MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT 2016

A Report to the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee

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Forward

This report is organized according to the 12 subject categories (or sections) of questions provided in the sunset review survey document prepared by the Senate Committee on Business, Professions and Economic Development.

This report is written in narrative form so the questions are not included. Section 12, Attachment E contains a copy of the sunset review questions. In addition to providing the requested attachments in sections 12, supplementary attachments have also been included as specified throughout the report.

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Section 1

Background and Description of the Board and Regulated Profession

- History and Functions of the Board
- Board Composition
- Board Committees and Their Functions
- Board and Committee Meetings/Quorum Issues
- Major Changes to the Board Since the Last Sunset Review
- Legislation Sponsored by the Board and Affecting the Board Since the Last Sunset Review
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History and Functions of the Board

The Medical Board of California (Board) was the first board started for consumer protection (of those currently within the Department of Consumer Affairs (DCA)), and its history dates back to 1876 with the passage of the first Medical Practice Act. In 1901, the Medical Practice Act was completely rewritten and the former California Medical Society Board, the Eclectic Medical Society Board, and the Homeopathic Medical Society Board all became the Board of Examinations, with nine Members. The membership of the Board was increased to 11 in 1907, and, in 1913, a revolving fund was created to fund the Board's activities. From 1950 to 1976, the Board expanded its role beyond physician licensing[1] and discipline to oversee various allied health professionals, such as physical therapists, psychologists, etc.

In 1976, significant changes were made to the Medical Practice Act, which essentially created today's Board. It was also the year that the Medical Injury Compensation Reform Act (MICRA) was established. MICRA created a cap of $250,000 for general damages in malpractice suits and limited attorney contingency fees. In addition, the Board membership changed drastically. The previous 11 member Board only had one non-physician member. Board membership increased to 19 members with seven of those being public members. Other changes included allowing the Board to have its own enforcement team of trained peace officers who would investigate complaints. Another change that was a significant step toward consumer protection was the establishment of mandatory reporting of hospital discipline and malpractice awards.

In 1990, further enhancements for consumer protection were made by requiring coroner reporting of deaths that were a result of physician involvement, requiring county courts to report physicians who had felony convictions, and requiring licensing applicants to supply fingerprints. It was also the year it was determined that Board cases would be prosecuted by a specialized unit within the Attorney General's (AG) Office – Health Quality Enforcement Section (HQES); law also established a Medical Quality Hearing Panel within the Office of Administrative Hearings, requiring specially trained and experienced Administrative Law Judges (ALJ) to hear Board cases. Another improvement in consumer protection included the establishment of the Interim Suspension Order and the mandate to the Board that consumer protection was its highest priority.

The Division of Allied Health was eliminated in 1993 through legislation and its duties were assigned to the Division of Licensing. The Board was consolidated from three to two Divisions, the Division of Licensing and the Division of Medical Quality. The availability of more public information was also mandated, including information about California's (and other jurisdictions') disciplinary actions, malpractice judgments, specific hospital peer review discipline and criminal convictions. There was also the establishment of the "Public Letter of Reprimand" to be used by the Board as a tool for its enforcement activities.

The Board received regulatory authority over licensed midwives in 1994 and, although other allied health professions later developed their own regulatory boards, the Board continues to

[1] The B&P Code uses the term "Physician's and surgeon's certificate", however, this report will use the terms physician and license.

have jurisdiction over licensed midwives. In 1996, outpatient surgery settings were required to be accredited and the Board had to approve the accrediting agencies. This new requirement addressed the growing issue of surgery being performed without safeguards in settings outside of a hospital.

In 1997, a telemedicine law was signed that required California licensure if the physician was in another state, but was treating patients located in California. More improvements to public disclosure occurred in 1998, including a requirement for information to be posted on the Board's website. This provided immediate access to a physician's profile, thus increasing consumer protection. The statute of limitations law passed in 1999, limiting the time frame in which an accusation could be filed by the Board.

In 2000, several additional public protection laws were passed, including required reporting of specified outcomes in outpatient surgery settings, revising laws pertaining to misleading and deceptive advertising, and requiring pain management and end of life care to be added to medical school curriculum. In 2003, in order to assist with the need for physicians in underserved areas, the Board sponsored the physician loan repayment program, which allowed the repayment of student loans (to a specified amount) for physicians who were willing to serve three years in an underserved area. This program has continued since 2003, although changes have been made, including placing the program under the Office of Statewide Health Planning and Development (OSHPD). It continues to fulfill its purpose (through the Health Professions Education Foundation (HPEF) within OSHPD of placing physicians in underserved areas.

In 2004, a legislatively mandated Enforcement Monitor's report was released. This report was the result of an in-depth review of the Board's Enforcement and Diversion Programs. The report included recommendations on improvements for both of these programs. A Final Enforcement Monitor report was issued in 2005 and again contained recommendations. A significant number of these recommendations were placed into legislation, including the recommendation to require the Board to operate under a vertical prosecution model (now called vertical enforcement/prosecution model – VE/P). This model requires the AG's Office to be involved in the Board's investigation activities as well as its prosecution activities. In order to fund this model, physicians' initial license and renewal fees were increased; however, the ability to order cost recovery for the costs of investigating and prosecuting an administrative case was eliminated.

The Board underwent a structural change in 2008 with the elimination of the Division of Licensing and the Division of Medical Quality and the establishment of just one Board. The membership of the Board was reduced from 21 to 15. Also in 2008, the Board's Diversion Program was eliminated.

In 2014, the Board underwent a significant staffing change when legislation required the movement of its sworn investigators into a special unit within the Department of Consumer Affairs' Division of Investigation. This unit, entitled the Health Quality Investigation Unit (HQIU), is under the authority of the DCA, but continues to investigate cases related to physicians and other allied health providers within the Board. (See Major Changes to the Board Since the Last Sunset Review for more details regarding these changes.)

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Prior to 2016, registered contact lens dispensers, registered dispensing opticians, registered non-resident contact lens sellers, and registered spectacle lens dispensers were under the Board's jurisdiction with the Registered Dispensing Program. Effective January 1, 2016, the authority over those licensees was moved to the Board of Optometry. The Board had proposed this change in its 2012 Sunset Review Report due to confusion to the public and licensees by having the Program within the Medical Board rather than the Board of Optometry.

While the Board has undergone significant changes since 1876, one thing that remains constant is the Board's mission of consumer protection. The current mission statement of the Board 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*."

In order to meet the Board's mission, the Board has taken an active role in keeping pace with the ever changing medical profession and practice. The Board's meeting agendas and 2014 strategic plan indicate the importance of staying current in an ever evolving professional field.

Functions

As a consumer protection agency, the Board is comprised of programs whose functions, duties, and goals are to meet the mandate of consumer protection. The Board's **Licensing Program** ensures that only qualified applicants, pursuant to the requirements in the Board's laws and regulations, receive a license or registration to practice. The Licensing Program has a Cashiering Unit that provides cashiering and renewal/survey functions and a Consumer Information Unit that serves as a call center for all incoming calls to the Board. The Licensing Program also processes renewals for all licensees/registrants and performs all of the maintenance necessary for licensees to remain current, including auditing the continuing education requirements, updating the records for changes of name/address, etc. In addition, the Licensing Program reviews international medical schools, including performing site visits, to ensure the schools meet the requirements for recognition so applicants from those schools can obtain licensure in California.

Via the **Enforcement Program**, allegations of wrongdoing are investigated and disciplinary or administrative action is taken as appropriate. The Board has a Central Complaint Unit (CCU) that receives and triages all complaints. If it appears that a violation may have occurred, the complaint is either transferred to the DCA's HQIU, which is comprised of sworn peace officers, or to the Board's Complaint Investigation Office (CIO), which is comprised of non-sworn special investigators.

The investigators (sworn or non-sworn) investigate the complaint (in coordination with deputy attorneys general (DAG) if sworn) and, if warranted, refer the case for disciplinary action. The Board's Discipline Coordination Unit processes all disciplinary documents and monitors the cases while they are at the AG's Office. If a licensee/registrant is placed on probation, the Board's Probation Unit monitors the individual while he/she is on probation to ensure he/she is complying with the terms and conditions of probation. The Probation Unit is comprised of Inspectors who are located throughout the state, housed within 11 statewide offices. Having inspectors state-wide eliminates excess travel and enables probationers to have face-to-face meetings with the inspectors for monitoring purposes.

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The Board has its own **Information Systems Branch** (ISB) that performs information technology functions. The ISB ensures that the Board's computer systems are functioning and looks for areas where technological improvements can help streamline the Board's enforcement and licensing processes. This unit has made significant improvements to the Board's functionality (see Major Changes section below). Having an ISB unit allows the Board to have immediate access to trained staff when problems arise, ensures the Board maintains current hardware/software, assists staff in understanding and protecting against cyber security attacks, and allows the Board to make changes to its website within a very short period of time.

Although these programs are the Board's core functions, the Board also engages in a number of activities to educate physicians, applicants, and the public. The Board provides information to physicians, as well as applicants, regarding the Board's functions, laws, and regulations. This information is provided by attending outreach events, providing articles on topics of interest to physicians and the public in the Board's Newsletter, and attending licensing fairs and orientations at medical schools and teaching hospitals (more information on applicant outreach is provided in Section 8). The Board provides outreach to the public by participating in educational meetings/seminars on the Board's laws and regulations. In addition, information on public health, the Board's complaint/enforcement process, and Board meetings is available for all interested parties via the website or through the mail. (More information is provided in Section 6, Public Information Policies.)

Board's Jurisdiction – Professions/Occupations

Under the Medical Practice Act, the Board has jurisdiction over physicians licensed by the state. The Board also has authority over individuals who are not licensed by the Board, but meet a special licensure exemption pursuant to statute that allows them to perform duties in certain settings. These are called special program registrants/organizations and special faculty permits. (More information is provided in Section 4, Licensing Program.)

In addition to the Board having authority over physicians, the Board also has statutory and regulatory authority over licensed midwives, medical assistants, registered polysomnographic trainees, registered polysomnographic technicians, registered polysomnographic technologists, research psychoanalysts, and student research psychoanalysts (for more information on each license/registration, see the appropriate section of this report).

The Board approves accreditation agencies that accredit outpatient surgery settings and issues Fictitious Name Permits to physicians practicing under a name other than their own. The Board also is required, pursuant to Business and Professions (B&P) Code section 651, to review and approve specialty boards who are not approved by the American Board of Medical Specialties (ABMS) but believe they have equivalent requirements. Pursuant to this section, a physician may not advertise that he/she is board certified unless he/she holds a board certification with a specialty board approved by the ABMS, a specialty board with an Accreditation Council for Graduate Medical Education (ACGME) accredited post graduate training program, or a specialty board with equivalent requirements approved by the Board. Therefore, the Board must review and either approve or disapprove these specialty boards based upon their equivalency.

The Board, with a few exceptions, does not have jurisdiction over facilities, business practices, reimbursement rates, or civil malpractice matters.

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Board Composition

Pursuant to B&P Code section 2001, the Board is comprised of fifteen (15) Board members, eight (8) physician members and seven (7) public members. The Governor appoints thirteen (13) members and two (2) are appointed by the Legislature (Senate Rules Committee and the Speaker of the Assembly). B&P Code section 2007 also requires that four of the physician members hold faculty appointments in a clinical department of an approved medical school in the state, but no more than four members of the board may hold full-time appointments to the faculties of such medical schools. See Section 12, Attachment F for the charts identifying the Board members' attendance at the Board's quarterly meetings.

Table 1b. Board Member Roster

Member Name (Include Vacancies)	Date First Appointed	Date Re-appointed	Date Term Expires	Appointing Authority	Type (public or professional)
Michelle Bholat, M.D.	02/25/15		06/01/18	Governor	Physician*
Michael Bishop, M.D.	12/21/11	07/09/13	06/01/17	Governor	Physician*
Judge Katherine Feinstein, J.D. (ret.)	01/13/16	06/02/16	06/01/20	Governor	Public
Dev Gnanadev, M.D.	12/21/11	06/02/15	06/01/19	Governor	Physician
Randy Hawkins, M.D.	03/02/15	06/02/16	06/01/20	Governor	Physician
Howard Krauss, M.D.	08/14/13		06/01/17	Governor	Physician*
Kristina Lawson, J.D.	10/26/15		06/01/18	Governor	Public
Sharon Levine, M.D.	02/11/09	07/29/11 06/02/15	06/01/19	Governor	Physician
Ronald Lewis, M.D.	08/14/13		06/01/17	Governor	Physician
Denise Pines	08/29/12	06/02/16	06/01/20	Governor	Public
Brenda Sutton-Wills, J.D.	04/06/16		06/01/19	Senate Rules Committee	Public
David Warmoth	02/29/16		06/01/19	Speaker of the Assembly	Public
Jamie Wright, J.D.	08/20/13	06/04/14	06/01/18	Governor	Public
Felix Yip, M.D.	0January 30, 2013	06/04/14	06/01/18	Governor	Physician*
Vacant			06/01/20	Governor	Public

Board Committees and Their Functions

The Board has six standing committees, five two-member task forces/committees, two panels, and one council that assist with the work of the Board. Two of the Board's committees, the two panels, and the council are statutorily mandated, while others are established by the Board to meet a specific need. Pursuant to the Board's strategic plan, the Board must convene every other year to discuss the purpose of each committee and re-evaluate the need for the

committees/subcommittees/task forces created by the Board. The Board conducted this review at its October 2014 and 2016 meetings; the following is a list of the Board's current committees and the purpose of each committee. More information, including committee membership can be found under Section 12, Attachment B and Attachment G.

Executive Committee (non-statutory)
This committee's purpose is to oversee various administrative functions of the Board, such as budgets and personnel, the strategic plan, and the review of legislation. The Executive Committee provides recommendations to the full Board, annually evaluates the performance of the executive director, and acts for the Board in emergency circumstances (as determined by the chair, and as allowed by law) when the full Board cannot be convened.

Licensing Committee (non-statutory)
This committee's purpose is to serve as an expert resource and advisory body to members of the Board and its Licensing Program by educating Board members and the public on the licensing process. It also serves to identify program improvements and review licensing regulations, policies, and procedures. The committee provides recommendations to the full Board.

Enforcement Committee (non-statutory)
This committee's purpose is to serve as an expert resource and advisory body to members of the Board and its Enforcement Program by educating Board members and the public on enforcement processes. It also serves to identify program improvements in order to enhance protection of healthcare consumers and review enforcement regulations, policies and procedures, and the Board's VE/P Model. The committee provides recommendations to the full Board.

Public Outreach, Education and Wellness Committee (non-statutory)
This committee's purpose is to develop various informational materials on issues the Board deems important for publication and Internet posting; develop and monitor the Board's outreach plan; monitor the Board's strategic communication plan; develop physician wellness information by identifying available activities and resources that renew and balance a physician's personal and professional life.

Application Review and Special Programs Committee (Statutory Committee – B&P Code sections 2099, 2072-2073, 2111-2113, 2115, 2135.5 and Title 16, California Code of Regulations (CCR), section 1301)
The purpose of this committee is to evaluate the credentials of certain licensure applicants regarding eligibility for licensure (for example, postgraduate training hardship petitions per 16 California Code of Regulations section 1321(d) and written licensing exam waiver requests per B&P Code section 2113). The committee also provides guidance, recommendations and expertise regarding special program laws and regulations, specific applications, medical school site visits, and issues of concern. The committee makes recommendations to the chief of licensing. See Section 12, Attachment H for specific sections of law.

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Special Faculty Permit Review Committee (Statutory Committee – B&P Code section 2168.1(c))
The purpose of this committee is to evaluate the credentials of applicants proposed by a California medical school to meet the requirements of B&P Code section 2168.1. The committee must determine whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need. The committee submits a recommendation to the Board for each proposed candidate for final approval or denial. See Section 12, Attachment I for specific sections of law.

Midwifery Advisory Council (Statutory Council – B&P Code section 2509)
This council's purpose is to develop solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including challenge mechanisms, midwife assistants, and examinations, as specified by the Board. This council makes recommendations to the full Board. See Section 12, Attachment J for specific sections of law.

Panel A (Statutory Committee – B&P Code section 2008)
The purpose of this panel is to carry out disciplinary actions as stated in B&P Code section 2004(c). See Section 12, Attachment K for specific sections of law.

Panel B (Statutory Committee – B&P Code section 2008)
The purpose of this panel is to carry out disciplinary actions as stated in B&P Code section 2004(c). See Section 12, Attachment K for specific sections of law.

Task Forces/Committees
The Board has five two-person task forces/committees that the president appoints as the need arises.

Editorial Committee
This committee reviews the Board's *Newsletter* articles to ensure they are appropriate for publication and provides any necessary edits to the articles.

Marijuana Task Force
This task force reviews and updates the Board's guidelines pertaining to the recommendation of marijuana for medicinal purposes, identifies best practices, and performs communication and outreach by engaging all stakeholders in the endeavor.

Midwifery Task Force
This task force reviews the current laws and regulations pertaining to license midwives and acts as a liaison with the Midwifery Advisory Council on issues that may come before the Board.

Prescribing Task Force
This task force identifies ways to proactively approach and find solutions to the epidemic of prescription drug misuse, abuse, and overdoses, as well as inappropriate prescribing of prescription drugs, through education, prevention, best practices, communication and outreach by engaging all stakeholders in the endeavor.

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Sunset Review Task Force
This task force meets with the Board's executive director and deputy director to review sunset review questions and responses.

Board and Committee Meetings/Quorum Issues

The Board, since 2013, has not had any meetings that had to be canceled due to a lack of a quorum.

The Board establishes its meetings for the following full year at its April/May meeting. This allows the Members to review their calendars and determine if the proposed dates work for them in the following year. In addition, it provides the Board staff with enough time to secure meeting space. The full Board holds quarterly meetings throughout the state. These meetings are usually during the months of January/February, April/May, July, and October/November. Board meeting are held statewide to allow for public and physician participation in areas all over the state. The Board holds its quarterly meetings in the Los Angeles, San Francisco, San Diego, and Sacramento areas. The ability to have the public and physicians in these areas attend meetings far outweighs the cost to hold these meetings statewide.

The committees of the Board meet on an as-needed basis and may meet off-cycle of the quarterly Board meetings. This allows for all interested parties to weigh in on the issues, for the committee members to have an expanded discussion, and for a decision to be made, if needed. That issue then moves forward in the form of a recommendation to the full Board at its next meeting.

Major Changes to the Board Since the Last Sunset Review

Reorganization
The most significant reorganization was the transfer of the Board's investigators (sworn peace officers), medical consultants, and investigative support staff to the DCA, Division of Investigation. Those positions were transferred pursuant to Senate Bill (SB) 304 (Price, Chapter 515, Statutes of 2013), effective July 1, 2014, to a new unit within DCA entitled the Health Quality Investigation Unit (HQIU). Although the bill required the transition of the investigative staff to DCA, the Board's Enforcement Program consisting of the Central Complaint Unit, Complaint Investigation Office, Discipline Coordination Unit, and Probation Unit remained under the purview and authority of the Board. This change requires that all complaints that need to be investigated by a sworn investigator are now transmitted to the HQIU for investigation outside of the Board's auspices. The Board worked with DCA to ensure a smooth transition of staff and also established a Memorandum of Understanding identifying the roles and functions of the Board and the HQIU.

The transfer of these positions required the Board to establish a new Chief of Enforcement (non-sworn) position at the Board to review all of the investigation closures of the HQIU to ensure the Board was in agreement with the disposition. The Board's Chief of Enforcement recently worked with the AG's Office and the HQIU management to establish case closure procedures that have assisted in this process. The Board also had to revise its regulations pertaining to citation and fine procedures, as the prior regulations listed positions that were

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transferred to the HQIU as having the authority to issue citations and fines.
Since the transition, the Board has not seen a change in the investigation process, however, the retention and recruitment of investigators has been an issue since this movement. The HQIU has a high vacancy rate, which has led to an increase in the time it takes to investigate the Board's complaints. The Board works with the DCA leadership to mitigate this vacancy rate. The HQIU recently hired limited-term special investigators (non-sworn) to assist with the less complex investigations in an effort to improve the investigation time frames.

In July 2014, the Board also established a new Complaint Investigation Office (CIO) made up of special investigators (non-sworn) who began working the less complex investigations for the Board. This unit comprised of six Special Investigators (non-sworn) and a Supervising Special Investigator I, is tasked with investigating quality of care investigations following a medical malpractice settlement or judgment, cases against physicians charged with or convicted of a criminal offense, and physicians petitioning for reinstatement of a license following revocation or surrender of his or her license. The establishment of the CIO has assisted in reducing the case load of the HQIU investigators, in addition to resulting in quicker resolution of these cases.

Finally, in January 2016, pursuant to Assembly Bill (AB) 684 (Alejo, Chapter 405, Statutes of 2015), the Registered Dispensing Optician Program (Program) and the registrations within that Program were moved under the authority of the Board of Optometry. The Board of Optometry took over the registration process for registered dispensing opticians, spectacle lens dispensers, contact lens dispensers, and nonresident contact lens sellers. In addition, the Board of Optometry also began receiving and investigating all complaints involving these registration types. Significant discussion had taken place previously regarding the relationship between this Program and the Board of Optometry. Both the Board and the Board of Optometry had brought this issue forward in their 2012 Sunset Review Reports. Because of the scope of the services performed by the registrants in this Program, the Board of Optometry received numerous calls from the public regarding the registrants of this Program. These calls would then have to be transferred to the Medical Board for action. This resulted in frustration on behalf of the public. In addition, several enforcement actions required collaboration between the Board and the Board of Optometry, which required two different investigators to work on the investigation. Due to these issues and other changes that were to become effective with AB 684, the determination was made to move this Program to the Board of Optometry. The Medical Board worked with the Board of Optometry to transfer all files and staff resulting in a smooth transition.

Change in Leadership

In February 2014, Kimberly Kirchmeyer was appointed as Executive Director of the Board, following her appointment as Interim Executive Director in June 2013. Ms. Kirchmeyer was previously the Board's Deputy Director and was the manager in several programs of the Board including the Discipline Coordination Unit, Central Complaint Unit, and Business Services Office.

In July 2016, Dev GnanaDev, M.D., became president of the Board. David Serrano Sewell held that position previously for two years. Mr. Seranno Sewell made public outreach and increased awareness of the Board a major goal, as well as increasing the use of Interim

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Suspension Orders and proactive enforcement. Dr. GnanaDev will continue to make these items a high priority for the Board.

Strategic Planning

In 2014, the Board went through the strategic planning process and adopted a new Strategic Plan at its May 2014 meeting. The Board receives updates on the progress of the Strategic Plan at the full Board, Executive Committee, and the Public Outreach, Education, and Wellness Committee meetings. (See Section 12, Attachment L for the 2014 Strategic Plan.) The Board will begin the process for a new strategic plan in 2017.

Other Improvements

In the last four years, the Board has made the elimination of opioid misuse and abuse one of its main focal areas for improvement. The Board has a significant role in this issue and took a very proactive approach to addressing this matter. The Board developed a Prescribing Task Force that held multiple meetings to identify best practices, hear from speakers regarding this issue, and update the Board's *Guidelines for Prescribing Controlled Substances for Pain*. This task force had numerous meetings with interested parties and discussions with experts in the field of pain management to develop this document, which was adopted by the Board in November 2014. These Guidelines are intended to educate physicians on effective pain management 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. The new Guidelines contain a significant amount of information and are supplemented with as many resources as practical via the appendices and links to websites that further assist a physician when prescribing controlled substances for pain. It discusses several areas, including understanding pain, special patient populations, patient evaluation and risk stratification, consultation, treatment plan and objectives, patient consent, pain management agreements, counseling patient on overdose risk and response, initiating an opioid trial, ongoing patient assessment, and several other areas.

The Board also developed two public service announcements (PSA) specific to the opioid overdose prevention issue. One PSA was specific to physicians and provided education on appropriately prescribing controlled substances to patients. The second PSA was intended for the public and featured Olympic swimmer and gold medalist Natalie Coughlin. This video was designed to alert consumers to the dangers of abusing prescription drugs. These PSAs have been used to provide information and guidance to the public and physicians on this important topic. They are available on the Board's website.

The Board also established, for a limited time, a group of investigators called Operation Rx Strike Force focused solely on investigating the most serious overprescribing cases. The strike force performed numerous search warrants, filed a number of actions, and arrested multiple physicians.

In September 2014, the Board hosted a free continuing medical education (CME) course in Los Angeles on Extended-Release and Long-Acting Opioid Analgesics Risk Evaluation and Mitigation Strategy (ER/LA Analgesics REMS) that was developed by the U.S. Food and Drug Administration. The course was well attended and physicians were able to obtain three CME credits for the three-hour course.

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In an effort to be proactive, and after the veto of a bill intended to require coroners to report opioid overdose deaths to the Board, the Board established a data use agreement with the California Department of Public Health (CDPH) to receive death certificates when the death was related to opioids. The Board was then able to use CURES to identify physicians who may be inappropriately prescribing controlled substances. In addition, the Board began to use the CURES system to identify physicians who may be inappropriately prescribing. The Board also requested information from pharmaceutical companies who had identified physicians who may have inappropriate prescribing issues. All these steps have assisted the Board in identifying physicians who may be inappropriately prescribing in an effort to eliminate opioid overdose deaths.

The Board also established an Outpatient Surgery Setting (OSS) Task Force in 2013 to review the Board's existing OSS Program and laws to explore ways to improve consumer protection. This Task Force held several meetings to obtain stakeholder feedback on the Board's proposed statutory changes that would increase consumer protection. Based upon the input from this Task Force, the Board sought legislation that would require adverse event reports occurring at these facilities to be sent to the Board, not the CDPH. The Board now receives these reports and is able to not only evaluate the facility, but also look into the care provided by the physician. The Board also recommended legislation that would require all physicians within the OSS to have peer review, would require a shorter time frame for the initial accreditation, and would require the OSS to check for peer review information for all physicians working within the facility.

In addition, the Board made significant improvements to the OSS database and website to make it more consumer friendly. The public can now go the Board's website and search for an OSS. The information contained on the database includes the owners of the facility, the types of services being performed, the status of the facility with the accreditation agency, and provides copies of the documents pertaining to an inspection of the OSS and any corrective action plans and follow-up inspections.

The Board has made significant changes to encourage consumer participation at its quarterly Board and committee meetings. Beginning in May 2014 the Board began allowing the public to listen and comment at its meetings via the telephone. The public is allowed to make comments and provide input on all agenda items. Consumers have successfully participated in Board and committee meetings by telephone since this change was implemented. This allows individuals who cannot travel to the Board's meetings to be able to provide input and comment to the Board.

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

The Board completely revamped its home webpage to make it more user-friendly and to further the Board's outreach campaign (see Section 6 for more information on the Board's campaign), which encourages patients to "Check Up on Your Doctor's License." The changes

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include easy access to the Board's license verification page, the page to file a complaint, and the page to find public enforcement documents all right from the Board's home page. The Board also made its license verification webpage more user-friendly and provided a document that outlines what the information provided on a physician's profile means.

Legislation Sponsored by the Board and Affecting the Board Since the Last Sunset Review

2013

- *AB 635 (Ammiano, Chapter 707) Drug Overdose Treatment: Liability*

This bill allowed health care providers to prescribe, dispense, and issue standing orders for an opioid antagonist to persons at risk of overdose, or their family member, friend, or other person in a position to assist persons at risk, without making them professionally, civilly or criminally liable, if acting within reasonable care. It also extended this same liability protection to individuals assisting in dispensing, distributing, or administering the opioid antagonist during an overdose. This bill required a person who is prescribed or possesses an opioid antagonist pursuant to a standing order to receive training provided by an opioid overdose prevention and treatment training program.

- *AB 1308 (Bonilla, Chapter 665) Midwifery*

This bill removed the physician supervision requirement for licensed midwives (LMs) and required LMs to only accept clients that meet the criteria for normal pregnancy and childbirth, as specified in this bill. If a potential client does not meet the criteria for normal pregnancy and childbirth, then the LM can 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. This bill allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the LMs' scope of practice. This bill required LMs to provide records and speak to the receiving physician if the client is transferred to a hospital. This bill required the hospital to report each transfer of a planned out-of-hospital birth to the Board and the California Maternal Quality Care Collaborative, using a form developed by the Board. This bill required all LMs to complete midwifery education programs and does not allow new licensees to substitute clinical experience for formal didactic education beginning January 1, 2015. This bill allowed the Board, with input from the Midwifery Advisory Council (MAC), to look at the data elements required to be reported by LMs, to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA). Lastly, this bill allowed LMs to attend births in alternative birth centers (ABCs) and changed the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

- *SB 304 (Lieu, Chapter 515) Healing Arts: Sunset Bill*

This was the Board's sunset bill, which included language on a portion of the new issues from the Board's 2012 Sunset Review Report, and did the following: amended law to accommodate two parts of the USMLE Step 3 examination; required licensees who have an email address to provide the Board with an email address by July 1, 2014, specified that the email address is confidential and not subject to public disclosure, and required the Board to send out a

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confirmation email to all physicians on an annual basis to ensure the Board has the correct email address for each physician; clarified that the corporate practice laws do not apply to physicians enrolled in an approved residency postgraduate training program or fellowship program; excluded 801.01 reports from upfront review by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint prior to referral to investigation; required health care facilities that have electronic health records to provide the authorizing patient's certified medical records to the Board within 15 days of receiving the request and subjected the health care facility to penalties if the facility does not adhere to the timeline; extended the timeframe in which an accusation must be filed once an interim suspension order is filed from 15 days to 30 days; for purposes of the Midwifery Practice Act, defined a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three-year postsecondary midwifery education program approved by the Board; allowed a CNM to supervise a midwifery student; specified that a physician and surgeon licensee's failure to comply with an order to compel a physical or mental examination constitutes grounds for issuance of an interim suspension order; and deleted the sunset date in the vertical enforcement statutes, making vertical enforcement permanent. Most importantly, this bill extended the Board's sunset date for four years until July 1, 2018.

This bill required the DCA director to approve the Board's selection of an Executive Director, if hired after January 1, 2014. This bill also amended existing law regarding international medical graduates who have attended a disapproved school. Existing law passed in 2012 required these individuals to have practiced in another state, federal territory, or Canadian province for 20 years. This bill changed the practice requirement to 12 years.

This bill also transferred all investigators and medical consultants employed by the Board and their support staff to the Department of Consumer Affairs' (DCA) Division of Investigation (DOI). This bill specified that the transfer shall occur by July 1, 2014.

- *SB 670 (Steinberg, Chapter 399) Physicians and Surgeons: Investigations*

This bill authorized the Board to inspect the medical records of a patient who is deceased without the consent of the patient's next of kin or a court order in any case that involves the death of a patient with certain conditions. This bill also revised the definition of unprofessional conduct to include repeated failure of a licensee, in the absence of good cause, to attend and participate in an interview by the Board if he or she is under investigation.

- *SB 809 (DeSaulnier, Chapter 400) Controlled Substances: Reporting: CURES*

This bill made findings and declarations regarding the Controlled Substance Utilization Review and Evaluation System (CURES) and established the Fund that would be administered by the Department of Justice (DOJ), which would consist of funds collected from boards that license prescribers and dispensers, for purposes of funding and upgrading the CURES system. The funds come from an increase to the renewal fee for each licensee by $6 per year, or $12 for each 2-year renewal cycle, effective April 1, 2014.

This bill required DOJ, DCA and the regulatory boards to identify and implement a streamlined application and approval process to provide access to CURES, and to make efforts to incorporate the CURES application at the time of license application or renewal. DOJ, DCA

and the regulatory boards were required to identify necessary procedures to enable prescribers and dispensers to delegate their authority to order CURES reports and develop a procedure to enable health care practitioners, who do not have a federal Drug Enforcement Administration (DEA) number, to opt out of applying for access to CURES.

This bill required the Board to periodically develop and disseminate information and educational materials related to assessing a patient's risk of abusing or diverting controlled substance and information on CURES to each licensed physician and general acute care hospital. This bill required prescribers and dispensers, before January 1, 2016, or upon receipt of a federal DEA number, to submit an application to DOJ to obtain approval to access information online regarding the controlled substance history of a patient from CURES.

2014

- *AB 809 (Logue, Chapter 404) Healing Arts: Telehealth*

This bill revised the informed consent requirements relating to the delivery of health care via telehealth by permitting consent to be made verbally or in writing, and by deleting the requirement that the health care provider who obtains the consent be at the originating site where the patient is physically located. This act was an urgency statute, which means it took effect immediately upon being signed into law.

- *AB 1535 (Bloom, Chapter 326) Pharmacists: Naloxone Hydrochloride*

This bill allowed pharmacists to furnish naloxone hydrochloride in accordance with standardized procedures or protocols developed and approved by the Board of Pharmacy (BOP) and the Board, in consultation with the California Society of Addiction Medicine, the California Pharmacists Association, and other appropriate entities. This bill specified that a pharmacist furnishing naloxone hydrochloride shall not permit the person to whom the drug is being furnished to waive the consultation required by the Board and the BOP. This bill required a pharmacist to complete a training program on the use of opioid antagonists that consists of at least one hour of approved continuing education on the use of naloxone hydrochloride, before furnishing naloxone hydrochloride. This bill allowed the BOP to adopt emergency regulations to establish the standardized procedures or protocols that would remain in effect until the final standardized procedures or protocols are developed.

- *AB 1838 (Bonilla, Chapter 143) Accelerated Medical School Programs –Board Co-Sponsored*

This bill allowed graduates of accelerated and competency-based medical school programs to be eligible for licensure in California, if the program is accredited by the Liaison Committee on Medical Education, the Committee on Accreditation of Canadian Medical Schools, or the Commission on Osteopathic College Accreditation.

- *AB 1886 (Eggman, Chapter 285) Medical Board Internet Posting: 10-Year Restriction – Board-Sponsored*

Public disciplinary information for currently and formerly licensed physicians used to only be allowed to be posted on the Board's website for 10 years. This bill changed the law to allow the Board to post the most serious disciplinary information on the Board's website for as long as it remains public, which for most actions is indefinitely. This bill changed the Board's less serious disciplinary website posting requirements, as follows: required malpractice settlement

information to be posted over a 5-year period, instead of a 10-year period (the posting would be in the same manner as specified in BPC Section 803.1); still required public letters of reprimand to be posted for 10 years; and required citations to be posted that have not been resolved or appealed within 30 days, and once the citation has been resolved, to only be posted for 3 years, instead of 5 years.

- *SB 1116 (Torres, Chapter 439) Physicians and Surgeons: STLRP*

This bill required the Board, by July 1, 2015, to develop a mechanism for physicians to pay a voluntary contribution, at the time of application for initial license or renewal, to the Steven M. Thompson Loan Repayment Program (STLRP).

- *SB 1466 (Sen. B&P Comm., Chapter 316) Omnibus – Board Co-Sponsored*

The Board's omnibus language included making the American Osteopathic Association-Healthcare Facilities Accreditation Program an approved accreditation agency for hospitals offering accredited postgraduate training programs. This bill also struck the word "scheduled" from existing law that requires physicians who perform a "scheduled" medical procedure outside of a hospital, that results in a death, to report the occurrence to the Board within 15 days.

2015

- *AB 679 (Allen, Chapter 778) Controlled Substances: CURES*

This bill amended existing law that required all health care practitioners that are authorized to prescribe, order, administer, furnish or dispense Schedules II, III, or IV controlled substances and pharmacists to be registered with CURES by extending the registration date from January 1, 2016, to July 1, 2016.

- *AB 684 (Alejo, Chapter 405) State Board of Optometry: RDO Program*

This bill authorized the establishment of landlord-tenant leasing relationships between a Registered Dispensing Optician (RDO), optometrist, and an optical company, as specified. This bill transferred the RDO Program from the Board to the California State Board of Optometry (CBO). This bill replaced one optometrist Board Member on the CBO with an RDO Board Member and established an RDO Advisory Committee in the CBO. Lastly, this bill established a three-year transition period for companies that directly employ optometrists to transition to leasing arrangements.

- *ABX2 15 (Eggman, Chapter 1) End of Life Option Act*

This bill established the End of Life Option Act (Act) in California, which became effective 90 days after the special session on healthcare financing ended (June 9, 2016) and remains in effect until January 1, 2026. This Act gives a mentally competent, adult California resident who has a terminal disease the legal right to ask for and receive a prescription from his or her physician to hasten death, as long as required criteria are met. This bill allowed the Board to update the attending physician checklist and compliance form, the consulting physician compliance form, and the attending physician follow up form, all required by this bill, when necessary. This bill included the actual forms to be used, until and unless they are updated by the Board.

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- *SB 277 (Pan and Allen, Chapter 35) Public Health: Vaccinations*

This bill deleted the personal belief exemption from the existing immunization requirements. This bill specified that if the California Department of Public Health adds an immunization to the list in the future, that personal belief exemptions would be allowed for that additional immunization. This bill exempted a child in a home-based private school or a pupil who is enrolled in independent study from the immunization requirements. This bill allowed a child who has submitted a personal belief exemption prior to January 1, 2016, to continue to attend school or daycare under the personal belief exemption until enrollment in the next grade span. This bill defined grade span as birth to preschool, kindergarten to grade 6, and grades 7 to 12. Lastly, this bill specified that when issuing a medical exemption, a physician must consider the family medical history of the child.

- *SB 396 (Hill, Chapter 287) Outpatient Settings and Surgical Clinics*

This bill required peer review evaluations for physicians and surgeons working in accredited outpatient settings. This bill allowed accredited outpatient setting facility inspections performed by Accreditation Agencies (AAs) be unannounced (after the initial inspection). For unannounced inspections, AAs must provide at least a 60-day window to the outpatient setting. The bill allowed an accredited outpatient setting and a "Medicare certified ambulatory surgical center" (i.e. ASC) to access 805 reports from the Board when credentialing, granting or renewing staff privileges for providers at that facility. This bill also delayed the report from the Board on the vertical enforcement and prosecution model from March 1, 2015, to March 1, 2016.

- *SB 408 (Morrell, Chapter 280) Midwife Assistants – Board-Sponsored*

This bill required midwife assistants to meet minimum training requirements and set forth the duties that a midwife assistant could perform, which are technical support services only. This bill allowed the Board to adopt regulations and standards for any additional midwife technical support services.

- *SB 643 (McGuire, Chapter 719) Medical Marijuana*

This bill added cases that allege a physician has recommended cannabis to patients for medical purposes without a good faith prior examination and medical reason therefor to the Board's priorities. This bill created a new section in law related to recommending medical cannabis, which states that physicians recommending cannabis to a patient for a medical purpose without an appropriate prior examination and a medical indication, constitutes unprofessional conduct. This bill prohibited a physician from recommending cannabis to a patient unless that physician is the patient's attending physician, as defined. This bill subjected physicians recommending cannabis to the definition of "financial interest" in existing law and did not allow a physician to accept, solicit, or offer any form of remuneration from or to a licensed dispenser, producer, or processor of cannabis products in which the licensee or his or her immediate family has a financial interest. This bill did not allow a cannabis clinic or dispensary to directly or indirectly employ physicians to provide marijuana recommendations, a violation would constitute unprofessional conduct. This bill did not allow a person to distribute any form of advertising for physician recommendations for medical cannabis unless the advertisement contains a notice to consumers, as specified. This bill required the Board to consult with the California Marijuana Research Program on developing and adopting medical guidelines for the appropriate administration and use of cannabis. This bill specified that a

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violation of the new section of law regulating medical cannabis recommendations is a misdemeanor and punishable by up to one year and county jail and a fine of up to five thousand dollars or by civil penalties of up to five thousand dollars and shall constitute unprofessional conduct.

- *SB 800 (Sen. B&P Comm., Chapter 426) Omnibus – Board Co-Sponsored*

The Board's omnibus language included a clarification that registration is required to practice as a polysomnographic technologist, technician, or trainee in California. This bill also made other technical, clarifying changes to fix an incorrect code section reference in existing law, deleted an outdated section of statute related to a pilot project that no longer exists, and clarified that a licensee cannot call themselves "doctor," "physician," "Dr.," or "M.D.," if their license to practice medicine has been suspended or revoked.

2016

- *AB 2024 (Wood, Chapter 496) Critical Access Hospitals: Employment*

This bill authorized, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. It specified a CAH can only employ physicians if the medical staff concurs by an affirmative vote that employing physicians is in the best interest of the communities served by the CAH and if the CAH does not interfere with, control, or otherwise direct the professional judgement of a physician. This bill required 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 employing physicians and their ability to recruit and retain physicians between January 1, 2017 and January 1, 2023, inclusive. This bill required the CAH's to also submit reports to OSHPD on an annual basis.

- *AB 2744 (Gordon, Chapter 360) Healing Arts: Referrals*

This bill specified 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.

- *AB 2745 (Holden, Chapter 303) Healing Arts: Licensing and Certification*

This Board-sponsored bill made clarifying changes to existing law to assist the Board in its licensing and enforcement functions. The bill clarified the Board's authority for the allied health licensees licensed by the Board. It allowed the Board to revoke or deny a license for registered sex offenders, allowed the Board to take disciplinary action for excessive use of drugs or alcohol, allowed allied health licensees to petition the Board for license reinstatement, and allowed the Board to use probation as a disciplinary option for allied health licensees.

This bill allowed all physician and surgeon licensees to apply for a limited practice license (LPL) LPL at any time. This bill ensured that physicians who have a disabled status license and want to change to a LPL have to meet the same requirements in existing law for a LPL. This bill also clarified 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 clarified existing law related to investigations of a deceased patient. Existing law allowed 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 required the Board to contact the physician

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that owns the records, however, in many cases the records do not reside with the physician. This bill allowed the Board to send a written request for medical records to the facility where the care occurred or where the records are located.

- *SB 482 (Lara, Chapter 708) Controlled Substances: CURES Database*

This bill required a health care practitioner that is authorized to prescribe, order, administer or furnish a controlled substance to 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, under specified conditions.

- *SB 1174 (McGuire, Chapter 840) Foster Children: Prescribing Patterns: Psychotropic Medications*

This bill added repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason to the Board's priorities. This bill required 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 foster children. This bill sunsets after 10 years and requires the Board to do an internal review in five years to consider the efficacy of the data review in relation to the Board's investigative and disciplinary actions.

- *SB 1177 (Galgiani, Chapter 591) Physician and Surgeon Health and Wellness Program*

This bill authorized the 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 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 authorized the Board to contract with a private third-party independent administering entity to administer the program. This bill specified that fees charged to participants shall cover the administrative costs incurred by the Board to administer the program.

- *SB 1189 (Pan and Jackson, Chapter 787) Postmortem Examinations or Autopsies: Physicians and Surgeons*

This bill specified that a forensic autopsy is the practice of medicine and can only be conducted by a licensed physician and surgeon.

- *SB 1261 (Stone, Chapter 239) Physicians and Surgeons: Fee Exemption: Residency*

SB 1261 deleted the California residency requirement for voluntary status licenses. However, it allowed out-of-state physicians to apply for a California license and ask for it to be put in voluntary status, or a current California licensee who resides out-of-state can request for his or her license be placed in voluntary status. Both options would result in the initial license fee and subsequent renewal fees being waived.

- *SB 1478 (Sen. B&P Comm., Chapter 489) Healing Arts*

This bill was a health omnibus bill for 2016. The provisions in this bill that impact the Board deleted outdated sections of the existing law that relate to the Board. This bill also specifies that all licensees that have been issued a license that has been placed in a retired or inactive

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status are exempt from paying CURES fees. This provision impacts all boards, including the Medical Board.

Regulation Changes Approved by the Board Since the Last Sunset Review

The following regulation changes have been completed since the last Sunset Report in 2012.

- Physician Availability During Use of Laser *(effective April 16, 2013)*

SB 100 (Price, Chapter 645, Statutes of 2011), among other things, amended Section 2023.5 of the Business and Professions Code to add subdivision (c), which required the Medical Board of California (Board) to adopt regulations on or before January 1, 2013, on the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures. However, the new law specified the regulations shall not apply to laser or intense pulse light devices approved by federal Food and Drug Administration for over-the-counter use by a health care practitioner or by an unlicensed person on himself or herself.

- Basic Life Support: Polysomnography Program *(effective June 18, 2013)*

A petition to amend the Board's Polysomnography Program regulations was filed by the American Health and Safety Institute with the Board in May 2012, and was heard in July 2012, at the Board's quarterly meeting. The Board granted the petition and moved forward to remove the requirement that Basic Life Support certification only be provided by the American Heart Association, and would instead require an applicant to possess at the time of application a current certificate in Basic Life Support issued by the American Heart Association or the American Health and Safety Institute.

- *Misdemeanor Convictions (effective July 1, 2013)*

Assembly Bill 1267 (Haldeman) added Section 2236.2 to the Business and Professions Code effective January 1, 2012. This statute required that the Board automatically place a physician's and surgeon's license on inactive status during any period of incarceration after a misdemeanor conviction and required that the board return the license to its prior or appropriate status within five days of receiving notice that the physician is no longer incarcerated. This regulation defined the notice that the Board will accept to restore the physician's and surgeon's license to its prior appropriate status.

In addition, Business and Professions Code section 803.1(b)(5) requires that the Board define the status of a license in regulation when disclosing that information on the Board's Internet site. This regulation provided a definition for the inactive license status as it applies to incarceration.

- Implementation of SB 1441 (disapproved October 9, 2014; resubmitted and approved March 25, 2015, effective July 1, 2015)

In September 2008, SB 1441 was signed into law. The Legislature declared that substance abuse monitoring programs, particularly for health care professionals, must operate with the

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highest level of integrity and consistency. The legislation, in part, mandated that the Department of Consumer Affairs (DCA) establish a Substance Abuse Coordination Committee (Committee), subject to the Bagley-Keene Open Meeting Act, comprised of the Executive Officers of the Department's healing arts boards, a representative of the California Department of Alcohol and Drug Programs, and chaired by the Director of DCA. The Committee was charged with developing consistent and uniform standards and best practices in sixteen specific areas for use in dealing with substance abusing licensees, whether or not a Board chooses to have a formal diversion program. The Board adopted regulations to implement SB 1441.

- Physician Assistant Supervision Requirements *(effective April 1, 2015)*

Physician Assistants (PA) are licensed health care practitioners that perform authorized medical services under the supervision of a licensed physician and surgeon (Business and Professions Code section 3502). Business and Professions Code section 3510 authorizes the Board to amend or adopt regulations under its jurisdiction, including regulations regarding the scope of practice for PAs. The PA Board is authorized to make recommendations to the Board concerning the scope of practice for PAs (Business and Professions Code section 3509).

Existing law permits a PA to act as first or second assistant in surgery under the supervision of an approved supervising physician. In 2011, a concern was raised by a PA licensee to the PA Board, that the current regulation at Section 1399.541 did not reflect current medical community standards when a PA acts as a first or second assistant in surgery. Additionally, the regulation was unclear regarding the degree of physician supervision of a PA acting as a first or second assistant in surgery.

Finally, the term, "approved supervising physician" as referenced in the current version of Section 1399.541(i)(2) needed to be removed as it was no longer accurate; legislation in 2002 eliminated the requirement that physicians who wish to supervise PAs be "approved" by the Medical Board (Senate Bill 1981 [Stats. 1998, Chapter 736] repealed Business and Professions Code Section 3515). After public discussion and deliberation, the PA Board relayed these concerns and recommended a proposal to the Medical Board for possible action.

To address the foregoing issues, the Medical Board proposed to amend section 1399.541 to permit authorized medical services without the personal presence of the supervising physician if the supervising physician is immediately available to the PA. "Immediately available" would be defined as able to return to the patient, without delay, upon the request of the PA or to address any situation requiring the supervising physician's services.

- Issuance of Citations *(effective August 31, 2015)*

16 CCR section 1364.10 authorized a "board official" to issue a citation, fine, and an order of abatement. The "board official" was defined as the chief, deputy chief, or supervising investigator II of the Enforcement Program, or the chief of licensing of the Board. The regulations (16 CCR sections 1364.12 and 1364.14) also required the board official who issued the citation to perform certain functions, including holding the informal conference, authorizing an extension, etc. However, the chief of licensing can only issue citations to physicians who practiced on a delinquent, inactive, or restricted license or to an individual who

practices beyond the exemptions authorized in Sections 2065 and 2066 of the Business and Professions Code (16 CCR section 1364.13).

As of July 1, 2014, the Board's sworn staff and their support staff were transferred to the DCA. Since this transfer, the only remaining staff permitted to issue a citation was the Chief of Licensing; however, the Chief of Licensing is not authorized to issue citations for minor violations of the Medical Practice Act, so this left no other staff person to issue those citations.

To address the forgoing issues, the Board proposed to amend the regulations to allow the Executive Director or his/her designee to issue citations and perform the functions once a citation is issued. In addition, the regulation requires the individual who issued the citation to perform subsequent functions, such as hold informal conferences. This regulation was amended to remove that requirement, because, if the person who issued the citation were to leave the Board, the subsequent functions would not be able to be performed until that position was filled or not at all. This rulemaking allowed the executive director or his or her designee to resolve the matter.

- *Disciplinary and Explanatory Information: Internet Postings (effective October 1, 2016)*

16 CCR section 1355.35(a) lists disclaimers and explanatory information the Board may provide with public disclosure information released on the Internet. Amendments to this section are needed to add disclaimers and explanatory information regarding court orders, misdemeanor convictions, licenses issued with a public letter of reprimand, and probationary licenses.

Additionally, the Board has received communications from physician attorneys regarding information found on its website related to administrative disciplinary actions. As such, it was determined court-ordered public disclosure screen types were needed to accurately reflect practice restrictions by the courts. Therefore, amendments to the chart found in section 1355.35(c) are necessary. This chart includes descriptions of the license status which is displayed on the Board's website and the public definition of the status code. Amendments were needed to add the status code description and definition for a 150-day temporary license for a family support issue, and the status code description and definition for a family support suspension.

- Physician and Surgeon Licensing Examination Passing Score *(effective January 1, 2017)*

The Board has enacted a resolution on a yearly basis to address the minimum passing examination score. This new regulation will clarify Business and Professions Code section 2177 and eliminate the need for the Board to pass a yearly resolution regarding the minimum passing score, by specifying the Board will accept the minimum passing score as determined by the examination agency approved by the Board.

- Outpatient Surgery Setting Accreditation Agency Standards *(effective January 1, 2017)*

Health and Safety Code (HSC) section 1248.15 states the Board shall adopt standards for accreditation and that outpatient settings regulated by this chapter with multiple locations shall

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have all of the sites inspected. 16 CCR section 1313.4 siad the actual sample size shall be determined by the accreditation agency. This was in conflict with HSC section 1248.15(a)(7) and was deleted.

HSC section 1248.35 states an accreditation agency shall, within 24 hours, report to the Board when it has issued a reprimand, suspended, placed on probation, or revoked any outpatient setting. Currently, 16 CCR section 1314.4 only specifies that denials and revocations must be reported to the Board. Therefore, reports of reprimands, placement on probation and suspensions must be added.

- Disciplinary Guidelines (pending)

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

- *Midwife Assistants (pending)*

B&P Code section 2516.5 was effective in 2016 and permitted licensed midwives and certified nurse-midwives to use midwife assistants in their practices. B&P Code section 2516.5 sets forth some minimum requirements for midwife assistants, references standards for medical assistants established by the Board pursuant to B&P Code 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 Board to establish via regulations. Additionally, subsection (b)(4) authorizes midwife assistants to "perform additional midwife technical support services under regulations and standards established by the board."

Accordingly, the purpose of this proposed rulemaking is to further define B&P Code 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.

Major Studies Conducted by the Board/Major Publications Prepared by the Board

The Board has completed numerous studies and publications in the last four years, some mandated by law, and some as requested by the Board. The links to the studies and publications have been listed below and are provided in Section 12, Attachment C. Below is a synopsis for each study and publication.

Vertical Enforcement and Prosecution Model Report to the Legislature – March 2016
The Board was mandated to provide a report to the Legislature regarding the implementation of the VE/P model in March 2016. This report provided information on the successes and

challenges of this type of model, and included a significant amount of statistical data, as well as recommendations for changes, including legislative changes.
http://www.mbc.ca.gov/Publications/vert_enf_model_report_2016_03.pdf

Board Newsletter – The Board publishes its Newsletter every quarter. The Newsletter contains useful information for both physicians and the public. The Board no longer mails this publication to all physicians every quarter, but instead emails it to all physicians who have provided email accounts to the Board (approximately 100,000). This has helped the Board save postage and printing costs and also allows for a more interactive Newsletter.
http://www.mbc.ca.gov/Publications/Newsletters/
Guide to Laws Governing the Practice of Medicine by Physicians and Surgeons – The Board provides this publication to all newly licensed physicians and anyone else who requests it. This publication is a reference source on the federal and state laws that govern a physician's medical practice. This publication was updated in 2013.
http://www.mbc.ca.gov/About_Us/Laws/laws_guide.pdf

Strategic Plan – The Board updated its Strategic Plan in 2014.
http://www.mbc.ca.gov/Publications/Strategic_Plan/strategic_plan_2014.pdf

Annual Report – Every year the Board provides statistical information on all Board programs via its Annual Report. A significant amount of the data provided in this report is required to be reported pursuant to B&P Code section 2313.
http://www.mbc.ca.gov/Publications/Annual_Reports/

Disciplinary Guidelines – The Board's Disciplinary Guidelines are used by the Board and the ALJs in identifying the penalty for a violation of the law. These were last updated in 2011, but are currently in the process of being updated through the regulatory process.
http://www.mbc.ca.gov/publications/disciplinary_guide.pdf

Uniform Standards – SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) required the Department of Consumer Affairs to develop uniform and specific standards to be used by each healing arts board in dealing with substance-abusing licensees in 16 specified areas. The Board adopted the Uniform Standards in 2014, and they became effective in 2015.
http://www.mbc.ca.gov/Publications/uniform_standards.pdf

Guidelines for Prescribing Controlled Substances for Pain – The Board updated these guidelines in November 2014 to include more information and resources for physicians to help improve outcomes of patient care and prevent overdose deaths due to opioid use.
http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

Opioid Overdose Prevention Public Service Announcements – The Board developed two public service announcements (PSA) specific to the opioid overdose prevention issue. One PSA was specific to physicians and provided education on appropriately prescribing controlled substances to patients. The second PSA was intended for the public and featured Olympic swimmer and gold medalist Natalie Coughlin. This video was designed to alert consumers to the dangers of abusing prescription drugs. These PSAs have been used to provide information and guidance to the public and physicians on this important topic.

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These YouTube videos are available for viewing at the bottom of the Board's homepage: http://www.mbc.ca.gov/ and on YouTube at: https://www.youtube.com/watch?v=Unt-RjFWJcI (provider PSA) and https://www.youtube.com/watch?v=7Rk3oVwpbqk (patient PSA).

Statute of Limitations Brochure, Don't Wait File a Complaint – The Board developed a brochure to inform consumers about the Board's statute of limitations and to encourage consumers to file complaints with the Board. This Brochure was developed with the input of consumer advocacy groups in response to their concerns that consumers are not aware of the Board's statute of limitations laws.
http://www.mbc.ca.gov/Consumers/Complaints/complaint_dontwait_flyer.pdf

Check up on Your Doctor's License Outreach Campaign Materials – In fall 2015, the Board launched an outreach campaign entitled "Check Up On Your Doctor's License." The campaign is designed to encourage all California patients to check up on their doctor's license using the Board's website. The Board updated its website to provide patients with information on how to use the Board's website and what the information means, including disciplinary action taken against a physician. The Board also developed brochures and video tutorials in English and Spanish that are posted on the Board's website and available on YouTube. The tutorials and brochures show patients step-by-step instructions on how to look up public information on any physician licensed in California.
Brochure (English) –
http://www.mbc.ca.gov/Publications/Brochures/CheckYourDoctor_English.pdf
Brochure (Spanish) –
http://www.mbc.ca.gov/Publications/Brochures/CheckYourDoctor_Spanish.pdf
Tutorial (English) – https://www.youtube.com/watch?v=oeBMNRv7GGw
Tutorial (Spanish) – https://www.youtube.com/watch?v=HS2xGGvmJ_M

National Association Memberships

In order to remain current with the national trends in medicine, the Board involves itself in national associations/organizations. In addition, several of the Board members and the executive director sit on committees for these entities in order to provide input and perspective from the State of California. As California has the largest number of licensed physicians, the activities and functions of the Board are very important on a national level. Not only does the Board receive valuable information from other states' processes and procedures, but other states also benefit from hearing about the methods and policies of the California Board. Additionally, there are several issues at a national level, e.g. opioid misuse and abuse, marijuana for medical purposes, telehealth and the ability to practice medicine across state lines without a license in each state (license portability), international standards and accreditation of schools, etc. The Board needs to be involved in these discussions because the impact of these national decisions could have an effect on the Board. The Board's perspective and opinions need to be relayed to these entities that may not otherwise understand the impact of their decisions on the Board, and, more importantly, on consumer protection.

Federation of State Medical Boards
The Board is a member of the Federation of State Medical Boards (FSMB), and has voting privileges (one vote) on matters that come before the FSMB. The FSMB is a national non-profit

organization representing the 70 medical and osteopathic boards of the United States and its territories. The Board has several members that participate in committees at the FSMB. The Board participated on the Special Committee on Ethics and Professionalism, Education Committee, Editorial Committee, the By-Laws Committee, Workgroup on Marijuana and Medical Regulation, Advisory Council of Board Executives, Federation Credential Verification Service Advisory Council, and various non-ongoing, single issue committees. A former Board member is on the FSMB Foundation.

Meetings of the FSMB attended:
April 2016 – San Diego, CA
April 2015 – Fort Worth, TX
April 2014 – Denver, CO
April 2013 – Boston, MA

Administrators in Medicine
The Board is also a member of the Administrators in Medicine (AIM). However, the AIM is not a voting body, it is a national not-for-profit organization for state medical and osteopathic board executives.

Meetings of the AIM attended:
April 2016 – San Diego, CA
November 2015 – Scottsdale, AZ
April 2015 – Fort Worth, TX
April 2014 – Denver, CO
April 2013 – Boston, MA

Educational Commission for Foreign Medical Graduates
The Board is a member of the Educational Commission for Foreign Medical Graduates (ECFMG). The Board is not a voting member of this organization. ECFMG is a private, nonprofit organization whose mission is to promote quality health care for the public by certifying international medical graduates for entry into U.S. graduate medical education, and by participating in the evaluation and certification of other physicians and health care professionals nationally and internationally.

International Association of Medical Regulatory Authorities
The Board is a member of the International Association of Medical Regulatory Authorities (IAMRA). This organization's purpose is to encourage best practices among medical regulatory authorities worldwide in the achievement of their mandate — to protect, promote and maintain the health and safety of the public by ensuring proper standards for the profession of medicine. The Board is not a voting member. The U.S. as a whole maintains the voting authority that is delegated to the FSMB.
The Board's executive director is a member of the Physician Information Exchange Workgroup.

Citizen Advocacy Center
Lastly, the Board is a member of the Citizen Advocacy Center (CAC). The Board is not a voting member. The CAC's mission is to increase the accountability and effectiveness of health care regulatory, credentialing, oversight and governing boards by advocating for a

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significant number of public members, improving the training and effectiveness of public and other board members, developing and advancing positions on relevant administrative and policy issues, providing training and discussion forums, and performing needed clearinghouse functions for public members and other interested parties.

Meetings attended:
April 25, 2016 - Washington, D.C., attended via Webinar
April 22, 2016 - Washington, D.C., attended via Webinar
March 20, 2012 - Washington, D.C., attended via Webinar

National Examination – United States Medical Licensure Examination (USMLE) Committee

The Board uses a national examination, the USMLE, to meet the examination requirements for licensure as a physician. The USMLE is jointly owned by the National Board of Medical Examiners (NBME) and the FSMB. As a member of the FSMB, the Board receives significant information regarding the USMLE, including changes being recommended, scoring data, etc. The Board's executive director is a new member of the USMLE State Board Advisory Panel and attends meetings via teleconference or in person when travel is approved.

Meetings attended
September 2016 – Philadelphia, PA
September 2015 – Washington D.C., attended via teleconference

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Section 2

Performance Measures and Customer Satisfaction Surveys

- Performance Measure Reports Published by the Department of Consumer Affairs
- Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs
- Consumer Surveys Conducted by the Board
  - Applicant Survey
  - Newsletter Survey
  - Website User Survey

Attachments

- Attachment M – Performance Measures
- Attachment N – Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs
- Attachment O – Consumer Satisfaction Survey Conducted by the Medical Board

Performance Measure Reports Published by the Department of Consumer Affairs

All quarterly and annual performance measure reports for FY 12/13, FY 13/14, and quarterly reports for FY 14/15, and FY 15/16 as published on the Department of Consumer Affairs (DCA) website are in Section 12, Attachment M. The DCA discontinued publishing an annual performance measure report after the FY13/14 report. Below is the 4th quarter report for FY 15/16.

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Department of Consumer Affairs

Medical Board of California

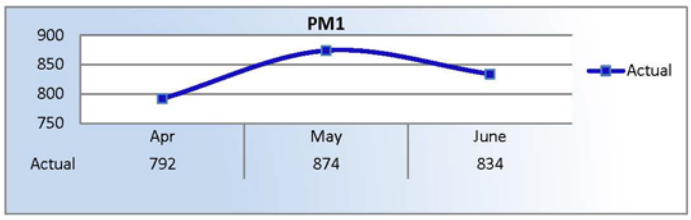
Performance Measures

Q4 Report *(April - June 2016)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

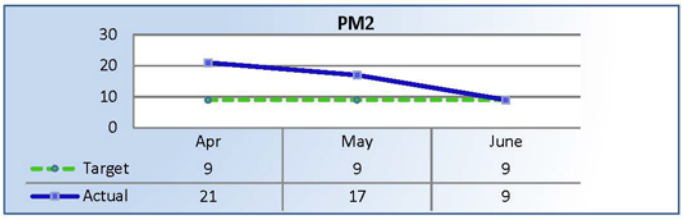


Total Received: 2,500 **Monthly Average**: 833

Complaints: 2,409 | **Convictions**: 91

PM2 | Intake

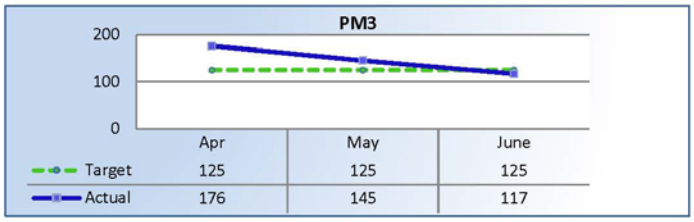
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 15 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

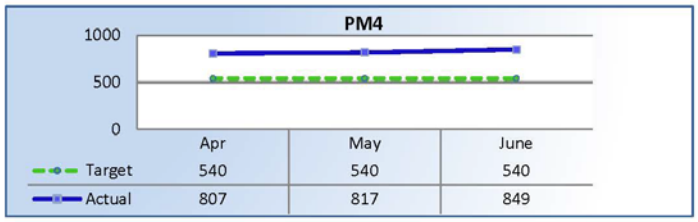


	Apr	May	June
Target	125	125	125
Actual	176	145	117

Target Average: 125 Days | **Actual Average:** 147 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	Apr	May	June
Target	540	540	540
Actual	807	817	849

Target Average: 540 Days | **Actual Average:** 825 Days

Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs

The Board includes a link to an online survey conducted by the Department of Consumer Affairs (DCA) in all letters sent to notify complainants that the Board closed their complaint. As an alternative to completing the survey online, a postcard version of the survey is also included in the USPS mailed closure letter. The prepaid postcard could be completed and mailed to DCA instead of completing the survey online. In early 2015, the Board also began including a QR code for complainants to scan and take the survey on their smart phone.

On average, the Board receives about 8,000 complaints per fiscal year. Although there are several options for complainants to complete the survey, the response rate continues to be extremely low compared to the number of complaints the Board receives. The highest rate of response was 92 in FY 12/13. The lowest rate of response was zero in FY 14/15, which may be partly due to the DCA revising the survey and its limited availability. There were only 22 responses in FY 13/14 and 16 responses in FY 15/16 out of 8,679 complaints in that same fiscal year. It is difficult to draw conclusions from this information due to the extremely low response rate.

Many survey participants are likely to give an unfavorable rating due to the rate of non-disciplinary action taken on complaints. This may also attribute to the low response rate to the survey. Many complainants may not complete the survey because of their disappointment with the Board's decision to close their complaints without taking disciplinary action against the licensee. Despite the Board's outreach and education efforts, it is possible that the complainants do not understand the Board's high burden of proof (clear and convincing) and the evidence needed to prosecute a case. Some complaints do not rise to the level of warranting disciplinary action and may result in a cease and desist letter or a citation/fine. For a complainant upset about his or her experience with a licensee, this is often seen as a disappointing result.

The results of the 12-question survey for fiscal years 12/13, 13/14 and 14/15 are in Section 12, Attachment N. The survey questions were changed and reduced from 12 to 7 questions in 2015 making it difficult to make a full comparison.

The results of the 16 responses for FY 15/16, with the new 7-question survey, are provided in the charts below. These results show complainants rated the Board unsatisfactory. When asked how well the Board explained the complaint process, 66% rated either very poor or poor. 69% rated either very poor or poor when asked how clearly was the outcome of their complaint explained to them. When asked how well the Board did in meeting the timeframe provided, 81% rated either very poor or poor. With regard to staff helpfulness and courteousness, 44% rated either good or very good. The Board continues to look for ways to improve its communication with complainants.

1. How well did we explain the complaint process to you?	FY 2015/16	
	%	Count
Very Poor	33%	5
Poor	33%	5
Good	13%	2
Very Good	20%	3
Total	100%	15

2. How clearly was the outcome of your complaint explained to you?	FY 2015/16	
	%	Count
Very Poor	56%	9
Poor	13%	2
Good	13%	2
Very Good	19%	3
Total	100%	16

3. How well did we meet the timeframe provided to you?	FY 2015/16	
	%	Count
Very Poor	50%	8
Poor	31%	5
Good	19%	3
Very Good	0%	0
Total	100%	16

4. How courteous and helpful was staff?	FY 2015/16	
	%	Count
Very Poor	31%	5
Poor	25%	4
Good	25%	4
Very Good	19%	3
Total	100%	16

5. Overall, how well did we handle your complaint?	FY 2015/16	
	%	Count
Very Poor	63%	10
Poor	25%	4
Good	0%	0
Very Good	13%	2
Total	100%	16

6. If we were unable to assist you, were alternatives provided to you?	FY 2015/16	
	%	Count
Yes	0%	0
No	81%	13
Not Applicable	19%	3
Total	100%	16

7. Did you verify the provider's license prior to service?	FY 2015/16	
	%	Count
Yes	38%	6
No	25%	4
Not Applicable	38%	6
Total	100%	16

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Consumer Surveys Conducted by the Board

As part of the Board's Strategic Plan, consumer surveys are being conducted. These surveys are a valuable tool for evaluating and enhancing the Board's organizational effectiveness and systems to improve services. There are three types of surveys being conducted by the Board: 1) Applicant Survey; 2) Newsletter Survey; and 3) Website User Survey.

The Board is using SurveyMonkey, a web-based system, to conduct these surveys. The applicant survey was started in August 2012. Information on the initial results were included in the 2012 Sunset Report and the 2013 Supplemental Sunset Report. The newsletter survey was launched in the Fall 2012 Newsletter. In March 2013, the Board began the website user survey.

An excerpt of the survey results for Fiscal Years (FY): 12/13, 13/14, and 14-15 are provided in Section 12, Attachment O. FY 15/16 results are provided within each type of survey below.

Applicant Survey

Initially, the applicant survey link was included in a letter sent to newly licensed physicians. Board student assistants sent these letters by email and regular mail. When the student assistant positions were eliminated, the Board was unable to continue sending these letters. Due to staffing constraints, there were no survey results from the third quarter of FY 13/14 to the second quarter of FY 14/15.

Shortly after initiating the survey in 2012, the Board decreased the number of questions from 17 to 5. This was done in an effort to increase the response rate and only include the most effective questions to measure applicants' satisfaction with the licensure process.

Beginning February 2015, the Board began sending email blasts to newly licensed physicians. Through the BreEZe system, email addresses are extracted twice monthly and an email with the survey link is sent.

In 2013, the Board revised the Physician's and Surgeon's Application. In addition, the online tutorials and clearer instructions were added to the website. These changes have contributed to increased positive survey results. Many applicants using the BreEZe system reported they were satisfied with the information it provided. On average, 91% of respondents stated the application instructions clearly state how to complete the application.

The Board continues to receive favorable ratings with regard to courteousness, helpfulness, and responsiveness of the staff person who processed the application. On average, about 70% of respondents reported they were either very satisfied or somewhat satisfied.

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1. Did the application instructions clearly state how to complete the application?

FY 2015-2016	Q1 132	Q2 174	Q3 224	Q4 231
Yes	91%	88%	91%	91%
No	9%	12%	9%	9%

2. If you visited the Medical Board's website for assistance, was the information helpful?

FY 2015-2016	Q1 132	Q2 174	Q3 224	Q4 231
Yes	86%	85%	89%	89%
No	14%	15%	11%	11%

3. If you used the BreEZe online system, how satisfied were you with the information it provided?

FY 2015-2016	Q1 132	Q2 174	Q3 224	Q4 231
Very satisfied	30%	29%	34%	32%
Somewhat satisfied	25%	32%	37%	39%
Somewhat dissatisfied	9%	9%	7%	6%
Very dissatisfied	10%	6%	2%	7%
Not Applicable, I did not use the Web Applicant Access System.	26%	24%	20%	16%

4. How satisfied were you with the courteousness, helpfulness, and responsiveness of the staff person who processed your application?

FY 2015-2016	Q1 132	Q2 174	Q3 224	Q4 231
Very satisfied	44%	48%	53%	52%
Somewhat satisfied	23%	21%	20%	21%
Somewhat dissatisfied	13%	10%	8%	11%
Very dissatisfied	15%	12%	12%	10%
Not applicable; I did not have any communication with the staff person who processed my application.	5%	9%	7%	6%

5. How satisfied were you with the application process?

FY 2015-2016	Q1 132	Q2 174	Q3 224	Q4 231
Very satisfied	35%	37%	38%	36%
Somewhat satisfied	26%	35%	36%	35%
Somewhat dissatisfied	23%	13%	14%	18%
Very dissatisfied	16%	15%	12%	11%

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Newsletter Survey

The newsletter survey link is included in the Newsletter. The Newsletter is produced four times per year and is sent electronically via email blast to all licensees and other interested parties. In addition, the Winter Newsletter is sent out annually via regular mail which also includes the newsletter survey link information. This allows all readers the opportunity to complete the survey.

This survey has produced a very low response rate. This can be attributed to the fact that the newsletters are only being distributed four times per year. Over the four fiscal years, the Board only received 204 responses. In early editions of the Newsletter, the survey link was near the end of the newsletter. In an effort to increase the response rate, the survey link is being advertised in a variety of areas of the newsletter.

The survey consists of 16 questions. Most questions were intended for the readers to rate the usefulness of each section of the newsletter. Out of the 16 questions, 4 rate the overall usefulness or satisfaction of the Newsletter.

The majority of the respondents reported being satisfied with the content of the Newsletter. The usefulness of the annual report question received very high ratings. Most respondents preferred to receive the Newsletter via email. In FY 15/16 fourth quarter, 100% of respondents said they prefer to receive the Newsletter by email. The majority of the respondents reported they were Physicians/Surgeons.

1. My overall satisfaction about the content of the Medical Board's Newsletter is:

FY 2015-2016	Q1 12	Q2 19	Q3 26	Q4 5
Excellent	20%	32%	13%	20%
Very Good	30%	28%	35%	40%
Good	30%	17%	26%	40%
Average	0%	6%	9%	0%
Disappointed	20%	17%	17%	0%

2. Please rate the usefulness of the Annual Report (fall issue):

FY 2015-2016	Q1 10	Q2 17	Q3 23	Q4 5
Very Useful	30%	18%	9%	40%
Informative	30%	41%	48%	60%
Somewhat Informative	30%	41%	30%	0%
Not Useful At All	10%	0%	13%	0%

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3. I prefer to receive the Newsletter:

FY 2015-2016	Q1 10	Q2 17	Q3 22	Q4 4
Via Email	60%	82%	63%	100%
Hard copy via Regular Mail	30%	18%	32%	0%
Social Media (when it becomes available)	10%	0%	5%	0%

4. My main interest in the Newsletter is as a:

FY 2015-2016	Q1 10	Q2 17	Q3 22	Q4 4
Physician / Surgeon	80%	100%	95%	100%
Associated Medical Professional	0%	0%	0%	0%
Interested Reader	20%	0%	0%	0%
Member of the Media	0%	0%	0%	0%
Government Member	0%	0%	5%	0%
Other	0%	0%	0%	0%

Website User Survey

The website user survey link is on the Board's website. Originally, the survey consisted of 17 questions. There were 277 responses in FY 13/14 and 113 responses in FY 14/15. The decline in the responses may be attributed to the changes in the Board's website layout in January 2014 and the implementation of BreEZe. In an effort to increase the declining response rate, the survey was decreased to 5 questions beginning in FY 14/15. There were 61 responses in FY 15/16

Of these 5 questions, 1 is intended to obtain readers' feedback on topics or suggestions for improvement and is not included in the survey results. The remaining 4 questions are intended to obtain readers' overall satisfaction while navigating the Board's website, as well as identifying the type of individuals who visit the Board's website.

The majority of website users were seeking information on license renewal, verifying a license, and filing a complaint. Unfortunately, with the implementation of the new BreEZe system in the second quarter of FY 13/14 most website users reported they were unable to find the information they were seeking and reported dissatisfaction with the Board's website. Some commented that the Board's website was confusing and cumbersome, others stated the renewal processing and verifying a license was not user-friendly. Prior to the BreEZe system, on average, 85% of the website users reported they were able to find the information they were seeking.

The Board has made many significant changes to the BreEZe system. In FY 15/16 fourth quarter, 60% of respondents stated they were successful in finding the information they were seeking.

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1. Which of the following best describes you?

FY 2015-2016	Q1 24	Q2 15	Q3 7	Q4 15
Consumer/Patient	42%	27%	57%	27%
Applicant (applying for licensure)	12%	27%	14%	0%
Current Licensee	17%	33%	29%	46%
Educator	0%	0%	0%	0%
Employer/Recruiter	0%	0%	0%	7%
Media	0%	0%	0%	13%
Other (please specify)	29%	13%	0%	7%

2. During your most recent visit to the Board's website, which of the following best describes the information you were seeking? [1/]

FY 2015-2016	Q1 24	Q2 15	Q3 7	Q4 15
License Renewal	12%	7%	29%	27%
Application for Licensure	12%	33%	14%	0%
Verifying a License	12%	20%	29%	27%
Filing a Complaint	29%	27%	14%	33%
Public Documents	8%	7%	0%	47%
Name/Address Change	4%	7%	14%	7%
Board Publications/Media	0%	0%	0%	7%
Continuing Education	0%	0%	0%	7%
Legislation/Regulation	0%	0%	0%	7%
Other (please specify)	33%	20%	43%	27%

[1/] Results exceeding 100% is attributed to raters having the option to choose multiple answers.

3. Were you successful in finding the information you were seeking?

FY 2015-2016	Q1 24	Q2 15	Q3 7	Q4 15
Yes	37%	40%	29%	60%
No	63%	60%	71%	40%

4. Overall, how satisfied are you with the Board's website?

FY 2015-2016	Q1 24	Q2 15	Q3 7	Q4 15
Extremely satisfied	21%	13%	0%	34%
Somewhat satisfied	17%	33%	29%	13%
Neither satisfied nor dissatisfied	17%	0%	0%	13%
Somewhat dissatisfied	8%	7%	14%	7%
Extremely dissatisfied	37%	47%	57%	33%

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Section 3

Fiscal and Staff

- Fiscal Issues
  - Board's Current Reserve Level, Spending, and Statutory Requirement
  - Deficit Projections and Anticipated Fee Changes
  - General Fund
  - Expenditures by Program Component
  - BreEZe Program Cost
  - Renewal Cycle and History of Fee Changes
  - Revenues and Reimbursements
  - Approved Budget Change Proposals (BCPs)
- Staffing Issues
  - Vacancy Rates
  - Reclassification Efforts
  - Succession Planning
  - Staff Development

Attachments

- Attachment P – DCA BreEZe Funding Chart
- Attachment Q – Revenue and Fee Schedule
- Attachment R – Budget Change Proposals

Fiscal Issues

Continuous Appropriation
The Board's fund is not continuously appropriated. The DCA prepares the Board's annual budget for inclusion in the Governor's proposed budget and the Board's appropriation is part of the Budget Act.

