assessment program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines" ~~a clinical training program that meets the criteria of Condition 18 of the current version of the Board's "Manual of Model Disciplinary Orders and Disciplinary Guidelines"~~ prior to resuming the practice of medicine. Respondent's period of non-practice while on probation shall not exceed two (2) years.

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

Periods of non-practice for a respondent residing outside of California, will relieve respondent of the responsibility to comply with the probationary terms and conditions with the exception of this condition and the following terms and conditions of probation: Obey All Laws; ~~and~~ General Probation Requirements; Quarterly Declarations; Abstain from the Use of Alcohol and/or Controlled Substances; and Biological Fluid Testing.

BUSINESS ORGANIZATION IN VIOLATION OF CHAPTER (B&P 2417)
Minimum penalty: Revocation
Effective January 1, 2002, Business and Professions Code section 2417 was added to read, in part, "(b) A physician and surgeon who practices medicine with a business organization knowing that it is owned or operated in violation of Section 1871.4 of the Insurance Code, Section 14107 or 14107.2 of the Welfare and Institutions Code, or Section 549 or 550 of the Penal Code shall have his or her license to practice permanently revoked."

VIOLATION OF PROBATION
Minimum penalty: 30 day suspension
Maximum penalty: Revocation
The maximum penalty should be given for repeated similar offenses or for probation violations revealing a cavalier or recalcitrant attitude. A violation of any of the following conditions of probation should result in, at minimum, a 60 day suspension:

1. Controlled Substances -Maintain Records and Access to Records and Inventories [8]
2. Biological Fluid Testing [11]
3. Professional Boundaries Program [17]
4. Psychiatric Evaluation [20]
5. Psychotherapy [21]
6 Medical Evaluation and Treatment [22]
7 Third Party Chaperone [25]

It is the expectation of the Medical Board of California that the appropriate penalty for a physician who did not successfully complete a clinical competence assessment ~~training~~ program ordered as part of his or her probation is revocation.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: July 13, 2016
ATTENTION: Members, Medical Board of California
SUBJECT: Interim Suspension Orders
STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:
This report is intended to provide the Members with an update on the strategies identified to expedite cases where an Interim Suspension Order (ISO) should be sought. No action is needed at this time.

BACKGROUND:
At the May 7, 2015 Medical Board of California (Board) Meeting, the Members directed the Executive Director to work with the Attorney General's Office (AGO) and the Health Quality Investigation Unit (HQIU) to identify strategies to expedite cases where an ISO should be sought and to report these strategies to the Board at the October 2015 meeting.

At the October 30, 2015 Board Meeting, after conducting a policy review of the handling of the ISOs, staff from the Board, AGO, and HQIU identified several improvements that could be implemented to expedite the investigation and issuance of an ISO. There were 14 different improvements or policy changes that were identified (see below for more information). Prior to the October 30, 2015 Board meeting, several of the recommendations had already been implemented by Board, AGO, and HQIU staff while some of the recommended improvements are still in progress, most have already been implemented with very positive results.

The statistics in the chart below, comparing fiscal year (FY) 14/15 to FY 15/16, show significant improvements, both in the time it takes to obtain a suspension/restriction (specifically ISOs) and in the number of suspension/restrictions orders issued. Although the focus of this study was ISOs, the information below identifies all suspensions issued by the Board for both fiscal years. From the statistics below, there was a 157% increase in the number of ISOs issued and a 150-day decrease in the length of time it took to obtain an ISO.

Suspension/Restriction Type	Issued FY 14/15	Issued FY 15/16	*Average Days FY 14/15	*Average Days FY 15/16
Stipulated Agreements	0	1	0	394
Automatic Suspension Orders	4	0	293	0
Cease Practice Orders	9	14	N/A	N/A
Interim Suspension Orders	**14**	**36**	**588**	**438**
Out-of-State Suspension Orders	11	18	71	82
Penal Code section 23/Court Orders	14	15	179	192
TOTAL	**52**	**84**		

* This time is calculated from the time a complaint is received until the suspension/restriction order is issued. This does not include cases where more than one suspension/restriction was issued.

The following is a list of improvements/policy changes that were identified to be implemented with the status of their implementation.

1) Expert training – for cases alleging physical or mental impairment, training needs to be provided to the Board's subject matter experts on report writing and clarity of reports. The reports need to specifically indicate whether the individual is safe to practice without any restrictions.
   - This recommendation has been partially implemented in that the HQIU staff discusses with the experts the need to provide a clear report when the review is assigned. Board staff in the Expert Reviewer Program needs to identify physicians who specifically conduct these reviews and then establish a training program that can be used for these specific reviewers.
2) If an expert report states that the individual needs to have restrictions in order to practice safely, an ISO should be considered to pursue an order instituting those restrictions.
   - This recommendation has been implemented. Both the AGO and the HQIU identify these cases upon receipt of the review and then pursue an ISO.
3) Board monitoring of all investigation/prosecution cases – on a monthly basis, the Board needs to monitor cases that are at the AGO and at the HQIU to ensure all cases that could be an ISO are moving forward.
   - The Board staff have begun to run reports that can be used to track cases at the AGO, however, Board staff still need to identify reports that can be utilized and reviewed for HQIU.
4) Close monitoring by the Board of the requirement in Business and Professions Code (BPC) section 2220(a) – BCP section 2220(a) specifically states that within 30 days of receipt of a BPC section 805 or 805.01 report, the Board must investigate the circumstances to determine if an ISO should be issued. A process needs to be in place for follow up by the Board with HQIU and the AGO to see if this determination is made in the required timeframe.
   - This recommendation was implemented. The Chief of Enforcement maintains a log of 805 or 805.01 reports and contacts the HQIU to determine the status of the investigation. However, more discussion on the implementation of this process needs to occur between the Board and the HQIU.
5) Central Complaint Unit's (CCU) immediate transfer of BPC 805 and 805.01 reports – the Board's CCU will immediately transfer these reports via email to both the HQIU and AGO upon receipt in order to expedite the process.
   - This recommendation was fully implemented, and staff from the CCU immediately transfer these cases to the HQIU and the AGO.
6) The Board, HQIU, and AGO report reconciliation – Board, HQIU, and AGO staff will, on a monthly basis, reconcile reports for cases that have been referred to the AGO to request an ISO. This will ensure that cases that have been identified as ISO cases are actually prioritized by the Board, HQIU, and the AGO.
   - Board staff and staff from the AGO have begun to meet to reconcile reports, including those cases that were transmitted for an ISO.
7) Request that the Office of Administrative Hearings (OAH) expedites ISO decisions and serves the Board, along with the AG's Office, to ensure timely receipt of decisions where ISOs are issued, as well as denied. In addition, the Office of Administrative Hearings should also be specifically requested, when granting an ISO on an ex parte basis, to issue the ISO immediately at the conclusion of the ex parte hearing, rather than taking the matter under submission, so that the physician can be immediately and personally served with the ISO before leaving the Office of Administrative Hearings. Taking such matters under submission, in order to prepare a

detailed decision to be issued later is only appropriate at the conclusion of a noticed hearing on the ISO petition.

- The OAH has been setting ISO cases in a timely manner. However, OAH stated that only the AGO would be served with the ISO decisions. In regard to OAH immediately issuing the ISO, OAH stated that a Deputy Attorney General representing the Medical Board can request that the Administrative Law Judge (ALJ) issue an ex parte ISO at the conclusion of the hearing, but it is not always possible or appropriate for an ALJ to do so. OAH added that each case presents different facts and issues, and the ALJ may need to briefly take a matter under submission in order to reach a well-informed decision regarding whether an ex-parte ISO is legally and factually supported.

8) Recommend training to the OAH on impairment and how it impacts the practice of medicine. Such training could be provided by the Physician Assessment and Clinical Training Program Staff, if available.
   - The Board is working with OAH on providing training on several different topics and this will provided in the near future.
9) Update the investigation report synopsis – HQIU will clearly identify in the case synopsis of a Report of Investigation (ROI) that the case is being transmitted for an ISO and an Accusation.
   - The Board, HQIU, and the AGO changed the case disposition process and the decision to transmit the case for an ISO is clearly identified on the new case disposition form.
10) The Lead Prosecutor (LP) and the Supervising Investigator I should review each case immediately upon receipt and throughout the course of the investigation to determine if the case should be identified and handled as an ISO. In addition, during quarterly case reviews, both the LP and the Supervising Investigator I shall review all the cases to identify if there is a need to seek an ISO. Throughout the course of any investigation, the Deputy Attorney General and the Investigator assigned shall alert their chain of command that the evidence has changed the matter to an ISO.
   - Board staff will work with HQIU and the AGO to ensure this is being completed.
11) Add ISO cases to the Monthly Investigative Case Activity Report (MICAR) – adding these cases to the MICAR report will immediately inform the Senior Assistant Attorney General that a case is being transmitted for an ISO so that the case can be closely monitored.
   - The Board will work with HQIU to ensure this is being completed.
12) Any disagreement on whether a case should be processed as an ISO should be immediately placed into the dispute resolution process and follow the chain of command.
   - With the new vertical enforcement manual, the dispute resolution process is clearly delineated and is being used by both HQIU and AGO.
13) As soon as possible, establish a parallel criminal/administrative investigation policy and process for cases where HQIU designates a Board investigation as criminal. Providing for a parallel policy will help protect the Board's integrity in its investigation process when these dual pathways arise. Additionally, staff anticipates this policy will eliminate the need to wait for a criminal case to proceed through the criminal process before seeking an ISO (or a Penal Code section 23 Order). This may result in an investigator assigned to the criminal investigation and a separate investigator assigned to the administrative investigation. This would allow the investigations that have been designated as criminal by HQIU, which may also be ISO cases, to proceed in the administrative process if warranted by the evidence.

   As stated at the May 2016 Board meeting, a policy has been developed and approved by HQIU and AGO.
14) Create an activity code within the BreEZe system to identify a case as an ISO case for monitoring and statistics.

- Board staff is working on obtaining a code in the BreEZe system.

Board staff will continue to work on implementing all of these recommendations. Several of the recommendations will include working with HQIU and AGO. Although the ISO timelines and the number of ISOs obtained has seen significant improvements, full implementation of these recommendations will further enhance the ISO process and assist the Board in meeting its mission of consumer protection.

MEDICAL BOARD REPORT

DATE REPORT ISSUED: July 12, 2016
ATTENTION: Members, Medical Board of California (Board)
SUBJECT: Public Outreach Campaign Update
BOARD CONTACT: Ronald Lewis, M.D., Chair, Public Outreach, Education, and Wellness Committee

Requested Action:
This report is intended to provide the Members with an update on the "Check Up On Your Doctor's License" Campaign.

Outreach Activity Update Summary:

The Office of Public Affairs has continued to work very hard to educate and spread the message of the importance of being an informed patient and to encourage the patients/consumers to be educated with regards to their physician.

A tutorial titled "Check Up On Your Doctor's License" was completed in June, 2016 and is available on the main page of the Board's website, in addition to YouTube. This tutorial walks the patient through the steps needed to check on a physician's license. It is designed to educate while engaging the interest of the viewer.

The "Check Up On Your Doctor's License" brochure has recently been translated into Spanish and is being laid out for printing. It should be available shortly.

The state warrants that went out in June, 2016 from the California State Controller's Office all had a message printed on the bottom encouraging state employees, vendors, and contractors to "Check up on Their Doctor's License." Staff has also made arrangements to reserve another global message using state warrants issued in April of 2017, and is currently looking into possibly providing printed inserts. The cost of inserts to be distributed with state warrants is $1,200.00.

Staff has been extremely successful partnering with a number of counties and cities in California to get its message out. Attached is a detailed listing of the work done so far. The list includes Orange County, Contra Costa County, Tulare County, Monterey County, Los Angeles County, Kern County, Stanislaus County, Fresno County, and the City of San Francisco. The list continues to grows as Board staff continue to reach out to these counties and cities.

In addition, the California State Retiree publication featured an image of the Board's "Check Up On Your Doctor's License" brochure soon to be followed by CalPERS who will be publishing a short blurb about the Board's campaign in its next member quarterly newsletter "PERSpective."

At this time based on the successful outreach the Board has placed its messaging in publications that have the capacity to reach approximately 17 million Californians.

Outreach to the Legislature was also very successful. As a result of the Board's Legislative Day, the Board was able to get Senator Richard Pan, M.D. to agree to display and give out the "Check Up On Your Doctor's License" brochures. The Board also had its first successful legislative tweet (or retweet) of the Board's messaging.

Board staff will continue to reach out to counties and cities. Staff is also trying to reach out to unions and other large community organizations. In addition, staff will continue to partner with Legislators at Town Halls, and are always looking to do outreach events with other agencies as well. Board staff will begin a Public Service Announcement (PSA) for broadcast distribution and hopes to have that completed by the next Board Meeting.

Check Up on Your Doctor's License Campaign
Priority One Outreach Activities Update

Outreach Activity	Status Update
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	The tutorial was completed in June 2016 and is available on YouTube and posted on the Board's website's main page http://www.mbc.ca.gov/ "Check Up On Your Doctor's License – Tutorial"
Develop a PSA that can be provided to entities to air	Board staff will begin work on the PSA now that the tutorial is complete. The PSA should be completed by the October 2016 Board Meeting.
Include information about the Board on utility bills throughout the state	The Public Affairs Manager will be working to launch the partnership with Tammi Watt's (nurse practitioner) and PG&E's proposed Health Center for employees before the end of the year. The Board would provide brochures, newsletters, Op-Ed's and presentations at their staff outreach events.
Include information about the Board on city, county, and state employee paystubs	A message encouraging state employees, vendors and contractors to "Check Up On Their Doctor's License" appeared at the bottom of all State Warrants for June 2016, **reaching 439,916 individuals.** The April 2016 issue (pg. 8) of the "California State Retiree" publication featured an image of the Board's "Check Up On Your Doctor" brochure, **reaching 34,000 state retirees.** The Orange County Health Care Agency published a ½ page write-up in its June employee newsletter "What's Up" titled "Have You Done a Checkup on your Doctor's License?" **reaching 3,000 agency employees.** On June 7, 2016, Contra Costa County started running the Board's message on its cable TV bulletin board which is available to all county residents, **reaching potentially up to 1.11 million individuals.** On May 17, 2016, San Bernardino County posted the Board's information on the San Bernardino County website**, reaching potentially 2,139,570 individuals.**

Check Up on Your Doctor's License Campaign
Priority One Outreach Activities Update

Outreach Activity	Status Update
Include information about the Board on city, county, and state employee paystubs (cont.)	On May 25, 2016, the Tulare County Health Department agreed to schedule the Board's messaging on Twitter and Facebook pages throughout the year. In addition the information was added on the "Spotlight" section of its website. In addition they have created a network of digital signs that appear throughout its county buildings and Area Family Resource Centers/County Clinics that will carry the Board's messaging and a small article will appear in the County Newsletter in the future, **reaching potentially 466,339 individuals.** On May 31, 2016, the Monterey County Health Department posted an article about the campaign on its website**.** They have also promised to post social media as well, **reaching 431,344 individuals.** They have asked for brochures in Spanish, which the Board has developed and ordered. On June 7, 2016, the Los Angeles County Department of Health Services began posting the Board's information on the Patient Resources section of its website, **reaching potentially 10.12 million individuals.** On June 7, 2016, the Kern County Department of Public Health indicating they would immediately start to share the Board's information on all its social media sites (Twitter and Facebook), **reaching potentially 875,589 individuals.** On June 8, 2016, Stanislaus County Health Services posted the Board's message in its various facilities, **reaching 525,491 individuals.** On June 13, 2016 Fresno County began to run a feature on its intranet for the "Check Up On Your Doctor" campaign, targeting Fresno County readership, **reaching 7,000 employees.**

Check Up on Your Doctor's License Campaign
Priority One Outreach Activities Update

Outreach Activity	Status Update
Include information about the Board on city, county, and state employee paystubs (cont.)	On July 6, 2016, the San Francisco Department of Public Health published the Board's information on its website as well as through social media, **reaching potentially 852,469 individuals.** CalPERS will be running a short article on the campaign in its next member quarterly newsletter PERSpective. The publication is mailed to member homes and is available on the internet, **reaching 1.7 million members.** CalPERS will also be posting a bulletin on its intranet site **reaching 2,900 CalPERS employees.** Board staff is currently working with Alameda and San Joaquin County finalizing dates, and continue to reach out to the remaining California cities and counties.
Work with the AARP to provide Board information at their conferences, in their publications, and on their website	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 regarding AARP. Board staff is waiting to hear back from Mr. Beach who represents Northern California.

Check Up on Your Doctor's License Campaign
Priority One Outreach Activities Update

Outreach Activity	Status Update
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	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, which 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.** 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. Board staff is still working on this. **Potential target readership is 120,000 California members.**
Provide an interview and PSA to iHeart Radio with Board staff and/or with Board Members Interview/PSA on NPR and Capitol Public Radio	The Board's Public Affairs Manager will work to get these interviews scheduled after the Board's PSA is completed – **September 2016.**
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	The Board's Legislative Day was held on May 11, 2016. Board Members met with legislators who are members of policy committees that impact the Board (such as the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee). Additionally, 20 copies of the California State Retiree Article and the Board's outreach brochure were handed out to legislators at the State Capitol.

Check Up on Your Doctor's License Campaign
Priority One Outreach Activities Update

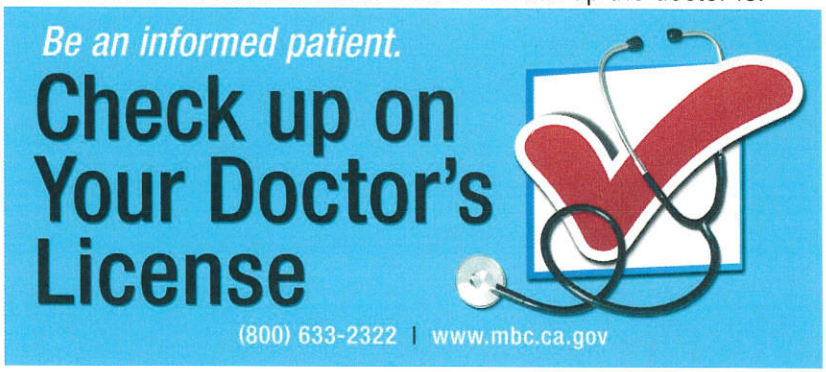
Outreach Activity	Status Update
Encourage Legislative Members, Congressional Members, and local government to include information and a link to the Board's website in their newsletters and to Tweet the Board's link and post the Board's link on their websites (cont.)	On May 17, 2016 the Board tweeted "Be an informed patient – check up on your doctor's license status" accompanied by the graphic on the cover of the brochure. On May 23, 2016, Assembly Member Sebastian Ridley-Thomas re-tweeted the Board's May 17 tweet. Senator Richard Pan, M.D. agreed to display and give out the Board's "Check Up on your Doctor's License" brochures in his office.
General Outreach activity	"Check up on your Doctor's License" brochures have been translated into Spanish and should be ready for printing shortly. On May 11, 2016, the Board had an exhibit at the Department of Consumer Affairs (DCA) Earth, Safety and Wellness Day at DCA headquarters, passing out the "Check Up On Your Doctor's License" brochures, as well as instructing attendees on how to look up a license and what the information on the website means. **There were approximately 300 attendees.** On June 17, 2016, the Public Affairs Manager gave a presentation on the importance of "Checking on Your Doctor's License" at a Town Hall event with Assemblyman Jim Cooper in Sacramento at the ACC Senior Services Center. **There were approximately 100 attendees.**

HAVE YOU DONE A CHECKUP ON YOUR DOCTOR'S LICENSE?