Board's Current Reserve Level, Spending, and Statutory Requirement
Pursuant to B&P Code section 2435, the Board's statutory reserve should be between two to four months. At the end of FY 15/16, the Board had a fund reserve of $27,001,000, which equates to a 5.1 months' reserve. However, it is projected that the Board will be within its statutory mandate at the end of FY 16/17, depending upon the repayment of the Board's outstanding general fund loan. The Board has been prudent in approving training, submitting travel requests, and monitoring expenditures. Nevertheless, with the Board's vacancy rate decreasing from a high of eight percent at one point to four percent currently, in addition to the costs for a new database, the Board has seen an increase in its expenditures.

The Outpatient Settings fund is also under the purview of the Board. Table 2a shows the revenue and expenditures for the Outpatient Settings Program (Program). When the law passed to create this Program, the Board loaned $150,000 to its implementation. This loan has not been repaid. However, the fund is currently at a level where the Board can seek repayment of this loan. Beginning in FY 16/17, the Board will begin billing this Program for repayment of the loan, while still ensuring its solvency.

Deficit Projections and Anticipated Fee Changes
In looking at the Board's current and projected fund condition, it appears the Board will be within its statutory mandate of two to four months' reserve by FY 2016/17. The Board is scheduled to receive $6 million of its $15 million outstanding general fund loan in FY 16/17. Should this occur, the Board's fund reserve would be at 4.7 months' reserve at the end of FY 16/17. With the uncertainty of the state's fiscal condition, it is unknown whether the projections for future fiscal years will remain as anticipated. Should future budget restrictions impact the Board, even though it is a special fund agency, the Board may not be below its statutory mandate at the time identified in the fund condition. The Board will continue to evaluate its fund condition in consideration of future budget modifications, including augmentations or spending restrictions. If the Board continues with its current spending level and the reserve were to be below the mandated level in FY 2018/19, then a fee increase would be warranted. The Board presents a fund condition report at each of its quarterly Board meetings so the members and the public are aware of the Board's budget.

General Fund
The Board has made two loans to the general fund. The first loan was in FY 2008/09 for $6 million and the second loan was for $9 million in FY 2011/12. The Board is anticipating repayment of these loans, $6 million in FY 2016/17 and final payment of $9 million in FY 2017/18. Should this repayment schedule not occur, and if the Board should fall below its statutory mandate of two to four months' reserve, then the Board will request full payment, including interest, for these loans.

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Table 2. Fund Condition (Contingent Fund of the Medical Board of California)						
(Dollars in Thousands)	**FY 2012/13**	**FY 2013/14**	**FY 2014/15**	**FY 2015/16**	**FY 2016/17**	**FY 2017/18**
Beginning Balance [1]	24,574	26,732	28,666	28,369	27,001	19,327
Revenues and Transfers	52,895	56,404	54,563	56,816	55,619	56,591
Total Revenue	$77,469	$83,136	$83,229	$85,185	$82,628	$75,918
Budget Authority	55,922	59,014	60,439	62,064	63,293	64,480
Expenditures [2]	50,970	54,983	55,142	58,184	63,293	64,480
Loans to General Fund	0	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	0	0	0	[3]	[3]
Fund Balance	$26,499	$28,153	$28,087	$27,001	$19,327	$11,438
Months in Reserve	5.4	5.8	5.4	5.1	3.6	2.2

[1] Beginning balance is the Adjusted Beginning Balance of the Fund Condition Statement which includes the prior year adjustment and fund assessment adjustments.
[2] Expenditures are net of the state operations, scheduled and unscheduled reimbursements, and statewide assessments. FYs 16/17 and 17/18 expenditures (and revenues) are projections.
[3] The Board is scheduled to receive loan repayments of $6 million in FY 16/17 and $9 million in FY 17/18. However, as of the printing of this document no funds have been received by the Board. Should the $6 million be repaid in FY 16/17 as scheduled, the Board's fund condition would be 4.8 months reserve at the end of FY 16/17.

Table 2a. Fund Condition (Outpatient Setting Fund of the Medical Board of California)						
(Dollars in Thousands)	**FY 2012/13**	**FY 2013/14**	**FY 2014/15**	**FY 2015/16**	**FY 2016/17**	**FY 2017/18**
Beginning Balance [1]	257	324	337	335	385	363
Revenues and Transfers	70	18	1	1	5	0
Total Revenue	$327	$342	$338	$336	$390	$363
Budget Authority	27	27	27	27	27	27
Expenditures [2]	1	1	1	1	27	27
Loans to General Fund	0	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	0	0	0	0	0
Fund Balance	$326	$340	$337	$335	$363	$336

[1] Beginning balance is the Adjusted Beginning Balance of the Fund Condition Statement which includes the prior year adjustment and fund assessment adjustments.
[2] Expenditures are net of the state operations, scheduled and unscheduled reimbursements, and statewide assessments.

Expenditures by Program Component

Table 3 below indicates the amount of expenditures in each of the Board's programs. In addition, the Budget Distribution chart, which is in the Board's Annual Report every year, reflects the budgeted (not actual) expenditures and percentage in each of the Board's

Programs (including pro rata) for FY 2015/16. The Enforcement Program (including the Attorney General's Office, the Office of Administrative Hearings, the Health Quality Investigation Unit, and Probation Monitoring) makes up approximately 73 percent of the Board's overall expenditures. Although the Board cannot order cost recovery for investigation and prosecution of a case, the Board can order that probation monitoring costs be reimbursed. The Licensing Program accounts for approximately 14 percent of the Board's expenditures, while the ISB accounts for approximately six percent. The Executive and Administrative Programs make up the remaining seven percent of the Board's overall expenditures.

Table 3. Expenditures by Program Component ***(list dollars in thousands)***

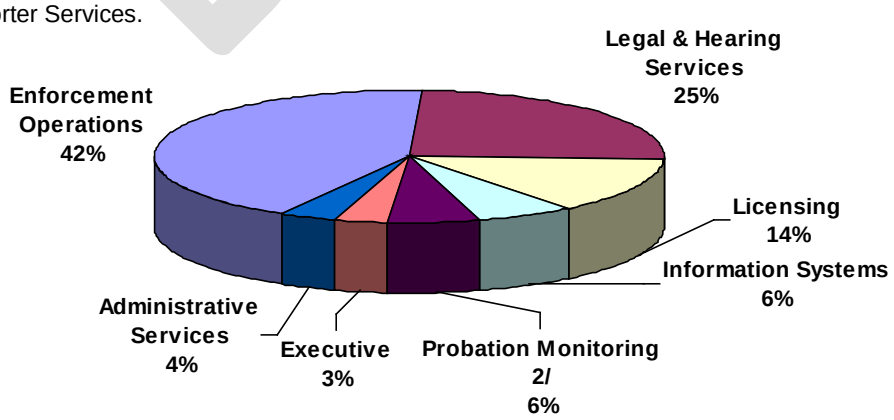
	FY 2012/13		FY 2013/14		FY 2014/15		FY 2015/16	
	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E	Personnel Services	OE&E
Enforcement	15,850	21,357	17,434	23,224	5,615	19,317	6,088	18,780
Examination	0	0	0	0	0	0	0	0
Licensing	3,635	2,098	3,861	2,224	3,863	2,214	4,184	2,925
Administration [1]	4,101	1,823	3,888	1,734	3,965	1,560	4,170	1,911
DCA Pro Rata [2]	0	4,318	0	4,968	0	21,399	0	22,827
Diversion (N/A)	0	0	0	0	0	0	0	0
TOTALS [3]	**$23,586**	**$29,596**	**$25,183**	**$32,150**	**$13,443**	**$44,490**	**$14,442**	**$46,443**

[1] Administration includes costs for executive staff, board, administrative support, and fiscal services.
[2] In FY 14/15, Pro Rata includes Health Quality Investigation Unit expenditures of $16,313,540. In FY 15/16, the amount was $16,335,960.
[3] Totals exclude both scheduled and unscheduled reimbursements.

Budget Distribution ***(budgeted, not actual)***

Enforcement Operations [2]	$26,331,000	42.4%
Legal & Hearing Services [1]	15,322,000	24.7%
Licensing [2]	8,522,000	13.7%
Information Systems	3,970,000	6.4%
Probation Monitoring [2]	3,606,000	5.8%
Executive	2,000,000	3.2%
Administrative Services	2,313,000	3.8%
Total	**$62,064,000**	**100.0%**

[1] Includes Attorney General Services, Office of Administrative Hearings, and Court Reporter Services.
[2] Budget amounts were adjusted for Attorney General Services, Office of Administrative Hearings, and Court Reporter Services.



BreEZe Program Costs

The BreEZe program was approved in 2009 and was intended to address legacy systems deficiencies. The Board was one of ten DCA boards and bureaus scheduled for Release 1 of Breeze in October 2013. The actual costs incurred by the Board from FY 09/10 through FY 15/16 total over $3.96 million and are inclusive of vendor costs, DCA staff and other related costs. The Board is anticipating project costs of $1.66 million in FY 2016-17. Funding will be requested for projected ongoing maintenance costs of $3.17 million for FY 2017-18 and FY 2018-19. A full summary of actual expenditures and projected future costs can be found in Section 12, Attachment P. It is important to note that these costs do not capture the numerous Board staff hours spent on the project.

Renewal Cycle and History of Fee Changes

The Board's main source of revenue is from the physician's renewal fees. This is illustrated below in the Revenues and Reimbursements chart, which is included in the Board's Annual Report. Both the fees for the allied health programs and physician's renewal fee have remained the same since the last Sunset Report. Prior to that, the Board's physician and surgeon's initial licensure and renewal fees were increased effective January 1, 2006, from $600 to $790, its first increase since 1994, in order to support the Vertical Enforcement/Prosecution model. Effective January 1, 2007, the physician's initial licensure and renewal fees were increased by $15 to $805 based upon the average amount of cost recovery that the Board had received in the prior three fiscal years that would no longer be received by the Board. Effective July 1, 2009, the physician's initial licensure and renewal fees were decreased by $22 to $783, a reduction mandated as a result of the elimination of the Board's Diversion Program on July 1, 2008. This is the current physician's initial licensure and renewal fee. While there was not an initial licensure or renewal fee change since the last report, a $12 fee for CURES was added to the renewal fee in April 2014. This fee is received by the Board and transferred to the Department of Justice, CURES program.

The full schedule can be found in Section 12, Attachment Q. Below is a list of the significant funding sources.

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
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA **PHYSICIANS AND SURGEONS ONLY**							
Application Fee (B&P 2435)	442.00	442.00	3,014	3,080	3,124	3,516	6.20%
Initial License Fee (B&P 2435) (16 CCR 1351.5)	783.00	790.00	1,546	1,672	1,706	1,881	3.32%
Initial License Fee (Reduced) (B&P 2435)	391.50	395.00	1,471	1,625	1,590	1,751	3.09%
Biennial Renewal Fee (B&P 2435) (16 CCR 1352)	783.00	790.00	45,740	48,638	46,962	48,478	85.51%

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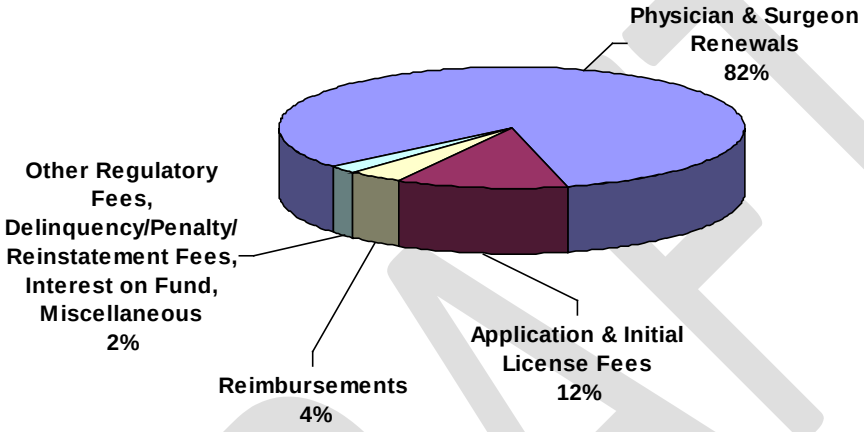
Revenues and Reimbursements		
Physician & Surgeon Renewals	$48,478,000	82.1%
Application & Initial License Fees	7,148,000	12.1%
Reimbursements	2,269,000	3.8%
Other Regulatory Fees, Delinquency/Penalty/ Reinstatement Fees, Interest on Fund, Miscellaneous	1,191,000	2.0%
Total [1]	**$59,086,000**	**100%**

[1] Includes revenues and reimbursements. In Table 2, reimbursements are reflected as a reduction in Expenditures.



Approved Budget Change Proposals (BCPs)

The Board knows that in order to meet its mandatory functions, it must have the staff and resources to perform the necessary duties. However, the Board is also mindful of the State's economic situation and the efforts not to increase position authority unless there is a justifiable workload. With all of this in mind, the Board only requested BCPs when it was absolutely necessary based upon an increase in workload or due to new legislation. Information is provided below on each BCP submitted in the last four fiscal years, and Table 5 will provide the requested data and the specifics on the BCP.

Operation Safe Medicine (OSM) – The OSM Unit was established and the Board received 6.0 limited term positions in order to investigate complaints of unlicensed activity received from the healthcare consumers and refer them for criminal prosecution. However, the positions were transferred and filled in the Board's Enforcement Program in order to maintain minimum staffing levels due to vacancy reductions and to fulfill its mission. In FY 12/13, the Board requested and received approval for the 6.0 positions to be established on a permanent basis in order to re-establish the OSM Unit to proactively address the ongoing problems with unlicensed activity. However, the Board received position authority only and not the associated funding and was required to redirect resources internally. In FY 14/15, OSM and the associated positions were transferred to the Health Quality Investigation Unit (HQIU).

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BreEZe System – BreEZe is the DCA's new licensing and enforcement system that enables consumers to verify a professional license and file a consumer complaint. Licensees and applicants can submit license applications, renew a license, and change their address among other services. The Board requested and received approval for $1.3 million in FY 12/13, $1.2 million in FY 13/14, $1.53 million in FY 14/15, and $2,403,000 in addition to $158,000 in FY 15/16 and FY 16/17 for continued support of the BreEZe project. The additional funding also subsidized credit card processing fees that occurred as a result of users who made credit card payments through the BreEZe system, which are program direct costs and are outside the scope of the BreEZe project. Additionally, the Department of Consumer Affairs (Department), Office of Information Services (OIS), requested and received approval for additional funding to fund increased contract costs with the project vendor and a resulting two-month schedule delivery extension.

Enforcement – The Board requested and received approval for 5.0 positions in FY 14/15 in order to reduce the time that it takes to complete the investigation of a consumer complaint. The additional positions handled the most critical components to the Expert Reviewer Training program, as poorly trained experts were providing opinions that had resulted in charges against physicians being dismissed. Furthermore, staff assisted with the ever-growing workload as a result of new legislation requiring the Board to prioritize its investigative and prosecutorial resources to ensure physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously and assisted with cases that had been reassigned to other District Offices. In FY 2016/17 the Board received an augmentation of $206,000 to fund enforcement costs of the expert reviewers and 1.0 position, and associated funding of $113,000 to address increased workload associated with the legislative mandates related to the reporting of adverse events by accredited outpatient surgery settings and hospital reports of transfers by licensed midwives of planned out-of-hospital births.

Legislation – The Board requested and received an augmentation of $577,000 in FY 2015/16 to implement Senate Bill (SB) 467 which requires the Department of Justice to submit a report of statistical information regarding cases referred by the Medical Board. In addition, with the passage of Assembly Bill (AB) 684, the Registered Dispensing Optician program was moved from the Board to the State Board of Optometry. In FY 2015/16, the Board requested and received a reduction of 0.5 in position authority and a reduction in funding of $39,000.

The full listing of BCPs can be found in Section 12, Attachment R.

Staffing Issues

Vacancy Rates

The Board has been very successful in both recruiting and retaining employees in each of its programs, which is reflected in the Board's vacancy rates over the past four years. Beginning in FY 2012/13, the Board had a 6 percent vacancy rate. The following year in FY 2013/14, it increased to 8 percent. The Board was able to lower this to 5 percent in the subsequent year, FY 2014/15. This past year, in FY 2015/16, the Board had a 4 percent vacancy rate.

As a result of Budget Letter (BL) 12-03, the Board was required to eliminate 18.1 positions as of FY 2012/13. In recognition of the impact of the reduction in workforce, the DCA authorized

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the Board to re-establish the lost positions in the temporary help blanket. Of the 18.1 positions eliminated through BL 12-03, the Board has thus far re-established a total of 13.6 positions. One Office Technician (Typing) (OT-T) position has been established in the Licensing Consumer Information Unit (call center), one Office Assistant (Typing) (OA-T) has been established in the Cashiering Office, and one OT-T in the Central Complaint Unit. A part-time 0.6 OT-T position has been established in the Probation North Unit. One Staff Services Manager II (SSM II) has been established in the Licensing Program and one (SSM II) has been established in Enforcement. One Management Services Technician (MST) has been established in the Central Complaint Unit. One Supervising Special Investigator and six Special Investigators have been established in the Complaint Investigation Office.

In FY 2014/15, Senate Bill 304 and the subsequent Budget Change Proposal transferred the Board's investigative staff, along with their support staff, to DCA's Division of Investigation and the newly formed Health Quality Investigation Unit. A total of 117 positions were transferred.

Reclassification Efforts

In FY 2014/15, a desk audit was conducted by the DCA Office of Human Resources to evaluate the work performed by the Board's Inspectors to determine if the duties being performed warranted position reclassification. The DCA determined that the Board's Inspectors would remain in the same classification; however, the DCA subsequently convened a department-wide review of the work performed by all DCA Inspectors. The findings of this review are currently pending.

As the duties for particular positions evolve due to operational need, the Board works with the DCA Office of Human Resources to reclassify its positions to ensure the efficient utilization of resources to enhance Licensing and Enforcement operations and facilitate the Board's mission statement, objectives, and goals. In particular, during FY 2015/16, the Board conducted a review of the functions of the Consumer Information Unit (Call Center). As a result, the Board will reclassify the positions within the Call Center to the Program Technician series to align with the duties performed. Furthermore, over the past few years, the Board has reclassified some positions in order to address the increased complexity of assignments; levels of responsibility and consequences involved; and, the need for staff oversight and professional development. Overall, the Board's reclassification efforts have addressed changes needed due to legislation, business processes, and operational efficiencies. As a result, the Board is better equipped to fulfill its mission of consumer protection.

Succession Planning

The Board uses policy and procedure manuals to ensure succession planning. Additionally, when available, the Board has the individuals leaving a position provide training to new staff and ensure the knowledge base is being transferred. The Board does everything it can with its existing resources to ensure that new staff receive the training needed to be successful.

The Board recognizes that the key to succession planning is developing staff to fill key leadership positions by developing their knowledge, skills and abilities in preparation for advancement into ever more challenging roles and positions of leadership. Individual Development Plans (IDP) are utilized to set reasonable goals for employees, assess job-related strengths, and aid in the development of employees to reach career goals resulting in both improved employee and organizational performance.

Staff Development

The Board's staff must be trained adequately and effectively in order for the Board to be able to meet its mission and mandates. For all staff, Board managers are held responsible for meeting with staff and discussing with them any needed or recommended training. Managers not only recommend training to the employee, but also discuss with the employee any training he/she may wish to pursue. The Board believes that providing staff with training opportunities will enhance the employee's performance and bring efficiencies to the work of the Board. The Board has provided on-site training specifically developed for staff such as communication workshops, and career development workshops, including one on how to prepare a statement of qualifications. These workshops are designed to enhance on-the-job performance and build a capable and prepared workforce as well as to inspire employees in the pursuit of professional growth throughout their career. The Board understands the importance of staff and is very supportive of every effort to keep staff knowledgeable and performing at their best.

In recognition that staff development also begins with strong leadership, the Board underwent a minor reorganization in 2015 which resulted in the addition of section chiefs within both the Licensing and Enforcement sections to provide direct leadership and mentoring to the managers. The section chiefs develop section performance standards, approve changes in program business processes, communicate program objectives, prioritize workload where resources may be limited and obtain the necessary resources to meet staff's development needs. The section chiefs develop the reporting managers to help them manage team goals effectively, monitor performance and help the managers to develop plans and tools to build strengths and close performance gaps for staff, matching staff development needs and goals with training opportunities. Overall, this will greatly improve employee morale and work performance, as well as enhance the Board's Licensing and Enforcement operations and facilitate the Board's mission, objectives and goals.

With travel restrictions from Executive Order B-06-11 still in place, the Board has been resourceful in seeking out webinars and providing free onsite training whenever possible. The Board has created its own New Employee Orientation which provides an overview of the Board's programs. The New Employee Orientation was developed to provide staff with a global perspective of the Board's operations, to help them understand their role in achieving the objectives and goals of the Board, and to encourage an environment where staff can contribute ideas that support the vision. In addition, the Board is also participating in the DCA Pilot Mentor Program. Further, when training is local or provided by the DCA, which is free, the Board encourages staff to attend. Over the past four fiscal years, the Board has spent the following on training:

FY 12/13 - $92,881
FY 13/14 - $64,991
FY 14/15 - $5,902
FY 15/16 - $13,569

The significant decrease in training costs in FY 14/15 and FY 15/16 is due to the transition of the Board's investigative staff to the DCA, Division of Investigation. The training for the investigator classification includes specific extensive peace officer training. With the elimination of those positions, those training costs were no longer included in the Board training expenditures.

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Section 4

Licensing Program

- Physicians
  - Performance Targets/Expectations
  - Timeframes for Application Review and Licensing - Performance Barriers/Improvements Made
  - Cycle Times
  - Verification of Applicant Information – Criminal History Information/ Prior Disciplinary Action
  - Applicant Fingerprints
  - Licensee Fingerprints
  - National Practitioner Databank and Physician Information
  - Primary Source Verification
  - Legal Requirements and Process for Out-of-State and Out-of-Country Applicants
  - Military Education
  - No Longer Interested Notification to DOJ
  - Examination Process
  - Examination Data – Pass Rates
  - Computer- Based Testing
  - Existing Statute Changes
  - School Approval
  - Legal Requirements Regarding Approval of International Schools
  - Continuing Education/Competency Requirements
  - Verification of CME
  - CME Audits
  - CME Course Approval
  - Auditing CME Providers
  - Licensees' Continuing Competence
- Fictitious Name Permits
- Special Faculty Permits
- Special Programs
- Medical Assistants
- Outpatient Surgery Setting Accreditation
- Specialty Board Certification

Licensing Program

The Licensing Program of the Board provides public protection by ensuring licenses or registrations are issued only to applicants who meet the minimum requirements of current statutes and regulations and who have not done anything that would be grounds for denial. The Board has the responsibility to enforce the Medical Practice Act and other related statutes and regulations.

In addition to the licensure of physicians, the Board licenses and/or issues registrations or permits for the following professionals, although in smaller numbers:

- Special Faculty Permits – B&P Code section 2168
- Special Programs – B&P Code sections 2072, 2073, 2111, 2112, 2113, and 2115 and 16 CCR section 1327
- Licensed Midwives
- Research Psychoanalysts/Student Research Psychoanalysts
- Polysomnographic Trainees, Technicians, and Technologists
- Sponsored Free Health Care Event Out-of-State Physician Registration

The Board also has a process to determine if an international medical school will be recognized by the Board. The recognition process is based upon B&P Code sections 2089-2089.5 and 16 CCR section 1314.1(a)(1) or 1314.1(a)(2). To be eligible for licensure as a physician in California, all international applicants must have received all of their medical school education from, and graduate from, a medical school that is recognized by the Board.

The Board approves Outpatient Setting Accreditation Agencies. Outpatient setting accreditation agencies accredit specific types of outpatient surgery centers that many licensed physicians use when performing surgical procedures.

In addition, the Board evaluates physician specialty boards that are not affiliated with, or certified by, the ABMS but believe they have equivalent requirements.

The Board also issues Fictitious Name Permits (FNP) that allow physicians to practice medicine under a name other than their own name, e.g., XYZ Medical Group. B&P Code section 2285 states: "The use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious name permit obtained pursuant to section 2415 constitutes unprofessional conduct."

This section on the Licensing Program will not include information on licensed midwives, research psychoanalysts, student research psychoanalysts, or the Polysomnographic Program. These licensing/registration types will be addressed in the Appendix section under their specific program.

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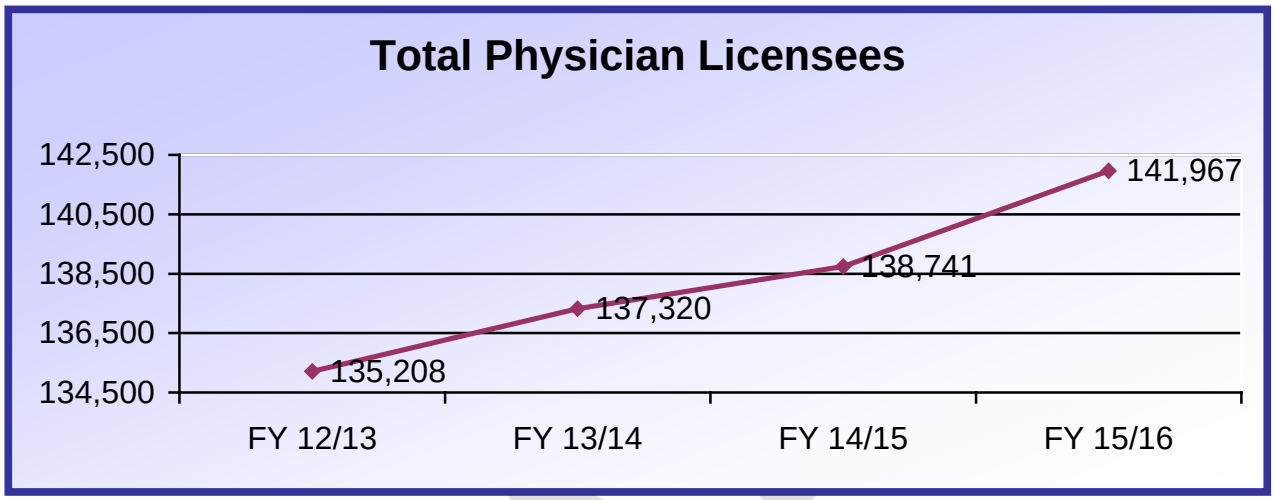
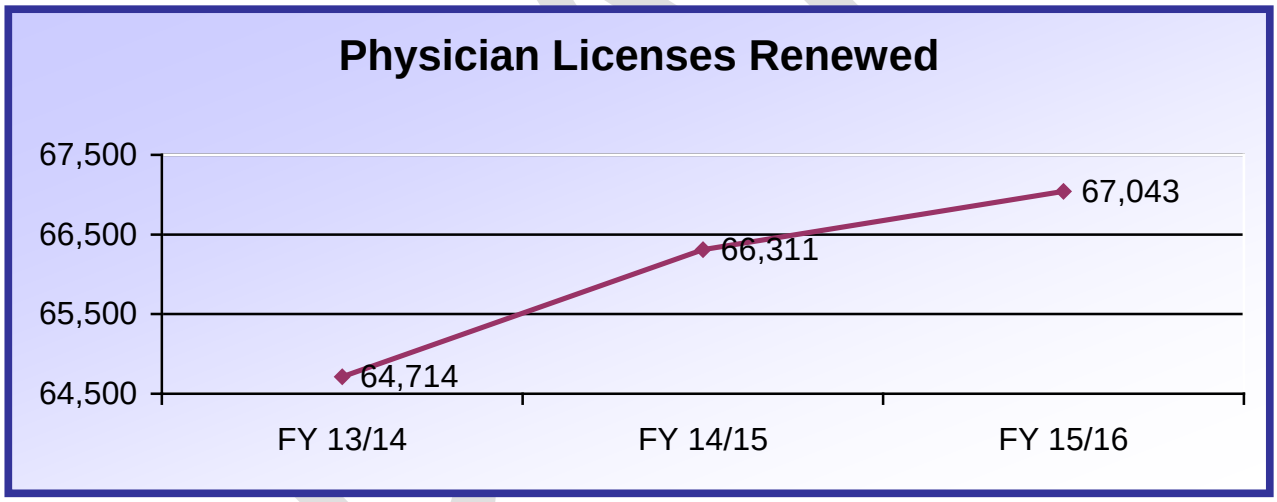
Physicians

While the Board has other license types and programs, the Board's largest workload is processing applications and issuing renewals for physicians. The Board continues to see an increase in the number of physicians in California as well as an increase in the number of renewals.





Performance Targets/Expectations

CCR, Title 16 section 1319.4 requires that within 60 working days of receipt of an application pursuant to Business and Professions Code (BPC) section 2102, 2103, 2135, or 2151 for a license to practice medicine, the Board shall inform the applicant in writing whether the application is complete and accepted for licensure or deficient and what specific information or documentation is required to complete the application. The Board is currently meeting this mandate.

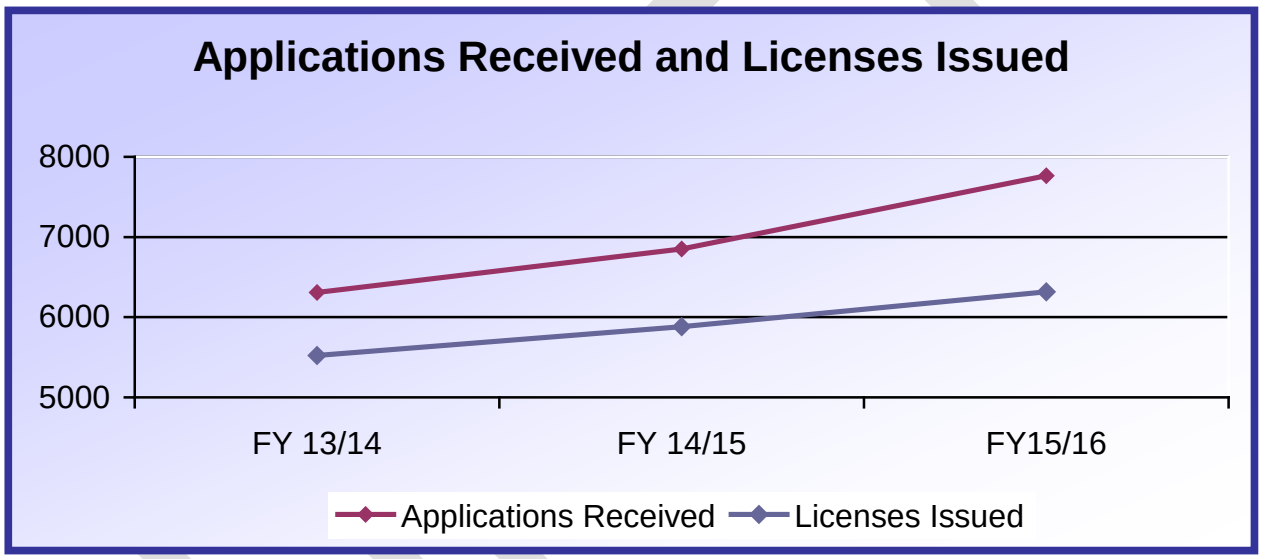
Although timeframes are defined in regulations (60 working days, approximately 90 calendar days), the Board has set expectations and a Strategic Plan objective that U.S./Canadian, international, and Postgraduate Training Authorization Letter (PTAL) applications be reviewed

within 45 calendar days. The Board has set expectations that all mail received for the licensing program be reviewed and documented within 7 business days.

The licensing staff provides weekly updates to the Board's executive director on meeting these goals, as well as provides an update to the Board members at the Board's quarterly meetings on how it is meeting its strategic plan objective. The Board is currently in compliance with the mandated timeframes and continues to identify opportunities to streamline and improve the application process.

Timeframes for Application Review and Licensing – Performance Barriers/Improvements Made

The Board has experienced an increase in the applications received each year for the past three years, an approximate increase of 1,455 total new applications (from FY 13/14 to FY 15/16). This is a 23% increase in applications. The staffing levels for review and processing of applications have remained the same.



As the application workload has increased, the Board experienced longer time frames for the review of new applications and pending mail during certain times of the year. In addition, the Board transitioned to BreEZe, in October 2013, which also impacted processing times.

The initial deployment of BreEZe resulted in the need for all business processes to be reviewed. Staff determined that changes would be needed, including changes to the BreEZe system. Management submitted BreEZe System Investigation Requests (SIR) to make necessary updates to the BreEZe system. The need for these changes impacted all facets of processing of applications, from the receipt of initial fees and application forms through the issuing of the license. However, since October 2014, most of the major changes to business processes have been completed and any further changes have been minor. Staff is currently trained and comfortable with BreEZe and the new business processes, and navigates more efficiently within the system. This has resulted in reducing processing timeframes.

Further, staff is required to input additional information into BreEZe to meet statutory requirements. It should be noted that staff previously could not input this information into the prior CAS/ATS systems. While the additional information is necessary, it does increase the time staff needs to process an application.

The increased receipt of applications, transition to the new BreEZe system, and the need for additional data resulted in the Board's inability to meet the Strategic Plan goal of review of initial applications within 45 days of receipt and review of pending mail within 7 days of receipt for approximately 20 weeks each year. In FY 2015/16 the Board missed the goal for 38 weeks. However, with an increased focus on business process changes and identifying efficiencies the Board's review time for both US/Canadian and international medical graduate (IMG) applications has significantly decreased. So far in FY 16/17 the Board has met its Strategic Plan every week and as of October 2016 is reviewing applications within 34 days, which is 11 days lower than the goal. This has been accomplished without any overtime.

This improvement has been obtained by undertaking several measures to address the factors that led to the increase in application review time. To initially address the increase of applications, staff performed overtime to process new applications, review pending mail, and issue licenses. The Board also completed a revision of the physician application, incorporating all required new legislation and notary jurat language. This revision also focused on streamlining the application process to the essential information and data required to meet the minimum requirements for licensure. The application has been implemented in a written format for immediate use and a request has been submitted for a change in BreEZe to implement the new on-line format. Part of this process will also result in streamlining, clarifying, and improving information to assist all applicants.

The Board hired a staff services manager II to assist the chief of licensing with the daily operations of the Licensing Program and to work closely with the managers to develop high performing teams through file reviews and setting weekly goals. The Board also recently hired two student assistants. These two positions will be utilized as floaters to assist where the need is greatest with respect to reviewing and processing applications and pending mail.

The Board completed an overhaul of the policies and procedures for the physician's application process. This complete review and revision is anticipated to result in further identification of business process changes; streamlining/clarifying current practices; incorporation of the 2016 physician's application revision; and more effective communication.

In addition, management identified a need to regularly meet with small groups of staff to identify challenges, inconsistencies, and factors impacting the processing of applications. Staff has been requested to share suggestions and recommendations that may improve processing and communication, with the understanding management will discuss/review and provide follow-up statuses. Management also identified the need for a specific "Licensing Email Que," which will ensure all routine questions are responded to by a designated employee that is not reviewing applications, thereby not taking time from these functions. Management further identified the need to explore the option to allow for primary source documents to be submitted to the Board through a secure electronic system, which will significantly reduce the overall processing time and limit the misdirection and loss of mail.

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Finally, management has recognized the substantial and significant changes that have occurred in medical education and postgraduate training over the past several years. As a result, staff forwarded proposals to the Board members requesting approval to move forward on two suggestions: 1) amending the required postgraduate training to three years for all applicants regardless of medical school of graduation; and 2) creating a re-entry process for applicants who previously left the practice of medicine and wish to return to active practice. (See Section 11, New Issues.)

Table 6.	**Licensee Population**				
		FY 2012/13	**FY 2013/14**	**FY 2014/15**	**FY 2015/16**
Physician and Surgeon	Active	135,208	137,320	138,741	141,967
	Out-of-State	27,753	27,728	27,313	28,017
	Out-of-Country	847	764	720	740
	Delinquent	12,232	16,252	16,167	16,180

Table 7a.		**Licensing Data by Type**									
Physician and Surgeon		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6,308	5,522	672	5,522	**	-	-	-	-	-
	(Renewal)	64,714	n/a	n/a	64,714	n/a	n/a	n/a	n/a	n/a	n/a
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6,850	5,882	355	5,882	**	-	-	-	-	-
	(Renewal)	66,311	n/a	n/a	66,311	n/a	n/a	n/a	n/a	n/a	n/a
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	7,763	6,317	245	6,317	6,597**	-	-	-	-	***
	(Renewal)	67,084	n/a	n/a	67,043	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.
** This number includes applicants who have applied for a PTAL and are awaiting completion of postgraduate training. No further action can be taken by the Board until notified by the applicant of completion of training.
*** See Table 7b below.

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Table 7b.	Total Licensing Data		
Physician and Surgeon	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	6,308	6,850	7,763
Initial License/Initial Exam Applications Approved	5,522	5,882	6,317
Initial License/Initial Exam Applications Closed	672	355	245
License Issued	5,522	5,882	6,317
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	-	-	6,597**
Pending Applications (outside of board control)*	-	-	-
Pending Applications (within the board control)*	-	-	-
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Physician license issued without prior issuance of a PTAL			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	167
Average Days to Application Approval (incomplete applications)*	-	-	167
Average Days to Application Approval (complete applications)*	-	-	n/a
Physician license issued with prior issuance of a PTAL ***			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	1350***
Average Days to Application Approval (incomplete applications)*	-	-	1350***
Average Days to Application Approval (complete applications)*	-	-	n/a
PTAL issued**			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	187
Average Days to Application Approval (incomplete applications)*	-	-	187
Average Days to Application Approval (complete applications)*	-	-	n/a
License Renewal Data:			
License Renewed	64,714	66,311	67,043

* Optional. List if tracked by the board.
** This number includes applicants who have applied for a PTAL and are awaiting completion of postgraduate training. No further action can be taken by the Board until notified by the applicant of completion of training.
***An International Medical School Graduate (IMG) must have a Postgraduate Training Authorization Letter (PTAL) in order to participate in a California postgraduate training position (residency) accredited by the Accreditation Council for Graduate Medical Education (ACGME). IMG's must have a minimum of 24 months of ACGME accredited training to be eligible for a physician's license and may train in an ACGME accredited residency program for a maximum of 36 months without a valid physician's license. Once a PTAL is approved, the PTAL file remains open until the PTAL holder obtains a license or PTAL holder's application file is closed for due diligence. Many of the PTAL holders do not obtain an ACGME accredited residency program for one or two years. Therefore, many of the PTAL holders have a PTAL file that is open for 5 or more years before obtaining licensure or closure for lack of due diligence

Cycle Times

In order to understand the Board's cycle times, it is first important to understand the Board's licensing process. As will be explained below in the Verification of Applicant Information and Primary Source Verification sections, the Board requires documents to be sent directly from the medical schools, postgraduate training programs, other state medical boards, etc., to the Board for proof of attendance, licensure, etc. Approximately 88-90% of the applications received and reviewed by the Board are deficient at the time of review. Upon initial review of the application, board staff notifies the applicant of the deficiencies.

Applicants should request the information from all of the appropriate entities at the time they send in their application to the Board. However, that does not always occur, or in the case of the international graduates, the delay could be due to the mail system or processing requirements in the countries outside of the U.S. Depending on the country and the medical school, obtaining primary source documents can take 60 to 120 days or more. Sometimes, it requires the applicant to pay high fees to the medical school to receive these documents.

Another common delay for many international medical school graduates is that many graduates may be deficient in clinical clerkship rotations that are required by California statute. If an applicant is deficient in medical school clinical clerkship rotations, the deficiencies will need to be remediated. Any remediation will need to be approved by the Board before the applicant remediates the deficiency. The deficiency in clinical clerkship rotations will depend on the medical school. This is a more common occurrence for U.S. citizens who attend and graduate from an international medical school and who deviate from the medical school's standard curriculum and/or arrange their own clinical clerkships.

Another reason for a delay in the licensure of U.S. applicants is the Board's encouragement to apply early. By law, an applicant attending postgraduate training in California cannot continue to practice beyond his/her second (U.S./Canadian graduate) or third (international graduate) year of training without obtaining his/her physician's license. The Board's Licensing Outreach Program reaches out to applicants encouraging them to apply early in order for them to be licensed well in advance of the "drop dead date." Applicants do not want to stop practice, and therefore apply early as advised. In some instances, they may not have completed the required postgraduate training (one year for U.S./Canadian or two years for international) resulting in the application remaining in pending status until documentation is provided regarding completion of this required training.

Other reasons for the delay of licensure for both U.S./Canadian and international graduates include applicants waiting to submit their licensure fee until all documents are received and reviewed, and requesting to delay licensure until their birth month instead of receiving the license upon completion. The Board does not prorate licensure fees, and the expiration date of a license is based upon the birth month of the applicant. In order to maximize their licensure fee, some applicants request to wait until their birth month for issuance of their license. This can result in a pending license for an additional 30-180 days in the licensure process. (See Section 11, New Issues.)

Lastly, in order to understand the Board's cycle times, it is important to understand the international graduate process. If an individual graduates from an international medical school,

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the Board requires at least two years of postgraduate training in an ACGME accredited training program. If an international graduate wants to attend postgraduate training in California, the Board requires that the individual obtain a postgraduate training authorization letter (PTAL) prior to attending postgraduate training. The application process to obtain a PTAL is almost identical to the process for licensure. The individual must provide primary source documentation, a completed application, and an application fee. Once the PTAL is approved, the individual may then seek and attend the postgraduate training. Once the individual completes the training, he/she then submits proof of that training (usually two years later) and the Board can then complete the process and issue the individual a license. Increased pending times arise when individuals apply for and obtain a PTAL but have not been accepted into a postgraduate training program. They may wait several years before being accepted into a training program. The Board has experienced PTAL applicants who have not been able to attend postgraduate training for five to six years (or more) after they were first issued a PTAL. The Board requires these applicants to provide updated information, as well as a statement identifying what they have done to obtain a postgraduate training slot. If warranted, the Board will issue an updated PTAL, so they can continue their search for postgraduate training in California.

In an effort to determine accurate cycle times with all of these caveats, the Board identifies individuals who were 1) U.S./Canadian graduates, 2) international graduates who did not require a PTAL (they already had postgraduate training) and 3) international graduates who applied for a PTAL, went to postgraduate training, and then went on to licensure.

Since there are so many areas outside of the Board's control in the licensure cycle times, the Board is the most concerned with the length of time it takes to perform the initial review an application and subsequent documents, as that is within the Board's control. The goals for the Licensing Program in regulation as well as the Strategic Plan are built on this premise. If an application is not reviewed timely, it only lengthens the licensure cycle time, because the applicant is unaware of the deficiencies. Therefore, the Board has set goals for the time in which review should be performed.

Verification of Applicant Information – Criminal History Information/ Prior Disciplinary Action

Applicants are required by law to truthfully answer all questions asked on the application for licensure. B&P Code section 480 states that the commission of any act involving dishonesty, fraud, or deceit is grounds for denial. The applicant must complete an application and sign it under penalty of perjury that all of the information contained is true and correct. Additionally, the Board requires that all applications be notarized.

Question 14 (2012 Application Revision) and Question 16 (2016 Application Revision) of the application references postgraduate training and requires the applicant to answer several questions related to possible issues during training. If an affirmative response to any of the questions is provided, the postgraduate training program director must provide a detailed narrative of the events and circumstances leading to the issues or actions. Copies of appropriate supplemental materials (rotation evaluations, performance evaluations, disciplinary materials, committee meeting minutes, letters to file, etc.) must also be provided from the postgraduate training program and be sent directly to the Board.

Form L2 of the application, Certificate of Medical Education, must be completed by each medical school attended by the applicant. If school officials provide an affirmative response to any of the questions under “Unusual Circumstances” on the form, they must provide a written explanation and provide supporting documents directly to the Board. To certify the form, school officials must affix their signature and the seal of the medical school.

Form L3A/B of the application, Certificate of Completion of ACGME/RCPSC (Accreditation Council for Graduate Medical Education/Royal College of Physicians and Surgeons of Canada) Postgraduate Training, must be completed for each year of postgraduate training completed, whether or not the entire residency was completed. The form is provided by the applicant to the training program for completion. The program director must provide all of the required information and responses on the form and affix the date, his/her original signature and the seal of the hospital and send it directly to the Board. The program director is then verified through the ACGME directory to confirm the person signing is the current program director. If the hospital does not have a seal, the program director’s signature must be notarized. If program directors provide an affirmative response to any of the questions under “Unusual Circumstances” on the form, they must provide a written explanation and provide supporting documents when necessary. Information provided on this form is then compared to information provided by the applicant to determine if any acts of dishonesty have occurred.

Question 15 (2012 Application Revision) and Question 24 (2016 Application Revision) of the application references any medical licenses that have ever been issued by any state or territory in the U.S. or Canadian province. The applicant must disclose all current and/or previous licenses held and provide a License Verification (LV) from each state or province, sent directly to the Board, verifying the applicant’s licensure information and whether any action has been taken against the license. If the LV indicates action has been taken, certified documents from the state or province must be provided detailing the circumstances related to the action and the outcome.

Questions 23-25 (2012 Application Revision) and Questions 42-45 (2016 Application Revision) of the application reference all convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If an affirmative response to any of these questions is provided, the applicant must submit a detailed narrative describing the events and circumstances leading to the arrest and conviction. Certified copies of the police report, arrest report and all court documents must be provided directly by the issuing agency to the Board. If the records are no longer available, the issuing agency or court must provide a letter to that effect. In addition, the applicant must respond to a question inquiring whether he/she is a registered sex offender. An affirmative response to this question will result in automatic denial of the applicant’s request for licensure.

All applicants must obtain fingerprint criminal record checks from both the DOJ and the Federal Bureau of Investigation (FBI) prior to the issuance of a physician’s medical license in California. If criminal history information is provided from the DOJ or FBI, this information is then compared to information provided by the applicant to determine if any acts of dishonesty have occurred. The Board does not receive criminal history on international applicants, except what is provided by DOJ and FBI. The Licensing Program has explored the option of requesting an Interpol check; however, it has been determined the complexity of the process and fees outweigh the potential benefit.

Questions 26-38 (2012 Application Revision) and Questions 27-41 (2016 Application Revision) on the application refer to discipline by a U.S military or public health service, state board or other governmental agency of any U.S. state, territory, Canadian province or country, or hospital . If an affirmative response to any of these questions is provided, the applicant must provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency must also provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline must be provided directly to the Board by the appropriate agency. Copies of pertinent investigatory and disciplinary documents must be provided to the Board directly by the appropriate authority.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case-by-case basis to determine if an unrestricted license should be issued, whether conditions should be imposed, or whether the applicant is eligible for licensure.

Applicant Fingerprints
Pursuant to B&P Code section 2082(e) applicants for a physician's license must submit either fingerprint cards or a copy of a completed Live Scan form in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction.

Licensee Fingerprints
All licensees with a current license have been fingerprinted. As fingerprinting is a requirement for licensure, a physician's license will not be issued prior to completion of this requirement. The Board receives subsequent reports from the DOJ following the initial submittal of fingerprints should there be any criminal occurrence. Subsequent arrest reports are reviewed by the Enforcement Program to determine if any action should be taken against the licensee.

National Practitioner Databank and Physician Information
The Board queries the National Practitioner Databank (NPDB) for certain applicants with issues of concern disclosed on the application or during the application process, and applicants who disclose a license in another state, territory or province. The NPDB is a confidential information clearinghouse created by Congress to improve health care quality, protect the public, and reduce health care fraud and abuse in the U.S.

The Board is also a member of the Federation of State Medical Boards (FSMB). As a member, the Board queries all applicants in the FSMB database. This database contains a record of disciplinary actions taken by other states and jurisdictions as well as any inappropriate behavior during an examination. Not only does the Board query the FSMB database, but the FSMB also has within its database where each individual holds a license (the FSMB obtains this information from the state licensing boards). When action is taken in a state and the FSMB receives notification, it automatically sends an email to the Board indicating the action taken. This information is received by the Board's Enforcement Program, which determines the appropriate action to take.

Queries are not submitted to the NPDB during the renewal process. The Board performed a study of the information provided to the NPDB compared to information received by the Board. Based upon this review, the Board believes it receives the same information from hospitals,

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malpractice carriers, court clerks, and physicians as is provided to the NPDB. The Board has mandatory reporting from several entities (most of which are the same as required to report to the NPDB), and believes it is already receiving the necessary information to ensure public protection.

Primary Source Verification

The Board requires that all documentation, including the applicant's medical education, examination history, postgraduate training and licensure history, be primary source verified. This includes verification from all medical schools that the applicant attended and/or graduated from, including completion of other forms to document education and training: L2 – Certificate of Medical Education; L3A/B – Certificate of Completion of ACGME/RCPSC Postgraduate Training; L5 – Certificate of Clinical Clerkships; L6 – Certificate of Clinical Training; official License Verification; USMLE/FLEX/NBME score reports; official certified copy of the diploma; official transcripts; and official English translations when in a language other than English.

Legal Requirements and Process for Out-of-State and Out-of-Country Applicants

The Board's requirements for licensure are determined by medical school of graduation: domestic (U.S. or Canadian) or international graduates. The Board does not grant licensure to any applicant without compliance with California requirements, and the Board does not recognize true reciprocity; each state has its own statutes and regulations regarding licensure and California has some of the strictest requirements regarding medical school education to ensure consumer protection.

U.S./Canadian Graduates – Applicants of approved U.S./Canadian medical schools are required to submit documentation codified in statute, regulation, and policy. These documents include the application forms completed and signed by the applicant (Form L1A-L1F); DOJ and FBI fingerprint responses (LiveScan or hard card); official examination score report; original Certificate of Medical Education (Form L2); certified medical school transcript; certified copy of the medical diploma; original license verifications; original Certificate of Completion of ACGME/RCPSC Postgraduate Training (Form L3A/B); and appropriate application, fingerprint and initial license fees. These forms and documents must be received directly from the issuing entity. The initial application forms completed by the applicant must be affixed with a wet signature and notarized. Board staff independently requests a report from the American Medical Association for each applicant. In addition, Board staff requests an NPDB report for applicants who disclose licensure in another state, territory or province; and for applicants who disclose affirmative responses to questions relative to medical school, postgraduate training, hospital, or state discipline.

B&P Code sections 2036, 2037, 2065, 2080, 2081, 2082, 2083, 2084, 2085, 2088, 2089, 2089.5, 2089.7, 2090, 2091, 2091.1, 2091.2, 2096, 2135, 2135.5, 2135.7, 2141, 2146, 2151, 2170, 2171, 2176, 2177, 2183, 2184 and 2186 provide the basis for specified requirements, documentation, and pathways to licensure. 16 CCR sections 1307, 1314, 1315, 1315.50, 1315.53, 1315.55, 1319.4, 1320, 1321, 1327, 1328, 1329.2, and 1351.5 also provide the basis for specified requirements, documentation, and fees.

International Graduates – Applicants of recognized international medical schools are required to submit documentation codified in statute, and regulation. These documents include the

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application forms completed and signed by the applicant (Form L1A-L1F); DOJ and FBI fingerprint responses (LiveScan or hard card); official examination score report including ECFMG; original Certificate of Medical Education (Form L2); certified medical school transcript; certified copy of the medical diploma; original license verifications; original Certificate of Completion of ACGME/RCPSC Postgraduate Training (Form L3A/B); original Certificate of Clinical Clerkships (Form L5); original Certificate of Clinical Training (Form L6); and appropriate application, fingerprint, and initial license fees. These forms and documents must be received directly from the issuing entity; the initial application forms completed by the applicant must be affixed with a wet signature and notarized. Board staff independently requests a report from the American Medical Association for each applicant. In addition, Board staff requests an NPDB report for applicants who disclose another state, territory or province license, and from applicants who disclose affirmative responses to questions relative to medical school, postgraduate training, hospital, or state discipline.

B&P Code sections 2036, 2037, 2066, 2080, 2081, 2082, 2083, 2084, 2088, 2089, 2089.5, 2089.7, 2090, 2091, 2091.1, 2091.2, 2096, 2100, 2102, 2103, 2104, 2105, 2107, 2135, 2135.5, 2135.7, 2141, 2143, 2171, 2176, 2177, 2183 and 2184 provide the basis for specified requirements, documentation and pathways to licensure. 16 CCR sections 1307, 1314.1, 1315, 1315.50, 1315.53, 1315.55, 1319.4, 1320, 1321, 1322, 1323, 1325, 1327,1328, 1329.2, and 1351.5 also provide the basis for specified requirements, documentation, and fees.

The Board does not waive documentation for applicants of U.S./Canadian or international medical schools; all required documentation must be submitted. The submission of all required documentation is the burden and responsibility of the applicant. The Board also does not waive documentation for applicants who are licensed in another state or country.

Once the applicant has established, by providing the required documentation, all mandatory requirements have been satisfied, and the Board has determined that the applicant has not done anything that would be grounds for denial, the application proceeds toward issuance of a license. Once an application is complete, a license can be issued in less than seven days (if not held for birth month issuance), and could be even issued in one day depending upon the licensure batch cycle.

B&P Code sections 2135, 2135.5 and 2135.7 provide some exceptions to deficiencies in medical school clinical clerkship minimum requirements, minimum postgraduate training requirements, license examination minimum requirements, or attending and/or graduating from an unrecognized or disapproved medical school, if the applicant meets the minimum requirements for holding an unrestricted, renewed and current license in another state for the specified number of years, and is certified by one of the American Board of Medicine Specialty affiliate boards. Board staff reviews each file to ensure an applicant who is eligible to apply is processed with the correct licensing pathway.

Military Education

The Board has no process, nor statutory or regulatory authority, to consider an applicant's military education, training and experience to satisfy licensing requirements, since the type of education provided by the military is not applicable to any of the Board's license types, except for physicians and surgeons. The military requirements for physicians and surgeons are the

same as the Board's requirements. The Board does recognize the US medical school, Uniformed Health Sciences University, based upon LCME approval. Additionally, postgraduate training programs (internship through fellowship) conducted at military hospitals with ACGME accreditation are also recognized.

The Board identifies applicants who indicate they are veterans of military services or spouses of veterans by application and/or submission of official documentation proving military status. The Board was not required to make any regulatory changes to conform to B&P Code section 35. The Board was able to comply by making internal policy processing changes. The Board has received 75 new physician applications pursuant to B&P Code section 114.3 and currently has 283 licensees in exempt fee military status. The Board received 83 physician applications that qualified for the expedited license process pursuant to B&P Code Section 115.5.

No Longer Interested Notification to DOJ

The Board implemented a process for No Longer Interested (NLI) notifications in 2013 and began this in 2013 with the implementation of the BreEZe project. When applicants fail to obtain licensure by the Board due to denial, withdrawal, or abandonment of their application, their file is closed and an NLI notification is sent to DOJ. An NLI notification will also be sent to DOJ for former licensees that have had their license revoked or surrendered for disciplinary action. These notifications will be sent after the appeal period has expired.

The DCA is working on an automated process in the BreEZe system that will electronically transmit NLI notifications to DOJ for boards and bureaus for licensees whose license has been canceled for non-renewal or voluntary surrender.

Examination Process

The Board requires applicants to pass nationally recognized examinations. The current required examinations are the United States Medical Licensing Examination (USMLE) Step 1, Step 2 Clinical Skills, Step 2 Clinical Knowledge and Step 3. The examination encompasses basic sciences, medical knowledge, patient diagnosis and treatment, and practical knowledge. The core areas tested are medicine, surgery, psychiatry, obstetrics/gynecology, pediatrics and family medicine.

The examination was developed in collaboration by the National Board of Medical Examiners (NBME) and the Federation of State Medical Boards (FSMB). These two organizations are member organizations. All U.S. states and territories are considered participating voting members. Examination requirements are established in B&P Code sections 2176, 2177 and 2184. The specific examinations and examination combinations acceptable to satisfy California requirements are set forth in 16 CCR section 1328. The validity of the examination is established by 16 CCR section 1329.2. The Board recently passed regulations to accept the minimum passing score as established by the FSMB and NBME respectively.

The Board does not require any California specific examination. The USMLE is the only examination required for licensure. In order for international medical school graduates to take the USMLE examinations the international medical school graduates must apply through the Educational Commission for Foreign Medical Graduates (ECFMG). The examination is not offered in any language other than English since the ECFMG requires all applicants to be

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proficient in the English language and verifies the applicants' proficiency in English during the examination process.

Examination Data – Pass Rates
The Board does not have statistics on the pass rates for the USMLE specific to California. However, the USMLE Web site contains the pass rates for all individuals who take the USMLE.

USMLE Pass Rate Statistic for First Time Takers				
Year	**2012**	**2013**	**2014**	**2015**
Step 1	94%	95%	95%	94%
Step 2 CK	97%	97%	96%	94%
Step 2 CS	97%	97%	95%	96%
Step 3	95%	96%	96%	98%

USMLE Pass Rate Statistic for Test Re-Takes				
Year	**2012**	**2013**	**2014**	**2015**
Step 1	68%	72%	68%	68%
Step 2 CK	72%	74%	70%	65%
Step 2 CS	92%	80%	84%	86%
Step 3	69%	78%	73%	74%

Computer- Based Testing
The Board delegated authority for administration of all national written examinations to the NBME and FSMB for the USMLE in 1998. These organizations are responsible for all facets of the USMLE: testing content, scoring, psychometric validity, examination integrity and administration. The USMLE offers Steps 1 and 2 CK of the examination as computer-based tests. The examinations are offered world-wide on an on-going basis. USMLE Step 2 CS and Step 3 are offered only in the US, and are offered as computer-based and mock patient-based.

Applicants are eligible for USMLE Steps 1 and 2 CK and 2 CS upon satisfactory completion of specific basic science curriculum coursework. At the time of eligibility, the applicant participates in and completes the application process, ultimately gaining admittance to the examinations. Once the scores are released and the applicant has passed Step 1 and Steps 2 CK and CS, the applicant continues with their medical education. The applicant is eligible for Step 3 immediately upon graduation from medical school. However, this examination is practical and clinical based: many graduates prefer to complete at least one year of postgraduate training prior to attempting the Step 3 examination. Per USMLE requirements, applicants must complete the entire examination series, Steps 1 through 3, within seven years from the date of the first passing examination.

Existing Statute Changes
Any existing statute changes needed for the Board to enhance the Licensing Program have been identified in the Section 11, New Issues. However, the Board does believe that there are sections no longer used or needed and would recommend the following sections for repeal.

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- Section 2072 – No longer utilized
- Section 2073 – No longer utilized
- Section 2115 – There appears to be no interest in this exemption as it has never been used

School Approval

The approval of U.S./Canadian medical schools differs from the recognition of international medical schools. The U.S./Canadian medical schools undergo a standardized evaluation by a nationally recognized entity, Liaison Committee on Medical Education (LCME). The international medical schools undergo an independent evaluation process, created and conducted by the Board, pursuant to B&P Code sections 2089, 2089.5 and 16CCR section 1314.1.

U.S./Canadian Medical Schools – Pursuant to B&P Code section 2084.5 the Board approves all U.S. and Canadian medical schools accredited by the Liaison Committee on Medical Education (LCME). This assessment is designed to evaluate the fiscal soundness, educational curriculum and physical facilities of the medical school. The LCME is the nationally recognized accrediting authority for allopathic medical education programs leading to the issuance of Medical Doctor (M.D.) degrees in the U.S. and Canada. B&P Code sections 2084, 2084.5, 2085, 2089, 2089.5 and 16 CCR sections 1314 and 1315 provide the basis for U.S./Canadian medical school approvals.

International Medical Schools – The Board recognizes international medical schools by historic approval by the World Health Organization and, more recently, by independently conducting an evaluation of the school's credentials based upon 16 CCR section 1314.1(a)(1) or a thorough and comprehensive assessment to evaluate the fiscal soundness, educational curriculum and physical facilities of the school and teaching hospitals pursuant to 16 CCR section 1314.1(a)(2). This evaluation is modeled from and consistent with the LCME assessment process. B&P Code sections 2084, 2089, 2089.5 and 16 CCR sections 1314.1 and 1315 provide the basis for international medical school recognition.

The Board does not coordinate or consult with BPPE in determining approved U.S./Canadian medical schools, or recognized international medical schools. The BPPE is not included in any part of the Board's process, although may be part of the process as the school obtains LCME approval.

The Board currently approves medical schools in the U.S. and Canada that are accredited by the LCME. As of September 20, 2016, the LCME list of accredited medical schools for both U.S. and Canada totals 162 allopathic medical schools. However, the Board's list of approved medical schools for U.S. and Canada is 203 medical schools. The difference is that the Board's list includes previous names of medical schools and current names of the same medical school. The LCME lists only the current name of the medical schools. These schools are reviewed by LCME officials on a seven year rotation; schools may be reviewed more frequently if a need is identified. Other schools are added to this list upon accreditation by the LCME. The Board currently recognizes 1,882 international medical schools. Some of these schools require a re-assessment every seven years as mandated in CCR section 1314.1. However, due to a lack of staffing the Board has been unable to conduct these reviews on a

seven-year basis. In addition, the Board currently only has three qualified licensing medical consultants to review international medical schools who only work on a very limited part-time basis. The Board has the authority to remove its recognition of international medical schools.

Legal Requirements Regarding Approval of International Schools

The Board's process to evaluate and assess international medical schools is comprised of many steps, various protocols, and copious amounts of staff time. The process may take as little as 30 days to as long as three or more years. The time frame is dependent upon timely receipt and review of documentation, expeditious approval of the out-of-country travel proposal, timely completion of the site visit report, and whether the international medical school meets the category for the Board's legal counsel and chief of licensing to approve or if the medical school must be presented to the Board members for a decision at a quarterly Board meeting.

All non-U.S./Canadian medical schools are subject to the Board's individual review and approval, and must demonstrate that they offer a resident course of professional instruction that is equivalent, not necessarily identical, to that provided in LCME-accredited medical schools. The law further provides that only students from "recognized" medical schools may complete clinical clerkship training in California facilities, and only graduates of "recognized" medical schools may qualify for licensure or complete postgraduate training in California.

16 CCR section 1314.1, which took effect in 2003, established a standard review process that informed consumers and international medical school administrators of the minimum standards expected of medical schools whose graduates wish to apply for licensure in California. Section 1314.1 essentially divides international medical schools into two specific types: 1) schools that are owned and operated by the government of the country in which the school is domiciled and the primary purpose of the school is to educate its citizens to practice medicine in that country [also known as "(a)(1) schools"] or 2) schools that have a primary purpose of educating non-citizens to practice medicine in other countries ["(a)(2) schools"].

16 CCR section 1314.1 exempts "(a)(1)" schools from the requirement for an in-depth individual review. This allows the Board to focus its resources on evaluating free-standing proprietary medical schools whose ability to satisfy minimal quality standards is more likely to be subject to question.

16 CCR section 1314.1 "(a)(2)" schools are required to complete the Board's Self-Assessment Report (SAR). This document, originally a 95-page instrument, was replaced in 2004 with the current streamlined SAR. At the same time, a protocol for site inspections of international medical schools was established. The SAR requires the schools to provide information relating to their mission and objectives, organization, curriculum, governance, faculty, admission standards, finances, and facilities.

The review process for "(a)(1)" schools is fairly simple. The review is triggered by an application received from a graduate of a medical school that has not previously been recognized. It is not uncommon for the school in question to have been previously recognized by the Board, but under a different name or university affiliation. Staff contacts the medical school to request information and supporting documentation to determine if it is eligible for

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recognition under 1314.1(a)(1). Staff, legal counsel, and the chief of licensing review the information from the school and make a determination regarding recognition. If the information provided by the school indicates it does not meet the requirements for recognition as an "(a)(1)" school, then the school is directed to submit the SAR if it wishes to pursue recognition.

Many steps are involved in the review of "(a)(2)" schools. While Board analytical staff can review the SARs for completeness and compliance with the regulatory standards, evaluating whether or not the academic programs are sufficient to meet the requirements needs the expertise of someone experienced in medical academics. The success of an adequate evaluation is therefore heavily dependent upon medical consultants experienced in medical education.

16 CCR section 1314.1 was updated in 2009 to add greater specificity to the Board's process for reviewing international medical schools. The update, which was based on the hands-on experiences gained by the Board's medical consultants and staff in reviewing international medical schools, brought the Board's standards in line with changes to LCME's new standards.

As part of the review, the medical consultant will recommend whether or not a site visit should be required. The on-site visit allows the Board's inspection team to verify the information that a medical school submits in its SAR and confirm that the school's program is integrated over long distances. B&P Code section 2089.5(d)(1) provides that the medical school shall bear the cost of any site inspection that the Board finds necessary to determine compliance. If the Board denies a medical school's recognition, the Board's position in any subsequent court action is stronger for having conducted an on-site review.

The reason schools in the "(a)(2)" category fail to gain recognition is typically due to major, global deficiencies in their educational program, resources, governance, etc., that cannot be easily remedied.

Continuing Education/Competency Requirements

Pursuant to B&P Code section 2190 the Board has adopted and administers standards for the continuing medical education (CME) of physicians. Each physician is required to complete not less than 50 hours of approved CME during each two-year period immediately preceding the expiration date of the license. One exception is permitted by 16 CCR section 1337(d), which states that any physician who takes and passes a certifying or recertifying examination administered by a recognized specialty board shall be granted credit for four consecutive years of CME credit for re-licensure purposes.

Since the last report, the transition to BreEZe in October 2013 impacted the ability to perform CME audits. Functionality necessary to automate the process and track audit information on a licensee was unavailable through the BreEZe system, which resulted in the Board's inability to perform the CME audit. The programming of the BreEZe system was not completed and available for performing CME audits until May 2016. In May 2016, Board staff once again began the process of auditing physicians and surgeons on a monthly basis.

Verification of CME

Physicians are required to certify under penalty of perjury upon renewal that they have met each of the CME requirements, that they have met the conditions which would exempt them from all or part of the requirements, or that they hold a permanent CME waiver. 16 CCR section 1338 allows the Board to audit a random sample of physicians who have reported compliance with the CME requirements. The Board requires that each physician retain records of all CME programs attended for a minimum of four years in the event of an audit by the Board.

CME Audits

Currently, the CME audit is performed on a monthly basis and is designed to randomly audit approximately 1% of the total number of renewing physicians per year. The process to select physicians to undergo the audit is done through an automatic batch job through the BreEZe system, based on requirements that have been programmed. If selected for the audit, proof of attendance at CME courses or programs is required to be submitted. Upon receipt of documents a manual review is performed by staff to determine compliance with the law.

If a physician fails the audit by either not responding or failing to meet the requirements as set forth by section 2190 of the B&P Code, the physician will be allowed to renew his or her license one time following the audit to permit him or her to make up any deficient CME hours. However, the Board will not renew the license a second time until all of the required hours have been documented to the Board. It is considered unprofessional conduct for a physician to misrepresent his or her compliance of meeting the CME requirements pursuant to 16 CCR section 1338(c). In addition, the Board has the authority to issue citations for failing to comply with CME requirements.

Prior to the conversion to BreEZe, the Board conducted 1,212 audits in FYs 12/13 and 13/14. Of those randomly selected physicians, 30 failed, which is approximately 2.5% of the physicians audited. As mentioned previously, the functionality to perform CME audits in BreEZe was not made available until May 2016. At this time the audits are being performed on monthly basis; however, due to the recent availability of the functionality, statistics regarding the outcomes of the audits are not currently available.

CME Course Approval

Approved CME consists of courses or programs designated by the American Medical Association (AMA) or the Institute for Medical Quality/California Medical Association (IMQ/CMA) as Category 1 credits related to one of the following: patient care, community health or public health, preventive medicine, quality assurance or improvement, risk management, health facility standards, the legal aspects of clinical medicine, bioethics, professional ethics, or improvement of the physician-patient relationship.

The following are approved CME courses:

- Programs accredited by the Institute for Medical Quality/California Medical Association (IMQ/CMA), the American Medical Association (AMA), and the Accreditation Council for Continuing Medical Education (ACCME) that qualify for *AMA PRA Category 1 Credit(s)*™;

- Programs which qualify for prescribed credit from the American Academy of Family Physicians (AAFP); and

- Other programs offered by other organizations and institutions acceptable to the Division.

The IMQ/CMA and AMA are responsible for approving CME providers as well as courses being designated as Category 1. The Board requires other organizations and/or institutions to obtain certification from one of the approved organizations listed above. However, the Board has provided CME credit for training that the Board provided directly to licensees on a very specific subject matter.

Auditing CME Providers
Pursuant to CCR section 1337.5(b) the Board may randomly audit courses or programs submitted for credit in addition to any course or program for which a complaint is received. If an audit is made, course organizers will be asked to submit to the Board: organizer(s) facility curriculum vitae; rationale for course; course content; educational objectives; teaching methods; evidence of evaluation; and attendance records. Credit towards the required hours of CME will not be received for any courses deemed unacceptable by the Board after an audit has been made.

Licensees' Continuing Competence
Committees have been formed to discuss issues related to the CME requirements as well as the procedures for performing audits. Future enhancements will continue to be discussed and researched for best practices. The Board is also looking at the Maintenance of Licensure/Certification (MOC) issue as proposed by the FSMB. This would require more in-depth and specific continuing education. The MOC programs are still fairly new and are continuing to be updated. The Board is monitoring the MOC programs and will continue to evaluate any need for statute or regulatory changes.

Fictitious Name Permits

Performance Targets/Expectations
16 CCR section 1350.2 requires that the Board shall, within a reasonable time after an application has been filed, issue an FNP or refuse to approve the application and notify the applicant of the reasons therefor. The Board has set an internal expectation that all applications received for FNPs be reviewed within 45 days. The Board is currently meeting this expectation and is reviewing applications within 45 days.

Timeframes for Application Processing – Performance Barriers and Improvements Made
The FNP application volume has slightly increased from the previous fiscal year. Average time to process an FNP application has remained fairly constant, within 45 days. Pending applications have remained the same as last fiscal year.

The Board is continuously striving to review and approve FNP applications within the set timeframes to ensure compliance with the law. Staff ensures that this occurs by reviewing policies and procedures within the Program for best practices and efficiencies.

Table 6.	Licensee Population				
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Fictitious Name Permit	Active	14,106	10,835	12,242	12,529
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	2,811	unknown	4,653*	4,772

* Data current as of 9/16/15.

Table 7a.		Licensing Data by Type									
Fictitious Name Permit		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,034	1,104	109	1,104	unk	-	-	-	-	-
	(Renewal)	3,833	n/a	n/a	3,833	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,370	1,202	67	1,202	unk	-	-	-	-	-
	(Renewal)	6,434	n/a	n/a	6,434	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,331	1,243	27	1,243	352**	-	-	-	-	-
	(Renewal)	5,058	n/a	n/a	5,058	-	-	-	-	-	-

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

Table 7b.	Total Licensing Data		
Fictitious Name Permit	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	1,034	1,370	1,331
Initial License/Initial Exam Applications Approved	1,104	1,202	1,243
Initial License/Initial Exam Applications Closed	109	67	27
License Issued	1,104	1,202	1,243
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	unknown	unknown	352**
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	3,833	6,434	5,058

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

Verification of Applicant Information – Criminal History Information/Prior Disciplinary Action

All FNP applicants, including every medical corporation shareholder, are checked for license status and enforcement actions, on the Board's database system, before the FNP is issued. If a licensee has an open or pending enforcement action, the enforcement staff is notified of the pending FNP application. Further, if the licensee does not have a renewed and current California medical license, the FNP application is denied. All FNP physician applicants are fingerprinted during the initial physician license application process. FNP permits are ineligible for renewal without a current and renewed physician license.

FNP applicants must disclose the type of business that they are applying for, such as professional medical corporation, individual, partnership, or medical group. For medical corporations, the applicant must provide a copy of the endorsed Articles of Incorporation. The FNP applicant's medical corporation is verified against the Secretary of State website for "Active" status. This confirms that the medical corporation is in good standing. This verification is performed to determine that the medical corporation meets the requirements of B&P Code section 2406.

Primary Source Verification

There is no need for primary source verification as there are no documents that would need this type of verification for the FNPs.

Special Faculty Permits

The Board is authorized to issue a Special Faculty Permit (SFP) to a person who is deemed to be academically eminent under the provisions of B&P Code section 2168. The physician must meet the eligibility requirements for issuance of an SFP, must be clearly outstanding in a specific field of medicine or surgery, and must have been offered, by the dean of a California medical school, a full-time academic appointment at the level of full professor or associate professor. In addition, a great need must exist, as clearly demonstrated by the school, to fill that position. This SFP authorizes the holder to practice medicine only within the facilities of the applicable medical school and any formally affiliated institutions.

A review committee was created by law to review applications and make recommendations to the full Board on the approval of such SFPs. The review committee consists of one representative from each of the ten medical schools in California and two Board members (one physician member and one public member) for a total of ten members.

California currently has 10 allopathic medical schools that are eligible to submit applications for SFP applicants:

- Loma Linda University
- Stanford University
- University of California – Davis
- University of California – Irvine
- University of California – Los Angeles

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- University of California – San Diego

- University of California – San Francisco
- University of Southern California
- University of California – Riverside
- California Northstate University College of Medicine

The SFP must be renewed every two years prior to the last day of the SFP holder's birth month. At the time of the SFP holder's renewal, the SFP holder must have the Dean sign the following certification: "Sponsoring medical school dean's certification: I certify under penalty of perjury under the laws of the State of California that this permit holder continues to meet the eligibility criteria set forth in section 2168, is still employed solely at the sponsoring institution, continues to possess a current medical license in another state or country, and is not subject to permit denial under section 480 of the Business and Professions Code."

The SFP holder is required to comply with continuing medical education requirements. In addition to the requirements set forth above, a SFP shall be renewed in the same manner as a physician's license.

Pursuant to B&P Code section 2168.4 and 16 CCR section 1315.02, the dean is required to report to the Board (within 30 days) that an SFP holder no longer meets the requirements to hold an SFP. Upon receipt of notification that an SFP holder no longer meets the requirements for an SFP, the Board will cancel the SFP.

SFP holders are listed on the Board's website with licensed physicians. The public can search the Board's website to verify an SFP holder's current status and public record. The complaint process is the same for an SFP holder, as it is for any complaint the Board receives for a licensed physician.

The Board is notified of any arrests and/or convictions of an SFP holder. An SFP may be denied, suspended, or revoked for any violation that would be grounds for denial, suspension, or revocation of a physician's license. To date the Board has not formally disciplined any SFP holder.

16 CCR section 1319.5 requires that the Board shall, within 60 working days of receipt of an application pursuant to B&P Code section 2168, inform the applicant in writing whether the application is complete or is deficient. The Board is meeting this requirement.

The Board sent a survey in March/April 2016 to the nine of the ten medical schools (at the time of the survey only nine of the medical schools had a representative on the Special Faculty Permit Review Committee (SFPRC)) asking for input regarding whether the Special Faculty Permit is still needed. The survey results were presented at the May 2016 Licensing Committee meeting and at the September 2016 SFPRC Meeting. The SFPRC Members determined there are no statutory changes needed for the SFP.

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Table 6.	Licensee Population				
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Special Faculty Permit	Active	17	19	22	25
	Out-of-State	n/a	n/a	n/a	n/a
	Out-of-Country	n/a	n/a	n/a	n/a
	Delinquent	0	0	0	0

Table 7a.	Licensing Data by Type										
Special Faculty Permit		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6	1	0	1	unk	-	-	-	-	-
	(Renewal)	2	n/a	n/a	2	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	2	3	0	3	unk	-	-	-	-	-
	(Renewal)	13	n/a	n/a	13	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	3	3	0	3	3**	-	-	-	-	***
	(Renewal)	8	n/a	n/a	8	-	-	-	-	-	-

* Optional. List if tracked by the board.
** Data current as of 9/13/16.
*** See chart 7b.

Table 7b. Total Licensing Data			
Special Faculty Permit	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	6	2	3
Initial License/Initial Exam Applications Approved	1	3	3
Initial License/Initial Exam Applications Closed	0	0	0
License Issued	1	3	3
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	unknown	unknown	3**
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)	-	-	273
Average Days to Application Approval (incomplete applications)*	-	-	273
Average Days to Application Approval (complete applications)*	-	-	n/a
License Renewal Data:			
License Renewed	2	13	8

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

All applicants for an SFP are subject to the same background check as a physician applicant. In addition, an SFP license holder is required to comply with the same CME requirements as a physician licensee. Primary source document requirements are the same for an SFP as a physician applicant.

Special Programs

The Board currently has seven special programs that provide limited exemptions for practice in California pursuant to B&P Code sections: 2072, 2073, 2111, 2112, 2113, 2115 and 16 CCR section 1327. Three of the seven programs have not been used for a minimum of five years or more and could be repealed. The following are summaries of each of the special programs:

B&P Code section 2072 – Employment in state institutions of persons licensed in another state
Physicians who are licensed in another state, register and are approved by the Board, and may be appointed to the medical staff within a state institution (State correctional facility or hospital) for up to two years. This section has not been used by any State correctional facility or hospital for over five years. A determination was made by the federal receiver to discontinue the use of this limited option to ensure qualified physicians were employed in these institutions. This section could be repealed.

B&P Code section 2073 – Employment in county general hospitals of persons licensed in another state
Physicians, who are licensed in another state, register and are approved by the Board, and may be employed on the resident medical staff within a county general hospital for up to two years. This section has not been used by any county general hospital for over seven years. This section could be repealed.

B&P Code section 2111 – Postgraduate medical school study by non-citizens
The dean of a California medical school may sponsor an international physician to participate in a visiting fellowship at the sponsoring medical school. The Board must approve the visiting physician prior to the visiting physician starting. The visiting physician may only practice medicine under the direct supervision of the head of the department to which he/she is appointed. The appointment is for one year and may be renewed annually two times for a maximum of three years. The intent is for the visiting fellow to learn a new skill to take back to his or her country. This training will not lead to licensure in California. This training category is used frequently by the medical schools, and the Board has a process to periodically review the program.

Primary source document requirements are the same as a physician applicant. In addition, a Section 2111 applicant is subject to the same background check as a physician applicant. Section 2111 registration holders do not have CME requirements.

B&P Code section 2112 – Participation in fellowship program by non-citizens
A licensed physician in another country may be sponsored by a hospital in this state that is approved by the Joint Commission. The Board must approve the visiting physician and the sponsoring hospital prior to the visiting physician starting. At all times, the visiting physician shall be under the direct supervision of a California licensed, board certified, physician, who

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has a clinical teaching appointment from a medical school that is approved by the Board and who is clearly an outstanding specialist in the field in which the international fellow is to be trained and other licensed physician faculty who have been approved by the Board to provide training and supervision for the Section 2112 registrant. In addition, the approval is for one year and may not be renewed more than four times. This training will not lead to licensure in California. This training category is not as common as the 2111, but has been used. The Board has a process to periodically review the program.

A Section 2112 applicant is subject to the same background check as a physician applicant. Primary source document requirements are the same as a physician applicant. In addition, Section 2112 registration holders do not have CME requirements.

B&P Code section 2113 – Certificate of registration to practice incident to duties as a medical school faculty member
The dean of a California medical school may sponsor an international physician who is licensed in his or her country to a full-time faculty position after approval by the Board. The approval is for one year and may be renewed twice. At the beginning of the third year the dean of the medical school may request renewal by submitting a licensing plan. If the plan is approved by the Board, the Board may renew the appointment two more times. The maximum time in a B&P Code section 2113 appointment is five years. At the end of five years the B&P Code section 2113 registrant must be licensed or the appointment is terminated. The time spent as a B&P Code section 2113 registrant may be used in lieu of the required ACGME accredited postgraduate training for licensure if it has been approved by the Board. The Board has a process to periodically review the program.

A Section 2113 applicant is subject to the same background check as a physician applicant. Primary source document requirements are the same as a physician applicant. In addition, Section 2113 registration holders do not have CME requirements.

B&P Code section 2115 – Postgraduate study fellowship program in specialty or subspecialty in medically underserved area
A physician in another country may be sponsored by a hospital in this state that is licensed by the State Department of Health Services or is exempt pursuant to the Health and Safety Code section 1206 subdivision (b) or (c). The Board must approve the visiting physician and the sponsoring hospital prior to the visiting physician starting. The hospital/fellowship program must be in a specialty or subspecialty and must be in a medically underserved area. At all times, the visiting physician shall be under direct supervision by a California licensed, board certified physician who is clearly an outstanding specialist in the field in which the international fellow is to be trained. Approval is for one year and may not be renewed more than four times. This section does not have any regulations to properly implement it as no hospital has shown interest in this program. This training will not lead to licensure in California. This section has not been used since it became law approximately ten years ago. This section could be repealed.

CCR section 1327 – Criteria for approval of clinical training programs for foreign medical students
Pursuant to B&P Code section 2064 a medical student enrolled in an international medical school recognized by the Board may practice medicine in a clinical training program approved

by the Board. A clinical training program shall submit a written application for such approval. 16 CCR section 1327 allows a hospital, that meets all of the minimum requirements and that has been approved by the Board, to provide clinical clerkships to international medical school students. This section requires the hospital to have a formal affiliation agreement with the school for the specific clerkships that will be taught in the training program.

Special Programs – CCR, Title 16 sections 1318, 1319.1, 1319.2, 1319.3, requires that the Board shall notify the applicant within 10 days of receipt of an application pursuant to B&P Code sections 2111, 2112, and 2113, and CCR, Title 16 section 1327. The Board is currently meeting this requirement.

Below are the statistics for these programs for the last two fiscal years.

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

Medical Assistants

The Board does not license or register medical assistants. However, the Board does approve certifying organizations that provide certification to medical assistants. 16 CCR section 1366.33 requires that within 60 working days of receipt of an application for an approval as a certifying organization, the Board shall inform the applicant in writing whether it is complete and accepted for filing or it is deficient and what specific information or documentation is required to complete the application. There are currently four approved certifying organizations. An initial application for an approved certifying organization was received and having met the requirements was approved by the Board in May 2015. The Board has set an internal expectation that new applications are to be reviewed within 60 calendar days. The Board should be able to meet this expectation for any new certifying organization applications.

16 CCR section 1366.31 outlines the requirements for applying as an approved certifying organization. The applicant must provide information sufficient to establish that the certifying organization meets the standards set forth in regulation. Upon receipt of an application for approval, the Board would establish a team to review the application and supporting documentation. The team would consist of Licensing staff, legal counsel and a medical consultant. All requirements set forth in law would have to be documented by the certifying agency. Upon completion, the application would be presented to the full Board for review and possible approval.

Outpatient Surgery Setting Accreditation

Currently, California law prohibits physicians from performing some outpatient surgeries, unless they are performed in an accredited, licensed, or certified setting.

Existing law specifies that on or after July 1, 1996, no physician shall perform procedures in an outpatient setting using anesthesia, except local anesthesia or peripheral nerve blocks, or both, complying with the community standard of practice, in doses that, when administered, have the probability of placing a patient at risk for loss of the patient's life-preserving protective reflexes, unless the setting is specified in Health and Safety Code section 1248.1. Outpatient settings where anxiolytics and analgesics are administered are excluded when administered, in compliance with the community standard of practice, in doses that do not have the probability of placing the patient at risk for loss of the patient's life-preserving protective reflexes.

As outlined in Health and Safety Code section 1248.1, certain outpatient surgery settings are excluded from the accreditation requirement, such as ambulatory surgical centers certified to participate in the Medicare program under Title 18, health facilities licensed as general acute care hospitals, federally operated clinics, facilities on recognized tribal reservations, and facilities used by dentists or physicians in compliance with Article 2.7 or Article 2.8 of Chapter 4 of Division 2 of the B&P Code.

Pursuant to Health and Safety Codes, the Board has adopted standards for accreditation and approval of accreditation agencies that perform the accreditation of outpatient settings, ensuring that the certification program shall include standards for multiple aspects of the settings' operations.

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The Board has approved the following five accreditation agencies as they have met the requirements and standards set forth by the Health and Safety Code:

- American Association for Accreditation of Ambulatory Surgery Facilities Inc. (AAASF) accredited July 01, 1996
- Accreditation Association for Ambulatory Health Care (AAAHC) accredited July 01, 1996
- The Joint Commission (JC) accredited July 01, 1996
- Institute for Medical Quality (IMQ) accredited October 08, 1997
- American Osteopathic Association/Healthcare Facilities Accreditation Program (HFAP) accredited July 19, 2013

Current law provides that any outpatient setting may apply to any one of the accreditation agencies for a certificate of accreditation. Accreditation shall be issued by the accreditation agency solely on the basis of compliance with its standards as approved by the Board under Chapter 1.3 of the Health and Safety Code.

The Board posts information regarding outpatient surgery settings on its website. The information on the website includes whether the outpatient setting is accredited or whether the setting's accreditation has been revoked, suspended, or placed on probation, or if the setting has received a reprimand by the accreditation agency.

The website data also includes all of the following:

- Name, address, medical license number and telephone number of any owners;
- Name and address of the facility;
- Name and telephone number of the accreditation agency; and
- Effective and expiration dates of the accreditation.

The approved accrediting agencies are required to notify and update the Board on all outpatient settings that are accredited. If the Board receives a complaint regarding an accredited outpatient setting, the complaint is referred to the accrediting agency for inspection. Once the inspection report is received the Board reviews the findings to determine if any deficiencies were identified in categories that relate to patient safety. The Board's Enforcement Program will review any patient safety deficiencies and if necessary, refer the matter for formal investigation. Inspection reports are required to be provided to the Board and posted on the website for public viewing. Also available to the public are the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed.

SB 304, (Lieu, Chapter 515, Statutes of 2013) added B&P Code sections 2216.3 and 2216.4, which require an accredited outpatient surgery setting to report adverse events, as defined in Health and Safety Code section 1279.1 to the Board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, no later than 24 hours after the adverse event has been detected.

The Board must ensure the accrediting agencies are following the law and performing the necessary functions for consumer protection.

Specialty Board Certification

Pursuant to Section 651 of the B&P Code and 16 CCR section 1365.5, a licensed physician may only advertise that he/she is a board certified specialist if he/she is certified by a member board of the ABMS, or a specialty board with an ACGME accredited postgraduate training program, or by a specialty board that has been approved by the Board. To date the Board has approved four specialty boards:

- American Board of Facial Plastic and Reconstructive Surgery (Approved February 3, 1995)
- American Board of Pain Medicine (Approved February 2, 1996)
- American Board of Sleep Medicine (Approved February 6, 1998)
- American Board of Spine Surgery (Approved May 10, 2002)

The Board was mandated pursuant to B&P Code section 651 to develop a specialty board recognition process to recognize specialty boards that are not member boards of ABMS. The Board developed regulations (CCR section 1365.5) for the review process and has an application that must be submitted by any specialty board that is seeking approval by the Board. The application fee is currently $4030.00. Once the application and the required application fee are received, the application is reviewed by an analyst. After the analyst has completed his/her review, the analyst's findings are presented to the appropriate licensing manager, chief of licensing, and the Board's legal counsel for review. If the application is complete and appears to meet the minimum requirements pursuant to B&P Code section 651 and CCR section 1365.5, the Board will have the application and all supporting materials reviewed by a medical consultant. Upon completion of the medical consultant's review, the report will be presented to the Board for review and a decision regarding the specialty board's application for approval. (See Section 10, Prior Sunset Issues for more on this requirement.)

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Section 5

Enforcement Program

- Performance Targets/Expectations
- Trends in Enforcement Data – Performance Barriers and Improvements
- Training
- Proactive Approach
- Legislative enhancements/amendments
- Enforcement Statistics
- Increases or Decreases in Disciplinary Action
- Case Prioritization
- Mandatory Reporting
- Settlements
- Statute of Limitations
- Unlicensed Activity and the Underground Economy
- Citation and Fine
- Citations and Fines – Types of Violations
- Informal Conferences or Administrative Procedure Act Appeals
- Common Citation and Fine Violations
- Citation and Fine Average Amounts – Pre- and Post-Appeal
- Franchise Tax Board Intercept Program
- Cost Recovery and Restitution
- Franchise Tax Board Intercept Program for Cost Recovery
- Restitution

Performance Targets/Expectations

The Board's enforcement functions are at the core of the Board's mission of consumer protection. The Board takes this role very seriously. The Board must ensure that all enforcement units within the Board are performing efficiently and effectively. In addition, the Board must work in conjunction with the DCA Health Quality Investigation Unit (HQIU) and the AG's Office to ensure investigations are completed timely and administrative actions are moved through the disciplinary process as expeditiously as possible. Some notable statistics for the Board for the last three years (FY 13/14 to FY 15/16) include:

- Investigating and closing 23,152 investigations;
- Referring 1,401 cases to the AG's Office for action;
- Filing 960 accusations and/or petitions to revoke probation;
- Obtaining 211 suspension/restriction orders;
- Revoking or accepting the surrender of 394 licenses;
- Placing 441 licensees on probation; and
- Issuing 283 public reprimands/public letters of reprimand.

B&P Code section 2319 states that the Board shall set as a goal that on average, no more than 180 days will elapse from the receipt of a complaint to the completion of an investigation. This section also states that if the Board believes that the case involves complex medical or fraud issues or complex business or financial arrangements then this goal should be no more than one year to investigate. Due to an increase in the number of complaints received, staff vacancies affecting both desk and field investigation workloads, and complexity of the cases, the overall average days to investigate a complaint was 230 days in FY 2015/2016.

Due to an increase in the average desk investigation timeframe, the Board reorganized its Central Complaint Unit (CCU) in 2016. This reorganization redistributed the span and control ratios between management and staff to an appropriate allocation, thus giving managers more time to meet with staff and make certain desk investigations are being processed in a timely manner. Also, CCU reinstituted quarterly case reviews where management meets with each staff person individually to discuss any processing concerns and to provide direction to complete the complaint investigation in the most efficient manner, thereby reducing case aging.

CCU management and staff once again have access to monthly caseload reports, which had been unavailable since the Board's transition to BreEZe. The reports are a tool to assist management and staff with monitoring the progress and age of assigned cases in an effort to reduce their overall case aging timeframes.

The CCU procedure manual is also being updated to include changes made to existing business processes following the Board's transition to BreEZe, and to add sections regarding online complaints and new complaint case types following recent legislative changes, such as vaccination exemption cases, cases pertaining to the End of Life Option Act, and new mandatory reporting requirements.

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Pursuant to B&P Code section 2220.08, the Board is required to have an upfront review by a medical expert on cases involving quality of care, with a limited exception. CCU staff is closely monitoring the time it takes for a medical expert to complete the review and is following up with the expert sooner to ensure this mandated review of the complaint is being done in a timely manner to reduce the overall case processing timeframe.

When a medical expert determines a complaint does warrant referral for further investigation, CCU transfers the complaint to the DCA, Division of Investigation (DOI), Health Quality Investigation Unit (HQIU) to be investigated by a sworn investigator (peace officer). There are thirteen HQIU field offices located throughout the State of California that handle these investigations.

On October 3, 2013, Governor Brown signed Senate Bill (SB) 304 (Lieu, Chapter 515), the Board's Sunset Review bill. This bill made a number of changes to the Board's statutes; however, one of the most significant amendments was the transfer of the Board's sworn investigators, medical consultants, and all support staff for these positions to the new HQIU within DCA, effective July 1, 2014. Although the sworn investigators are now under the authority of a different entity, the investigators still conduct the Board's field investigations in accordance with B&P Code section 2220.05. B&P Code section 2220.05 ensures that the Board prioritizes its investigative and prosecutorial resources to investigative, on a priority basis, allegations that represent the greatest harm.

The Board's investigations sent to HQIU must also be assigned to a Deputy Attorney General (DAG) from the AG's Office pursuant to Government Code section 12529.6. This section of law implemented the Vertical Enforcement and Prosecution (VE/P) model that became operative January 1, 2006. This law requires a DAG and an investigator to be jointly assigned to the investigation at the onset with the DAG providing direction of the investigation performed by the investigator.

The field's average investigation timeframe has increased. In FY 2014/2015 the timeframe was 382 days and during FY 2015/2016 the timeframe increased to 426 days. The HQIU's case processing timeframe increase is primarily due to the increased vacancy rate. It appears there are two root causes contributing to the investigator vacancies: investigator pay and the VE/P system itself. Investigators are leaving DOI to work at agencies that provide higher wages. To address the issue of inadequate wages, a retention pay proposal for HQIU investigators was submitted by DCA. The proposal is currently being evaluated by CalHR, and HQIU anticipates a decision within the next few months.

Regarding the VE/P model, HQIU and the Attorney General's Office continue to improve the working relationship between the two entities, including timelier communication regarding the progress of case investigations among the VE/P team and the reduction of scheduling conflicts related to setting up subject-respondent interviews. One tool developed to assist the VE/P team in working collaboratively on investigation cases was the update of the existing Joint VE/P Manual after the transition of the investigators to the DCA. This manual developed by staff from HQIU, AG's Office and the Board outlines protocols to be taken to reduce delays in the enforcement process and increases the accountability of the team to enhance consumer protection. In 2015, Board staff assisted staff from HQIU and the AG's

Office in conducting three statewide trainings regarding the protocols within the manual. The training covered topics such as: 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.

Two joint training sessions on B&P Code section 805 investigations were conducted in 2016 and included the training on the filing requirements set forth in the law, peer review files, and an overview of a typical 805 investigation. On November 2 and 9, 2016, HQIU and the AG's Office will also conduct subject interview training with the sworn and special investigators and DAGs.

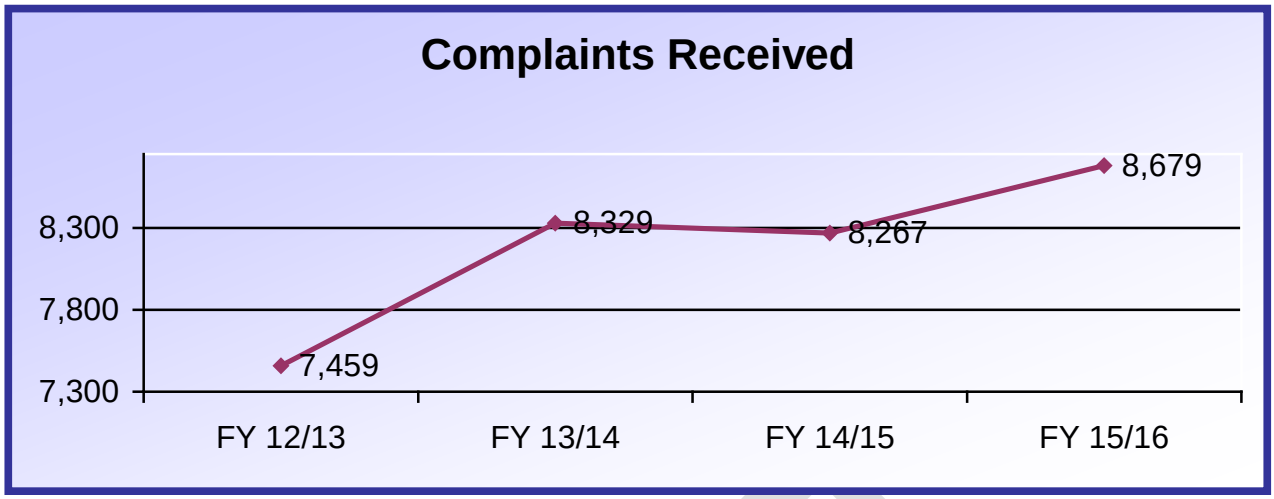
Lastly, a new cloud based content sharing solution was implemented by HQIU and the AG's Office to share confidential evidentiary materials regarding case investigations among the VE/P team in real-time. This development has helped to reduce the time it took for team members to receive important information about a case and as a result, the flow of instantaneous communications about the development of investigations has improved.

To assist with the sworn investigators' caseloads, on July 1, 2014, the Board established the Complaint Investigation Office (CIO). This unit, obtained through the Consumer Protection Enforcement Initiative positions, created six special investigators (non-sworn) and one supervising special investigator (non-sworn) positions. The complaint case types the CIO investigates include: physicians who have been charged with or convicted of a criminal offense, physicians petitioning for reinstatement of a license following revocation or surrender, and certain quality of care investigations following a malpractice settlement or judgment reported to the Board pursuant to B&P Code section 801.01. The ultimate goal in utilizing these positions is to assist in decreasing the number of cases currently assigned to the HQIU investigators by taking the less complex cases from the caseload, thus decreasing the time it takes to complete the investigation process.

In FY 14/15, 309 investigations conducted by non-sworn investigator were closed or referred to the AG's Office for filing of administrative action. The average number of day to close an investigation in that fiscal year was 102 days. In FY 15/16, 391 investigations were closed or referred to the AG's Office for filing of administrative action. The average number of days to close an investigation for FY 15/16 was 124 days. This increase in the average number of days to close an investigation is mainly due to an increase in the workload based on the amount of complaints resulting from medical malpractice settlement cases and criminal conviction cases. The Board is monitoring the growth in workload, and if the workloads continue to rise, may seek to hire additional non-sworn staff to address the issue.

Trends in Enforcement Data – Performance Barriers and Improvements

The Board has seen a continual increase in the number of complaints since the last sunset report. The average complaints received for the three fiscal years of the prior sunset report (FY 09/10 to FY 11/12) was 6861 complaints received; whereas the average of the three fiscal years included in this report (FY 13/14 to FY 15/16) is 8425, an increase of 1,564. Between FY 2014/2015 and FY 2015/2016 there was an increase of 412 complaints, which shows the numbers are continuing to increase.



Although this increase cannot be attributed to one particular reason, a contributing factor may be public outreach efforts to inform health care consumers of the Board's existence and its mission to provide consumer protection. Outreach efforts such as the "notice to consumers" requirement, the "Check Up On Your Doctor's License," and the "Don't Wait, File A Complaint" campaigns, are intended to better inform consumers about the license status of and disciplinary actions taken against physicians and increase awareness regarding the statute of limitation timeframes for filing a complaint. Additionally, with the Board's transition to BreEZe in October 2013, consumers gained the ability to submit a complaint online via the Board's website. Access to an online system has made it more convenient for the public to submit complaints to the Board, however, this enhancement may have also impacted the number of complaints submitted, resulting in an increase in workload. Legislative changes have also resulted in new mandatory reports being submitted to the Board, thus generating additional complaints requiring investigation. Lastly, the Board, over the last two years, has taken a proactive approach to obtaining complaints, and this also may have led to the increase in complaints.

With this increase in complaints, the Board has been unable to meet the requirement of B&P Code section 129 that requires complaints to be opened within 10-days of receipt. In 2016, the Board acquired another position to assist with opening complaints and this individual began employment in August 2016, so the Board anticipates the additional resource will reduce the processing time to open complaints.

In addition, for FY 16/17 the Board received approval to hire one analyst to address the caseload incurred following the addition of B&P Code section 2216.3 into statute. This new law requires the mandatory reporting of adverse events occurring in outpatient surgery settings to be reported to the Board. Also, B&P Code section 2510 was added into statute effective January 1, 2014. This law mandates hospitals report to the Board any planned out-of-hospital child birth deliveries that result in the patient being transferred to a hospital by an LM. This additional analyst will assist with reducing the Board's desk investigation timeframe.

As a direct result of the HQIU vacancy rate, the investigators are carrying higher caseloads and investigations are taking longer to complete. To mitigate these concerns, the HQIU received approval to hire limited term special (non-sworn) investigators and special investigator assistant positions. These new investigator positions will process the less complex cases and the investigator assistant positions will assist in providing support to the sworn and non-sworn staff by retrieving court records, medical records and releases, and serving subpoenas, thereby allowing the investigators to focus on conducting critical case investigation functions.

During FY 2015/2016, parallel prosecution guidelines were developed by the HQIU and the AG's Office to ensure that public protection is achieved in cases that are being submitted to the District Attorney's (DA) Office for criminal prosecution. The guidelines lay out a process for dual referrals to the DA Office and the AG's Office simultaneously. By incorporating dual referrals, the AG's Office is able to review the case for filing of an accusation and recommend any additional evidence needed to pursue administrative disciplinary action, including an assessment of all field complaint investigations to identify those cases that may necessitate interim suspension orders (ISO). This movement to concurrently prosecute investigation cases provides increased consumer protection.

In furthering the Board's mission of consumer protection, the Board directed staff to work with staff from the AG's Office and HQIU to identify improvements that could be made to expedite the issuance of Interim Suspension Orders (ISO). Government Code section 11529 authorizes an ALJ to impose an immediate suspension of a physician's license or place restrictions on the physician's practice, pending the outcome of an administrative hearing, if the Board can prove via a petition that to allow the licensee to continue to practice will endanger the public. Staff from the Board, AG's Office, and HQIU met and identified 14 improvements or policy changes to meet this objective. The improvements/policy changes identified include, but are not limited to, training Board experts to indicate in their findings whether an individual is currently unsafe to practice without any restrictions; monitoring investigation/prosecution cases on a monthly basis to ensure cases that warrant an ISO are moving forward; strict enforcement of B&P Code section 2220(a), which states that within 30-days of receipt of a report pursuant to B&P Code sections 805 or 805.01 the Board must investigate the circumstances to determine if an ISO should be issued; and provide OAH training to ALJs regarding physician impairment.

Due to these changes, there was a significant improvement in both the time it takes to obtain an ISO and the number of ISOs issued from FY 14/15 to FY 15/16. Although the focus of this study was ISOs, the information below identifies all suspensions issued by the Board for both fiscal years. As indicated in the chart below, the improvements yielded a 157 percent increase in the number of ISOs issued and a 150-day decrease in the length of time to obtain an ISO.

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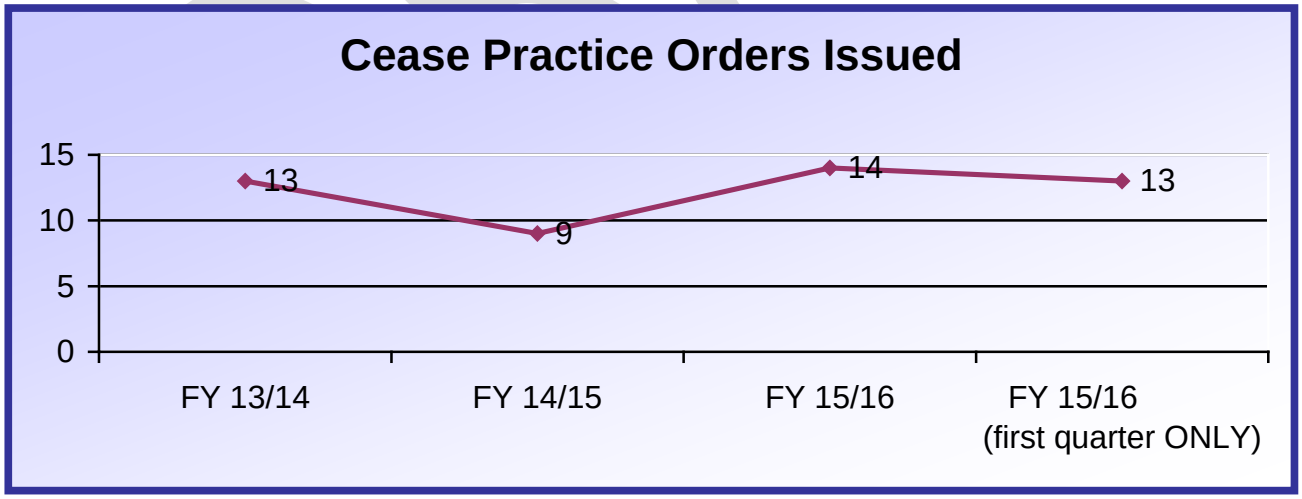
Suspension/Restriction Type	Issued FY 14/15	Issued FY 15/16	*Average Days FY 14/15	*Average Days FY 15/16
Stipulated Agreements	0	1	0	394
Automatic Suspension Orders	4	0	293	0
Cease Practice Orders	9	14	N/A	N/A
Interim Suspension Orders	**14**	**37**	**588**	**438**
Out-of-State Suspension Orders	11	18	71	82
Penal Code section 23/Court Orders	14	15	179	192
TOTAL	**52**	**85**		

The Board's Probation Unit has been ensuring that physicians who are not compliant with their probationary order have action taken expeditiously against their license, whether it is a issuing a citation and fine or a cease practice order, or referring the matter to the AG's Office for appropriate action. The managers have been reviewing and updating policies and procedures and providing training to staff. The Board has focused specifically on issuing cease practice orders for individuals who are not in compliance, and the order allows the Board to issue such an order. The Board's disciplinary guidelines were amended to include language providing that, for certain conditions, if the probationer was not in compliance, the Board could issue a cease practice order. In addition, the new Uniform Standards contain language that also allows the Board to issue a cease practice order when the probationer is not complying with a condition. The chart below indicates the number of cease practice orders the Board has issued over the last three fiscal years and also includes the number of cease practice orders issued in the first quarter of FY 16/17. As noted in the chart, in the first quarter, the Board has already issued nearly as many orders as were issued in the full prior fiscal year.



Training

The Board knows that the medical expert's review of the case is vital to the Board's investigation. Therefore, the Board continues to provide expert reviewer training to physicians who assist with the investigation and prosecution of cases. In the mid 1990's training of the experts was minimal. However, the current training offered has expanded into a full day that involves overviews of the complaint and field investigation process, legal considerations when providing an opinion, a discussion of real case scenarios to provide an understanding of the difference between extreme and simple departures from the standard of care, report writing, and tips to provide effective testimony during a hearing. The participants engage with the presenters through interactive computer equipment to test their knowledge of the materials being presented and the training utilizes presenters from the Board, HQIU, the AG's Office, an attorney who represents respondent physicians, and a retired administrative law judge. This training was provided on March 19, 2016, in San Diego, October 8, 2016, in San Francisco, and November 5, 2016, in Los Angeles.

Additionally, the Board launched a recruitment plan at its July 2016 Board meeting to increase the enrollment of physicians to participate in the Expert Reviewer Program. The three-stage plan, expected to be completed by the fall of 2017, includes enhancements to the Board's website and newsletter regarding the program, the creation of a brochure that highlights the important aspects of being an effective expert, the advertisement and solicitation of new experts in external newsletters and magazines, and the development of short videos that will be maintained on the Board's website to entice further participation into the program.

The Board intends to also provide training during FY 2016/2017 to the CCU medical experts that provide the upfront review of complaints to further its goal of reducing the average desk investigation timeframe. This training will provide similar elements to the expert reviewer training provided to those physicians who perform the final review, however, it will not need to include the training on providing testimony at a hearing.

Also in regard to training, Government Code section 11371 requires that all ALJs receive medical training as recommended by the Board. In coordination with the OAH, the Board continues to identify training for the ALJs who hear Board disciplinary cases. The statewide training is conducted via a video conference to the ALJs in their respective offices. This efficient and cost-effective model allows the OAH to hold training sessions with presenters and ALJs without accruing travel expenses or interrupting hearings. Since July 2015, the Board, through medical experts, has provided four training sessions to ALJs in the topics of anatomy and systems of the body, prescribing practices, medical record keeping, and co-morbid patients. In addition, training is scheduled to be conducted in emergency room procedures and fitness for duty evaluations by the end of 2016. At the conclusion of the year, the Board will have provided six training sessions to the OAH, fulfilling its strategic objective to provide training to the ALJs. In 2017, a needs assessment will be conducted to determine what other topics of interest the ALJs may be interested in and, based on that assessment, further training will be developed and provided.

Proactive Approach

An area where the Board has moved forward in the last two years is in taking a proactive approach to the complaint process. In most circumstances the Board is reactive and waits until a complaint is received for the Board to initiate a complaint. However, beginning with the

opioid epidemic, the Board decided that it would try to identify physicians who may be in violation of the law prior to receiving a complaint from a patient or other source. The Board began to use the CURES system to identify physicians who may be inappropriately prescribing. In addition, the Board requested information from pharmaceutical companies who had identified physicians who may have prescribing issues. The Board also established a data use agreement with the California Department of Public Health to receive death certificates when the death was related to opioids. All these steps have assisted the Board in identifying physicians who may be inappropriately prescribing.

The Board has also established a data use agreement with the Department of Health Care Services (DHCS) and the California Department of Social Services (CDSS) to obtain information related to physicians prescribing to foster care children. This issue was raised by the Legislature and the Board determined that if it could obtain information from these two entities, it may be able to identify physicians who are inappropriately prescribing, as the Board does not receive complaints related to this issue.

Finally, the Board has taken a more active role in reviewing news articles and websites in order to identify physicians who may need investigating. All of these proactive steps are extremely important to the Board's role of consumer protection.

Legislative enhancements/amendments

Over the last four years, the Board has identified several changes to statute that would assist in the enhancement of the Board's Enforcement Program and decrease the timeframes for the enforcement process. Several of the legislative recommendations for enforcement improvements in the last sunset report were placed in the Board's sunset bill. In addition, the Board either sponsored or supported and provided technical assistance to other bills that provided enforcement enhancements in the last four years. The changes listed below have had legislation passed to implement these changes. However, several changes still require legislation and are identified in Section 11, New Issues.

SB 670 (Steinberg, Chapter 399, Statutes of 2013) Physicians and Surgeons: Investigations

This bill amended B&P Code section 2225 to authorize the Board to obtain a deceased patient's medical records from a physician without the consent of the patient's next of kin or a court order in any case that involves the death of a patient with certain conditions. Prior to this bill going into effect, the Board would have to either obtain written authorization from the decedent's next of kin or pursue a subpoena, which requires enough evidence to sustain the enforcement of that subpoena. To have to obtain the authorization or the subpoena resulted in delays in the case and, in some instances, resulted in the Board not being able to move forward with the case. This bill also enhanced B&P Code section 2234(h), which states that it is unprofessional conduct for a licensee who is under investigation to fail to attend and participate in an interview of the Board. Both of these changes enhanced the Board's ability to investigate cases in a more expeditious manner.

SB 1466 (Sen. B&P Comm., Chapter 316, Statutes of 2014) Omnibus – Board Co-Sponsored

The Board's omnibus language in this bill amended B&P Code section 2240(a), which required physicians who perform a "scheduled" medical procedure outside of a hospital, which results in a death, to report the occurrence to the Board within 15 days. The amendment removed the word "scheduled" from the law, thereby requiring all deaths to be reported, whether it was from

a “scheduled” or an unscheduled procedure. This change ensured the Board is receiving more information that could identify a physician who may be a danger to the public.

AB 2745 (Holden, Chapter 303, Statutes of 2016) Healing Arts: Licensing and Certification
This Board-sponsored bill made clarifying changes to existing law to assist the Board in its enforcement functions, specifically related to the Board’s oversight of licensed midwives, polysomnographic registrants, and research psychoanalysts. Specifically, it allowed the Board to revoke or deny a license/registration for applicants and licensees/registrants of these professions who have convictions and have to register as sex offenders or who are impaired due to excessive use of drugs or alcohol. In addition, it allowed these licensees/registrants to petition the Board for license reinstatement, and allowed the Board to use probation as a disciplinary option for these licensees/registrants.

In addition, this bill amended B&P Code section 2225 to allow the Board to obtain a copy of the medical records of a deceased patient without the approval of the next of kin from a facility, such as a hospital, as well as from the physician. Previous law only allowed the Board to contact the physician that owns the records, however, in many cases the records do not reside with the physician. This bill allows the Board to send a written request for medical records to the facility where the care occurred or where the records are located.

All these changes to the Board’s laws have assisted the enforcement program in performing its crucial functions and assisting the Board in meeting its mission of consumer protection.

Enforcement Statistics

Table 9a, b, and c. Enforcement Statistics Physicians and Surgeons ***(including Special Faculty Permits)***

	FY 2013/14	FY 2014/15	FY 2015/16
COMPLAINT			
Intake			
Received	8,005	7,946	8,340
Closed	0	0	0
Referred to INV	8,030	7,867	8,493
Average Time to Close	7 days	12 days	15 days
Pending (close of FY)	197	217	117
Source of Complaint			
Public	5,333	5,486	5,656
Licensee/Professional Groups	274	251	279
Governmental Agencies	946	678	656
Other	1,452	1,527	1,749
Conviction / Arrest			
CONV Received	324	321	339
CONV Closed	0	0	0
Referred to INV	315	317	339
Average Time to Close	9 days	13 days	13 days
CONV Pending (close of FY)	7	2	5

Table 9a, b, and c.	Enforcement Statistics Physicians and Surgeons *(including Special Faculty Permits)*		
	FY 2013/14	**FY 2014/15**	**FY 2015/16**
LICENSE DENIAL			
License Applications Denied	0	2	6
SOIs Filed	4	6	9
SOIs Withdrawn	0	1	3
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	144 days	125 days	113 days
ACCUSATION			
Accusations Filed	273	310	299
Accusations Withdrawn	17	14	7
Accusations Dismissed	0	10	7
Accusations Declined	16	14	8
Average Days Accusations	507 days	513 days	551 days
Pending (close of FY)	112	104	57
DISCIPLINE			
Disciplinary Actions			
Proposed(PD)/Default (DD) Decisions	PD 39 DD 21 Total 60	PD 37 DD 22 Total 59	PD 34 DD 30 Total 64
Stipulations	183	214	205
Average Days to Complete	953 days	970 days	907 days
AG Cases Initiated	497	471	433
AG Cases Pending (close of FY)	427	428	450
Disciplinary Outcomes			
Revocation	45	40	39
Surrender	71	80	80
Suspension	1	0	0
Probation with Suspension	15	13	3
Probation	109	110	117
Probationary License Issued	15	10	14
Public Reprimands	44	54	62
Other	4	3	2
PROBATION			
New Probationers	152	146	140
Probations Successfully Completed	53	66	63
Probationers (close of FY)	In State 530 Out of State 117 Total 647	In State 493[1] Out of State 89 Total 582	In State 499 Out of State 105 Total 604
Petitions to Revoke Probation Filed	30	21	27
Probations Revoked	6	5	10
Probations Surrendered	6	5	7
Probation Extended with Suspension	1	1	0
Probation Extended	12	12	9
Public Reprimands	1	0	1

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Table 9a, b, and c.	Enforcement Statistics Physicians and Surgeons *(including Special Faculty Permits)*		
	FY 2013/14	**FY 2014/15**	**FY 2015/16**
Petitions to Revoke Probation Withdrawn	3	2	0
Petitions to Revoke Probation Dismissed	0	0	1
Probations Modified	3	1	1
Probations Terminated	36	27	15
Probationers Subject to Drug Testing	157	158	158
Drug Tests Ordered	4,432	4,595	5,612
Positive Drug Tests	653[2]	607[2]	597[2]
Petition for Reinstatement Granted	8	11	8
[1] The Board's Annual Report lists 614 probationers, however, it included cases monitored for Public Reprimand/Public Letter of Reprimand conditions and not just probationers. [2] These totals include positive tests for over-the-counter, non-prohibited drugs like Dextromethorphan; alcohol positives from participants who are not ordered to abstain from alcohol; naltrexone or other drugs lawfully prescribed; and instances where there is alcohol in the urine, but not the metabolite for alcohol (which does not indicate consumption but a medical condition). Positive tests that were violations of a probationers' order were as follows: FY 13/14 – 31; FY 14/15 – 4; and FY 15/16 – 17.			
DIVERSION – Not Applicable			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			
INVESTIGATION			
All Investigations			
First Assigned	8,507	8,291	8,863
Closed	6,879	7,731	8,542
Average days to close	312 days[3]	228 days	230 days
Pending (close of FY)	3,568	4,179	4,649
Desk Investigations			
Closed	5,341	7,485	9,001
Average days to close	67 days	140 days	146 days
Pending (close of FY)	2,411	3,065	3,005
Non-Sworn Investigation			
Closed	n/a	309	391
Average days to close	n/a	102 days	124 days
Pending (close of FY)	n/a	184	340
Sworn Investigation			
Closed	1,331	1,097	767
Average days to close	245 days	382 days	426 days
Pending (close of FY)	1,157	930	1,304
COMPLIANCE ACTION			
ISO & TRO Issued	ISO=21 TRO=0 Total=21	ISO=14 TRO=0 Total =14	ISO=37 TRO=0 TOTAL=37

Table 9a, b, and c.	Enforcement Statistics Physicians and Surgeons *(including Special Faculty Permits)*		
	FY 2013/14	**FY 2014/15**	**FY 2015/16**
PC 23 Orders Granted/Issued	17	7	10
Court Orders	0	7	6
Other Suspension Orders	36	24	32
Public Letter of Reprimand[4]	45	32	44
Cease & Desist/Warning	6	5	2
Referred for Diversion	n/a	n/a	n/a
Compel Examination (Filed)	12	12	20
CITATION AND FINE			
Citations Issued	45	5[5]	55[6]
Average Days to Complete	196 days	39 days	540 days
Amount of Fines Assessed	$51,800	$10,000	$46,450
Reduced, Withdrawn, Dismissed	$55,150	$2,500	$9,750
Amount Collected	$31,350	$17,250	$18,400
CRIMINAL ACTION			
Referred for Criminal Prosecution	67	76	41

[3] The report used to gather this statistic used different methodology than in FY14/15 and FY15/16 due to the transition to BreEZe in FY13/14.
[4] These public letters of reprimand are issued prior to an accusation being filed, but are considered disciplinary action and are issued pursuant to B&P Code section 2233.
[5] Effective July 1, 2014, the Board's sworn staff within the Enforcement Program transferred to the DCA, HQIU. The authority to issue a citation by the Enforcement Program was lost due to this transition. The statistic reflects citations issued by the Board's Chief of Licensing only.
[6] Effective August 31, 2015, the Board's Enforcement Program regained authority to issue a citation.

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Table 10.	Enforcement Aging Physicians and Surgeons *(including Special Faculty Permits)*					
	FY 2012/13	**FY 2013/14**	**FY 2014/15**	**FY 2015/16**	**Cases Closed**	**Average %**
Attorney General Cases (Average %)						
Closed Within:						
1 Year	82	24	38	42	186	17%
2 Years	77	65	66	65	273	24%
3 Years	78	80	83	67	308	27%
4 Years	48	55	62	64	229	20%
Over 4 Years	36	39	34	31	140	12%
Total Cases Closed	321	263	283	269	1,136	100%
Investigations (Average %)						
Closed Within:						
90 Days	4,156	3,759	2,664	3,337	13,916	46%
180 Days	1,922	1,614	1,982	1,947	7,465	24%
1 Year	709	888	2,026	2,206	5,829	19%
2 Years	582	558	977	922	3,039	10%
3 Years	66	59	80	130	335	1%
Over 3 Years	2	1	2	0	5	<1%
Total Cases Closed	7,437	6,879	7,731	8,542	30,589	100%

Increases or Decreases in Disciplinary Action

As reflected in the chart above, the disciplinary actions over the last three years have not seen a significant increase or decrease, but have remained steady. However, in comparing the statistics for the last three years to the statistics provided in the prior Sunset Review Report there has been an increase in the actions taken. As seen in the chart below, there has been:

- a 28% increase in the number of revocations/surrenders; and
- a 10% increase in the number of licensees placed on probation (includes probation, probation with suspension, probationary licenses issue, and probation extended).

In addition, the overall average number of days to complete a disciplinary action has decreased over the last three fiscal years by five percent.

	Prior Sunset Review Report			**Three Year Average**	**Current Sunset Review Report**			**Three Year Average**
Fiscal Year	**09/10**	**10/11**	**11/12**		**13/14**	**14/15**	**15/16**	
Suspension/ Restriction Order Issued	62	69	78	**70**	74	52	85	**70**
***Revocation and Surrender**	105	84	117	**102**	128	130	136	**131**
***Probation and Probation with Suspension**	127	121	153	**134**	152	146	143	**147**

Case Prioritization

The Board's complaint priorities are outlined in Business and Professions Code section 2220.05 in order to ensure that physicians representing the greatest threat of harm are

identified and disciplined expeditiously. The Board must ensure that it is following this section of law when investigating complaints received by the Board. The statute identifies the following types of complaints as being the highest priority of the Board:

- 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;
- drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient;
- 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;
- 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;
- sexual misconduct with one or more patients during a course of treatment or an examination; and
- practicing medicine while under the influence of drugs or alcohol.

Mandatory Reporting

There are a significant number of reporting requirements designed to inform the Board about possible matters for investigation. The Board includes information in its Newsletter regarding mandatory reporting, conducts presentations regarding requirements for reporting, and posts information on its website regarding the reporting. The Board continues to look for opportunities to educate those who are mandated to report to ensure they are in compliance. These reports provide the Board with the information necessary to begin an investigation of a physician who might be a danger to the public. In general, it appears most of these reports are being submitted to the Board; however, there is no way to verify if the Board receives 100% of the reports.

B&P Code section 801.01 requires the reporting to the Board of settlements over $30,000 or arbitration awards or civil judgments of any amount. The report must be filed within 30 days by either the insurer providing professional liability insurance to the licensee, the state or governmental agency that self-insures the licensee, the employer of the licensee if the award is against or paid for by the licensee, or the licensee if not covered by professional liability insurance. In general, it appears that these reports are being submitted to the Board within the statutory timeframe. The Board has reminded insurers of the reporting requirements and the importance of providing correct data. During the last four fiscal years the average settlement amount was $478,112.

B&P Code section 802.1 requires physicians to report criminal charges as follows: the bringing of an indictment charging a felony and/or any conviction of any felony or misdemeanor, including a verdict of guilty or plea of no contest.

These incidents appear to be reported as required. The Board is able to confirm that the reporting requirement is being met based on reports of arrest and convictions independently

reported to the Board by the DOJ through subsequent arrest notifications. In addition, the Board conducts Lexis/Nexis searches to identify any arrests being reported in the media. The Board issues citations to physicians who fail to report their criminal conviction as required by this statute. In FY 12/13, the Board issued 36 citations for failing to report pursuant to B&P Code section 802.1; in FY 13/14, the Board issued 17 citations; in FY 14/15, the Board did not issue any citations; and in FY 15/16, the Board issued 4 citations. It is important to note that due to SB 304 and the transition of all sworn staff to DCA, the Board lost the ability to issue citations from July 1, 2014 to August 31, 2015. The Board remedied this through the rulemaking process.

B&P Code section 802.5 requires a coroner who receives information, based on findings reached by a pathologist that indicates that a death may be the result of a physician's gross negligence, to submit a report to the Board. The coroner must provide relevant information, including the name of the decedent and attending physician as well as the final report and autopsy.

The Board does not believe that it is receiving reports from coroners as required by statute. The total number of reports filed pursuant to B&P Code section 802.5 between FY 13/14 and 15/16 is eleven.

B&P Code sections 803, 803.5 and 803.6 require the clerk of a court that renders a judgment that a licensee has committed a crime, or is liable for any death or personal injury resulting in a judgment of any amount caused by the licensee's negligence, error or omission in practice, or his or her rendering of unauthorized professional services, to report that judgment to the board within 10 days after the judgment is entered. In addition, the court clerk is responsible for reporting criminal convictions to the Board and transmitting any felony preliminary hearing transcripts concerning a licensee to the Board.

The Board does not believe that it is receiving reports from the court clerks as required by statute. The total number of reports filed pursuant to 803 and 803.6 between FY 13/14 and 15/16 is thirty-one.

B&P Code section 805 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report when a physician's application for staff privileges or membership is denied or the physician's staff privileges or employment is terminated or revoked for a medical disciplinary cause. The reporting entities are also required to file a report when restrictions are imposed or voluntarily accepted on the physician's staff privileges for a cumulative total of 30 days or more for any 12-month period. The report must be filed within 15 days after the effective date of the action taken by the peer review body. In FY 15/16, 127 reports were received pursuant to B&P Code section 805. By comparing information with the National Practitioners Databank (NPDB), the Board believes it is receiving those reports where the facility believes a report should be issued. Every year the Board does a comparison with the NPDB to ensure it has received the same reports provided to the NPDB.

B&P Code section 805.01 requires the chief of staff and chief executive officer, medical director, or administrator of a licensed health care facility to file a report within 15 days after the peer review body makes a final decision or recommendation to take disciplinary action which must be reported pursuant to section 805. This reporting requirement became effective

January 2011 and is only required if the recommended action is taken for the following reasons:

- Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients in such a manner as to be dangerous or injurious to any person or the public.
- The use of, or prescribing for or administering to him/herself, any controlled substance; or the use of any dangerous drug, as defined in Section 4022, or of alcoholic beverages, to the extend or in such a manner as to be dangerous or injurious to the licentiate, or any other persons, or the public, or to the extent that such use impairs the ability of the licentiate to practice safely.
- 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 effort prior examination of the patient and medical reason therefor.
- Sexual misconduct with one or more patients during a course of treatment or an examination.

The Board provides notification each January through its Newsletter in an article entitled, "Mandatory Reporting Requirements for Physicians and Others," that entities are required to file 805.01 reports, and also wrote a separate article for the Fall 2015 Newsletter entitled, "Patient Protection is Paramount: File Your 805.01 Reports," in an effort to boost compliance with the requirement. However, the Board believes entities are not submitting 805.01 reports as required. In FY 15/16, five reports were received pursuant to B&P 805.01, while in this same fiscal year, 127 B&P Code section 805 reports were received. The Board is seeking additional tools to incentivize compliance with 805.01 reporting. (For more information on this recommendation, see Section 11, New Issues.)

B&P Code section 2216.3 was added into statute on January 1, 2014, requiring accredited outpatient surgery settings to report an adverse event to the Board no later than five days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. In FY 14/15 the Board received 104 adverse event reports. In FY 15/16 111 were received. Adverse events appear to be reported as required, with the number of reports received by the Board increasing as outpatient surgery settings became familiar with the law and gained an understanding of the types of events that should be reported.

B&P Code section 2240(a) requires a physician and surgeon who performs a medical procedure outside of a general acute care hospital that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, to report, in writing, on a form prescribed by the Board, that occurrence to the Board within 15 days after the occurrence. In FY 14/15 the Board received nine patient death reports and in FY 15/16, ten reports were received. The Board requested changes to this section of law to increase consumer protection. SB 1466 (Sen. B&P Comm., Chapter 316, Statutes of 2014) struck the word "scheduled" from existing law that required physicians who performed a "scheduled" medical procedure outside of a hospital, that resulted in a death to report the occurrence to the Board

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within 15 days. Deaths from all medical procedures outside of a general acute care hospital that result in death, whether or not they were "scheduled," have to be reported to the Board.

Settlements

The Board uses its Manual of Model Disciplinary Orders and Disciplinary Guidelines (Disciplinary Guidelines) (Title 16, CCR, section 1361) and the Uniform Standards for Substance Abusing Licensees (Uniform Standards) (Title 16, CCR, section 1361.5) as the framework for determining the appropriate penalty for charges filed against a physician. B&P Code section 2229 identifies that protection of the public shall be the highest priority for the Board, but also requires that wherever possible, the actions should be calculated to aid in the rehabilitation of the licensee. While the Disciplinary Guidelines and Uniform Standards frame the recommended penalty, the facts of each individual case may support a deviation from the guidelines. After the filing of an accusation and/or petition to revoke probation, a respondent physician must file a Notice of Defense within 15 days indicating they intend to present a defense to the accusation and/or petition to revoke probation or that they are interested in a settlement agreement. If the individual requests a hearing, existing law (Government Code sections 11511.5 and 11511.7) requires that a prehearing conference be held to explore settlement possibilities and prepare stipulations, as well as schedule a mandatory settlement conference, in an attempt to resolve the case through a stipulated settlement before proceeding to the administrative hearing.

The assigned deputy attorney general (DAG) reviews the case, any mitigation provided, the strengths and weaknesses of the case, the Board's Disciplinary Guidelines, and, when applicable, any prior disciplinary action against the respondent physician, and drafts a settlement recommendation that frames the recommended penalty. In addition, this settlement recommendation takes into account consumer protection and B&P Code section 2229(b), which states that the Board shall "take action that is calculated to aid in the rehabilitation of the licensee, or where, due to a lack of continuing education or other reasons, restriction on scope of practice is indicated, to order restrictions as are indicated by the evidence." The DAG's recommendation is then reviewed and either approved or edited by the supervising DAG. Once that approval is received, the DAG submits the settlement recommendation to the Board's executive director for review and consideration.

The Board's executive director (or chief of enforcement) reviews the settlement recommendation using the same criteria as the DAG and either approves or changes the settlement recommendation. The DAG then negotiates with the respondent physician and/or their counsel to settle the case with the recommended penalty. Both the prehearing settlement conference and the mandatory settlement conference have the assistance of an administrative law judge (ALJ). This ALJ reviews the case and hears information from the DAG and the respondent physician and/or their counsel and then assists in negotiating the settlement. During the settlement conference, the Board representative must be available to authorize any change to the previously agreed settlement recommendation.

If a settlement agreement is reached, the stipulated settlement document must be approved by a panel of the Board, unless the settlement is for a stipulated surrender. The Board then has the ability to adopt the settlement as written, request changes to the settlement, or request the matter go to hearing. In the process to settle a case, public protection is the first priority, and must be weighed with rehabilitation of the physician. When making a decision on a stipulation,

the panel members are provided the strengths and weaknesses of the case, and weigh all factors.

The settlement recommendations stipulated to by the Board must provide an appropriate level of public protection and rehabilitation. Settling cases by stipulations that are agreed to by both sides facilitates consumer protection by rehabilitating the physician in a more expeditious manner. By entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the Board more timely than if the matter went to hearing. In addition, the Board may get more terms and conditions through the settlement process than would have been achieved if the matter went to hearing.

Fiscal Year	12/13	13/14	14/15	15/16
Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	72	61	44	56
*Pre-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	N/A	N/A	N/A	N/A

*The Board only has the ability to settle a pre-accusation/petition to revoke probation/statement of issues matter. It cannot have a hearing on a matter prior to the filing of an accusation/petition to revoke probation/statement of issues. In addition, the Board only has the authority to offer a public letter of reprimand (B&P Code sections 2233 and 2221.05), a probationary license to an applicant (B&P Code section 2221) or a surrender as a disposition of a pre-accusation/petition to revoke probation/statement of issues matter. In all other cases, an accusation/petition to revoke probation/statement of issues must be filed and it must follow the Administrative Procedure Act. Therefore, there are no cases that went to hearing for a pre-accusation/petition to revoke probation/statement of issues case.

Fiscal Year	12/13	13/14	14/15	15/16
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Settlement	205	183	214	205
Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Hearing	70	39	37	34
*Post-Accusation/Petition to Revoke Probation/Statement of Issues Cases resulting in a Default Decision	40	21	22	30

*Default decisions are included as they represent another method through which a disciplinary action can be taken and should be considered in the types of case resolutions.

Fiscal Year	12/13	13/14	14/15	15/16
Percentage of Cases resulting in a Settlement	72%	80%	81%	80%
Percentage of Cases resulting in a Hearing	18%	13%	12%	11%
*Percentage of Cases resulting in a Default Decision	10%	7%	7%	9%

*Default decisions are included as they represent another method through which a disciplinary action can be taken and should be considered in the types of case resolutions.

Statute of Limitations

B&P Code section 2230.5 sets forth that an accusation against a licensee pursuant to Government Code section 11503 shall be filed within three years after the Board discovers the act or omission alleged as the grounds for disciplinary action, or within seven years after the act or omission alleged as the grounds for disciplinary action occurs, whichever occurs first.

Exceptions to this law include an accusation alleging the procurement of a license by a fraud or misrepresentation, in which case there is no statute of limitation, or if it is proven that the licensee intentionally concealed from discovery his or her incompetence, gross negligence or repeated negligent acts which would be the basis for filing an accusation. For allegations of sexual misconduct, the accusation shall be filed within three years of when the board discovers the act or omission or within 10 years after the act or omission occurs, whichever occurs first. If the alleged act or omission involves a minor, the seven-year statute of limitations period provided for and the 10-year limitations period provided for regarding sexual misconduct allegations shall be tolled until the minor reaches the age of majority.

The chart below identifies the number of complaints filed with the Board after the seven-year statute of limitations had elapsed or would elapse before the investigation could be completed. The Board maintains these complaints as a part of the physician's complaint history and advises the complainant that administrative action against the physician cannot be pursued because the statute of limitations has passed. The chart also identifies the unit where the file was located when the case had to be closed due to the loss of the statute of limitations.

Fiscal Year	13/14	14/15	15/16
Central Complaint Unit	129	145	152
Complaint Investigation Office	4	4	1
Health Quality Investigation Unit	2	1	5
Attorney General's Office	1	1	0
Total	136	151	158

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Unlicensed Activity and the Underground Economy

The Board continues to investigate unlicensed activity through the efforts of investigators from the DCA, HQIU's Operation Safe Medicine (OSM). In FY 2012/2013 OSM received permanent position authority for four special investigators and one working supervising special investigator to address the unlicensed practice of medicine in the State of California. Due to vacancies in OSM in FY 2015/2016, other investigators from the HQIU have been working unlicensed complaints.

Unlicensed Investigations Per Fiscal Year	13/14	14/15	15/16
Referred for Criminal Prosecution*	16	23	14
Felony Convictions	7	3	2
Misdemeanor Convictions	14	7	1
Referred to Administrative Action for Aiding and Abetting Unlicensed Practice of Medicine	11	7	7

* A number of criminal cases are still pending conviction.

The unlicensed practice of medicine is currently not designated as a priority by B&P Code section 2220.05, however the volume and seriousness of the cases investigated by OSM warrant continued efforts to mitigate this unscrupulous activity and to provide public protection to California patients.

Highlights of cases involving unlicensed practice of medicine that have been investigated by OSM or the HQIU field offices are:

- Three unlicensed individuals working out of the same clinic were arrested multiple times for unlicensed practice of medicine. Two of these individuals were prior licensees who were revoked. One of the prior licensees was convicted of involuntary manslaughter concerning the death of a patient. Two of the unlicensed individuals were convicted of felony unlicensed practice and additional felony charges are pending against all three individuals.

- An unlicensed individual treated a minor who had HIV and eventually died. The unlicensed individual was sentenced to 6 years and 4 months in prison and ordered to pay restitution.

- An unlicensed individual treated numerous patients for various illnesses, including cancer. He charged thousands of dollars for fraudulent miracle treatments. He was convicted of felony unlicensed practice and is awaiting sentencing.

- An unlicensed individual was charged with unlicensed practice, conspiracy and sexual misconduct for illegally performing medical services and sexually assaulting a patient. A licensee was also charged in this case for aiding and abetting the unlicensed practice of medicine. The cases are pending conviction.

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- A medical assistant for a San Diego orthopedic doctor was posing as the team physician for a local high school football team. The individual was arrested and convicted of unlicensed practice of medicine.

- An unlicensed person was practicing psychology by counseling children. The case was filed by the Los Angeles City Attorney's office and the individual was convicted of misdemeanor unlicensed practice of medicine.

- At a weight loss clinic in Garden Grove, a medical assistant was dispensing controlled substances without physician supervision The subject was convicted of a misdemeanor unlicensed practice of medicine.

- An aesthetician was running a medical spa with her husband, a registered nurse, in Korea Town, Los Angeles, paying a physician to be a medical director on paper. The subject was convicted of misdemeanor unlicensed practice of medicine. The licensee was convicted of aiding and abetting the unlicensed practice.

- An unlicensed individual was performing medical services and sexually assaulting patients. He was convicted and sentenced to 20 years.
- An unlicensed woman in Fremont who practiced Ayurvedic holistic healing provided the undercover investigator with several compounded powders and liquids to treat "particles" in her system. Ayurvedic holistic medicine uses herbal, mineral or metal compounds and special diets to treat ailments. The powders turned out to contain dangerously high levels of lead, mercury and other heavy metals.

In spite of the outstanding efforts of OSM and the HQIU field offices to curtail unlicensed activity, there are times when a District Attorney or City Attorney will not file charges against an individual for the unlicensed practice of medicine. In these instances, the Board can issue an administrative citation for violation of B&P Code sections 2052 and 2054. The following chart represents the number of citations issued for the unlicensed practice of medicine.

Fiscal Year	13/14	14/15	15/16
Citations Issued for B&P Code section 2052 and 2054	2	0	4

Citation and Fine

The Board's regulations, 16 CCR section 1364.10, authorized a "board official" to issue a citation, fine, and an order of abatement. The "board official" was defined as the chief, deputy chief, or supervising investigator II of the Enforcement Program, or the chief of licensing of the Board. The regulations (sections 1364.12 and 1364.14) also required the board official who issued the citation to perform certain functions, including holding the informal conference, authorizing an extension, etc. However, the chief of licensing could only issue citations to physicians who practiced on a delinquent, inactive, or restricted license or to an individual who practices beyond the exemptions authorized in sections 2065 and 2066 of the Business and Professions Code (section 1364.13).

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With the transfer of the Board's sworn staff on July 1, 2014, the only remaining staff permitted to issue a citation was the chief of licensing; however, the chief of licensing was not authorized to issue citations for minor violations of the Medical Practice Act, so this left no other staff person to issue those citations.

The Board amended its regulations to allow the executive director or his or her designee to issue citations and perform the functions once a citation is issued. These regulatory changes became effective in August 2015.

The Board has a new rulemaking package pending to amend 16 CCR sections, 1364.10, 1364.11, 1634.13, and 1364.15. These amendments give authority to the Board to issue a citation for violations of law to licensed midwives, and polysomnographic technologists, technicians, and trainees. Furthermore, the Board is proposing other changes to the list of citable offenses, including adding citation authority for not registering for CURES and for not following the standard of care when considering medical exemptions for vaccinations. A public hearing on these regulatory changes was held on October 28, 2016.

A citation order can include a fine and/or order of abatement. The amount of the fine takes into consideration the violation type, factors surrounding any violation(s), cooperation of the subject and his/her efforts to reach compliance, prior complaint history, prior citations, and any impact on the public. In 2005, the Board amended its regulations to increase the maximum fine amount to $5,000. Since the last Sunset Review Report, the Board has issued four citations with a $5,000 fine.

Citations and Fines – Types of Violations

The Board issues citations primarily for technical violations of the law, such as failing to comply with advertising statutes, failing to report criminal convictions, or failure to report a change of address to the Board. The Board also has the authority to issue citations for the unlicensed practice of medicine. This administrative remedy is used when the local district attorney chooses not to pursue criminal charges against the individual or when licensing finds unlicensed activity during the review of an application for licensure. This has been an effective tool in response to the increase in laypersons working in medi-spa settings providing services that require medical knowledge and training, and for the physicians who are being charged with aiding and abetting the unlicensed practice of medicine. The Board also issues citations to licensees for minor violations of the terms and conditions of their probationary order.

The Board has increasingly issued citations for violations identified during the course of an investigation that do not rise to the level to support disciplinary action, such as the physician failing to maintain an adequate medical record to document the treatment provided. In these situations, the Board may require the physician complete an educational component, such as a medical recordkeeping course, in order to satisfy the citation. In a variety of situations, the Board is able to address an identified deficiency with an educational component and remediate the physician without the expense of an administrative action and hearing.

Informal Conferences or Administrative Procedure Act Appeals

The Board does not conduct Disciplinary Review Committees for appeals of a citation. This chart depicts the number of requests received for an informal conference and the number of requests for hearings to appeal a citation and fine.

Fiscal Year	Requests for Informal Office Conferences	Request for Hearings (Appeals)	Total
12/13	75	3	78
13/14	19	3	22
14/15	3	0	3
15/16	20	3	23

Common Citation and Fine Violations
This chart identifies the Board's top five most common violations for which citations are issued. The top five are all violations of the Business and Professions Code.

	Top Five Violations Charged
1	Section 2266 – Failure to Maintain Adequate and Accurate Medical Records
2	Section 802.1 – Failure to Report Criminal Convictions
3	Section 2021(b) – Failure to Report Change of Address
4	Section 2052 – Unlicensed Practice of Medicine
5	Section 2264 – Aiding and Abetting Unlicensed Practice of Medicine

Citation and Fine Average Amounts – Pre- and Post-Appeal
The Board is utilizing its citation authority to gain compliance with existing statutes or to improve the physician's skills by requiring the completion of educational courses in order to stratify the citation. The data from FY 15/16 indicates that two (4%) citations were withdrawn once an educational course was completed by the physician. During this same time period, approximately two citations were withdrawn following the informal conference due to concerns about the evidence available to support the violation as charged in the citation. There was one citation withdrawn following the informal conference or appeal without either an educational course being ordered or compliance achieved before the informal conference. In cases where the fine amounts were modified following an informal conference or appeal, during FYs 12/13 to 15/16, the average fine as originally issued was $1,300 and was reduced to $422 following an appeal.

Franchise Tax Board Intercept Program
The Board utilizes a number of strategies to collect outstanding fines. B&P Code section 125.9 authorizes the Board to add the amount of the assessed fine to the fee for license renewal. When the physician has not paid an outstanding fine, a hold is placed on his or her license and it cannot be renewed without payment of the renewal fee and the fine amount. This same statute also authorizes the Board to pursue administrative action for failing to pay the fine within 30 days of the date of assessment, if the citation has not been appealed. The Board will

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pursue outstanding fines through Franchise Tax Board's (FTB) intercept program; however, the two administrative sanctions available to the Board have been very successful in collecting outstanding fines from licensees. The Board also issues citations to unlicensed individuals and utilizes FTB's intercept program to collect outstanding fines in these cases.

Cost Recovery and Restitution

Effective January 1, 2006, the legislature eliminated the Board's ability to recover costs for administrative prosecutions. However, if a physician's license was revoked or surrendered through the administrative process and this individual petitions to reinstate his or her license, some administrative law judges will order cost recovery for unpaid balances incurred prior to January 1, 2006, if the petition for reinstatement is granted.

The Board orders probationers to pay a per annum fee for monitoring costs. A probationer cannot successfully complete probation without these costs being paid in full, therefore there is very little money that remains uncollected. However, if a probationer's license is revoked or surrendered while on probation, the Board does not collect any outstanding fees prior to the revocation or surrender. However, should the individual petition to reinstate his or her license, some administrative law judges will order cost recovery for the outstanding probation monitoring costs upon reinstatement, if reinstatement of the license occurs.

The Board does seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered by the courts and received by the Board for criminal prosecutions.

Fiscal Year	13/14	14/15	15/16
Criminal Cost Recovery ordered	$86,610	$18,300	$134,174
Criminal Cost Recovery received	$38,330	$84,291	$59,385

Franchise Tax Board Intercept Program for Cost Recovery

Because the legislature eliminated the Board's ability to recover investigation costs, all licensees whose licenses are revoked, surrendered, or ordered to serve probation do not pay any cost recovery costs. However, the Board still uses the FTB Intercept Program for monies ordered prior to 2006. Of those physicians ordered to pay cost recovery, 63 have been reported to the FTB Intercept Program. The Board rarely receives monies from the FTB to satisfy these unpaid costs. The total amount outstanding for prior cost recovery, including those reported to FTB, is $2,720,467.22.

The Board does not use the FTB to collect unpaid probation monitoring costs, as failure to pay these costs is considered a violation of probation for which additional disciplinary action is sought.

Restitution

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice of medicine can be referred by the Board to the local district or city attorney for prosecution, and if a Judge may order restitution.

Table 11.	Cost Recovery			(list dollars in thousands)
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Total Enforcement Expenditures [1]	$41,525	$45,626	$46,331	$47,695
Potential Cases for Recovery [2]	n/a	n/a	n/a	n/a
Cases Recovery Ordered	1	0	1	0
Amount of Cost Recovery Ordered	$45,000	$0	$52,093	$0
Amount Collected	$21,004	$2,450	$8,658	$1,950

[1] Includes Health Quality Investigation expenditures of $16,313,540 in FY 14/15 and $16,335,960 in FY 15/16 and Pro Rata. Excludes both scheduled and unscheduled reimbursements.

[2] "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act. Since the Board cannot order investigative cost recovery this is not applicable.

Table 12.	Restitution			(list dollars in thousands)
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Amount Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

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Section 6

Public Information Policies

- Board's Website and Posting Meeting Materials and Minutes
- Webcasting
- Meeting Calendars
- Complaint Disclosure Policy and Posting Accusations/Disciplinary Actions
- Information Available to the Public
- Consumer Outreach and Education

Board's Website and Posting Meeting Materials and Minutes

The Board uses the internet in several areas to keep the public and licensees informed about the Board's activities. The Board's website, subscription list, licensee/applicant email service, and Twitter account are all methods the Board uses to ensure information is getting out to licensees, applicants, and the public.

The Board's website contains information and is continually updated to reflect upcoming Board activities, changes in laws or regulations, and other relevant information of interest to its stakeholders. Prior to all Board and committee meetings, the agenda is posted on the Board's website, including links to all available agenda materials that are included in the meeting packets. This information is posted at least 10 days prior to the meeting, and additional post-agenda items materials are added as they become available. This information remains available on the website indefinitely. The Board and committee draft minutes are posted on the Board's website as an agenda item for the next Board/committee meeting, and are therefore posted at least 10 days in advance of the next meeting. The draft minutes will always remain as an agenda item for that meeting. In addition, once the minutes have been formally approved and adopted by the Board/committee at the subsequent meeting, those final minutes are posted on the Board's website where they remain indefinitely. This happens within thirty days after the meeting in which the minutes were approved.

The Board helps get information to the public in a timely manner, using several methods. First, the Board uses a subscription service on its website to send subscriber alerts to interested parties. The public can go to the Board's website and choose from a list of items (i.e. board meeting information, Newsletters and news releases, proposed regulations, and Board enforcement actions) that they can "subscribe" to in order to receive email alerts relating to that item. Subscribers will automatically be sent email information when the Board updates something the person has subscribed to, such as when the Board posts a new meeting agenda or takes disciplinary action against a licensee. The Board wants to ensure the public has every opportunity to receive up-to-date information about the Board.

The second method in which the public and licensees receive timely information from the Board is via Twitter. Information regarding Board meetings, minutes, press releases, the Newsletter, DEA drug take back days, etc. is tweeted to those who follow the Board via Twitter. The Board has also used Twitter to get information out to licensees about important law or regulation changes, FDA alerts, recall information, etc. The Board believes that social media is an important outreach tool and has used this to get information out in an expeditious manner.

Finally, the Board uses emails it has obtained from applicants and licensees to get out important information about the Board to those individuals, including law or regulation changes, specific CME opportunities, FDA alerts and warnings, Newsletters, or information from other state agencies pertinent to physicians. The Board does not over-utilize this resource, because it wants licensees to understand that if information is coming to them via email from the Board, then it is important information that may impact their license or that requires them to do something.

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Webcasting
The Board webcasts all of its Board meetings and most of its committee meetings. The Board will continue to webcast all Board and committee meetings; however, this is dependent upon DCA resources. When DCA staff is not available to webcast a meeting, the meeting is filmed and subsequently posted on the Board's website. The webcast of the Board's meetings, at this time, remain on the Board's website indefinitely.

In addition to webcasting, which provides the public a way to view the Board meeting, the Board began allowing the public to listen and comment at its meetings via the telephone. The public calls a specific number and can listen to the Board meeting and can make comments and provide input on all agenda items. Consumers have successfully participated in Board and committee meetings by telephone since the Board began offering this option in 2014. This allows individuals who cannot travel to the Board's meetings the ability to provide input and comment to the Board.

Meeting Calendars
Board meeting calendars are reviewed and approved by the Board during the April/May Board meeting for the following calendar year, and are posted on the website as soon as the dates are approved by the Board. Because committee meetings are only held on an as-needed basis they are not set for the entire year but are posted as soon as a date is selected or when it is known the committee is going to meet.

Complaint Disclosure Policy and Posting Accusations/Disciplinary Actions
The information the Board posts to a licensee's profile and can provide to the public is specifically set forth in statute (B&P Code sections 803.1 and 2027). The Board is very committed to ensuring the public is provided information regarding license status and disciplinary or administrative actions against its licensees. In fact, the Board recently sponsored legislation (AB1886, Eggman, Chapter 285, Statutes of 2014) to change the website posting requirements to provide information to the public for a longer period of time. The Board exceeds the DCA recommended minimum standards and is consistent with DCA website posting of accusations and disciplinary actions. In the event that the portion of the Board's website that enables consumers to look up a physician is not operational at the time the information is requested, the Board provides a phone number for consumers to call to ask about Board accusations and disciplinary actions. In addition to the information the DCA recommends in its minimum standards for disclosure, the Board's website provides the following information:

- If a physician has been disciplined or formally accused of wrongdoing by the Board (public reprimands and public letters of reprimand are only available for ten years on the website).
- If a physician's practice has been temporarily restricted or suspended pursuant to a court order.
- If a physician has been disciplined by a medical board of another state or federal government agency.
- If a physician has been convicted of a felony reported to the Board after January 3, 1991.
- If a physician has been convicted of a misdemeanor after January 1, 2007, that results in a disciplinary action or an accusation being filed by the Board, and the accusation is not subsequently withdrawn or dismissed.

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- If a physician has been issued a citation (that has not been withdrawn or dismissed) for a minor violation of the law by the Board within the last three years.
- If a physician has been issued a public letter of reprimand at time of licensure within the last three years.
- Any hospital disciplinary actions that resulted in the termination or revocation of the physician's privileges to provide health care services at a healthcare facility for a medical disciplinary cause or reason reported to the Board after January 1, 1995.
- All malpractice judgments and arbitration awards reported to the Board after January 1, 1998 (between January 1, 1993 and January 1, 1998, only those malpractice judgments and arbitration awards more than $30,000 were required to be reported to the Board).
- All malpractice settlements over $30,000 reported to the Board after January 1, 2003, that meet the following criteria:
    - Four or more in a 5-year period (beginning 1/1/03) if the physician practices in a high-risk specialty (obstetrics, orthopedic surgery, plastic surgery and neurological surgery).
    - Three or more in a 5-year period (beginning 1/1/03) if the physician practices in a low-risk specialty (all other specialties).

Information Available to the Public

In addition to the information above regarding public record actions, the Board discloses the following information regarding past and current licensees:

- License number;
- License type;
- Name of the licensee or registrant, as it appears in the Board's records;
- Address of record;
- Address of record county;
- License status;
- Original issue date of license
- Expiration date of license;
- School name; and
- Year graduated.

The Board provides the following voluntary survey information as supplied by the licensee:

- Licensee's activities in medicine;
- Primary and secondary practice location zip code;
- Telemedicine primary and secondary practice location zip code;
- Training status;
- Board certifications;
- Primary practice area(s);
- Secondary practice area(s);
- Post graduate training years;
- Ethnic background;
- Foreign Language(s); and
- Gender.

Unless prohibited by law, the Board provides the actual documents on the website for the following:

- Accusation/petition to revoke or amended accusation;

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- Public letter of reprimand;
- Citation and fine;
- Suspension/restriction order; and
- Administrative/disciplinary decision.

The Board's website and the information it provides to consumers was recently ranked top in the nation by *Consumer Reports*.

Consumer Outreach and Education

In late August 2015, the Board launched a successful outreach campaign entitled "Check Up On Your Doctor's License." The campaign is designed to encourage all California patients to check up on their doctor's license using the Board's website. In addition, the Board updated its website to provide patients with information on how to use the Board's website and what the information means, including disciplinary action taken against a doctor. The Board also developed brochures in English and Spanish and a video tutorial in English and Spanish that is posted on the Board's website and available on YouTube. The Board has successfully worked with numerous counties and cities in California, as well as the California State Retirees, CalSTRS, and CalPERS in getting its campaign information in publications, websites, tweets, and Facebook. In addition, the Board worked with the State Controller's Office to include information about the Board's campaign on payroll warrants for all state employees and vendors. At this time, the outreach campaign has the potential of reaching 17 million California health care consumers. The Board saw an increase in its web hits and placement in Google, Yahoo, and Bing web search analytics.