Written by Karen Smith on May 31, 2016. Posted in Front Page, News

The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps a consumer make an informed choice when choosing a doctor.

To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov. If you do not have a computer, call (800) 633-2322 and someone at the Medical Board will look up the doctor for you.



To use the website, click on "License Search" on the home page. Then choose the license type by clicking the checkbox for "Physician and Surgeon." Then click "Search by Name."

Enter the doctor's last name and first initial. If it is a common last name, enter the entire first name. Make sure the names are spelled correctly. Then click on "Search."

Click on his or her name. Review license details, including verifying whether any disciplinary actions are listed at the bottom of the page.

If you have any questions regarding the information on the doctor's profile, you may contact the Medical Board or discuss it with your doctor.

The Medical Board also encourages consumers to sign up for the MBC Subscribers' Alerts on the home page to be notified by email of disciplinary actions taken against a physician's license, including probationary status, suspension or revocation.

Encouraging patients to check up on their doctor's license is part of the Medical Board's ongoing mission of consumer protection. For more information or assistance, please call (800) 633-2322.

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Tags: doctor, medical board

- CountyWire Home
- SBCounty Home
- Comments or Questions

Get e-mail updates when this information changes.

« Vote early, take a ballot selfie in the 2016 Presidential Primary Election
Poll workers needed for the 2016 Presidential Primary Election »

Check up on your doctor's license

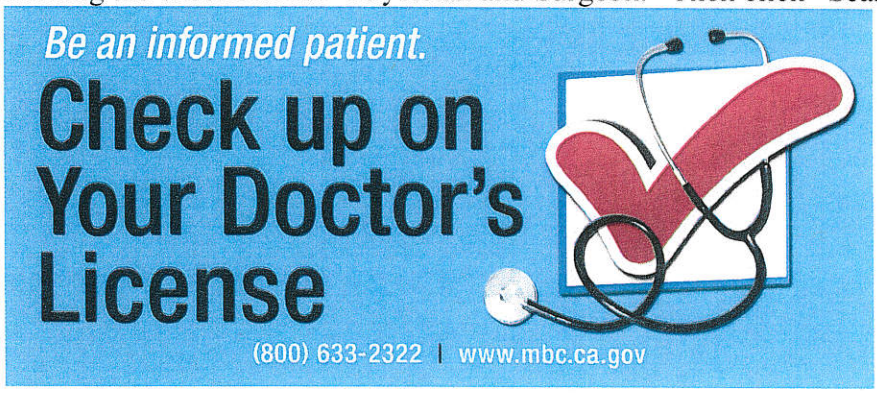
Published May 17, 2016 | By Administrator

The Medical Board of California has made it easier than ever for Californians to check up on their doctors.

The Medical Board encourages consumers to check up on their doctor's license. Such a checkup is simple and helps consumers make informed choices when choosing a doctor.

To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov. Please note: if you do not have a computer, call (800) 633-2322 and someone at the Medical Board will look up the doctor for you.

To use the website, click on "License Search" on the home page. Then choose the license type by clicking the checkbox for "Physician and Surgeon." Then click "Search by Name."



Enter the doctor's last name and first initial. If it is a common last name, enter the entire first name. Make sure the names are spelled correctly. Then click on "Search."

Click on his or her name. Review license details, including verifying whether any disciplinary actions are listed at the bottom of the page.

If you have any questions regarding the information on the doctor's profile, you may contact the Medical Board or discuss it with your doctor.

Have You Done a Checkup on Your Doctor's License?

You can now perform a quick, online checkup of your doctor's medical license thanks to a new outreach program created by the Medical Board of California.

Visit the BreEZE Online License site and search by your physician's name to view his or her profile, license details, and details of any past disciplinary actions. You can also register at www.mbc.ca.gov to receive email alerts from the Medical Board related to any future disciplinary actions taken against your physician's license that include probation, suspension or revocation.

Access to this information may help you make a more educated decision about your healthcare provider. Prefer the phone? Please call (800) 633-2322.

Orange County Older Adult Dashboard Launches

The number of older adults aged 65 and over is rapidly growing and it is estimated that one in five residents of Orange County will be 65 or older in 2030. To understand the health of Orange County adults and define areas of success and disparities for indicators, the Health Care Agency and the Orange County Aging Services Collaborative's Orange County Healthy Aging Initiative (OCHAI) worked together to launch the Orange County Older Adult Dashboard.

The dashboard has more than 70 health, social, and economic indicators for Orange County's older adults and shows how Orange County compares to state and national benchmarks. Here's a peek at some of the indicators available on the dashboard. Click the links to see each indicators trends and disparities.

	Almost half of single elders in Orange County live below the Elder Economic Security Index, which estimates the cost of living for a single elder in Orange County.
	More than one in ten Orange County Medicare beneficiaries age 65 and older were treated for Alzheimer's Disease or Dementia. This puts us in the bottom half compared to all U.S. counties.
	More than one in four Orange County Medicare beneficiaries over 65 years of age were treated for Diabetes.

Stay tuned for an Older Adult report with themes and trends for key issues this summer. For more resources, data and tools, visit www.ochealthiertogether.org/index.php.

News

CalPERS to receive $130 million in settlement

A case involving inflated grades of residential mortgage deals that later faltered was solved in March when Moody's and Moody's Investors' Service agreed to pay CalPERS a record $130 million.

The lawsuit stems from losses the pension fund suffered after the collapse of the housing market and defaults on formerly AAA-rated securities that were backed by pools of residential mortgages, according to CalPERS.

CalPERS, the largest pension fund in the United States, brought the lawsuit against Moody's and other rating agencies in 2009. CalPERS previously settled with Fitch Ratings and Standard & Poor's, the other rating agencies that were named in the lawsuit. S&P, a unit of McGraw Hill Financial Inc., settled with CalPERS in 2015 for $125 million, bringing the total recovery from the now-concluded lawsuit to $255 million.

"This resolves our lawsuit against Moody's and restores money that belongs to our members and employers," said Matthew Jacobs, general counsel for CalPERS. "We are eager to put this money back to work to help ensure the long-term sustainability of the fund."

CalPERS sustained losses from investments in three structured investment vehicles that relied on the liquidity of assets that turned out be "illiquid," such as subprime RMBs, CDOs and other asset-backed securities, CalPERS said.

In the lawsuit, CalPERS alleged that Moody's made "negligent misrepresentations" by assigning the investments their highest credit rating. This caused significant losses as the market for structured finance securities collapsed in late 2007.

In addition to obtaining a substantial recovery for investment losses, this case was path-breaking in that the settlements rank as the largest known recovery from Moody's and S&P in a private lawsuit for civil damages. The case also established through a landmark appellate court decision that rating agencies can be liable for negligent misrepresentations under California law for their ratings of privately-placed securities.

"This should serve as a cautionary reminder to all investors who rely on rating agencies to guide their investments," Jacobs added.

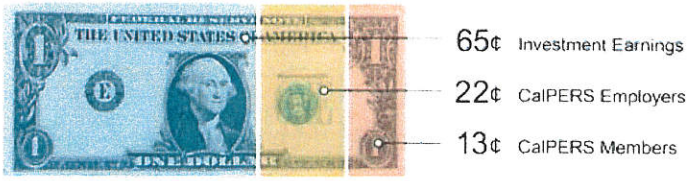
Who pays? The CalPERS Pension Buck identifies the income sources of public employee pensions

Some people believe that taxpayers fund the total cost of public pensions. This is not true.

The largest contribution comes from CalPERS investment dollars, with additional funding from employee and employer contributions.

The CalPERS Pension Buck illustrates the sources of income that fund public employee pensions. Pension fund income over the last 20 years (as of June 2015) shows that every dollar spent on public employee pensions comes from 65 cents of investment earnings, 22 cents from employers and 13 cents from employees.

CalPERS pension payments generate nearly $31 billion of economic activity per year in California, supporting almost 105,000 jobs and generating more than $716 million in sales and property tax revenue every year.



Source: CalPERS income over the last 20 years as of June 2015

In the fiscal year that ended June 2015, CalPERS paid out almost $19.4 billion in pension benefits using investment income and contributions from participating public employers and their employees (our members). Public employees who are CalPERS members contribute up to 15.25 percent of their take-home pay to help fund their own pensions.

Pensions pay it forward. After CalPERS pension dollars are paid, they continue to boost California's economy. According to the most recent economic data

- Nearly 105,000 jobs were supported
- More than $716 million was added to California's coffers from sales and property tax
- CalPERS pension payments boosted California's economy by nearly $31 billion

* Economic data of pension payments as of June 30, 2014

CalPERS

Printed at CalPERS PUB 175 2015

Have you done a checkup on your doctor's license?

The Medical Board of California encourages consumers to check up on their doctor's license. Such a checkup is simple and helps a consumer make an informed choice when choosing a doctor.

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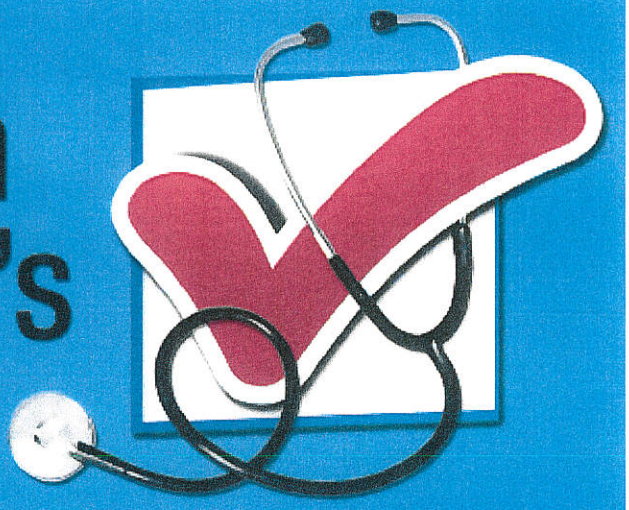
Encouraging patients to check up on their doctor's license is part of the Medical Board's ongoing mission of consumer protection. For more information or assistance, please call **(800) 633-2322**.

Be an informed patient.

Check up on Your Doctor's License



(800) 633-2322 | www.mbc.ca.gov

- **Have you done a checkup on you doctor?**
- **Has disciplinary action been taken against his/her medical license?**

- **The Medical Board of California encourages consumers to check up on their doctor's license to make an informed choice when choosing a doctor.**
- To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov, and click on "License Search".
- Choose the license type by clicking the checkbox for "Physician and Surgeon." Then click "Search by Name."
- Enter the first and last names, and click "Search".
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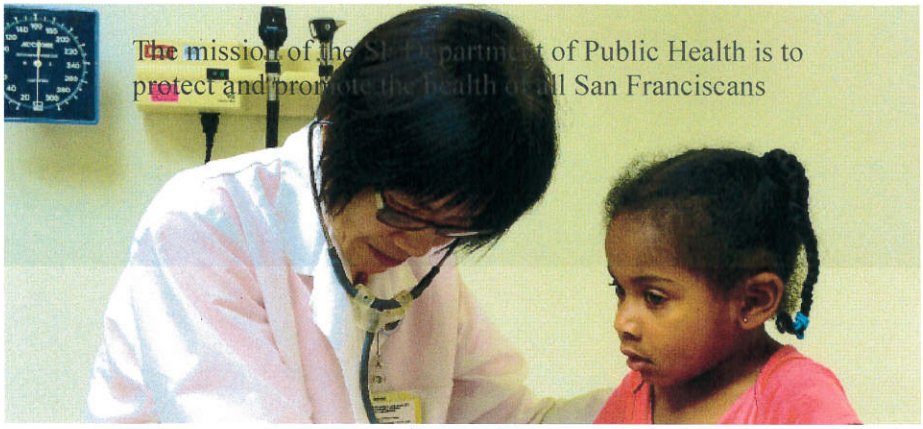
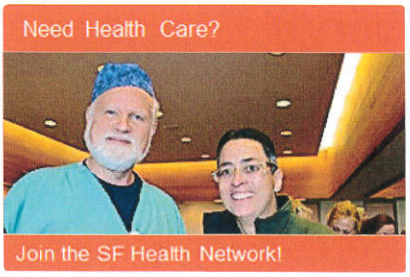
- If you have any questions regarding the information on the doctor's profile, you may contact the Medical Board at (800) 633-2322.





New: Health Advisory: Outbreak of Meningococcal Disease involving Men who Have Sex With Men in Southern California; Recommendations for San Francisco

New: Health Update: Orlando Mass Shooting

Health Advisory: Benzathine Penicillin G Shortage

Request to Report Overdoses and Deaths due to Illicitly Obtained Fentanyl

Health Advisory for Zika Virus, Information for Health Care Providers

LEARN MORE

Tweets by DPH

SFDPH
@SF_DPH

The Medical Board of California encourages consumers to check up on their doctor's licenses ow.ly/8Kw6301ZGNx

SF Health Department recommends vaccination against Meningococcal disease for HIV-positive people and gay men

The California Department of Public Health has announced an outbreak of Meningococcal disease in Los Angeles and Orange counties, mostly affecting gay and bisexual men.

Given that it is Pride week in San Francisco, and we expect visitors from many places and lots of celebration, the San Francisco Health Department is recommending that HIV-positive people, gay men and other men or transgender people who have sex with men get vaccinated.

It is one important way to take charge of your health. Please help by spreading the word.

LEARN MORE

Quick Search

Choose an option

How does this restaurant rate?

Environmental Health Inspectors inspect over 7,000 locations including **restaurants, bars, markets, bakeries, pushcarts, stadium food facilities** and any other facility that serves food to the public. Inspections reduce the number of food-related illnesses by providing information to the public.

LEARN MORE

Pre-Exposure Prophylaxis (PrEP)

The San Francisco Department of Public Health strongly endorses the new Centers for Disease Control and Prevention (CDC) guidelines on provision of HIV pre-exposure prophylaxis (PrEP) for at-risk HIV-uninfected populations. Click on the links below for more information about PrEP:

LEARN MORE

FACT SHEET

FOR MEDICAL PROVIDERS

SFDPH SUPPORTED MEDICAL HOMES

Statement on Orlando Shootings

Our hearts are heavy in the wake of another tragic mass shooting in our country. We stand with the victims and their families and loved ones at this time.

We don't know, and may never know, the reason for this horrible act of hate and terror. The fact that it took place at a gay nightclub that features Latin music causes concern for LGBT and Latino populations, who have faced violence and discrimination for generations.

Now, we must pull together and care for ourselves and each other. Let us redouble our efforts to be compassionate and to keep our community safe and healthy.

FULL TEXT HERE

Stay Connected

Health Commission

The Health Commission holds two committee meetings in addition to its twice-a-month regular meeting. These two meetings are the Finance & Planning Committee and the Community & Public Health Committee. Others are Joint conference Committees for San Francisco General Hospital & Laguna Honda Hospital.

LEARN MORE

Video of the full Health Commission meetings can be found on SFGovTV.

SFGov tv

New Health Insurance Options Under the Affordable Care Act

On January 1, 2014, new health benefits made available by the passage of the Patient Protection and Affordable Care Act went into effect. This means many San Franciscans will have new health care coverage options.

LEARN MORE

Get Covered SAN FRANCISCO

Recent DPH Files and Reports

Most Popular DPH Topics

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- DPH 2013-2014 Annual Report
- MHSA Fiscal Year 2015-2016 Annual Report
- Avatar Documentation
- CBHS Provider Directory
- Integrated Surveillance Report for Communicable Diseases
- Director's Reports
- CDTA Documents
- Zuckerberg San Francisco General Patients & Visitors Information
- SFGH Key Contact Information
- Birth and Death Certificates
- Women, Infants, and Children Program
- Education and Training
- Maternal, Child & Adolescent Health

Any questions, comments, or suggestions pertaining to this site may be directed to the DPH Webmaster

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Patient Resources

Take a minute to learn about the health hazards of discarding prescription drugs down the drain and the advantages of creating an advanced health care directive to ensure your wishes are met. Check this page often for updated resources.

How to Dispose of Prescription Drugs

If you have a medicine cabinet full of expired or unused medications, don't discard them down the sink! Disposing of expired, unused, or unwanted drugs down the sink or toilet poses serious health hazards to the Los Angeles County water supply and the environment. Click on the links below to find out about environmentally-appropriate disposal options:

NO DRUGS DOWN THE DRAIN

888 CLEAN LA

Advanced Health Care Directive

The California legislature has enacted law allowing you to give instructions about your health care by completing an advanced health care directive form. You also have the right to name someone else to make health care decisions for you. This form lets you do either or both of these things. It also lets you express your wishes regarding donation of organs and the designation of your primary physician. For more information and to download a sample form click the following link:

http://oag.ca.gov/consumers/general/adv_hc_dir

Forms

The following forms are available online to assist patients obtain copies of their medical record, authorize release of health information to other entities, amend their health record, and obtain other services. Select and complete the appropriate form and bring it to the Department of Health Services facility where you receive care.

Get more information.

Notice of Privacy Practices

The Notice of Privacy Practices describes how the Department of Health Services and its facilities may use and share patient health information and how patients can exercise their health privacy rights.

Get more information.

Apply For Social Services Online

The Los Angeles County Department of Public Social Services (DPSS) announces a convenient way for residents in need of assistance to apply for services online, without having to visit a district office. Residents can now apply for Medi-Cal, CalWORKS, CalFresh and General Relief benefit programs by visiting the Your Benefits Now (YBN) website.

https://www.dpssbenefits.lacounty.gov

Obtain a Copy of Your Medical Record

You can obtain a copy of your medical record by phone or fax, or file your request in person at the DHS facility where you receive care. Click the link below to access required forms and other information. Be sure to complete and sign any forms and provide required documentation. If you plan to file your request in person, print and complete the form prior to your visit. Copy requests can take up to 10 days to process.