The Board employs a public information officer to direct outreach and education activities. In addition, the Board has a Public Outreach, Education and Wellness Committee that discusses and makes recommendations on needed outreach and education. There are four main ways the Board provides education and outreach:

(1) Personal/speaking appearances;
(2) Brochures and publications;
(3) Licensing education outreach; and
(4) Twitter, Subscriber's Alerts, and the website.

Personal/speaking appearances are one of the main ways the Board provides outreach and education. Board staff attends community events to distribute materials, provide presentations, and raise awareness about the Board. Due to budget restrictions, the Board cannot attend all outreach events, but does make an effort to do as many presentations as possible. The Board posted a notice in its Newsletter offering a Board presenter to both public and licensee groups. The Board has been making numerous presentations to physician groups regarding the opioid misuse and abuse issue where the Board's *Guidelines for Prescribing Controlled Substances* are reviewed and discussed. In addition, presentations are provided to public organizations educating them on opioid misuse and abuse. The Board also provides education to licensee groups/organizations on the Board's complaint and disciplinary process and provides information on awareness of the Board's laws and regulations. Consumer education presentations include information on how to ensure a physician is licensed and in good standing as well as how to file a complaint.

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Brochures and publications are available on the Board's website and are provided at community outreach events (all can be easily downloaded and printed locally). For the events that Board staff are unable to participate in, brochures are supplied to the event organizers for distribution. These publications include:

- A Patient's Guide to Blood Transfusion – English and Spanish
- A Woman's Guide to Breast Cancer Diagnosis and Treatment – English, Spanish, Chinese, Japanese, Korean, Russian, Tagalog, Vietnamese
- Professional Therapy Never Includes Sex – English and Spanish
- What You Need to Know About Prostate Cancer – English and Spanish
- Information and Services for Consumers – English and Spanish
- Don't Wait, File a Complaint!
- How Complaints Are Handled
- Most Asked Questions About Medical Consultants
- Questions and Answers About Investigations
- Manual of Model Disciplinary Orders and Disciplinary Guidelines
- Uniform Standards for Substance-Abusing Licensees
- Guidelines for Prescribing Controlled Substances for Pain
- Tip Sheets – English, Spanish, Chinese, Russian, Thai, Korean, Hmong, Vietnamese
- Guide to the Laws Governing the Practice of Medicine
- From Quackery to Quality Assurance
- Preserve a Treasure – Know When Antibiotics Work
- Medical Board Annual Report
- Medical Board Quarterly Newsletter
- Check Up on Your Doctor's License Brochure

Licensing Education Outreach allows Board staff to work directly with postgraduate program directors and deans to assist them in understanding the licensure laws and the issues their "interns/residents" might face in the licensing process. In addition, it allows staff to work one-on-one with medical residents to understand the licensing process and to inform them what documents are needed for licensure. This allows students and residents to meet personally with Board staff, to answer any questions they may have, and review their documents before they submit an application. This saves the Board both time and labor, and avoids the rush of last minute applications for licensure, which can create a situation that delays licensing due to the overwhelming volume of applications coming into the Board at one time. Due to this outreach, the Board has been able to encourage applicants to submit applications as soon as possible, therefore eliminating the large influx of applications at one time. In addition, Board staff will attend new medical student orientation sessions and postgraduate trainee orientation sessions. The intent is to provide information about the Board and to answer questions.

Subscriber's Alerts provide information to individuals who have subscribed to receive specific Board information. An individual can go to the Board's website and sign up to receive these alerts by submitting their email address. The different categories include Board meetings, Newsletters and news releases, enforcement actions, and regulations. When the Board posts information related to these categories, an email is sent to the subscriber with either a link to the information (such as the Board's Newsletter) or with the information itself (such as a listing of the physician's name and the disciplinary action the Board is taking against the physician's license) in the email.

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Twitter is something the Board began to use in early 2015 and has been an excellent source of outreach. The Board is able to provide information quickly to those who follow the Board, including notification of outreach events, CME events, Board meetings, tutorials that are available, etc. In addition, individuals can notify the Board of an issue through Twitter. For example, one individual made a comment about her application. The Board was able to identify the individual and contact her to assist in the process.

The Board's w*ebsite* is used as the main source of communication between interested parties and the Board. The Board's website provides electronic editions of all the Board publications, Newsletters, meeting agendas, laws, regulations and meeting materials. On the website under the "About Us" tab is information about the Board, including its history, Board members, and Board staff.

The website also includes links to helpful documents and other entities' websites. Some of these useful links are:

- Advanced Health Care Directive Registry
- Collagen - Information to Patients Regarding Collagen Injections
- Consumer's Guide to Healthcare Providers
- HIPAA - Protecting the Privacy of Patients' Health Information
- Medical Spas - What You Need to Know
- Patient Access to Medical Records
- Resources Available to Help Reduce Cost to Patients of Life-Saving Mammograms
- Specialty Board Advertising
- How to Choose a Doctor / Physician License Information
- Role of the Medical Board of California
- Enforcement Process
- Conviction - How it Might Affect a Medical License
- California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care
- CURES Information
- End of Life Option Act
- Public Disclosure Information

The Board also includes Frequently Asked Questions (FAQ) on numerous topics for both the public and licensees. Some of these FAQs include:

- Complaint Process
- General Office Practices/Protocols
- Internet Prescribing and Practicing
- Medical Records
- Physician Credentials/Practice Specialties
- Public Information/Disclosure
- Medical Assistants
- Cosmetic Treatments
- Fictitious Name Permits

The Board's website is also a tool for updating information and submitting applications, as well as research. Licensees may renew their license to practice medicine, apply for a physician's

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and surgeon's license, update an email address, update the physician survey, and update an address of record.

The website also includes the Board's laws and regulations, including proposed regulations, which govern the practice of medicine in California. It also provides statistics concerning the Board's Enforcement and Licensing Programs.

The website serves as the Board's main way to communicate with the public, licensees and applicants. In the last fiscal year the Board had almost 2 million hits to its website. There has been a decrease in the last two fiscal years compared to FYs 12/13 and 13/14. This decrease is mostly likely associated with the implementation of the DCA BreEZe database in FY 13/14 because the public can now use the BreEZe website to lookup information on the Board's licensees, rather than having to come to the Board's website for this information.

Fiscal Year	FY 12/13	FY 13/14	FY 14/15	FY 15/16
Website Hits	2,585,505	2,294,121	1,827,718	1,906,115

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Section 7

Online Practice Issues

- Online Practice Regulation

Online Practice Regulation

The Board actively investigates complaints regarding inappropriate online practice. These types of complaints follow the same investigative and prosecutorial process as all other complaints received by the Board. The Board has seen an increase in the number of complaints regarding the use of telehealth. As technology advances, the Board must be aware of situations where physicians are not complying with telehealth laws and not following the standard of care in providing services to patients. One of the most frequent violations is physicians treating California patients via telehealth from another state without having a California license. In the past, complaints regarding telehealth were not prevalent. However, over the last few years, as technology advanced, more complaints have been received regarding care provided via telehealth, including complaints of unlicensed practice, inappropriate care, and the corporate practice of medicine. With future advances in technology, including applications available on electronic devices, etc., this will continue to be an issue that the Board needs to be vigilant about ensuring consumers are protected.

Individuals using telehealth technologies to provide care to patients located in California must be licensed in California. Pursuant to B&P Code section 2290.5, licensees are held to the same standard of care, and retain the same responsibilities of providing informed consent, ensuring the privacy of medical information, and any other duties associated with practicing medicine regardless of whether they are practicing via telehealth or face-to-face, in-person visits. Board staff attends conferences regarding telehealth practices and have discussions with other state regulatory boards to develop best practices regarding telehealth as this new technology expands and becomes more widespread within California.

Telehealth is simply a tool to provide patient care. There definitely is a need to regulate telehealth, just as there is a need to regulate an in-person medical examination. Without ensuring physicians are following the standard of care in every practice setting, the patients in California can be put at risk.

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Section 8

Workforce Development and Job Creation

- Workforce Development
- Assessment of the Impact of Licensing Delays
- Board's Efforts to Inform Potential Licensees of Licensing Requirements/Process
- Barriers to Licensure/Employment
- Workforce Development Data

Workforce Development

The Board does not specifically create jobs or provide training to the citizens of California to learn specific job skills. However, the Board's ability to process the license applications the Board receives, and timely issue licenses to those applicants who have met the minimum qualifications, allows these new licensees to apply for and/or continue working in California healthcare professions. In most instances, individuals may not obtain employment to perform the duties of one of the professions regulated by the Board until properly licensed. The Board received 7,763 physician's and surgeon's applications in FY 2015/16. This was an increase of 913 physician's and surgeon's applications compared to FY 2014/15. The Board issued 6,316 physician's and surgeon's licenses in FY 2015/16. This was an increase of 443 more physician's and surgeon's licenses issued than in FY 2014/15.

At the time of initial licensure and renewal of a physician's and surgeon's license, the Board collects $25.00, which is transferred to the Health Professions Education Foundation (HPEF) to help fund the Steven M. Thompson California Physician Corps Loan Repayment Program that is administrated by HPEF. This Program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans in exchange for their service in a designated medically underserved area for a minimum of three years. There is a requirement that most participants be selected from the specialty areas of family practice, internal medicine, pediatrics, and obstetrics/gynecology. However, up to 20% of the participants may be selected from other specialty areas.

In addition, physicians and surgeons at the time of initial licensure or renewal may contribute money to provide training for family physicians and other primary-care providers who will serve in medically underserved areas. The money the Board collects for the family physician training program is transferred to the Office of Statewide Health Planning and Development.

Assessment of the Impact of Licensing Delays

The Board licenses physicians who are at various stages of their career. A significant number of the Board's applicants are unlicensed residents and fellows (medical school graduates who still are in post-graduate training). Pursuant to B&P Code sections 2065 and 2066, these unlicensed trainees must be licensed once they have reached the maximum license exemption period. The maximum length for licensure exemption pursuant to B&P Code section 2065 is 24 months of Accreditation Council for Graduate Medical Education (ACGME) and/or the Royal College of Physicians and Surgeons of Canada (RCPSC) accredited postgraduate training in the U.S. or Canada. All accredited postgraduate training must be completed in the U.S. or Canada. The maximum length for licensure exemption pursuant to B&P Code section 2066 is 36 months of ACGME and/or RCPSC accredited postgraduate training in the U.S. or Canada. June 30th is typically the last day of the exemption period (the last day of the ACGME/RCPSC academic year).

If these applicants are not licensed by that date, the trainee cannot move forward to the next year of training. This causes unexpected vacancies in the training program, requires other staff to work overtime to fill the vacancy, and impedes a hospital's ability to provide health care. Although the Board has not conducted an assessment on the impact of licensing delays, staffs' frequent contact with representatives of hospitals, teaching programs, professional groups, etc., regularly make the Board aware of the implications of licensing delays.

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Approximately 10 years ago the Board came to recognize the importance of solidifying a process that had been, until then, very informal. The Board proactively contacted all 175 California-based teaching hospitals and 850 program directors and asked them to identify the unlicensed residents and fellows who required licensure by the end of the training year. This information gave the Board unprecedented advance notice on the workload coming later in the year and the hospitals became aware of their own staffs' licensing requirements. This new collaboration has become a landmark-opportunity that benefits applicants, their employers, and the Board. The Board has identified one Licensing Program manager to act as liaison between the Board and hospital GME staff to build and facilitate improved communications and customer service.

Once an application has been received, governing regulations require staff to complete the initial review within 60 business days (which equates to approximately 90 calendar days). The Board has set a goal of keeping the initial review time to 45 calendar days or less, half the regulatory timeframe. In the last four years, the Board has met this goal 64% of the time. During this period, the initial review of some files has occurred in 30 calendar days and the longest interval from receipt of an application to date of review was 68 calendar days, which is still within the Board's statutory requirement.

Board's Efforts to Inform Potential Licensees of Licensing Requirements/Process
Licensing education and outreach program – In 2001, the Board created a licensing education and outreach program. The purpose of the program is to build improved working relationships with California's teaching hospitals, the Graduate Medical Education (GME) staff, and applicants who need a license to move forward with their postgraduate training or fellowship. The program has been expanded across all geographic regions of the state, including small and large hospitals, private and public hospitals, and those governed by the University of California, Office of the President.

Beginning Fall 2009, education and outreach was expanded to include hospital recruiters and credentialing staff to better explain the licensing process for those hiring faculty or other professional positions. The intent is to demystify the licensing process and to discuss how their anticipated hiring dates might best dovetail with the Board's other obligations. About that same time, the audience was broadened to include medical groups, community clinics and health centers, professional societies, etc.

It is critical that this function of the Board continue as it has vastly improved the process of getting applicants licensed before their statutory deadline and has significantly reduced the backlog of processing applications.

The goals of the program are mainly achieved through three avenues at teaching hospitals: (1) participation in licensing workshops, (2) presentations at resident orientation and/or during grand rounds, and more-recently, (3) at the medical student level. Then, when Board staff is planning to be in a certain geographic area, contact is made with other nearby entities that could benefit from a workshop, and visits to those multiple sites are included. It has been a long-standing policy of the Board that if the proposed audience was small, visits could not be planned unless other visits at nearby hospitals could be coordinated during the same trip.

Licensing workshops or "licensing fairs" – Without these events, applicants do not have the impetus to start the application process and submit the required materials in a timely manner. Realistically, human nature is to procrastinate, and residents already are overwhelmed by lengthy work-related obligations: the number of work-hours generally comprises 80 hours a week averaged over a four week period, single shifts of up to 24 hours, additional overnight call scheduled for every third day, and only 8-10 hours off between each exhausting shift. In addition to facing a plethora of paperwork they want to avoid or delay, the residents would have to make time in their already-busy schedule to get photos taken for the application, make an appointment to have their fingerprints scanned at a remote site, package and ship their diplomas to the Board, and pay for the services of a notary.

The Board has been instrumental in encouraging hospitals to coordinate these events. While the Board's participation is important to the success of the event, staff gives credit to the hospitals for being the sponsor. At these events, the hospital hires a notary, a mobile fingerprinting service (directly tied in with the California DOJ's Live Scan service), copying machine to copy and/or reduce the diploma, and a photographer--everything that is needed for the standard application process. This is a "one-stop shopping" opportunity for applicants to complete much of the application process. If there are no unusual circumstances, residents can complete the entire paperwork in less than 45 minutes.

Additionally, the outreach staff has been trained on how to handle questions from applicants with criminal histories, substance abuse problems, mental health issues, problems during their medical school or postgraduate careers, etc. While staff has been strictly directed by legal counsel not to discuss the specifics of these cases, the applicants often seek advice from staff about what types of documentation, evidence of rehabilitation, etc., are needed to continue in the application process. Naturally, most applicants are not comfortable discussing these issues in front of their colleagues, so the outreach staff will spend extra time in a private setting to discuss the process. Annually, it is estimated that over 2,200 applicants have had a face-to-face meeting with the outreach staff, representing fully one-third of the Board's annual applicants.

Participation at "new resident orientation" and during grand rounds – Medical school students generally graduate in May or June of each year; the postgraduate training year runs from July 1 of one year to June 30 of the following year. As part of a teaching hospital's new resident orientation held in mid-June to early-July, the Board's outreach manager is one of several guest speakers. Staff offers an introduction to the Board and its mission and roles, outlines the licensing process, and offers a notice about licensing deadlines, requirements, and the consequences of inappropriate personal behaviors, training performance issues, etc.

These new medical school graduates (in the past, often referred to as "interns;" now generally called "first year postgraduate residents" or "PGY1s") assume that once they have graduated from medical school, they officially are a fully-functioning physician. They are unaware of the other statutory requirements they must meet before a license can be granted. Further, most are unaware of the deadlines for licensure and the ramifications of failing to meet those deadlines—at a minimum, they must cease all clinical training, and to the extreme, they are subject to termination of employment. Either option is an extreme hardship to the teaching hospitals, which would suddenly be faced with a vacancy in the training program and in the

provision of health care services. Professionalism, ethics, etc., are topics covered in the presentation.

Because of the proximity of the teaching hospital to Sacramento, staff was able to attend both orientation sessions at UC-San Francisco and made teleconference presentations for the orientation sessions at Loma Linda. However, for the remaining incoming residents and fellows (approximately 1,000 trainees at the other mentioned hospitals), this opportunity has been lost due to travel restrictions.

Presentations to medical students – The Board recognizes that a significant number of students who attend medical school in California will commence their postgraduate training in other states. But the problematic issues facing applicants in our state will be issues of concern for other licensing jurisdictions. Therefore, when the Board's staff is present at a teaching hospital affiliated with one of California's medical schools, arrangements are made to present an informative and advisory talk to the students. These presentations only happen when the visit can coincide with another outreach event. To date, presentations have been made to medical students at UC-Davis, UC-San Diego, Loma Linda University and the University of Southern California.

This outreach (primarily the review of applications before they are submitted, providing an explanation of what other training, educational, and criminal history, documents are needed, etc.) is preventative in nature and helps keep the workload of the Board's staff consistent. Although the Board does not have quantifiable statistics to underscore this claim, comments from the senior licensing staff and the long-term GME staff at the hospitals indicate that there have been significantly fewer mistakes and problems since the outreach program began. Also, with the convenience of having all services provided at the licensing fair, it seems that many residents are applying earlier in the year, thus getting licensed earlier. This can only be seen as an advantage for the operational needs of the Board's Licensing Program staff, the teaching hospitals, and other health care facilities.

In past years, the Board has had to perform numerous hours of overtime in the spring and early-summer months in order to meet the June 30 deadline. The reason for this overtime was, in part, due to the fact that applicants submitted their applications late in the academic year, and, therefore, there was a significant increase in applications, which staff was unable to process in a time frame that met the applicants' expectations and needs. If the Board did not have this outreach program, the Board would not be able to meet the needs of the applicants or the hospitals providing health care in California. Simply stated, the costs of supporting this education and outreach program are significantly less than the delay to California patients/consumers who need health care and are not able to obtain the necessary health care due to delays in the Board's ability to issue licenses to physicians and surgeons in a reasonable timeframe.

Barriers to Licensure/Employment

The Board does not believe there are any barriers to licensure, with the exception of individuals who apply for licensure who have attended an international medical school that is not recognized by the Board. In addition, the applicant may have completed clinical rotations in a facility that was not affiliated with the medical school pursuant to B&P Code section 2089.5

affiliations. If the Board was to require three years postgraduate training, as recommended, and changes were made to the law as provided in the Section 11 - New Issues, this barrier would be eliminated.

Workforce Development Data

The Board collects data but does not have the resources to evaluate the information gathered. Instead, it provides assistance and resources to other agencies and/or official research groups, such as the Office of Statewide Health Planning and Development, California HealthCare Foundation, and the University of California, San Francisco, that study workforce issues relative to physicians in California. This assistance includes providing statistics, office space, and staff assistance to survey California licensed physicians for workforce data collection.

The Board collects and publishes characteristics for each licensee. This is performed through an extensive survey that is completed by physicians when they are initially licensed and updated each renewal period as part of the renewal process. The information requested from physicians includes data on years of postgraduate training; time spent in teaching, research, patient care, telemedicine, and administration; practice locations; areas of practice; and board certification. In addition, the survey requests information on race/ethnicity, foreign language, and gender. However, these questions are optional but equally important in efforts to examine physician demographics.

The survey offers key advantages over other methods of estimating the supply of practicing physicians in California, both statewide and at the local level. The information provided was helpful in identifying physician workforce shortages throughout the state and allowed underserved populations access to medical care. The California Health Care Foundation (CHCF) and the University of California's Program on Access to Care provided support to UC-San Francisco staff as they analyzed the data. Multiple reports have been written using information obtained by the Board's survey data in conjunction with other data the Board has assisted in obtaining.

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Section 9

Current Issues

- Status of Uniform Standards for Substance-Abusing Licensees
- Status of the Consumer Protection Enforcement Initiative (CPEI) regulations
- BreEZe

Status of Uniform Standards for Substance-Abusing Licensees
With the elimination of the Board's Diversion Program in 2008, the Board reviewed the Uniform Standards to determine which of the standards apply to the Board and needed to have regulations implemented. After review and discussion by the Board, regulations were drafted to implement the Uniform Standards and submitted to the Office of Administrative Law (OAL) for notice on September 6, 2013. A public hearing on the regulations was held at the Board's October 25, 2013 meeting. Due to numerous comments and recommended changes, legal counsel made edits to the regulatory language that were approved at the Board's February 2014 meeting. Therefore, a second notice went out in April 2014 with the second modified text. The Board reviewed comments and discussed the regulations at its May 2014 meeting. The final regulations were submitted to OAL on August 26, 2014. On October 15, 2014, the Board was notified that the regulations were disapproved. The Board held a special teleconference meeting on December 1, 2014 for the Members to review necessary changes to the regulations. A third amended text was posted for comment on December 8, 2014, and the regulations were resubmitted to OAL on Feb 10, 2015, for final review. On March 25, 2015, OAL approved the Board's regulations implementing the Uniform Standards with an effective date of July 1, 2015.

The Board provided the new regulations to the AG's office as well as the Office of Administrative Hearings for use with all decisions of the Board that involve a substance-abusing licensee. The Board has been using the Uniform Standards since they became effective.

SB 1177 (Galgiani, Chapter 591, Statutes of 2016) implemented a Physician Health and Wellness Program (Program). Due to the implementation of this Program, the Board's Uniform Standards regulations will need to be amended to implement this new Program. The law requires the Program to comply with the Uniform Standards and therefore regulations will need to be drafted to ensure compliance.

Status of the Consumer Protection Enforcement Initiative (CPEI) regulations
Part of the DCA's Consumer Protection Enforcement Initiative (CPEI) was the identification of legislative changes the DCA thought would assist boards in improving their enforcement processes. Several of the suggested amendments were based upon existing law in the Medical Practice Act. The proposed amendments were placed in SB 1111 (Negrete McLeod), which did not pass through the Legislature. The DCA reviewed the legislation and determined that nine of the amendments could be made through a regulatory change. In reviewing the list of proposed regulations from the DCA, the Board has determined that it either already has authority requiring the action or the Board does not believe that it can be done through the regulatory process. The following is a list of the proposed regulations and the Board's actions.

1. Board delegation to executive officer regarding stipulated settlements to revoke or surrender license: Permit the Board to delegate to the executive officer the authority to adopt a "stipulated settlement" if an action to revoke a license has been filed and the licensee agrees to surrender the license, without requiring the Board to vote to adopt the settlement.

- The Board already has this authority in B&P Code section 2224. The Board's executive director also has the authority to adopt a default decision, which results in revocation of the license. This has helped expedite the Board's enforcement process.

2. Require an ALJ who has issued a decision finding that a licensee engaged in any act of sexual contact with a patient or who has committed or been convicted of sexual misconduct to order revocation which may not be stayed.

   - The Board has a specific statute, B&P Code section 2246, that states any decision that contains a finding of fact that the licensee engaged in any act of sexual exploitation, as described in B&P Code section 729(b)(3) to (5), with a patient shall contain an order of revocation. Since the Legislature has already examined this issue with respect to the Board, it would be broadening the statute the Board tried to mandate revocation for other types of sexual misconduct through the regulatory process.

3. Require the Board to deny a license to an applicant or revoke the license of a licensee who is registered as a sex offender.

   - The Board already has this authority in existing law. B&P Code section 2232 requires the Board to revoke a license if a physician is required to register as a sex offender. Section 2221(c) requires the Board to deny a license to any applicant who is required to register as a sex offender.

4. Define in regulation that participating in confidentiality agreements regarding settlements is unprofessional conduct.

   - The Board already has this authority in existing law, B&P Code section 2220.7.

5. Require a licensee to comply with a request for medical records or a court order issued in enforcement of a subpoena for medical records. Define in regulation that failure to provide documents and noncompliance with a court order is unprofessional conduct.

   - The Board already has this authority in existing law, B&P Code sections 2225 and 2225.5.

6. Authorize the Board to order an applicant for licensure to be examined by a physician or psychologist if it appears that the applicant may be unable to safely practice the licensed profession due to a physical or mental impairment; authorize the Board to deny the application if the applicant refuses to comply with the order; and prohibit the Board from issuing a license until it receives evidence of the applicant's ability to safely practice.

   - The Board already has this authority in existing law. The Board has broad authority for applicant investigations in B&P Code section 2144. If the applicant refuses to submit to an evaluation, the Board can deny the license.

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7. Define in regulation that sexual misconduct is unprofessional conduct.

    - The Board already has this authority in existing law, B&P Code section 726.

8. Make it unprofessional conduct for a licensee to fail to furnish information in a timely manner or cooperate in a disciplinary investigation. Define in regulation that failure to provide information or cooperate in an investigation is unprofessional conduct.

    - Board sponsored legislation, AB 1127 (Brownley, Chapter 115, Statutes of 2011) to require physicians to attend physician interviews (B&P Code section 2234(h)). SB 670 (Steinberg, Chapter 399, Statutes of 2013) further amended this section to strengthen this requirement.

9. Require a licensee to report to the Board any felony indictment or charge or any felony or misdemeanor conviction. Define in regulation that failure to report an arrest, conviction, etc. is unprofessional conduct.

    - The Board already has this authority in existing law, B&P Code section 802.1.

BreEZe

The Medical Board of California (Board) transitioned to the BreEZe database on October 3, 2013. Release 1 of BreEZe went live on October 8, 2013. Since that time, there have been 118 releases that included major, minor, and emergency service request changes, which have been implemented. The Board's Information System Branch (ISB) and other Board staff have worked with the DCA Office of Information Services (OIS) and vendor analysts/developers to define, prioritize, test, and implement these service requests. The Board is active in the BreEZe Licensing User Group, the Enforcement User Group, and the Business Report User Group.

After Go-Live, the Board's Consumer Information Unit (CIU) began receiving many requests for BreEZe online support from applicants, licensees, and consumers, so the ISB's technical support Help Desk began providing technical support for BreEZe online users. In FY 13/14, the ISB Help Desk received 14,403 public support requests via phone or email; in FY 14/15, 16,678 requests; and in FY 15/16, 17,353 requests.

As with any new system, many lessons have been learned and issues have been corrected. ISB and other Board staff are working on requests for updates to the transactions available online to simplify and streamline the processes for applicants, licensees, consumers, and staff. Once these updates are made to transactions currently available online, the Board would like to make more transactions available online for additional license types (Licensed Midwives, Fictitious Name Permits, etc.). Updating the BreEZe online complaint transaction is also a project the Board hopes to implement in 2017, since enhancements added with BreEZe Release 2 in January 2016 made customizing the online complaint transaction possible.

Staff members had to adjust to business process changes in BreEZe. With additional data entry required in BreEZe, data quality assurance is more important than ever. The Board's ISB developers are working with Board programs to develop the reports required to support their business processes and data quality assurance. In July 2016, DCA OIS released the

Quality Business Interactive Reporting Tool (QBIRT), which will make report development much faster, allowing reports to be developed, maintained, and made available to users independent of the BreEZe release cycles. The Board's ISB developers received training on report development in QBIRT and are currently working on reports for the Board's licensing and enforcement programs.

Currently, the Board has 60 service requests pending assignment to an upcoming release in 2017. Since Release 1 Go-Live, the Board has submitted 11 service requests per month on average. Based on regular 6-week release cycles, the Board has had 10 service requests implemented on average per release over the last 6 releases (since Release 2). The Board also has 8 large scope service requests that, because of the effort involved, were required to be submitted as work authorizations before the BreEZe Change Control Board (CCB). The CCB approved these WAs for Impact Analysis.

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Section 10

Board Action and Response to Prior Sunset Issues

- Prior Sunset Issues

Prior Sunset Issues
This section is laid out differently than other sections to accommodate the format of the response requested by the Senate Business, Professions, and Economic Development Committee. The issue stated is the issue raised by the 2012 Sunset Review. The background section is a synopsis of why the issue arose, or in many cases, the issues raised by the Board through the 2012 Sunset Review Report. The staff recommendation is from the Sunset Review Committee itself. The Board Response (April 2013) provides the Board's actions and response that were provided after the 2013 Sunset Review hearing. The Board Response 2016 provides an update on the actions taken to address the issue raised since the last Sunset Review.

ISSUE #1 (2012): (AB 2699 Implementation: Out-of-State Physicians Providing Free Health Care Services.) How many physicians and surgeons have been exempted from licensure pursuant to AB 2699?

Background: AB 2699 (Bass, Chapter 270, Statutes of 2010) exempts from California licensure specified health care practitioners who are licensed or certified in other states and who register with the board and who provide health care services on a voluntary basis to uninsured or underinsured persons in California, as specified.

The MBC states that it was the first board within DCA to enact regulations to implement these provisions set forth in BPC § 901. The regulations allow physicians who are licensed, but not in California, to participate in sponsored free health care events. The regulations provide the rules and documents for registration of sponsored free health care events and the physicians who volunteer their services. Physicians must hold a license in good standing in another state to register.

At the time of the writing of the Sunset Report, the MBC stated that since the regulations only became effective in August 2012, that no applications had yet been received.

Staff Recommendation: ***The MBC should inform the Committee how many physicians and surgeons have been exempted from licensure pursuant to the regulations adopted to implement AB 2699.***

Board Response (April 2013):
AB 2699 added B&P Section 901, which provided a framework under which a health care practitioner licensed and in good standing in another state, may provide health care services for a limited time in California without obtaining California licensure, under specified circumstances. These professional services can only be provided at free health care events sponsored by certain approved entities. Although AB 2699 became effective in 2011, the program could not be implemented until regulations were in place. The Board adopted regulations that became effective on August 20, 2012. The Board received one and approved one application for an individual to attend an event in April 2013.

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Board Response (2016):
As of September 2016, the Board received 34 applications pursuant to B&P Code section 901 and approved 32 applications.

ISSUE #2 (2012): Is a statutory change needed to accommodate changes to the United States Medical Licensing Examination?

Background: In its Sunset Report, the MBC has raised the following new issue. Individual state medical boards set their own rules, regulations and requirements for passage of examinations to demonstrate an applicant's qualifications for medical licensure. In California, the MBC receives examination results from the United States Medical Licensing Examination (USMLE) program, which is used to determine if an individual will be granted licensure to practice medicine in California.

The examination consists of three steps, which must be passed sequentially in order to be eligible to move on to the next examination step. The steps are defined as:

- Step 1: Focuses primarily on understanding and application of key concepts of basic biomedical sciences.
- Step 2: Focuses primarily on knowledge, skills, and understanding of clinical science that forms the foundation for safe and competent supervised practice.
- Step 3: Focuses primarily on the knowledge and understanding of the biomedical and clinical science essential for the unsupervised, general practice of medicine.

The USMLE Composite Committee and its parent organizations, the Federation of State Medical Boards (FSMB), and the National Board of Medical Examiners (NBME), have approved plans to change the structure of the USMLE. Step 3 is slated to be the first examination impacted. The USMLE has stated the changes to Step 3 will "occur no earlier than 2014". The plans call to divide Step 3 into two separate exams, one day in length each, and will focus on different sets of competencies. The two examinations will be scored separately and applicants must pass each. There may also be new testing formats to focus on competencies not currently addressed in Step 3. Step 3 of the USMLE will remain known as Step 3; however, it will be a two-part examination.

The MBC recommends that the language of BPC § 2177 be amended to accommodate two parts of the Step 3 examination, and any new evolving examination requirement.

Staff Recommendation: ***The MBC should submit to the Committee specific language to amend BPC § 2177 to accommodate two parts to Step 3 of the USMLE, and to accommodate future examination changes.***

Board Response (April 2013):
Language was submitted on March 5, 2013 to Senate Business, Professions, and Economic Development (B&P) Committee staff that would amend B&P Code section 2177 to accommodate two parts for Step 3 of the United States Medical Licensing Examination.

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Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue. No further action is needed.

ISSUE #3 (2012): (Physician Shortages Anticipated.) Should changes be made to allow Medical School Programs to utilize Accelerated 3-Year and Competency-Based Medical School Programs?

Background: The MBC has raised the following as a new issue in its Sunset Report. A nationwide physician shortage is projected to reach 90,000+ physicians by the year 2020. Nearly half of that shortage is projected for primary care doctors (family physicians, pediatricians, and family practitioners).

A significant deterrent to becoming a physician is the substantial cost of medical education. At an estimate cost of $80,000 per year, a medical student can easily accrue a debt of up to $400,000 upon graduation.

In an effort to reduce the nationwide shortage of primary care doctors, as well as lessen burdens on medical students, there is a movement toward an accelerated 3-year curriculum. This curriculum would allow medical students to receive the same amount of education in a concentrated, modified year-round education schedule, by eliminating the existing summer breaks, which occur currently in the standard four-year program. Reducing or eliminating the summer breaks allows for an accelerated curriculum completion date.

The MBC additionally indicates that other medical schools are proposing competency-based tracks for students that excel and can progress at a faster rate than the standard 4-year program. Other programs may also be examining major clinical instruction in clinical settings outside of a traditional hospital setting.

It remains unknown how many weeks of clinical training in each of the core subjects and the total number clinical training weeks are required for graduation. Therefore, the MBC states that it is currently unable to determine if these accelerated programs meet the requirements of BPC §§ 2089–2091.2.

If it is determined that the accelerated programs do not meet the requirements of BPC §§ 2089 – 2091.2, legislative changes may be required in order to license graduates from the accelerated curriculum programs.

The MBC points out that in addition to the expedited degree process, the practice of medicine has evolved such that the majority of clinical practice is no longer hospital based. The teaching of medicine must likewise be allowed to evolve with the practice.

The MBC recommends a review of the statutes to determine if increased flexibility is needed. If it is determined that a change is required, a provision to accommodate an accelerated medical degree program and other variations of clinical instruction outside of a hospital by an LCME accredited institution must be added.

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Staff Recommendation: ***The MBC should commence, in cooperation with the appropriate stakeholders, a review of the applicable provisions of California law to determine if increased flexibility is needed in order to authorize LCME-accredited accelerated medical degree curriculum to meet the requirements for licensure in California. If it is determined that a legislative change is required, the MBC should submit to the Committee the appropriate amendment language.***

Board Response (April 2013):
The issue of potential accelerated 3-year and competency-based medical school programs is one that the MBC is aware of occurring in other states. Although these programs do not yet exist in California, the MBC does want to learn more by working with interested parties, as graduates of these programs may come to the MBC for licensure and California may have programs similar to these in the future. The MBC needs to be proactive on this in order to ensure there are no obstacles to licensure. Per Senate B&P Committee staff's recommendation, the MBC will work with the appropriate stakeholders to review applicable provisions of existing law to determine if increased flexibility is needed. If the MBC does determine that a legislative change is required, the MBC will work with the Committee staff and submit appropriate language.

Board Response (2016):
The Board did review this issue and determined that if the medical school program was approved by the LCME that it should be considered to meet the requirements for licensure, no matter the length of the program. Therefore, in 2014, the Board co-sponsored legislation with the University of California, AB 1838 (Bonilla, Chapter 143, Statutes of 2014), to state that any medical school or medical school program accredited by the LCME meets the requirements for medical education for licensure as a physician and surgeon.

ISSUE #4 (2012): There should be consistency in the amount of time a physician and surgeon may be out of practice without receiving additional clinical training before renewing their license and/or allowing them to continue practice.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2229 mandates that protection of the public shall be the highest priority for the MBC, and that whenever possible disciplinary actions shall be calculated to aid in the rehabilitation of licensees.

In addition, the MBC's Disciplinary Guidelines provide that, in the event a licensee experiences a period of non-practice of more than 18 months while on probation, the licensee shall successfully complete a clinical training program prior to resuming the practice of medicine. This short timeframe (18 months) has been adopted because the licensee already is on probation, and an 18-month period of non-practice has been identified as the reasonable cut off point before a clinical training program is required.

However, for a physician who has let his or her license expire, BPC § 2456.3 states, in part, "a license which has expired may be renewed at any time within 5 years after its expiration." In order to renew the license, the physician must simply submit the renewal paperwork, CME verifications, and pay the fees and penalties. Hypothetically, the license can be returned to

active status even if the physician has not practiced medicine for up to five or more years. For example, a physician who, during the last two renewal cycles, did not practice clinical medicine, and then allowed the license to lapse four years prior to renewing, could go back into some sort of clinical practice. The physician has not practiced for eight years, but can renew, pay fees, demonstrate that CME has been obtained, and go back into practice. Although the Board is not aware that this hypothetical ever has happened, it is a potential scenario that Board could face.

The Board recommends that legislation be considered to bring some consistency in the time that a physician may be out of practice before he/she has to show competency. If it is believed that five years is too long, then there may need to be a legislative change, but this is an issue worthy of study so it may be addressed. The study must include the availability of training programs to address re-entry training needs.

Staff Recommendation: ***The MBC should study the issue of whether allowing a physician to return to practice after a lapse in licensure or of practice of more than 18 months without completing additional training provides adequate public protection. The MBC should make recommendations to the Committee on its findings.***

Board Response (April 2013):
The MBC would like to see consistency in the amount of time a physician may be out of practice. The MBC believes this issue should be further researched and studied, specifically if 18 months out of practice without additional training is an appropriate standard to use. The Federation of State Medical Boards has issued a paper on this matter and the MBC will work with it to research this matter and determine the appropriate action to take. Per Senate B&P Committee staff's recommendation, the MBC will study this issue and make recommendations to the Committee on its findings.

Board Response (2016):
The Board held an interested parties meeting to discuss this issue. Due to limited input the Board was not able to determine the appropriate changes to bring consistency. The issue of re-entry is a nationwide issue and the Board is continuing to study this issue to evaluate whether legislative changes are needed.

ISSUE #5 (2012): Should there be a mandatory requirement for licensees to submit their Email address to the MBC, if they possess one?

Background: The MBC has raised the following as a new issue in its Sunset Report. The MBC believes it would be beneficial to require all licensees to provide the Board with an email address, if they possess one. Currently, providing an email address to the MBC is optional for applicants and licensees. An email address is requested on the application and renewal forms. When an email address is provided, it is considered confidential. When appropriate, the MBC sends some correspondence electronically instead of mailing to the physical address on record. This practice has proven to be a quicker, more convenient, and potentially more reliable delivery method while saving printing and postage costs. For example, the Board's Summer 2012 Newsletter was sent electronically via email to approximately 113,800 licensees and 6,800 applicants. In addition, when there is a FDA alert, it can be relayed in the same day the alert is released.

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On rare occasions, licensee email addresses are used to send notices of important law changes, emergency regulations, as well as other urgent issues affecting licensees and public health. The MBC states that in such cases Executive and MBC staff review and approve these rare, relatively infrequent emails that are distributed.

The Board regularly posts information on its Internet Website to alert licensees of urgent issues. The Board also uses a subscriber list service to notify individuals about items of interest relating to the activities of the Board via email. Subscribers may choose to receive email alerts for some or all of the offered topics. This is a valuable tool to get important information to licensees and other interested parties, but it is not widely used by licensees. As of August 2012, there were less than 4,000 subscribers for each topic.

The MBC recommends a legislative change to require that licensees provide the Board with an email address, if they possess one. In addition, the language should state the email address provided will be confidential.

While Committee staff strongly agrees with the idea of using email addresses to communicate with licensees, staff questions the ultimate effectiveness of the proposed mandate. Since the MBC already requests email addresses on license renewal forms, and the proposed mandate is to require licensees to submit an email address, if they possess one. It leaves the possibility open of a licensee refusing or failing to submit an email address. Furthermore, since the proposal to make it a requirement, licensees and violation of the law could be subject to disciplinary action unprofessional conduct under BPC § 2234 (a).

Staff Recommendation: ***The MBC should address the concerns of Committee staff stated above, and submit to the Committee appropriate amendment language regarding licensees providing email addresses to the Board, if they possess one. The language should additionally require the MBC to keep a provided email address confidential.***

Board Response (April 2013):
The MBC agrees with the Senate B&P Committee staff's concern on the effectiveness of this proposal. Committee staff is correct that including the requirement for email addresses, but only if a licensee possesses an email address, leaves the possibility open of a licensee refusing or failing to submit an email address. In response to this concern, the MBC has submitted language on March 5, 2013 to Committee staff that would require all licensees to provide the MBC with an email address. The language also makes it clear that any email address provided to the MBC is confidential and not subject to public disclosure.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue requiring physicians to provide an email address if they have one. No further action is needed.

ISSUE #6 (2012): Should the MBC continue to provide to the public information regarding a physician and surgeon's postgraduate training?

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 803.1 states the Board shall disclose a physician's approved postgraduate training; § 2027

further requires the MBC Website to contain everything required to be disclosed in section 803.1. The Board currently collects limited postgraduate training information, and will disclose it upon request, but only posts the number of years completed in postgraduate training. This information is based upon information self-certified by the physician. The names of all the postgraduate training taken are not easily obtained for posting, thus it is not disclosed on the Website.

The MBC states that this information is submitted by applicants for a physician license during the time in which most applicants are in the first or second year of postgraduate training. The Board only collects the postgraduate information at the time of licensure. Any additional training they receive is not collected by the Board.

Additionally, the Board does not currently request additional postgraduate training information that the applicant may have received. If the Board were to begin to require it, the Board might then be required to verify this additional information. The collection of this information and the posting would be a huge and costly task.

The Board is unsure of the added value to consumer protection with the addition of specific postgraduate training program information on a physician's profile. To most members of the public, postgraduate training information is not the important information to use to determine if this is the correct physician for the patient. What is important to the public is whether the individual is board certified and what the practice specialty is for the physician. This is the information most members of the public want to know and find valuable. This information is not required but most physicians do provide it on their survey.

The Board recommends that the law should be amended to eliminate the requirements for the Board to post a physician's approved postgraduate training.

Committee staff is cautious about reducing board disclosures about licensees. Such information is generally believed to be valuable for consumers to make informed choices about the licensed professionals that they deal with. However, the MBC has indicated that the information required to be posted may very well be outdated and irrelevant to the licensee's practice, and thus fall short of giving consumers sound choices based upon valid information.

Staff Recommendation: ***The MBC should further discuss this proposal with stakeholders, including those stakeholders representing consumer interests and advise the Committee of the results of those discussions, and if appropriate the MBC should submit to the Committee amendment language to eliminate the requirement for the MBC to post a physician's approved postgraduate training.***

Board Response (April 2013):
Existing law requires the Board to post information on physicians' approved postgraduate training. The MBC only collects limited postgraduate training information, thus it is not disclosed on the MBC's Web site. Currently, the MBC only posts the number of years completed in postgraduate training, and this information is self-certified by the physician. The MBC is not convinced that postgraduate training program information is valuable for consumers or that this information helps consumers make informed choices. Senate B&P

Committee staff has recommended that the MBC further discuss this proposal with stakeholders, including stakeholders representing consumer interests. The MBC will hold an interested parties meeting on this issue to have these discussions and update the Committee on the results. If the discussions support this disclosure requirement being eliminated, the MBC will submit language to Committee staff.

Board Response (2016):
At the July 1, 2014 Board meeting, the Board approved staff's recommendation to not pursue elimination of the requirement for the Board to disclose postgraduate training on the physician's website profile, as this was now possible in the current BreEZe system. The Board is currently working to edit the database to provide postgraduate training at the time of licensure as part of a physician's public disclosure.

ISSUE #7 (2012): Clarify that the employment of physicians and surgeons in Accredited Residency Training Programs and/or Fellowship Programs does not violate the prohibition against the Corporate Practice of Medicine.

Background: The MBC has raised the following as a new issue in its Sunset Report. A question has been raised regarding whether the employment of residents is a violation of the prohibition against the corporate practice of medicine.

The policy in BPC § 2400 against the corporate practice of medicine is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The MBC has a long standing interpretation that physicians in an ACGME accredited postgraduate training (accredited residency) and/or fellowships do not meet the criteria for the prohibition against the corporate practice of medicine for several reasons, including:

a. U.S. and Canadian medical school graduates training in California may practice medicine in an accredited residency program for up to 2 years before requiring a license to continue in the residency program. (BPC § 2065)

b. International medical school graduates training in California may practice medicine in an accredited residency program for up to 3 years. (BPC § 2066)

c. Residents do not practice medicine independently, since residents work under the supervision of a residency program director and other teaching faculty.

The MBC believes that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The MBC has determined that the corporate practice of medicine as it relates to accredited residency and fellowship programs should be addressed as a specific exemption. The MBC states that there is clearly an emerging need to remove any possible misinterpretations regarding the corporate practice of medicine for accredited residency programs. This will ensure California accredited residency/fellowship programs are not in danger of closing due to the concerns regarding the prohibition of the corporate practice of medicine.

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The Board recommends that legislation be introduced to clarify that residents in California accredited resident/fellowship programs are exempt from corporate practice laws related to how they are paid.

Staff Recommendation: ***Committee staff agrees that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The MBC should submit to the Committee specific language to clarify that participation in an accredited physician residency training program is not a violation of the prohibition against the corporate practice of medicine.***

Board Response (April 2013):
In response to questions raised by interested parties, the MBC would like to clarify in statute that the employment of residents in accredited/approved residency programs is not a violation of the prohibition against the Corporate Practice of Medicine. The MBC submitted language on March 5, 2013 to Senate B&P Committee staff to clarify this issue.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue clarifying that residents in accredited/approved residency programs are not in violation of the prohibition against the corporate practice of medicine. No further action is needed.

ISSUE #8 (2012): Should the requirement for the MBC to approve non-American Board of Medical Specialties be eliminated?

Background: The MBC has raised the following as a new issue in its Sunset Report:

The Law and History. In 1990, SB 2036 (McCorquodale), sponsored by the California Society of Plastic Surgeons, among others, sought to prohibit physicians from advertising board certification by boards that were not member boards of the American Board of Medical Specialties (ABMS). It added BPC § 651(h) to prohibit physicians from advertising they are "board certified" or "board eligible" unless they are certified by any of the following:

- An ABMS approved specialty board.
- A board that has specialty training that is approved by the Accreditation Council for Graduate Medical Education (ACGME).
- A board that has met requirements equivalent to ABMS and has been approved by the MBC.

The ultimate effect is to provide that unless physicians are certified by a board, as defined by law, physicians are prohibited from using the term "board certified" or "board eligible" in their advertisements. The law does not, however, prohibit the advertising of specialization, regardless of board certification status.

To implement BPC § 651, the MBC adopted regulations which are substantially based on the requirements of ABMS, including number of diplomates certified, testing, specialty and subspecialty definitions, bylaws, governing and review bodies, etc. The most notable requirement relates to the training provided to those certified by the specialty boards. In the

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regulations, training must be equivalent to an ACGME postgraduate specialty training program in "scope, content, and duration."

Since the regulations were adopted, the MBC has reviewed a number of specialty board applications, and has approved four boards:

- American Board of Facial Plastic & Reconstructive Surgery
- American Board of Pain Medicine
- American Board of Sleep Medicine
- American Board of Spine Surgery.

The MBC has also disapproved two boards:

- American Academy of Pain Management
- American Board of Cosmetic Surgery.

Consumer Protection Function. The purpose of the law and regulation is to provide protection to consumers from misleading advertising. Board certification is a major accomplishment for physicians, and while board certification does not ensure exemplary medical care, it does guarantee that physicians were formally trained and tested in a specialty, and, with the ABMS' Maintenance of Certification (MOC) requirements to remain board-certified, offers assurances that ongoing training, quality improvement, and assessment is occurring.

At the time the legislation was promoted, a number of television news programs covered stories from severely injured patients that were victims of malpractice from physicians who advertised they were board certified, when, in fact, they had no formal training in the specialty advertised. The law put an end to physicians' ability to legally advertise board certification if the certifying agency was not a member board of ABMS.

Is the Program Still Relevant? As explained, the law merely addresses advertising, and does not in any way require physicians to be board certified or formally trained to practice in a specialty or in the specialty of which they practice. Physicians only need to possess a valid physician's license to practice in any specialty. As prospective patients usually are covered by insurance, searching for a physician in most specialties is generally done through their insurance directory. At present, insurance companies generally only choose board-certified physicians for their panels, or those physicians whose credentials they have vetted.

The same is generally true for the granting of hospital privileges. Hospitals grant privileges after conducting a review of qualifications. This process, called "credentialing" will include looking into the background of a physician, including accredited training and board certification. For that reason, most physicians who are granted privileges will be board-certified in the specialty for which they are granted privileges, or similarly highly, formally trained.

<u>Therefore, the "board certification" advertising prohibition is primarily meaningful for elective procedures; that is to say, those procedures that are not reimbursed by insurance or those performed outside of hospitals or hospital clinic settings.</u>

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Cost of Program. The cost for the MBC to administer the program has been minimal in recent years, since there has only been one recent application. It is likely that non-ABMS certifying boards have been deterred from filing applications due to the law, the strict regulations, the demanding review process, and the fee.

Processing the application for meeting the basic requirements can be done by an analyst. The evaluation of the medical training, however, must be performed by a physician consultant that is an expert with academic experience. Generally the consultant used is an emeritus professor of medicine and former training program director who has served on residency review committees. (Residency review committees are part of the ACGME/ABMS review process.)

Therefore, a medical education expert must be hired to perform a review of the specialty board's formal training program. The cost of the expert varies, but when the fee regulations were promulgated in the 1990s, it was estimated that such a review would require from 80 to 160 hours to complete. At present, the cost of hiring an expert would be from $5,000 to $11,000.

The current application fee for a specialty board application is $4,030. (The fee was determined not by hours, however, but by the average costs of all three boards at the time they had been reviewed.) By law, however, the Board has the authority to raise the fee to cover reasonable costs associated with processing the application.

Ultimately, the costs of processing specialty board applications has not been the major expense in this program. The cost comes when an application is denied, and litigation results, and thereby legal costs.

Risk of Lawsuits and Potential Payouts. Since the program's inception, the MBC has only denied two specialty boards. American Academy of Pain Management was denied, and filed four suits against the MBC, including one in Federal Court. American Board of Cosmetic Surgery applied for approval twice, was denied both times, and filed suit on the second denial.

The MBC states that it has prevailed in all litigation, but the cost has been considerable. While AG billing methods makes it difficult to ascertain the exact cost of legal representation specific to the suits, MBC estimates its litigation costs conservatively to be in excess of $200,000.

Use of Medical Consultants and Experts. When the original legislation was introduced in 1990, the MBC opposed the bill because it could see tremendous problems in implementation. The ABMS is a well-established, huge organization with tremendous resources, both in revenue, infrastructure, and expertise, far beyond the MBC's resources.

The law asks the MBC 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. In contrast, the MBC must use academic medical training experts to conduct reviews and provide recommendations to the MBC. Unlike the ABMS process, the MBC is not a part of developing the curriculum or training programs, but is being required to consider whether or not the criteria for certification and the training provided is "equivalent" as defined by the regulation.

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Other than the Board, Who Could Fulfill this Function? According to the MBC, three entities have the expertise to review and evaluate the quality of medical specialty boards' training and certification criteria: (1) ABMS, (2) ACGME, and to a lesser degree (3) medical schools that provide ABMS designed and ACGME accredited residency training programs. Unfortunately, according to the MBC, it would be inappropriate for any of these entities to judge a competing specialty board training program.

Factors to Consider. To determine whether or not this program's benefits outweigh its cost, the MBC recommends consideration of the following:

1. The existing law is designed to prevent consumers from being misled by physician advertising – to deter physicians from advertising board certification. In that sense, the law has provided such a deterrent, and the MBC has the legal authority to combat this practice.

2. Physicians are not prohibited from advertising that they specialize in procedures for which they have little training or qualifications, and may advertise that they are members or "diplomates" of various boards that are not ABMS or the equivalent. The current law only relates to advertising, and does nothing to prevent physicians from practicing in specialties for which they are not certified.

3. The cost of processing applications has been minimal; however, the cost of litigation has been substantial. Should more specialty boards apply and be disapproved, it is likely that there will be future legal costs.

The Board recommends that the Legislature delete the provision requiring the MBC to approve non-ABMS specialty boards. For consumer protection, the law should continue to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the MBC. In addition, the law could be amended to prevent the use of other misleading terms.

Staff Recommendation: ***The MBC should submit a specific legislative proposal to the Committee to delete the provision requiring the MBC to approve non-ABMS specialty boards, and to prevent the use of other misleading terms. Consideration should be given to amending BPC § 651(h) to delete the MBC's authority to approve non-ABMS specialty boards, and to prevent the use of other misleading terms in physician and surgeon advertising, as recommended by the MBC.***

Board Response (April 2013):
The MBC is recommending that the statute be amended to require physicians to advertise as board certified only if they have been certified by ABMS boards and the four additional boards currently approved by the MBC. The MBC submitted language on March 5, 2013 to Senate B&P Committee staff to amend the statutes in this regard.

Board Response (2016):
The Board's last sunset review bill, Senate Bill 304, included language to amend B&P Code section 651(h), which would have fully addressed this issue, but those amendments were

pulled out in committee due to opposition from the American Board of Cosmetic Surgery and the California Academy of Cosmetic Surgery.

The same concerns that prompted the Board to raise this issue during the 2013 sunset review process still exist, and the Board asks that this issue be resolved by adopting the Board's proposed amendment to B&P Code section 651(h).

ISSUE #9 (2012): Enforcement program shortfalls.

Background: In November and December of 2012, the *Los Angeles Times* published a series of four articles which were the outcome of an intensive review of the epidemic of prescription drug-related deaths in four Southern California counties. In the investigation, reporters examined coroners' records and interviewed doctors, regulators, law enforcement officials and relatives of those who died from overdoses. The investigators also created and analyzed a searchable database of 3,700 drug related deaths during a 5-year span (2005-2011) in Southern California to identify those tied to doctors' prescriptions.

An examination of coroner records by the *Times* found that:

- In 47% of those cases (1,762 deaths) drugs for which the deceased had a prescription were the sole cause or a contributing cause of death.
- A small number of doctors were associated with a disproportionate number of those fatal overdoses. 0.1% of the practicing physicians (71 physicians) in the 4 counties wrote prescriptions for drugs that caused or contributed to 298 deaths. That is 17% of the total deaths linked to doctors' prescriptions.
- Each of the 71 physicians prescribed drugs to 3 or more patients who died.
- 4 of the physicians had 10 or more patients who fatally overdosed.
- One physician had 16 patients who died.

The *Times* found that the 71 physicians with 3 or more fatal overdoses among their patients are primarily pain specialists, general practitioners and psychiatrists. Four of the physicians have been convicted of drug offenses in connection with their prescriptions, and a fifth is awaiting trial on second-degree murder charges in the overdose deaths of 3 patients. The remaining physicians have clean records with the MBC, according to the *Times*.

[Note these numbers: in FY 00/2001 the MBC initiated 2,320 investigations, and in FY 11/12, 1,577 investigations were opened – a decrease of 42%.]

The Board's Enforcement Program has faced significant challenges in the last four years that have impacted the Program's performance.

Average times from complaint intake to the completion of the investigation have also increased. In the Board's 2002 Report, in FY 00/01 it took 257 days on the average, and in FY 11/12 it took 347 – an increase of 74%.

The *Times* articles further stated that there are about 30 fewer investigators today than in 2001.

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Historical background. Because of skyrocketing medical malpractice insurance costs, in 1975, AB 1 (Keene) enacted the Medical Injury Compensation Reform Act of 1975 (MICRA), a measure carefully designed to comprehensively address three issues — tort reform, medical quality control, and insurance regulation — that were of interest to the 4 sets of stakeholders "at the table" (physicians, lawyers, insurance companies, and patients).

MICRA created the cap of $250,000 for punitive damages in malpractice suits, a cap that remains to this day and is unique to civil actions brought against professional licensees. In addition, attorney contingency fees were also limited.

As a trade-off in order to reach such a sweeping agreement, however, the medical profession had to make concessions too. The concession made was a new, improved, better equipped, less physician oriented and more publicly minded Medical Board. In addition, the Board would have its own enforcement team, trained peace officers that would investigate complaints against doctors. Part of the Act required mandatory reporting to the Board of hospital discipline and malpractice awards.

The rationale of this compromise was simple. Punitive damages do not remedy injury. Prevention of malpractice that could occur, due to a more efficient Medical Board, would save lives and injury, and, after much debate, the bill was passed and a new Board was born.

The reforms of MICRA were balanced partially on the creation of a regulatory board which would engage in vigorous enforcement of the law against bad doctors in order to protect the safety of consumers.

In 2005, SB 231 (Figueroa) made a number of changes recommended by the MBC's Enforcement Monitor. Among those changes was the establishment of a Vertical Enforcement (VE) pilot program. Under VE, prosecutors from the Attorney General's (AG) Health Quality Enforcement Section (HQES) are paired with MBC investigators from the initial assignment of the case for investigation all the way through the final prosecution of the case. The idea is to bring about better cases and better outcomes for the safety of patients.

As initially drafted, the VE program in SB 231 in 2005 would have transferred the MBC's investigators to the HQES in the AG's office. This would have placed the investigator and prosecutor in the same office under the same agency, a practice, as is done in numerous other law enforcement shops throughout the country. Ultimately the transfer of investigators was taken out of the bill, but the idea of paring prosecutors and investigators from start to finish on a case remained.

Even though progress has been made in improving investigations and prosecution of disciplinary cases involving physicians and surgeons under VE over the last 6 years, there still is a long way to go to ensure the public is well protected.

Staff Recommendation: ***The VE program should be continued, and additional improvements should be identified which would further enhance the collaborative efforts of the MBC investigators and HQE prosecutors.***

Board Response (April 2013):
In 2005, SB 231 established the Vertical Enforcement (VE) pilot program. Under VE, MBC investigators are paired with prosecutors from the Attorney Generals' Health Quality Enforcement Section (HQES) from the initial assignment of cases for investigation, all the way through the final prosecution of the case. The MBC believes this model is working and does not think that the Legislature should revisit the original proposal to move MBC investigators to the Department of Justice. The MBC submitted a supplemental report to the Senate B&P Committee on Monday, March 4th, which included a review of pertinent data for the VE program. The MBC believes that the benefits of VE are significant and does not believe that any legislative amendments to the program need to be made at this time. The MBC recognizes there have been challenges in the implementation of VE, but those challenges can be overcome through continued collaboration between the MBC and HQES, and revisions to the procedural manuals used by both staffs. Here are some areas that the MBC is committed to working on in a collaborative manner with HQES:

- The MBC will be working with HQES to establish best practices and identify other areas where improvements can be made. As issues arise, the MBC will meet with HQES to resolve any issues and will formalize the resolution in the VE Manual. In addition to the quarterly supervisor meetings, quarterly meetings with MBC and HQES management, a Subcommittee of the MBC has been established in order to determine what progress has been made and what amendments or enhancements need to be made to the VE model and Manual.
- In order to reduce the DAG's workload so they may reallocate resources to high priority items, the MBC is recommending that criminal conviction cases that do not involve quality of care, should not require DAG involvement until the matter is ready for the filing of an Accusation. This will enable the DAGs to focus on high priority matters, such as interim suspension orders, enforcement subpoenas, preparing the expert reviewers for hearing, etc.
- Interim suspension orders are essential to consumer protection. These orders remove a physician who has a potential to endanger the public from practicing medicine. With the DAGs being involved earlier in the case, this allows them to know the case and be able to prepare the necessary documents to petition the court for the suspension. This results in obtaining the suspension order in a more expeditious manner. The MBC plans on continuing to focus on these cases with management of HQES, which will result in better consumer protection.
- Subpoena enforcement actions for obtaining medical records and a physician interview are critical as the MBC is unable to determine whether the physician's actions are egregious until the medical records have been obtained and reviewed and the physician interviewed. The MBC adopted a "zero tolerance" policy in 2009 for delays in medical record acquisition and the physician interview. The DAG's attention to the process of subpoena enforcement is essential and eliminating the DAGs time on criminal conviction cases will assist in a reduction in the time to process these subpoenas.
- The MBC through its Expert Reviewer Training Program has determined that the experts need more communication and preparation with the DAGs. It is recommended that the DAG have the expert review the Accusation prior to filing and meet with the expert prior to the hearing to review the case and prepare for testifying. This will prepare the expert for the hearing and ensure the expert understands the hearing process.

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The MBC realizes the importance of the VE model and will continue to strive towards its improvement with the overall goal of meeting the MBC's mandate of consumer protection.

The MBC looks forward to working with the Senate B&P Committee, the Attorney General's (AG's) Office, and interested parties, to identify improvements that would further enhance collaborative efforts of both the MBC and the AG's Office.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) extended the vertical enforcement/prosecution model. In addition, the Board submitted a report to the legislature in March 2016 identifying improvements in the VE model and providing recommendations for further enhancement. It is important to note that with the movement of the investigators to the DCA, Division of Investigation, the VE model is now under the authority of the DCA and the AG's Office.

ISSUE #10 (2012): (JURISDICTION OVER UTILIZATION REVIEW DECISIONS.) Should the Medical Board investigate complaints that relate to utilization review decisions in the workers' compensation system regarding physicians and surgeons who may have violated the standard of care?

Background: The MBC has for many years publicly asserted that when a medical director of a health plan or a utilization review physician in the workers' compensation system uses medical judgment to delay, deny or modify treatment for an enrollee or injured worker, that act constitutes the practice of medicine. This position, expressly stated on the MBC's website, has been presumed to be a correct interpretation of the Medical Practice Act by Legislators, regulators, physicians, and others involved with the Board. If a decision which is contrary to the standard of care leads directly to patient harm, the MBC should have clear authority to investigate the matter to determine whether the physician has engaged in unprofessional conduct.

In the workers' compensation system, an insurer or self-insured employer is entitled to retain a physician to conduct "utilization review" of treatment recommendations made by the injured worker's physician. This decision can have the effect of determining what treatment the injured worker will receive. The utilization review physician is supposed to exercise his or her independent medical judgment. However, concerns have been expressed by treating physicians that insurer or self-insured employer rules that violate the standard of care are being enforced by utilization review physicians. If this were the case, and a patient is harmed, it has been assumed that the utilization review physician's decision would be subject to MBC oversight. Recent actions and statements by the MBC staff contradict this assumption.

Complaints alleging that utilization review decisions made by California-licensed physicians that: (1) violate the standard of care, and (2) cause significant harm, have been rejected by MBC staff as being outside the Board's jurisdiction. Certainly, the MBC does not have the authority to direct an insurer to pay for treatment – that is within the authority of the Division of Workers' Compensation, but the existence of an administrative remedy for the harmed patient is no more a barrier to MBC jurisdiction over the physician than a medical malpractice award is to a patient harmed by standard of care violations in the group health care market.

Staff Recommendation: ***The MBC should have jurisdiction over medical decisions made by California-licensed physicians and surgeons who conduct utilization reviews. The MBC should also report to the Committee on its plan to direct enforcement staff to implement enforcement oversight over these decisions. The MBC should also make the worker's compensation system aware of this requirement.***

Board Response (April 2013):
The issue of the MBC's authority regarding workers compensation utilization review decisions, has recently been brought to the MBC's attention. This issue was brought up at the MBC's January 31, 2013 Enforcement Committee meeting in particular, and then again at the Full Board Meeting on February 1, 2013. The Enforcement Committee has asked for a full discussion regarding this issue. Therefore, this item will be on the agenda for the next Enforcement Committee meeting on April 25, 2013 in Los Angeles. Board staff will keep the Senate B&P Committee informed of the discussion at the Enforcement Committee Meeting and any action taken by the Full Board, including decisions on enforcement oversight and any necessary notification to the worker's compensation system.

Board Response (2016):
The Board had this item on several Board Meeting agendas and indicated that utilization review was the practice of medicine. The Board also confirmed that utilization review is the practice of medicine in a letter to Assembly Member Perea, then Chair of the Assembly Insurance Committee, in June 2013. In addition, when the complaints pertain to quality of care, those complaints are processed and action is taken, if warranted. They are not closed as non-jurisdictional. In addition, Board staff has provided presentations to the Board members and placed an article in the Board's Newsletter regarding this issue.

ISSUE #11 (2012): (PUBLIC DISCLOSURE PRACTICES OF THE MBC.) To what extent have the recommendations made by the California Research Bureau regarding public disclosure been implemented?

Background: SB 231 (Figueroa, Chapter 674, Statutes of 2005) required the Little Hoover Commission to conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the MBC. SB 1438 (Figueroa, Chapter 223, Statutes of 2006) then transferred the responsibility to conduct the study to the California Research Bureau (CRB) of the California State Library. The study titled *Physician Misconduct and Public Disclosure Practices at the Medical Board of California* was completed November 2008 and offered 11 policy options for improving public access to information about physician misconduct.

Although some options required legislation to implement a couple of the recommendations, most could be implemented by the MBC without legislation. For example, the MBC expanded the physician profile on its license lookup Website to include items from the physician survey including board certification. In addition, the MBC adopted a regulation in 2010 that requires a physician inform consumers where to go for information or where to file a complaint about California physicians.

However, it is unclear to what extent that the other recommendations in the CRB Report have been implemented. Are there additional policy or regulatory changes that could be made by

the MBC to implement the recommendations? Are there statutory changes that should be made to implement recommendations in the report?

Staff Recommendation: ***The MBC should inform the Committee to what extent the 11 policy options recommendations made by the California Research Bureau have been implemented? In its response, the MBC should identify and recommend to the Committee whether additional MBC policies or regulations should be changed and whether additional legislation should be enacted to implement the recommendations made by the CRB.***

Board Response (April 2013):
The California Research Bureau (CRB) conducted a study titled "Physician Misconduct and Public Disclosure Practices" in 2008, which offered 11 policy options for improving public access to information about physician misconduct. These options focused on improving public disclosure and access. Since this report, the MBC has made significant changes to ensure transparency and expedite public notice regarding MBC actions. The MBC adopted a regulation (effective June 27, 2010), which requires all physicians in California to inform their patients that they are licensed by the Medical Board of California, and to include the MBC 's contact information. This information can be posted in the physician's office or given to the patient in writing. The MBC has developed a subscriber's list that allows any individual to go to the MBC's Web site and sign up to receive regular information feeds from the MBC via an email alert, including disciplinary action taken against a physician, new proposed regulations, the release of the MBC's Newsletter, or notification of an upcoming meeting. The MBC also now posts all MBC agendas and meeting materials online, allowing the public to review the entire MBC packet, prior to the MBC meetings. The MBC has begun Webcasting its meetings when possible, and those Webcasts remain available for viewing on the MBC's Web site.

The MBC also revamped and improved the look-up function on its Web site public disclosure screen. Members of the public can now verify that a physician's license is renewed and current, see any disciplinary action (or other actions, such as a conviction, malpractice judgment award, other state discipline, etc.), view the information physicians have provided in their physician survey (such as ethnicity, foreign language spoken, board certification, etc.), and view any disciplinary documents based upon the MBC's action.

The following indicates the policy options from the CRB and how the MBC has implemented the recommendation or the reason for not implementing the recommendation. The MBC believes that legislation should be sought based upon one item (#2) of the CRB report. The method of receiving information regarding a physician should be consistent no matter the method of request (CRB Policy Option 2). The MBC requested, in its Sunset Review Report, a change in statute to eliminate the ten year requirement for public disclosure. MBC staff provided language on March 5, 2013 to the Senate B&P Committee for this legislative change (see Committee Issue 36 below).

Policy Option 1: Add a "public disclosure" component to the Medical Practice Act's list of the Medical Board of California's (MBC) responsibilities in Business and Professions Code Section 2004.

MBC Action and Response: Although public disclosure is not listed in section 2004, there are other sections in the Medical Practice Act that require public disclosure which the Board takes very seriously (Business and Professions Code section 803.1 and 2027). The MBC has worked diligently to post all items on a physician's profile allowed by law. The addition of this item into statute seems redundant.

Policy Option 2: Standardize the MBC's statutory disclosure requirements across different outlets (e.g., Internet vs. in-person or in-writing requests), including requiring permanent disclosure of past disciplinary actions, citation/fine actions, administrative actions, and malpractice judgments, arbitration awards and settlements.
MBC Action and Response: The study appropriately indicated the laws regarding disclosure and access to records are inconsistent, and should be amended. Any change in the length of time actions are posted on the Board's Web site requires a legislative change. The MBC raised this issue in its Sunset Review Report. The MBC requested that the limited ten year posting requirement for its Web site be removed. The MBC submitted language on March 5, 2013 to the Senate B&P Committee staff to make this amendment.

Policy Option 3: Direct the MBC to expand and revise its Internet physician profiles to better conform to current law, e.g. displaying specialty board certification and postgraduate training information.
MBC Action and Response: The MBC has implemented a new physician profile display that includes self-reported board certification, the number of years of postgraduate training and other information provided on the physician survey. The MBC plans to enhance the look up system for searches on partial or similar spelled names once the new BreEZe system is implemented and fully operational.

Policy Option 4: Direct the MBC to investigate and provide summaries of those investigations to the public for each reported malpractice judgment, arbitration award and settlement.
MBC Action and Response: This suggestion requires a legislative change and the MBC has not approved moving this forward as it is uncertain of the benefit of these types of summaries now that the public has easy access to the disciplinary record.

Policy Option 5: Direct the MBC to study ways to enhance public outreach in order to better identify cases of potential physician misconduct.
MBC Action and Response: The report suggested the MBC audit physicians' or hospitals' records. The Board does not have the ability to review patient records without a release or a reason to subpoena the records. Therefore, this would require a legislative change, additional funding, and staff. The MBC believes that studying its own data to identify possible educational opportunities may be more attainable. As requested by the MBC Board Members, the MBC staff has plans to begin the process of data review in early summer 2013.

Policy Option 6: Direct the MBC to require physicians to notify patients that complaints about care may be submitted to the Board.
MBC Action and Response: In 2010, California Code of Regulations section 1335.4 "Notice to Consumers" became effective to require physicians to post information in the office or inform patients in writing on how to contact the MBC. The notice requires the inclusion of the MBC's telephone number and Web site address.

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Policy Option 7: Direct the MBC to expand information provided on its Internet physician profiles to include additional biographical data, including age, gender and training.
MBC Action and Response: The Board's Web site was revised to include this information if the physician has agreed to post this information (with the exception of age). The Web site can display gender, ethnicity, and foreign language proficiency in addition to all the other information, including board certification, postgraduate training years, etc. However, because this information is not mandated, a physician may decline to disclose this information on his/her physician profile. To require posting, the data a legislative change would be necessary and could be very controversial due to the information the MBC is being requested to add, i.e. age and gender. Therefore, the MBC has taken the approach to post this information (except age) if approved by the physician.

Policy Option 8: Direct the MBC to provide on its Internet physician profiles links to evidence-based, physician-level performance information provided by external organizations, such as the California Physician Performance Initiative.
MBC Action and Response: To add the information to the MBC's physician profiles requires a legislative change. However, the MBC is not certain of the benefit of this information or the accuracy. The MBC believes at this time that there are many flaws in the quality and consistency of "physician level performance information" provided by external organizations, as these organizations measure different things. Until this work matures to the point that the information is valid, risk adjusted, and universally available for all licensees, it would be misleading to add this information to the Web site.

Policy Option 9: Direct the MBC to sponsor and publish research projects based on the contents of the Board's complaints, discipline, public disclosure and licensing databases.
MBC Action and Response: As staff time and funding permits, further research will be completed. The MBC's current Strategic Plan has a significant number of studies that MBC plans to conduct. The MBC is beginning to perform these studies and will be providing the information obtained on its Web site and in its Newsletter.

Policy Option 10: Direct the MBC and the California Board of Registered Nursing to develop methods for sharing and publicizing information about supervisory relationships between physicians and nurse practitioners.
MBC Action and Response: The report recommends tracking and posting the nurse practitioners and physician assistants who work under the physician's supervision. With the number of physicians in the state and the frequent changes that occur in employment, this may be an unmanageable task without any significant benefit. As complaints are received by each board, if there is a need to investigate the supervisor, the information is shared between boards for appropriate action.

Policy Option 11: Encourage the MBC to improve public access to and utility of MBC-provided information, such as establishing a web log ("blog") to provide notices of disciplinary actions now distributed via an email notification service to subscriber.
MBC Action and Response: The MBC currently emails disciplinary/administrative action notifications to any individual who requests to be on the MBC's Subscriber's list. The public documents are available on the MBC's Web site and the MBC's Newsletter maintains a list of disciplinary actions taken in the last quarter. In addition, the MBC currently has a Webmaster who responds to emails to the MBC. In addition, the MBC's Education Committee has begun

a discussion exploring the potential role of social media as an avenue to expand public access to MBC information.

Board Response (2016):
Prior to 2014, public disciplinary information for currently and formerly licensed physicians could only be posted on the Board's website for 10 years. The Board sponsored AB 1886 (Eggman, Chapter 285, Statutes of 2014), which allows the Board to post the most serious disciplinary information on the Board's website for as long as it remains public. This bill changed the website posting requirements, as follows: requires malpractice settlement information to be posted over a 5-year period, instead of a 10-year period (the posting would be in the same manner as specified in BPC Section 803.1); still requires public letters of reprimand to be posted for 10 years; and requires citations to be posted that have not been resolved or appealed within 30 days, and once the citation has been resolved, to only be posted for 3 years, instead of 5 years. All other disciplinary documents remain on the Board's website indefinitely.

In addition to the information above regarding public record actions, the Board discloses the following information regarding past and current licensees:

- License number;
- License type;
- Name of the licensee or registrant, as it appears in the Board's records;
- Address of record;
- Address of record county;
- License status;
- Original issue date of license
- Expiration date of license;
- School name; and
- Year graduated.

The Board provides the following voluntary survey information as supplied by the licensee:

- Licensee's activities in medicine;
- Primary and secondary practice location zip code;
- Telemedicine primary and secondary practice location zip code;
- Training status;
- Board certifications;
- Primary practice area(s);
- Secondary practice area(s);
- Post graduate training years;
- Ethnic background;
- Foreign Language(s); and
- Gender.

Unless prohibited by law, the Board provides the actual documents on the website for the following:

- Accusation/petition to revoke or amended accusation;
- Public letter of reprimand;

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- Citation and fine;
- Suspension/restriction order; and
- Administrative/disciplinary decision.

The Board's website and the information it provides to consumers was recently rated by *Consumer Reports*. The Board's website ranked #1 in the nation for the information it provides to consumers.

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

In late August 2015, the Board launched a successful outreach campaign entitled "Check Up On Your Doctor's License." The campaign is designed to encourage all California patients to check up on their doctor's license using the Board's website. The Board recently completely revamped its home webpage to make it more user-friendly and to further the Board's outreach campaign. The changes include easy access to the Board's license verification page, the page to file a complaint, and the page to find public enforcement documents all right from the Board's home page. The Board also made its license verification webpage more user-friendly and provided a document that outlines what the information provided on a physician's profile means. The Board also developed brochures in English and Spanish and a video tutorial in English and Spanish that is posted on the Board's website and available on YouTube. The Board has successfully worked with numerous counties and cities in California, as well as the California State Retirees, CalSTRS, and CalPERS in getting its campaign information in publications, websites, tweets, and on Facebook. In addition, the Board worked with the State Controller's Office to include information about the Board's campaign on payroll warrants for all state employees and vendors. At this time, the outreach campaign has the potential of reaching 17 million California health care consumers.

ISSUE #12 (2012): (SURGICAL CLINIC OVERSIGHT BY MBC.) Has MBC fully implemented all the provisions of SB 100? Are there functions that the MBC should continue to improve as it implements SB 100?

Background: SB 100 (Price, Chapter 645, Statutes of 2011) provided for greater oversight and regulation of surgical clinics, and other types of clinics such as fertility and outpatient settings, and to ensure that quality of care standards are in place at these clinics and checked by the appropriate credentialing agency. Accrediting agencies that accredit these outpatient settings are approved by the MBC. Specifically, SB 100 included the following provisions:

1. Laser or Intense Pulse Light Devices. On or before January 1, 2013, the MBC shall adopt regulations regarding the appropriate level of physician availability needed within clinics or other settings using laser or intense pulse light devices for elective cosmetic procedures.

   In 2010 the MBC established the Advisory Committee on Physician Responsibility in the

Supervision of Affiliated Health Care Professionals (Advisory Committee) to determine the appropriate level of physician supervision at medical spa clinics. The Advisory

2. Committee conducted several meetings on this issue; however, it is unclear whether recommendations were established and adopted. The MBC should update the Committee on the findings and recommendations of the Advisory Committee and whether the MBC has adopted the regulations relating to physician availability at clinics or settings that use laser or intense pulse light devices.