MyWellness - Your Online Medical Portal

Did you know you can now view your medical record online? DHS is now using an electronic medical record system, ORCHID, across its health facilities. If you're a DHS patient, you can access your medical record through the MyWellness patient portal. At your next appointment, ask the registration clerk how to sign up. Once you're registered, you can view your lab results, medications, and more securely on your computer or mobile device.

http://dhs.lacounty.gov/wps/portal/dhs/mywellness/

Cancer Diagnosis? Caring Help is Available

The Southern Los Angeles Patient Navigation and Wellness Center helps those battling cancer overcome barriers with caring assistance. A patient navigation program is free of charge and helps link individuals to services. The wellness center offers a variety of nutrition, exercise and other support programs for you and your family. The project's geographic focus includes Crenshaw, Watts, Compton, Westchester, El Segundo, Hawthorne, Gardena and Inglewood.

http://southlapnwc.com/

Save a Life with Phone App

If you're trained in Cardio-Pulmonary Resuscitation (CPR), the PulsePoint app for iOS and Android alerts you when a sudden cardiac arrest occurs in a public place in your immediate vicinity. You get informed at the same time as emergency responders. You're given detailed instructions where to go, including the location of automatic external defibrillators (AEDs) nearby. Effective CPR administered immediately after a cardiac arrest can potentially double or triple the victim's chance of survival, but less than half of victims receive that immediate help.

http://www.fire.lacounty.gov/lacofd-pulse-point/

Wellness Center Serves Boyle Heights Community

Step into the stunning Wellness Center at the Historic General Hospital (LAC+USC Medical Center) in East L.A. and build health and wellness into your life. The Center is open to everyone, and offers a full calendar of events and resources from 15 community health nonprofits housed there. Enjoy the open space and walking trails, take a Zumba, healthy cooking or alternative spirituality class, or come in to learn more about diabetes and other medical conditions.

http://www.thewellnesscenterla.org/

Medi-Cal App Now Available

The Medi-Cal app is the official app of Medi-Cal, California's Medicaid program, which is administered by the California Department of Health Care Services. Current and prospective Medi-Cal beneficiaries should use this app to find local help, like phone numbers for LA County offices, learn about enrollment, get preventive health information, set up reminders, and get important messages about benefits.

http://www.dhcs.ca.gov/med50th/Pages/Medi-Cal_App.aspx

Do a Checkup on Your Doctor's License

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Marijuana for Medical Purposes

This statement was adopted by the full Medical Board on May 7, 2004 and amended in October 2014.

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

> "(A) To ensure that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person's health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine, or any other illness for which marijuana provides relief; and
>
> (B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction."

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

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

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

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

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

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

1. Although it could trigger federal action, making a recommendation in writing to the patient will not trigger action by the Medical Board of California.

2. A patient need not have failed on all standard medications in order for a physician to recommend or approve the use of marijuana for medical purposes.
3. The physician should determine that marijuana use is not masking an acute or treatable progressive condition, or that such use will lead to a worsening of the patient's condition.
4. The Act names certain medical conditions for which marijuana may be useful, although physicians are not limited in their recommendations to those specific conditions. In all cases, the physician should base his/her determination on the results of clinical trials, if available, medical literature and reports, or on experience of that physician or other physicians, or on credible patient reports. In all cases, the physician must determine that the risk/benefit ratio of marijuana is as good, or better, than other treatment options that could be used for that individual patient.
5. A physician who is not the primary treating physician may still recommend marijuana for a patient's symptoms. However, it is incumbent upon that physician to consult with the patient's primary treating physician or obtain the appropriate patient records to confirm the patient's underlying diagnosis and prior treatment history.
6. The initial examination for the condition for which marijuana is being recommended must be an appropriate prior examination and meet the standard of care. Telehealth, in compliance with Business and Professions Code section 2290.5, is a tool in the practice of medicine and does not change the standard of care.
7. Recommendations should be limited to the time necessary to appropriately monitor the patient. Periodic reviews should occur and be documented at least annually or more frequently as warranted.
8. If a physician recommends or approves the use of marijuana for a medical purpose for a minor, the parents or legal guardians must be fully informed of the risks and benefits of such use and must consent to that use.

Physicians may wish to refer to the following CMA documents:

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

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

Model Guidelines for the Recommendation of Marijuana in Patient Care

Report of the FSMB Workgroup on Marijuana and Medical Regulation

Adopted as policy by the Federation of State Medical Boards
April 2016

INTRODUCTION

Over the past two decades, the attitudes and laws in the United States have become more tolerant towards marijuana, with the proportion of adults using the substance doubling between 2001 and 2013. Due to the increasing number of state governments authorizing the use of marijuana and marijuana infused product for "medicinal purposes," state medical and osteopathic boards now have the added responsibility for the regulatory oversight of physicians choosing to incorporate the recommendation of marijuana in patient care and management.

The Federation of State Medical Boards (FSMB) Chair, J. Daniel Gifford, MD, FACP, appointed the Workgroup on Marijuana and Medical Regulation to develop model policy guidelines regarding the recommendation of marijuana in patient care, including conditions, diseases, or indications for which marijuana may be recommended. The Workgroup was further tasked with the development of a position statement or white paper regarding the regulation of licensees who use marijuana, which will be addressed in a separate document.

In order to accomplish this charge, the Workgroup reviewed existing laws and medical and osteopathic board rules, regulations and policies related to marijuana; reviewed current literature and policies related to the incorporation of marijuana by health care professionals in their professional practice and related research; and reviewed cases of board disciplinary actions related to the recommendation of marijuana in patient care and/or use and abuse of marijuana by licensees.

This policy document is intended as a resource to state medical boards in regulating physicians and physician assistants (or other licensees regulated by the board) with a full and unrestricted license participating in marijuana programs and may also be valuable in educating licensees as to the board's expectations when recommending marijuana to a patient for a particular medical condition. The guidelines should in no way be construed as encouraging or endorsing physicians to recommend marijuana as a part of patient care.

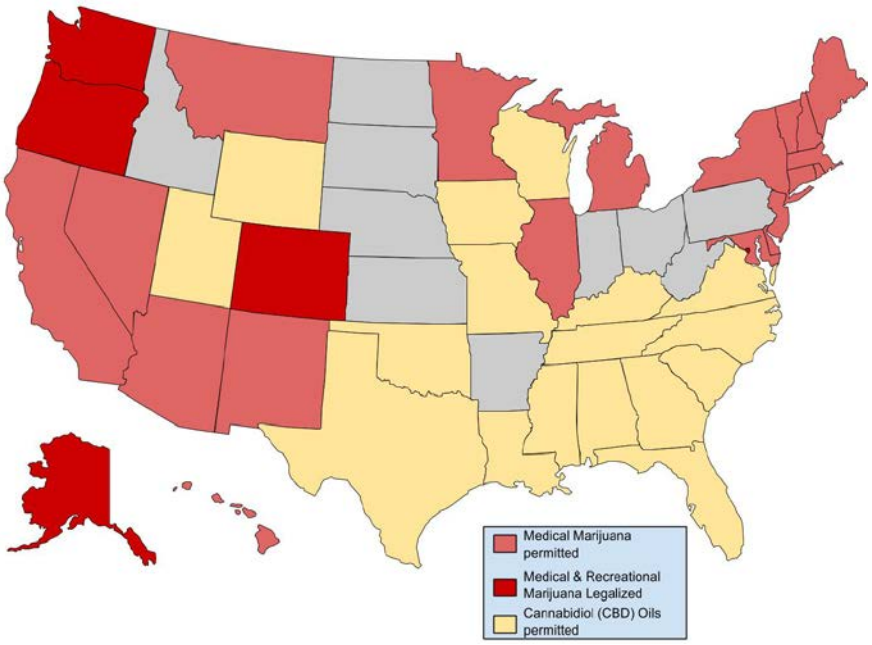
In developing the model guidelines that follow, the Workgroup conducted a comprehensive review of marijuana statutes, rules, and state medical board policies currently enacted across the country, and considered research reports, peer-reviewed articles, and policy statements regarding the recommendation of marijuana in patient care. In addition, a survey of FSMB member boards was conducted to determine which issues related to marijuana and medical regulation are of high priority to state boards. Fifty-one out of 70 state boards completed the survey, yielding a 72.9% response rate. Many boards reported several issues being most important to their board about

marijuana and medical regulation, including guidance on handling recreational use by physicians (31.4%), guidance on handling marijuana for medical use by physicians (47.1%), and model guidelines for recommending marijuana for medical purposes to patients (49.0%).

Section One. Background.

Marijuana has been suggested for alleviating symptoms of a range of debilitating medical conditions, such as cancer, HIV/AIDS, multiple sclerosis, Alzheimer's Disease, post-traumatic stress disorder (PTSD), epilepsy, Crohn's Disease, and glaucoma, as well as an alternative to narcotic painkillers. Accordingly, marijuana use in patient care has increased in popularity nationwide since 1996 when California voters passed Proposition 215, making it the first state to allow marijuana to be recommended in patient care. Since then, 22 other states, in addition to the District of Columbia and Guam, have enacted laws or passed ballot initiatives establishing comprehensive "medical marijuana programs," authorizing marijuana for medical purposes.[1] Moreover, 17 states have enacted laws to permit limited use of cannabidiol (CBD) oils for the treatment of specific illnesses and symptoms.[2] See Figure 1.

Figure 1: State Map of Marijuana and Cannabidiol Oils Laws



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[1] The states and territories that have enacted comprehensive marijuana programs are: Alaska (AS 17.37.070), Arizona (A.R.S. § 36-2801), California (Cal. Health & Safety Code § 11362.7 et seq.), Colorado (Colo. Rev. Stat. § 25-1.5-106), Connecticut (Conn. Gen. Stat. §420f-21a-408), Delaware (Del. Code tit. 16 § 4901A et seq.), District of Columbia (D.C. Code § 7-1671.01 et seq.), Guam (10 Guam Code Ann. § 122501 et seq.), Hawaii (Haw. Rev. Stat. § 329-121), Illinois (410 Ill. Comp. Stat. § 130/10), Maine (Me. Stat. tit. 22, § 2422 et seq.), Maryland (Md. Code, Health Gen. § 13-3301 et seq.), Massachusetts (105 Code of Mass. Regs. 725.000), Michigan (Mich. Comp. Laws § 333.26423), Minnesota (Minn. Stat. § 152.21 et seq.), Montana (Mont. Code Ann. § 50-46-301 et seq.), Nevada (NRS 453A), New Hampshire RSA 126-X), New Jersey (N.J.S.A. C.24:6I-3), New Mexico (N.M. Stat. § 26-2B-1 et seq.), New York (NY Pub Health Law § 3360), Oregon (Or. Rev. Stat. § 475.300 et seq.), Rhode Island (R.I. Gen. Laws § 21-28.6-3), Vermont (18 V.S.A. § 4472 et seq.), and Washington (RCS 69.51A).
Recreational Marijuana Ballot Initiatives: Alaska (2014); Colorado (2012); District of Columbia (2014); Oregon (2014); Washington (2012).

[2] The states that have enacted laws permitting limited use of cannabidiol oils are: Alabama, Florida, Georgia, Iowa, Kentucky, Louisiana, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

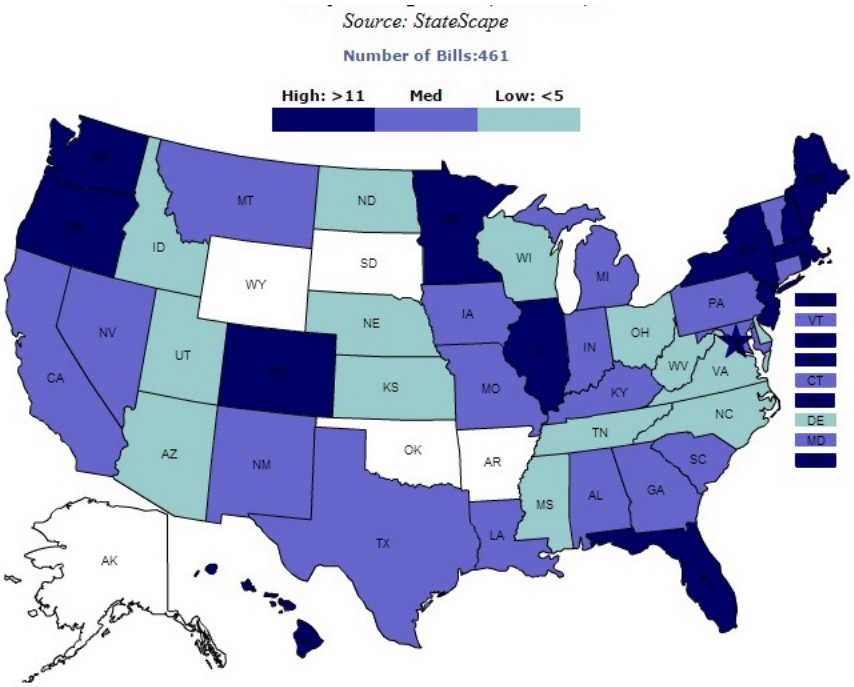
Although states have enacted laws permitting the use of both medical and recreational marijuana, the prescribing of marijuana remains illegal under federal law, as marijuana has not been subject to the U.S. Food and Drug Administration's evaluation and approval process. Marijuana is classified in federal law as a Schedule 1 substance under the Controlled Substance Act.[3] As a Schedule 1 substance, the federal government classifies marijuana as a substance with high potential for dependency or addiction, with no accepted medical use. Federal law prohibits knowingly or intentionally distributing, dispensing, or possessing marijuana.[4] Additionally, a person who aids and abets another in violating federal law or engages in a conspiracy to purchase, cultivate, or possess marijuana may be punished to the same extent as the individual who commits the crime.[5]

Providers and state regulators should continue to monitor usage and adverse effects of marijuana. See Figure 2. Based on the increasing number of states permitting the recommendation of marijuana in patient care, the U.S. Department of Justice updated its marijuana enforcement policy in August 2013. The updated policy reiterates marijuana's classification as an illegal substance under federal law, but advises states and local governments that authorize marijuana-related conduct to implement strong and effective regulatory and enforcement systems to address any threat state laws could pose to public safety, public health, and other interests. Should these state efforts be insufficient, the federal government may seek to challenge the regulatory structure itself and bring forward individual enforcement actions.[6]

The Guidelines that follow are designed to communicate to state medical board licensees that if marijuana is recommended, these recommendations should be consistent with accepted professional and ethical practices.

[3] 21 U.S.C. §812.
[4] 21 U.S.C. §841-44.
[5] 18 U.S.C. §2; 21 U.S.C. §846.
[6] James M. Cole, "Guidance Regarding Marijuana Enforcement [Memorandum]," Washington, DC: Department of Justice. (August 19, 2013).

Figure 2: Marijuana Legislation (2013-2015)



AL 5	AZ 4	CA 11	CO 14	CT 5	DC 27	DE 3	FL 20	GA 6	HI 50
IA 11	ID 1	IL 21	IN 5	KS 3	KY 5	LA 6	MA 18	MD 8	ME 17
MI 10	MN 14	MO 9	MS 3	MT 8	NC 3	ND 2	NE 4	NH 15	NJ 19
NM 5	NV 8	NY 15	OH 1	OR 15	PA 8	RI 21	SC 10	TN 3	TX 5
US 1	UT 1	VA 4	VT 6	WA 26	WI 1	WV 4			

Section Two. Definitions.

For the purposes of these guidelines, the following definitions apply:

"Marijuana" means the leaves, stems, flowers, and seeds of all species of the plant genus cannabis, whether growing or not. It does not include the mature stalks of the plant, fiber produced from the stalks, oil or cake made from the seeds of the plant, any other compound, manufacture, salt, derivative, mixture or preparation of the mature stalks, fiber, oil or cake or sterilized seed of the plant which is incapable of germination.

"Medical Marijuana Program" is the term used in some state statutes, rules, and regulations that provide for the medical use, cultivation and dispensing of marijuana for medical purposes, which may or may not include specific medical conditions for which a physician (or other licensed health care provider) may issue a recommendation, attestation, or authorization for a patient to obtain and use marijuana.

"Cannabidiol (CBD) Oil" means processed cannabis plant extract, oil, or resin that contains a high percentage of cannabidiol, but a low percentage of tetrahydrocannabinol.

"Tetrahydrocannabinol (THC)" means the primary psychoactive compound in cannabis, delta-9-tetrahydrocannabinol (THC), which is a partial agonist at cannabinoid receptors in the body.

Section Three. Guidelines.

The [Name of Board] has adopted the following guidelines for the recommendation of marijuana in patient care:

Physician-Patient Relationship: The health and well-being of patients depends upon a collaborative effort between the physician and the patient. The relationship between a patient and a physician is complex and based on the mutual understanding of the shared responsibility for the patient's health care. The physician-patient relationship is fundamental to the provision of acceptable medical care. Therefore, physicians must have documented that an appropriate physician-patient relationship has been established,[7] prior to providing a recommendation, attestation, or authorization for marijuana to the patient. Consistent with the prevailing standard of care, physicians should not recommend, attest, or otherwise authorize marijuana for themselves or family member.

Patient Evaluation: A documented in-person medical evaluation and collection of relevant clinical history commensurate with the presentation of the patient must be obtained before a decision is made as to whether to recommend marijuana for medical use. At minimum, the evaluation should include the patient's history of present illness, social history, past medical and surgical history, alcohol and substance use history, family history with emphasis on addiction or mental illness/ psychotic disorders, physical exam, documentation of therapies with inadequate response, and diagnosis requiring the marijuana recommendation.

Informed and Shared Decision Making: The decision to recommend marijuana should be a shared decision between the physician and the patient. The physician should discuss the risks and benefits of the use of marijuana with the patient. Patients should be advised of the variability and lack of standardization of marijuana preparations and the effect of marijuana. Patients should be reminded not to drive or operate heavy machinery while under the influence of marijuana. If the patient is a minor or without decision-making capacity, the physician should ensure that the patient's parent, guardian or surrogate is involved in the treatment plan and consents to the patient's use of marijuana.

[7] The health and well-being of patients depends upon a collaborative effort between the physician and patient. The relationship between the physician and patient is complex and is based on the mutual understanding of the shared responsibility for the patient's health care. Although the Board recognizes that it may be difficult in some circumstances to precisely define the beginning of the physician-patient relationship, particularly when the physician and patient are in separate locations, it tends to begin when an individual with a health-related matter seeks assistance from a physician who may provide assistance. However, the relationship is clearly established when the physician agrees to undertake diagnosis and treatment of the patient, and the patient agrees to be treated, whether or not there has been an encounter in person between the physician (or other appropriately supervised health care practitioner) and patient. FSMB *Model Policy for the Appropriate Use of Telemedicine Technologies in the Practice of Medicine* (HOD 2014).