3. In vitro fertilization. The MBC shall adopt standards that it deems necessary for outpatient settings that offer in vitro fertilization.

   The MBC should inform the Committee how many outpatient settings that offer in vitro fertilization are currently accredited, and whether any new standards were adopted for outpatient settings that offer in vitro fertilization.

   Additionally, the MBC should inform its licensees that settings that offer in vitro fertilization must be accredited.

4. Clinics outside the definition of outpatient settings. The MBC may adopt regulations it deems necessary to specify procedures that should be performed in an accredited outpatient setting for facilities or clinics that are outside the definition of outpatient setting.

   The MBC should inform the Committee whether it has adopted regulations for clinics that are outside the definition of outpatient settings. Additionally, the MBC should inform its licensees of any regulations that are adopted.

5. Reporting Requirements. An outpatient setting shall be subject to specified adverse reporting requirements and penalties for failure to report.

   SB 100 subjected outpatient settings to the adverse event reporting requirements contained in Section 1279.1 of the Health and Safety Code. An outpatient setting must report to the Department of Public Health within 5 days after the adverse event has been detected, or, if that event is an ongoing urgent or emergent threat to the welfare, health, or safety of patients, personnel, or visitors, not later than 24 hours after the adverse event has been detected. Adverse events include surgical events, product or device events, patient protection events, environmental events, criminal events, an adverse event or series of adverse events that cause the death or serious disability of a patient, personnel, or visitor. Civil penalties in the amount not to exceed $100 for each day that the adverse event is not reported may be assessed by DPH.

   The MBC should inform the Committee whether it has established an arrangement or a memorandum of understanding with DPH to obtain information on outpatient settings with adverse reports. Additionally, the MBC should notify all outpatient settings of this requirement and inform accrediting agencies of its obligation to report to the DPH adverse events that are found during inspections.

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6. Information on the Internet Website. The MBC shall obtain and maintain a list of accredited outpatient settings from the information provided by the accreditation agencies approved by the MBC, and shall notify the public by placing the information on its Internet Website, whether an outpatient setting is accredited or the setting's accreditation has been revoked, suspended, or placed on probation, or the setting has received a reprimand by the accreditation agency. Specifies the information that must be posted on the Internet Website.

   Committee staff tried searching the MBC's list of outpatient settings and encountered several flaws. First, the Internet page for Outpatient Surgery Settings is not easy or intuitively found on the MBC Website. Second, after accessing the Outpatient Surgery Setting Database, Committee staff found that you have to scroll through page after page of listings in order to find the information on the particular surgery center you are looking for. A consumer cannot just plug in the name of the surgery center they are looking for to get the information. Ultimately, the database is presented in such a way that it appears that the relevant information would at best be difficult for consumers to find. The MBC should update the database lookup so that consumers may more easily find useful information on an outpatient setting.

Staff Recommendation: *The MBC* should update the Committee on its efforts to implement SB 100, including: (1) The findings and recommendations of the Advisory Committee and whether the Board has adopted regulations relating to physician availability at clinics or settings that use laser or intense pulse light devices; (2) How many outpatient settings that offer in vitro fertilization are currently accredited, and whether any new standards were adopted for outpatient settings that offer in vitro fertilization; (3) Whether the Board has adopted regulations for clinics that are outside the definition of outpatient settings; (4) Whether the Board has established an arrangement or a memorandum of understanding with DPH to obtain information on outpatient settings with adverse reports. The MBC should further do the following, and report back to the Committee: (1) Inform licensees and the public that settings that offer in vitro fertilization must be accredited. (2) Inform of any regulations for clinics that are outside the definition of outpatient settings that are adopted by the Board. (3) Notify all outpatient settings of the reporting requirement under Health and Safety Code § 1279.1 and inform accrediting agencies of its obligation to report adverse events that are found during inspections to the DPH. (4) Update the database lookup so that consumers may more easily find useful information on outpatient settings.

Board Response (April 2013):
SB 100 (Price, Chapter 645, Statues of 2011) required the MBC to adopt regulations on or before January 1, 2013, on the appropriate level of physician availability necessary within clinics or other settings using laser or intense pulse light devices for elective cosmetic surgery. The MBC held two interested parties meetings via the MBC's Physician Supervisory Responsibilities Committee. The first meeting was in April, 2012 in Long Beach, and the second meeting was held on July 20, 2012 in Sacramento. MBC staff received feedback at both of these meetings and drafted regulatory language based on discussions at these meetings.

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The regulatory language is as follows: "Whenever an elective cosmetic procedure involving the use of a laser or intense pulse light device is performed by a licensed health care provider acting within the scope of his or her license, a physician with relevant training and expertise shall be immediately available to the provider. For the purposes of this section, "immediately available" means contactable by electronic or telephonic means without delay, interruptible, and able to furnish appropriate assistance and direction throughout the performance of the procedure and to inform the patient of provisions for post procedure care. Such provisions shall be contained in the licensed health care provider's standardized procedures or protocols."

The public regulatory hearing was held on October 26, 2012, where the MBC adopted the above language. These adopted regulations were sent to Office of Administrative Law (OAL) on March 4, 2013 for its review and approval. If the regulation is approved by OAL, it will become effective in approximately 60 days or around May 4, 2013. The MBC also voted, in the interest of public protection, to recommend a statutory change to require that the regulations apply to all clinic settings (not only those using laser or intense pulse light devices for elective cosmetic surgery), and to require the MBC adopt regulations to establish the knowledge, training, and ability a physician must possess in order to supervise other health care providers. This need for legislation was provided in the MBC's Sunset Review Report. The MBC will submit to the Senate B&P Committee staff, upon submission of this report, language that can be considered for this enhancement.

SB 100 requires the MBC to adopt standards it deems necessary for outpatient settings that offer in vitro fertilization and allows the MBC to adopt regulations to specify procedures that should be performed in an accredited setting for facilities or clinics that are outside the definition of an outpatient setting. The MBC has not held public workshops on these, thus it has not yet adopted either regulation. The MBC had focused on adopting the availability regulations required by SB 100 and implementing other public disclosure elements of the bill prior to addressing these two regulatory elements. The MBC will consider the adoption of further regulations through public workshops in the summer/fall of 2013.

The MBC does not gather information on the types of outpatient settings, so it does not have data on the number of outpatient settings that offer in vitro fertilization. This is something the MBC may be able to collect in the future, especially if standards are adopted for this type of outpatient setting. The MBC will continue to research these issues and keep the Committee apprised of its progress and notified when public workshops will be held.

SB 100 requires outpatient settings to report adverse events under Health and Safety Code Section 1279.1 to the California Department of Public Health (CDPH). The MBC has met with CDPH several times on this issue. CDPH is working on a memorandum of understanding (MOU) so it can legally share these adverse event reports with the MBC. However, this MOU has not yet been finalized; as such, the MBC has not yet received any adverse event reports from CDPH. The MBC will continue to work with CDPH on this issue and keep the Committee apprised of its progress. MBC staff met with the four accrediting agencies to inform them of the requirements of SB 100, including adverse event reporting and asked them to notify their outpatient settings. The MBC will determine if the accrediting agencies notified the outpatient surgery settings and if not, then the MBC will notify the settings. The MBC has provided information on SB 100 and its requirements to all physicians, including those who work in outpatient settings, via its newsletter in January 2012.

Lastly, pursuant to SB 100, the MBC has created the Outpatient Surgery Setting Database, which can be accessed through the MBC's Web site. A consumer can search by owner name or setting name to access pertinent information intended to provide transparency and help consumers make informed decisions. The MBC agrees that this database is not the most user friendly system at this time. However, the MBC has already made significant improvements to this database to make it more consumer friendly. The MBC will work with the accrediting agencies to ensure the required data continues to be received in a timely manner and posted on the Web site. In addition, in order to make the database easier for consumers to find, the MBC recently added a link to this database on its home page. This allows users to go directly from the MBC's home page to perform a search for an outpatient setting. The MBC will continue to make improvements as necessary to ensure consumers are informed.

The MBC has invited the four accreditation agencies to present at its next Board Meeting in April 2013 on the accreditation process, procedures, and requirements. This will allow the MBC to determine the communication between the accreditation agencies and the outpatient settings and ensure this is being conducted. The MBC will continue to update the Committee on the actions taken to implement SB 100.

Board Response (2016):

Although the Board has not yet adopted standards for outpatient settings that offer in vitro fertilization, it is in part because the Board has not been notified of any issues in these outpatient settings that require additional standards related to the in vitro fertilization services being provided in these settings. The Board may need to look into this matter further if it becomes aware of issues that need to be addressed in these settings.

Regarding clinics that fall outside the definition of outpatient settings, the Board is aware that there may be some clinics performing procedures, but are not using the level of anesthesia to require accreditation. However, to specify procedures in regulations that would require accreditation would be very difficult. Medicine is constantly evolving and if the Board were to name actual procedures in regulations, the procedure name could easily change to not be covered by the Board's regulations. In addition, new procedures are being developed and performed on a continuous basis. Any regulations adopted by the Board could not possibly keep up with the advancements and evolution in medicine and the development of new procedures.

On July 1, 2013, the regulations regarding the appropriate level of physician availability necessary within clinics or other settings using laser or intense pulse light devices for elective cosmetic surgery became effective; no further action is needed on this item.

Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) required adverse events to be reported the Board, instead of CDPH. The Board now receives these reports and is able to not only evaluate the facility, but also look into the care provided by the physician.

The Board established an Outpatient Surgery Setting (OSS) Task Force in 2013 to review the Board's existing OSS Program and laws to explore ways to improve consumer protection. This Task Force held several meetings to obtain stakeholder feedback on the Board's proposed

statutory changes that would increase consumer protection. Based upon the input from this Task Force, the Board sought legislation in 2015 (SB 396, Hill, Chapter 287), which was signed into law, that required all physicians within the OSS to have peer review, required a shorter time frame for the initial accreditation, and required the OSS to check for peer review information for all physicians working within the facility.

In addition, the Board made significant improvements to the OSS database and website to make it more consumer friendly. The public can now go to the Board's website and search for an OSS. The information contained on the database includes the owners of the facility, the types of services being performed, the status of the facility with the accreditation agency, and provides copies of the documents pertaining to an inspection of the OSS and any corrective action plans and follow-up inspections.

ISSUE #13 (2012): Implementation of peer review requirements pursuant to SB 700.

Background: In 2008 a study required by BPC § 805.2 was completed, which involved a comprehensive study of the peer review process. The study, performed by Lumetra, also included an evaluation of the continuing validity of BPC §§ 805 and 809 through 809.8 and their relevance to the conduct of peer review in California. The study found, among other things, that there were inconsistencies in the way entities conduct peer review, select and apply criteria, and interpret the law regarding BPC § 805 reporting and § 809 hearings.
SB 820 (Negrete McLeod, 2009) sought to define the requirements and clarify the peer review process based on the results of the study; however the bill was vetoed. Subsequently, SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) was enacted, which focused on enhancements to the peer review system and made other improvements to peer review.

Staff Recommendation: ***The MBC should report to the Committee regarding the implementation of SB 700, and the extent to which it is receiving the reports required under SB 700.***

Board Response (April 2013):
Pursuant to Business and Professions Code section 805, certain peer review bodies must report to the MBC actions pertaining to staff privileges, membership, or employment. In FY 2011/12, 114 reports were received pursuant to section 805, however, the MBC does not track the number of reports received pursuant to the individual subdivisions of section 805. The MBC has noticed a decline in the number of 805 reports received.

SB 700 (Negrete McLeod, Chapter 505, Statutes of 2010) added Section 805.01 to require the chief of staff of a medical or professional staff, a chief executive officer, medical director, or other administrator of a peer review body, to file a report following a formal investigation within 15 days after a peer review final determination that specified acts may have occurred, including gross negligence, substance abuse, and excessive prescribing of controlled substances. From January 1, 2011 (the first report received is dated April 1, 2011) to March 11, 2013 there were 25 reports received by the MBC pursuant to section 805.01. This bill also required the MBC to post a factsheet on the its Web site that explains and provides information on 805 reporting, in order to help consumers understand the process and what 805 reporting means. The fact sheet was posted on the MBC's Web site on December 30, 2010.

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The MBC not only notified the licensees of the new reporting under section 805.01 in its Newsletter, but has had several articles about 805 reporting in its Newsletter. The MBC also incorporates these reporting requirements into outreach provided to the groups who would be required to report.

There are multiple potential explanations to account for the observed decline in 805 reporting, including: hospitals finding problems earlier and sending physicians to remedial training prior to an event occurring that would require an 805 report; with the implementation of electronic health records and the mining of medical record data by the health entities, early identification is a real possibility; the growing use of hospitalists providing care to hospitalized patients, concentrating the care in the hands of physicians who specialize in inpatient care and who are less prone to errors than physicians who provide the care on only an occasional basis; etc. Or, the decline may be due to under- reporting. However, because the MBC does not have jurisdiction over the hospitals, it has no way of knowing the reason for the decline. CDPH and other hospital accrediting agencies have the authority to review hospital records and conduct inspections of the hospitals. For this reason, the MBC is recommending that existing law be amended to require state agencies and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC. The MBC has submitted language on March 5, 2013 to Senate B&P Committee staff on this issue.

Board Response (2016):
The language submitted to the Senate B&P Committee as stated in the April 2013 response did not result in any legislative change. However, the Board continues to believe that entities are not reporting as required pursuant to B&P Code section 805.01. This may be due, in part, to the fact that there are no penalties required for not reporting pursuant to B&P Code section 805.01. Therefore, the Board has added a new issue in Section 11 of this document, which requests a legislative change to require penalties for failing to report as required under B&P Code section 805.01. Additionally, the Board continues to recommend that existing law be amended to require state agencies and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board. This will give the Board an ability to determine whether facilities are sending in B&P Code section 805 and 805.01 reports as required, and to take appropriate action if such facilities are not reporting as required.

ISSUE #14 (2012): (BETTER USE OF HEALTH CARE INFORMATION.) Should the MBC engage stakeholders to identify areas in which alternative approaches may be used to analyze current data collected on healthcare facilities and practices in order to improve or enhance the practice of health care providers?

Background: The federal American Recovery and Reinvestment Act (ARRA), enacted by Congress in 2009, calls for the development of a nationwide health information technology infrastructure. To support its development, ARRA created the State Health Information Exchange Cooperative Agreement Program (HIE), which provides federal funding to states and "state-designated entities" to establish and implement statewide HIE networks.

HIE is defined as the mobilization of health care information electronically across organizations within a region, community or hospital system. The goal of the HIE is to facilitate access to and retrieval of clinical data to provide safer and timelier, efficient, effective, and equitable

patient-centered care. The HIE is also useful to public health authorities to assist in analyses of the health of the population. The systems also facilitate the efforts of physicians and clinicians to meet high standards of patient care through electronic participation in a patient's continuity of care with multiple providers.

In addition to the HIEs, various Federal agencies and insurance companies require hospitals to collect patient satisfaction data among other data. The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) also requires hospitals to submit data on patient satisfaction as part of the re-accreditation process.

In light of the national focus on the use of health information technology, as well as the requirements of JCAHO and insurance companies, it is prudent that California begin to explore ways to utilize the aggregate data that is being collected to examine health care patterns across the state.

Staff Recommendation: ***Recommend that the MBC take steps toward creating a Task Force to discuss how aggregate data can be utilized for each task force member's respective purposes. The group would be requested to examine the aggregate data already required to be reported to federal government in order to identify trend lines across the state. Ultimately, these findings could be used to identify standards for best practices. Task force members may include the following:***

- ***Medical Board of California***
- ***California Hospital Association***
- ***Institute for Medical Quality***
- ***Joint Commission on Accreditation of Health Care Organizations***
- ***Department of Public Health***
- ***Institute for Population Health Improvement***
- ***Citizen Advocacy Center***
- ***Center for Public Interest Law***

Board Response (April 2013):
Senate B&P Committee Staff has recommended that the MBC take steps to create a Task Force to discuss how clinical care aggregate data reported to the federal government by health care facilities can be utilized in order to identify trend lines and health care patterns across the state. The MBC has not discussed and taken a position on this proposal. The MBC would need to examine how this fits within the mission and role of the MBC. In addition, the MBC does not have oversight over the health care facilities that are collecting this data. The MBC may consider participation in such a task force, but it may not be the appropriate agency to lead this broad public health effort, as the MBC is a regulatory agency with accountability for the oversight of individual physician practice and behavior, without the resources or knowledge base to evaluate the performance of health systems in California.

Board Response (2016):
The Board believes that obtaining and sharing data is very important. However, the Board continues to believe that it is not the appropriate agency to lead this broad public health effort, especially since the Board does not have oversight authority over the vast majority of health care facilities.

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ISSUE #15 (2012): (ADOPTION OF UNIFORM SUBSTANCE ABUSE STANDARDS.) Has the MBC adopted all of the Uniform Standards developed by the Department of Consumer Affairs Substance Abuse Coordination Committee? If not, why not?

Background: The Medical Board of California (MBC) operated a physician's substance abuse "Diversion Program" for 27 years, which utilized statutory authority granted to "divert" a physician into the Diversion Program for treatment and rehabilitation in lieu of facing disciplinary action. In 2007, the Diversion Program was terminated following the release of several audits exposing the egregious shortcomings of the program, which in many cases put patients at tremendous risk. Since the end of the diversion program, physicians dealing with alcohol or substance abuse issues, mental illness, or other health conditions that may interfere with their ability to practice medicine safely can seek private treatment and monitoring services. However, California is one of only 5 states in the United States that does not have a physician health program to coordinate and provide care and referral services for physicians suffering from these maladies.

The Legislature enacted SB 1441 (Ridley-Thomas, Chapter 548, Statutes of 2008) to establish within the DCA a Substance Abuse Coordination Committee (SACC) to develop uniform standards and controls for healing arts programs dealing with licensees with substance abuse problems by January 1, 2010. SB 1441 requires each healing arts board within the Department to use the uniform standards developed by SACC regardless of whether the board has a formal diversion program.

The SACC completed its work and developed uniform standards in 16 specific areas identified by SB 1441. The uniform standards were published in April 2011. Since that time various boards within DCA have struggled with the uniform standards. Some boards have been reluctant to adopt the standards, contending that the standards are optional, or that certain standards are not applicable.

However, the Legislative Counsel, in a written opinion titled Healing Arts Boards: Adoption of Uniform Standards (# 1124437) dated October 27, 2011, states: "[W]e think that the intent of the Legislature in enacting Section 315.4 was not to make the uniform standards discretionary but to 'provide for the full implementation of the Uniform Standards' . . . Accordingly, we think the implementation by the various healing arts boards of the uniform standards adopted under Section 315 is mandatory."

An Attorney General Informal Legal Opinion, February 29, 2012, and a DCA Legal Counsel Opinion, dated April 5, 2012 both agree with this opinion.

The MBC has not yet adopted the Uniform Standards. At its January 31, 2013 Enforcement Committee meeting, the staff assessment of the Uniform Standards was that 8 of the 16 standards did not apply to the MBC, since they specifically reference a diversion program or elements typically found in a diversion program. Ultimately, the Enforcement Committee did not move forward on the proposal, choosing instead to have staff draft a more complete plan to implement the Uniform Standards.

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Staff Recommendation: ***The MBC should fully implement the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as required by SB1441. The MBC should report back to the Committee by July 1, 2013 of its progress in implementing the Uniform Standards.***

Board Response (April 2013):
The MBC has and will fully implement the uniform standards that apply to the MBC. The MBC adopted regulations that were effective in July 2012 that adopted several of the uniform standards, including cease practice orders for positive tests. At the MBC's last Enforcement Committee Meeting, the Committee Chair requested that staff bring back for discussion, the issue of implementation of all uniform standards. These standards will be discussed at the April Enforcement Committee Meeting in Los Angeles. The MBC will report back to the Committee on the outcome of this meeting and the MBC's plan for full implementation of the uniform standards.

Board Response (2016):
The Board reviewed the Uniform Standards to determine which of the standards apply to the Board and needed to have regulations implemented. After review and discussion by the Board, regulations were drafted to implement the Uniform Standards and were submitted to the Office of Administrative Law (OAL) for notice on September 6, 2013. A public hearing on the regulations was held at the Board's October 25, 2013 meeting. Due to numerous comments and recommended changes, legal counsel made edits to the regulatory language that were approved at the Board's February 2014 meeting. Therefore, a second notice went out in April 2014 with the second modified text. The Board reviewed comments and discussed the regulations at its May 2014 meeting. The final regulations were submitted to OAL on August 26, 2014. On October 15, 2014, the Board was notified that the regulations were disapproved. The Board held a special teleconference meeting on December 1, 2014 for the Members to review necessary changes to the regulations. A third amended text was posted for comment on December 8, 2014, and the regulations were resubmitted to OAL on Feb 10, 2015, for final review. On March 25, 2015, OAL approved the Board's regulations implementing the Uniform Standards with an effective date of July 1, 2015.

The Board provided the new regulations to the AG's office as well as the Office of Administrative Hearings for use with all decisions of the Board that involve a substance-abusing licensee. The Board has been using the Uniform Standards since they became effective.

ISSUE #16 (2012): Stipulated settlements below the Disciplinary Guidelines.

Background: In October 2012, an investigative report by the *Orange County Register* (Register) found that from July 2008 to June 2011, the MBC settled with disciplined physicians for penalties or conditions which were below the MBC's own Disciplinary Guideline standards. In the negotiated settlements, which were the focus of the investigation, the *Register* found 62 of 76 cases in which patients had been killed or permanently injured had negotiated settlements with physicians. According to the *Register*, 63% of those cases were settled for penalties below the Board's own minimum recommendations under its Disciplinary Guidelines.

Often times licensing boards resolve a disciplinary matter through negotiated settlement, typically referred to as a "stipulated settlement." This may be done, rather than going to the expense of lengthy administrative hearing on a disciplinary matter.

According to the Citizen Advocacy Center (a national organization focusing on licensing regulatory issues nationwide) "It is not uncommon for licensing boards to negotiate consent orders [stipulated settlements] 80% of the time or more."

A stipulated settlement is not necessarily good or bad from a public protection standpoint. However, it is important for a licensing board to look critically at its practices to make sure that it is acting in the public's interest when it enters into a stipulated settlement and that it is acting in the best way to protect the public in each of these stipulated decisions.

Each board adopts disciplinary guidelines through its regulatory process. Consistent with its mandated priority to protect the public, a board establishes guidelines that the board finds appropriate for specific violations by a licensee.

The disciplinary guidelines are established with the expectation that Administrative Law Judges hearing a disciplinary case, or proposed settlements submitted to the board for adoption will conform to the guidelines. If there are mitigating factors, such as a clear admission of responsibility by the licensee early on in the process, or clear willingness to conform to board-ordered discipline, or other legal factors, a decision or settlement might vary from the guidelines. At other times in a disciplinary case there can be problems with the evidence, but the licensee admits to wrongdoing in a matter and may be willing to settle a case without going to a formal hearing. However when there are factors that cause the discipline to vary from the guidelines, they should be clearly identified in order to ensure that the interest of justice is being served.

Staff Recommendation: ***The MBC should discuss with the Committee its policies regarding stipulated settlements and the reasons why it would settle a disciplinary case for terms less than those stated in the Board's Disciplinary Guidelines. What is the consumer protection rationale for settling administrative cases for terms that are below those in the Disciplinary Guidelines? Are these recommendations of the Attorney General's Office or decisions made by the MBC staff independent of the AG?***

Board Response (April 2013):
The MBC uses the disciplinary guidelines as a framework for determining the appropriate penalty for charges filed against a physician. Business and Professions Code section 2229 identifies that protection of the public shall be highest priority for the MBC, but also requires that wherever possible, the actions should be calculated to aid in the rehabilitation of the licensee. While the disciplinary guidelines frame the recommended penalty, the facts of each individual case may support a deviation from the guidelines. Once the administrative action has been filed, existing law (Government Code Section 11511.5 and 11511.7) requires that a prehearing conference be held to explore settlement possibilities and prepare stipulations, as well as a mandatory settlement conference, in an attempt to resolve the case through a stipulated settlement before proceeding to the administrative hearing.

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The Deputy Attorney General (DAG) responsible for prosecuting the MBC's case prepares a settlement recommendation that outlines the strengths and weaknesses of the MBC's case. The DAG will use the MBC's disciplinary guidelines to frame the recommended penalty, based upon what violations can be proven. The DAG negotiates to settle a case with a recommended penalty, but may ask the MBC representative for authority to reduce the penalty based on evidentiary problems; this type of negotiation is similar to what happens in criminal cases. In the negotiations to settle a case, public protection is the first priority, and must be weighed with rehabilitation of the physician.

When making a decision on a stipulation, the MBC is provided the strengths and weaknesses of the case, and weighs all factors. The settlement recommendations stipulated to by the MBC must provide an appropriate level of public protection and rehabilitation. Settling cases by stipulations that are agreed to by both sides expedites the rehabilitation of physicians and ensures consumer protection by rehabilitating the physician in a more expeditious manner. By entering into a stipulation, it puts the individual on probation or restriction sooner and the public is able to see the action taken by the MBC more timely than if the matter went to hearing. Currently, approximately 70% of cases are settled by stipulation. The MBC does not believe at this time any changes are needed in the way it approaches stipulated settlements, as consumer protection is always the MBC's primary mission.

Board Response (2016):
The Board's response provided in April 2013 addressed this issue. The Information previously provided is still applicable. The Board still does not believe any changes are needed, as consumer protection is the Board's primary mission.

ISSUE #17 (2012): (CPEI IMPLEMENTATION.) Why has the MBC not filled staffing positions provided under CPEI in FY 2010-11?

Background: In response to a number of negative articles about the length of time licensing boards take to discipline licensees who are in violation of the law, in 2010, the DCA launched the Consumer Protection Enforcement Initiative (CPEI) to overhaul the enforcement process of healing arts boards. According to the DCA, the CPEI is a systematic approach designed to address three specific areas: Legislative Changes, Staffing and Information Technology Resources, and Administrative Improvements. Once fully implemented, the DCA expects the healing arts boards to reduce the average enforcement completion timeline to between 12 -18 months. The DCA requested an increase of 106.8 authorized positions and $12,690,000 (special funds) in FY 2010-11 and 138.5 positions and $14,103,000 in FY 2011-12 and ongoing to specified healing arts boards for purposes of funding the CPEI. As part of CPEI, the MBC was authorized to hire 22.5 positions, including 20.5 (non-sworn) special investigators and 2 supervisors/managers.

However, the MBC has had very little success in filling these positions. An MBC staff report dated January 11, 2013, indicates that of the 22.5, positions authorized in 2010, 2.5 allocated for the MBC performing investigations for the Osteopathic Medical Board and the Board of Psychology were transferred to those boards. Of the remaining positions, 2 were filled – a manager and an analyst in its CCU. This left the MBC with 18 unfilled CPEI positions.

According to the MBC the statewide budget crisis severely impacted its efforts to fill the remaining CPEI positions. Workforce cap position reductions, statewide hiring freeze, elimination of position due to a statewide mandate for a 5% salary saving reduction effectively eliminated all of the remaining CPEI positions.

In 2012, the MBC states that it was notified that it could reestablish the positions in the temporary help blanket as long as the Board always maintains a 5% vacancy rate to meet the required salary reduction level, and the MBC began the process of identifying positions to establish and hiring to fill those positions.

The MBC has determined that it will request the re-establishment of 14.5 positions in the following areas in order to improve the enforcement timeframes as originally planned in the CPEI. According to the staff report, the MBC has determined where those positions will be allocated to meet the demands of CPEI.

It is troubling to Committee staff that the MBC has not done more to fill these positions. It is the understanding of staff that the hiring freeze did not apply to filling the positions established by the CPEI BCP. If this is the case, why did the MBC not fill the positions or purse exemptions to the existing hiring restrictions?

In addition, the BCP authorized the MBC to hire 20.5 non-sworn special investigators. It is understood by the Committee that MBC staff may have some reluctance to hire non-sworn personnel to assist in investigations when the board's enforcement unit has been typically staffed with sworn (peace officer) investigators. However, if the reluctance to fill positions authorized by the Legislature is because the positions are not of the traditionally desired classification, it calls into question the management of the MBC, and whether the MBC is flaunting the will of the Legislature and undermining public protection. Clearly the Legislature expected that the boards would immediately fill these positions once approved by the Administration. Considering some of the major enforcement problems which have been identified regarding this Board , both in the media, by consumer advocates and by this Committee, and some of those problems being directly related to staffing issues, it seems completely inappropriate that this Board would stall for any reason in the hiring of additional investigators. It raises the question to what extent will the remaining CPEI positions, and the functions that the MBC intends for them to carry out, enable the MBC to achieve the goals established by CPEI?

Staff Recommendation: ***The MBC should update the Committee on the current status of its efforts to fill the CPEI positions. The MBC should further advise the Committee of the appropriate level of staffing necessary to implement the goals of CPEI.***

Board Response (April 2013):
The MBC originally received 22.5 CPEI positions effective fiscal year (FY) 2010/2011. The MBC began to fill these positions by hiring an additional manager and one Staff Services Analyst in the Central Complaint Unit. This left the MBC with 20.5 CPEI positions. As stated above there were several factors that impeded the filling of these remaining positions.

Because the MBC conducted investigations for the Osteopathic Medical Board of California (OMBC) and the Board of Psychology (BOP), 2.5 of the CPEI positions authorized for the MBC

were to assist in those boards' investigations. However, these boards determined that they would rather have the positions under their specific authority. Therefore, in FY 2011/2012, those 2.5 positions were taken from the MBC and provided to the OMBC and the BOP. This left the MBC with 18 CPEI positions.

The MBC began to develop a plan to hire non-sworn investigators and initiated the process to write duty statements and justifications to establish these positions. However, during FY 2010/2011, the MBC was required to decrease its positions due to a requested workforce cap drill. The MBC therefore did not move to fill any of its positions due to the uncertainty of the number of positions it would lose. The final direction on how many positions the MBC would lose due to the workforce cap (2.5 positions) was not provided to the MBC until June 2011. With the loss of these 2.5 positions, the MBC had 15.5 remaining CPEI positions.

The MBC was notified it could re-class some of the CPEI positions and again the MBC began to identify where to establish these 15.5 positions and into which classification to best address the needs of the MBC and to enhance consumer protection. However, the MBC was also under a hiring freeze, which required the MBC to request hiring freeze exemptions for any position the MBC wanted to fill, including CPEI positions. The MBC had to set priorities in submitting freeze exemptions. The MBC had several existing investigator and medical consultant positions that were vacant and therefore requested exemptions for these classifications in order to continue to process investigations. Additionally, there were several licensing positions that were vacant. The MBC determined that exemptions for the existing vacancies with a pending workload were higher priority than the establishment of new positions.

The hiring freeze was lifted in November of 2011 and the MBC again began discussion to fill the CPEI positions. However, in early 2012, the MBC was notified that it would be required to eliminate 18.1 positions due to the 5% salary savings reduction. Rather than eliminate existing staff or investigator positions, the MBC used the 15.5 vacant CPEI positions (and 2.6 other vacant positions) to meet the reduction requirement.

Although the MBC no longer has the CPEI positions, it was notified in September 2012 that it could reestablish these positions in the temporary help blanket as long as the MBC always maintains a 5% vacancy rate to meet the required salary reduction level. The MBC identified a plan to reestablish 14.5 positions into classifications that would best meet the needs of the MBC. Specifically, the MBC determined the need to address the loss of investigator positions in the district offices to meet the concept of the CPEI with the intent to lower the enforcement timeframe and improve consumer protection. This plan was presented to and approved by the MBC, and also included in the MBC's Supplemental Sunset Report. The MBC had submitted the appropriate paperwork to the Department of Consumer Affairs to fill 11 of these positions. However, the MBC was recently notified by DCA that the CPEI positions cannot be reclassified and can only be filled with non-sworn special investigators. The MBC will work on a plan to identify the functions that can be performed by these individuals in non-sworn positions within the constraints of law. Once this is done, it will submit paperwork to fill the positions in an effort to reduce the enforcement timeframes and continue to improve consumer protection.

The MBC Executive staff is of the opinion that a reduction in an investigator's workload will assist the MBC in meeting the goals of the CPEI. The MBC staff identified a means to obtain

additional investigator positions without an increase in budget authority via the reclassification of these positions. The plan identified in the MBC's Supplemental Sunset Report identified the manner in which the CPEI positions could be reclassified in order to meet the goals of the CPEI, ultimately reducing the time it takes to investigate a physician who is found to be in violation of the law.

Board Response (2016):
The Board developed a plan that was discussed at its June 2013 Board meeting to fill the CPEI positions. In July 2014, using the CPEI positions, the Board established the Complaint Investigation Office (CIO) made up of special investigators (non-sworn) who began working the less complex investigations for the Board. This unit, comprised of six special investigators (non-sworn) and a supervising special investigator I, is tasked with investigating quality of care investigations following a medical malpractice settlement or judgment, cases against physicians charged with or convicted of a criminal offense, and physicians petitioning for reinstatement of a license following revocation or surrender of his or her license. The establishment of the CIO has assisted in reducing the case load of the HQIU investigators, in addition to resulting in quicker resolution of these cases. Based upon the success of the CIO, the Board is considering hiring four more special investigator positions to be housed in Southern California to further assist with caseload reduction.

ISSUE #18 (2012): Reporting of Patient Deaths to the MBC.

Background: BPC § 2240 requires any physician and surgeon who performs a scheduled medical procedure outside of a general acute care hospital, as defined, that results in the death of any patient on whom that medical treatment was performed by the physician and surgeon, or by a person acting under the physician and surgeon's orders or supervision, shall report, in writing on a form prescribed by the board, that occurrence to the board within 15 days after the occurrence.

In its Report, the MBC states that is concerned that it may not be receiving the reports from physicians as is required by statute because the number of patient death reports filed each year is very low. The MBC indicates that there is no way to currently verify if the Board receives 100% of the reports but those that are provided are submitted within the 15-day statutory timeframe. The Board has the authority to issue a citation to the physician for failing to file a report as required. The Board can also charge the failure to file the report as a cause of action in any administrative action being taken against the physician regarding the incident. The MBC states that it reminds physicians of their mandated reporting obligations in the quarterly Newsletter.

The MBC should inform the Committee how many deaths were reported pursuant to this section. Additionally, the MBC should take steps to inform, not only licensees but also accrediting agencies that accredit outpatient settings that this requirement exists. The Board should further coordinate with accrediting agencies how this requirement can be incorporated in the accrediting agencies' inspection reports of outpatient settings.

Staff Recommendation: ***The MBC should inform the Committee how many deaths were reported pursuant to Section 2240. Additionally, the MBC should take steps to inform, not only licensees but also accrediting agencies that accredit outpatient settings about***

the reporting requirement in Section 2240. MBC should also coordinate with accrediting agencies how this requirement can be incorporated in the accrediting agencies' inspection reports of outpatient settings.

Board Response (April 2013):
Business and Professions Code section 2240 requires physicians who perform medical procedures outside of a hospital (in outpatient surgery settings) that result in a patient death, to report to the MBC within 15 days. The number of reports received pursuant to section 2240 is reported in the MBC's Annual Report. In FY 2011/12, the MBC received seven (7) reports. The MBC does list all mandated reports for physicians in the January issue of the Newsletter every year, which goes out to all physicians, applicants and subscribers; the Newsletter is also posted on the home page of the MBC's Web site. Pursuant to Senate B&P Committee staff's recommendation, the MBC will work on informing the Accreditation Agencies (AAs) and discuss with the Agencies the desire to include this information in the outpatient setting inspection reports. The MBC will keep the Committee apprised of these discussions.

Board Response (2016):
The Board, prior to January 1, 2014, did not receive adverse event reports (including deaths in an outpatient setting). These reports prior to January 1, 2014, were sent to the California Department of Public Health. SB 304 (Lieu Chapter, 515, Statutes of 2013) added Business and Professions Code section 2216.3 that requires an outpatient setting accredited pursuant to Section 1248.1 of the Health and Safety Code to report adverse events to the Board. Adverse event reports are reviewed by the Board's Enforcement Program. On December 31, 2013, the Board sent correspondence to all of the approved accreditation agencies (AA) notifying the AAs of the new law and requirements.

Adverse events can result in the AA conducting an inspection and/or the Board can request the AA to conduct an inspection on the specific outpatient setting. In addition, the Board has the authority to inspect the outpatient setting.

Note: The Board is not properly staffed to conduct outpatient setting inspections, as the Board does not have physicians on staff that are trained in performing these inspections. However, the accreditation agencies are properly staffed to perform outpatient setting inspections and surveys.

ISSUE #19 (2012): There appears to be a low use of the MBC's Interim Suspension Authority.

Background: Government Code § 11529 authorizes the administrative law judge of the Medical Quality Hearing Panel in the Office of Administrative Hearings to issue an interim order suspending a license of a physician, or imposing drug testing, continuing education, supervision of procedures, or other license restrictions. Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act or the appropriate practice act governing each allied health profession, or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or

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welfare. When an ISO is issued, the MBC has 15 days to file and serve a formal accusation under the Government Code to revoke the license of the physician.

This interim suspension order (ISO) authority was the first of its kind for DCA's regulatory boards, and was established in 1990 by SB 2375 (Presley, Chapter 1597, Statutes of 1990). This provision was intended to immediately halt the practice of very dangerous physicians in egregious cases.

A number of the recent newspaper articles critical of the MBC's enforcement practices have highlighted the time it takes to remove a dangerous doctor from practice. Enforcement statistics from the MBC's sunset report show that for the last 3 fiscal years, an average of 23 ISOs or temporary restraining orders (TRO) have been issued.

	FY 2009/10	FY 2010/11	FY 2011/12
ISO & TRO Issued	19	22	28

In 2004, the MBC Enforcement Monitor's Initial Report stated: "MBC's enforcement output statistics indicate a troubling decline in the efforts to use the powerful ISO/TRO authority in the recent past. ISOs/TROs sought by HQE on behalf of the MBC diminished from a high of 40 in 2001–2002 to 26 in the 2003–04 fiscal year (a decline of 40%). Given the importance of these public safety circumstances, a decline in the use of these tools is a source of concern to the Monitor." Since that time, ISO/TROs have remained low. According to the MBC, it sought 36 ISOs in FY 2011/12 although there were only 28 granted.

In discussing the challenges faced with obtaining an ISO, regulatory boards often point out the level of standard that must be demonstrated to obtain the ISO, and the difficulty in filing a formal accusation within 15 days from the time the ISO is issued.

Committee staff raises the issue of whether there should be a lower standard in order for an ALJ to issue an ISO. Furthermore, should there be lengthier timeframes (longer than 15 days) for the filing of an accusation after an ISO has been issued? In addition, in cases where the MBC is seeking to simply restrict a physician's prescribing privileges (rather than suspend the entire license), it may be an appropriate consumer protection tool to lower the standard for obtaining an ISO and for lengthening the timeframes for filing an accusation against a physician.

Staff Recommendation: ***The MBC should inform the Committee of the reasons why it believes that the number of ISOs and TROs has remained low in recent years. The MBC should further advise the Committee on whether Government Code § 11529 should be amended to provide for changes to the ISO or TRO process, so that it may enhance its use by the MBC to quickly remove dangerous physicians from practice.***

Board Response (April 2013):
In the Senate B&P Committee's background paper it stated that there has been a low use of Interim Suspension Orders (see above). However, it is important to point out that in addition to interim suspension orders (ISOs) and temporary restraining order (TROs), the MBC utilizes restrictions pursuant to Penal Code 23, which are issued as part of a criminal hearing process, as a condition of bail. Restrictions are also imposed via a stipulated agreement to not practice

or a stipulated agreement to a restriction. The MBC can also require physicians to cease practice if they fail to comply with a term or condition of their probation. In 2001/02, a total of 42 of these suspensions/restrictions were issued. This has remained fairly constant over the years, and for last fiscal year, 2011/12, again a total of 42 of these suspensions/restrictions were issued.

An ISO is considered extraordinary relief and pursuant to Government Code section 11529, a standard of proof must be met in order for an ISO to be granted. Since every case presents its own set of circumstances, it is difficult to generalize why an ISO is not currently in place for a particular licensee. Before an ISO can be requested, there are a number of steps that must be taken (gathering medical records, obtaining patient consent, medical consultant review, etc.) in order to prove that a licensee's continued practice presents an immediate danger to public health, safety, or welfare. Once the investigation progresses and the Attorney General's office reviews the case, a determination is made as to whether there is enough evidence to warrant requesting an ISO, which must be granted by an Administrative Law Judge (ALJ). Even after the ISO is requested, if an ALJ determines there is insufficient evidence, the ISO request can be denied. Due diligence must be taken to ensure that seeking an ISO is the correct course of action.

There is a 15-day time restraint in existing law to file an accusation after being granted an ISO, and a 30-day time restraint between the accusation being filed and a hearing being set. This means an investigation must be nearly complete in order to petition for an ISO. At this time, the MBC has not identified, discussed, or taken a position on any potential modifications or enhancements to the existing statutes for ISOs. This matter would be an issue for all boards within the Department of Consumer Affairs. The MBC believes that any avenue that would provide more consumer protections is warranted.

Board Response (2016):
SB 304 (Lieu Chapter, 515, Statutes of 2013) extended the time in which to file an accusation from 15 days to 30 days, which has assisted the Board in issuing ISOs.

In addition, the Board worked with the Attorney General's Office and the Department of Consumer Affairs' Health Quality Investigation Unit to identify and implement several improvements to expedite and increase the issuance of ISOs. The Board saw a significant increase in ISOs issued from fiscal year 14/15 to 15/16 due to these improvements. The number of ISOs issued increased from 14 to 36, which is a 157% increase. In addition, the average time to obtain an ISO was reduced from 588 days in fiscal year 14/15 to 438 days in fiscal year 15/16, a 150 day reduction. Implementation of additional improvements is planned and will continue to enhance the ISO process, allowing the Board to meet its mission of consumer protection.

ISSUE #20 (2012): Use of MBC's Authority to cite and fine physicians who fail to produce records within 15 days.

Background: In the 2005 JCBCCP review of the MBC, the issue of physicians withholding records in violation of BPC § 2225 was raised. Physicians have 15 days from the time they receive a patient's signed release to turn those medical records over to the MBC for its investigation of complaints. Subsequently, SB 231 amended Section 2225 to authorize the

MBC to use its cite and fine authority for a physician for failure to provide requested records within the 15-day time period.

It is unclear whether the MBC has used this authority and whether this authority has proven helpful in obtaining physician compliance.

Staff Recommendation: ***The MBC should inform the Committee of its use of cite and fine authority under BPC § 2225. How many citations have been issued? What are the fine amounts that have been assessed? How has this authority worked to obtain compliance with the 15 day record production requirement?***

Board Response (April 2013):
The MBC has utilized its authority to issue citations for failing to provide medical records to the MBC when provided with the patient's authorization for medical records. Since 2008, 19 citations have been issued with a standard fine amount for each citation of $1000.

It is important to remember that a citation can only be issued for those cases where the MBC has the patient authorization to release the medical records. In most cases, the citations are issued in conjunction with a complaint undergoing the initial review in the Central Complaint Unit. In 2006, a citation was issued to a physician for failing to respond to the MBC's request for records on two patients. The physician failed to respond to the citation and the matter was referred for administrative action and the physician was ultimately assessed at fine of $244,000 for failing to provide medical records to the MBC. The case underwent a number of appeals and was ultimately resolved in 2008. As a result of the lessons learned in that case, the Central Complaint Unit revised their methods of documenting evidence of non-compliance before a case is referred for a citation. The MBC's current protocol requires two written notifications to the physician and a phone conversation directly with the physician before a citation can be issued. While the number of citations may be limited to 3-4 per year, the goal is to ensure that the physician provides records timely to the MBC and that goal is being accomplished, as evidenced in the decrease in processing time in the Central Complaint Unit.

Board Response (2016):
The Board continues to use its citation and fine authority to issue citations for violations of B&P Code section 2225. It should be noted that with the transition of the Board's investigators in fiscal year 2014/2015 the Board temporarily lost its ability to issue certain citations. However, the Board's regulations were amended to fix this unintended consequence, and since the Board's 2013 response, 11 citations have been issued for violations of B&P section 2225.

ISSUE #21 (2012): Require Coroner Reporting of Prescription Drug Overdose Cases to the MBC.

Background: The epidemic of prescription drug overdoses is plaguing the nation and the number of deaths related to prescription drugs is overwhelming. At a time when the Board believes it should be receiving more coroner reports than ever, the number of reports received is at an all-time low. Only four reports were received in FY 2011/2012, and only one of the reports indicated a drug related death.

A recent *LA Times* series that analyzed coroners' reports for over 3000 deaths occurring in four counties (Los Angeles, Orange, Ventura and San Diego) where the cause of death was overdose by prescription drugs. The analysis found that in nearly half of the cases where prescription drug overdose was listed as the cause of death, there was a direct connection to a prescribing physician. The report also found that more than 80 of the doctors whose names were listed on prescription bottles found at the home of or on the body of a decedent had been the prescribing physician for 3 or more dead patients, including one doctor who was linked to as many as 16 dead patients.

The Board has reason to believe numerous deaths have occurred in the state that are related to prescription drug overdoses. However, complaints regarding drug-related offences are often hard for the Board to obtain. In most instances, patients who are receiving prescription drugs in a manner that is not within the standard of practice are unlikely to make a complaint to the Board.

BPC § 802.5 requires a coroner to report to the Board when he/she receives information based on findings by a pathologist indicating that a death may be the result of a physician's gross negligence or incompetence.

This section requires the coroner to make a determination that the death may be the result of a physician's gross negligence or incompetence. In order to alleviate the coroners from making this determination in prescription drug overdose cases, all deaths related to prescription drug overdoses should be reported to the Board for further investigation. This would allow the Board to review the documentation to determine if the prescribing physician was treating in a correct or inappropriate manner. This would increase consumer protection and ensure the Board is notified of physicians who might pose a danger to the public so action can be taken prior to another individual suffering the same outcome.

The Board recommends that BPC § 802.5 be amended to require coroners to report all deaths related to prescription drugs to the Board.

SB 62 (Price) was introduced on January 8, 2013, and would expand the coroner reporting requirement to further require that a coroner to file a report with the MBC when the coroner receives information that is based on findings by, or documented and approved by a pathologist that indicates that a death may be the result of prescription drug use.

This proposed change would help to connect the dots and create a very necessary pathway for prescription drug overdose deaths to be reported directly to the MBC and other health care boards that can take necessary action against their licensees who may have been directly involved. If boards are receiving reports from coroners throughout the state, they will be better armed with the necessary tools to make a correlation to their licensees in overprescribing circumstances and take action.

The provisions of SB 62 are consistent with the recommendation made in the MBCs report.

Staff Recommendation: ***Statutory changes should be made to require a coroner to file a report with the MBC and any other relevant health care boards when the coroner receives information that is based on findings by, or documented and approved by a***

pathologist that indicates that a death may be the result of prescription drug use. MBC should also inform all coroners in the state about any statutory changes to the coroner reporting requirements.

Board Response (April 2013):
The MBC is supportive of SB 62 (Price), which will require deaths related to prescription drug use to be reported to the MBC. The MBC believes this bill will increase consumer protection and ensure the MBC is notified of physicians who might pose a danger to the public, so disciplinary action can be taken by the MBC. It is imperative that the MBC know about these cases. If SB 62 is signed into law, the MBC will ensure that coroners are informed of their new reporting requirements. The MBC attempts to notify all reporters of their reporting requirements on an annual basis. With the new Public Information Officer in place, the MBC will enhance its notification to groups like coroners and court clerks.

Board Response (2016):
Although the Board supported SB 62 as discussed in the 2013 response, this bill was vetoed. However, after the veto of this bill intended to require coroners to report opioid overdose deaths to the Board, the Board established a data use agreement with the California Department of Public Health (CDPH) to receive death certificates when the death was related to opioids. The Board is then able to use CURES to identify physicians who may be inappropriately prescribing controlled substances. The Board continues to believe that required reporting is the best solution; however, this proactive approach has assisted in identifying physicians who may be inappropriately prescribing.

ISSUE #22 (2012): Controlled Substance Utilization Review and Evaluation System (CURES) and California Prescription Drug Monitoring Program (PDMP) Funding.

Background: In 1997, California established an automated prescription monitoring program (also known as CURES) within the DOJ, Bureau of Narcotic Enforcement, that required the electronic reporting of Schedule II drugs prescribed by physicians and dispensed by pharmacies. The goal was twofold; to assist law enforcement agencies in identifying possible drug diversion and to assist regulatory agencies in identifying prescribers who may be prescribing excessive medications to the public.

Since 2003, physicians have been able to obtain "patient history" or activity reports from DOJ to assist in identifying those patients who may be "doctor shopping" or may have altered the quantity of drugs prescribed from the original order. “Doctor shoppers” are prescription-drug addicts who visit dozens of physicians and emergency rooms to obtain multiple prescriptions for drugs. It was felt that if physicians and pharmacies had real-time access to controlled substance history information at the point of care it would help them make better prescribing decisions and cut down on prescription drug abuse in California. The Patient Activity Reports (PAR) were generated from DOJ after the physician made a written request for the report.

In 2005, SB 151 expanded the reporting to CURES to include any prescriptions dispensed for Schedules II and III. Reporting for Schedule IV prescriptions was added shortly thereafter. The CURES database grew to contain over 100 million entries of controlled substance drugs that were dispensed in California and DOJ responded to over 60,000 requests from practitioners and pharmacists for PARs.

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In 2009, DOJ launched an online PDMP database to provide real-time access to PARs. The on-line system made it easier for physicians to track their patients' prescription-drug history and provided health professionals, law enforcement agencies, and regulatory boards with faster computer access to patients' controlled-substance records. Under the new system, a pain-management physician examining a new patient complaining of chronic back pain would be able to look up the patient's controlled-substance history to determine whether the patient legitimately needed medication or was a "doctor shopper". In the past, the physician's request would have taken several days for a response from DOJ. With the new on-line system, physicians should have been able to identify "doctor shoppers" and other prescription-drug abusers before they wrote them another prescription. Unfortunately, this system still needs to be upgraded to provide rapid response, made more user friendly, and available on the most up-to-date technology system (e.g. smartphone, tablet, iPad, etc.) in order to get the prescribers and dispensers who should be using the system, to actually use it in day-to-day practice.

The Budget Act of 2011 eliminated all general fund support of the CURES/PDMP, which included funding for system support, staff support, and related operating expenses. DOJ temporarily redirected 5 staff to maintain support for the system, which included such tasks such as processing new user applications, responding to emails and voicemails from users, etc. While 5 regulatory boards at the DCA provide some funding for system maintenance, the level of funding is inadequate to maintain a minimal functioning PDMP, and certainly not enough funding to enhance the system to meet today's demand.

With 7,500 pharmacies and 158,000 prescribers reporting prescription information annually, CURES is the largest online prescription-drug monitoring database in the U.S. Its goal is to reduce drug trafficking and abuse of dangerous prescription medications, lower the number of emergency room visits due to prescription-drug overdose and misuse, and reduce the costs to health care providers related to prescription-drug abuse.

Prescription-drug abuse costs the state and consumers millions of dollars each year and can have serious consequences for both abusers and the public. Each year, hundreds of people die from prescription-drug overdoses in California. A recent article published in the *American Medical News* indicates that real-time access to prescription drug monitoring program databases results in a sizeable drop in the number of inappropriate prescriptions written for opioids and benzodiazepines, according to a study in British Columbia.

The Board believes that maintaining and upgrading a CURES/PDMP is essential not only for the medical community utilizing the system but as a tool used by the regulatory boards to identify prescribers who are not providing California citizens with quality medical care and are contributing to the epidemic of prescription drug abuse in this State.

The MBC recommends that legislation be considered to provide an adequate funding source for CURES. The prescribers/dispensers should include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, podiatrists, pharmaceutical companies, and the public. This funding source should support the necessary enhancements to the computer system and provide for adequate staffing to run the system.

Staff Recommendation: ***The MBC should advise the Committee whether CURES is currently working for its investigatory and regulatory purposes. Does MBC query CURES as a tool in its investigations? Should it do so? MBC should provide an update on its usage by the Board, and how it can be improved. Does the MBC recommend that consideration should be given to using licensing fees of various health related boards to adequately funding CURES in the future and the these licensing boards have primary responsibility for any actions to be taken against its licensees?***

Board Response (April 2013):
The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs, some of which 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, including the MBC, to access patient controlled substance history information through a secure Web site.

Since the inception of CURES, the MBC has utilized the reports available through the CURES data base as a valuable tool throughout the investigative process. As part of the intake or triage review of new complaints received in the MBC's Central Complaint Unit, when allegations of excessive or inappropriate prescribing are made, the prescriber history report is generated from CURES. The report provides the MBC with information on the quantity of prescriptions written by the physician, which can then be referred to a medical expert for review. The medical expert reviews the report to determine whether the quantity of medication being prescribed to a patient or patients is either appropriate or excessive and a field investigation can be initiated as a result. The medical expert also helps focus on specific patients who may be receiving a concerning amount or combination of controlled substances, as these patients generally do not complain to the MBC about the physician who is prescribing to them. The MBC's Central Complaint Unit also utilizes the CURES data base to evaluate complaints related to care being provided to specific patients; particularly when the complaint is made by a patient's family and if the patient refuses to provide an authorization for release of medical records. A patient activity report would be generated to identify whether the patient is receiving controlled substances from more than one prescriber or is receiving an excessive amount of controlled substances from a single provider. If deemed to be an issue, the MBC would then need to subpoena the medical records since an authorization for release could not be obtained from the patient.

When a case alleging inappropriate prescribing is sent from the MBC's Central Complaint Unit to the field, investigators will utilize the CURES reports for a variety of reasons. The investigator typically will initially run a CURES report that lists all patients to whom a physician is prescribing. The investigator will look for patients who reside far away from the physician's office or the pharmacy where prescriptions are being filled; patients who are using a variety of pharmacies to "cash" the prescriptions (this is done to avoid detection by pharmacy personnel); numerous people with the same surname receiving scheduled drugs from the same physician; and the combination of drugs being prescribed and the age of the patient. Once a sampling of patients who fit an aberrant prescribing pattern is identified, the

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investigator will then run the individual patient CURES report to learn of all the prescribers who are writing scheduled drugs to the patient. Investigators will then begin acquiring the information upon which a determination will be made whether or not the prescribing is within the standard of care.

Investigators also use CURES reports for cases alleging self-prescribing or physician impairment. In these instances, a CURES report is run for the individual physician to determine if he or she is receiving a concerning amount of prescriptions.

It is important to note that the CURES report does not stand alone as an investigative tool. It is a critical "roadmap" that leads the investigator to the evidence that ultimately will be utilized for prosecution, should that become necessary.

The MBC uses the CURES database to monitor physicians who have been placed on probation following disciplinary action for excessive or inappropriate prescribing. A common condition of probation ordered for inappropriate prescribing violations is to limit or restrict the controlled substances that a physician can prescribe. For example, a physician may be ordered to not prescribe Schedule II controlled substances during the period of probation. The MBC's Probation Unit will generate a report from CURES showing the physician's prescribing history in order to ensure that the doctor is complying with their probation condition. The Probation Unit can also order a patient activity report to ensure that physicians who are required to abstain from the use of controlled substances are not receiving or writing prescriptions in violation of this condition.

The MBC believes CURES is a very important enforcement tool, however the system needs to be fully funded and upgraded to be more real time and able to handle inquiries from all prescribers in California. The MBC has been very supportive in the past of any effort to get CURES more fully funded in order for the PDMP to be at optimum operating capacity.

As stated above, the MBC has supported in the past and recommends that legislation be considered to provide an adequate funding source for CURES. The funding should come from prescribers/dispensers (including physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists), pharmaceutical companies, and the public.

Board Response (2016):

The Board continues to believe that CURES is an invaluable tool not only for licensees, but for the Board in its investigative functions. With the release of CURES 2.0, significant improvements have been made to the system. In addition, SB 809 (DeSaulnier, Chapter 400, Statutes of 2013) required each physician (and other licensees within DCA) to pay a $12 fee at each renewal for the operation and maintenance of the CURES system and required all prescribers to register with the CURES system. In addition, SB 482 (Lara, Chapter 708) was just signed into law and requires 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.

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ISSUE #23 (2012): Exclude medical malpractice reports from requirements of a medical expert review by the MBC.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2220.08 requires that before a quality of care complaint is referred for investigation it must be reviewed by a medical expert with the expertise necessary to evaluate the specific standard of care issue raised in the complaint. While, the rationale for the up-front specialty review makes sense, it may not make sense in the case of Medical Malpractice cases that have been reported to the Board.

The Board believes that medical malpractice cases reported pursuant to section 801.01 after the civil action has been concluded would be appropriate to exclude from the upfront specialty review as well. Unlike complaints filed by the public, medical malpractice cases have had the benefit of review by a number of medical experts. Typically both the plaintiff and the defendant will obtain an expert to review the care provided by the physician and opine as to whether the standard of care was met.

Whether the case settles prior to trial or proceeds through the litigation process, it has been subjected to numerous reviews, all by medical experts. The outcome from the medical malpractice case is required to be reported to the Board by the insurance carrier or employer who pays the award on behalf of the physician. According to the MBC, there is little benefit to obtain an initial medical expert review on these cases and this additional review adds approximately two months to the time it takes to refer the case to investigation.

The Board recommends that medical malpractice reports be excluded from the requirements of section 2220.08 consistent with the exception made for reports filed pursuant to section 805.

Staff Recommendation: ***Legislation should be enacted to exclude medical malpractice reports from the requirements of a medical expert review under BPC § 2220.08.***

Board Response (April 2013):
The MBC agrees with Senate B&P Committee Staff's recommendation and submitted language on March 5, 2013 to Committee staff for this proposal.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue. No further action is needed.

ISSUE #24 (2012): Require medical facilities to produce medical records within 15 days.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2225.5 (a) (1) requires a licensee to produce the certified medical records of a patient, pursuant to the patient's authorization, within 15 business days of the receipt of the request. However, subsection § 2225.5 (b) requires a facility 30 days to produce the certified records. This disparity may have been seen as appropriate prior to the implementation of Electronic Health Records (EHR).

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However, today most facilities (hospitals) maintain EHRs, which reduces the time required to retrieve and prepare medical records in response to requests. In an effort to reduce investigation time, consideration should be given to whether there is a need to allow a facility twice the amount of time to produce records than is allowed for production from the office of a licensee.

Additionally, if a subpoena duces tecum were served, the facility would have 15 days to produce the same records that they would be allowed 30 days to produce if requested via patient authorization. Therefore, the disparity should be eliminated and consistency established by affording 15 days for production of medical records by both the licensee and facilities.

The Board recommends that the law be amended to allow a facility only 15 days to provide medical records, upon request, if the facility has EHRs.

Staff Recommendation: ***BPC § 2225.5 (b) should be amended to require a facility to produce medical records within 15 days, if the facility has implemented Electronic Health Records (EHR).***

Board Response (April 2013):
The MBC agrees with Senate B&P Committee Staff's recommendation and has submitted language on March 5, 2013 to Committee staff for this proposal.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue. No further action is needed.

ISSUE #25 (2012): Consider requiring the Department of Public Health and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility.

Background: The MBC has raised the following as a new issue in its Sunset Report. Pursuant to BPC § 805, certain peer review bodies must report actions pertaining to staff privileges, membership, or employment. Specifically, the chief of staff of a medical or professional staff or other a chief executive officer, a medical director or administrator of any peer review body, or a chief executive officer or administrator of any licensed health care facility or clinic must report the following within 15 days of the action:

- A peer review body denies or rejects a licensee's application for staff privileges or membership for a medical disciplinary cause or reason.
- A licensee's staff privileges, membership, or employment are revoked for a medical disciplinary cause or reason.
- Restrictions are imposed, or voluntarily accepted, on staff privileges, membership, or employment for a total of 30 days or more within any 12 month period for medical disciplinary reasons.
- A resignation, leave of absence, withdrawal or abandonment of the application or for the renewal of privileges occurs after receiving notice of a pending investigation initiated for a medical disciplinary cause or reason.

- A summary suspension of staff privileges, membership, or employment is imposed for a period in excess of 14 days.

The Board has noticed a decline in the number of 805 reports received, and indicated in the following chart:

	FY 01/02	FY 02/03	FY 03/04	FY 04/05	FY 05/06	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
805 reports received	151	162	157	110	138	126	138	122	99	93	114

The MBC suggests that the decline in reporting may be due to the fact the hospitals are finding problems earlier and sending physicians to remedial training prior to requiring 805 reporting. With the implementation of electronic health records and the mining of data, early identification is a real possibility. MBC further believes that the decline may also be due to hospitals not reporting.

However, because the Board does not have jurisdiction over the hospitals, it has no way of knowing the reason for the decline. The California Department of Public Health (CDPH) and other hospital accrediting agencies have the authority to review hospital records. In addition, these entities do inspections of the hospitals. If the CDPH had to send information to the Board based upon its inspections, it would allow the Board to review the information and determine if an 805 was received from the entity. If the Board did not receive the appropriate reporting, the Board would issue a fine to the entity and would also investigate the actions of the physician.

The MBC recommends amending existing law to require CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC. The MBC also recommends a requirement that these entities notify the Board if a hospital is not performing peer review.

Staff notes that since MBC is the agency with jurisdiction to enforce the peer review provisions, it may be appropriate for MBC to enter into an arrangement such as a memorandum of understanding (MOU) with CDPH and hospital accrediting agencies to have this information referred to MBC.

Staff Recommendation: ***The MBC should further discuss with the Committee the proposal, and consideration should be given to MBC entering into an arrangement or a MOU with CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC; and to further require that these entities notify the Board if a hospital is not performing peer review.***

Board Response (April 2013):
As stated above, the MBC has noticed a decline in the number of 805 reports received through the years. The decline in 805 reporting may be due to the fact the hospitals are finding problems earlier and sending physicians to remedial training prior to requiring 805 reporting or

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it may be due to hospitals just not reporting. However, because the MBC does not have jurisdiction over the hospitals, it has no way of knowing the reason for the decline. CDPH and other hospital accrediting agencies have the authority to review hospital records and conduct inspections of the hospitals.

The MBC does not believe that entering into an MOU would legally require these entities to provide the information to the MBC. The information obtained during an inspection is for the use of CDPH and the other hospital accrediting agencies and therefore, it may not be able to be provided to the MBC. Therefore, the MBC is recommending that existing law be amended to require state agencies and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the MBC. The MBC submitted language on March 5, 2013 to Committee staff on this issue.

Board Response (2016):
The Board submitted statutory language to the Committee to require CDPH and hospital accrediting agencies to send these incidents to the Board. However, legislation has not been authored regarding this issue. The Board looks forward to working with the Committee toward a legislative change.

ISSUE #26 (2012): Require that Expert Reviewer Reports be provided to the MBC in a timely fashion.

Background: The MBC has raised the following as a new issue in its Sunset Report. The Administrative Procedure Act (APA) includes limited discovery provisions that do not assist in discovering opposing expert information. The MBC states that in some instances, once the Board received this information, it has to amend the accusation and therefore increase the timeframe for administrative action. In the civil context, the best tool to find out information from opposing experts would be to depose the expert. However, the APA only allows depositions in extreme circumstances, which do not usually apply to Board cases (Government Code section 11511).

It may not be appropriate to amend and expand the discovery provisions under the APA, because the APA applies to all administrative hearings. Any modification to the APA exclusive discovery provisions would impact the disciplinary proceedings of other administrative agencies and perhaps add costs and delays to these proceedings. The MBC recommends that instead of making any changes to the APA, the best way to make changes regarding expert testimony as it relates to MBC disciplinary cases is to amend BPC § 2334 which relates to expert testimony in disciplinary cases before the Board.

The MBC states that since its implementation, Section 2334 has been beneficial to the DAGs prosecuting Board cases. First, upon receipt of an expert witness disclosure, the DAGs can assess the qualifications of the respondent's expert in relation to the Board's expert.

Second, based upon respondent's brief narrative of his/her expert's opinions, the DAGs can provide that to the Board's expert to see if it changes his/her previously expressed opinions in the case. If it does change the Board's expert's opinion in a material way, the DAGs can reassess the settlement recommendation in the case and, with client approval, make a revised settlement offer. In this manner, Section 2334 directly promotes settlement in Board cases,

which can often result in imposition of public protection measures in advance of the case proceeding to hearing.

Third, where cases do not settle, the brief narrative required by Section 2334 is also helpful to DAGs in preparing the Board's expert to testify at the administrative hearing. Fourth, by requiring respondents to confirm that their experts have, in fact, agreed to testify, Section 2334 helps to prevent defense counsel from listing various experts, who have not actually agreed to testify at the hearing. Finally, in those cases where respondents fail to make the required disclosures, their experts are routinely excluded. Since discovery is so limited in proceedings governed by the APA, section 2334 provides at least some information to the DAGs and the Board on this most important aspect of quality-of-care cases.

While section 2334 has been beneficial, the MBC believes it could be improved. The legislative history of section 2334 reveals that, during the legislative process, consideration was given to requiring both sides to exchange expert witness reports. The Board requires its own experts to prepare expert witness reports that, under the APA, must be produced in discovery. Requiring respondents to produce expert reports addressing each of the quality-of-care issues raised in the pending accusation would be of enormous benefit to the entire disciplinary process. It is believed that more cases would settle prior to hearing, thus avoiding the months of waiting by both sides while the parties await the commencement of hearings.

The deadline for both sides to make the required disclosures under section 2334 is only 30 calendar days prior to the commencement date of the hearing. That deadline is too late in the process and, as a result, can delay early settlement. If the date were, for example, 90 calendar days before the commencement date of the hearing or 180 calendar days after service of the accusation on respondent, then settlements may occur earlier, thus the imposition of public protection measures would occur sooner.

The term "commencement date" as used in Section 2334 should be defined and clarified. It should be the first hearing date initially set by OAH, regardless of any subsequent continuances of the hearing. There needs to be clarification on this term, since the MBC states that in one instance the Superior Court has construed the term to mean the date that opening statements are given. Such an interpretation makes the disclosure deadline a "moving target" when hearings are delayed. This prolongs the entire administrative disciplinary process and delays consumer protection.

The Board recommends amending Section 2334 to require the respondent to provide the full expert witness report. Additionally, there needs to be specificity in the timeframes for providing the reports, such as 90 days from the filing of an accusation. This would provide enhanced consumer protection, as the physician who is found to be in violation of the law would be placed on probation, monitored, or sanctioned in a more expeditious manner, according to MBC.

Staff Recommendation: ***Consideration should be given to amending BPC § 2334 to: (1) require a respondent to provide the full expert witness report; (2) clarify the timeframes for providing the reports, such as 90 days from the filing of an accusation.***

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Board Response (April 2013):
In an effort to enhance consumer protection, section 2334 of the Business and Professions Code should be amended as identified in the Senate B&P Committee staff's recommendation. The MBC submitted language on March 5, 2013 to Committee staff to clarify the date and require the complete expert report be produced by the respondent.

Board Response (2016):
This amendment was in the April 13, 2013 version of SB 304, however, it was removed from the bill on August 12, 2013. The Board continues to believe that this change would assist in the Board's role of consumer protection.

ISSUE #27 (2012): Licensed Midwives: Physician Supervision.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2057 authorizes a licensed midwife, under the supervision of a licensed physician and surgeon who has current practice or training in obstetrics, 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. BPC § 2507(f) requires the MBC by July 1, 2003 to adopt regulations defining the appropriate standard of care and level of supervision required for the practice of midwifery. Due to the inability to reach consensus on the supervision issue, the MBC bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR § 1379.19). Three previous attempts to resolve the physician supervision issue via legislation and/or regulation have been unsuccessful due to the widely divergent opinions of interested parties and their inability to reach consensus.

Although required by law, physician supervision is essentially unavailable to licensed midwives performing home births, as California physicians are generally prohibited by their malpractice insurance companies from providing supervision of licensed midwives who perform home births.

According to insurance providers, if physicians supervise, or participate, in a home birth they will lose their insurance coverage resulting in loss of hospital privileges. The physician supervision requirement creates numerous barriers to care, in that if the licensed midwife needs to transfer a patient/baby to the hospital, many hospitals will not accept a patient transfer from a licensed midwife as the primary provider who does not have a supervising physician. MBC states that California is currently the only state that requires physician supervision of licensed midwives. Among states that regulate midwives, most require some sort of collaboration between the midwife and a physician.

The MBC, through the Midwifery Advisory Council has held many meetings regarding physician supervision of licensed midwives and has attempted to create regulations to address this issue. The concepts of collaboration, such as required consultation, referral, transfer of care, and physician liability have been discussed among the interested parties with little success. There is disagreement over the appropriate level of physician supervision, with licensed midwives expressing concern with any limits being placed on their ability to practice independently. The physician and liability insurance communities have concerns over the safety of midwife-assisted homebirths, specifically delays and/or the perceived reluctance of midwives to refer patients when the situation warrants referral or transfer of care. MBC states

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that it appears the physician supervision requirement needs to be addressed through the legislative process.

In general, Committee staff agrees with the recommendation of MBC, noting that appropriate access to care, and patient safety would argue that an appropriate solution needs to be found regarding licensed midwife and physician supervision and/or collaboration.

Staff Recommendation: ***The MBC should reach a consensus with stakeholders on this important issue and then submit a specific legislative proposal to the Committee regarding the appropriate level of supervision required for the practice of midwifery.***

Board Response (April 2013):
The MBC agrees with the Senate B&P Committee staff's recommendation. The physician supervision requirement needs to be addressed through the legislative process, as many of the barriers to care identified by midwives focus around this one issue. AB 1308 (Bonilla) is a bill sponsored by the American College of Obstetricians and Gynecologists (ACOG). This bill requires the MBC to adopt regulations by July 1, 2015 defining the appropriate standard of care and level of supervision required for the practice of midwifery. The MBC will be actively working with ACOG and interested parties on the bill, as these issues need to be resolved in order to ensure consumer protection. The MBC will keep the Committee updated on its progress.

Board Response (2016):
AB 1308 (Bonilla, Chapter 665, Statutes of 2013) removed the requirement of licensed midwife (LM) supervision by a physician and surgeon; authorized an LM to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery; and authorized an LM to attend cases of "normal" birth, as specified.

The Board has held interested parties meetings in an effort to develop regulations to define "normal." While the interested parties were able to reach consensus on most issues, agreement has not been reached around the issue of allowing LMs to attend homebirths for women who want a vaginal birth after cesarean section (VBAC) without a physician consult and approval, if certain conditions are met.

The Board has created a task force to further consider this issue and to work toward proceeding with the rulemaking process. At this time, no further legislative action is needed.

ISSUE #28 (2012): Allow Licensed Midwives to have Lab Accounts and obtain Medical Supplies.

Background: The MBC has raised the following as a new issue in its Sunset Report. Licensed midwifes have difficulty securing diagnostic lab accounts, even though they are legally allowed to have lab accounts. Many labs require proof of physician supervision. In addition, licensed midwives are not able to obtain the medical supplies they have been trained and are expected to use: oxygen, necessary medications, and medical supplies that are included in approved licensed midwifery school curriculum (CCR § 1379.30). The inability for a licensed midwife to order lab tests often means the patient will not obtain the necessary tests

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to help the midwife monitor the patient during pregnancy. In addition, not being able to obtain the necessary medical supplies for the practice of midwifery adds additional risk to the licensed midwife's patient and child.

The MBC, through the Midwifery Advisory Council held meetings regarding the lab order and medical supplies/medication issues and has attempted to create regulatory language to address this issue. However, based upon discussions with interested parties it appears the lab order and medical supplies/medication issues will need to be addressed through the legislative process.

Staff Recommendation: ***Legislation should be enacted to clarify that a licensed midwife may order laboratory tests, and obtain medical supplies. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.***

Board Response (April 2013):
The MBC agrees with the Senate B&P Committee staff's recommendation. The ordering of laboratory tests and obtaining of medical supplies by midwives needs to be addressed through the legislative process. AB 1308 (Bonilla) is a bill sponsored by the American College of Obstetricians and Gynecologists (ACOG). This bill would allow a Licensed Midwife to directly obtain supplies, order tests, and receive reports that are necessary to his or her practice of midwifery, consistent with the scope of practice for a Licensed Midwife. The MBC will be actively working with ACOG and interested parties on the bill, as this issue needs to be resolved in order to assist the Licensed Midwives in their practice of midwifery and to protect their patients. The MBC will keep the Committee updated on its progress.

Board Response (2016):
AB 1308 (Bonilla, Chapter 665, Statutes of 2013) addressed this issue and no further action is needed.

ISSUE #29 (2012): Clarify Midwifery education and clinical training.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2514 authorizes a "bona fide student" who is enrolled or participating in a midwifery education program or who is enrolled in a program of supervised clinical training to engage in the practice of midwifery as part of that course of study if: (1) the student is under the supervision of a physician or a licensed midwife who holds a clear and unrestricted California midwife license and who is present on the premises at all times client services are provided; and (2) the client is informed of the student's status. There has been disagreement between the MBC and some members of the midwifery community regarding what constitutes a "bona fide student." The MBC believes the current statute is very clear regarding a student midwife.

Some members of the midwifery community hold that an individual who has executed a formal agreement to be supervised by a licensed midwife but is not formally enrolled in any approved midwifery education program qualifies the individual as a student in apprenticeship training. Many midwives consider that an individual may follow an "apprenticeship pathway" to licensure.

The original legislation of the Midwifery Practice Act, included the option to gain midwifery experience that will then allow them to pursue licensure via the "Challenge Mechanism" detailed in BPC § 2513 (a) which allows an approved midwifery education program to offer the opportunity for students to achieve credit by examination for previous clinical experience. According to MBC, this provision was included to allow for those who had been practicing to meet the requirements for licensure. The statute clearly states a midwife student must be formally enrolled in a midwifery educational institution in order to participate in a program of supervised midwifery clinical training. A written agreement between a licensed midwife and a "student" does not qualify as a "program of supervised clinical training". Accordingly, these types of arrangements are not consistent with the provisions of BPC § 2514. A Task Force consisting of members of the Midwifery Advisory Council has recently been formed to examine this issue. However, the issue of students/apprenticeships may need to be addressed through the legislative process, according to MBC.

Staff Recommendation: ***Recommend legislation should be enacted to clarify when an individual is considered a bona fide student, and to clarify that a written agreement does not meet the requirement of a program of supervised clinical training. The MBC should submit a specific legislative proposal to the Committee regarding this recommendation.***

Board Response (April 2013):
The MBC agrees with Senate B&P Committee Staff's recommendation and submitted language on March 5, 2013 to Committee staff for this proposal.

Board Response (2016):
Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) addressed this issue. No further action is needed.

ISSUE #30 (2012): Clarify the role of a Midwife Assistant.

Background: The MBC has raised the following as a new issue in its Sunset Report. A concern revolves around the use of "assistants" by a licensed midwife and the duties the assistant may legally perform. It has been brought to the attention of the MBC that licensed midwives use midwife assistants. Currently, there is no definition for a midwife assistant, the specific training requirements or the duties that a midwife assistant may perform.

MBC states that the law does not address the use of a midwife assistant, the need for formal training or not, or the specific duties of an assistant. Current statute does not provide a licensed midwife with the authority to train or supervise a midwife assistant who is actually assisting with the delivery of an infant. The issue of a midwife assistant is not an issue that can be addressed with regulation with the current statutes that regulate the practice of midwifery. The issue of the midwife assistants should be addressed with legislation, according to MBC.

Staff Recommendation: ***The MBC should provide more information regarding the proposal to address the issue of midwife assistants in legislation.***

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Board Response (April 2013):
The MBC agrees with the Senate B&P Committee staff's recommendation in that the issue of the midwife assistants should be addressed with legislation. However, the MBC needs to research and gather more information before it can make an informed decision on what the language regarding midwife assistants should include. The MBC will conduct this research and report back to Committee staff with more information on this issue, including suggesting language for legislation.

Board Response (2016):
SB 408 (Morrell, Chapter 280, Statutes of 2015) addressed the issue of midwife assistants by defining their scope of practice and education requirements. The Board is currently going through the regulatory process to further implement this bill.