Treatment Agreement: A health care professional should document a written treatment plan that includes:

- Review of other measures attempted to ease the suffering caused by the terminal or debilitating medical condition that do not involve the recommendation of marijuana.
- Advice about other options for managing the terminal or debilitating medical condition.
- Determination that the patient with a terminal or debilitating medical condition may benefit from the recommendation of marijuana.
- Advice about the potential risks of the medical use of marijuana to include:
    - The variability of quality and concentration of marijuana;
    - The risk of cannabis use disorder;
    - Exacerbation of psychotic disorders and adverse cognitive effects for children and young adults;
    - Adverse events, exacerbation of psychotic disorder, adverse cognitive effects for children and young adults, and other risks, including falls or fractures;
    - Use of marijuana during pregnancy or breast feeding;
    - The need to safeguard all marijuana and marijuana-infused products from children and pets or domestic animals; and
    - The need to notify the patient that the marijuana is for the patient's use only and the marijuana should not be donated or otherwise supplied to another individual.
- Additional diagnostic evaluations or other planned treatments.
- A specific duration for the marijuana authorization for a period no longer than twelve months.
- A specific ongoing treatment plan as medically appropriate.

Qualifying Conditions: At this time, there is a paucity of evidence for the efficacy of marijuana in treating certain medical conditions. Recommending marijuana for certain medical conditions is at the professional discretion of the physician. The indication, appropriateness, and safety of the recommendation should be evaluated in accordance with current standards of practice and in compliance with state laws, rules and regulations which specify qualifying conditions for which a patient may qualify for marijuana.

Ongoing Monitoring and Adapting the Treatment Plan: Where available, the physician recommending marijuana should register with the appropriate oversight agency and provide the registry with information each time a recommendation, attestation, authorization, or reauthorization is issued [see Appendix 1]. Where available, the physician recommending marijuana should check the state Prescription Drug Monitoring Program (PDMP) each time a recommendation, attestation, authorization, or reauthorization is issued.

The physician should regularly assess the patient's response to the use of marijuana and overall health and level of function. This assessment should include the efficacy of the treatment to the patient, the goals of the treatment, and the progress of those goals.

Consultation and Referral: A patient who has a history of substance use disorder or a co-occurring mental health disorder may require specialized assessment and treatment. The physician should seek a consultation with, or refer the patient to, a pain management, psychiatric, addiction or mental health specialist, as needed.

Medical Records: The physician should keep accurate and complete medical records. Information that should appear in the medical record includes, but is not necessarily limited to the following:

- The patient's medical history, including a review of prior medical records as appropriate;
- Results of the physical examination, patient evaluation, diagnostic, therapeutic, and laboratory results;
- Other treatments and prescribed medications;
- Authorization, attestation or recommendation for marijuana, to include date, expiration, and any additional information required by state statute;
- Instructions to the patient, including discussions of risks and benefits, side effects and variable effects;
- Results of ongoing assessment and monitoring of patient's response to the use of marijuana;
- A copy of the signed Treatment Agreement, including instructions on safekeeping and instructions on not sharing.

Physician Conflicts of Interest: A physician who recommends marijuana should not have a professional office located at a dispensary or cultivation center or receive financial compensation from or hold a financial interest in a dispensary or cultivation center. Nor should the physician be a director, officer, member, incorporator, agent, employee, or retailer of a dispensary or cultivation center.

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Appendix 1: Registration

Many states that permit the recommendation of marijuana to patients for the treatment of serious medical conditions have laws establishing a registry to track and monitor the utilization of marijuana in patient care.[8]

In these states, physicians recommending marijuana to patients for the treatment of conditions are required to register with the regulatory agency overseeing the marijuana program, and must provide the registry with information each time a recommendation is issued.

The state's registry is required by law to regularly perform analyses of the number of recommendations issued. With the statistical review of physician recommendations, the regulating agency periodically determines whether a physician should be referred to the state medical or osteopathic board for review and possible sanction.

The following are common factors oversight agencies rely on in referring physicians to the state board for possible abuse of marijuana recommendations:

1. Physician caseload as determined by the number of patients for whom marijuana is recommended. A high caseload is calculated as 3,521 or more patient recommendations in one year for a general practitioner. This reflects the recommendation of patients equal to or greater than the national average of patient visits per year for a generalist physician as reported by the Centers for Disease Control and Prevention (Co. Registry Policy # 2014-04_001);
2. The plant and ounce recommendations by the physician. Physicians recommending an amount of marijuana above the standard set within a state's statutes will be referred to the state medical board for review;
3. Age demographics of the patient caseload. According to the CDC, older adults have a significantly higher prevalence of chronic conditions than younger adults. Physicians for whom more than one-third of the patient caseload is under the age of 30 may be recommended for referral; and
4. Other circumstances determined by the overseeing agency. The oversight agency may also refer physicians to the state medical board if there is evidence of potential violation of the constitution, statutes, state medical board regulations or any violation of the Medical Practice Act.

If evidence supports a referral, the overseeing agency will issue a formal referral to the state medical board with the physician's identifying information, the reason for the referral, and any statistical data supporting the referral. Once the referral is received, the state medical board typically reviews the documentation and conducts an investigation as deemed appropriate.

[8] *See e.g.* Colorado Medical Marijuana Registry; *See e.g.* Minnesota Medical Cannabis Registry

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ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT

Adopted as policy by the Federation of State Medical Boards in April 2015

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ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT

INTRODUCTION

As early as 1914, the Federation of State Medical Boards of the United States and its member boards recognized the need for what was to become *A Guide to the Essentials of a Modern Medical Practice Act*. First published in 1956, the stated purposes of the document have always been the same:

1. to serve as a guide to those states that may adopt new medical practice acts or may amend existing laws and

2. to encourage the development and use of consistent standards, language, definitions and tools by boards responsible for physician and physician assistant regulation.

Changes in medical education, in the practice of medicine and in the diverse responsibilities that face medical boards necessitate regular revision of medical practice acts. The *Essentials* has undergone numerous revisions in order to respond to these changes and to provide assistance to member boards in the evaluation and revision of their medical practice acts. The Federation urges member boards to consider including any recommendation contained in the Essentials in its medical practice act or under its rules.

The *Essentials* applies equally to practice acts that govern physicians who have acquired the M.D. or D.O. degree in the same statute or in separate statutes. The terms used herein should be interpreted throughout with this understanding.

PREAMBLE

An essential is that element, quality or property that is indispensable in making a body, character, or structure what it is. It constitutes the essence. The Federation of State Medical Boards of the United States believes that each of the 19 sections of this document express an essential of a modern medical practice act and that the recommendations in each section are basic to the realization of that essential.

Section I: Statement of Purpose
The medical practice act should be introduced by a statement of policy specifying the purpose of the act. This statement should include language expressing the following concepts:

A. The practice of medicine is a privilege granted by the people acting through their elected representatives.

B. In the interests of public health, safety, and welfare, and to protect the public from the unprofessional, improper, incompetent, unlawful, fraudulent, and/or deceptive practice of medicine, it is necessary for the government to provide laws and regulations to govern the granting and subsequent use of the privilege to practice medicine.

C. The primary responsibility and obligation of the state medical board is to act in the sovereign interests of the government by protecting the public through licensing, regulation and education as directed by the state government.

Section II: Definitions

A. Definitions: As used in this Act, the following terms shall have the following meanings:
"Assessment Program" means a formal system to examine or evaluate a physician's competence within the scope of the physician's practice.

"Competence" means possessing the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively within the scope of the physician's practice while adhering to professional ethical standards.

"Dyscompetence" means failing to maintain acceptable standards of one or more areas of professional physician practice.

"Impairment" means a physician's inability to practice medicine with reasonable skill and safety due to:

1. mental, psychological, or psychiatric illness, disease, or deficit;

2. physical illness or condition, including, but not limited to, those illnesses or conditions that would adversely affect cognitive, motor, or perceptive skills; or

3. habitual, excessive, or illegal use or abuse of drugs defined by law as controlled substances, illegal drugs, alcohol, or of other impairing substances.

"Incompetence" means lacking the requisite abilities and qualities (cognitive, non-cognitive, and communicative) to perform effectively in the scope of the physician's practice.

"Licensed physician" means a physician licensed to practice medicine in the jurisdiction.

"Physician assistant" means a skilled person who by training, scholarly achievements, submission of acceptable letters of recommendations, and satisfaction of other requirements of the Board has been licensed for the provision of patient services under the supervision and direction of a licensed physician who is responsible for the performance of that person.

"Physician Assistant Council" means a council appointed by the Board or other means that reviews matters relating to physician assistants reports its findings to the Board and makes recommendations for action. The medical practice act should provide definitions of the practice of medicine as governed by the act as well as exceptions to the act. These provisions of the act should implement or be consistent with the following:

"Practice of medicine" means:

1. advertising, holding out to the public, or representing in any manner that one is authorized to practice medicine in the jurisdiction;

2. offering or undertaking to prescribe, order, give, or administer any drug or medicine for the use of any other person;

3. offering or undertaking to prevent or to diagnose, correct, and/or treat in any manner or by any means, methods, or devices any disease, illness, pain, wound, fracture, infirmity, defect, or abnormal physical or mental condition of any person, including the management of pregnancy and parturition;

4. offering or undertaking to perform any surgical operation upon any person;

5. rendering a written or otherwise documented medical opinion concerning the diagnosis or treatment of a patient or the actual rendering of treatment to a patient within a state by a physician located outside the state as a result of transmission of individual patient data by electronic or other means from within a state to such physician or his or her agent;

6. rendering a determination of medical necessity or a decision affecting the diagnosis and/or treatment of a patient; and

7. using the designation Doctor, Doctor of Medicine, Doctor of Osteopathic Medicine/Doctor of Osteopathy, Physician, Surgeon, Physician and Surgeon, Dr., M.D., D.O., or any combination thereof in the conduct of any occupation or profession pertaining to the prevention, diagnosis, or treatment of human disease or condition unless such a designation additionally contains the description of another branch of the healing arts for which one holds a valid license in the jurisdiction where the patient is located.

"Remediation" means the process whereby deficiencies in physician performance identified through an examination or assessment program are corrected, resulting in an acceptable state of physician competence.

"Supervising physician" means a licensed physician in good standing in the same jurisdiction as the physician assistant who the Board approved to supervise the services of a physician assistant, and who has in writing formally accepted the responsibility for such supervision.

B. The medical practice act shall not apply to:

1. students while engaged in training in a medical school approved or recognized by the state medical board, unless the Board licenses the student;

2. those providing service in cases of emergency where no fee or other consideration is contemplated, charged or received by the physician or anyone on behalf of the physician;

3. commissioned medical officers of the armed forces of the United States and medical officers of the United States Public Health Service or the Veterans Administration of the United States in the discharge of their official duties and/or within federally controlled facilities, provided that such

persons who hold medical licenses in the jurisdiction should be subject to the provisions of the act and provided that all such persons should be fully licensed to practice medicine in one or more jurisdictions of the United States, further the military physician should be subject to the Military Health System Clinical Quality Assurance (CQA) Program 10 U.S.C.A. § 1094; Regulation DOD 6025.13-R;

4. those practicing dentistry, nursing, optometry, podiatry, psychology, or any other of the healing arts in accord with and as provided by the laws of the jurisdiction;

5. those practicing the tenets of a religion or ministering religious based medical procedures or ministering to the sick or suffering by mental or spiritual means in accord with such tenets;

6. a person administering a lawful domestic or family remedy to a member of his or her own family;

7. those fully licensed to practice medicine in another jurisdiction of the United States who briefly render emergency medical treatment or briefly provide critical medical service at the specific lawful direction of a medical institution or federal agency that assumes full responsibility for that treatment or service and is approved by the state medical board; and

8. a physician licensed in another state, territory, or jurisdiction of the United States is exempted from the licensure requirements in (state) if the physician is employed or formally designated as the team physician by an athletic team visiting (state) for a specific sporting event and the physician limits the practice of medicine in (state) to medical treatment of the members, coaches and staff of the sports entity that employs (or has designated) the physician.

C. For the purpose of the medical practice act, the practice of medicine is determined to occur where the patient is located in order that the full resources of the state are available for the protection of that patient.

Section III: The State Medical Board

The medical practice act should provide for a separate state medical board, acting as a governmental agency, (referred to hereafter as the Board) to regulate the practice of medicine, including the licensure and discipline of physicians, in the jurisdiction. These provisions of the act should implement or be consistent with the following:

A. Whatever the professional regulatory structure established by the government of the jurisdiction, physicians should bear the primary responsibility for licensing and regulating the medical profession for the protection of the public, without abusing physicians in the discharge of that duty. Every Board should include both physician and public members. All Board members shall act to further the interest of the state, and not their personal interests.

B. Whatever the professional regulatory structure established by the government of the jurisdiction, the Board, within the context of the act and the requirements of due process, should have, at a minimum, the following powers and responsibilities:

1. Promulgate rules and regulations;

2. Select and/or administer licensing examination(s);

3. Develop and adopt policies and guidelines related to medical practice, other health care professions, and regulation;

4. Evaluate medical education and training of applicants;

5. Evaluate or verify certification of medical and training programs to determine if these pro- grams are appropriately preparing physicians for the practice of medicine;

6. Evaluate previous professional performance of applicants;

7. Issue or deny initial or endorsement licenses;

8. Maintain secure and complete records on individual licensees;

9. Provide the public with a profile of all licensed physicians;

10. Approve or deny applications for license renewal;

11. Develop and implement methods to identify physicians who are in violation of the medical practice act;

12. Develop and implement methods to identify and rehabilitate, if appropriate, physicians with an alcohol, drug and/or psychiatric illness;

13. Receive, review, and investigate complaints including sua sponte complaints;

14. Review and investigate reports received from entities having information pertinent to the professional performance of licensees;

15. Review, investigate, and take appropriate action to enjoin reports received concerning the unlicensed practice of medicine;

16. Share investigative information at the early stages of a complaint investigation with other Boards;

17. Issue subpoenas, subpoenas duces tecum, administer oaths, receive testimony, and conduct hearings;

18. Discipline licensees found in violation of the medical practice act;

19. Develop policies for disciplining or rehabilitating physicians that demonstrate inappropriate

sexual behavior with patients or other professional boundaries violations;

20. Institute actions in its own name and enjoin violators of the medical practice act;

21. Acknowledge receipt of complaints or other adverse information to persons or entities reporting to the Board and to the physician, and inform them of the final disposition of the matters reported;

22. Develop and implement methods to identify dyscompetent physicians and physicians who fail to meet acceptable standards of care;

23. Develop or identify and implement methods to assess and improve physician practice;

24. Develop or identify and implement methods to ensure the ongoing competence of licensees;

25. Establish appropriate fees and charges to ensure active and effective pursuit of its legal responsibilities;

26. Develop and adopt its budget;

27. Develop educational programs to facilitate licensee awareness of provisions contained in the medical practice act and to facilitate public awareness of the role and function of state medical boards; and

28. Acquire real property or other capital for the administration and operation of the Board.

C. Members of the Board, whether appointed or elected, should serve staggered terms to ensure continuity. All appointments and elections should be confirmed through the legislative branch of the jurisdiction.

D. The length of terms on the Board should be set to permit development of effective skill and experience by members (e.g., three or four years). However, a limit should be set on consecutive terms of service (e.g., two or three).

E. Members of the Board should receive appropriate compensation for services and reimbursement for expenses at the State's current approved rate.

F. A member of the Board should be subject to removal only when he or she

1. ceases to be qualified;

2. is found guilty of a felony or an unlawful act involving moral turpitude by a court of competent jurisdiction;

3. is found guilty of malfeasance, misfeasance or nonfeasance in relation to his or her Board duties by a court of competent jurisdiction;

4. is found mentally incompetent by a court of competent jurisdiction;

5. fails to attend three successive Board meetings without just cause as determined by the Board or, if a new member, fails to attend a new members' training program without just cause as determined by the Board;

6. is disciplined for violations of the medical practice act; or

7. is found in violation of the conflict of interest/ethics law.

G. All physician members of the Board should hold full and unrestricted medical licenses in the jurisdiction, should be persons of recognized professional ability and integrity, and should have resided, practiced in the jurisdiction long enough to have become familiar with policies and practice in the jurisdiction (e.g., five years).

H. The Board should include public members who:

1. are not licensed physicians or providers of health care;

2. have no substantial personal or financial interests in the practice of medicine or with any organization regulated by the Board;

3. have no immediate familial relationships with individuals involved in the practice of medicine or any organization regulated by the Board;

4. are residents of the State; and

5. are individuals of recognized ability and integrity.

I. The Board should be authorized to appoint committees from its membership. To effectively perform its duties under the Act, the Board should also be authorized to hire, discipline, and terminate staff, including an executive secretary or director. It should also be assigned adequate legal counsel by the office of the attorney general and/or be authorized to employ private counsel or its own full-time attorney.

J. The Board should conduct, and new members should attend, a training program designed to familiarize new members with their duties and the ethics of public service.

K. Travel, expenses, and daily compensation should be paid for each Board member's attendance, in or out of state, for education or training purposes approved by the Board and directly related to Board duties.

L. Telephone or other telecommunication conference should be an acceptable form of Board meeting if the president/chair alone or another officer and two Board members believe the Board's business can be properly conducted by teleconference. The Board shall be authorized to establish procedures by which its committees may meet by telephone or other telecommunication conference

system.

Section IV: Examinations

The medical practice act should provide for the Board's authority to approve an examination(s) of medical knowledge satisfactory to inform the Board's decision to issue a full, unrestricted license to practice medicine and surgery in the jurisdiction.

A. In order to ensure a high quality, valid, and reliable examination of physician preparedness to practice medicine, the Board may delegate the responsibilities for examination development, administration, scoring, and security to a third party or nationally recognized testing entity. Such an examination should be consistent with recognized national standards for professional testing such as those reflected in Standards for Educational and Psychological Testing.

B. No person should receive a license to practice medicine in the jurisdiction unless he or she has successfully completed all components of an examination(s) identified as satisfactory to the Board.

1. The currently administered USMLE Steps 1,2,3 or COMLEX-USA Levels 1,2,3; or

2. previously administered examinations such as the FLEX, NBME Parts or NBOME Parts; or

3. a combination of these examinations identified as acceptable by the Board.

C. The examination(s) approved by the Board shall be in the English language and designed to ascertain an individual's fitness for an unrestricted license to practice medicine and surgery.

D. The Board may stipulate the numeric score or performance level required for passing the examination(s) or accept the recommended minimum passing score as determined by the developers of the examination.

E. The Board should be authorized to limit the number of times an examination may be taken, to require applicants to pass all examinations within a specified period, and to specify further medical education required for applicants unable to do so.

F. In order to support periodic or mandated reviews of its approved examination(s), the Board should be provided with reasonable access by the third party or testing entity in order to review the examination design, format, and content, as well as performance data and relevant procedures for test administration, security, and scoring.