ISSUE #31 (2012): SB 122 implementation for Out-of-State Licensed Physicians.

Background: SB 122 (Price, Chapter 789, Statutes of 2012), among other things, made clarifications to the licensing by MBC of physicians who have attended foreign medical schools. The bill was intended to address a concern by the Author that physicians who have been practicing in other states in good standing for many years were being refused a license to practice in California because the foreign medical school they attended has not been recognized by the MBC, even though it may have been recognized in another state. The Author believed that the MBC should at least be able to have the discretion to review the practice and other qualifications of the physician and surgeon who has been practicing in another state, and make a determination whether they are competent to practice within California even though they may have attended a foreign medical school that is currently not on the MBC's approved list of medical schools.

The Author worked with the MBC in drafting the final amendments which went into the bill to provide the MBC with the tools it needs to license such physicians who had been practicing safely in other states for a number of years but who the MBC had refused to issue a license to because of attendance at an unrecognized medical school or at a disapproved medical school.

Ultimately the language identified by the MBC required a physician who had attended an unrecognized medical school must practice for 10 years in another state in order to become licensed in California, and a physician who had attended a disapproved medical school had to practice for 20 years in another state in order to become licensed in California.

Staff Recommendation: ***The MBC should advise the Committee of its implementation of SB 122. How many licenses have been issued under the new provisions? How does the MBC propose to handle those cases of physicians who have a mixed combination of medical education, having received part of their education at an unrecognized medical school, and part at a disapproved medical school? Does the MBC anticipate that regulations could authorize a physician with a mixed combination of education to become licensed under the 10 year requirement? Does the MBC think that further legislation is needed to clarify such cases?***

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Board Response (April 2013):
SB 122 Price (Statutes 2012, Chapter 789) allows applicants who have attended and/or graduated from an unrecognized or disapproved school to be eligible for licensure in California if they have continuously practiced in another state for 10 years if they went to an unrecognized school, or 20 years if they went to a disapproved school. Following the letter of the law, if an individual completes any of his or her medical schooling at a disapproved school, the 20 year rule would apply. This bill allows the MBC to combine the period of time the applicant has held a license in other states and continuously practiced, but applicants shall have a minimum of five years of continuous practice and licensure in a single state. This bill specifies that continuous licensure and practice includes any postgraduate training after 24 months in a postgraduate training program. The applicant must also meet specified criteria in order to be eligible for licensure in California (must be certified by an ABMS specialty board; must have successfully completed the licensing examination required in existing law; must have successfully completed three years of postgraduate training; must not have any discipline on their license in another state or any adverse judgments or settlements relating to the practice of medicine; must not be subject to licensure denial; and must not have held a healing arts license that has been the subject of disciplinary action by a healing arts board of this state or by another state or federal territory).

In addition, SB 122 allows the MBC to adopt regulations to establish procedures for accepting transcripts, diplomas, and other supporting information and records when the originals are not available due to circumstances outside the applicant's control. This bill also allows the MBC to adopt regulations authorizing the substitution of additional specialty board certifications for years of practice or licensure when considering the licensure of a physician and surgeon.

Before SB 122 was signed into law, if an individual attended and/or graduated from an unrecognized or disapproved international medical school, he/she would have not been eligible for licensure in California. The MBC previously did not recognize education acquired at an unrecognized or disapproved school as satisfying the standards set forth in the applicable statutes and regulations.

The language contained in SB 122 that was signed into law is the language drafted and supported by the MBC. The MBC supported this language because requiring 10 and 20 years of continuing practice in another state, among other requirements, are substantial enough to ensure consumer protection. In addition, allowing individuals that meet the requirements in this bill to be eligible for licensure in California, will provide another pathway for competent physicians to obtain a California license and serve patients in California.

For implementation, applications received that meet the requirements of SB 122 (Business and Professions Code section 2135.7) go to the MBC's Application Review Committee (ARC) to determine eligibility. To date, the MBC has received two applications pursuant to this new section (BPC 2135.7). One application has been reviewed by the ARC and the individual has been licensed. One application contained deficiencies that need to be resolved prior to processing.

The MBC also received two applications in which the applicant does not meet the criteria of B&P Code section 2135.7 at this time. Additionally, one previous applicant had requested an

Administrative Hearing. The hearing was held and the final decision was to have the applicant reviewed by the ARC. The application is now complete and will be reviewed at the next ARC, to be held April 26, 2013.

At this time, the MBC has only held one ARC, thus it is too early to determine the regulations that are needed until more applications are received pursuant to Business and Professions Code section 2135.7. Once the MBC starts receiving more applications and issues are determined, staff will work on identifying the need for regulations. This will most likely take place in summer/fall 2013 with discussion at the Licensing Committee. The MBC does not believe any statutory amendments need to be made at this time.

Board Response (2016):
The Board continues to believe that statutory amendments are unnecessary. No issues have been brought forward regarding this law since its inception. The Board has issued 20 licenses pursuant to this section of law over the last three years.

The following chart is includes applications received, licensed, ineligible and closed for lack of due diligence.

Physician Applications Pursuant to B&P Code section 2135.7	FY 12/13	FY 13/14	FY 14/15	FY 15/16	TOTALS
Applications Received	9	4	10	5	28
Licenses Issued	3	2	8	7	20
Ineligible Applicants	4	0	0	0	4
Applications Closed (for lack of due diligence)	0	0	1	0	1

ISSUE #32 (2012): Continued Utilization by the MBC of Vertical Enforcement Prosecution (VE).

Background: In 2005, SB 231 (Figueroa, Chapter 674, Statutes of 2005) created a pilot program establishing a vertical prosecution model, also known as vertical enforcement (VE) program to handle MBC investigations and prosecutions. VE requires Board investigators and Attorney General (AG) Health Quality Enforcement Section (HQES) prosecutors to work together from the beginning of an investigation to the conclusion of legal proceedings. The MBC and the HQES have used the VE program since 2006, and a number of modifications have been made since its inception to make the program more efficient.

In 2010, VE was extensively studied by Benjamin Frank, LLC. The report, titled *Medical Board of California – Program Evaluation* made several conclusions, including that the insertion of DAGs into the investigative process did not translate into more positive disciplinary outcomes or a decrease in investigation completion times, and recommended scaling back and optimizing DAG involvement in investigations. The AG's Office took great exception to certain portions of the report, namely the cost of VE in the investigation phase of the case and that greater DAG involvement under the VE model has not translated into greater public protection.

The MBC states that although the investigation timelines have shortened, it is unknown if this is due to VE or if it is due to increased efficiencies in enforcement processes and procedures in general. In order to more fully determine the level of success of the VE program, the MBC and the AG have engaged in discussions of the accumulated data from the VE cases. At this time, the analysis of the VE program by the MBC and the AG has not been fully completed. The Committee anticipates greater detail to be furnished by the Board and the AG's office later in 2013.

What MBC has concluded thus far is that significant improvements in actions taken have occurred and are identified below:

Comparing fiscal year (FY) 2006/2007 to FY 2011/2012:

- 47% more cases were referred to the Attorney General's Office,
- 74% more probation violation cases were referred to the Attorney General's Office,
- 49% more license restrictions/suspensions were imposed while administrative action was pending,
- 203% more cases were referred for criminal action,
- 35% more revocations were issued,
- 25% more cases resulting in probation were issued, and
- 26% more disciplinary actions were issued.

Committee staff anticipates hearing from the MBC and the AG as the sunset process moves forward. However, the VE program should continue and further ways should be explored to make the collaborative relationship between investigators and prosecutors more effective to carrying out a vigorous enforcement process to protect the public.

Staff Recommendation: ***Recommend continuing the VE program, and explore further ways to improve the collaborative relationship between investigators and prosecutors to improve the effectiveness of the MBC enforcement program.***

Board Response (April 2013):
As stated in Issue 9 above, the MBC believes that the benefits of VE are significant and does not believe that any legislative amendments need to be made at this time. The MBC recognizes there have been challenges in the implementation of VE, but those challenges can be overcome through continued collaboration between the MBC and HQES, and revisions to the procedural manuals used by both staffs. The MBC realizes the importance of the VE model and will continue to strive towards its improvement with the overall goal of meeting the MBC's mandate of consumer protection. The MBC looks forward to working with the AG's Office to identify improvements that would further enhance collaborative efforts of both the MBC and the AG's Office.

Board Response (2016):
As stated in Issue 9 above, Senate Bill (SB) 304 (Lieu, Chapter 515, Statutes of 2013) extended the vertical enforcement/prosecution model. In addition, the Board submitted a report to the legislature in March 2016 identifying improvements in the vertical enforcement/prosecution model and providing recommendations for further enhancement. It is important to note that with the movement of the investigators to the DCA, Division of

Investigation the VE/P model is now under the authority of the DCA and the AG's Office.

ISSUE #33 (2012): Should the MBC's authority to issue a cease practice order be expanded to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination?

Background: Under BPC § 820, the MBC may order a physical or mental health examination of a licensee whenever it appears that a licensee's ability to practice may be impaired by physical or mental illness. The examination order is part of the investigation phase, and allows the MBC to make a substantive determination that the licentiate's ability to practice his or her profession actually has become impaired because of mental or physical illness.

Failure to comply with an examination order constitutes grounds for suspension or revocation of the individual's certificate or license (BPC 821). However, the process for suspension or revocation for refusal to submit to a duly-ordered examination can be lengthy, as demonstrated by a recent court case in which a licentiate of the Board of Registered Nursing refused a psychiatric examination yet continued to practice for months thereafter (see *Lee v Board of Registered Nursing*, 209 Cal. App. 4th 793; 147 Cal. Rptr. 3d 269; Sept. 26, 2012).

To refuse or delay compliance with an examination order poses risks for consumers because of the possibility that a mentally or physically ill practitioner could continue to see patients until the MBC completes suspension or revocation proceedings under BPC § 821. Public protection would be better served if the MBC has the authority to issue a cease practice order in cases where compliance with an examination order under BPC § 820 is delayed beyond a reasonable amount of time (perhaps 15-30 days).

Staff Recommendation: ***Recommend amendments to the MBC's authority to issue a cease practice order to expand to situations where in the course of a fitness to practice investigation a licensee refuses to undergo a duly ordered physical or mental health examination.***

Board Response (April 2013):
The MBC agrees with Senate B&P Committee staff's recommendation. Public protection will be better served if the statue is amended to give the MBC the authority to issue a cease practice order in cases where the licentiate delays or fails to comply with an order issued under Business and Professions Code section 820 within the specified time frame as set forth in the order. This does require a legislative change and language was submitted on March 5, 2013 to Senate B&P Committee staff to address this issue.

Board Response (2016):
This amendment was in the April 13, 2013 version of SB 304, however, it was removed from the bill on August 12, 2013. The Board continues to believe that this change would assist in the Board's role of consumer protection.

ISSUE #34 (2012): (REQUIREMENT FOR A FICTITIOUS NAME PERMIT.) Should the exemption for accredited outpatient settings to obtain a fictitious permit be removed?

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Background: Current law requires that a physician and surgeon, whether as a sole proprietor, a partnership, group or professional corporation, who desires to practice in any other name must obtain and maintain a fictitious name permit that is issued by the MBC.

Additionally, BPC § 2285 provides that the use of any fictitious, false, or assumed name, or any name other than his or her own by a licensee either alone, in conjunction with a partnership or group, or as the name of a professional corporation, in any public communication, advertisement, sign, or announcement of his or her practice without a fictitious-name permit constitutes unprofessional conduct. This requirement does not apply to the following:

- Licensees who are employed by a partnership, a group, or a professional corporation that holds a fictitious name permit.
- Licensees who contract with, are employed by, or are on the staff of, any clinic licensed by the State Department of Health Services, as specified.
- An outpatient surgery setting granted a certificate of accreditation from an accreditation agency approved by the MBC.
- Any medical school approved by the MBC or a faculty practice plan connected with the medical school.

SB 100 required that as part of the accreditation process, the accrediting agency shall conduct a reasonable investigation of the prior history of the outpatient setting, including all licensed physicians and surgeons who have an ownership interest therein, to determine whether there have been any adverse accreditation decisions rendered against them. For the purposes of this section, "conducting a reasonable investigation" means querying the MBC and the Osteopathic Medical Board to ascertain if either the outpatient setting has, or, if its owners are licensed physicians and surgeons, if those physicians and surgeons have, been subject to an adverse accreditation decision. Additionally, SB 100 required the MBC to obtain and maintain a list of accredited outpatient settings and notify the public by placing the information on the Internet Website. The information to be posted includes the name, address, and telephone number of any owners and their medical license numbers, and the name and address of the facility.

Staff Recommendation: ***In order for the public to get accurate information on outpatient settings that do business under a fictitious name, BPC § 2285 (c) should be amended to delete the exemption for outpatient settings that are accredited.***

Board Response (April 2013):
Existing law (Business and Professions Code section 2285) requires a licensee that uses fictitious, false, or an assumed name, or any name other than his or her own, to obtain a fictitious name permit (FNP). The purpose of a FNP is to allow a licensed physician and surgeon or podiatrist to practice under a name other than his or her own, while still allowing for the MBC and consumers to know the actual name of the individual that is associated with that fictitious name (that way a consumer can utilize the MBC's Web site to look up the physician's profile that is associated with the FNP). Currently, outpatient surgery settings are exempted from the requirement to obtain a fictitious name permit.

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Committee staff has suggested in the background paper that existing law be amended to delete the exemption for outpatient settings that are accredited. However, this would not significantly increase consumer protection because a FNP is only issued to the owner of the facility, not to all physicians working in the facility. In addition, the Accreditation Agencies are already mandated to obtain the name of the owners of an outpatient setting. Requiring these owners to also get a fictitious name permit duplicates information that is already gathered and will cost the licensee additional time and money. The MBC has not yet discussed or taken a position on this issue; however, MBC staff is willing to work with Committee staff to discuss this issue further. There may be other amendments that would be better to ensure consumer protection and meet the goal of identifying physicians in an outpatient surgery center. MBC staff commits to working with Committee staff on this issue.

Board Response (2016):
The Board discussed this issue with Committee staff, however, no legislation was carried regarding this issue. In addition, the Board is unsure if the change will obtain the desired result.

ISSUE #35 (2012): What is the status of BReEZe implementation by the MBC?

Background: The BreEZe Project will provide DCA boards, bureaus, and committees with a new enterprise-wide enforcement and licensing system. BreEZe will replace the existing outdated legacy systems and multiple "work around" systems with an integrated solution based on updated technology.

BreEZe will provide all DCA organizations with a solution for all applicant tracking, licensing, renewal, enforcement, monitoring, cashiering, and data management capabilities. In addition to meeting these core DCA business requirements, BreEZe will improve DCA's service to the public and connect all license types for an individual licensee. BreEZe will be web-enabled, allowing licensees to complete applications, renewals, and process payments through the Internet. The public will also be able to file complaints, access complaint status, and check licensee information. The BreEZe solution will be maintained at a three-tier State Data Center in alignment with current State IT policy.

BreEZe is an important opportunity to improve the BPM operations to include electronic payments and expedite processing. Staff from numerous DCA boards and bureaus have actively participated with the BreEZe Project. Due to increased costs in the BreEZe Project, SB 543 (Steinberg, Chapter 448, Statutes of 2011) was amended to authorize the Department of Finance (DOF) to augment the budgets of boards, bureaus and other entities that comprise DCA for expenditure of non-General Fund moneys to pay BreEZe project costs.

The MBC is scheduled to begin using BreEZe in the "Early Spring" of 2013. It would be helpful to update the Committee about MBC's current work to implement the BreEZe project.

Prior to the DCA BreEZe project, the Board determined that it was in need of a new information technology system that would allow data transfer with the Department of Justice (DOJ) as well as improve complaint processing. This Complaint Resolution Information Management System (CRIMS) would provide the Board with needed technological efficiencies that would assist in streamlining the enforcement process. The Board was beginning to

develop requirements for this new system when the BreEZe project was initiated. Since the scope of the BreEZe project, which incorporated the requirements for CRIMS, was also a replacement of the Board's archaic licensing system, the Board stopped working on the CRIMS project and joined the DCA in working on the BreEZe project.

Staff Recommendation: ***The MBC should update the Committee about the current status of its implementation of BreEZe. What have been the challenges to implementing this new system? What are the costs of implementing this system? Is the cost of BreEZe consistent with what the MBC was told the project would cost? Will BreEZe interact with the AG's information technology to allow seamless and usable data to be transferred between the MBC and the DOJ?***

Board Response (April 2013):
The Department of Consumer Affairs is working on a project to replace the current licensing and enforcement legacy systems in addition to about 80 existing workaround databases. The MBC has been extremely involved in this project from its inception. The most significant challenges to implementing the system are: 1) testing the new system, 2) training the necessary staff, and 3) verifying the data being converted. These activities take a significant amount of staff time in addition to the regular day-to-day work of the MBC. The MBC in its original sunset report stated that it had already put over 10,000 staff hours into this project. Additionally, the MBC in its supplemental report estimated it would put 14,000 staff hours in prior to the implementation of the system. This number did not include the 3,768 hours so far spent in training nor the time staff will take to become fully knowledgeable of the system once it is implemented. The MBC has had staff do overtime in order to keep the current functions of the MBC while also having to perform the testing and data validation needed for the project.

The BreEZe project will cost the MBC approximately $1.2 million dollars for each 5 years after the project is implemented. Based upon the funding structure for the project, the MBC does not have to pay until the implementation of the project. This cost is consistent with what the MBC was originally told. The MBC has been told that the BreEZe system has the capability of interacting with the Department of Justice's system in the sharing of data. However, this is not scheduled for the first two releases. It may occur in Release 3 or after the system completely roles out.

Board Response (2016):
The Board transitioned to the BreEZe database on October 3, 2013. Release 1 of BreEZe went live on October 8, 2013. Since that time, there have been 118 releases that included major, minor, and emergency service request changes, which have been implemented. The Board's Information System Branch (ISB) and other Board staff have worked with the DCA's Office of Information Services (OIS) and vendor analysts/developers to define, prioritize, test, and implement these service requests. The Board is active in the BreEZe Licensing User Group, the Enforcement User Group, and the Business Report User Group.

After Go-Live, the Board's Consumer Information Unit (CIU) began receiving many requests for BreEZe online support from applicants, licensees, and consumers, so the ISB's technical support Help Desk began providing technical support for BreEZe online users. In FY 13-14, the ISB Help Desk received 14,403 public support requests via phone or email; in FY 14-15, 16,678 requests; and in FY 15-16, 17,353 requests.

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As with any new system, many lessons have been learned and issues have been corrected. ISB and other Board staff are working on requests for updates to the transactions available online to simplify and streamline the processes for applicants, licensees, consumers, and staff. Once these updates are made to transactions currently available online, the Board would like to make more transactions available online for additional license types (Licensed Midwives, Fictitious Name Permits, etc). Updating the BreEZe online complaint transaction is also a project the Board hopes to implement in 2017, since enhancements added with BreEZe Release 2 in January 2016 made customizing the online complaint transaction possible.

Staff members had to adjust to business process changes in BreEZe. With additional data entry required in BreEZe, data quality assurance is more important than ever. The Board's ISB developers are working with Board programs to develop the reports required to support their business processes and data quality assurance. In July 2016, DCA OIS released the Quality Business Interactive Reporting Tool (QBIRT), which will make report development much faster, allowing reports to be developed, maintained, and made available to users independent of the BreEZe release cycles. The Board's ISB developers received training on report development in QBIRT and are currently working on reports for the Board's Licensing and Enforcement programs.

Currently, the Board has 60 service requests pending assignment to an upcoming release in 2017. Since Release 1 Go-Live, the Board has submitted 11 service requests per month on average. Based on regular 6-week release cycles, the Board has had 10 service requests implemented on average per release over the last six releases (since Release 2). The Board also has eight large scope service requests that, because of the effort involved, were required to be submitted as Work Authorizations (WAs) before the BreEZe Change Control Board (CCB). The CCB approved these WAs for Impact Analysis.

ISSUE #36 (2012): (PUBLIC DISCLOSURE.) The limited ten year posting requirement for the MBC's Website should be removed.

Background: The MBC has raised the following as a new issue in its Sunset Report. BPC § 2027 was amended effective January 1, 2003 to require the Board to remove certain public disclosure information from its Website. Specifically, the amendment stated:

"From January 1, 2003, the information described in paragraphs (1) (other than whether or not the licensee is in good standing), (2), (4), (5), (7), and (9) of subdivision (a) shall remain posted for a period of 10 years from the date the board obtains possession, custody, or control of the information, and after the end of that period shall be removed from being posted on the board's Internet Website. Information in the possession, custody, or control of the board prior to January 1, 2003, shall be posted for a period of 10 years from January 1, 2003."

The information contained in these subsections pertaining to a physician's license, that would require removal, include: any license or practice suspension/restriction; any enforcement actions (e.g. probation, public reprimand, etc.); any disciplinary action in California or any other state as described in BPC § 803.1; any current accusations; any malpractice judgment or arbitration award; any misdemeanor conviction that resulted in disciplinary action; and any information required pursuant to 803.1. The only items that would remain on a physician's

profile on the Board's Website after ten years would be a felony conviction and hospital disciplinary action that resulted in termination or revocation of a physician's hospital staff privileges (unless those privileges were reinstated and then the information will only remain posted for 10 years from the date of restoration).

Although the statute requires the removal of the information from the Board's Website, these records are considered to be indefinitely public and therefore can be obtained from the Board's office via phone or in person. However, most members of the public would not know to call the Board unless they fully read and understood the Board's disclaimers. If the public does read the disclaimer and calls the Board, staff will copy the documents and provide them to the public.

The Board will begin the removal of the documents January 1, 2013. There are several concerns pertaining to the removal of this information. First, the MBC is unsure whether the removal of this information is beneficial to the public. In today's society, transparency is foremost in the public's mind. If the Board has information that it is not providing to the public in an easy to access format, the Board is not doing its due diligence related to transparency. No matter how many disclaimers the Board puts on its Website, and no matter how eye catching it may be, individuals have a tendency not to read the disclaimers. Therefore, the public will believe the physician he/she is looking up has never had any action taken by the Board. If a bad outcome occurs, and the individual subsequently finds that the Board had information but it wasn't posted on the physician's profile, this will raise concerns about the Board's effectiveness in protecting consumers.

Additionally, the MBC states that there is increased workload associated with the removal of this information. Currently, the Board receives very few requests for documents due to the fact the information is easily accessible and printable from the Board's Website. Once these documents are removed, if the public were to read the disclaimers, the Board's call volume will increase because the public will want to know whether there is information on a physician that "may" be available at the Board's headquarters, but cannot be posted on the Board's Website. This will result in additional inquiries to the MBC, and the workload associated with determining if there are documents available, making the copies, and either scanning and emailing the documents or mailing the documents (plus postage to mail).

While the MBC understands this information has an impact on a physician, the MBC also believes the public has the right to review the information and make its own decision regarding the physician based upon the circumstances of the case, including how long ago the action took place.

In addition, the statute provides that the information shall remain posted for 10 years from the date the MBC obtains possession, custody, or control of the information. However, this is vague. The MBC states that it is not sure if its interpretation of the law is what was intended by the Legislature. For example, for individuals who are placed on probation, the Board has interpreted the law to mean that the 10 years begins from the effective date of the decision and that would be when the information was in the Board's possession. If an individual were on probation for 7 years, once probation was completed, the information would only be posted for those 3 additional years. The MBC states that it does not know if this was the Legislature's intention, or if the information should be posted for 10 years from the date the probation was

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completed. For malpractice judgments, the MBC interprets the law to mean the Board would keep this action on the Website for 10 years from the date the Board receives this information, not the date of the judgment. The MBC may not receive the information timely, and the judgment may have been issued a significant amount of time prior to the MBC's receipt, leading to inconsistency in how certain types of information is posted under the law.

The MBC recommends elimination of the 10 year posting requirement in order to ensure transparency to the public. The MBC further recommends that if the Legislature does not wish to eliminate the requirement for the 10 year posting, that it specify a date, or have the MBC do that in regulations, when the 10 years begins/ends for these cases.

Staff Recommendation: ***Recommend that in the interest of transparency and disclosure of information to the public, BPC § 2027 should be amended to remove the 10 year limit on how long information should be posted on the MBC's Internet Website.***

Board Response (April 2013):
The MBC agrees with the Senate B&P Committee staff's recommendation. In the interest of consumer protection, the MBC recommends elimination of the 10 year posting requirement in order to ensure transparency to the public; the MBC submitted language on March 5, 2013 to the Senate B&P Committee staff for this amendment.

Board Response (2016):
The Board sponsored AB 1886 (Eggman, Chapter 285, Statutes of 2014), which allows the Board to post the most serious disciplinary information on the Board's website for as long as it remains public. This bill changed the website posting requirements, as follows: requires malpractice settlement information to be posted over a 5-year period, instead of a 10-year period (the posting would be in the same manner as specified in BPC Section 803.1); still requires public letters of reprimand to be posted for 10 years; and requires citations to be posted that have not been resolved or appealed within 30 days, and once the citation has been resolved, to only be posted for 3 years, instead of 5 years. All other disciplinary documents remain on the Board's website indefinitely.

ISSUE #37 (2012): Registered Dispensing Optician Program: Should the RDO Program be Transferred to Another State Agency?

Background: The MBC has raised the following as a new issue in its Sunset Report.
The MBC regulates the allied health professions of registered contact lens dispensers, registered dispensing opticians, registered non-resident contact lens sellers, registered spectacle lens dispensers under the provisions of Chapter 5.5 of Division 2 of the BPC (Commencing with Section 2550) through the Registered Dispensing Optician Program (RDO Program).

In its Sunset Report, the MBC discusses transferring regulation of the RDO Program to another entity such as the State Board of Optometry (SBO) or to the Department of Consumer Affairs to be operated as a program, board or committee within the Department.

The MBC states that SBO reported it receives about 20-30 calls a month from consumers who believe they received services from an optometrist, when in reality they received services from

an individual or business that is a registrant with the RDO Program. Almost all of these calls are complaint related and many times include a combination of issues which also involve an optometrist and optometric assistant. Further, many consumers do not understand that the functions of the optometrist and the RDO are different. Unfortunately, consumers incorrectly assume that optometrists and registrants of the RDO Program are the same profession, resulting in confusion as to which agency a complaint should be submitted.

What may lead to further confusion is that current law does not allow optometrists and RDO registrants to have commingling business relationships. BPC § 655 provides that an optometrist shall not have any membership, proprietary, interest, co-ownership, landlord-tenant relationship, or any, profit-sharing arrangement in any form, directly or indirectly, with an RDO registrant and vice versa.

There have been lengthy legal battles regarding the validity of B&P Section 655; both the California State and United States Federal courts have made it clear that California law prohibits certain relationships between optometrists and RDO registrants and that these laws are valid and constitutional. The most recent ruling came from the United States Court of Appeals for the Ninth Circuit on June 13, 2012. The ruling affirmed the decision of April 2010 by a U.S. District Judge that the state acted well within its rights to prohibit these types of relationships. The Plaintiffs-Appellants, National Association of Optometrists & Opticians, LensCrafters, Inc., and Eye Care Centers of America, Inc., could seek review by an enlarged circuit panel or at the Supreme Court.

AB 778 (Atkins, 2011) would have authorized a registered dispensing optician, an optical company, a manufacturer or distributor of optical goods, or a non-optometric corporation to own a specialized health care service plan that provides or arranges for the provision of vision care services. It would have also allowed shared profits with the specialized health care service plan, contract for specified business services with the specialized health care service plan, and jointly advertise vision care services with the specialized health care service plan. This bill eventually died in the Senate Business, Professions and Economic Development Committee.

MBC has suggested that moving the RDO Program to the SBO might lead to more efficient investigation of complaints by eliminating the need for two agencies to investigate the same complaint when it involved an optometrist and an RDO Program registrant. The MBC has also suggested as another option to transfer the RDO Program to the Department of Consumer Affairs as a program or bureau.

Committee staff points out that The RDO Program has budget authority for one position to perform the Program functions. If the RDO Program were moved into its own program or bureau, it would no doubt demand more staff and thus, ultimately escalate costs and registration fees.

Staff does note, however, that there has been success over the last 20 years or more of combining related regulatory issues into a single board. Of particular note are the following:

- Combining of cosmetology regulation with barbering regulation into the Board of Barbering and Cosmetology.

- Combined regulation of the funeral home industry and the cemetery industry by the Cemetery and Funeral Bureau.
- Combined regulation of architects and landscape architects by the California Board of Architecture.
- Combined regulation of land surveyors, professionals engineers, geologists and geophysics by the Board for Professional Engineers, Land Surveyors and Geologists.
- Combined regulation of the electronic and appliance repair industry and the home furnishing and thermal insulation industry into the Bureau of Home Furnishings and Thermal Insulation, Electronic and Appliance Repair.
- Combined regulation of speech-language pathology and audiology along with the hearing aid dispenser regulation in the Speech-Language Pathology, Audiology and Hearing Aid Dispensers Board.

Although, practitioners have at times recoiled at the prospect of such combined regulation and fought against it, the successful combinations of related regulatory programs shown above demonstrate the reality that related professions may be successfully regulated together.

Staff Recommendation: ***Recommend the MBC to initiate discussions with the Department of Consumer Affairs, the State Board of Optometry, stakeholders from each of the interested professional groups, and interested consumer representatives to discuss the potential need, usefulness, or problems with transferring regulation of the RDO Program from the MBC to another board or program. The MBC should report its findings and recommendations back to the Committee by July 1, 2014.***

Board Response (April 2013):
The MBC will initiate discussions with the Department of Consumer Affairs, the State Board of Optometry, stakeholders from each of the interested professional groups, and interested consumer representatives to discuss the potential need, usefulness, or problems with transferring regulation of the RDO Program from the MBC to another board or program. The MBC will report its findings and recommendations back to the Committee by July 1, 2014.

Board Response (2016):
AB 684 (Alejo, Chapter 405, Statutes of 2015) transitioned the RDO Program from the Board to the Board of Optometry effective January 1, 2016. No further action is necessary.

ISSUE #38 (2012): Consolidate the licensing and regulation of osteopathic physicians and surgeons under the MBC.

Background: Since the initiative establishing the Osteopathic Act and the Osteopathic Medical Board of California (OMBC) in 1922, California's public policy has been clear that osteopathic physicians and surgeons (DOs) are to be treated equally with physicians and surgeons (MDs) licensed under the MBC. BPC § 2453(a) states: "It is the policy of this state that holders of MD degrees and DO degrees shall be accorded equal professional status and privileges as licensed physicians and surgeons."

Moreover, this equality is so firmly established that it extends to a statutorily mandated rule of non-discrimination. BPC § 2453(b) states:

Notwithstanding any other provision of law, no health facility subject to licensure under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code, no health care service plan, nonprofit hospital service plan, policy of disability insurance, self-insured employer welfare benefit plan, and no agency of the state or of any city, county, city and county, district, or other political subdivision of the state shall discriminate with respect to employment, staff privileges, or the provision of, or contracts for, professional services against a licensed physician and surgeon on the basis of whether the physician and surgeon holds an MD or DO degree.

This equality, as well as the vastly coextensive education and training of MDs and DOs, and the exact parity of their unrestricted licenses and scopes of practice, raise a perennial question: Is there a continual need to have two separate regulatory bodies for these virtually identical professions? The question is particularly timely in light of the Governor's well-publicized desire to eliminate redundancies and inefficiencies in state government, and particularly in the structure of the state's boards and commissions.

The primary difference between DOs and MDs appears to be essentially one of emphasis. According to the Osteopathic Board, DOs have a different philosophy of medicine, focused on the interrelationship of the body's systems, a focus MDs do not share. Aside from that, both professions apparently have identical licenses, identical scopes of practice, and must be treated by insurers, hospitals, and government entities identically. They are held to apparently virtually identical standards of practice by hospital Peer Review Organizations and liability insurers, and, both the Osteopathic Board and the MBC use the same prosecutors when their licensees are subject to formal accusations. MBC already conducts all investigations and HQE conducts all prosecutions for the Osteopathic Board. OMBC simply has too few licensees to support a separate enforcement program — at least one of the physicians highlighted in the *LA Times* series (Dr. Lisa Tseng) is an osteopath, and it took the OMBC many years to suspend her license.

Is there a continuing need for two separate boards to regulate those who hold unrestricted licenses as physicians and surgeons?

If DO regulation were transferred to the MBC, it would appear appropriate to include osteopathic physician membership on the MBC.

Staff Recommendation: ***The MBC should discuss with the Committee the possibility of consolidating the OMBC into the MBC to provide a single regulatory authority over all physicians and surgeons in California.***

Board Response (April 2013):
The Senate B&P Committee background paper has asked if there is a continued need to have two separate regulatory bodies for these virtually identical professions, especially in light of the fact that OMBC has too few licensees to support a separate enforcement program.

This is not an issue that the MBC has fully discussed or taken action to approve or disapprove. The MBC agrees that the Committee(s) should take the lead on this issue and possibly hold an informational hearing on the subject of this potential consolidation of the MBC and the OMBC.

In the meantime, staff can take this issue back to the MBC for a fuller discussion and direction to staff, so the MBC could fully participate in any consolidation effort led by the Committee.

Board Response (2016):
The Board believes that this is a complicated issue that would require a legislative change and possibly an initiative change, if the Legislature believes a consolidation is necessary. The Board still agrees that the Committee(s) should take the lead on this issue. The Board would participate in any discussions on this matter.

ISSUE #39 (2012): (CONTINUED REGULATION BY THE BOARD.) Should the licensing and regulation of physicians and surgeons be continued and be regulated by the current Board membership?

Background: The public interest is best protected by the presence of a strong licensing and regulatory board with oversight over physicians and surgeons and the associated allied professions. Since the inception of MICRA in 1975, a strong and vigorous enforcement agency has been demanded in order to represent the interests of patients, their families and the people of California.

The MBC faces considerable challenges to being the consumer protection agency that is needed in the coming years. Sharp criticism has been levied against the board in recent years. However, the MBC has faced a number of challenges in seeking to fulfill its consumer protection mission: Budget crises, budget restrictions, hiring freezes, vacancies, staff furloughs have all contributed to limiting the Board's operations. However the Board needs to be proactive in its approach; finding new ways to use technology to accomplish its consumer protection purposes.

The MBC should be continued with a 4-year extension of its sunset date so that the Legislature may once again review whether the issues and recommendations in this Background Paper have been addressed.

Staff Recommendation: ***Recommend that the licensing and regulation of physicians and surgeons and allied health professions continue to be regulated by the current board members of the Medical Board of California in order to protect the interests of the public and be reviewed once again in four years.***

Board Response (April 2013):
The Board appreciates the opportunity of the Sunset Review process and looks forward to working with both the Senate and the Assembly B&P Committees and their staff on issues that have been identified for future consideration. The MBC is pleased that Committee staff has recommended that the licensing and regulation of physicians and surgeons and allied health professions continue to be regulated by the current Board Members of the Medical Board of California in order to protect the interests of the public and be reviewed once again in four years.

Board Response (2016):
No response necessary.

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Section 11

New Issues

- Expiration Date of Licenses
- Postgraduate Training
- Accredited Outpatient Settings – Data Reporting
- Accredited Outpatient Settings – Adverse Event Reporting
- New Language for Notice to Consumers on Signs and in Written Statements
- Penalties for Failing to File a Report Pursuant to Business and Professions Code Section 805.01
- Licensing Program Enhancements
- Physician Reentry at Initial Licensure
- HPEF Board Membership
- Board of Podiatric Medicine
- Board Panel Membership
- Enforcement Enhancements

The Board has developed the following issues that it believes the Legislature should consider in its examination of the Board. These issues are items that the Board believes will assist the Board in its role of consumer protection and/or assist the Board in fulfilling its regulatory obligations.

Expiration Date of Licenses

The Board currently utilizes a physician's birth date to calculate license expiration dates. The purpose of the birth date renewal initially was to ensure that the Board did not have to process a large number of applications or renewals during peak times. However, with the intensive licensing outreach performed by the Board's Licensing Outreach Manager to potential licensees, licenses are not issued only during certain months, but are issued throughout the year.

The Board does give applicants the option of waiting until their birth month for their physician and surgeon license to be issued. However, if an applicant cannot wait until their birth month to receive their application, their initial license will not be valid for a full two years, resulting in overpayment to the Board.

The issue of applicants paying for a license, but not getting their full two years of licensure has been one that has generated legislative interest. AB 483 (Patterson, 2015) would have required all boards and bureaus under DCA to prorate the initial licensing fees for physicians and surgeons to ensure that licensees are not overcharged. However, the proration requirement would result in delays in issuing licenses for physicians and surgeons and increased workload.

Board staff believes that a two-year license would be a better way to resolve the issue of license fee overpayment. The Board does not have any issues with peak times, so a two-year license will ensure that applicants are not overcharged and will not create any additional steps in the licensure process. In addition, a large percentage of licensees renew online, thereby decreasing the impact to the Board's renewal processing workload. AB 773 (Baker, Chapter 336, Statutes of 2015) would have allowed the Board to issue a two-year license for Board licensees and Board of Psychology licensees. However, amendments were taken in Senate Appropriations Committee to remove the Board from the bill. The Board would like to include language in its sunset bill to allow the Board to issue a two-year license and no longer use licensees' birthdates to calculate license expiration dates.

Postgraduate Training

Requirements for postgraduate training in California are currently set in B&P Code sections 2065 and 2066. Section 2065 requires an applicant who graduated from an LCME-approved domestic (US/Canada) medical school to complete one year of ACGME/RCPSC accredited postgraduate training, not to exceed two years of ACGME/RCPSC accredited postgraduate training. Section 2066 requires an applicant who graduated from a recognized international medical school pursuant to 16 CCR section 1314.1 to complete two years of ACGME/RCPSC accredited postgraduate training, not to exceed three years of ACGME/RCPSC accredited postgraduate training.

Graduates of US/Canada medical schools are deemed to meet the minimum undergraduate clinical requirements (4 weeks psychiatry, 4 weeks family medicine, 8 weeks medicine, 6

weeks obstetrics and gynecology, 6 weeks pediatrics, 8 weeks surgery, plus another 4 weeks from one of the clinical core subjects, and 32 weeks ofelectives) through LCME approval of the medical school.

Graduates of international medical schools must meet the same undergraduate clinical requirements. However, due to the lack of national/international accreditation organization such as LCME, the Board has provided several options, specified in B&P Code section 2089.5, in which the undergraduate clinical rotations may be satisfied. Unfortunately, not all international medical schools have established their medical education to satisfy California's licensing requirements; most international medical schools have established curriculums to meet only the needs of their native population. When an international medical school graduate applies for postgraduate training and/or licensure in California, many are unable to easily satisfy the requirements of B&P Code section 2089.5. The applicants' encounter challenges requiring multiple communications between the Board and the medical school; documentation relative to formal affiliation agreements between the medical school and other medical schools; documentation relative to formal affiliation agreements between the medical school and other hospitals; documentation from ACGME/RCPSC hospitals in the US/Canada; and documentation of European Region Action Scheme for the Mobility of University Students (ERASMUS) programs in the European Union (EU). Even with this documentation, it is not unlikely that the applicant's undergraduate clinical rotations will be deemed deficient due to the failure to meet one of the options outlined in B&P Code section 2089.5. This determination will then require the applicant to remediate the deficient training, which is a hardship for the applicant in both his or her professional and personal life.

The Board recommends amending B&P Code sections 2065 and 2066 to require all applicants, regardless of school of graduation, to satisfactorily complete a minimum of three years of ACGME/RCPSC postgraduate training prior to the issuance of a full unrestricted license to practice. During this process, the board will issue training permits and identify the scopes of practice for each year, in conjunction with the postgraduate training programs. This recommendation is based upon the industry-recognized standard of completion of postgraduate training leading to ABMS certification: the fewest number of training years required for ABMS is three years for specialties of family medicine, internal medicine, pediatrics, etc. In exchange, the Board proposes to eliminate the international medical school recognition process outlined in 16 CCR section 1314.1, and the criteria set forth in BPC sections 2089 and 2089.5. The Board would require that individuals graduate from a medical school listed in the World's Directory. The justification for this proposal is based upon multiple factors.

An applicant's participation and satisfactory completion of a nationally recognized and administered ACGME/RCPSC postgraduate training program provides the most accurate assessment of a physician's abilities in the six core competencies required to be eligible for ABMS certification. The ACGME/RCPSC in the US and Canada must meet the same educational and experience requirements; all programs are accredited by the same entity; all programs undergo specified re-accreditation assessments; and all programs are judged by the same standards. This equitable evaluation process ensures the programs set the same criteria, requirements, and standards AND all participants in these programs meet the same criteria, requirements, and standards. This assurance is a more effective assessment of an applicant's eligibility for licensure than where he/she attended medical school and completed

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undergraduate clinical rotations. This proposed process will ensure physicians satisfactorily completing three years of ACMGE/RCPSC postgraduate training, in any specialty, have developed and demonstrated competency in the same skill sets of patient care in a monitored and structured setting.

The elimination and repeal of the Board's international medical school recognition process set forth in 16 CCR section 1314.1 will significantly improve the application processing time for international graduates, eliminating many of the hurdles and obstacles that contribute to delays in processing their applications. Whether the applicant is applying for permission to participate in postgraduate training or a full unrestricted license, the processing time will be greatly reduced and will allow these applicants to be competitive in their careers, ultimately to the benefit of medical consumers in California. The repeal of B&P Code sections 2089 and 2089.5, and 16 CCR section 1314.1 will eliminate the Board's responsibility for the evaluation and assessment of medical education from international medical schools throughout the world. The Board does not have sufficient staff resources with appropriate knowledgeable of how medical education is developed and delivered, nor sufficient numbers of highly-trained and educated medical consultants to properly and adequately conduct these assessments and render decisions. Also, the repeal of B&P Code sections 2089 and 2089.5, and CCR, Title 16, section 1314.1 will allow the Board's international medical school staff to be reallocated to fulfill the Board's mission of providing permission to participate in postgraduate training and issuing medical licenses, thereby improving the processing times for all international applicants.

The elimination and repeal of the Board's specified options to satisfy undergraduate clinical rotations set forth in B&P Code section 2089.5 will also significantly improve application processing time for international graduates, eliminating many of the hurdles and obstacles that contribute to delays to processing their applications. The repeal of B&P Code section 2089.5 will eliminate the Board's responsibility for the evaluation and assessment of undergraduate clinical rotations with respect to location and affiliation; where and who approved the undergraduate clinical rotation would no longer be of grave concern to the Board. Rather, the focus and concern will be on the applicant's performance in a US/Canada based postgraduate training program. Also, the repeal of B&P Code sections 2089 and 2089.5 will allow the Board to revise the basic application and eliminate two forms required only of international medical school graduates. The application will then require the same documentation from US/Canada and international graduates

The repeal of B&P Code sections 2089 and 2089.5, and 16 CCR section 1314.1 and changing the requirement to three years of postgraduate training will result in significant improvement in processing timeframes for applicants of international medical schools. California consumers will benefit by the addition of postgraduate trainees demonstrating competence in formally-structured and monitored training programs, and ultimately the licensure of these fully and equitably trained physicians to provide medical care in California. The Board's re-focus on the most important issue—demonstration of satisfactory completion and competence in a formally-structured and monitored US/Canada postgraduate training program supersedes where an applicant earned a medical degree and/or completed a six-week undergraduate clinical rotation.

B&P Code section 2135.7 became effective January 1, 2013, and was amended two times with effective dates of January 1, 2014, and January 1, 2015. Section 2135.7 allows individuals

who attended and/or graduated from international medical schools that the Board does not recognize or that the Board previously disapproved to qualify for licensure in California if the individual applicants meet the minimum requirements pursuant to B&P Code section 2135.7. Prior to B&P Code section 2135.7, individuals who attended and/or graduated from an unrecognized and/or disapproved international medical school were not eligible to apply for a California physician's and surgeon's license.

Accredited Outpatient Settings – Data Reporting

Per existing law, Health and Safety Code section 1216, clinics licensed by the California Department of Public Health (CDPH), including surgical clinics, are required to report aggregate data to the Office of Statewide Health Planning and Development (OSHPD). This data includes number of patients served and descriptive background, number of patient visits by type of service, patient charges, and any additional information required by CDPH and OSHPD. Before *Capen v. Shewry*, this data was being collected for the majority of outpatient settings, as they were licensed as surgical clinics. However, when physician-owned outpatient settings fell under the jurisdiction of the Board, this reporting was no longer required, which resulted in a serious deficiency of outpatient settings data. This data deficiency was highlighted in the California Health Care Foundation (CHCF) Report, "Ambulatory Surgery Centers: Big Business, Little Data," which was released in June 2013. This issue was also mentioned in CHCF's follow-up report, Outpatient Surgery Services in California: Oversight, Transparency and Quality," which was released in July 2015.

The Board believes it is very important to require both accredited and licensed outpatient settings to report data to OSHPD, as this data will provide important information on procedures being done in ASCs and will make the Board and other regulatory agencies aware of any issues or areas of concern, so that consumer protection enhancements can be addressed if they are needed.

Language to require data reporting to OSHPD was included in SB 396 (Hill, Chapter 287, Statutes of 2015). The language would have required the same data reporting for accredited outpatient settings as is required for surgical clinics. However, due to concerns raised by stakeholders that the data required to be reported was too broad and would not provide the appropriate health outcome data, this language was removed from SB 396. Senator Hill did state in meetings with stakeholders that this issue would be addressed during the Board's sunset review process. The Board did hold an interested parties meeting with stakeholders, staff from OSHPD, and staff from the Senate Business, Professions and Economic Development Committee on May 26, 2016. The Board would like to set forth, via a legislative amendment, criteria it believes should be required to be reported to OSHPD.

Accredited Outpatient Settings – Adverse Event Reporting

Per existing law, B&P Code section 2216.3, accredited outpatient settings are required to report adverse events to the Board. This was required as part of the Board's last sunset bill, SB 304 (Lieu, Chapter 515, Statutes of 2013). The adverse events that are required to be reported are the same adverse events that hospitals are required to report to the California Department of Public Health (CDPH), as the language in 2216.3 just references the adverse event reporting requirements for hospitals, which is in Health and Safety (H&S) Code section 1279.1.

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Accredited outpatient settings have been reporting these adverse events to the Board, however, just pointing to the hospital adverse events reporting section has proven to be problematic, as some of the adverse events for hospitals really don't apply to accredited outpatient settings (i.e., an infant discharged to the wrong person, maternal death, a stage 3 or 4 ulcer, etc.) In addition, there may be adverse events that occur in accredited outpatient settings that do not apply to hospitals, but should be added to the adverse event reporting requirements for accredited outpatient settings.

This has resulted in confusion for some outpatient settings in what they should report to the Board if the event doesn't fit into a specific category listed in H&S Code section 1279.1. The Board would like to hold an interested parties meeting with stakeholders to gather information on what types of adverse events should be on the list, but are not currently included, and also gather information on what adverse events are on the list that do not apply to outpatient settings. Once the stakeholder meeting is held, the Board would like to include language in its sunset bill to list adverse events for accredited outpatient settings in B&P Code Section 2216.3, instead of referring to Health and Safety Code Section 1279.1. The Board believes this will help to clarify the appropriate types of adverse events that need to be reported to the Board by accredited outpatient settings.

New Language for Notice to Consumers on Signs and in Written Statements

Senate Bill 2238 (Chapter 879, Statutes of 1998), introduced by the Business and Professions Committee, enacted B&P Code section 138, which required each board within the Department of Consumer Affairs to initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates to provide notice to their clients or customers that the practitioner is licensed by the state.

When this bill was first introduced, it contained the following language for B&P Code section 138, in pertinent part:

> 138. (a) Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide written notice to their clients or customers that the licentiate must be licensed in good standing with that board in order to practice lawfully, and the means for contacting the licensing board for the purpose of seeking information or filing a complaint.

The bill went through several amendments, and ultimately states the following:

> 138. Every board in the department, as defined in Section 22, shall initiate the process of adopting regulations on or before June 30, 1999, to require its licentiates, as defined in Section 23.8, to provide notice to their clients or customers that the practitioner is licensed by this state. A board shall be exempt from the requirement to adopt regulations pursuant to this section if the board has in place, in statute or regulation, a requirement that provides for consumer notice of a practitioner's status as a licensee of this state.

The regulations adopted by the Board pursuant to this section reflect the limited language provided for in B&P Code section 138. The Board believes that consumer protection will be furthered by expanding the statutory language as to what is to be included in the notice, and

how it is to be delivered to consumers, if not for all boards, then for licensees of the Medical Board.

The current language does not provide sufficient information about what the Board does, and what information can be learned through contacting the Board to encourage consumers to reach out to learn about their medical providers or to make a complaint when warranted. Therefore, the Board recommends amending B&P Code section 138.

Penalties for Failing to File a Report Pursuant to Business and Professions Code Section 805.01

Senate Bill 700 (Negrete McLeod, Chapter 505, Statutes of 2010) added Section 805.01 to the B&P Code, and requires specified individuals, such as the chief of staff of a medical staff, to file a report with the Board within 15 days after a peer review body makes a final decision or recommendation regarding the disciplinary action proposed to be taken against a licentiate following a formal investigation based on the peer review body's determination that certain specified acts may have occurred, regardless of whether a hearing is held pursuant to B&P Code section 809.2. The specified acts triggering this report, in short, are:

1) Incompetence, or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients;
2) The use of, or prescribing for or administering to himself or herself, any controlled substance; or the use of any dangerous drug or alcohol to the extent or in such a manner as to be dangerous to the licentiate, any other person, or the public, or to the extent that the use impairs the licentiate's ability to practice safely;
3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or doing so without a good faith prior examination of the patient and a medical reason therefor;
4) Sexual misconduct with one or more patients during a course of treatment or examination.

The purpose of 805.01 reports is to provide the Board with early information about these serious charges so that the Board may investigate and take appropriate action to further consumer protection at the earliest possible moment. Accordingly, for any allegations listed above, the Legislature determined that an 805.01 report must be filed once a formal investigation has been completed, and a final decision or recommendation regarding the disciplinary action to be taken against the licentiate has been determined by the peer review body, even when the licentiate has not yet been afforded a hearing to contest the findings.

The Board sees 805.01 reports as an important tool for consumer protection, yet since the enactment of B&P Code section 805.01, very few reports have been filed. The statistics below show the number of 805.01 reports that have been filed per fiscal year (FY) since enactment:

FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
16	9	2	4	5

Over that same time period, the statistics below show the number of 805 reports that have been filed per fiscal year (FY) over the same time period:

FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16
114	107	105	96	127

The Board believes entities are not submitting 805.01 reports as required. The Board provides notification each January through its Newsletter in an article entitled, "Mandatory Reporting Requirements for Physicians and Others," that entities are required to file 805.01 reports, and also wrote a separate article for the Fall 2015 Newsletter entitled, "Patient Protection is Paramount: File Your 805.01 Reports," in an effort to boost compliance with the requirement, but the Board is seeking additional tools to incentivize compliance with 805.01 reporting.

If an entity fails to file an 805 report with the Board, they could receive a fine of up to $50,000 per violation, or $100,000 per violation if it is determined that the failure to file the 805 report was willful. In contrast, there is no penalty for an entity's failure to file an 805.01 report, despite the serious nature of the charges involved.

The Board recommends that B&P Code section 805.01 be amended to allow the Board to fine an entity up to $50,000 per violation for failing to submit an 805.01 report to the Board, or $100,000 per violation if it is determined that the failure to report was willful.

Licensing Program Enhancements

The Board has reviewed the statutes pertaining to the licensing program and believes several amendments are necessary. The Board recommends repealing the following sections for the reasons stated below.

- Section 2052.5: There appears to be no interest in this specific program; it has never been used. In addition, the telehealth law in B&P Code section 2290.5 provides guidance for the use of telehealth.
- Section 2072: This program is no longer utilized.
- Section 2073: This program is no longer utilized.
- Section 2104: There is no need for this program and this would be an unnecessary expense to California hospitals. In addition, all Fifth Pathway programs have been eliminated. There are many Board recognized medical schools that individuals may attend, making this statute unnecessary.
- Section 2104.5: There appears to be no interest in this program, and there is no need for a Fifth Pathway program. There are many Board recognized medical schools that individuals may attend, making this statute unnecessary.
- Section 2115: There appears to be no interest in this exemption, as it has never been used. There are no regulations for this statute. In addition, SB 1139 (Lara, Chapter 786, Statutes of 2016) was recently signed into law and makes this program unnecessary.

Physician Reentry at Initial Licensure

The Board continues to receive applications for medical licensure from individuals who have not practiced clinical medicine for many years. In addition, the B&P Code section 2428, authorizes a previous California licensee to apply for issuance of the former license, provided all requirements and criteria set forth in the statute are met. Most applicants satisfy these requirements. Also, applicants who were licensed in other states generally satisfy the requirements of the various statutes authorizing licensure in this state. However, not all of

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these applicants have updated their clinical competency by practicing in a monitored/supervised clinical setting.

The Board requires individuals who have not practiced medicine for five or more years (based upon B&P Code section 2428) to undertake a recognized national assessment of their knowledge and clinical skills. Many of these assessment programs exist, both in and out of California. Private entities in California, Texas, Colorado, Pennsylvania, and several other states offer a structured formal program designed to assess the skills necessary to practice medicine. These assessments include several components: computer-based testing; mock patient encounters; observership/discussions with a practicing physician; mock oral questions; and a general medical examination. The results from the various assessments are evaluated by a team and provided in a report. The report indicates how the applicant performed in each assessment, and coursework or clinical practice recommendations are specified. The clinical practice recommendations represent the hurdle, in that California does not have a provision for a monitored and/or supervised clinical practice of medicine to meet any recommendations. In the United States, only Texas has implemented a limited license to allow for such practice.

The Board recommends the creation of a statute that will authorize the board to issue a Limited Educational Permit to these impacted physicians, thereby allowing them the opportunity to participate in and complete the assessment-recommended clinical practice prior to obtaining a California license. The Limited Educational Permit would be limited and restricted by location, scope of practice, required supervision and length of practice time. For instance, a Limited Educational Permit would be issued to applicant Dr. Jones, to practice at the University of California, San Diego teaching hospital, in the areas of family medicine and pediatrics, under the supervision/direction of the Chairs of Family Medicine and Pediatrics, for a period of 90 days. All patient encounters would need to be supervised; patient records would need to be audited; and a formal assessment of clinical skills would need to be provided to the Board by the supervisor at the end of the 90 days, with a determination of whether the applicant is safe to practice medicine or additional clinical training is needed. At the end of the 90 days, the Limited Educational Permit would be terminated and the applicant would not engage in further clinical practice until the Board received the formal assessment, reached a determination of the applicant's eligibility for licensure, and communicated that information to the applicant. This process would ensure the Board has oversight for these individuals. It will also assure the Board and consumers that the applicant has met the minimum requirements to safely and competently practice as an independent physician. The ultimate licensure of these physicians benefits all patients in California.

HPEF Board Membership

The California Physician Corps Loan Repayment Program ("Program") was created by Assembly Bill 982 (Chapter 1131, Statutes of 2002) and carried by Assembly Member Marco Firebaugh. This bill was co-sponsored by the Board to further the Board's charge of consumer protection and to undertake innovative and proactive steps to tackle the significant issue of increasing access to health care for the underserved. The Program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of their student loans in exchange for their service in a designated medically underserved area for a minimum of three years.

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AB 920 (Aghazarian, Chapter 317, Statutes 2005) moved the Program from the Board to the Health Professions and Education Foundation (HPEF), a 501(c)(3) public benefit corporation, which receives administrative support from the Office of Statewide Health Planning and Development. Since 1990, HPEF has administered statewide scholarship and loan repayment programs for a wide range of health-profession students and recent graduates and is funded through grants and contributions from public and private agencies, hospitals, health plans, foundations, corporations, and individuals, as well as through a surcharge on the renewal fees of various health professionals. This transfer helped the Program seek donations and secure funding through writing grants and enable it to grow and increase access to care for Californians. Following the implementation of a detailed transition plan, the loan repayment program was moved to HPEF on July 1, 2006.

Although the Program moved to the HPEF, AB 920 also required that two members of the HPEF Board be appointed by the Medical Board. However, the law also provided a sunset date of January 1, 2011 for this provision. AB 1767 (Hill, Chapter 451, Statutes of 2010) extended the sunset date of the two members appointed by the Medical Board to the HPEF from January 1, 2011, to January 1, 2016.

There was no subsequent legislation to extend the sunset date from January 1, 2016, and, therefore, the two members appointed by the Medical Board to the HPEF were removed effective January 1, 2016. However, the Board believes that representation by the Medical Board on the HPEF is still necessary. The Board's physician licensees each provide a mandatory $25 to the HPEF for these student loans. While there is a Board staff member that assists in the scholarship award process, the Board believes that the Board should have a voice on the HPEF. Therefore, the Board would recommend that legislation be introduced to require that two members of the HPEF be appointed by the Medical Board as previously required.

Board of Podiatric Medicine

As legislation was going through in 2015, it became clear that existing law does not accurately portray the Board's relationship with the Board of Podiatric Medicine (BPM). In existing law it appears that the Board oversees and houses the BPM, when that is not the case. The Board would like to make changes to the laws that regulate the BPM, in Article 22 of the Business and Professions Code to clarify that the BPM is its own board and is completely separate from the Medical Board.

Prior to this issue being brought forward, the Board did not issue licenses for the BPM. In addition the Board does not have any impact on the enforcement decisions of the BPM. For the past two decades, the BPM has been issuing its own podiatric licenses, but with the Medical Board seal, separate and apart from the Medical Board. The Board does provide shared services for the BPM, which means BPM pays Board staff to do some work for BPM. This work includes processing complaints and disciplinary actions for the BPM. If an investigation is warranted, these complaints are sent to the DCA for investigation. The Board provides shared services to BPM under the shared services agreement and the Board is currently working with DCA staff on a memorandum of understanding to formalize this agreement between the Board and BPM. Nothing in the statute requires the Board to perform these services. This is solely done through the shared services agreement.

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In discussions with the BPM and DCA, it was determined that since the law states that the BPM recommends applicants to the Board for the issuance of the license, the processes that were followed for the last two decades were changed to have the Board actually issue the license via the BreEZe computer system. The Board has no authority over who is licensed and does not have the ability to deny licensure for any applicant. The Board only provides the update to the BreEZe system to issue the physical license. The Board has been doing this for the past several months. However, the Board does not believe that this is appropriate, as the BPM, who has the authority over the decision as to whether an applicant should have a license or not, should be the entity issuing a podiatrist license.

The Board would like to make these technical, clarifying changes to make it clear that the BPM is its own board that performs its own licensing functions. The Board believes this is important, as it does not have any control over the BPM, and the law should accurately reflect each board's actual responsibilities. The Board also believes these changes will not have any effect on BPM licensees or their scope, as it is not changing the role of the Board or the BPM or either board's practices or functions.

Board Panel Membership

Section 2001 of the B&P Code states that the Board is comprised of 15 Members, eight physicians and seven public members. In addition, section 2004(c) states that the Board's responsibilities shall include carrying out the disciplinary actions appropriate to the findings made by a panel or an administrative law judge. Further, section 2008 authorizes the establishment of panels by the Board to fulfill section 2004(c). Section 2008 also includes a requirement that the panel cannot be comprised of less than four members and that the number of public members cannot exceed the number of licensed physician and surgeon members. It also adds that the Board president cannot be a member of a panel unless there is a vacancy on the Board. Unfortunately, the specific requirements in section 2008 have caused a conflict due to the requirement that the Board President cannot be a member if there is full membership, but that there also cannot be more public members than physician members on a panel.

The Board has implemented sections 2004 and 2008 over the past several years by having two panels of the Board, with the number of members on each panel dependent upon the number of members currently appointed to the Board. Depending upon the Board's membership, the number of individuals on a panel could vary from four to seven. When there is a full complement of members, the Board should have two panels each made up of seven members. The problem arises when the Board has a full complement of members, eight physicians and seven public members, and the Board president is a physician member. In this instance, the Board president cannot sit on a panel pursuant to section 2008, however, this results in there being more public members than physician members on a panel or requiring that a public member also not be on a panel during the tenure of the Board President. For example, if the Board president is a physician, that leaves a remainder of seven physicians and seven public members to be divided between two panels. One panel could be made up of four physicians and four public members, but the other panel would be made up of four public members and three physicians, thus violating of the requirement in section 2008 that the number of public members not exceed the number of physician members on a panel.

Therefore, the Board recommends that the requirement that the Board president not be on a panel be eliminated to resolve this unintended conflict.

Enforcement Enhancements

Business and Professions Code Section 2232

When physicians are convicted of certain sexual offenses, they are required to register as sex offenders pursuant to Penal Code section 290. In order to protect the public from physicians who may be a threat, the Legislature enacted B&P Code section 2232, which requires the "prompt revocation" of a physician and surgeon's license when a licensee has been required to register as a sex offender. Allowing physicians who are sex offenders to continue to practice medicine is contrary to this legislative mandate and public policy. Streamlining and expediting the process of revoking these licenses would protect the public from being harmed by one of these dangerous physicians.

Unfortunately, as section 2232 is currently written, obtaining a prompt revocation has proven to be difficult and fails to advance the public policy intended. The current process is as follows: once the Board learns that a doctor has been convicted of a crime requiring that he or she register as a sex offender, the Board requests the AG's Office file an Accusation. The Accusation, along with several other documents, are served on the respondent physician, and he or she has 15 days to file a Notice of Defense (NOD). The Board and the AG's Office are required to wait to receive that NOD, and once received, the AG's Office files a 'Request to Set' with the Office of Administrative Hearings (OAH), which asks OAH to schedule the matter for hearing. Once the hearing is set, pursuant to Government Code section 11509, the AG's Office is then required to send the respondent physician a "Notice of Hearing" no less than 10 days prior to the date of the hearing. Therefore, over a month will have passed before a hearing can even be set from notification that a physician is a registered sex offender. If OAH does not quickly set the hearing after the Request to Set has been filed, a prompt revocation can actually turn into a several-month delay. In the meantime, because there are no restrictions on the license, the offending doctor may practice medicine and the public is at risk for possible further harm, unless the Board has been able to seek either a Penal Code section 23 Order or an Interim Suspension Order.

The problem with section 2232 is caused by the failure to define "prompt," or to provide the tools for prompt revocation. Therefore, the Board recommends amendments to B&P Code section 2232 for an automatic revocation. Automatic revocations are not new to professional licensees. Teachers who have been convicted of certain sex offenses are suspended by the Commission on Teacher Credentials, without a hearing beforehand. Once the conviction becomes final, the teacher's license is revoked. Education Code Section 44425, subdivision (a) provides in pertinent part that when a holder of a teacher credential has been convicted of certain sex offenses as defined in Education Code section 44010, the Commission on Teacher Credentialing immediately shall suspend the credential. (Emphasis added.) When the conviction becomes final or when imposition of sentence is suspended, the commission immediately shall revoke the credential. Subdivision (c) provides that the revocation shall be final without possibility of reinstatement of the credential if the conviction is for a felony sex offense as defined in section 44010.

When the Board is notified of a conviction, and a physician has been ordered to register as a sex offender, rather than filing an Accusation and going through the lengthy administrative

process, the Board should be authorized to file a pleading that immediately revokes the physician's license. Should the respondent physician want a due process hearing regarding the prompt revocation, he or she would need to request a hearing in writing. In other words, the Board would automatically revoke the license of a registered sex offender, and then it would be up to the physician to request a prompt hearing. This shifts the waiting onto the physician rather than the public.

Physicians who are ordered to register as sex offenders have had their due process rights satisfied at the criminal level. In addition, if the physician requests a hearing at OAH after the revocation, under the proposed statute, their due process rights will be satisfied a second time by allowing review of the Board's decision.

Business and Professions Code Section 2225
B&P Code section 2225 provides in pertinent part: "Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon…and his or her patients a privileged communication, those provision shall not apply to investigations or proceedings conducted under this chapter."

The Board relies on this section to obtain medical records either through patient authorization or via subpoena. Recently, the Board faced a challenge to its authority to obtain records from a physician who practiced psychiatry and was accused of inappropriately prescribing medications. The patient authorized the Board to obtain his medical records, but then rescinded the authorization and objected to the Board's subpoena for his medical records out of fear that the physician would stop prescribing to him. The superior court granted the Board's motion for subpoena enforcement. The appellate court, however, initially determined that B&P Code section 2225 did not allow the Board to obtain psychotherapy records when the patient objected and invoked the psychotherapist-patient privilege provided by Evidence Code section 1014[2].

The Board is concerned that similar challenges will be made in the future, and if successful, the Board's ability to investigate physicians who declare themselves to be psychiatrists will be significantly hampered, especially in the area of overprescribing controlled substances where the patient may refuse to sign an authorization and object to a subpoena for records due to issues with addiction and/or financial gain (in cases of diversion of prescription medications). The Board's ability to investigate and protect the public depends upon its ability to enforce investigational subpoenas with a proper showing of good cause, regardless of the physician's specialty.

In light of the above, the Board recommends that B&P Code section 2225 be amended to make it clear that invocation of the psychotherapist-patient privilege is not a barrier to the Board obtaining psychotherapy records via a subpoena upon a showing of good cause.

[2] The appellate court granted the Board's request for a reconsideration, and then dismissed the physician's appeal as moot, as the physician surrendered his license, making subpoena enforcement in this case unnecessary.

Government Code Section 11529

The language in Government Code section 11529 requires that if the Board pursues and obtains an Interim Suspension Order (ISO), it has 30 days to file an accusation. The law includes other requirements too. However, in some instances the Board may not file an accusation, but instead will file a petition to revoke probation. However, the Government Code does not have language for a petition to revoke probation to be treated the same as an accusation. A petition to revoke probation is very similar to an accusation in that it is still the charging document identifying what the physician has done to violate the law, however, because the physician is on probation, the board is seeking to revoke that probation and the violations are violations of the physician's probationary order. Therefore, the Board is recommending an amendment to Government Code section 11529(c) to add petitions to revoke probation.

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Part II

Midwifery Program

- Background and Description of Midwifery Program
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program

History and Functions of the Midwifery Program

A licensed midwife (LM) is an individual who has been issued a license to practice midwifery by the Medical Board of California (Board). The Midwifery Practice Act, contained in Business and Professions Code sections 2505 to 2521, was enacted in 1993 and became effective in 1994, with the first direct entry midwives licensed in September 1995. The practice of midwifery authorizes the licensee to attend cases of normal pregnancy and childbirth and to provide prenatal, intrapartum, and postpartum care, including family-planning care, for the mother and immediate care for the newborn. The LM can practice in a home, birthing clinic, or hospital environment.

Pathways to licensure for LMs include completion of a three-year postsecondary education program in an accredited school approved by the Board or through a challenge mechanism. Business and Professions (B&P) Code section 2513(a)-(c) allows a midwifery student and prospective applicant the opportunity to obtain credit by examination for previous midwifery education and clinical experience. Prior to licensure, all midwives must take and pass the North American Registry of Midwives (NARM) examination, adopted by the Board in 1996, which satisfies the written examination requirements set forth in law.

In order to provide the guidance necessary to the Board on midwifery issues, effective January 1, 2007, the Board was mandated to have a Midwifery Advisory Council (MAC). The MAC is made up of LMs (pursuant to B&P Code section 2509 at least half of the MAC shall be LMs), a physician, and two non-physician public members. The Board specifies issues for the MAC to discuss/resolve and the MAC also identifies issues and requests approval from the Board to develop solutions to the various matters. Some items that have been discussed include challenge mechanisms, required reporting, student midwives, midwifery regulation changes, midwife assistants, transfer reporting form, etc. The MAC Chair attends the Medical Board meetings and provides an update on the issues and outcomes of the MAC.

Effective January 2014 the scope of LMs was significantly changed, when Assembly Bill (AB) 1308 (Bonilla, Chapter 665) eliminated the requirement for physician supervision and authorized an LM to attend cases of “normal” birth, as specified. It also authorized an LM 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. (See Major Legislation.)

The bill also required the Board to develop regulations to define “normal.” Although the Board has held interested parties meeting, those regulations have not been finalized. The Board has created a task force to further consider this issue and to work toward proceeding with the rulemaking process.

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Major Legislation/Regulations Since the Last Sunset Review

Legislation

2013

- *AB 1308 (Bonilla, Chapter 665) Midwifery*

This bill removed the physician supervision requirement for LMs and required LMs to only accept clients that meet the criteria for normal pregnancy and childbirth, as specified in the bill. 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 continue to care for 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. The bill allowed LMs to directly obtain supplies and devices, obtain and administer drugs and diagnostic tests, order testing, and receive reports that are necessary to his or her practice of midwifery and consistent with the LMs scope of practice. The bill required LMs to provide records and speak to the receiving physician if the client is transferred to a hospital. The bill also required the hospital to report each transfer of a planned out-of-hospital birth to the Board and the California Maternal Quality Care Collaborative, using a form developed by the Board. The bill required all LMs to complete midwifery education programs and does not allow new licensees to substitute clinical experience for formal didactic education beginning January 1, 2015. In addition, the bill allowed the Board, with input from the Midwifery Advisory Council, to look at the data elements required to be reported by LMs, to better coordinate with other reporting systems, including the reporting system of the Midwives Alliance of North America (MANA). Lastly, the bill allowed LMs to attend births in alternative birth centers (ABCs) and changed the standards of certification that must be met by an ABC to those established by the American Association of Birth Centers.

- *SB 304 (Lieu, Chapter 515) Healing Arts: Sunset Bill*

This was the Board's sunset bill, which included language on a portion of the new issues from the Board's 2012 Sunset Review Report, including changes to the laws pertaining to midwifery. The bill defined a "bona fide student" as an individual who is enrolled and participating in a midwifery education program or who is enrolled in a program of supervised clinical training as part of the instruction of a three-year postsecondary midwifery education program approved by the Board and allowed a certified nurse midwife to supervise a midwifery student.

2015

- *SB 408 (Morrell, Chapter 280) Midwife Assistants – Board-Sponsored*

This bill required midwife assistants to meet minimum training requirements and set forth the duties that a midwife assistant could perform, which are technical support services only. This bill allowed the Board to adopt regulations and standards for any additional midwife technical support services.

2016

- *AB 2745* (Holden, Chapter 303*) Healing Arts: Licensing and Certification*

This bill clarified the Board's authority for licensed midwives (LMs), allowed the Board to revoke or deny a license for LMs that are registered sex offenders, clarified that the Board can use probation as a disciplinary option for LMs, required LMs placed on probation to pay probationary monitoring fees, and allowed LMs to petition the Board for license reinstatement.

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Regulations

- Midwife Assistants (pending)

  B&P Code section 2516.5 was effective in 2016 and permitted LMs and certified nurse midwives to use midwife assistants in their practices. B&P code section 2516.5 sets forth some minimum requirements for midwife assistants, references standards for medical assistants established by the Board pursuant to B&P code 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 Board to establish via regulations. Additionally, subsection (b)(4) authorizes midwife assistants to "perform 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.

  The regulation hearing was held on July 29, 2016, at the Board's quarterly meeting. The final rulemaking package is being finalized for submission to the Department of Consumer Affairs and the Office of Administrative Law.

- Citations (pending)

  The Board is in the rulemaking process to amend 16 CCR sections 1364.10, 1364.11, and 1364.13 to include authority to issue citations with orders of abatement and fines to unlicensed and licensed midwives. Adding these statutes and regulations as citable offenses is necessary to provide the Board with the administrative authority to bring LMs into compliance with these sections, furthering consumer protection. A public hearing was held October 28, 2016.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2016 Medical Board Sunset Report

Section 3 – Fiscal and Staff Issues

The fees collected for the Midwifery Program go into the Licensed Midwifery Fund. When this Program began in 1994, it received a $70,000 loan from the General Fund. In order to ensure solvency, this loan was paid off over the course of the next ten years and paid in full in 2004.

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Beginning in FY 2014/15, an appropriation was established to fund the personnel needed to administer the Midwifery Program. Starting in FY 2016/17, the Board will request payment from the Midwifery Program for the staff resources to perform the licensing and enforcement functions of the Program. The Board will be analyzing the impact of this appropriation to determine if a future fee increase is necessary to ensure the solvency of this fund. There have been no General Fund loans from the Licensed Midwifery Fund.

Licensed Midwives submit an application and initial license fee of $300 and have a biennial renewal fee of $200. The renewal fee comprises about 81 percent of the fees received in the Licensed Midwifery Fund.

Table 2. Fund Condition Midwifery						
(Dollars in Thousands)	**FY 2012/13**	**FY 2013/14**	**FY 2014/15**	**FY 2015/16**	**FY 2016/17**	**FY 2017/18**
Beginning Balance [1]	185	218	254	298	328	356
Revenues and Transfers	36	39	46	46	41	41
Total Revenue	$221	$257	$300	$344	$369	$397
Budget Authority	0	0	13	13	13	13
Expenditures [2]	0	0	0	0	13	13
Loans to General Fund	0	0	0	0	0	0
Accrued Interest, Loans to General Fund	0	0	0	0	0	0
Loans Repaid From General Fund	0	0	0	0	0	0
Fund Balance	$221	$257	$300	$344	$356	$384

1 Beginning balance is the Adjusted Beginning Balance of the Fund Condition Statement which includes the prior year adjustment and fund assessment adjustments.
2 Expenditures are net of state operations, scheduled and unscheduled reimbursements, and statewide assessments.

Table 4. Fee Schedule and Revenue							
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**
LICENSED MIDWIFERY FUND							
Duplicate Cert Fee	25.00		100	100	50	75	0.17%
Application and Initial License Fee (B&P 2520 and 16 CCR 1379.5)	300.00	300.00	9,000	9,300	13,500	7,800	17.54%
Biennial Renewal Fee (B&P 2520 and 16 CCR 1379.5)	200.00	200.00	26,000	28,200	31,200	36,000	80.94%
Delinquency Fee (B&P 2520 and 16 CCR 1379.5)	50.00	50.00	200	350	700	600	1.35%

Approved Budget Change Proposals (BCP)

Licensed Midwifery Program – The Licensed Midwifery Program (Program) was housed within the Board and did not have any spending authority or any authorized positions. In FY 2014/15,

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the Board requested and received $13,000 in annual spending authority in order for the Program to reimburse the Board for services it provided.

Table 5.	Budget Change Proposals (BCPs)							
			Personnel Services				OE&E	
BCP ID #	Fiscal Year	Description of Purpose of BCP	# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1110-19	14/15	Licensed Midwifery Program - Workload request based on G.C. 13308.05	N/A	N/A	N/A	N/A	13,000	13,000

For staffing issues, refer to Full 2016 Medical Board Sunset Report.

Section 4 – Licensing Program

Application Review

16 CCR section 1379.11 requires the Board to inform an applicant for licensure as a midwife in writing within 30 days of receipt of an application as to whether the application is complete and accepted for filing or is deficient and what specific information is required. The midwifery program's goals have been to review all applications received within 30 days. The program has met these goals and is currently reviewing applications for licensure as a midwife within 30 days. The Board is currently in compliance with the mandated timeframes and is also reaching the internal goals that have been set by the program.

Due to the small number of new applications received, processing times have neither decreased nor increased significantly during the last four years. The Board has seen a slight increase in applications each year and anticipates that these numbers will continue to grow. Pending applications for the program are very small and those in a pending status are outside of the Board's control, because they are incomplete.

The tables below show the Midwifery Program licensee population, licenses issues and licenses renewed.

Table 6.	Licensee Population				
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Licensed Midwife	Active	297	313	361	365
	Out-of-State	23	21	24	24
	Out-of-Country	0	0	0	0
	Delinquent	24	35	43	40

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Table 7a.		Licensing Data by Type									
Licensed Midwife		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	31	28	0	28	unk	-	-	-	-	-
	(Renewal)	140	n/a	n/a	140	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	44	42	1	42	unk	-	-	-	-	-
	(Renewal)	152	n/a	n/a	152	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	26	29	0	29	4**	-	-	-	-	***
	(Renewal)	170	n/a	n/a	170	-	-	-	-	-	-

* Optional. List if tracked by the board.
** Data current as of 9/13/16.
*** See Table 7b below.