Section V: Requirements for Full Licensure

The medical practice act should provide minimum requirements for full licensure for the independent practice of medicine that bear a reasonable relationship to the qualifications and fitness necessary for such practice. These provisions of the act should implement or be consistent with the following:

A. The applicant should provide the Board, or its agent, and attest to, or provide the means to obtain and verify the following information and documentation in a manner required by the Board:

1. his or her full name and all aliases or other names ever used, current address, Social Security number, and date and place of birth;
2. a signed photograph not more than two (2) years old and, at the board's discretion, other documentation of identity;

3. originals of all documents and credentials required by the Board, notarized photocopies, or other verification acceptable to the Board of such documents and credentials;

4. a list of all jurisdictions, United States or foreign, in which the applicant is licensed or has ever applied for licensure to practice medicine or is authorized or has ever applied for authorization to practice medicine, including all jurisdictions in which any license application or authorization has been withdrawn;

5. a list of all jurisdictions, United States or foreign, in which the applicant has been denied licensure or authorization to practice medicine or as any other health care professional or has voluntarily surrendered a license or an authorization to practice medicine or as any other health care professional;

6. a list of all sanctions, judgments, awards, settlements, or convictions against the applicant in any jurisdiction, United States or foreign, that would constitute grounds for disciplinary action under the medical practice act or the Board's rules and regulations;

7. a detailed educational history, including places, institutions, dates, and program descriptions of all his or her education including all college, pre-professional, professional, and professional postgraduate education;

8. a detailed chronological life history, including places and dates of residence, employment, and military service (United States or foreign) including periods of absence from the active practice of medicine;

9. all Web sites associated with the applicant's practice and professional activities;

10. a list and current status of all specialty certifications and the name of certifying organization; and

11. any other information or documentation the Board determines necessary.

B. The applicant should possess the degree of Doctor of Medicine or Doctor of Osteopathic Medicine/Doctor of Osteopathy from a medical college or school located in the United States, its territories or possessions, or Canada that was approved by the Board or by a private nonprofit accrediting body approved by the Board at the time the degree was conferred. No person who graduated from a medical school that was not approved at the time of graduation should be examined for licensure or be licensed in the jurisdiction based on credentials or documentation from that school nor should such a person be licensed by endorsement.

C. Should the applicant graduate from a medical school in a foreign country, other than Canada, the

applicant should meet all the requirements established by the Board to determine the applicant's fitness to practice medicine.

D. The applicant should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).

E. The applicant should have passed the USMLE Steps 1, 2, 3 or COMLEX Levels 1, 2, 3 or a predecessor examination (FLEX, NBME Parts, NBOME Parts) or a combination of these examinations identified as accredited by the Board.

F. The applicant should have demonstrated a familiarity with the statutes and regulations of the jurisdiction relating to the practice of medicine and the appropriate use of controlled or dangerous substances.

G. The applicant should be physically, mentally, and professionally capable of practicing medicine in a manner acceptable to the Board and should be required to submit to a physical, mental, professional competency, or chemical dependency examination(s) or evaluation(s) if deemed necessary by the Board.

H. The applicant should not have been found guilty by a competent authority, United States or foreign, of any conduct that would constitute grounds for disciplinary action under the regulations of the Board or the act. The Board may be authorized, at its discretion, to modify this restriction for cause, but it should be directed to use such discretionary authority in a consistent manner.

I. If the applicant's license is denied or in accordance with Board policy, the applicant should be allowed a personal appearance before the Board or a representative thereof for interview, examination or review of credentials. At the discretion of the Board, the applicant should be required to present his or her original medical education credentials for inspection at the time of personal appearance.

J. The applicant should be held responsible for verifying to the satisfaction of the Board the validity of all credentials required for his or her medical licensure. The Board or its agent should verify medical licensure credentials directly from primary sources, and utilize recognized national physician information services (e.g., the Federation of State Medical Boards' Board Action Data Bank and Credentials Verification Service, the files of the American Medical Association and the American Osteopathic Association, and other national data banks and information resources.)

K. The applicant should have paid all fees and have completed and attested to the accuracy of all application and information forms required by the Board before the Board's verification process begins. The Board should require the applicant to authorize the Board to investigate and/or verify any information provided to it on the licensure application.

L. Applicants should have satisfactorily passed a criminal background check.

Section VI: Graduates of Foreign Medical Schools

The medical practice act should provide minimum requirements, in addition to those otherwise established, for full licensure of applicants who are graduates of schools located outside the United States, its territories or possessions, or Canada. These provisions of the act should implement or be consistent with the following:

A. Such applicants should possess the degree of Doctor of Medicine, Bachelor of Medicine, or a Board-approved equivalent based on satisfactory completion of educational programs acceptable to the Board.
B. Such applicants should be eligible by virtue of their medical education, training, and examination for unrestricted licensure or authorization to practice medicine in the country in which they received that education and training.

C. Such applicants should have passed an examination acceptable to the Board that adequately assesses the applicants' medical knowledge.

D. Such applicants should be certified by the Educational Commission for Foreign Medical Graduates or its Board-approved successor(s), or by an equivalent Board-approved entity.

E. Such applicants should have a demonstrated command of the English language satisfactory to the Board.

F. Such applicants should have satisfactorily completed at least thirty-six (36) months of progressive post-graduate medical training accredited by the Board, the Accreditation Council for Graduate Medical Education (ACGME), or the American Osteopathic Association (AOA).

G. All credentials, diplomas, and other required documentation in a foreign language submitted to the Board by or on behalf of such applicants should be accompanied by certified English translations acceptable to the Board.

H. Such applicants should have satisfied all of the applicable requirements of the United States Immigration and Naturalization Service.

Section VII: Licensure by Endorsement, Expedited Licensure by Endorsement, and Temporary and Special Licensure

The medical practice act should provide for licensure by endorsement, expedited licensure by endorsement, and in certain clearly defined cases, for temporary and special licensure. These provisions of the act should implement or be consistent with the following:

A. Endorsement for Licensed Applicants:
The Board should be authorized, at its discretion, to issue a license by endorsement to an applicant who:

1. has complied with all current medical licensing requirements save that for examination administered by the Board;

2. has passed a medical licensing examination given in English by another state, the District of Columbia, or a territory or possession of the United States or Canada, provided the Board determines that examination was equivalent to its own current examination, or an independent testing agent designated by the Board; and

3. has a valid current medical license in another state, the District of Columbia, or a territory or possession of the United States or Canada.

B. Expedited Licensure by Endorsement:
The Board should be authorized, at its discretion, to issue an expedited license by endorsement to an applicant who provides documentation of:

1. identity as required by the Board;

2. all jurisdictions in which the applicant holds a full and unrestricted license;

3. graduation from an approved medical school;

a. Liaison Committee on Medical Education (LCME) or American Osteopathic Association (AOA) approved medical school;

b. Fifth Pathway certificate; or

c. Educational Commission for Foreign Medical Graduates (ECFMG) certificate

4. passing one or more of the following examinations acceptable for initial licensure within three attempts per step/level;

a. United States Medical Licensing Examination (USMLE) Steps 1-3 or its predecessor examinations (National Board of Medical Examiners (NBME) I-III or the Federation Licensing Examination (FLEX).

b. Examinations offered by the National Board of Osteopathic Medical Examiners (COMLEX-USA) Levels 1-3 or its predecessor examination(s).

c. Medical Council of Canada Qualifying Examinations (MCCQE) or its predecessor examination(s) offered by the Licentiate Medical Council of Canada.

5. successful completion of the total examination sequence within seven (7) years, except when in combination with a Ph.D. program;

6. successful completion of three (3) years of progressive postgraduate training in a program accredited by the Accreditation Council on Graduate Medical Education (ACGME) or the AOA; and/or

7. certification or recertification by a medical specialty board recognized by the American Board of Medical Specialties (ABMS) or the AOA within the previous ten (10) years. Lifetime certificate holders who have not passed a written specialty recertification examination must demonstrate successful completion of the Special Purpose Examination (SPEX), Comprehensive Osteopathic Medical Variable Purpose Examination (COMVEX) or applicable recertification examination.

Boards should obtain supplemental documentation including, but not limited to:

1. Criminal background check;

2. Absence of current/pending investigations in any jurisdiction where licensed;

3. Verification of specialty board certification; and

4. Professional experience.

Physicians desiring an expedited process for licensure must utilize the Federation Credentials Verification Service (FCVS), or credentials verification meeting equivalent standards for verification of core credentials, including:

1. medical school diploma,

2. medical school transcript,

3. dean's certificate,

4. examination history,

5. disciplinary history,

6. identity (photograph and certified birth certificate or original passport),

7. ECFMG certificate, if applicable,

8. Fifth Pathway certificate, if applicable, and postgraduate training verification.

C. Temporary Licensure:
The Board should be authorized to establish regulations for issuance of a temporary medical license for the intervals between Board meetings. Such a license should:

1. be granted only to an applicant demonstrably qualified for a full and unrestricted medical license under the requirements set by the medical practice act and the regulations of the Board and

2. automatically terminate within a period specified by the Board.

D. Special Licensure:
The Board should be authorized to issue conditional, restricted, probationary, limited or otherwise circumscribed licenses as it determines necessary. It is to the discretion of the state medical board to set the criteria for issuing special purpose licenses. This provision should include, but not be limited to, the ability to issue a special license for the following purposes:

1. to practice medicine across state lines;

2. to provide medical services to a traveling sports team, coaches and staff for the duration of the sports event;

3. to provide volunteer medical services to under-insured/uninsured patients;

4. to provide medical services to youth camp enrollees, counselors and staff for the duration of the youth camp; and

5. to engage in the limited practice of medicine in an institutional setting by a physician who is licensed in another jurisdiction in the United States.

Section VIII: Limited Licensure for Physicians in Postgraduate Training

The medical practice act should provide that all physicians in all postgraduate training in the state or jurisdiction who are not otherwise fully licensed to practice medicine should be licensed on a limited basis for educational purposes. These provisions of the act should implement or be consistent with the following:

A. To be eligible for limited licensure, the applicant should have completed all the requirements for full and unrestricted medical licensure except postgraduate training or specific examination requirements.

B. Issuance of a limited license specifically for postgraduate training shall occur only after the applicant demonstrates that he or she is accepted in a residency program. The application for limited licensure should be made directly to the Board in the jurisdiction where the applicant's postgraduate training is to take place.

C. The Board should establish by regulation restrictions for the limited license to assure that the holder will practice only under appropriate supervision and within the confines of the program within which the resident is enrolled.

D. The limited license should be renewable annually and upon the written recommendation of the supervising institution, including a written evaluation of performance, until the Board regulations require the achievement of full and unrestricted medical licensure.

E. Program directors responsible for postgraduate training should be required annually to provide the Board a written report on the status of program participants having a limited license.

1. The report should inform the Board about program participants who have successfully completed the program, have departed from the program, have had unusual absences from the program, or have had problematic occurrences during the course of the program.

2. The report should include an explanation of any disciplinary action taken against a limited licensee for performance or behavioral reasons which, in the judgment of the program director, could be a threat to public health, safety, and welfare; unapproved or unexplained absences from the program; resignations from the program or nonrenewal of the program contract; dismissals from the program for performance or behavioral reasons; and referrals to substance abuse pro-grams not approved by the Board.

3. Failure to submit the annual program director's report shall be considered a violation of the mandatory reporting provisions of the medical practice act and shall be grounds to initiate such disciplinary action as the Board deems appropriate, including fines levied against the supervising institution and suspension of the program director's medical license.

F. The disciplinary provisions of the medical practice act should apply to the holders of the limited and postgraduate training license as if they held full and unrestricted medical licensure.

G. The issuance of a limited license should not be construed to imply that a full and unrestricted medical license would be issued at any future date.

Section IX: Disciplinary Action Against Licensees

The medical practice act should provide for disciplinary and/or remedial action against licensees and the grounds on which such action may be taken. These provisions of the act should implement or be consistent with the following:

A. Range of Actions: A range of progressive disciplinary and remedial actions should be made available to the Board. These should include, but not be limited to, the following:

1. revocation of the medical license;

2. suspension of the medical license;

3. probation;

4. stipulations, limitations, restrictions, probation, and conditions relating to practice;

5. censure (including specific redress, if appropriate);

6. reprimand;

7. chastisement, letters of concern, and advisory letters;

8. monetary redress to another party;

9. a period of free public or charity service, either medical or non-medical;

10. satisfactory completion of an educational, training and/or treatment program(s), or professional developmental plan;

11. levy fine; and

12. payment of administrative and disciplinary costs.

The Board should be authorized, at its discretion, to take disciplinary, non-disciplinary, public or non-public actions, singly or in combination, as the nature of the violation requires and to promote public protection.

B. Letter of Concern or Advisory Letter: The Board should be authorized to issue a confidential (if allowed by state law), non-reportable, non-disciplinary letter of concern, or advisory letter to a licensee when evidence does not warrant formal discipline, but the Board has noted indications of possible errant conduct by the licensee that could lead to serious consequences and formal action if the conduct were to continue. In its letter of concern or advisory letter, the Board should also be authorized,

at its discretion, to request clarifying information from the licensee.

C. Examination/Evaluation: The Board should be authorized, at its discretion, to require profes-sional competency, physical, mental, or chemical dependency examination(s) or evaluation(s) of any applicant or licensee, including withdrawal and laboratory examination of bodily fluids, tissues, hair, or nails.

D. Grounds for Action: The Board should be authorized to take disciplinary action for unprofes-sional or dishonorable conduct, which should be defined to mean, but not be limited to, the following:

1. fraud or misrepresentation in applying for or procuring a medical license or in connection with applying for or procuring periodic renewal of a medical license;

2. cheating on or attempting to subvert the medical licensing examination(s);

3. the commission or conviction or the entry of a guilty, nolo contendere plea, or deferred adjudication (without expungement) of:

a. misdemeanor whether or not related to the practice of medicine and any crime involving moral turpitude;

b. or a felony, whether or not related to the practice of medicine. The Board shall revoke a licensee's license following conviction of a felony, unless a 2/3 majority vote of the board members present and voting determined by clear and convincing evidence that such licensee will not pose a threat to the public in such person's capacity as a licensee and that such person has been sufficiently rehabilitated to warrant the public trust;

4. conduct likely to deceive, defraud, or harm the public;

5. disruptive behavior and/or interaction with physicians, hospital personnel, patients, fam-ily members, or others that interferes with patient care or could reasonably be expected to adversely impact the quality of care rendered to a patient;

6. making a false or misleading statement regarding his or her skill or the efficacy or value of the medicine, treatment, or remedy prescribed by him or her or at his or her direction in the treatment of any disease or other condition of the body or mind;

7. representing to a patient that an incurable condition, sickness, disease, or injury can be cured;

8. willfully or negligently violating the confidentiality between physician and patient except as required by law;

9. professional incompetency as one or more instances involving failure to adhere to the applicable standard of care to a degree which constitutes negligence, as determined by the board;

10. being found mentally incompetent or of unsound mind by any court of competent jurisdiction;

11. being physically or mentally unable to engage in the practice of medicine with reasonable skill and safety;

12. practice or other behavior that demonstrates an incapacity or incompetence to practice medicine;

13. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of medicine;

14. giving false, fraudulent, or deceptive testimony while serving as an expert witness;

15. practicing medicine under a false or assumed name;

16. aiding or abetting the practice of medicine by an unlicensed, incompetent or impaired person;

17. allowing another person or organization to use his or her license to practice medicine;

18. commission of any act of sexual misconduct, including sexual contact with patient surrogates or key third parties, which exploits the physician-patient relationship in a sexual way;

19. habitual or excessive use or abuse of drugs, alcohol, marijuana or other substances that impair ability;

20. failing or refusing to submit to an examination or any other examination that may detect the presence of alcohol or drugs upon Board order or any other form of impairment;

21. prescribing, selling, administering, distributing, diverting, ordering or giving any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug for other than medically accepted therapeutic purposes;

22. knowingly prescribing, selling, administering, distributing, ordering, or giving to a habitual user or addict or any person previously drug dependent, any drug legally classified as a controlled substance or recognized as an addictive or dangerous drug, except as otherwise permitted by law or in compliance with rules, regulations, or guidelines for use of controlled substances and the management of pain as promulgated by the Board;

23. prescribing, selling, administering, distributing, ordering, or giving any drug legally classified as a controlled substance or recognized as an addictive drug to a family member or to himself or herself;

24. violating any state or federal law or regulation relating to controlled substances;

25. signing a blank, undated, or predated prescription form;

26. obtaining any fee by fraud, deceit, or misrepresentation;

27. employing abusive, illegal, deceptive, or fraudulent billing practices;

28. directly or indirectly giving or receiving any fee, commission, rebate, or other compensation for professional services not actually and personally rendered, though this prohibition should not preclude the legal functioning of lawful professional partnerships, corporations, or associations;

29. disciplinary action of another state or federal jurisdiction against a license or other authorization to practice medicine or participate in a federal program (payment or treatment) based upon acts or conduct by the licensee similar to acts or conduct that would constitute grounds for action as defined in this section, a certified copy of the record of the action taken by the other state or jurisdiction being conclusive evidence thereof;

30. failure to report to the Board any adverse action taken against oneself by another licensing jurisdiction (United States or foreign), by any peer review body, by any health care institution, by any professional or medical society or association, by any governmental agency, by any law enforcement agency, or by any court for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

31. failure to report or cause a report to be made to the Board any physician upon whom a physician has evidence or information that appears to show that the physician is incompetent, guilty of negligence, guilty of a violation of this act, engaging in inappropriate relationships with patients, is mentally or physically unable to practice safely, or has an alcohol or drug abuse problem;

32. failure of physician who is the chief executive officer, medical officer, or medical staff to report to the Board any adverse action taken by a health care institution or peer review body, in addition to the reporting requirement in 31. (note: a report under 31 may need to wait until the peer review and due process procedures are completed, but the report under 30 must be reported immediately without waiting for the final action of the health care institution and applies to all physicians not just staff physicians);

33. failure to report to the Board surrender of a license limitation or other authorization to practice medicine in another state or jurisdiction, or surrender of membership on any medical staff or in any medical or professional association or society has surrendered the authority to utilize controlled substances issued by any state or federal agency, or has agreed to a limitation to or restriction of privileges at any medical care facility while under investigation by any of those authorities or bodies for acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

34. any adverse judgment, award, or settlement against the licensee resulting from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

35. failure to report to the Board any adverse judgment, settlement, or award arising from a medical liability claim related to acts or conduct similar to acts or conduct that would constitute grounds for action as defined in this section;

36. failure to provide pertinent and necessary medical records to another physician or patient in a

timely fashion when legally requested to do so by the subject patient or by a legally designated representative of the subject patient regardless of whether the patient owes a fee for services;

37. improper management of medical records, including failure to maintain timely, legible, accurate, and complete medical records and to comply with the Standards for Privacy of Individually Identifiable Health Information, 45 CFR Part 160 and 164, of the Health Insurance Portability and Accountability Act of 1996.