Table 7b.	Total Licensing Data		
Licensed Midwife	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	31	44	26
Initial License/Initial Exam Applications Approved	28	42	29
Initial License/Initial Exam Applications Closed	0	1	0
License Issued	28	42	29
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	unknown	unknown	4**
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)	-	-	44
Average Days to Application Approval (incomplete applications)*	-	-	44
Average Days to Application Approval (complete applications)*	-	-	n/a
License Renewal Data:			
License Renewed	140	152	170

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

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Verification of Application Information
Applicants are required by law to disclose truthfully all questions asked on the application for licensure. Out-of-state and out-of-country applicants must meet the same requirements as California applicants.

The application forms and license verifications (LV) are valid for one year. After one year, they must be updated to ensure that correct and current information accurately reflects any change in an applicant's credentials. The Board requires primary source verification for certification of midwifery education, examination scores, LVs, diplomas, certificates, and challenge documentation.

Two questions on the application refer to discipline by any other licensing jurisdiction for the practice of midwifery or any other healing arts license type. If an affirmative response to either of these questions is provided, the applicant must provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency must also provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline must be provided directly by the appropriate agency. Copies of pertinent investigatory and disciplinary documents must be provided to the Board directly by the appropriate authority.

One question on the application refers to convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If an affirmative response to this question is provided, the applicant must submit a detailed narrative describing the events and circumstances leading to the arrest and/or conviction. Certified copies of the police report, arrest report and all court documents must be provided directly by the issuing agency to the Board. If the records are no longer available, the issuing agency or court must provide a letter to that effect.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case-by-case basis to determine if a license should be issued or whether the applicant is eligible for licensure.

Individuals applying for a midwifery license must submit either fingerprint cards or a copy of a completed Live Scan form in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction. Criminal record history reports are obtained from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to issuing a license.

All Licensed Midwives with a current license have been fingerprinted. As fingerprinting is a requirement for licensure, a midwife's license will not be issued prior to completion of this requirement. The Board receives supplemental reports from the DOJ and FBI following the initial submittal of fingerprints should future criminal convictions occur post licensure. Supplemental reports will be reviewed by the Enforcement Program to determine if any action should be taken against the licensee.

A midwifery applicant must disclose all current and/or previous licenses held and provide a LV from each state or province to be sent directly to the Board verifying the applicant's licensure information and whether any action has been taken against the license. If the LV indicates

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action has been taken, certified documents from the state or province must be provided detailing the circumstances related to the action and the outcome.

Pursuant to B&P Code section 2512.5(a)(1), upon successful completion of the education requirements, the applicant shall successfully complete a comprehensive licensing examination adopted by the board which is equivalent, but not identical, to the examination given by the American College of Nurse Midwives. The examination for licensure as a midwife may be conducted by the Division of Licensing under a uniform examination system, and the division may contract organizations to administer the examination in order to carry out this purpose.

The comprehensive licensing examination developed by the North American Registry of Midwives' (NARM) was adopted by the Board in May 1996, and satisfies the written examination requirements as outlined in law. It is a computer-based test that requires a minimum passing score of 75. The NARM does not provide information regarding pass rates.

School Approvals

The Board approves midwifery schools by independently conducting a thorough and comprehensive assessment to evaluate the school's educational program curriculum and the program's academic and clinical preparation equivalent. Schools wishing to obtain approval by the Board must submit supporting documentation to verify that they meet the requirements of B&P Code section 2512.5(2). Currently BPPE does not provide any role in approval of midwifery schools.

Currently there are 11 approved midwifery schools. The thee-year program at each approved school has been accepted as meeting the educational requirements for a license as a midwife in California. Approval was granted based on the program meeting the requirements listed in B&P Code section 2512.5(a)(2) and 16 CCR section 1379.30. The re-assessment of approved schools is not currently mandated by law or regulation as it pertains to the midwifery program; however, the Board has begun looking into ways in which the reassessment process could be completed to ensure approved schools are maintaining compliance with B&P Code section 2512.5(a)(2).

If an international midwifery school were to apply for approval by the Board it would be required to submit the same documentation and requirements as a U.S. school. As of this date, the Board has yet to receive an application for approval of an international midwifery school.

Continuing Education/Competency Requirements

Under Article 10 of the Medical Practice Act commencing with Section 2518 of the B& P Code, the Board has adopted and administers standards for the continuing education (CE) of midwives. The Board requires each LM to document that the license holder has completed 36 hours of CE in areas that fall within the scope of the practice of midwifery as specified by the Board.

Since the last report, the transition to BreEZe in October 2013 impacted the ability to perform CE audits. Functionality necessary to automate the process and track audit information on a licensee was unavailable through the BreEZe system, which resulted in the Board's inability to

perform the CE audit. The programming was available in the BreEZe system on May 2016. In May 2016, following BreEZe improvements, Board staff once again began the process of auditing licensed midwives on a monthly basis.

Each midwife is required to certify under penalty of perjury, upon renewal, that they have met the CE requirements. 16 CCR section 1379.28 requires the Board to audit a random sample of midwives who have reported compliance with the CE requirements. The Board requires that each midwife retain records for a minimum of four years of all CE programs attended which may be needed in the event of an audit by the Board. Currently, the CE audit is performed on a monthly basis and is designed to randomly audit approximately 1% of the total number of renewing midwives per year. The process to select midwives to undergo the audit is done through an automatic batch job through the BreEZe system, based on requirements that have been programmed. If selected for the audit, proof of attendance at CE courses or programs is required to be submitted. Upon receipt of documents a manual review is performed by staff to determine compliance with the law.

If a midwife fails the audit by either not responding or failing to meet the requirements as set forth by 16 CCR section 1379.28, the midwife will be allowed to renew his or her license one time following the audit to permit them to make up any deficient CE hours. However, the Board will not renew the license a second time until all of the required hours have been documented to the Board. It is considered unprofessional conduct for any midwife to misrepresent his or her compliance with CCR section 1379.28.

Prior to the conversion to BreEZe, the Board conducted no audits in fiscal years 2012 and 2013. As mentioned previously, the functionality to perform CE audits in BreEZe was not made available until May 2016. At this time the audits are being performed on a monthly basis; however, due to the recent availability of the functionality, statistics regarding the outcomes of the audits are not currently available.

Approved CE consists of courses or programs offered by: the American College of Nurse Midwives, the Midwives Alliance of North America, a midwifery school approved by the Board, a state college or university or by a private postsecondary institution accredited by the Western Association of Schools and Colleges, a midwifery school accredited by the Midwives Education Accreditation Council, programs which qualify for Category 1 credit from the California Medical Association or the American Medical Association, the Public Health Service, the California Association of Midwives, the American College of Obstetricians and Gynecologists, and those approved by the California Board of Registered Nursing or the board of registered nursing of another state in the United States.

The Board approves the CE programs that offer the CE courses. 16 CCR section 1379.27 defines the criteria for approval of courses. The Board has not received any recent applications for CE providers or courses. The Board has previously approved several programs, as noted above.

16 CCR section 1379.27(b) requires the Board to randomly audit courses or programs submitted for credit in addition to any course or program for which a compliant is received. If an audit is made, course providers will be asked to submit documentation to the Board concerning each of the items described in section 1379.27(a) of Title 16 of the CCR.

Section 5 – Enforcement Program

The licensee population in the Midwifery Program is small and the number of disciplinary actions filed against licensees is also proportionally small with a total of three disciplinary actions being filed over the past three fiscal years. The Board utilizes its disciplinary guidelines as a model for disciplinary action imposed on midwifes.

The majority of the complaints received regarding licensed midwifes relate to the care provided during labor and delivery that resulted in an injury to the infant or mother. These complaints are considered to be the highest priority. The Board also receives complaints regarding the unlicensed practice of midwifery which are also considered "urgent" complaints. The Program's complaint prioritization policy is consistent with DCA's guidelines.

The midwifery program does not have a statute of limitation requirement in statute but recognizes public protection as its highest authority and strives to investigate each complaint as quickly as possible.

The Board has seen an increase in complaints filed against licensed midwifes in the last three fiscal years and the Board expects the complaint volume to continue to increase because of the implementation of B&P Code section 2510. B&P Code section 2510 is a mandatory report that requires hospitals to report to the Board each transfer to a hospital done by a licensed midwife of a planned out-of-hospital birth. In FY 2014/2015 the Board received 152 complaints against a LM, 138 of which were reports regarding transfers to hospitals by licensed midwives of a planned out-of-hospital birth. In FY 2015/2016, 158 complaints were received and 148 were the result of the mandated reporting. It is important to point out these specific reports because they are not a complaint of inappropriate treatment, but a mandated report received by the Board.

Table 9a, b, and c. Enforcement Statistics Licensed Midwives

	FY 2013/14	FY 2014/15	FY 2015/16
COMPLAINT			
Intake			
Received	25	*152	*158
Closed	0	0	0
Referred to INV	25	*153	*164
Average Time to Close	9 days	34 days	19 days
Pending (close of FY)	0	3	2
Source of Complaint			
Public	9	7	5
Licensee/Professional Groups	7	*139	*149
Governmental Agencies	3	2	0
Other	6	4	4
Conviction / Arrest			
CONV Received	0	0	0
CONV Closed	0	0	0

Table 9a, b, and c.	Enforcement Statistics Licensed Midwives		
	FY 2013/14	FY 2014/15	FY 2015/16
Average Time to Close	0 days	0 days	0 days
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied	0	0	0
SOIs Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0 days	0 days	0 days
ACCUSATION			
Accusations Filed	0	1	0
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	0 days	198 days	0 days
Pending (close of FY)	0	0	1
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions	0	1	0
Stipulations	0	0	1
Average Days to Complete	0 days	1131 days	674 days
AG Cases Initiated	0	1	1
AG Cases Pending (close of FY)	1	1	1
Disciplinary Outcomes			
Revocation	0	0	0
Surrender	0	0	1
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary License Issued	0	0	0
Public Reprimand	0	1	0
Other	0	0	0
PROBATION			
New Probationers	0	1	0
Probations Successfully Completed	0	0	0
Probationers (close of FY)	0	1	1
Petitions to Revoke Probation Filed	0	0	0
Probations Revoked	0	0	0
Probations Surrendered	0	0	0
Public Reprimand	0	0	0
Petition to Revoke Probation Withdrawn	0	0	0
Petition to Revoke Probation Dismissed	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probations Extended	0	0	0

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Table 9a, b, and c.	Enforcement Statistics Licensed Midwives		
	FY 2013/14	FY 2014/15	FY 2015/16
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	1	0
DIVERSION – Not Applicable			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			
INVESTIGATION			
All Investigations			
First Assigned	25	*154	*164
Closed	23	*125	*190
Average days to close	56 days	69 days	58 days
Pending (close of FY)	9	*36	*13
Desk Investigations			
Closed	28	*122	*186
Average days to close	44 days	60 days	46 days
Pending (close of FY)	3	*31	*12
Non-Sworn Investigation			
Closed	n/a	0	0
Average days to close	n/a	0 days	0 days
Pending (close of FY)	n/a	0	0
Sworn Investigation			
Closed	2	*4	*4
Average days to close	139 days	315 days	496 days
Pending (close of FY)	6	5	1
COMPLIANCE ACTION			
ISO & TRO Issued	0	0	0
PC 23 Orders Issued/Granted	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	n/a	n/a	n/a
Cease & Desist/Warning	0	0	0
Referred for Diversion	n/a	n/a	n/a
Compel Examination	0	0	0
CITATION AND FINE – Not Applicable			
Citations Issued			
Average Days to Complete			
Amount of Fines Assessed			
Reduced, Withdrawn, Dismissed			
Amount Collected			
CRIMINAL ACTION			

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Table 9a, b, and c.	Enforcement Statistics Licensed Midwives		
	FY 2013/14	FY 2014/15	FY 2015/16
Referred for Criminal Prosecution	0	0	0

Table 10.	Enforcement Aging Licensed Midwives					
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	0	0	0%
2 Years	2	0	0	1	3	60%
3 Years	1	0	0	0	1	20%
4 Years	0	0	1	0	1	20%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	3	0	1	1	5	100%
Investigations (Average %)						
Closed Within:						
90 Days	10	15	82	154	261	73%
180 Days	6	7	34	26	73	20%
1 Year	0	1	7	6	14	4%
2 Years	4	0	2	3	9	3%
3 Years	0	0	0	1	1	<1%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	20	23	*125	*190	358	100%

*These numbers include, and the increase is due to, the change in law requiring each transfer to a hospital done by a licensed midwife of a planned out-of-hospital birth to be reported to the Board. This is a mandated report that is reviewed by the Board's Enforcement Program.

Cite and Fine

The Board does not have authority to issue citations and fines or orders of abatement to LMs. The Board is in the rulemaking process to amend the regulations to include authority to issue citations and fines with orders of abatement to unlicensed individuals and LMs. A public hearing was held October 28, 2016.

Cost Recovery and Restitution

Business and Professions Code section 125.3 provides the Board with authority to collect investigation and prosecution costs of midwifery cases. Based on the Cost Recovery figures in Table 11, for FY 12/13 through FY 15/16 $19,000 administrative cost recovery was ordered.

The Board does not seek restitution for consumers. Restitution is ordered by the criminal courts.

Fiscal Year	FY 13/14	FY 14/15	FY 15/16
Criminal Cost Recovery Ordered	$10,500	$0	$0
Criminal Cost Recovery Received	$17,256	$0	$0

Table 11. Cost Recovery (list dollars) in thousands)				
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Total Enforcement Expenditures	$0	$0	$0	$0
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	0	2	0
Amount of Cost Recovery Ordered	$0	$0	$8,500	$0
Amount Collected	$12,265	$1,600	$7,700	$1,550

* "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	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2016 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2016 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2016 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2016 Medical Board Sunset Report

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Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2016 Medical Board Sunset Report

Section 11 – New Issues

None

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Part III

Polysomnographic Program

- Background and Description of Polysomnographic Program
- Licensing Program
- Enforcement Program

Section 1 – Background and Description of Polysomnographic Program

History and Functions of the Polysomnographic Program

Polysomnography is the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. Polysomnography includes, but is not limited to, the process of analysis, monitoring, and recording of physiologic data during sleep and wakefulness to assist in the treatment of disorders, syndromes, and dysfunctions that are sleep-related, manifest during sleep, or disrupt normal sleep activities.

The Legislature enacted the regulation of the Polysomnographic Program (Program), under the jurisdiction of the Board in 2009. This Program registers individuals that are involved in the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders. The Board promulgated regulations to implement the program. The Polysomnography Practice regulations were filed in January 2012 and became operative in February 2012. In April 2012, the Board began accepting applications for the Polysomnographic Program. The Polysomnographic Program registers individuals as polysomnographic trainees, technicians or technologists.

The polysomnographic trainee registration is required for individuals under the direct supervision of a supervising physician, polysomnographic technologist or other licensed health care professionals who provide basic supportive services as part of their education program, including, but not limited to, gathering and verifying patient information, testing preparation and monitoring, documenting routine observations, data acquisition and scoring, and assisting with appropriate interventions for patient safety in California. In order to qualify as a polysomnographic trainee, one must have either a high school diploma or GED and have completed at least six months of supervised direct polysomnographic patient care experience, or be enrolled in a polysomnographic education program approved by the Board. Applicants must also possess at the time of application a current certificate in basic life support issued by the American Heart Association.

The polysomnographic technician registration is required for individuals who may perform the services equivalent to that of a polysomnographic trainee under general supervision *and* may implement appropriate interventions necessary for patient safety in California. In order to qualify for a polysomnographic technician registration, an individual must meet the initial requirements for a polysomnographic trainee *and* have at least six months experience at a level of polysomnographic trainee.

The polysomnographic technologist registration is required for individuals who under the supervision of a physician, are responsible for the treatment, management, diagnostic testing, control, education, and care of patients with sleep and wake disorders in California. Registrants are required to have a valid, current credential as a polysomnographic technologist issued by the Board of Registered Polysomnographic Technologists; graduated from a polysomnographic educational program that has been approved by the Board; and taken and passed the Board of Registered Polysomnographic Technologist examination given by the Board of Registered Polysomnographic Technologists.

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Initially, the Program received an influx of applications. During the first two years, there was a steady increase in the number of applications received. Since that time, the number of applications received has leveled off and has maintained a consistent volume.

Major Legislation/Regulations Since the Last Sunset Review

Legislation

2015

- *SB 800 (Sen. B&P Comm., Chapter 426) Omnibus – Board Co-Sponsored*

The Board's omnibus language included a clarification that registration is required to practice as a polysomnographic technologist, technician, or trainee in California.

2016

- *AB 2745* (Holden, Chapter 303*) Healing Arts: Licensing and Certification*

This bill clarified the Board's authority for polysomnographic technologists, technicians, and trainees; specified that the Board can use probation as a disciplinary option for polysomnographic registrants; and required registrants placed on probation to pay probationary monitoring fees. In addition, it allowed the Board to take disciplinary action for excessive use of drugs or alcohol, allowed the Board to revoke or deny a license for polysomnographic registrants that are registered sex offenders, and allowed former registrants to petition the Board for reinstatement.

Regulations

- Basic Life Support: Polysomnography Program (effective June 18, 2013)

A petition to amend the Board's the Polysomnography Program regulations was filed by the American Health and Safety Institute with the Board in May 2012, and was heard in July 2012, at the Board's quarterly meeting. The Board granted the petition and moved forward to remove the requirement that basic life support certification only be provided by the American Heart Association, and would instead require an applicant to possess at the time of application a current certificate in basic life support issued by the American Heart Association or the American Health and Safety Institute.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2016 Medical Board Sunset Report

Section 3 – Fiscal and Staff

Refer to Full 2016 Medical Board Sunset Report

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Section 4 – Licensing Program

Application Review

Current law does not define the required time to review an initial application for the Polysomnography Program; however, the Board has set an internal expectation that all new applicants will be notified in writing within 30 days of receipt of an application as to whether the application is complete and accepted for filing or is deficient and what specific information is required. This applies to all registration types under the polysomnography program, including applications for Polysomnographic Trainee, Polysomnographic Technician, and Polysomnographic Technologist. The Board is currently meeting this expectation and is reviewing applications within 30 days.

The polysomnography application volume remains consistent with previous years. Average time to process a polysomnography application has remained fairly constant, within 30 days. Pending applications for the program are very small and those in a pending status are outside of the Board's control.

The tables below show the Polysomnographic Program data.

Table 6. Registration Population

		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Polysomnographic Trainee	Active	9	30	45	60
	Out-of-State	unknown	unknown	unknown	0*
	Out-of-Country	unknown	unknown	unknown	0*
	Delinquent	unknown	unknown	5**	6
Polysomnographic Technician	Active	40	78	78	79
	Out-of-State	unknown	unknown	unknown	3*
	Out-of-Country	unknown	unknown	unknown	0*
	Delinquent	unknown	unknown	16**	25
Polysomnographic Technologist	Active	329	554	512	572
	Out-of-State	unknown	unknown	unknown	24*
	Out-of-Country	unknown	unknown	unknown	0*
	Delinquent	unknown	unknown	84**	81

* Data current as of 9/13/16.
** Data current as of 9/16/15.

Table 7a. Registration Data by Type

Polysomnographic Trainee		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	26	19	0	19	unk	-	-	-	-	-
	(Renewal)	0	n/a	n/a	0	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	31	25	0	25	unk	-	-	-	-	-
	(Renewal)	7	n/a	n/a	7	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	27	25	0	25	30**	-	-	-	-	***
	(Renewal)	10	n/a	n/a	10	-	-	-	-	-	-

Polysomnographic Technician		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	72	35	0	35	unk	-	-	-	-	-
	(Renewal)	0	n/a	n/a	0	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	18	19	0	19	unk	-	-	-	-	-
	(Renewal)	28	n/a	n/a	28	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	17	17	0	17	42**	-	-	-	-	***
	(Renewal)	28	n/a	n/a	28	-	-	-	-	-	-

Polysomnographic Technologist		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	143	114	0	114	unk	-	-	-	-	-
	(Renewal)	0	n/a	n/a	0	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	48	46	1	46	unk	-	-	-	-	-
	(Renewal)	383	n/a	n/a	383	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	58	44	0	44	100**	-	-	-	-	***
	(Renewal)	110	n/a	n/a	110	-	-	-	-	-	-

* Optional. List if tracked by the board.
** Data current as of 9/13/16.
*** See Table 7b below.

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Table 7b. Total Registration Data			
Polysomnography Program	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	241	97	102
Initial License/Initial Exam Applications Approved	168	90	86
Initial License/Initial Exam Applications Closed	0	1	0
License Issued	168	90	86
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	unknown	unknown	172**
Pending Applications (outside of board control)*	-	-	-
Pending Applications (within the board control)*	-	-	-
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Polysomnographic Trainee			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	105
Average Days to Application Approval (incomplete applications)*	-	-	105
Average Days to Application Approval (complete applications)*	-	-	n/a
Polysomnographic Technician			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	80
Average Days to Application Approval (incomplete applications)*	-	-	80
Average Days to Application Approval (complete applications)*	-	-	n/a
Polysomnographic Technologist			
Average Days to Application Approval (All - Complete/Incomplete)	-	-	78
Average Days to Application Approval (incomplete applications)*	-	-	79
Average Days to Application Approval (complete applications)*	-	-	28
License Renewal Data:			
License Renewed	0	418	148

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

Verification of Application Information

Polysomnographic applicants are required by law to disclose truthfully all questions asked on the application for registration. Out-of-state and out-of-country applicants must meet the same requirements as California applicants. The application forms and Licensing Verification (LV) are valid for one year. After one year, they must be updated to ensure that correct and current information accurately reflects any change in an applicant's qualifications. The Board requires primary source verification for proof of enrollment, diploma and transcripts from Board approved polysomnographic education programs, examination scores, LV, certification of Basic Life Support, and the Verification of Experience form.

A question on the application refers to any licenses/registrations that have been held by the applicant to practice polysomnography or other healing arts in another state or country. The applicant must disclose all current and/or previous licenses/registrations held and provide an LV from each state or province to be sent directly to the Board verifying the applicant's licensure information and whether any action has been taken against the license. If the LV indicates action has been taken, certified documents from the state or province must be provided detailing the circumstances related to the action and the outcome.

Two questions on the application refer to discipline by any other licensing/registering jurisdiction for the practice of polysomnography or any other healing arts license type. If an affirmative response to either of these questions is provided, the applicant must provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency must also provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline must be provided directly to the Board by the appropriate agency. Copies of pertinent investigatory and disciplinary documents must be provided directly to the Board by the appropriate authority.

One question on the application refers to convictions, including those that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If an affirmative response to this question is provided, the applicant must submit a detailed narrative describing the events and circumstances leading to the arrest and/or conviction. Certified copies of the police report, arrest report and all court documents must be provided directly by the issuing agency to the Board. If the records are no longer available, the issuing agency or court must provide a letter to that effect.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case-by-case basis to determine if a registration should be issued or whether the applicant is eligible for registration.

All applicants applying for a polysomnographic registration must submit either fingerprint cards or a copy of a completed Live Scan form in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction. Criminal record history reports are obtained from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to issuing a license.

The Board receives supplemental reports from the DOJ and FBI following the initial submittal of fingerprints should future criminal convictions occur post licensure. Supplemental reports will be reviewed by the Enforcement program to determine if any action should be taken against the registrant.

An examination is not required for the trainee or technician registration types; however, the polysomnographic technologist registration requires an applicant to have taken and passed a national examination (Registered Polysomnographic Technologist Exam) administered by the Board of Registered Polysomnographic Technologist. This is the only examination approved by the Board for purposes of qualifying for registration pursuant to Chapter 7.8 of Division 2 of the B&P Code. This is a computer based test that requires a minimum passing score of 350.

Section 5 – Enforcement Program

Since the Board's last Sunset Report of 2012, the Board has received 25 complaints against a polysomnographic trainee, technician, or technologist during the last three fiscal years and only one complaint investigation led to the Board filing an accusation for formal disciplinary action.

The Board has not seen a significant increase in the number of complaints received during the last three fiscal years and the average number of complaints from FYs 12/13 through 15/16 is eight.

The Polysomnographic Program does not have any mandatory reporting.

Below are several tables that provide enforcement statistics regarding polysomnographic complaints.

Table 9a, b, and c. Enforcement Statistics Polysomnography Program

	FY 2013/14	FY 2014/15	FY 2015/16
COMPLAINT			
Intake			
Received	4	11	10
Closed	0	0	0
Referred to INV	4	11	10
Average Time to Close	11 days	10 days	33 days
Pending (close of FY)	0	0	0
Source of Complaint			
Public	1	5	1
Licensee/Professional Groups	1	0	1
Governmental Agencies	1	4	5
Other	1	2	3
Conviction / Arrest			
CONV Received	3	3	1
CONV Closed	0	0	0
Average Time to Close	51 days	12 days	9 days
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied	0	0	0
SOIs Filed	0	0	2
SOIs Withdrawn	0	0	1
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0	0	157
ACCUSATION			
Accusations Filed	0	0	1

Table 9a, b, and c. Enforcement Statistics Polysomnography Program			
	FY 2013/14	FY 2014/15	FY 2015/16
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	0 days	0 days	360 days
Pending (close of FY)	0	1	0
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions	0	0	0
Stipulations	0	0	0
Average Days to Complete	0 days	0 days	0 days
AG Cases Initiated	0	1	3
AG Cases Pending (close of FY)	0	1	4
Disciplinary Outcomes			
Revocation	0	0	0
Voluntary Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary License Issued	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	0
Probations Successfully Completed	0	0	0
Probationers (close of FY)	0	0	0
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probations Extended	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0
DIVERSION – Not Applicable			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			
INVESTIGATION			
All Investigations			
First Assigned	7	16	11
Closed	4	13	10

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Table 9a, b, and c. Enforcement Statistics Polysomnography Program			
	FY 2013/14	FY 2014/15	FY 2015/16
Average days to close	93 days	153 days	138 days
Pending (close of FY)	3	5	7
Desk Investigations			
Closed	5	12	13
Average days to close	46 days	42 days	112 days
Pending (close of FY)	2	4	4
Non-Sworn Investigation			
Closed	n/a	2	2
Average days to close	n/a	149 days	89 days
Pending (close of FY)	n/a	1	0
Sworn Investigation			
Closed	4	3	2
Average days to close	108 days	244 days	95 days
Pending (close of FY)	1	0	3
COMPLIANCE ACTION			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	0	0	0
Referred for Diversion	0	0	0
Compel Examination	0	0	0
CITATION AND FINE			
Citations Issued	0	0	0
Average Days to Complete	0	0	0
Amount of Fines Assessed	0	0	0
Reduced, Withdrawn, Dismissed	0	0	0
Amount Collected	0	0	0
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

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Table 10. Enforcement Aging Polysomnography Program						
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	0	0	0%
2 Years	0	0	0	0	0	0%
3 Years	0	0	0	0	0	0%
4 Years	0	0	0	0	0	0%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	0	0	0	0	0	0%
Investigations (Average %)						
Closed Within:						
90 Days	0	3	6	5	14	52%
180 Days	0	0	1	3	4	15%
1 Year	0	1	6	1	8	30%
2 Years	0	0	0	1	1	3%
3 Years	0	0	0	0	0	0%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	0	4	13	10	27	100%

The Board does not have authority to issue citations and fines or orders of abatement to polysomnographic trainees, technicians or technologists. The Board is in the rulemaking process to amend the regulations to include authority to issue citations and fines with orders of abatement to unlicensed and registered polysomnographic trainees, technicians or technologists. A public hearing was held October 28, 2016.

The Polysomnographic Program has the ability to order cost recovery and restitution, however no cases have resulted in discipline and therefore no cost recovery or restitution have been ordered.

Table 11. Cost Recovery (list dollars in thousands)				
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Total Enforcement Expenditures	$0	$0	$0	$0
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

* "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	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2016 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2016 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2016 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2016 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

None

Section 11 – New Issues

None

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Part IV

Research Psychoanalyst

- Background and Description of Research Psychoanalyst Program
- Licensing Program
- Enforcement Program

Section 1 – Background and Description of Research Psychoanalyst

History and Functions of the Research Psychoanalyst Program

The Legislature enacted the regulation of research psychoanalysts (RP) under the jurisdiction of the Medical Board of California (Board) in 1977. A registered RP is an individual who has graduated from an approved psychoanalytic institution and is registered with the Board. Additionally, students, who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a Student RP, may engage in psychoanalysis under supervision.

Sections 2529 and 2529.5 of the Business and Professions (B&P) Code authorizes individuals who have graduated from an approved psychoanalytic institute to engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts. It also requires that they register with the Board. Students who are enrolled in an approved institute may engage in psychoanalysis under supervision and must also register with the Board. A doctorate degree, or its equivalent, and graduation from a psychoanalytic institution approved by the Board are required prior to registration.

An RP may engage in psychoanalysis as an adjunct to teaching, training or research. "Adjunct" means that the RP may not render psychoanalytic services on a fee-for-service basis for more than an average of one-third of his or her total professional time, including time spent in practice, teaching, training or research. Such teaching, training or research shall be the primary activity of the RP. This primary activity may be demonstrated by:

1. A full-time faculty appointment at the University of California, a state university or college, or an accredited or approved educational institution as defined in section 94310 (a) and (b), of the Education Code;
2. Significant ongoing responsibility for teaching or training as demonstrated by the amount of time devoted to such teaching or training or the number of students trained; or
3. A significant research effort demonstrated by publications in professional journals or publication of books.

Students and graduates are not entitled to state or imply that they are licensed to practice psychology, nor may they hold themselves out by any title or description of services incorporating the words: psychological, psychologist, psychology, psychometrists, psychometrics or psychometry.

Major Legislation/Regulations Since the Last Sunset Review

2016

- *AB 2745* (Holden, Chapter 303*) Healing Arts: Licensing and Certification*

This bill clarified the Board's authority for RPs, allowed the Board to take disciplinary action for excessive use of drugs or alcohol, and allowed the Board to revoke or deny a license for RPs that are registered sex offenders.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2016 Medical Board Sunset Report

Section 3 – Fiscal and Staff

Refer to Full 2016 Medical Board Sunset Report

Section 4 – Licensing Program

Application Review

16 CCR section 1367.4 requires that the Board informs an applicant for registration as a RP in writing within 11 days of receipt of the initial application form whether the application is complete and accepted for filing or is deficient and what specific information is required. The Board is in compliance with this mandated timeframe.

Due to the small number of new applications received, processing times have neither decreased nor increased significantly during the last four years. Pending applications for the program are very small and those in a pending status are outside of the Board's control, because they are incomplete.

The tables below show the RP registration population, registrations issued, and registrations renewed.

Table 6.	**Registration Population**				
		FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Research Psychoanalyst	Active	91	76	89	82
	Out-of-State	6	4	6	3
	Out-of-Country	2	2	2	2
	Delinquent	31	42	14	25

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Table 7a. Registration Data by Type											
Research Psychoanalyst		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)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5	3	0	3	unk	-	-	-	-	-
	(Renewal)	70	n/a	n/a	70	-	-	-	-	-	-
FY 2014/15	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5	7	1	7	unk	-	-	-	-	-
	(Renewal)	12	n/a	n/a	12	-	-	-	-	-	-
FY 2015/16	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	4	6	0	6	1**	-	-	-	-	***
	(Renewal)	78	n/a	n/a	78	-	-	-	-	-	-

* Optional. List if tracked by the board.
** Data current as of 9/13/16.
*** See Table 7b below.

Table 7b. Total Registration Data	FY 2013/14	FY 2014/15	FY 2015/16
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	5	5	4
Initial License/Initial Exam Applications Approved	3	7	6
Initial License/Initial Exam Applications Closed	0	1	0
License Issued	3	7	6
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	unknown	unknown	1**
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)	-	-	84
Average Days to Application Approval (incomplete applications)*	-	-	84
Average Days to Application Approval (complete applications)*	-	-	n/a
License Renewal Data:			
License Renewed	70	12	78

* Optional. List if tracked by the board.
** Data current as of 9/13/16.

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Verification of Application Information
RP applicants are required by law to truthfully disclose all questions asked on the application for licensure. The application is valid for one year. After one year, an application must be updated to ensure that correct and current information accurately reflects any change in an applicant's qualifications. Out-of-state and out-of-country applicants must meet the same requirements as California applicants.

An examination is not required prior to registration as an RP. Qualification for registration is based on educational requirements and training. An RP applicant must disclose on the application 1) the names and locations of all schools where professional instruction was received; and 2) the name and location of the school where psychoanalytic training was received. To verify this information, the applicant must request 1) an official transcript verifying that a doctorate degree, or its equivalent, has been granted; and 2) an official certification from the dean verifying the student's current status. The Board requires primary source verification and requires the schools to send these documents directly to the Board for review.

Currently, the RP application includes two questions that refer to criminal action and convictions, including those convictions that may have been deferred, set aside, dismissed, expunged or issued a stay of execution. If an affirmative response to these questions is provided, the applicant must submit a detailed narrative describing the events and circumstances leading to the arrest and/or conviction. Certified copies of the police report, arrest report and all court documents must be provided directly by the issuing agency to the Board. If the records are no longer available, the issuing agency or court must provide a letter.

Further, the RP application includes three questions that refer to discipline by any other licensing jurisdiction or governmental agency for any professional license/registration. If an affirmative response to any of these questions is provided, the applicant must provide a detailed narrative of the events and circumstances leading to the action(s). The involved institution or agency must also provide a detailed summary of the events and circumstances leading to any action. Certified copies of all orders of discipline must be provided directly by the appropriate agency. Copies of pertinent investigatory and disciplinary documents must be provided to the Board directly by the appropriate authority.

All reports of criminal history, prior disciplinary actions, or other unlawful acts of the applicant are reviewed on a case by case basis to determine if a registration should be issued or whether the applicant is eligible for registration.

All applicants applying for an RP registration must submit either fingerprint cards or a copy of a completed Live Scan form in order to establish the identity of the applicant and in order to determine whether the applicant has a record of any criminal convictions in this state or in any other jurisdiction. Criminal record history reports are obtained from both the Department of Justice (DOJ) and the Federal Bureau of Investigation (FBI) prior to the Board issuing a registration.

All RPs with a current registration have been fingerprinted. As fingerprinting is a requirement for registration, an RP registration will not be issued prior to completion of this requirement. The Board receives subsequent arrest reports from the DOJ and FBI following the initial

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submittal of fingerprints. These supplemental reports are reviewed by the Board's Enforcement Program to determine if any action should be taken against the registrant.

School Approvals

16 CCR section 1374 defines the requirements for a psychoanalytic institute to be deemed acceptable. The Board is tasked with determining, based on documentation submitted by the institute, whether or not it meets the mandated requirements. The Bureau for Private Postsecondary Education does not play a role in determining the qualifications of a psychoanalytic institute for approval.

The Board has approved 19 research psychoanalytic institutions. These institutions have met the requirements for psychoanalytical training as defined in B&P Code section 2529. B&P Code section 2529 also states that education received at an institute deemed equivalent to one of the approved institutions would be acceptable. In order to be deemed an equivalent psychoanalytic institute, such an institute, department or program would have to meet the requirements as outlined in 16 CCR section 1374. Current law does not define the timeframe required for reviewing psychoanalytical institutes. International psychoanalytical institutes are required to submit the same documentation and meet the same requirements as a U.S. institute.

Section 5 – Enforcement Program

Since the Board's last Sunset Report of 2012, the Board has received 3 complaints against RPs, however no disciplinary actions have been filed or taken against registered RPs.

The complaints received by the Board do not relate to the care and treatment being provided and instead relate to billing practices or other issues outside the jurisdiction of the Board. The RP Program utilizes the physician's disciplinary guidelines as a model for any disciplinary actions that would be imposed on registrants.

The complaint prioritization policy for handling complaints filed against research psychoanalysts is consistent with DCA's guidelines. Currently, there are no mandatory reporting requirements for registered RPs.

The Research Psychoanalyst Program does not have a statute of limitations established in statute. The Board recognizes public protection as its highest priority and therefore strives to investigate each complaint as quickly as possible.

This registration category is extremely limited and only applies to students and graduates engaging in psychoanalysis services at specific psychoanalytic institutes. There are not any known cases of unlicensed practice. However, should such a complaint be received, the Board would use it's investigative resources to pursue and prosecute, if appropriate, individuals providing psychoanalysis services without the proper registration.

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Below are several tables that provide Enforcement statistics regarding RPs.

Table 9a, b, and c. Enforcement Statistics Research Psychoanalyst	FY 2013/14	FY 2014/15	FY 2015/16
COMPLAINT			
Intake			
Received	2	0	1
Closed	0	0	0
Referred to INV	2	0	1
Average Time to Close	3 days	0 days	20 days
Pending (close of FY)	0	0	0
Source of Complaint			
Public	1	0	1
Licensee/Professional Groups	1	0	0
Governmental Agencies	0	0	0
Other	0	0	0
Conviction / Arrest			
CONV Received	1	1	1
CONV Closed	1	1	1
Average Time to Close	9 days	11 days	12 days
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL			
License Applications Denied	0	0	0
SOIs Filed	0	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI	0 days	0 days	0 days
ACCUSATION			
Accusations Filed	0	0	0
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations	0 days	0 days	0 days
Pending (close of FY)	0	0	0
DISCIPLINE			
Disciplinary Actions			
Proposed/Default Decisions	0	0	0
Stipulations	0	0	0
Average Days to Complete	0 days	0 days	0 days
AG Cases Initiated	0	0	0
AG Cases Pending (close of FY)	0	0	0
Disciplinary Outcomes			
Revocation	0	0	0
Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0

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Table 9a, b, and c.	Enforcement Statistics Research Psychoanalyst		
	FY 2013/14	FY 2014/15	FY 2015/16
Probation	0	0	0
Probationary License Issued	0	0	0
Public Reprimand	0	0	0
Other	0	0	0
PROBATION			
New Probationers	0	0	0
Probations Successfully Completed	0	0	0
Probationers (close of FY)	0	0	0
Petitions to Revoke Probation Filed	0	0	0
Public Reprimand	0	0	0
Petitions to Revoke Probation Withdrawn	0	0	0
Petitions to Revoke Probation Dismissed	0	0	0
Probations Revoked	0	0	0
Probations Modified	0	0	0
Probations Terminated	0	0	0
Probations Extended	0	0	0
Probationers Subject to Drug Testing	0	0	0
Drug Tests Ordered	0	0	0
Positive Drug Tests	0	0	0
Petition for Reinstatement Granted	0	0	0
DIVERSION – Not Applicable			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			
INVESTIGATION			
All Investigations			
First Assigned	2	1	2
Closed	0	2	1
Average days to close	0 days	134 days	960 days
Pending (close of FY)	2	1	2
Desk Investigations			
Closed	2	1	2
Average days to close	56 days	1 days	2 days
Pending (close of FY)	0	0	1
Non-Sworn Investigation			
Closed	n/a	2	1
Average days to close	n/a	120 days	275 days
Pending (close of FY)	n/a	0	0
Sworn Investigation			
Closed	0	0	1
Average days to close	0 days	0 days	672 days

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Table 9a, b, and c. Enforcement Statistics Research Psychoanalyst			
	FY 2013/14	FY 2014/15	FY 2015/16
Pending (close of FY)	2	1	1
COMPLIANCE ACTION			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	0
Other Suspension Orders	0	0	0
Public Letter of Reprimand	n/a	n/a	n/a
Cease & Desist/Warning	0	0	0
Referred for Diversion	n/a	n/a	n/a
Compel Examination	0	0	0
CITATION AND FINE			
Citations Issued	0	0	0
Average Days to Complete	0	0	0
Amount of Fines Assessed	0	0	0
Reduced, Withdrawn, Dismissed	0	0	0
Amount Collected	0	0	0
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	0	0

Table 10. Enforcement Aging Research Psychoanalyst						
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	0	0	0	0	0	n/a
2 Years	0	0	0	0	0	n/a
3 Years	0	0	0	0	0	n/a
4 Years	0	0	0	0	0	n/a
Over 4 Years	0	0	0	0	0	n/a
Total Cases Closed	0	0	0	0	0	n/a
Investigations (Average %)						
Closed Within:						
90 Days	0	0	0	0	0	0%
180 Days	0	0	1	0	1	25%
1 Year	1	0	1	0	2	50%
2 Years	0	0	0	0	0	0%
3 Years	0	0	0	1	1	25%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	1	0	2	1	4	100%

Citation and Fine

The RP Program has not utilized its citation and fine authority primarily because there are no technical violations that would be appropriate to resolve through the administrative remedy.

Cost Recovery and Restitution

The RP Program has the ability to order cost recovery and restitution, however no cases have resulted in discipline and therefore no cost recovery or restitution have been ordered.

Table 11.	**Cost Recovery**			**(list dollars in thousands)**
	FY 2012/13	FY 2013/14	FY 2014/15	FY 2015/16
Total Enforcement Expenditures	$0	$0	$0	$0
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

* "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	$0	$0	$0	$0
Amount Collected	$0	$0	$0	$0

Section 6 – Public Information Policies

Refer to Full 2016 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2016 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2016 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2016 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

None

Section 11 – New Issues

None

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Section 12

Attachments

- Attachment A – Board Member Administrative Procedure Manual
- Attachment B – Current Organizational Chart Showing Relationship of Committees to the Board and Membership of Each Committee
- Attachment C – Major Studies and Publications
- Attachment D – Year-End Organizational Charts
- Attachment E – Sunset Report Form with Questions
- Attachment F – Board Member Attendance
- Attachment G – Board Member Committee Roster
- Attachment H – B&P Code Section and CCR Section for Application Review and Special Programs Committee
- Attachment I – B&P Code Section for Special Faculty Permit Review Committee
- Attachment J – B&P Code Section for Midwifery Advisory Council
- Attachment K – B&P Code Section for Panel A/B
- Attachment L – Strategic Plan
- Attachment M – Performance Measures
- Attachment N – Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs
- Attachment O – Consumer Satisfaction Survey Conducted by the Medical Board
- Attachment P – DCA BreEZe Funding Chart
- Attachment Q – Revenue and Fee Schedule
- Attachment R – Budget Change Proposals

Attachment A

Board Member Administrative Procedure Manual

State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA

Board Member Administrative Procedure Manual

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Revised 4/13

Chapter 1. Introduction

Overview

The Medical Board of California (MBC) was created by the California Legislature in 1876. Today the MBC is one of the boards, bureaus, commissions, and committees within the Department of Consumer Affairs (DCA), part of the State and Consumer Services Agency under the aegis of the Governor. The Department is responsible for consumer protection and representation through the regulation of certain licensed professions and the provision of consumer services. While the DCA provides oversight in various areas including, but not limited to, budget change proposals, regulations, and contracts, and also provides support services, MBC has policy autonomy and sets its own policies procedures, and initiates its own regulations. (See Business and Professions Code sections 108, 109(a), and 2018.)

The MBC is presently comprised of 15 Members. By law, seven are public Members, and eight are physicians. The Senate Rules Committee and the Speaker of the Assembly each appoint one public member. Board Members may serve two full four-year terms. Board Members fill non-salaried positions, and are paid $100 per day for each day worked and are reimbursed travel expenses.

This procedure manual is provided to Board Members as a ready reference of important laws, regulations, and Board policies, to guide the actions of Board Members and ensure Board effectiveness and efficiency.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by law.

Definitions

B&P	Business and Professions Code
SAM	State Administrative Manual
President	Where the term “President” is used in this manual, it includes “his or her designee”

General Rules of Conduct

Board Members shall not speak to interested parties (such as vendors, lobbyists, legislators, or other governmental entities) on behalf of the Board or act for the Board without proper authorization.

Board Members shall maintain the confidentiality of confidential documents and information.

Board Members shall commit time, actively participate in Board activities, and prepare for Board meetings, which includes reading Board packets and all required legal documents.

Board Members shall respect and recognize the equal role and responsibilities of all Board Members, whether public or licensee.

Board Members shall act fairly and in a nonpartisan, impartial, and unbiased manner.

Board Members shall treat all applicants and licensees in a fair and impartial manner.

Board Members' actions shall uphold the Board's primary mission – protection of the public.

Board Members shall not use their positions on the Board for political, personal, familial, or financial gain.

Chapter 2. Board Meeting Procedures

Frequency of Meetings
(B&P Code sections 2013, 2014)

The Board shall meet at least once each calendar quarter in various parts of the state for the purpose of transacting such business as may properly come before it.

Special meetings of the Board may be held at such times as the Board deems necessary.

Four Members of a panel of the Board shall constitute a quorum for the transaction of business at any meeting of the panel.

Eight Members shall constitute a quorum for the transaction of business at any Board meeting.

Due notice of each meeting and the time and place thereof shall be given each member in the manner provided by the law.

Board Member Attendance at Board Meetings
(B&P Code sections 106, 2011)

Board Members shall attend each meeting of the Board. If a member is unable to attend, he or she must contact the Board President and ask to be excused from the meeting for a specific reason. The Governor has the power to remove from office any member appointed by him for continued neglect of duties, which may include unexcused absences from meetings.

Board Members shall attend the entire meeting and allow sufficient time to conduct all Board business at each meeting.

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

Meetings are subject to all provisions of the Bagley-Keene Open Meetings Act. This act governs meetings of state regulatory boards and meetings of committees of those boards where the committee consists of more than two Members. It specifies meeting notice and agenda requirements and prohibits discussing or taking action on matters not included on the agenda.

If the agenda contains matters that are appropriate for closed session, the agenda must cite the particular statutory section and subdivision authorizing the closed session.

Quorum
(B&P Code section 2013)

Eight of the Members of the Board constitute a quorum of the Board for the transaction of business. The concurrence of a majority of those Members of the Board present and voting at a duly noticed meeting at which a quorum is present shall be necessary to constitute an act or decision of the Board.

Agenda Items
(Board Policy)

Any Board Member may submit items for a meeting agenda to the Executive Director not fewer than 30 days prior to the meeting with the approval of the Board President or Chair of the Committee.

Notice of Meetings
(Government Code section 11120 et seq.)

In accordance with the Open Meetings Act, meeting notices (including agendas for Board, Committee, or Panel meetings) shall be sent to persons on the Board's mailing list at least 10 calendar days in advance. The notice shall include the name, work address, and work telephone number of a staff person who can provide further information prior to the meeting.

Notice of Meetings to be Posted on the Internet
(Government Code section 11125 et seq.)

Notice shall be given and also made available on the Internet at least 10 days in advance of the meeting and shall include the name, address, and telephone number of any person who can provide further information prior to the meeting, but need not include a list of witnesses expected to appear at the meeting. The written notice shall additionally include the address of the Internet site where notices required by this article are made available.

Record of Meetings
(B&P Code section 2017)

The Board and each Committee or Panel shall keep an official record of all their proceedings. The minutes are a summary, not a transcript, of each Board or Committee meeting. They shall be prepared by staff and submitted to Members for review before the next meeting. Minutes shall be approved at the next scheduled meeting of the Board, Committee, or Panel. When approved, the minutes shall serve as the official record of the meeting.

Tape Recording/Web Casting
(Board Policy)

The meeting may be tape-recorded if determined necessary for staff purposes. Tape recordings will be disposed of upon approval of the minutes in accordance with record retention schedules. The meeting will be Web cast, as DCA staff is available, including the Committees of the Board. The Web cast will be posted on the Board's Web site within two weeks and kept for 10 years or more.

Meeting Rules
(Board Policy)

The Board will use Robert's Rules of Order, to the extent that it does not conflict with state law (e.g. Bagley-Keene Open Meeting Act), as a guide when conducting its meetings.

Public Comment
(Board Policy)

Due to the need for the Board to maintain fairness and neutrality when performing their adjudicative function, the Board shall not receive any substantive information from a member of the public regarding any matter that is currently under or subject to investigation or involves a pending criminal or administrative action.

1. If, during a Board meeting, a person attempts to provide the Board with substantive information regarding matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the person shall be advised that the Board cannot properly consider or hear such substantive information, and the person shall be instructed to refrain from making such comments.

2. If, during a Board meeting, a person wishes to address the Board concerning alleged errors of procedure or protocol or staff misconduct, involving matters that are currently under or subject to investigation or involve a pending administrative or criminal action, the Board will address the matter as follows:

    a. Where the allegation involves errors of procedure or protocol, the Board may designate either its Executive Director or a Board employee to review whether the proper procedure or protocol was followed and to report back to the Board.
    b. Where the allegation involves significant staff misconduct, the Board may designate one of its Members to review the allegation and to report back to the Board.

3. The Board may deny a person the right to address the Board and have the person removed if such person becomes disruptive at the Board meeting.

(Government Code section 11120 et seq.)

4. Persons wishing to address the Board or a Committee of the Board shall be requested to complete a speaker request slip in order to have an appropriate record of the speaker for the minutes. At the discretion of the Board President or Chair of the Committee, speakers may be limited in the amount of time to present to give adequate time to everyone who wants to speak. In the event the number of people wishing to address the Board exceeds the allotted time, the Board President or Chair of the Committee may limit each speaker to a statement of his/her name, organization, and whether they support or do not support the proposed action

Written Comment
(Board Policy)

Prior to a Board meeting, an individual or group may submit materials related to a meeting agenda item to the Executive Director and request that the material be provided to the Board or Committee Members. Upon receipt of such a request, the Executive Director will verify that the materials are related to an open session agenda item (no materials will be distributed regarding complaints, investigations, contested cases, litigation, or other matters that may be properly discussed in closed session) and then forward the materials to the Board or Committee Members. When forwarding the applicable materials

to the Board members, the Executive Director may include information regarding existing law, regulation, or past Board action relevant to the issue presented. The written communication must be provided at least four business days prior to the meeting in order to ensure delivery to the Board Members.

NOTE: This section is not applicable to a formal regulatory hearing.

Chapter 3. Travel & Salary Policies & Procedures

Travel Approval
(DCA Memorandum 96-01)

The Board President's approval is required for all Board Members for travel, except for travel to regularly scheduled Board and Committee meetings to which the Board Member is assigned.

Travel Arrangements
(Board Policy)

Board Members should make their own travel arrangements but are encouraged to coordinate with the Executive Director's Administrative Assistant on lodging accommodations.

Out-of-State Travel
(SAM section 700 et seq.)

For out-of-state travel, Board Members will be reimbursed for actual lodging expenses, supported by vouchers, and will be reimbursed for meal and supplemental expenses. Out-of-state travel for all persons representing the State of California is controlled by and approved by the Governor's Office.

Travel Claims
(SAM section 700 et seq. and DCA Memorandum 96-01)

Rules governing reimbursement of travel expenses for Board Members are the same as for management-level state staff. All expenses shall be claimed on the appropriate travel expense claim forms. The Executive Director's Administrative Assistant maintains these forms and completes them as needed. Board Members should submit their travel expense forms immediately after returning from a trip and no later than two weeks following the trip.

For the expenses to be reimbursed, Board Members shall follow the procedures contained in DCA Departmental Memoranda, which are periodically disseminated by the Executive Director and are provided to Board Members.

Salary Per Diem
(B&P Code section 103)

Compensation in the form of salary per diem and reimbursement of travel and other related expenses for Board Members is regulated by B&P Code Section 103.

In relevant part, this section provides for the payment of salary per diem for Board Members "for each day actually spent in the discharge of official duties," and provides that the Board Member "shall be reimbursed for traveling and other expenses necessarily incurred in the performance of official duties."

Accordingly, the following general guidelines shall be adhered to in the payment of salary per diem or reimbursement for travel:

1. No salary per diem or reimbursement for travel-related expenses shall be paid to Board Members, except for attendance at an official Board, Committee, or Panel meeting, unless a substantial official service is performed by the Board Member. Attendance at gatherings, events, hearings, conferences, or meetings other than official Board, Committee, or Panel meetings, in which a substantial official service is performed, shall be approved in advance by the Board President. The Executive Director shall be notified of the event and approval shall be obtained from the Board President prior to Board Member's attendance.
2. The term "day actually spent in the discharge of official duties" shall mean such time as is expended from the commencement of a Board, Committee, or Panel meeting to the conclusion of that meeting.

For Board-specified work, Board Members will be compensated for actual time spent performing work authorized by the Board President. That work includes, but is not limited to, authorized attendance at other gatherings, events, meetings, hearings, or conferences. It includes preparation time for Board, Committee, or Panel meetings.

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

Chapter 5. Board Administration & Staff

Board Administration
(DCA Reference Manual)

Board Members should be concerned primarily with formulating decisions on Board policies rather than decisions concerning the means for carrying out a specific course of action. It is inappropriate for Board Members to become involved in the details of program delivery. Strategies for the day-to-day management of programs and staff shall be the responsibility of the Executive Director. Board Members should not interfere with day-to-day operations, which are under the authority of the Executive Director.

Strategic Planning

The Board will conduct periodic strategic planning sessions.

Executive Director Evaluation
(Board Policy)

Board Members shall evaluate the performance of the Executive Director on an annual basis.

Board Staff
(DCA Reference Manual)

Employees of the Board, with the exception of the Executive Director, are civil service employees. Their employment, pay, benefits, discipline, termination, and conditions of employment are governed by a myriad of civil service laws and regulations and often by collective bargaining labor agreements. Because of this complexity, it is most appropriate that the Board delegate all authority and responsibility for management of the civil service staff to the Executive Director. Board Members shall not intervene or become involved in specific day-to-day personnel transactions.

Business Cards

Business cards will be provided to each Board Member with the Board's name, address, telephone and fax number, and Web site address.

Chapter 6. Other Policies & Procedures

Board Member Disciplinary Actions
(Board Policy)

A member may be censured by the Board if, after a hearing before the Board, the Board determines that the member has acted in an inappropriate manner.

The President of the Board shall sit as chair of the hearing unless the censure involves the President's own actions, in which case the Vice President of the Board shall sit as President. In accordance with the Open Meeting Act, the censure hearing shall be conducted in open session.

Removal of Board Members
(B&P Code sections 106 & 2011)

The Governor has the power to remove from office, at any time, any member of any Board appointed by him or her for continued neglect of duties required by law or for incompetence or unprofessional or dishonorable conduct.

Resignation of Board Members
(Government Code section 1750)

In the event that it becomes necessary for a Board Member to resign, a letter shall be sent to the appropriate appointing authority (Governor, Senate Rules Committee, or Speaker of the Assembly) with the effective date of the resignation. Written notification is required by state law. A copy of this letter also shall be sent to the director of the Department, the Board President, and the Executive Director.

Conflict of Interest
(Government Code section 87100)

No Board Member may make, participate in making, or in any way attempt to use his or her official position to influence a governmental decision in which he or she knows or has reason to know he or she has a financial interest. Any Board Member who has a financial interest shall disqualify himself or herself from making or attempting to use his or her official position to influence the decision. Any Board Member who feels he or she is entering into a situation where there is a potential for a conflict of interest should immediately consult the Executive Director or the Board's legal counsel.

Board Members should refrain from attempting to influence staff regarding applications for licensure or potential disciplinary matters.

Gifts from Candidates
(Board Policy)

Gifts of any kind to Board Members from candidates for licensure with the Board shall not be permitted.

Request for Records Access
(Board Policy)

No Board Member may access the file of a licensee or candidate without the Executive Director's knowledge and approval of the conditions of access. Records or copies of records shall not be removed from the MBC's office.

Meetings with the Public and Interested Parties
(Board Policy)

Interested parties may request to meet with a Board Member on a matter or matters under the Board's jurisdiction. Members must remember that the power of the Board is vested in the Board itself and not with any individual Board Member. For that reason, Board Members are cautioned to not express their personal opinions as a Board policy or position or represent that the Board has taken a position on a particular issue when it has not. It is strongly suggested that Board Members disclose their attendance at any meeting of this type at the next scheduled Board meeting as identified in the next section, "Communication with Interested Parties".

Communication with Interested Parties

Board Members are required to disclose at Board Meetings all discussions and communications with interested parties regarding any item pending or likely to be pending before the Board. The Board minutes shall reflect the items disclosed by the Board Members. All agendas will include, as a regular item, a disclosure agenda item where each Member relays any relevant conversations with interested parties.

Media Inquiries
(Board Policy)

If a Board Member receives a media call, the Member should promptly refer the caller to the Board's Public Information Officer who is employed to interface with all types of media on any type of inquiry. Members are recommended to make this referral as the power of the Board is vested in the Board itself and not with any individual Board Member. Expressing a personal opinion can be seen as a Board policy or position and may be represented as the Board has taken a position on a particular issue when it has not.

A Board Member who receives a call should politely thank the caller for the call, but state that it is the Board's policy to refer all callers to the Public Information Officer. The Board Member should then send an email to the Executive Director indicating they received a media call and relay any information supplied by the caller.

Service of Lawsuits

The Board Members may receive service of a lawsuit against themselves and the Board pertaining to a certain issue (e.g. a disciplinary matter, a complaint, a legislative matter, etc.). To prevent a confrontation, the Board Member should accept service. Upon receipt, the Board Member should notify the Executive Director of the service and indicate the name of the matter that was served and any other pertinent information. The Board Member should then mail the entire package that was served to the Executive Director as soon as possible. The Board's legal counsel will provide instructions to the Board

Members on what is required of them once service has been made. The Board Members may be required to submit a request for representation to the Board to provide to the Attorney General's Office.

Ex Parte Communications
(*Government Code section 11430.10 et seq.)*

The Government Code contains provisions prohibiting *ex parte* communications. An "*ex parte*" communication is a communication to the decision-maker made by one party to an enforcement action without participation by the other party. While there are specified exceptions to the general prohibition, the key provision is found in subdivision (a) of section 11430.10, which states:

> *"While the proceeding is pending, there shall be no communication, direct or indirect, regarding any issue in the proceeding to the presiding officer from an employee or representative or if an agency that is a party or from an interested person outside the agency, without notice and an opportunity for all parties to participate in the communication."*

An applicant who is being formally denied licensure, or a licensee against whom a disciplinary action is being taken, may attempt to directly contact Board Members.

If the communication is written, the member should read only enough to determine the nature of the communication. Once he or she realizes it is from a person against whom an action is pending, he or she should reseal the documents and send them to the Executive Director, or forward the email.

If a Board Member receives a telephone call from an applicant or licensee against whom an action is pending, he or she should immediately tell the person he or she cannot speak to him or her about the matter. If the person insists on discussing the case, he or she should be told that the Board Member will be required to recuse himself or herself from any participation in the matter. Therefore, continued discussion is of no benefit to the applicant or licensee.

If a Board Member believes that he or she has received an unlawful *ex parte* communication, he or she should contact the Board's assigned attorney or Executive Director.

Board Member Training Requirements

Upon initial appointment, Board Members will be given an overview of Board operations, policies, and procedures by Board Executive Staff.

(B&P Code section 453)

Every newly appointed Board Member shall, within one year of assuming office, complete a training and orientation program offered by the Department of Consumer Affairs. This is in addition to the Board orientation given by Board staff. This is a one-time training requirement.

(Government Code section 11146)

All Board Members are required to file an annual Form 700 statement of economic interest. Members must also complete an orientation course on the relevant ethics statutes and regulations that govern the official conduct of state officials. The Government Code requires completion of this ethics orientation within the first six months of appointment and completion of a refresher every two years thereafter.

(Government Code section 12950.1)

AB 1825 (Chapter 933, Statutes of 2004, Reyes) requires supervisors, including Board Members, to complete two hours of sexual harassment prevention training by January 1, 2006, and every two years thereafter.

Appendix 1
Board Member Responsibilities

Board members represent the State of California and although he/she is an individual member, Members have an obligation to represent the Board as a body. Each member should carefully consider each responsibility and time commitment prior to agreeing to become a Board Member.

Attending meetings (12-20 days per year)

- Attend all meetings; be prepared for all meetings by reviewing and analyzing all Board materials; actively participate in meeting discussions; serve on committees of the Board to provide expertise in matters related to the Board

Disciplinary Matters (12-40 days per year)

- Review and analyze all materials pertaining to disciplinary matters and provide a fair, unbiased decision; timely respond to every request for a decision on any disciplinary matter; review and understand the Board's disciplinary guidelines; review and amend the Board's disciplinary guidelines on a regular basis to align with the policies set by the Board

Policy Decision Making (included above)

- Make educated policy decisions based upon both qualitative and quantitative data; obtain sufficient background information on issues upon which decisions are being made; seek information from Board staff regarding the functions/duties/requirements for the licensees being overseen; allow public participation and comment regarding matters prior to making decisions; ensure public protection is the highest priority in all decision making

Governance (2-4 days per year)

- Monitor key and summary data from the Board's programs to evaluate whether business processes are efficient and effective; obtain training on issues pertaining to the Board (e.g. budget process, legislative process, enforcement/licensing process, etc.); make recommendations regarding improvements to the Board's mandated functions

- Participate in the drafting and approval of a Strategic Plan; oversee the Strategic Plan on a quarterly basis to ensure activities are being implemented and performed; monitor any new tasks/projects to ensure they are in-line with the Strategic Plan

- Provide guidance and direction to the Executive Officer on the policies of the Board; annually evaluate the Executive Officer; assist the Executive Officer in reaching the goals for the Board

Outreach (1-4 days per year)

- When approved by the Board, represent the Board in its interaction with interested parties, the legislature, and the Department of Consumer Affairs

Training (2 day per year)

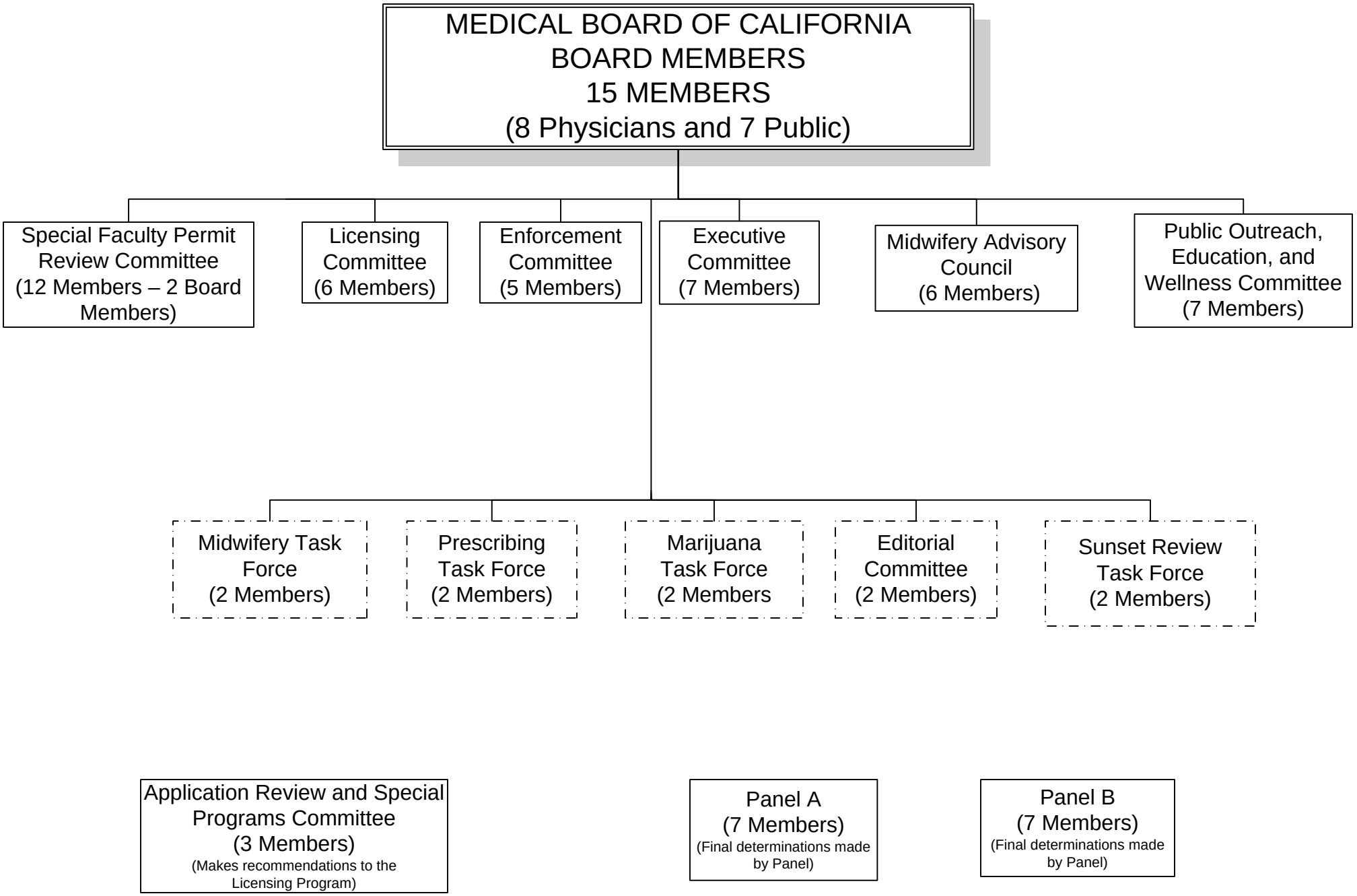
- Obtain the required Board Member training, i.e. Board Member Orientation Training, Sexual Harassment Prevention Training, and Ethics Training

Total Time: 29 – 70 days per year

DCA Orientation: July 27, 2010

Attachment B

Current Organizational Chart Showing Relationship of Committees to the Board and Membership of Each Committee Manual


MEDICAL BOARD OF CALIFORNIA
BOARD MEMBERS
15 MEMBERS
(8 Physicians and 7 Public)
Special Faculty Permit Review Committee (12 Members – 2 Board Members)
Licensing Committee (6 Members)
Enforcement Committee (5 Members)
Executive Committee (7 Members)
Midwifery Advisory Council (6 Members)
Public Outreach, Education, and Wellness Committee (7 Members)
Midwifery Task Force (2 Members)
Prescribing Task Force (2 Members)
Marijuana Task Force (2 Members
Editorial Committee (2 Members)
Sunset Review Task Force (2 Members)
Application Review and Special Programs Committee (3 Members) (Makes recommendations to the Licensing Program)
Panel A (7 Members) (Final determinations made by Panel)
Panel B (7 Members) (Final determinations made by Panel)

Attachment C

Major Studies and Publications

- Vertical Enforcement and Prosecution Model Report to the Legislature March 2016
- Board Newsletter
- Guide to Laws Governing the Practice of Medicine by Physicians and Surgeons
- Strategic Plan
- Annual Report
- Disciplinary Guidelines
- Uniform Standards
- Guidelines for Prescribing Controlled Substances for Pain
- Opioid Overdose Prevention Public Service Announcements
- Statute of Limitations Brochure, Don't Wait File a Complaint
- Check up on Your Doctor's License Outreach Campaign Materials

Major Studies Conducted by the Board
and
Major Publications Prepared by the Board

- **Vertical Enforcement and Prosecution Model Report to the Legislature March 2016**
  http://www.mbc.ca.gov/Publications/vert_enf_model_report_2016_03.pdf

- **Board Newsletter**
  http://www.mbc.ca.gov/Publications/Newsletters/

- **Guide to Laws Governing the Practice of Medicine by Physicians and Surgeons** http://www.mbc.ca.gov/About_Us/Laws/laws_guide.pdf

- **Strategic Plan** http://www.mbc.ca.gov/Publications/Strategic_Plan/strategic_plan_2014.pdf

- **Annual Report** http://www.mbc.ca.gov/Publications/Annual_Reports/

- **Disciplinary Guidelines** http://www.mbc.ca.gov/publications/disciplinary_guide.pdf

- **Uniform Standards** http://www.mbc.ca.gov/Publications/uniform_standards.pdf

- **Guidelines for Prescribing Controlled Substances for Pain**
  http://www.mbc.ca.gov/Licensees/Prescribing/Pain_Guidelines.pdf

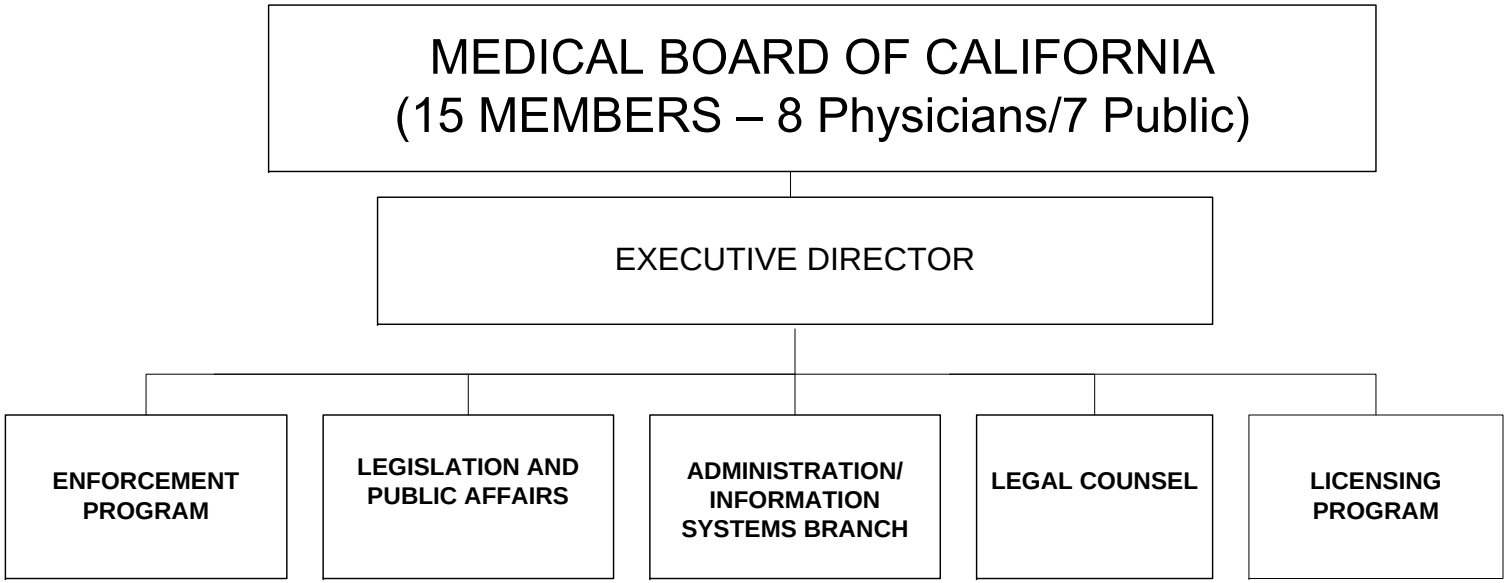
- ***Opioid Overdose Prevention Public Service Announcements***
  Provider PSA – https://www.youtube.com/watch?v=Unt-RjFWJcI
  Patient PSA – https://www.youtube.com/watch?v=7Rk3oVwpbqk

- **Statute of Limitations Brochure, Don't Wait File a Complaint**
  http://www.mbc.ca.gov/Consumers/Complaints/complaint_dontwait_flyer.pdf

- ***Check up on Your Doctor's License Outreach Campaign Materials***
  Brochure (English) –
  http://www.mbc.ca.gov/Publications/Brochures/CheckYourDoctor_English.pdf
  Brochure (Spanish) –
  http://www.mbc.ca.gov/Publications/Brochures/CheckYourDoctor_Spanish.pdf
  Tutorial (English) – https://www.youtube.com/watch?v=oeBMNRv7GGw
  Tutorial (Spanish) – https://www.youtube.com/watch?v=HS2xGGvmJ_M

Attachment D

Year-End Organizational Charts



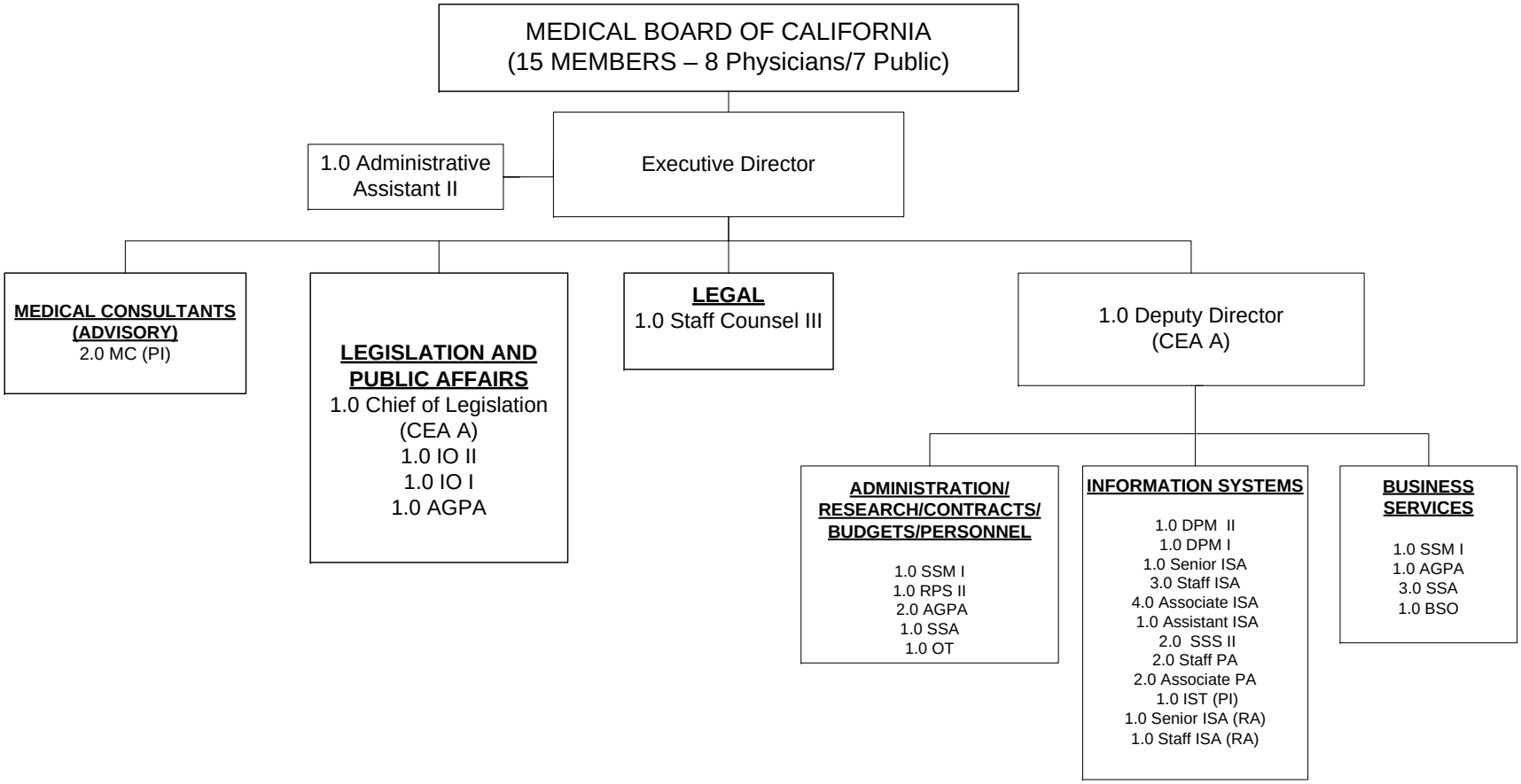
FY 2015/2016
160.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