38. failure to furnish the Board, its investigators, or representatives information legally requested by the Board or failure to comply with a Board subpoena or order;

39. failure to cooperate with a lawful investigation conducted by the Board;

40. violation of any provision(s) of the medical practice act or the rules and regulations of the Board or of an action, stipulation, or agreement of the Board;

41. engaging in conduct calculated to, or having the effect of, bringing the medical profession into disrepute, including but not limited to, violation of any provision of a national code of ethics acknowledged by the Board;

42. failure to follow generally accepted infection control procedures;

43. failure to comply with any state statute or board regulation regarding a licensee's reporting responsibility for HIV, HVB (hepatitis B virus), seropositive status or any other reportable condition (including child abuse and vulnerable adult abuse) or disease;

44. practicing medicine in another state or jurisdiction without appropriate licensure;

45. conduct which violates patient trust, exploits the physician-patient relationship, or violates professional boundaries;

46. failure to offer appropriate procedures/studies, failure to protest inappropriate managed care denials, failure to provide necessary service, or failure to refer to an appropriate provider within such actions are taken for the sole purpose of positively influencing the physician's or the plan's financial wellbeing;

47. providing treatment or consultation recommendations, including issuing a prescription via electronic or other means, unless the physician has obtained a history and physical evaluation of the patient adequate to establish diagnosis and identify underlying conditions and/or contraindications to the treatment recommended/provided;

48. violating a Board formal order, condition of probation, consent agreement, or stipulation;

49. representing, claiming, or causing the appearance that the physician possesses a particular medical specialty certification by a Board recognized certifying organization (ABMS, AOA) if not true;

50. failing to obtain adequate patient informed consent;

51. using experimental treatments without appropriate patient consent and adhering to all necessary and required guidelines and constraints;

52. any conduct that may be harmful to the patient or the public;

53. failing to divulge to the Board upon legal demand the means, method, procedure, modality, or medicine used in the treatment of an ailment, condition, or disease;

54. conduct likely to deceive, defraud, or harm the public;

55. the use of any false, fraudulent, or deceptive statement in any document connected with the practice of the healing arts including intentional falsifying or fraudulent altering of a patient or medical care facility record;

56. failure to keep written medical records which accurately describe the services rendered to the patient, including patient histories, pertinent findings, examination results, and test results;

57. delegating professional responsibilities to a person when the licensee knows or has reason to know that such person is not qualified by training, experience, or license to perform them;

58. using experimental forms of therapy without proper informed patient consent, without conforming to generally accepted criteria or standard protocols, without keeping detailed legible records, or without having periodic analysis of the study and results reviewed by a committee or peers; and

59. failing to properly supervise, direct, or delegate acts which constitute the healing arts to persons who perform professional services pursuant to such licensee's direction, supervision, order, referral, delegation, or practice protocols.

Section X: Procedures for Enforcement and Disciplinary Action

The medical practice act should provide for procedures that will permit the Board to take appropriate enforcement and disciplinary action when and as required, while assuring fairness and due process to licensees. These provisions of the act should implement or be consistent with the following:

A. Board Authority: The Board should be empowered to commence legal action to enforce the provisions of the medical practice act and to exercise full discretion and authority with respect to disciplinary actions. In the course of an investigation, the Board's authority should include the ability to issue subpoenas to licensees, health care organizations, complainants, patients, and witnesses to produce documents or appear before the Board or staff to answer questions or be deposed. The Board should have the power to enforce its subpoenas, including disciplining a non-compliant licensee, and it is incumbent upon the subpoenaed party to seek a motion to quash the subpoena.

B. Administrative Procedures: The existing administrative procedures act or similar statute, in whole or in part, should either be applicable to or serve as the basis of the procedural provi-

sions of the medical practice act. The procedural provisions should provide for Board investigation of complaints; notice of formal or informal charges or allegations to the licensee; a fair and impartial hearing for the licensee before the Board, an examining committee or hearing officer; an opportunity for representation of the licensee by counsel; the presentation of testimony, evidence and arguments; subpoena power and attendance of witnesses; a record of the proceedings; and judicial review by the courts in accordance with the standards established by the jurisdiction for such review. The Board should have subpoena authority to conduct comprehensive reviews of a licensee's patient and office records and administrative authority to access otherwise protected peer review records. The Board should not need the patients' consent to obtain copies of medical records, nor shall health care institutions' peer-review privilege bar the Board from obtaining copies of peer review information. Once in the Board's possession, the patient records and peer review records should have the same legal protection from disclosure as they have when in the possession of the licensee, the patient or the peer-review organization.

C. Standard of Proof: The Board should be authorized to use preponderance of the evidence as the standard of proof in its role as trier of fact for all levels of discipline.

D. Informal Conference: Should there be an open meeting law, an exemption to it should be authorized to permit the Board, at its discretion, to meet in informal conference with a licensee who seeks or agrees to such a conference. Disciplinary action taken against a licensee because of such an informal conference and agreed to in writing by the Board and the licensee should be binding and a matter of public record. However, license revocation and suspension should be held in open formal hearing, unless executive session is permitted by the State's open meetings law. The holding of an informal conference should not preclude an open formal hearing if the Board determines such is necessary.

E. Summary Suspension: The Board should be authorized to summarily suspend or restrict a license prior to a formal hearing when it believes such action is required to protect the public from an imminent threat to public health and safety. The Board should be permitted to summarily suspend or restrict a license by means of a vote conducted by telephone conference call or other electronic means if appropriate Board officials believe such prompt action is required. Proceedings for a formal hearing should be instituted simultaneously with the summary suspension. The hearing should be set within a reasonable time of the date of the summary suspension. No court should be empowered to lift or otherwise interfere with such suspension while the Board proceeds in a timely fashion.

F. Cease and Desist Orders/Injunctions: The Board should be authorized to issue a cease-and-desist order and/or obtain an injunction to restrain any person or any corporation or association and its officers and directors from violating any provision of the medical practice act. Violation of an injunction should be punishable as contempt of court. No proof of actual damage to any person should be required for issuance of a cease-and-desist order and/or an injunction, nor should issuance of an injunction relieve those enjoined from criminal prosecution, civil action, or administrative process for violation of the medical practice act.

G. Board Action Reports: All the Board's final disciplinary actions, non-administrative license withdrawals, and license denials, including related findings of fact and conclusions of law, should be matters of public record. The Board should report such actions and denials to the Board Action Data Bank of the Federation of State Medical Boards of the United States within 30 days of the action being taken, to any other data repository required by law, and to the media. Voluntary surrender of

and voluntary limitation(s) on the medical license of any person should also be matters of public record and should also be reported to the Federation of State Medical Boards of the United States and to any other data repository by law. The Board should have the authority to keep confidential practice limitations and restrictions due to physical impairment when the licensee has not violated any provision in the medical practice act.

H. Tolling Periods of License Suspension or Restriction: The Board should provide, in cases of license suspension or restriction, that any time during which the disciplined licensee practices in another jurisdiction without comparable restriction shall not be credited as part of the period of suspension or restriction.

I. The Board should have the authority, at its discretion, to share investigative and adjudicatory files with other state and territorial medical boards at any time during the investigational or adjudicative process.

Section XI: Impaired Physicians

The medical practice act should provide for the limitation, restriction, conditioning, suspension or revocation of the medical license of any licensee whose mental or physical ability to practice medicine with reasonable skill and safety is impaired.

The Board should have available to it a confidential impaired physician program approved by the Board and charged with the evaluation and treatment of licensees who are in need of rehabilitation. The Board may directly provide such programs or through a formalized contractual relationship with an independent entity whose program meets standards set by the Board. The Board shall have the ability to monitor or audit the program to ensure the program meets the requirements of the Board.

The Board should be authorized, at its discretion, to require a licensee or applicant to submit to a mental or physical examination, body fluid, nail, or hair follicle test, or a chemical addiction, abuse, or dependency evaluation conducted by an independent evaluator designated or approved in advance by the Board. The results of the examination or evaluation should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to mental or physical examination or a chemical addition, abuse, or dependency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board. If a licensee or applicant fails to submit to an examination or evaluation when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal.

If the Board finds, after an evaluation, examination or hearing, that a licensee is mentally, physically, or chemically impaired, it should be authorized to take one or more of the following actions:

A. direct the licensee to submit to therapy, medical care, counseling, or treatment acceptable to the Board and comply with monitoring to ensure compliance;

B. suspend, limit, restrict, or place conditions on the licensee's medical license for the duration of the impairment and monitoring or treatment; and/or

C. revoke the licensee's medical license.

Any licensee or applicant who is prohibited from practicing medicine under this provision should be afforded at reasonable intervals an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been prohibited from practicing medicine.

While all impaired licensees should be reported to the Board in accord with the mandatory reporting requirements of the medical practice act, unidentified and unreported impaired licensees should be encouraged to seek treatment. To this end, the Board should be authorized, at its discretion, to establish rules and regulations for the review and approval of a medically directed Physician Health Program (PHP). Those conducting a Board-approved PHP should be exempt from the mandatory reporting requirements relating to an impaired licensee who is participating satisfactorily in the program, or the Board should hold its report in confidence and without action, unless or until the impaired licensee ceases to participate satisfactorily in the program. The Board should require a PHP to report any impaired licensee whose participation is unsatisfactory to the Board as soon as that determination is made. Participation in an approved PHP should not protect an impaired licensee from Board action resulting from a report of his or her impairment from another source. The Board should be the final authority for approval of a PHP, should conduct a review of its approved program(s) on a regular basis and should be permitted to withdraw or deny its approval at its discretion. The PHP should be required to report to the Board information regarding any violation of the medical practice act by a PHP participant, other than the impairment, even if the violation is unrelated to the licensee's impairment.

Section XII: Dyscompetent and Incompetent Licensees

The medical practice act should provide for the restriction, conditioning, suspension, revocation, or denial of the medical license of any licensee who the Board determines to be dyscompetent or incompetent. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to develop and implement methods to identify dyscompetent or incompetent licensees and licensees who fail to provide the appropriate quality of care. The Board should also be authorized to develop and implement methods to assess and improve licensee practices.

B. The Board should have access to a Board-approved assessment program charged with assessing licensees' clinical competency.

C. The Board should be authorized, at its discretion, to require a licensee or an applicant for licensure to undergo a physician competency evaluation conducted by a Board-designated independent evaluator at licensee's own expense. The results of the assessment should be admissible in any hearing before the Board or hearing officer, despite any claim of privilege under a contrary rule or statute. Every person who receives a license to practice medicine or who files an application for a license to practice medicine should be deemed to have given consent to submit to a physician competency evaluation, and to have waived all objections to the admissibility of the results in any hearing before the Board or hearing officer. If a licensee or applicant fails to submit to a competency assessment when properly directed to do so by the Board, the Board should be permitted to enter a final order upon proper notice, hearing, and proof of refusal to submit to such an evaluation.

D. If the Board finds, after evaluation by the assessment program, that a licensee or applicant for

licensure is unable to competently practice medicine, it should be authorized to take one or more of the following actions:

1. suspend, revoke, or deny the licensee's medical license or application;
2. restrict or limit the licensee's practice to those areas of demonstrated competence and comply with monitoring to ensure compliance;

3. place conditions on the licensee's license; and/or

4. direct the licensee to submit to a Board approved remediation program and comply with monitoring to ensure compliance to resolve any identified deficits in medical knowledge or clinical skills acceptable to the Board.

E. Any licensee or applicant for licensure who is prohibited from practicing medicine, or who has had restrictions or conditions placed upon his license, under Subsection D of this section should be afforded, at reasonable intervals, an opportunity to demonstrate to the satisfaction of the Board that he or she can resume or begin the practice of medicine, or can practice without the restrictions or conditions, with reasonable skill and safety. A license should not be reinstated, however, without the payment of all applicable fees and the fulfillment of all requirements as if the applicant had not been previously prohibited.

F. The Board should be authorized to require the assessment program to provide to the Board a written report of the results of the assessment with recommendations for remediation of the identified deficiencies.

G. The Board should have access to Board approved remedial medical education programs for referral of licensees in need of remediation. Such programs shall incorporate and comply with standards set by the Board. During remediation, the program shall provide, at Board determined intervals, written reports to the Board on the licensee's progress. Upon completion of the remediation program, the program shall provide a written report to the Board addressing the remediation of the previously identified areas of deficiency. The Board should be authorized to mandate that the licensee undergo post-remediation assessment to identify areas of continued deficit. The licensee shall be responsible for all expenses incurred as part of the assessment and the remediation.

Section XIII: Compulsory Reporting and Investigation

The medical practice act should provide that certain persons and entities report to the Board any possible violation of the act or of the Board's rules and regulations by a licensee. These provisions of the act should implement or be consistent with the following:

A. Any person should be permitted to report to the Board in a manner prescribed by the Board, any information he or she believes indicates a medical licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

B. The following should be required to report to the Board promptly and in writing any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction,

limitation, loss or denial of a licensees staff privileges or membership that involves patient care:

1. all licensees licensed under the act,

2. all licensed health care providers,

3. the state medical associations and its components,

4. all hospitals and other health care organizations in the state, to include hospitals, medical centers, long term care facilities, managed care organizations, ambulatory surgery centers, clinics, group practices, coroners, etc.,

5. all chiefs of staff, medical directors, department administrators, service directors, attending physicians, residency directors, etc.,

6. all liability insurance organizations,

7. all local medical/osteopathic societies,

8. all local professional societies,

9. all state agencies,

10. all law enforcement agencies in the state,

11. all courts in the state,

12. all federal agencies (e.g., DEA, FDA, and CMS),

13. all peer review bodies in the state, and

14. resident training program directors.

C. A licensee's voluntary resignation from the staff of a health care organization or voluntary limitation of his or her staff privileges at such an organization should be promptly reported to the Board by the organization if that action occurs while the licensee is under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol or drug impairment.

D. Malpractice insurance carriers, the licensee's attorney, a hospital, a group practice, and the affected licensees should be required to file with the Board a report of each final judgment, settlement, arbitration award, or any form of payment by the licensee or on the licensee's behalf by any source upon any demand, claim, or case alleging medical malpractice, battery, dyscompetence, incompetence, or failure of informed consent. Licensees not covered by malpractice insurance carriers should be required to file the same information with the Board regarding themselves. All such reports should be made to the Board promptly (e.g., within 30 days).

E. The Board should be permitted to investigate any evidence that appears to show a licensee is or

may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine.

F. Any person, institution, agency, or organization who reports in good faith and not made in bad faith, a licensee pursuant to subsections (A) or (B) of this section should not be subject to civil damages or criminal prosecution for so reporting. A bad faith report is grounds for disciplinary action under the medical practice act. There should be no monetary liability on the part of, and no cause of action for damages should arise against, any person, institution, agency, or organization for reporting in good faith.

G. To assure compliance with compulsory reporting requirements, specific civil penalties should be established for demonstrated failure to report (e.g., up to $10,000 per instance).

H. The Board should promptly acknowledge all reports received under this section. The Board should promptly notify persons or entities reporting under this section of the Board's final disposition of the matters reported.

Section XIV: Protected Action and Communication

The medical practice act should provide legal protection for the members of the Board and its staff and for those providing information to the Board in good faith. These provisions of the act should implement or be consistent with the following:

A. Qualified Immunity

1. There shall be no liability on the part of, and no action for damages against, any member of the board, its agents, its employees, or any member of an examining committee of physicians appointed or designated by the board, for any action undertaken or performed by such person within the scope of the duties, powers, and functions of the board or such examining committee as provided for in this Part when such person is acting in good faith and in the reasonable belief that the action taken by him is warranted.

2. No person, committee, association, organization, firm, or corporation providing information to the board in good faith and in the reasonable belief that such information is accurate and, whether as a witness or otherwise, shall be held, by reason of having provided such information, to be liable in damages under the law of the state or any political subdivision thereof.

3. In any suit brought against the board, its employees or agents, any member of an examining committee appointed by the board or any person, firm, or other entity providing information to the board, when any such defendant substantially prevails in such suit, the court shall, at the conclusion of the action, award to any such substantially prevailing party defendant against any such claimant the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this Section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

4. There shall be no liability on the part of and no action for damages against any corporation, foundation, or organization that enters into any agreement with the board related to

the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith, and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

5. There shall be no liability on the part of and no action for damages against any person who serves as a director, trustee, officer, employee, consultant, or attorney for or who otherwise works for or is associated with any corporation, foundation, or organization that enters into any agreement with the board related to the operation of any committee or program to identify, investigate, counsel, monitor, or assist any licensed physician who suffers or may suffer from alcohol or substance abuse or a physical or mental condition which could compromise such physician's fitness and ability to practice medicine with reasonable skill and safety to patients, for any investigation, action, report, recommendation, decision, or opinion undertaken, performed, or made in connection with or on behalf of such committee or program, in good faith and in the reasonable belief that such investigation, action, report, recommendation, decision, or opinion was warranted.

6. In any suit brought against any corporation, foundation, organization, or person described in Subsection 4 or 5 of this Section, when any such defendant substantially prevails in the suit, the court shall, at the conclusion of the action, award to any substantially prevailing party defendant against any claimant the cost of the suit attributable to such claim, including reasonable attorney fees, if the claim was frivolous or brought without a reasonable good faith basis. For purposes of this Subsection, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains a judgment for damages, permanent injunction, or declaratory relief.

B. Indemnity and Defense

The state should defend a current or former member, officer, administrator, staff member, committee member, examiner, representative, agent, employee, consultant, witness, contractor, or any other person serving or having served the Board against any claim or action arising out of the act, omission, proceeding, conduct, or decision related to his or her duties undertaken or performed in good faith and within the scope of the function of the Board. The State should provide and pay for such defense and should pay any resulting judgment, compromise or settlement.

C. Protected Communication

1. Every communication made by or on behalf of any person, institution, agency,or organization to the Board or to any person(s) designated by the Board relating to an investigation or the initiation of an investigation, whether by way of report, complaint or statement, should be privileged. No action or proceeding, civil or criminal, should be permitted against any person, institution, agency or organization that made such a communication in good faith.

2. The protections afforded in this provision should not be construed as prohibiting a respondent or his or her legal counsel from exercising the respondent's constitutional right of due process under the law.

Section XV: Unlawful Practice of Medicine: Violations and Penalties

The medical practice act should provide a definition of the unlawful practice of medicine and penalties for such unlawful practice. These provisions of the act should implement or be consistent with the following:

A. It should be unlawful for any person, corporation, or association to perform any act constituting the practice of medicine as defined in the medical practice act without first obtaining a medical license in accord with that act and the rules and regulations of the Board. Other licensed health care professionals may provide medical services within the scope of their authorizing license.

B. The Board should be authorized to issue a cease-and-desist order and/or obtain injunctive relief against the unlawful practice of medicine by any person, corporation, or association.

C. It should be a felony crime for any person, corporation, or association that performs any act constituting the practice of medicine as defined in the medical practice act, or causing or aiding and abetting such actions.

D. A physician located in another state practicing within the state by electronic or other means without a license (full, special purpose or otherwise) issued by the Board should be deemed guilty of a felonious offense.

Section XVI: Periodic Renewal

The medical practice act should provide for the periodic renewal of medical licenses to permit the Board to review the qualifications of licensees on a regular basis. These provisions of the act should implement or be consistent with the following:

A. At the time of periodic renewal, the Board should require the licensee to demonstrate to its satisfaction his or her continuing qualification for medical licensure. The Board should design the application for licensure renewal to require the licensee to update and/or add to the information in the Board's file relating to the licensee and his or her professional activity. It should also require the licensee to report to the Board the following information:

1. Any action taken for acts or conduct similar to acts or conduct described in the medical practice act as grounds for disciplinary action against a licensee by:

a. any jurisdiction or authority (United States or foreign) that licenses or authorizes the practice of medicine or participation in a payment or practice program;

b. any peer review body;

c. any specialty certification board;

d. any health care organization;

e. any professional medical society or association;

f. any law enforcement agency;

g. any health insurance company;

h. any malpractice insurance company;

i. any court; and

j. any governmental agency.

2. Any adverse judgment, settlement, or award against the licensee or payment by or on behalf of the licensee arising from a professional liability demand, claim, or case.

3. The licensee's voluntary surrender of or voluntary limitation on any license or authorization to practice medicine in any jurisdiction, including military, public health, and foreign.

4. Any denial to the licensee of a license or authorization to practice medicine by any jurisdiction, including military, public health, and foreign.

5. The licensee's voluntary resignation from the medical staff of any health care organization or voluntary limitation of his or her staff privileges at such an organization if that action occurred while the licensee was under formal or informal investigation by the organization or a committee thereof for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol, or drug impairment.

6. The licensee's voluntary resignation or withdrawal from a national, state, or county medical society, association, or organization if that action occurred while the licensee was under formal or informal investigation or review by that body for any reason related to possible medical incompetence, unprofessional conduct, mental, physical, alcohol, or drug impairment.

7. Whether the licensee has abused or has been addicted to or treated for addiction to alcohol or any chemical substance.

8. Whether the licensee has had any physical injury, impairment, condition, disease, or mental or psychological illness that adversely affected or interrupted his or her practice of medicine.

9. The licensee's completion of continuing medical education or other forms of professional maintenance and/or evaluation, including specialty board certification or recertification, within the renewal period.

B. The Board should be authorized, at its discretion, to require continuing medical education for license renewal and to require documentation of that education. The Board should have the authority to audit, randomly or specifically, licensees for compliance.

C. The Board should require the licensee to apply for license renewal in a manner prescribed by the board and attest to the accuracy and truthfulness of the information submitted.

D. The Board should be directed to establish an effective system for reviewing renewal forms. It should also be authorized to initiate investigations and/or disciplinary proceedings based on information submitted by licensees for license renewal.

E. Failure to report fully and correctly should be grounds for disciplinary action by the Board.

Section XVII: Physician Assistants

The medical practice act should provide for the Board to license and regulate physician assistants. These provisions of the act should implement or be consistent with the following:

A. Administration: The Board should administer and enforce these provisions of the medical practice act with the advice and assistance of the Physician Assistant Council.

B. Physician Assistant Licensing

1. No person should perform or attempt to practice as a physician assistant without first obtaining a license from the Board and having a supervising physician.

2. An applicant for licensure as a physician assistant should complete all Board application forms and pay a nonrefundable fee. The forms should request the applicant provide their name and address and such additional information as the Board deems necessary. The Board may issue a license to a physician assistant applicant who fulfills all board requirements for licensure. However, a licensed physician assistant is prohibited from practicing until they have an agreement with a supervising physician(s).

3. Each licensed physician assistant should renew their license and file updated documentation stating their name and current address and any additional information as required by the Board. A fee set by the Board should accompany each renewal and filing of updated documentation.

4. The Board may require written notification by the supervising physician and the physician assistant if the relationship is changed or severed for a reason that would have an adverse effect for patient care.

5. Persons not licensed by the Board who hold themselves out as physician assistants should be subject to penalties applicable to the unlicensed practice of medicine.

C. Rules and Regulations: The Board should be empowered to adopt and enforce rules and regulations for:

1. setting qualifications of education, skill, and experience for the licensing of a person as a physician assistant and providing forms and procedures for licensure and for renewal; and

2. evaluating applicants for licensure as physician assistants.

D. Disciplinary Actions: The Board should be empowered to deny, revoke, or suspend any license, to limit or restrict the location of practice, to issue reprimands, to remove the authorization of a supervising physician, and to limit or restrict the practice of a physician assistant upon grounds and according to procedures similar to those for such disciplinary actions against licensed physicians. Such actions should be reported to the Federation of State Medical Boards.

E. Duties and Scope of Practice: A physician assistant should be permitted to provide those medical services delegated to them by the supervising physician that are within their training and experience.

F. Responsibility of Supervising Physician: Every physician supervising or employing a physician assistant should be legally responsible for the delegation of health care tasks, the performance and the acts and omissions of the physician assistant. Nothing in these provisions, however, should be construed to relieve the physician assistant of any responsibility for any of their own acts and omissions. No physician should have under their supervision more staff, physician assistant, or otherwise than the physician can adequately supervise. In the event the supervising physician is absent, he or she must provide for appropriate supervision of the physician assistant by another licensed physician. Each and every relationship should adhere to all statutory requirements for licensure.

G. The Board should be authorized, at its discretion, to require evidence of satisfactory completion of continuing medical education for license renewal.

Section XVIII: Rules and Regulations

The medical practice act should authorize the Board to promulgate rules and regulations to facilitate the enforcement of the act. These provisions of the act should implement or be consistent with the following:

A. The Board should be authorized to adopt and enforce rules and regulations to carry out the provisions of the medical practice act and to fulfill its duties under the act.

B. The Board should adopt rules and regulations in accord with administrative procedures established in the jurisdiction.

Section XIX: Funding and Fees

The medical practice act should provide that Board fees be adequate to fund the Board's effective regulation of the practice of medicine under the act and that those fees paid by licensees be used only for purposes related to licensee licensure, discipline, and Board administration. These provisions of the act should implement or be consistent with the following:

A. The Board should be fully supported by the revenues generated from its activities, including fees, charges and reimbursed costs, which the Board should deposit in an appropriate account, and the Board should also receive all interest earned on the deposit of such revenues. Such funds should be appropriated continuously. All fines levied by the Board may be deposited in the State General Fund, unless otherwise allowed by law. All administrative, investigative and adjudicatory costs recoupment should be deposited in the Board's account.

B. The Board should develop and adopt its own budget reflecting revenues, including the interest thereon, and costs associated with each health care field regulated. Revenues and interest thereon, from each health care field regulated should fully support Board regulation of that field. The budget should include allocations for establishment and maintenance of a reasonable reserve fund.

C. The Board should be authorized to set fees and charges pursuant to its proposed budget needs. Reasonable notice should be provided for all increases or decreases in fees and charges.

D. The Board should operate on the same fiscal year as the State.

E. A designated officer of the Board or employee, at the direction of the Board, should oversee the collection and disbursement of funds.

F. The State Auditor's Office (or the equivalent State office) should routinely audit the financial records of the Board and report to the Board and the Legislature.

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Medical Board of California

Report to the Legislature
Vertical Enforcement
and Prosecution Model

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Kimberly Kirchmeyer, Executive Director, Medical Board of California

March 2016

Report to the Legislature
Vertical Enforcement and Prosecution Report
March 2016

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Introduction and Brief History

Effective January 1, 2006, the Medical Board of California (Board) and the Department of Justice Health Quality Enforcement Section (HQES) were required by the Legislature to implement a vertical enforcement and prosecution model (VE/P) for conducting investigations and prosecutions. The Board and HQES have been operating under this model since that date.

The VE/P model requires the joint and simultaneous assignment of a complaint to a Board investigator and a deputy attorney general (DAG), who are to handle the matter for its duration. The assigned Board investigator, under the direction of a DAG, is responsible for obtaining the evidence needed to permit a decision to be made regarding whether to prosecute the matter. The Legislature clearly contemplated that VE/P would be a collaborative team approach to enforcement and prosecution. The Board and HQES have created a joint manual and modified it several times in an attempt to foster this collaborative team concept.

The Board has reported to the Legislature on the VE/P model in 2007, 2009, 2010 (as part of an evaluation of all of the Board's programs), 2012, and 2013 (as part of the supplement to the Sunset Review report). The Sunset Review report submitted in November 2012 contained only a narrative; the supplement submitted in spring 2013 contained the statistical data regarding the case processing timelines.

Effective July 1, 2014, SB 304 (Chap. 515, Stats. 2013) made a significant change to the VE/P model by moving the Board's sworn investigators from the Board to the Division of Investigation within the Department of Consumer Affairs (DCA). This action removed the Board's authority to supervise and direct investigations and transferred that authority to DCA. The Board now has authority only over the initial complaint intake phase and the final decision.

Costs

In Fiscal Year (FY) 2006-07, the Board received an augmentation of $2.5 million dollars to fund the Attorney General (AG) expenses to implement the VE/P model. As a result of this increase in its legal services budget, the Department of Justice (DOJ) redirected two attorney positions to assist in evaluating and screening complaints and seven attorney positions to implement the VE/P model.

Additional funding was required due to an increase in the attorney hourly billing rate in FY 2009-10. To date the Board has spent $18.6 million implementing the VE/P model, as summarized below.

Attorney General - Vertical Enforcement and Prosecution Cost

Fiscal Years	05/06	06/07	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	Total
Administrative/ Prosecution Costs	$4,249,107	$5,452,751	$5,672,572	$5,056,973	$5,659,588	$6,010,600	$6,825,814	$5,689,727	$6,561,224	$5,854,443	**$57,032,798**
VE/P Investigation Costs*	$94,713	$723,097	$1,667,688	$2,233,166	$2,903,709	$2,275,182	$2,396,296	$1,984,058	$2,176,666	$2,120,793	**$18,575,367**
Investigations Initiated	1,062	941	961	847	1,003	1,089	1,132	1,164	1,114	944	10,257
Total	**$4,343,820**	**$6,175,848**	**$7,340,260**	**$7,290,139**	**$8,563,297**	**$8,285,783**	**$9,222,110**	**$7,673,785**	**$8,737,890**	**$7,975,236**	**$75,608,165**

**This represents the costs incurred by HQES to direct investigations. It does not include Board or DCA's Health Quality Investigation Unit (HQIU) costs to conduct investigations. The cost for HQIU in FY 14/15 (the year in which it came into existence) was $16,313,540.*

Statistics and Analysis

The primary benefits that the Legislature believed would come out of VE/P were described in the analyses prepared for the Legislature as: greater effectiveness, improved timeliness, and greater cost-effectiveness.

The first such analysis in the Senate Committee on Business, Professions, and Economic Development (April 25, 2005) for the bill that required the VE/P model (SB 231--Chap. 274, Stats. 2005) provided in pertinent part:

> *"Vertical prosecution teams allow lawyers and investigators to view each case as a whole, rather than as two, separate and independent steps: the investigation and then the prosecution. The problem is an obvious one to anyone who practices this kind (or any other kind) of law - investigating a case and litigating a case are not independent at all; one informs the success or failure of the other. The two are entirely interrelated and interdependent."*

* * *

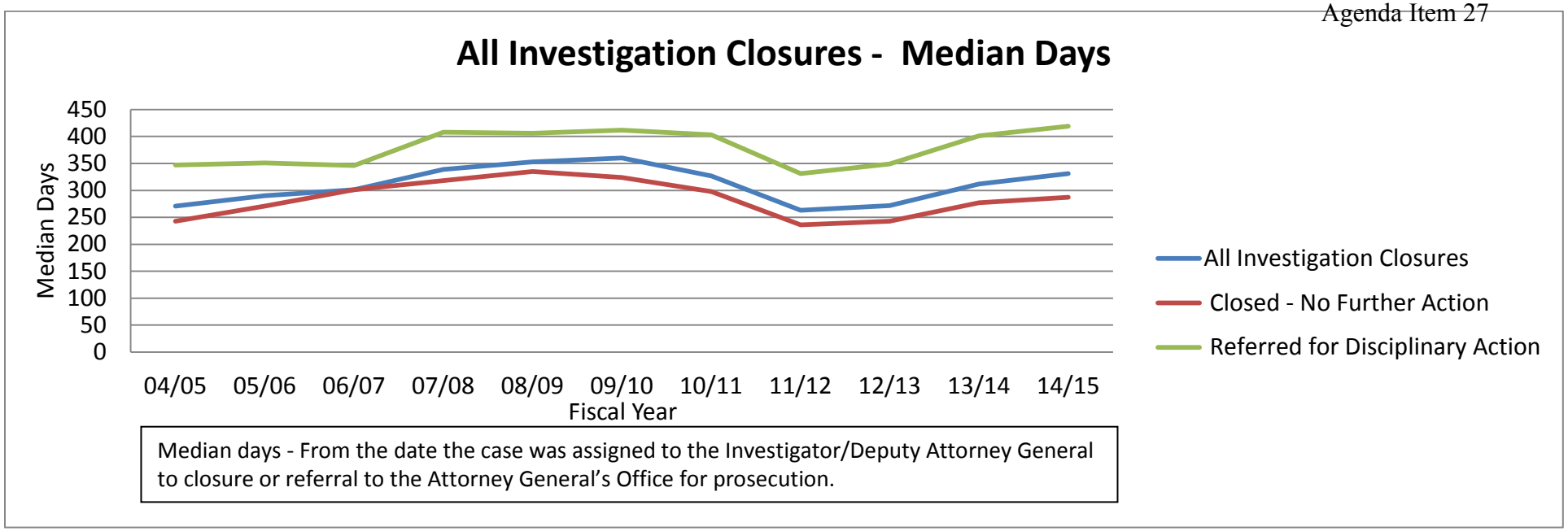
"In addition to its effectiveness, Vertical Prosecution can be more cost-effective for the Board. With an attorney keeping an eye on developing evidence - or lack of evidence - the Vertical Prosecution team can discover poor or unwarranted cases earlier, and not waste their joint time in pursuing them. This would have the additional benefit of clearing the license of an accused physician earlier."

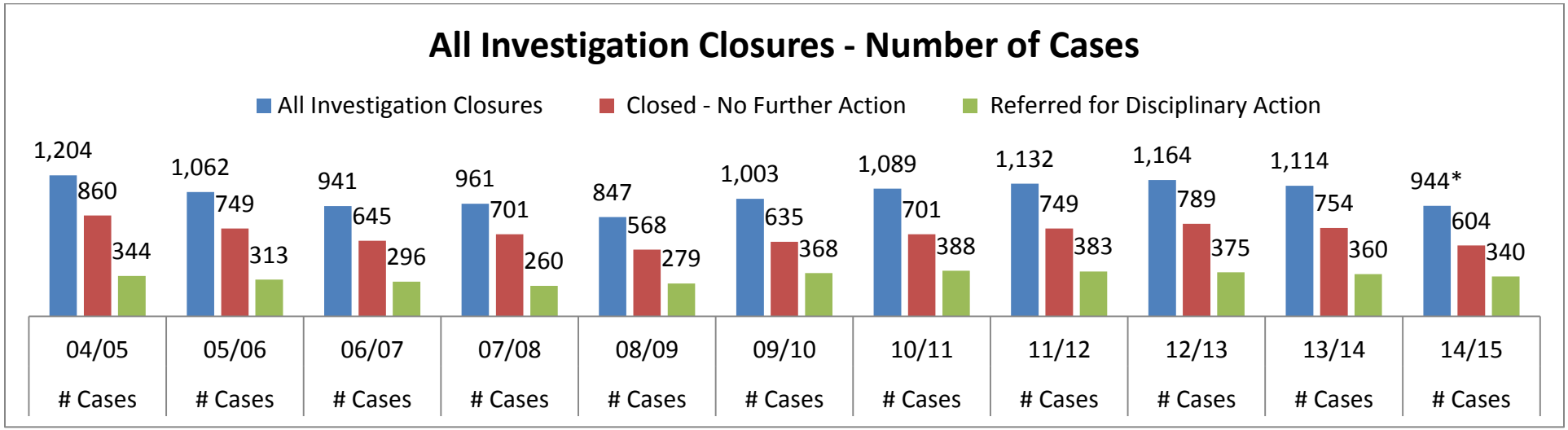
"There is a 'compromise' proposal currently in existence, called Deputy in District Office (or DIDO). . . . Under this program, attorneys work part-time in Board district offices, and can help investigators work up cases. However, this program falls far short of true Vertical Prosecution. As the Report notes, after more than eight years in operation, the half-measure has proved to have many flaws, and has not delivered the true benefits that Vertical Prosecution would."

VE/P has been in operation for almost 10 years. The Legislature anticipated that use of a VE/P model would improve timeliness of prosecution and an increase in the number of cases prosecuted, as well as be more cost-effective.

This report focuses on the number of cases and the median processing times. The Board selected the median number of days (rather than the average) to provide a truer picture of the time frames. The data contained in the graphs on the following pages and table (Appendix A) are derived from the Board's records only. The Board recognizes that different agencies will have a different focus when compiling data. The Board's records indicate that VE/P, as currently practiced, has not resulted in significant improvement in the length of time it takes to prosecute a case. However, there was an increase in the number of accusations filed.

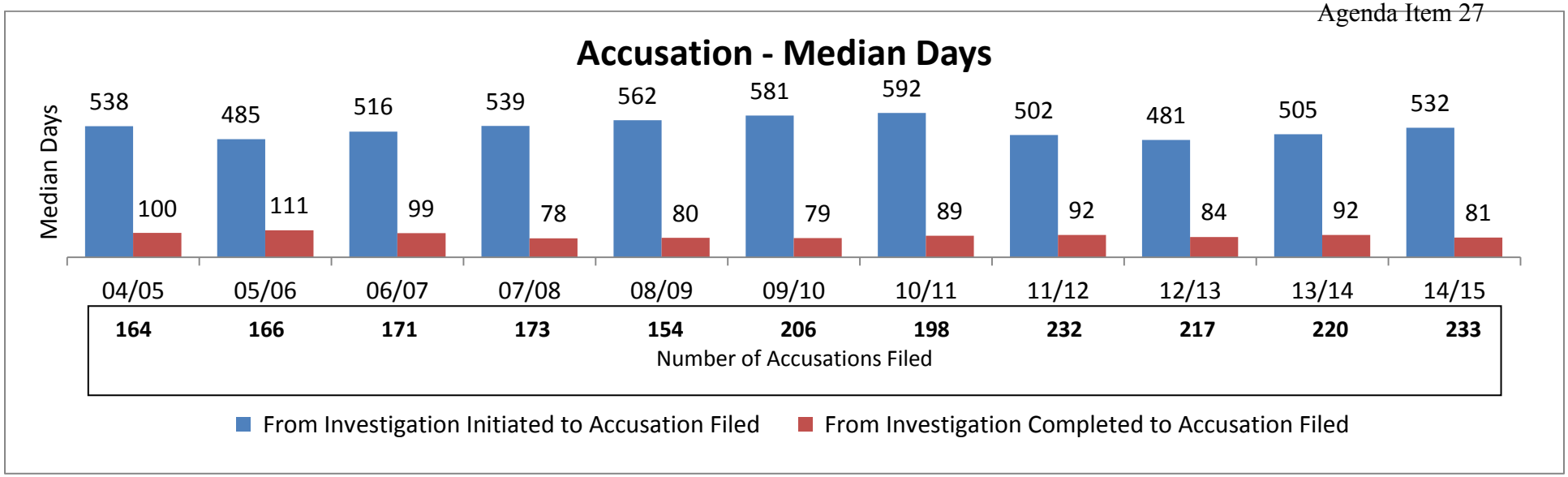
There are factors that impact the median day graphs on the following pages and Appendix A. A factor is the vacancy rate within the investigative unit. With respect to the graphs on pages 6 and 7, and the table in Appendix A, the median days reported reflect another factor. This factor is the time attributable to the administrative hearing portion of the disciplinary process, managed by the Office of Administrative Hearings, which is intended to provide due process to physicians. Neither HQES, HQIU, nor the Board have any control over this time.

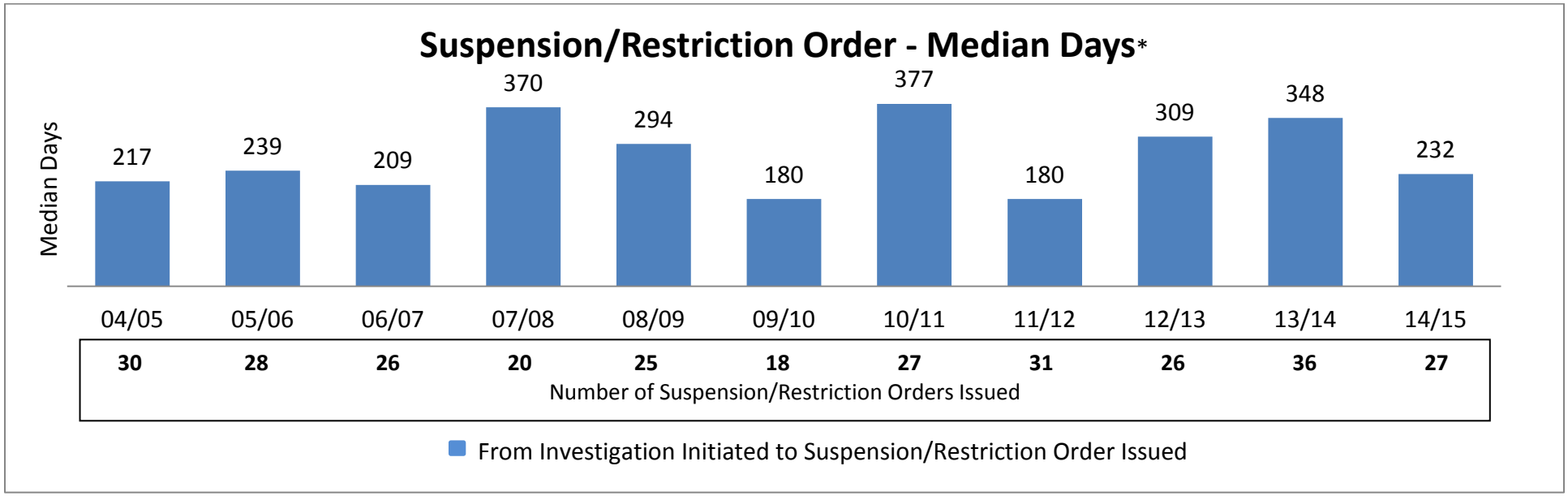




* This decrease is due to the Board initiating, in July 2014, a complaint investigation office of non-sworn special investigators who began investigating cases that would have been sent to HQIU.

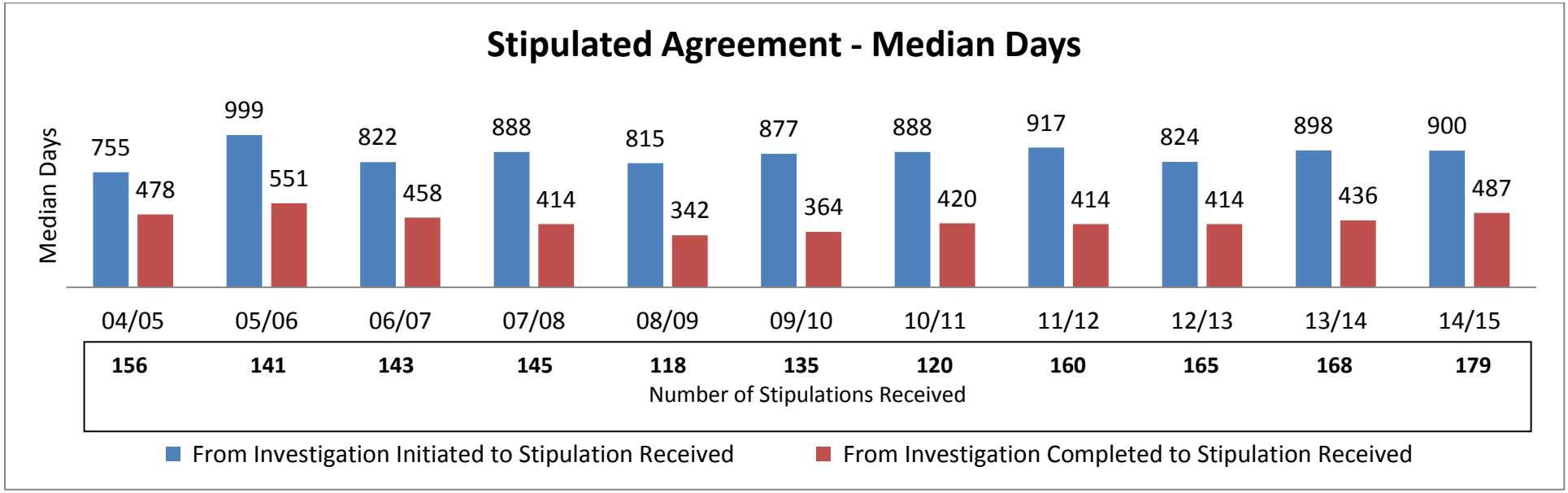
The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

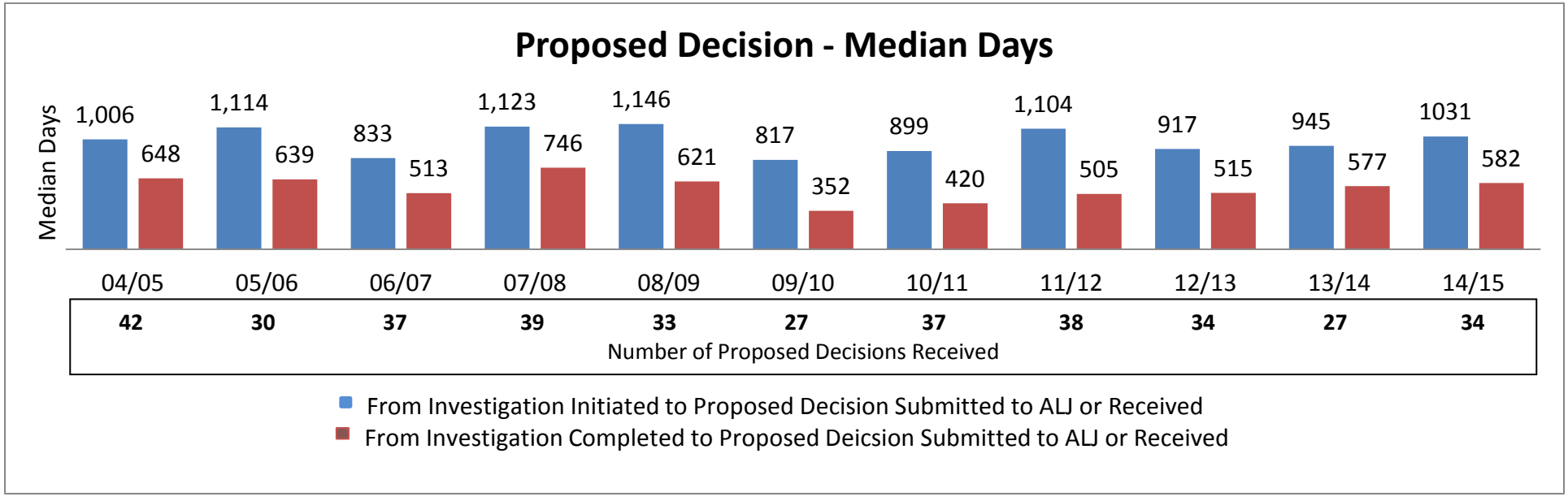




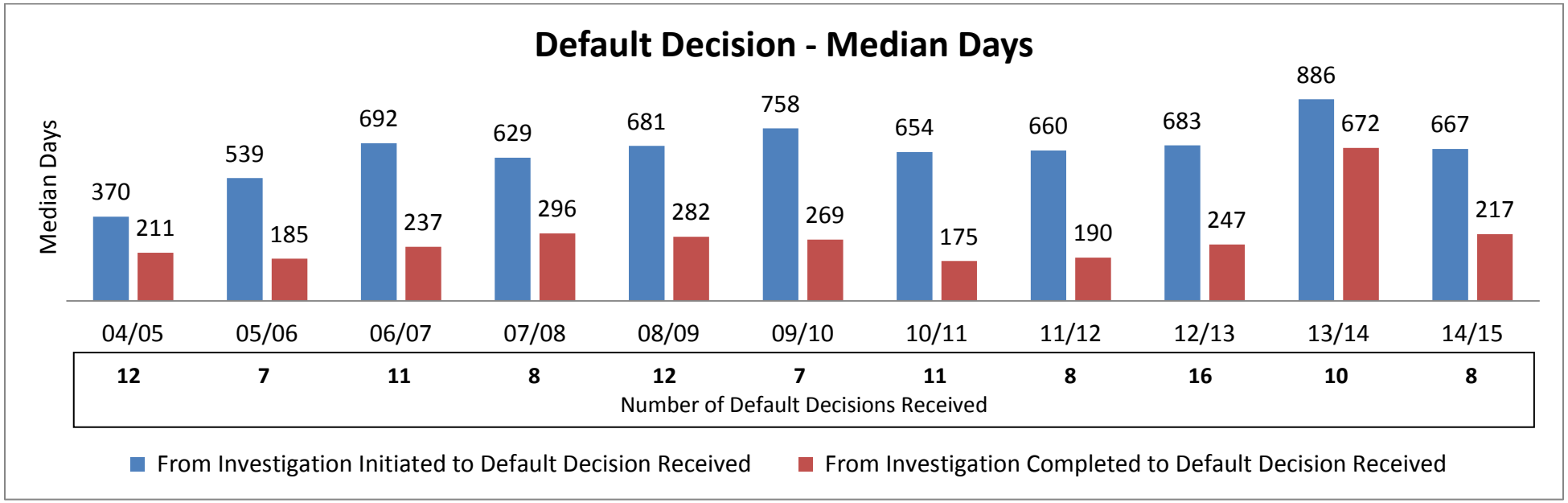
* This data includes: interim suspension orders, Penal Code section 23 restrictions, stipulated agreements to restrictions/suspension, and temporary restraining orders. It does not include out-of-state suspension orders, automatic suspension orders, or orders to cease practice while on probation.

The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P. The time units measured in the top graph are the same as those measured in the prior report, i.e. accusation times are measured from investigation initiated to accusation filed and from investigation completed to accusation filed.





The graphs above exclude the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. They also exclude all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P. The time units measured are the same as those measured in the prior report.



The graph above excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P. The time units measured are the same as those measured in the prior report.

Improvements Since the Last Report

1. The Board and HQES utilized protocols contained in a joint manual to implement the VE/P model. With the transfer on July 1, 2014, of the Board's sworn investigators to HQIU, a revised manual was needed. The Board, DCA, HQES, and HQIU worked together to create a new protocol. Effective July 1, 2015, this new protocol implements the recommendation from the 2013 Sunset Review Report that those who are part of the VE/P team take steps to improve their collaborative relationship.

2. Joint training was delivered to HQE and HQIU staff on the new 2015 Vertical Enforcement and Prosecution Protocol. One training session was held in Sacramento on July 14, 2015, and two were held in Los Angeles on July 20, 2015. Each session was approximately two hours long. The training sessions covered the highlights of the new protocol, including: the shared goal of protecting the public; a fresh start to teamwork; the importance of communication between team members; excellence and professionalism; and the rationale behind changes to certain parts of the new protocol. The sessions invited questions to clarify the roles and activities of each team member in the VE/P process.

3. Two joint training sessions on 805 investigations are currently planned for March 2016. They will each be approximately four hours long and will cover the filing requirements set forth in the law, peer review files, and an overview of a typical 805 investigation.

4. Increasing computer capabilities and compatibilities with HQES in order to share case information. In the VE/P model, it is imperative that investigators and attorneys be able to share case information. However, the agencies involved in the VE/P process have their own separate computer systems that do not communicate with each other. In furtherance of the legislative requirements contained in Gov. Code Section 12529.6(e)(1), the HQES contracted with a publicly traded company to provide a secure cloud-based content sharing solution, which facilitates real-time sharing of confidential evidentiary material between investigators in HQIU and DAGs in HQES, as well as permitting client oversight by the Medical Board's executive director and her staff. The security and functionality of the service was first vetted by the Attorney General's Department of Criminal Justice Information Services. This program (and the procedures to utilize it) are in the process of being developed.

Recommendations

The recommendations listed below are those offered by the Board. The Department of Justice and the Department of Consumer Affairs are encouraged to separately bring to the Legislature whatever additional recommendations they might have regarding VE/P.

1. Govt. Code Section 12529.6(b) (Appendix B) requires that the investigator assigned to a case shall, "under the direction but not the supervision of the deputy attorney general," be responsible for obtaining evidence in the matter. The Board recognizes that this provision may interfere with the investigators and attorneys being a true team and recommends that a mechanism be found to more fully utilize the expertise brought to the team by both the investigator and the DAG.

2. VE/P does not apply to cases handled in-house by the Board's non-sworn staff. There are times when Board staff would benefit from being able to consult with HQES while processing those matters. Therefore, the Board recommends that Gov. Code Section 12529.6(b) be modified to clearly permit the Board's staff, at its discretion, to consult with HQES on cases handled by its non-sworn staff.

3. Delete the reference to the Board contained in Government Code Section 12529.6(e) to reflect the transition of investigators from the Board to DCA.

4. DCA and HQES should utilize the new joint manual and develop additional strategies and procedures to assist investigators and attorneys to further improve the VE/P model.

Appendix A

Investigation Time Frames - Median Days

The table below excludes the following case types: out-of-state, headquarters, Operation Safe Medicine, probation violations, petitions for modification/termination of probation terms, and petitions for reinstatement. It also excludes all cases that were referred solely to the District/City Attorney for criminal action as they are not in VE/P.

	04/05		05/06		06/07		07/08		08/09		09/10		10/11		11/12		12/13		13/14		14/15	
	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
All Investigation Closures	271	1,204	290	1,062	301	941	339	961	353	847	360	1,003	327	1,089	263	1,132	272	1,164	312	1,114	331	944
Closed - No Further Action	243	860	271	749	301	645	318	701	335	568	324	635	298	701	236	749	243	789	277	754	287	604
Referred for Disciplinary Action	347	344	351	313	346	296	408	260	406	279	412	368	403	388	331	383	349	375	401	360	419	340
Accusations	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Accusation Filed	538	164	485	166	516	171	539	173	562	154	581	206	592	198	502	232	481	217	505	220	532	233
From Investigation Completed to Accusation Filed	100		111		99		78		80		79		89		92		84		92		81	
Suspension/Restriction Orders	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Suspension/Restriction Order Issued	217	30	239	28	209	26	370	20	294	25	180	18	377	27	180	31	309	26	348	36	232	27
Stipulated Agreements	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Stipulation Received	755	156	999	141	822	143	888	145	815	118	877	135	888	120	917	160	824	165	898	168	900	179
From Investigation Completed to Stipulation Received	478		551		458		414		342		364		420		414		414		436		487	
Proposed Decisions	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Proposed Decision Submitted to ALJ or Received	1,006	42	1,114	30	833	37	1,123	39	1,146	33	817	27	899	37	1,104	38	917	34	945	27	1031	34
From Investigation Completed to Proposed Decision Submitted to ALJ or Received	648		639		513		746		621		352		420		505		515		577		582	
Default Decisions	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#	Median	#
From Investigation Initiated to Default Decision Received	370	12	539	7	692	11	629	8	681	12	758	7	654	11	660	8	683	16	886	10	667	8
From Investigation Completed to Default Decision Received	211		185		237		296		282		269		175		190		247		672		217	

Appendix B

California Government Code Section 12529.6

12529.6. (a) The Legislature finds and declares that the Medical Board of California, by ensuring the quality and safety of medical care, performs one of the most critical functions of state government. Because of the critical importance of the board's public health and safety function, the complexity of cases involving alleged misconduct by physicians and surgeons, and the evidentiary burden in the board's disciplinary cases, the Legislature finds and declares that using a vertical enforcement and prosecution model for those investigations is in the best interests of the people of California.

(b) Notwithstanding any other provision of law, as of January 1, 2006, each complaint that is referred to a district office of the board for investigation shall be simultaneously and jointly assigned to an investigator and to the deputy attorney general in the Health Quality Enforcement Section responsible for prosecuting the case if the investigation results in the filing of an accusation. The joint assignment of the investigator and the deputy attorney general shall exist for the duration of the disciplinary matter. During the assignment, the investigator so assigned shall, under the direction but not the supervision of the deputy attorney general, be responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action.

(c) The Medical Board of California, the Department of Consumer Affairs, and the Office of the Attorney General shall, if necessary, enter into an interagency agreement to implement this section.

(d) This section does not affect the requirements of Section 12529.5 as applied to the Medical Board of California where complaints that have not been assigned to a field office for investigation are concerned.

(e) It is the intent of the Legislature to enhance the vertical enforcement and prosecution model as set forth in subdivision (a).

The Medical Board of California shall do all of the following:

(1) Increase its computer capabilities and compatibilities with the Health Quality Enforcement Section in order to share case information.

(2) Establish and implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model.

(3) Establish and implement a plan to assist in team building between its enforcement staff and the staff of the Health Quality Enforcement Section in order to ensure a common and consistent knowledge base.