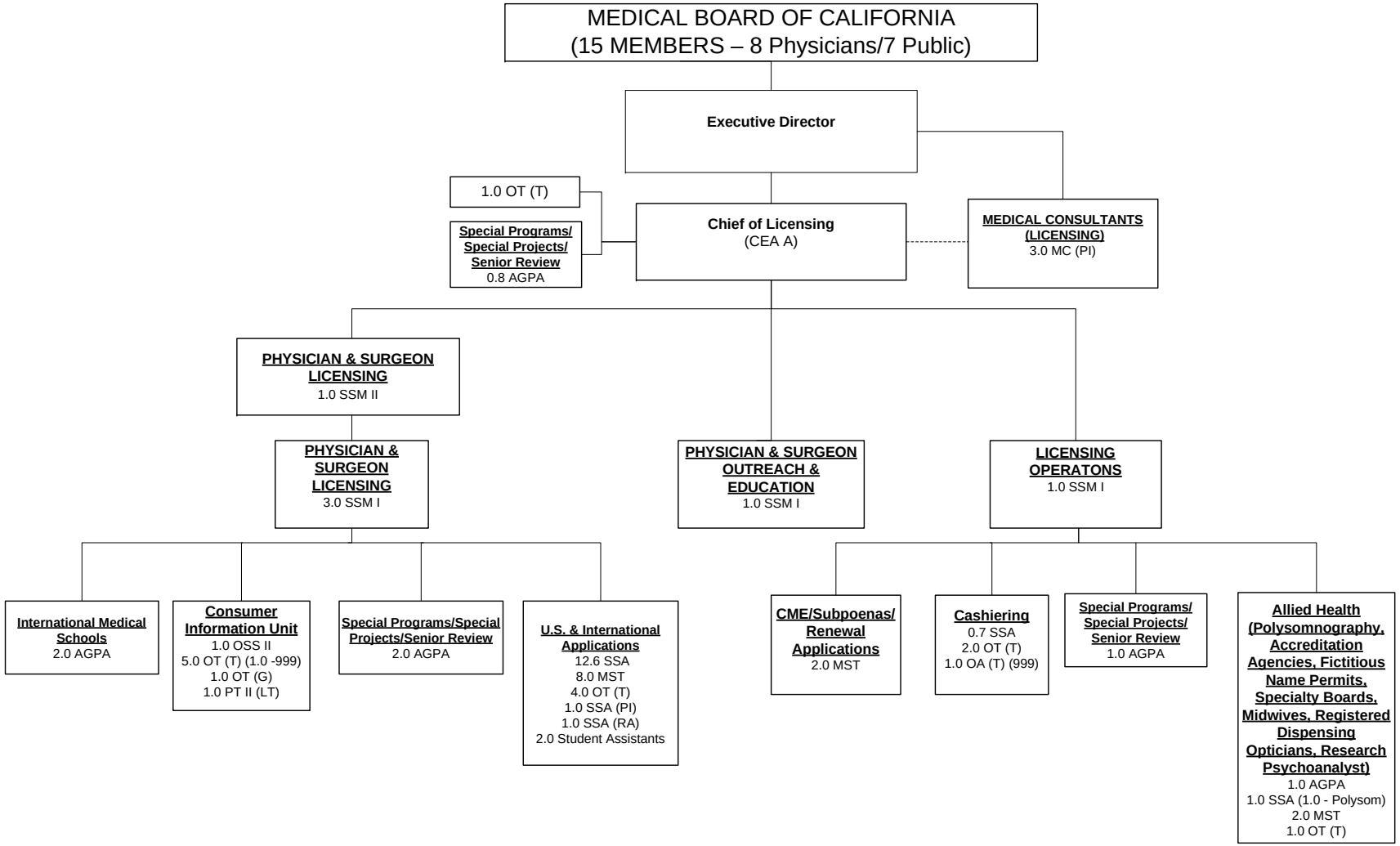
Administrative and Executive Programs

FY 2015/2016



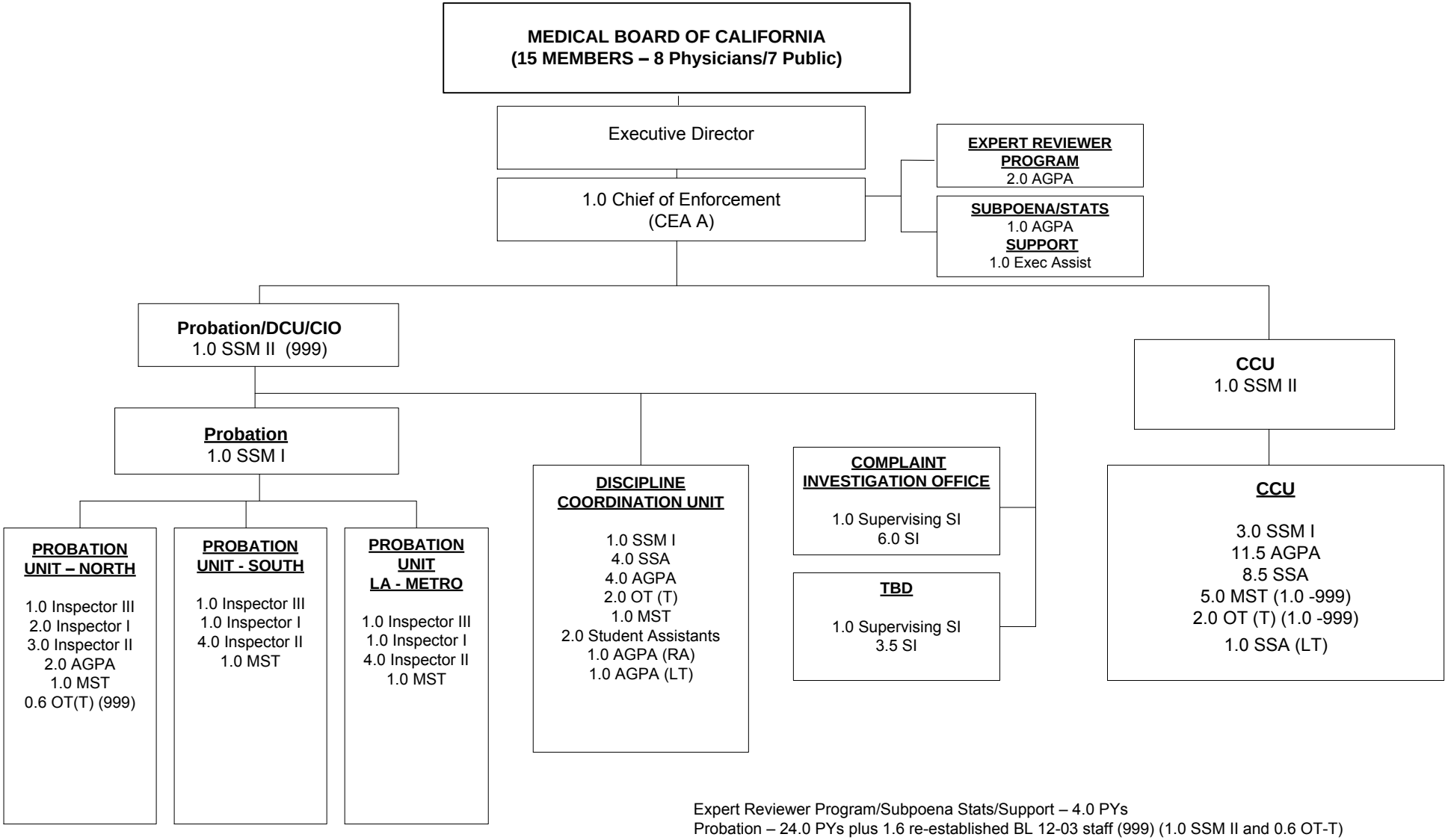
Information Systems Branch – 17.0 PYs plus 1.0 permanent intermittent (IST) and 2.0 retired annuitants (Sr. ISA & SISA)
Administrative Services including Research Program Specialist II – 6.0 PYs
Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Licensing Program
FY 2015/2016

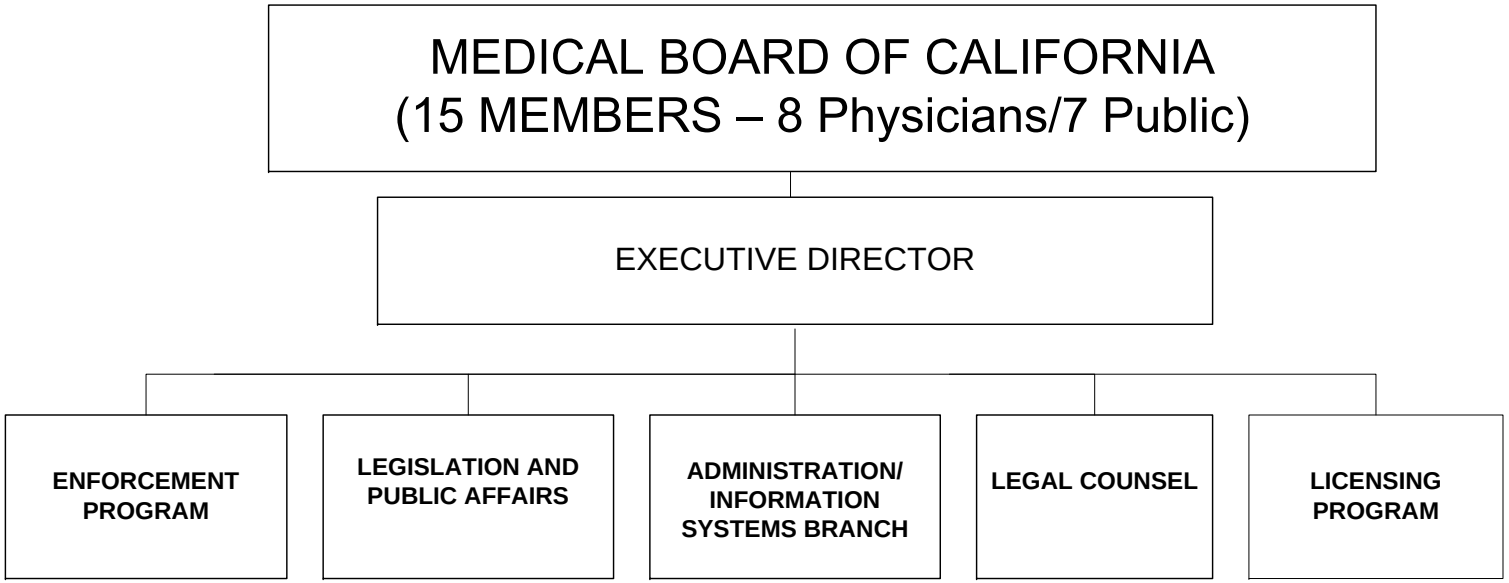


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 3.0 re-established BL 12-03 (999) (1.0 SSM II, 1.0 OT-T, 1.0 OA-T), 4.0 permanent intermittent (1.0 SSA, 3.0 MC), 1.0 retired annuitant (SSA), 1.0 limited term (PT II)

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Enforcement Program
Discipline Coordination Unit
Complaint Investigation Office
Central Complaint Unit
Probation Unit
FY 2015/2016



Expert Reviewer Program/Subpoena Stats/Support – 4.0 PYs
Probation – 24.0 PYs plus 1.6 re-established BL 12-03 staff (999) (1.0 SSM II and 0.6 OT-T)
Discipline Coordination Unit – 12.0 PYs plus 2.0 student assistants, 1.0 retired annuitant (AGPA), 1.0 limited term (AGPA)
Complaint Investigation Office – 7.0 re-established BL 12-03 staff (999), 4.5 vacant
Central Complaint Unit – 29.0 PY plus 2.0 re-established BL 12-03 staff (999) (1.0 MST and 0.6 OT-T) and 1.0 limited term (SSA)



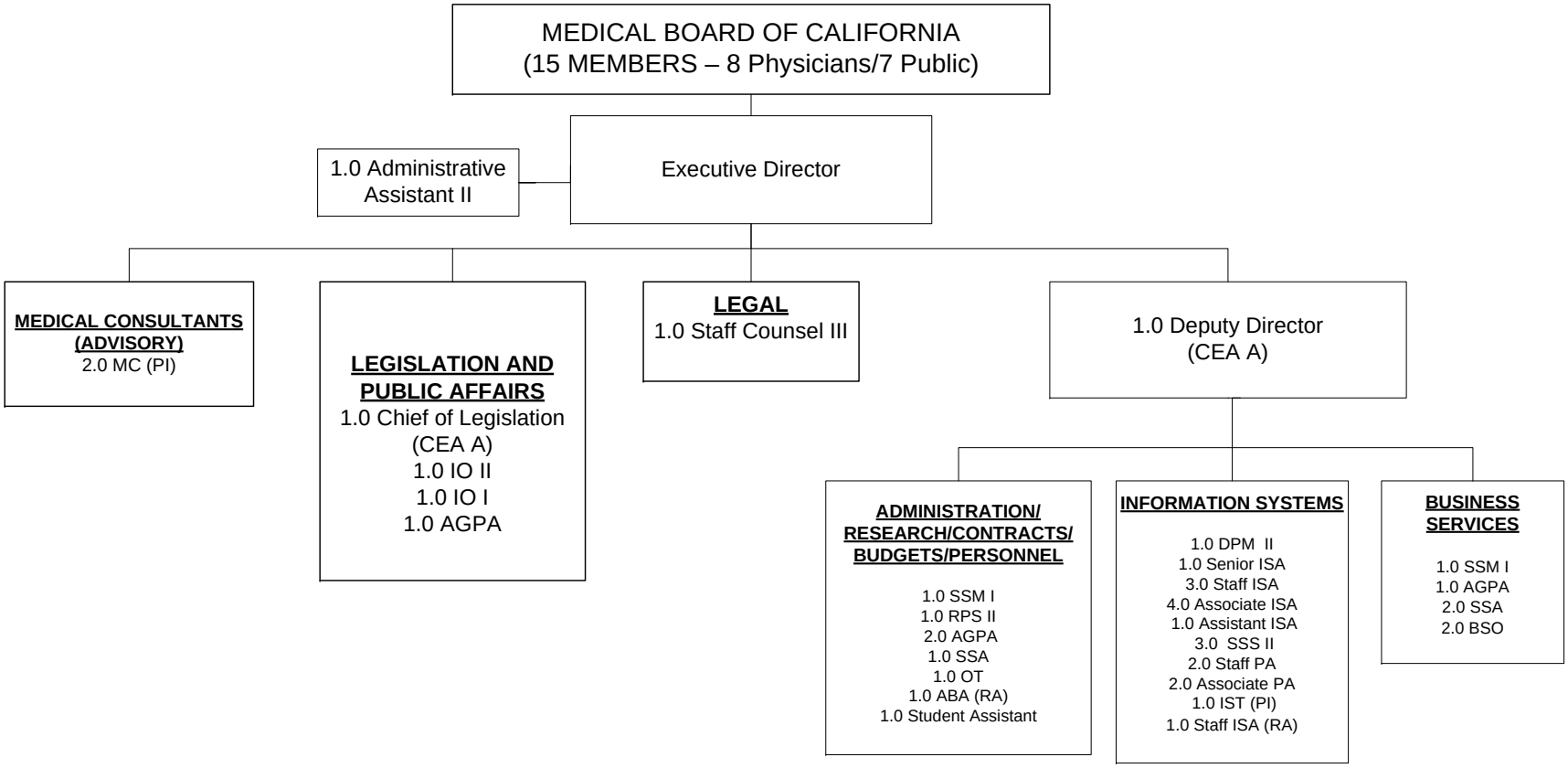
FY 2014/2015
160.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

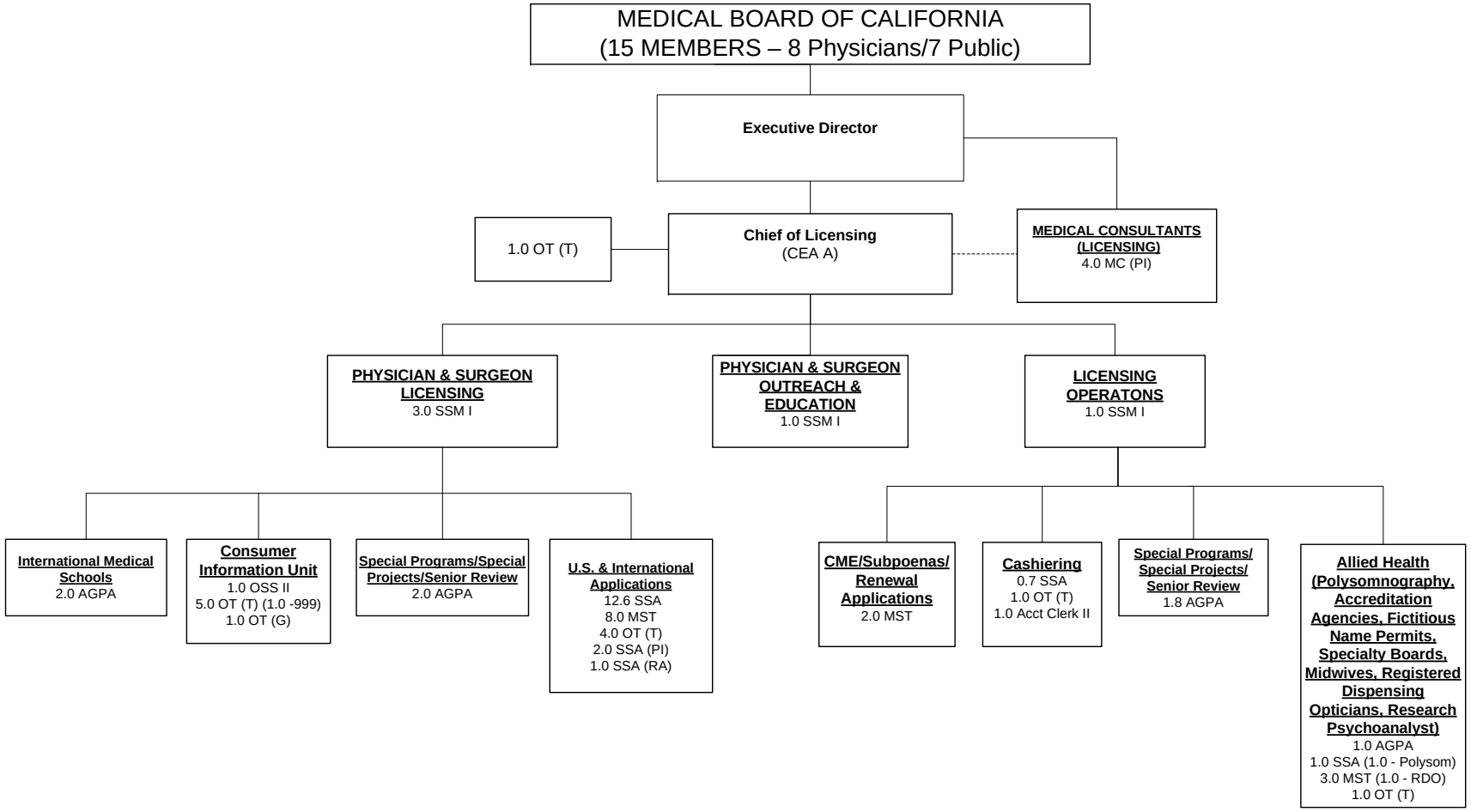
Administrative and Executive Programs

FY 2014/2015



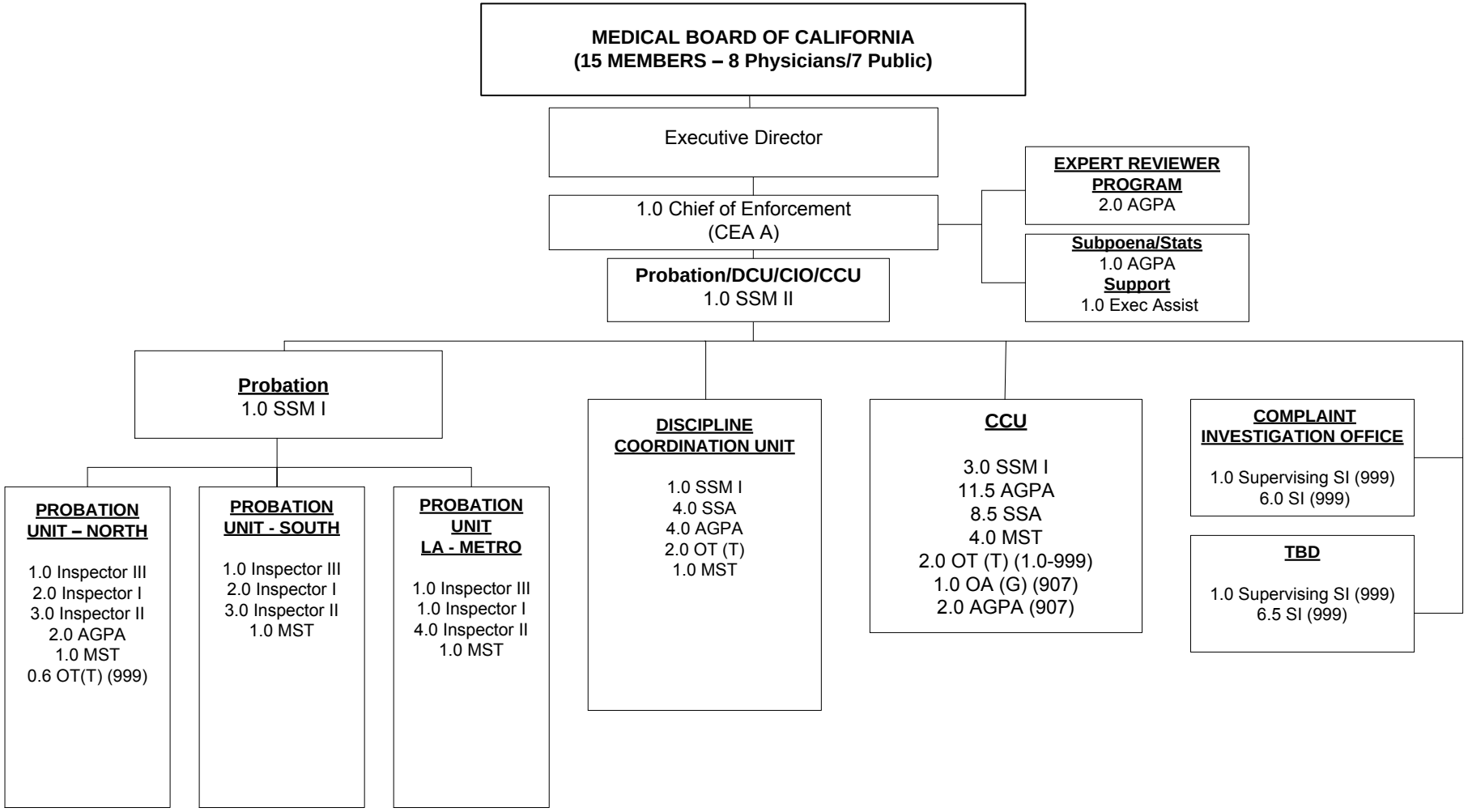
Information Systems Branch – 17.0 PYs plus 1.0 permanent intermittent (IST) and 1.0 retired annuitant (SISA)
Administrative Services including Research Program Specialist II – 6.0 PYs, plus 1.0 retired annuitants (ABA) and 1.0 Student Asst.
Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Licensing Program
FY 2014/2015

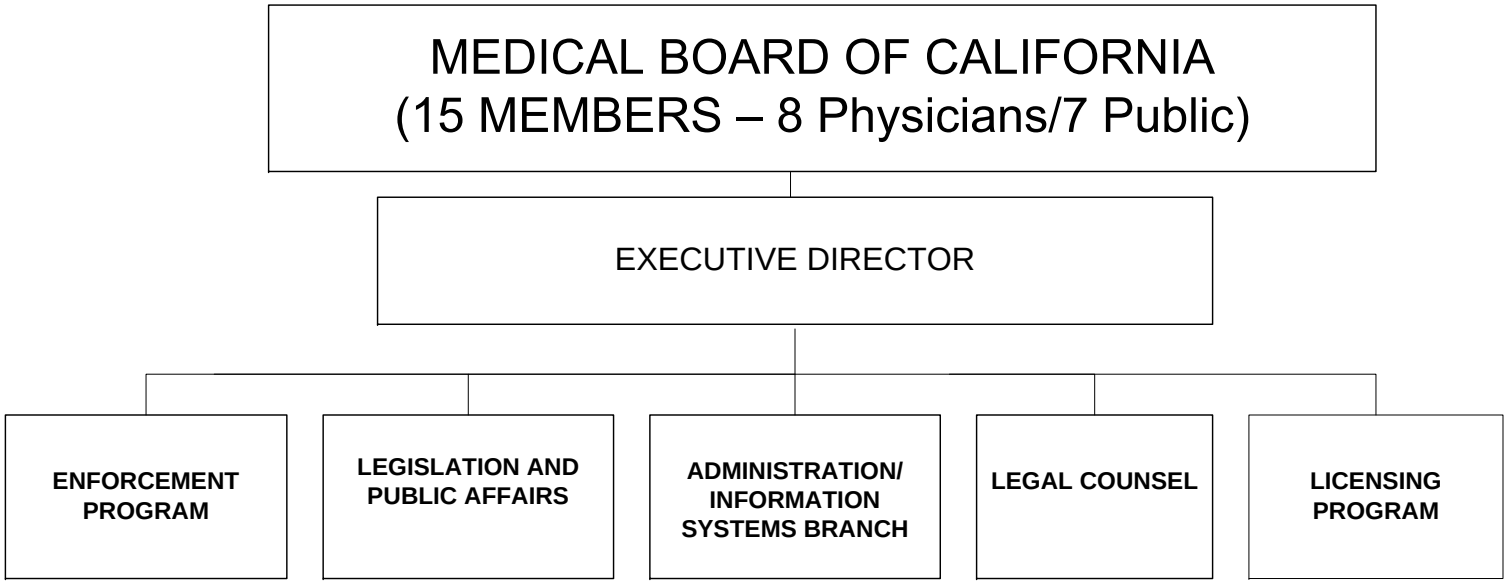


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 1.0 re-established BL 12-03 (999) (OT-T), 6.0 permanent intermittent (2.0 SSA, 4.0 MC), 1.0 retired annuitant (SSA), Registered Dispensing Opticians Program (Agency Code 599) 1.0 (MST)

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Enforcement Program
Discipline Coordination Unit
Complaint Investigation Office
Central Complaint Unit
Probation Unit
FY 2014/2015



Expert Reviewer Program/Subpoena Stats/Support – 4.0 PY
Probation – 24.0 PYs plus 0.6 re-established BL 12-03 staff (999) (1.0 SSM II and 1.0 OT-T)
Discipline Coordination Unit – 12.0 PYs
Complaint Investigation Office – 7.0 re-established BL 12-03 staff (999), 7.5 vacant
Central Complaint Unit – 28.0 PY plus 1.0 re-established BL 12-03 staff (999) (OT-T) and 3.0 temp help blanket (907) (1.0-OA-G, 2.0 AGPA)



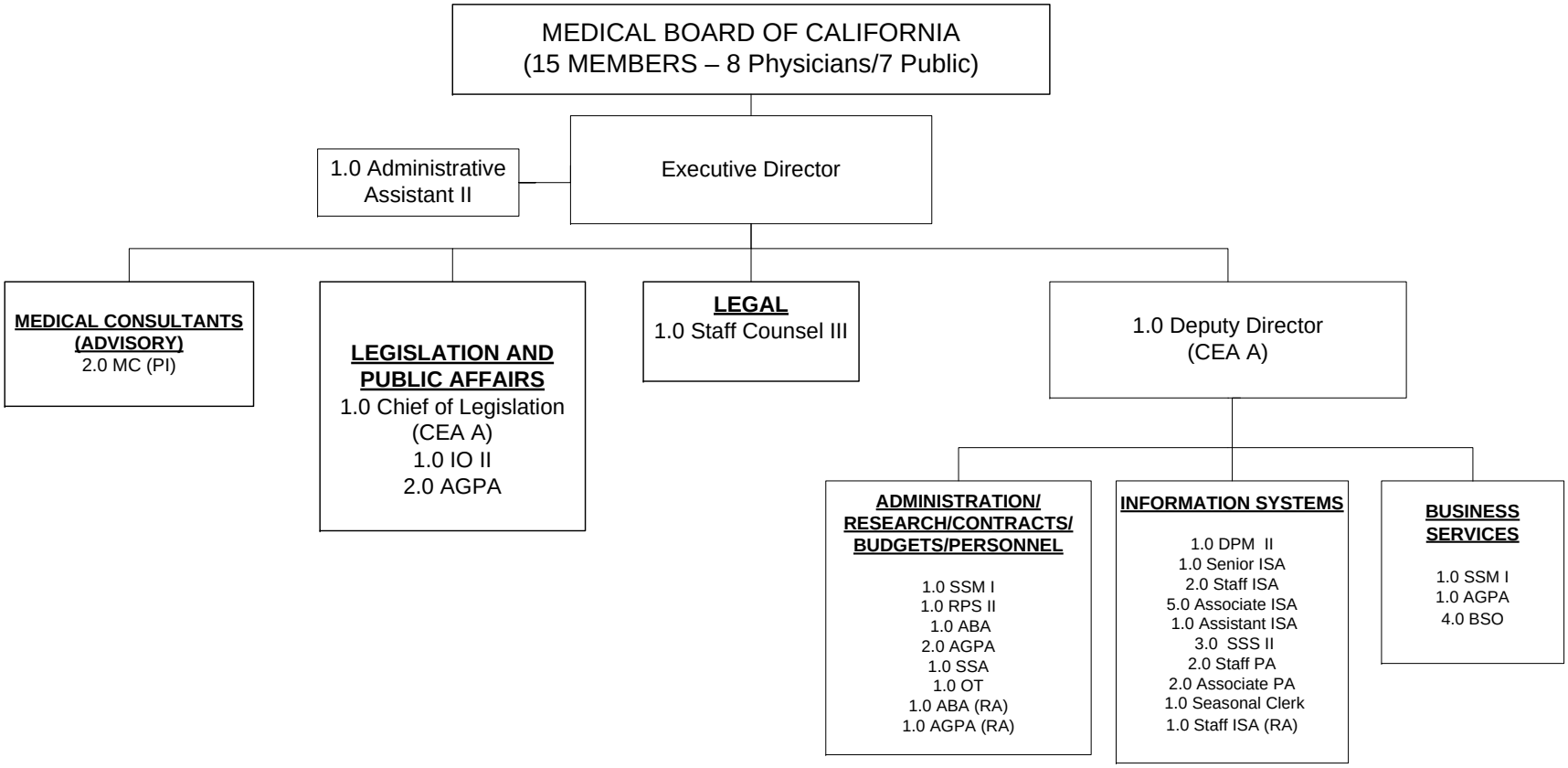
FY 2013/2014
271.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

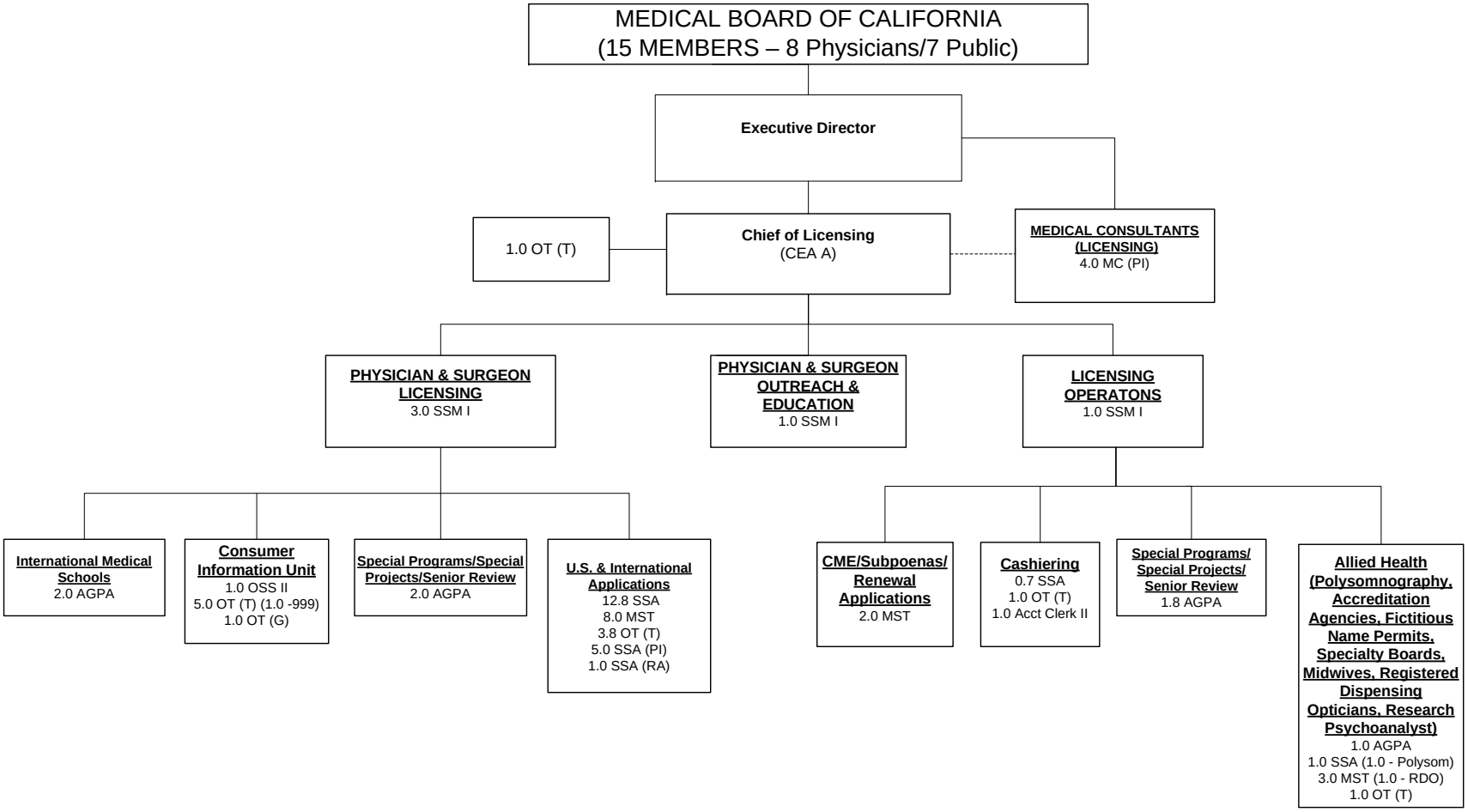
Administrative and Executive Programs

FY 2013/2014



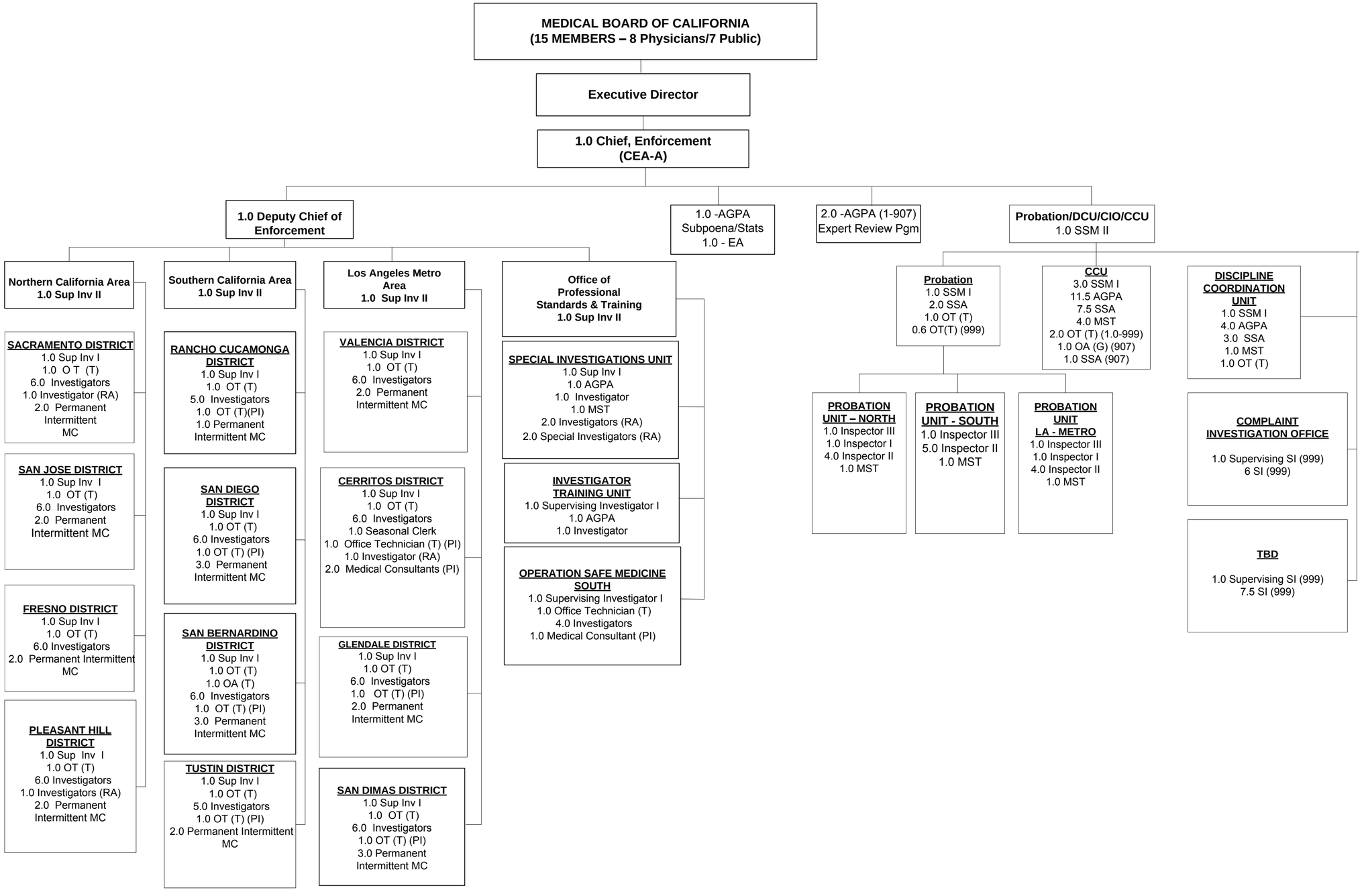
Information Systems Branch – 17.0 PYs plus 1.0 seasonal clerk and 1.0 retired annuitant (SISA)
Administrative Services including Research Program Specialist II – 7.0 PYs, plus 2.0 retired annuitants (1.0 -ABA, 1.0 -AGPA)
Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Licensing Program
FY 2013/2014

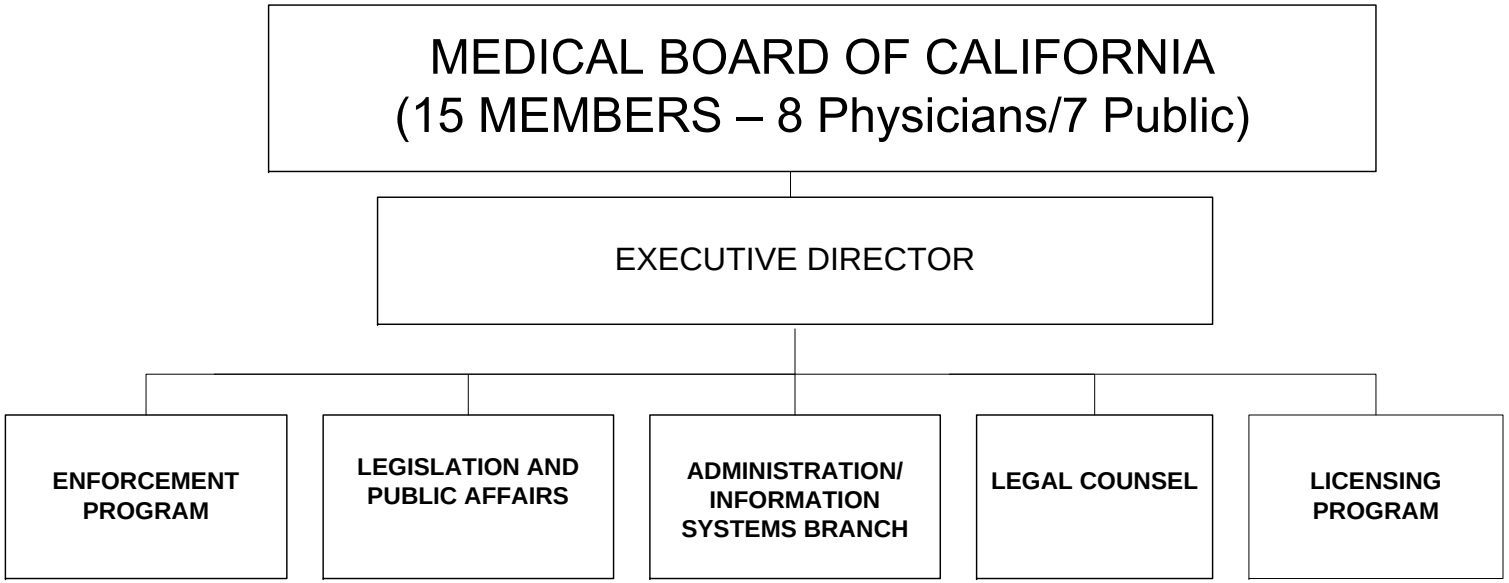


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 1.0 re-established BL 12-03 (999) (OT-T), 9.0 permanent intermittent (5.0 SSA, 4.0 MC), 1.0 retired annuitant (SSA), Registered Dispensing Opticians Program (Agency Code 599) 1.0 (MST)

Department of Consumer Affairs
Medical Board of California
Enforcement Program
FY 2013/2014



Subpoena Stats/Exec Assist /Expert Reviewer Program – 3.0 PY plus 1.0 temp help blanket (907) (AGPA)
Investigations – 100.0 PYs (Total includes chief, deputy chief) plus retired annuitants, permanent intermittents and a seasonal clerk)
Office of Standards and Training/OSM – 14.0 PYs plus 4.0 retired annuitant (2.0 Investigators, 2.0 Special Investigators) 1.0 permanent intermittent MC
Probation – 25.0 PYs plus 0.6 re-established BL 12-03 staff (999) (OT-T)
CCU/DCU – 37.0 PYs plus 1.0 re-established BL 12-03 staff (999) (OT-T) and 2.0 temp help blanket (907) (1.0 OA-G, 1.0 SSA)



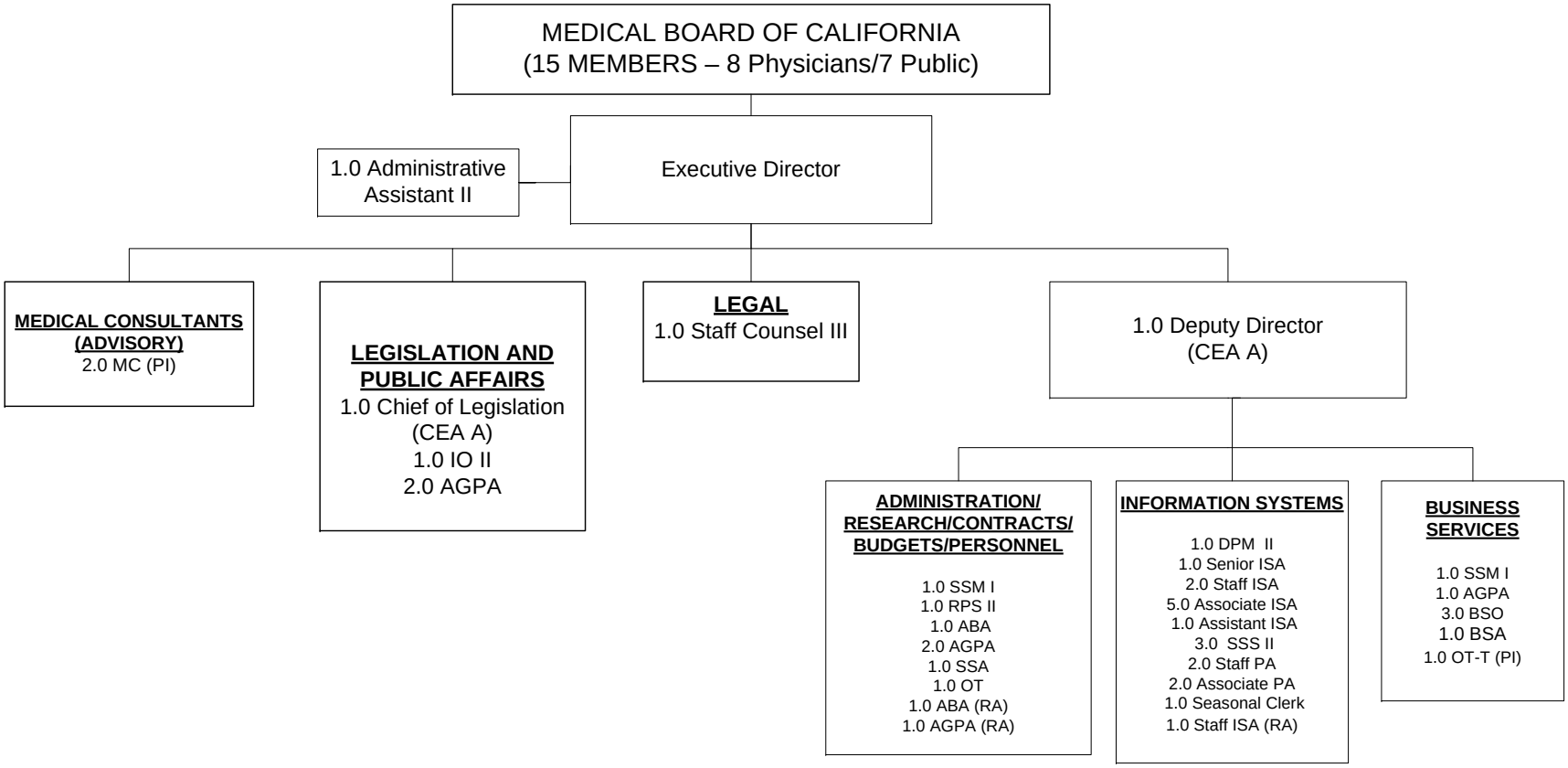
FY 2012/2013
271.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs

MEDICAL BOARD OF CALIFORNIA

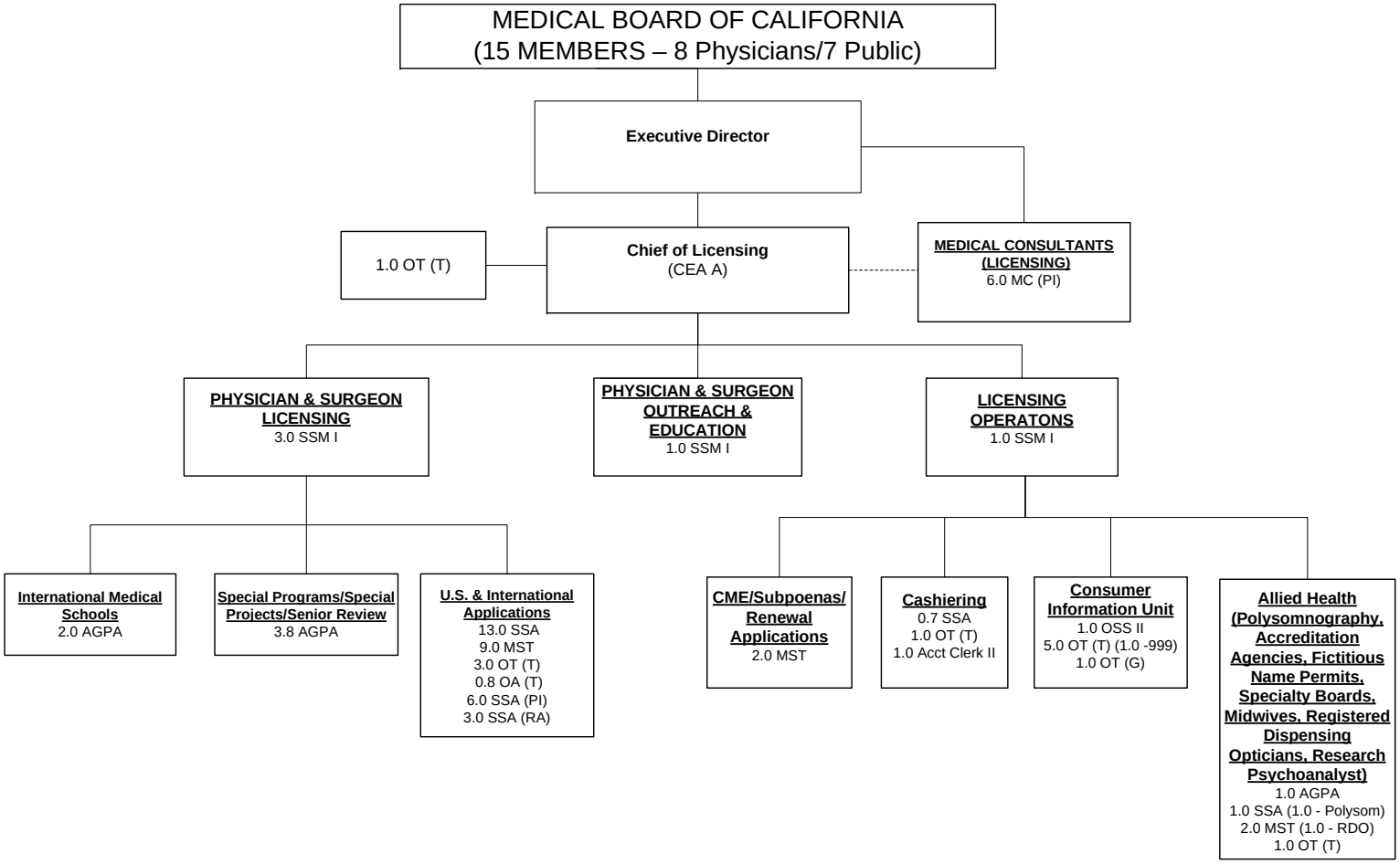
Administrative and Executive Programs

FY 2012/2013



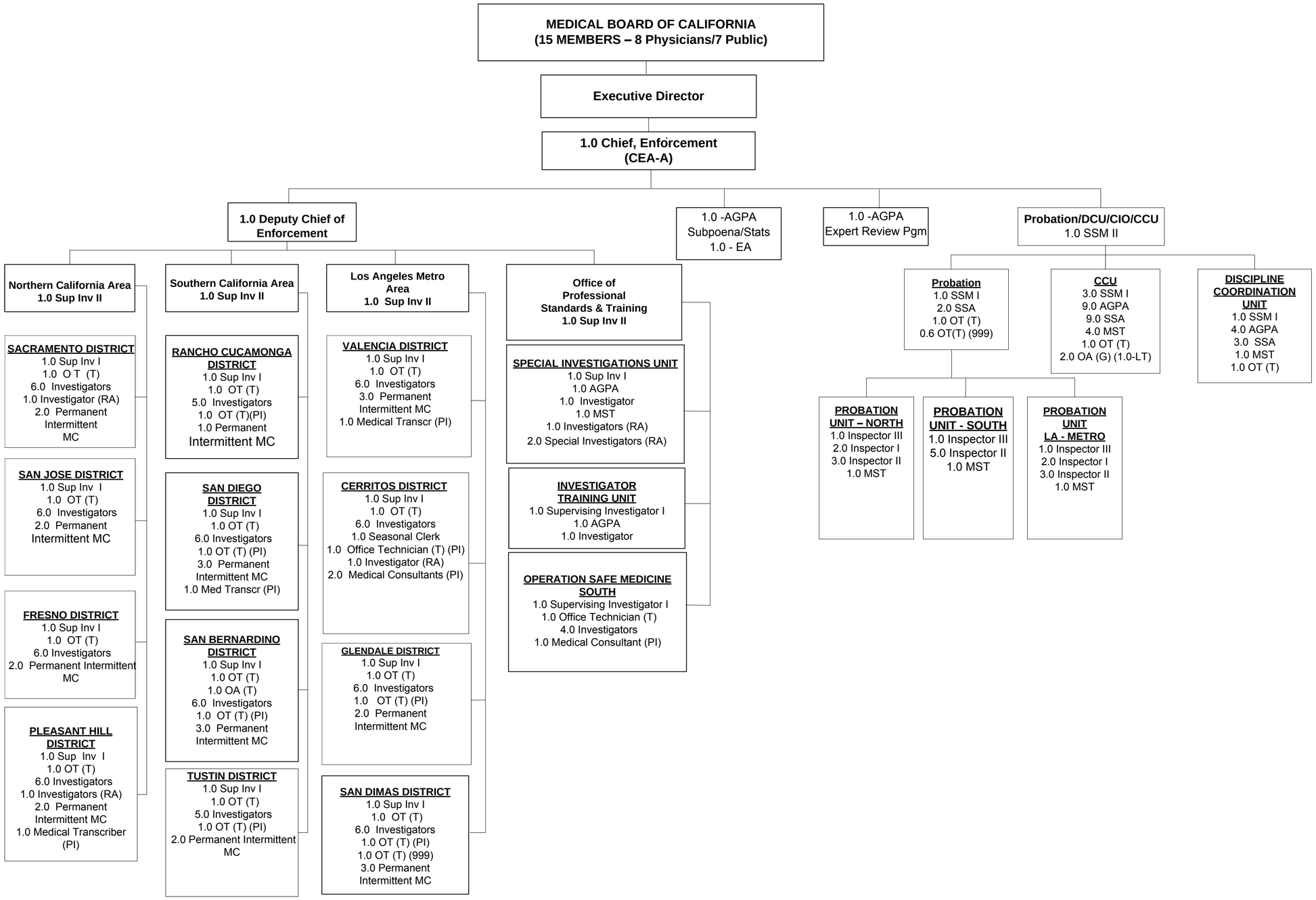
Information Systems Branch – 17.0 PYs plus 1.0 seasonal clerk and 1.0 retired annuitant (SISA)
Administrative Services including Research Program Specialist II – 7.0 PYs, plus 2.0 retired annuitants (1.0 -ABA, 1.0 -AGPA)
Business Services – 6.0 PYs plus 1.0 permanent intermittent (OT-T)

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
Licensing Program
FY 2012/2013



Licensing 52.3 PYs plus Polysomnography 1.0 (SSA), 1.0 re-established BL 12-03 (999) (OT-T), 12.0 permanent intermittent (6.0 SSA, 6.0 MC), 3.0 retired annuitant (SSA), Registered Dispensing Opticians Program (Agency Code 599) 1.0 (MST)

Department of Consumer Affairs
Medical Board of California
Enforcement Program
FY 2012/2013



Subpoena Stats/Exec Assist/Expert Reviewer Program – 3.0 PY
Investigations – 100.0 PYs (Total includes chief, deputy chief) plus retired annuitants, permanent intermittents and a seasonal clerk)
Office of Standards and Training/OSM – 14.0 PYs plus 4.0 retired annuitant (1.0 Investigator, 2.0 Special Investigators) 1.0 permanent intermittent MC
Probation – 25.0 PYs plus 0.6 re-established BL 12-03 staff (999) (OT-T)
CCU/DCU – 37.0 PYs plus 1.0 limited term (OA-G)

Attachment E

Sunset Report Form with Questions

[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)?

Attachment F

Board Member Attendance

Board Member Attendance

Table 1a.	Attendance		
Michelle Bholat, M.D.			
Date Appointed: February 25, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel B Meeting	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel B Meeting	October 29, 2015	San Diego	Yes
Enforcement Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Special Faculty Permit Review Committee	December 3, 2015	Sacramento	Yes
Panel B Meeting	January 21, 2016	Sacramento	Yes
Enforcement Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 21, 2016 January 22, 2016	Sacramento	Yes
Interim Quarterly Board Meeting	February 26, 2016	Teleconference	Yes
Interim Panel B Meeting	March 21, 2016	Teleconference	Yes
Panel B Meeting	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel B Meeting	July 28, 2016	San Francisco	Yes
Enforcement Committee	July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes
Michael Bishop, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 25, 2012	San Diego	Yes
Licensing Committee	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes

Panel A Meeting	January 30, 2013	Burlingame	Yes
Licensing Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Panel A Meeting	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Prescribing Task Force	September 23, 2013	Sacramento	Yes
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Interim Panel A Meeting	December 9, 2013	Teleconference	Yes
Committee on Physician Supervisory Responsibilities	February 5, 2014	Burlingame	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Prescribing Task Force	February 19, 2014	Sacramento	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Prescribing Task Force	June 19, 2014	Sacramento	Yes
Panel A Meeting	July 24, 2014	Sacramento	Yes
Licensing Committee	July 24, 2015	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Prescribing Task Force	September 29, 2014	Sacramento	Yes
Panel A Meeting	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	No
Panel A Meeting	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Prescribing Task Force	April 13, 2015	Sacramento	Yes
Panel A Meeting	May 7, 2015	Los Angeles	Yes

Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Licensing Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	No
Panel A Meeting	May 5, 2016	Sacramento	Yes
Licensing Committee	May 5, 2016	Sacramento	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Sacramento	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Silvia Diego, M.D.

Date Appointed: July 30, 2010

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	October 25, 2012	San Diego	Yes
Application Review Committee	October 25, 2012	San Diego	Yes
Licensing Committee	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel A Meeting	January 30, 2013	Burlingame	Yes
Licensing Committee	January 31, 2013	Burlingame	Yes
Executive Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013- February 1, 2013	Burlingame	Yes
Application Review Committee	February 1, 2013	Burlingame	Yes
Education and Wellness Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 25, 2013	Los Angeles	Yes
Panel A Meeting	April 25, 2013	Los Angeles	Yes

Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Application Review Committee	April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Education and Wellness	July 17, 2013	Sacramento	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Executive Committee	October 23, 2013	Riverside	No
Panel A Meeting	October 24, 2013	Riverside	No
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	No
Interim Panel A Meeting	December 9, 2013	Teleconference	No
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Education and Wellness Committee	February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Application Review Committee	February 7, 2014	Burlingame	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes
Executive Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Judge Katherine Feinstein, (ret.)			
Date Appointed: January 13, 2016			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Interim Board Meeting	February 26, 2016	Teleconference	No
Panel A Meeting	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Dev GnanaDev, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel B Meeting	January 31, 2013	Burlingame	Yes
Enforcement Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Panel B Meeting	April 25, 2013	Los Angeles	Yes
Enforcement Committee	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Executive Committee	October 23, 2013	Riverside	Yes
Enforcement Committee	October 23, 2013	Riverside	Yes
Panel B Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Interim Panel B Meeting	March 26, 2014	Teleconference	Yes
Panel B Meeting	May 1, 2014	Los Angeles	Yes
Executive Committee	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel B Meeting	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Interim Panel B Meeting	September 24, 2014	Los Angeles	Yes
Panel B Meeting	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel B Meeting	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes

Panel B Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel B Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Licensing Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel B Meeting	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel B Meeting	January 21, 2016	Sacramento	No
Quarterly Board Meeting	January 22, 2016	Sacramento	No
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Interim Panel B Meeting	March 21, 2016	Teleconference	Yes
Panel B Meeting	May 5, 2016	Los Angeles	Yes
Licensing Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel B Meeting	July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes
Randy W. Hawkins, M.D.			
Date Appointed: March 2, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes
Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes

Interim Board Meeting	February 26, 2016	Teleconference	Yes
Panel A Meeting	May 5, 2016	Los Angeles	Yes
Licensing Committee	May 5, 2016	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes
Howard Krauss, M.D.			
Date Appointed: August 14, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Education and Wellness Committee	February 6, 2014	Burlingame	No
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	No No
Interim Panel B Meeting	March 26, 2014	Teleconference	Yes
Panel B Meeting	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel B Meeting	July 24, 2014	Sacramento	Yes
Education and Wellness Committee	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Interim Panel B Meeting	September 24, 2014	Teleconference	Yes
Panel B Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee Meeting	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel B Meeting	January 29, 2015	Sacramento	Yes
Education and Wellness Committee	January 29, 2015	Sacramento	Yes

Enforcement Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel B Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel B Meeting	July 30, 2015	Burlingame	Yes
Education and Wellness Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel B Meeting	October 29, 2015	San Diego	Yes
Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Enforcement Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel B Meeting	January 21, 2016	Sacramento	Yes
Enforcement Committee	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Interim Panel B Meeting	March 21, 2016	Teleconference	No
Panel B Meeting	May 5, 2016	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel B Meeting	July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes
Kristina Lawson, J.D.			
Date Appointed: October 26, 2015			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	January 21, 2016	Sacramento	Yes
Patient Notification Task Force	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Interim Panel B	March 21, 2016	Teleconference	Yes

Panel B Meeting	May 5, 2016	Los Angeles	No
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel B Meeting	July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes
Sharon Levine, M.D.			
Date Appointed: February 11, 2009			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel B Meeting	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel B Meeting	January 31, 2013	Burlingame	Yes
Enforcement Committee	January 31, 2013	Burlingame	Yes
Executive Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Education and Wellness Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 25, 2013	Los Angeles	Yes
Panel B Meeting	April 25, 2013	Los Angeles	Yes
Enforcement Committee	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Education & Wellness Committee	July 17, 2013	Sacramento	Yes
Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Executive Committee	October 23, 2013	Riverside	Yes
Enforcement Committee	October 23, 2013	Riverside	Yes
Panel B Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Interim Panel B Meeting	March 26, 2014	Teleconference	Yes
Panel B Meeting	May 1, 2014	Los Angeles	No

Executive Committee	May 1, 2014	Los Angeles	No
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	No
Panel B Meeting	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes No
Interim Panel B Meeting	September 24, 2014	Teleconference	No
Panel B Meeting	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel B Meeting	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel B Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel B Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel B Meeting	October 29, 2015	San Diego	Yes
Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel B Meeting	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Patient Notification Task Force	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	No
Panel B Meeting	May 5, 2016	Los Angeles	No
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	No Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	No

Ronald Lewis, M.D.			
Date Appointed: August 14, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Interim Panel A Meeting	December 9, 2013	Teleconference	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2013	Burlingame	Yes
Application Review Committee	February 7, 2013	Burlingame	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel A Meeting	July 24, 2014	Sacramento	Yes
Licensing Committee	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Panel A Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel A Meeting	January 29, 2015	Sacramento	Yes
Enforcement Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel A Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Application Review and Special Programs Committee	July 31, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes

Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Patient Notification Task Force	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Panel A Meeting	May 5, 2016	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Application Review and Special Programs Committee	June 22, 2016	Teleconference	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Reginald Low, M.D.

Date Appointed: August 10, 2006

Meeting Type	Meeting Date	Meeting Location	Attended
Panel B Meeting	October 25, 2012	San Diego	No
Application Review Committee	October 25, 2012	San Diego	No
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	No
Panel B Meeting	January 31, 2013	Burlingame	Yes
Enforcement Committee	January 31, 2013	Burlingame	Yes
Executive Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Application Review Committee	February 1, 2013	Burlingame	Yes
Special Faculty Permit Review Committee	March 14, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	No
Executive Committee	April 25, 2013	Los Angeles	Yes
Panel B Meeting	April 25, 2013	Los Angeles	Yes
Enforcement Committee	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Application Review Committee	April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes

Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes

Elwood Lui

Date Appointed: October 25, 2013

Meeting Type	Meeting Date	Meeting Location	Attended
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Interim Panel B Meeting	March 26, 2014	Teleconference	Yes
Panel B Meeting	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel B Meeting	July 24, 2014	Sacramento	No
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	No
Interim Panel B Meeting	September 24, 2014	Teleconference	Yes
Panel B Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel B Meeting	January 29, 2015	Sacramento	No
Enforcement Committee	January 29, 2015	Sacramento	No
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	No
Panel B Meeting	May 7, 2015	Los Angeles	No
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	No

Denise Pines

Date Appointed: August 29, 2012

Meeting Type	Meeting Date	Meeting Location	Attended
Panel B Meeting	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel B Meeting	January 31, 2013	Burlingame	Yes
Licensing Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes

Panel B Meeting	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Panel B Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Education and Wellness	February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Interim Panel B Meeting	March 26, 2014	Teleconference	Yes
Panel B Meeting	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel B Meeting	July 24, 2014	Sacramento	Yes
Licensing Committee	July 24, 2014	Sacramento	Yes
Education and Wellness	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Interim Panel B Meeting	September 24, 2014	Los Angeles	Yes
Panel B Meeting	October 23, 2014	San Diego	No
Executive Committee	October 23, 2014	San Diego	No
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	No
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel B Meeting	January 29, 2015	Sacramento	Yes
Education and Wellness Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel B Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel B Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Licensing Committee	July 30, 2015	Burlingame	Yes

Education and Wellness Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel B Meeting	October 29, 2015	San Diego	Yes
Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel B Meeting	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	No
Interim Panel B Meeting	March 21, 2016	Teleconference	Yes
Panel B Meeting	May 5, 2016	Los Angeles	Yes
Licensing Committee	May 5, 2016	Los Angeles	Yes
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel B Meeting	July 28, 2016	San Francisco	No
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	No

Janet Salomonson, M.D.

Date Appointed: August 11, 2006

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	October 25, 2012	San Diego	Yes
Licensing Committee	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel A Meeting	January 30, 2013	Burlingame	Yes
Executive Committee	January 31, 2013	Burlingame	Yes
Licensing Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Education and Wellness Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	Yes
Panel A Meeting	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes

Education and Wellness Committee	July 17, 2013	Sacramento	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes

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

Date Appointed: June 12, 2007

Meeting Type	Meeting Date	Meeting Location	Attended
Panel B Meeting	October 25, 2012	San Diego	Yes
Application Review Committee	October 25, 2012	San Diego	Yes
Licensing Committee	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel B Meeting	January 31, 2013	Burlingame	No
Enforcement Committee	January 31, 2013	Burlingame	No
Licensing Committee	January 31, 2013	Burlingame	No
Executive Committee	January 31, 2013	Burlingame	No
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	No
Application Review Committee	February 1, 2013	Burlingame	Yes
Education and Wellness Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	Yes
Panel B Meeting	April 25, 2013	Sacramento	Yes
Enforcement Committee	April 25, 2013	Sacramento	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Sacramento	Yes
Special Board Meeting	June 4, 2013	Teleconference	No
Education and Wellness Committee	July 17, 2013	Sacramento	Yes
Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Enforcement Committee	October 23, 2013	Riverside	No
Panel B Meeting	October 24, 2013	Riverside	No
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Committee on Physician Supervisory Responsibilities	February 5, 2014	Burlingame	No
Education and Wellness Comm	February 6, 2014	Burlingame	No

Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	No
Application Review Committee	February 7, 2014	Burlingame	No
Interim Panel B Meeting	March 26, 2014	Teleconference	No
Panel B Meeting	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel B Meeting	July 24, 2014	Sacramento	No
Licensing Committee	July 24, 2014	Sacramento	No
Education and Wellness Committee	July 24, 2014	Sacramento	No
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	No
Interim Panel B Meeting	September 24, 2014	Los Angeles	Yes
Panel B Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	San Diego	Yes
Panel B Meeting	January 29, 2015	Sacramento	No
Education and Wellness Committee	January 29, 2015	Sacramento	No
Enforcement Committee	January 29, 2015	Sacramento	No
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	No
Panel B Meeting	May 7, 2015	Sacramento	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Sacramento	Yes
Panel B Meeting	July 30, 2015	Burlingame	No
Licensing Committee	July 30, 2015	Burlingame	No
Education and Wellness Committee	July 30, 2015	Burlingame	No
Application Review and Special Programs Committee	July 31, 2015	Burlingame	No
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	No
Panel B Meeting	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	Burlingame	Yes
Panel B Meeting	January 21, 2016	Sacramento	No

Quarterly Board Meeting	January 22, 2016	Sacramento	No
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Interim Panel B Meeting	March 21, 2016	Teleconference	No

David Serrano Sewell, J.D.

Date Appointed: September 11, 2012

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	October 25, 2012	San Diego	Yes
Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Panel A Meeting	January 30, 2013	Burlingame	Yes
Enforcement Committee	January 31, 2013	Burlingame	No
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Panel A Meeting	April 25, 2013	Sacramento	Yes
Enforcement Committee	April 25, 2013	Sacramento	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Sacramento	Yes
Special Board Meeting	June 4, 2013	Teleconference	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Executive Committee	October 23, 2013	Riverside	Yes
Enforcement Committee	October 23, 2013	Riverside	Yes
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Interim Panel A Meeting	December 9, 2013	Teleconference	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes
Executive Committee	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel A Meeting	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes

Panel A Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel A Meeting	January 29, 2015	Sacramento	No
Enforcement Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel A Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	No
Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	No
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	No
Panel A Meeting	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Patient Notification Task Force	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Public Outreach, Education and Wellness Committee	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	No

Brenda Sutton-Wills, J.D.

Date Appointed: April 6, 2016

Meeting Type	Meeting Date	Meeting Location	Attended
Panel B Meeting	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes

Panel B Meeting	July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Phil Tagami

Date Appointed: May 18, 2013

Meeting Type	Meeting Date	Meeting Location	Attended
Special Board Meeting	June 4, 2013	Sacramento	Yes
Panel B Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Enforcement Committee	October 23, 2013	Riverside	No
Panel B Meeting	October 24, 2013	Riverside	No
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	No

David Warmoth

Date Appointed: February 29, 2016

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Jamie Wright, J.D.

Date Appointed: August 20, 2013

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Interim Panel A Meeting	December 9, 2013	Teleconference	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes

Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Panel A Meeting	July 24, 2014	Sacramento	Yes
Licensing Committee	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Panel A Meeting	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel A Meeting	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Panel A Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Licensing Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Panel A Meeting	May 5, 2016	Los Angeles	No
Licensing Committee	May 5, 2016	Los Angeles	No
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes No

Barbara Yaroslavsky

Date Appointed: September 24, 2003

Meeting Type	Meeting Date	Meeting Location	Attended
Panel A Meeting	October 25, 2012	San Diego	Yes

Quarterly Board Meeting	October 25, 2012 October 26, 2012	San Diego	Yes
Midwifery Advisory Council	December 6, 2012	Sacramento	Yes
Panel A Meeting	January 30, 2013	Burlingame	Yes
Enforcement Committee	January 31, 2013	Burlingame	Yes
Executive Committee	January 31, 2013	Burlingame	Yes
Quarterly Board Meeting	January 31, 2013 February 1, 2013	Burlingame	Yes
Special Faculty Permit Review Committee	March 14, 2013	Sacramento	Yes
Midwifery Advisory Council	March 14, 2013	Sacramento	Yes
Education and Wellness Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 5, 2013	Sacramento	Yes
Executive Committee	April 25, 2013	Sacramento	Yes
Panel A Meeting	April 25, 2013	Los Angeles CA	Yes
Enforcement Committee	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Special Board Meeting	June 4, 2013	Sacramento	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Midwifery Advisory Council	August 8, 2013	Sacramento	No
Prescribing Task Force	September 23, 2013	Sacramento	Yes
Executive Committee	October 23, 2013	Riverside	Yes
Enforcement Committee	October 23, 2013	Riverside	Yes
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	Yes
Midwifery Advisory Council	December 5, 2013	Sacramento	Yes
Interim Panel A Meeting	December 9, 2013	Teleconference	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Education and Wellness Committee	February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Prescribing Task Force	February 19, 2014	Sacramento	Yes
Special Faculty Permit Review Committee	March 27, 2014	Teleconference	Yes
Midwifery Advisory Council	March 27, 2014	Sacramento	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes

Executive Committee	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes
Prescribing Task Force	June 19, 2014	Sacramento	Yes
Panel A Meeting	July 24, 2014	Sacramento	Yes
Education and Wellness Committee	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Midwifery Advisory Council	August 14, 2014	Sacramento	Yes
Special Faculty Permit Review Committee	August 14, 2014	Sacramento	Yes
Prescribing Task Force	September 29, 2014	Sacramento	Yes
Panel A Meeting	October 23, 2014	San Diego	Yes
Enforcement Committee	October 23, 2014	San Diego	Yes
Executive Committee	October 23, 2014	San Diego	Yes
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	Yes
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Midwifery Advisory Council	December 4, 2014	Sacramento	Yes
Panel A Meeting	January 29, 2015	Sacramento	Yes
Education and Wellness Committee	January 29, 2015	Sacramento	Yes
Enforcement Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes
Midwifery Advisory Council	March 26, 2015	Sacramento	Yes
Prescribing Task Force	April 13, 2015	Sacramento	Yes
Panel A Meeting	May 7, 2015	Los Angeles	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Los Angeles	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Executive Committee	July 30, 2015	Burlingame	Yes
Education and Wellness Committee	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Midwifery Advisory Council	August 13, 2015	Sacramento	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes

Public Outreach, Education and Wellness Committee	October 29, 2015	San Diego	Yes
Enforcement Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Midwifery Advisory Council	December 3, 2015	Sacramento	Yes
Special Faculty Permit Review Committee	December 3, 2015	Sacramento	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Enforcement Committee	January 21, 2016	Sacramento	Yes
Public Outreach, Education and Wellness Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Midwifery Advisory Council	March 10, 2016	Sacramento	Yes
Felix Yip, M.D.			
Date Appointed: January 30, 2013			
Meeting Type	**Meeting Date**	**Meeting Location**	**Attended**
Panel A Meeting	April 25, 2013	Los Angeles	Yes
Quarterly Board Meeting	April 25, 2013 April 26, 2013	Los Angeles	Yes
Interim Board Meeting	June 4, 2013	Sacramento	Yes
Panel A Meeting	July 18, 2013	Sacramento	Yes
Quarterly Board Meeting	July 18, 2013 July 19, 2013	Sacramento	Yes
Enforcement Committee	October 23, 2013	Riverside	Yes
Panel A Meeting	October 24, 2013	Riverside	Yes
Quarterly Board Meeting	October 24, 2013 October 25, 2013	Riverside	No
Interim Panel A Meeting	December 9, 2013	Sacramento	Yes
Panel A Meeting	February 5, 2014 February 6, 2014	Burlingame	Yes
Quarterly Board Meeting	February 6, 2014 February 7, 2014	Burlingame	Yes
Special Faculty Permit Review Committee	March 27, 2014	Teleconference	Yes
Panel A Meeting	May 1, 2014	Los Angeles	Yes
Enforcement Committee	May 1, 2014	Los Angeles	Yes
Quarterly Board Meeting	May 1, 2014 May 2, 2014	Los Angeles	Yes

Panel A Meeting	July 24, 2014	Sacramento	Yes
Quarterly Board Meeting	July 24, 2014 July 25, 2014	Sacramento	Yes
Special Faculty Permit Review Committee	August 14, 2014	Teleconference	Yes
Panel A Meeting	October 23, 2014	San Diego	No
Enforcement Committee	October 23, 2014	San Diego	No
Quarterly Board Meeting	October 23, 2014 October 24, 2014	San Diego	No
Interim Board Meeting	December 1, 2014	Teleconference	Yes
Panel A Meeting	January 29, 2015	Sacramento	Yes
Enforcement Committee	January 29, 2015	Sacramento	Yes
Quarterly Board Meeting	January 29, 2015 January 30, 2015	Sacramento	Yes No
Panel A Meeting	May 7, 2015	Sacramento	Yes
Quarterly Board Meeting	May 7, 2015 May 8, 2015	Sacramento	Yes
Panel A Meeting	July 30, 2015	Burlingame	Yes
Quarterly Board Meeting	July 30, 2015 July 31, 2015	Burlingame	Yes
Panel A Meeting	October 29, 2015	San Diego	Yes
Enforcement Committee	October 29, 2015	San Diego	Yes
Quarterly Board Meeting	October 29, 2015 October 30, 2015	San Diego	Yes
Panel A Meeting	January 21, 2016	Sacramento	Yes
Enforcement Committee	January 21, 2016	Sacramento	Yes
Quarterly Board Meeting	January 22, 2016	Sacramento	Yes
Interim Board Meeting	February 26, 2016	Teleconference	Yes
Panel A Meeting	May 5, 2016	Los Angeles	Yes
Quarterly Board Meeting	May 5, 2016 May 6, 2016	Los Angeles	Yes
Application Review and Special Programs Committee	June 22, 2016	Teleconference	Yes
Panel A Meeting	July 27, 2016 July 28, 2016	San Francisco	No Yes
Quarterly Board Meeting	July 28, 2016 July 29, 2016	San Francisco	Yes

Attachment G

Board Member Committee Roster

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

Committee	*Members*
Executive Committee	**Dev GnanaDev, M.D, President** Denise Pines, Vice President Ronald Lewis, M.D, Secretary Judge Katherine Feinstein, (ret.), Member at Large Howard Krauss, M.D., Licensing Committee Chair Kristina Lawson, Member at Large Felix Yip, M.D., Enforcement Committee Chair
Licensing Committee	**Howard Krauss, M.D., Chair** Michael Bishop, M.D. Dev GnanaDev, M.D. Randy Hawkins, M.D. Denise Pines David Warmorth
Enforcement Committee	**Felix Yip, M.D., Chair** Michelle Bholat, M.D. Judge Katherine Feinstein, (ret.) Sharon Levine, M.D. Ronald Lewis, M.D. Jamie Wright
Application Review and Special Programs Committee	**Michael Bishop, M.D., Chair** Kristina Lawson Felix Yip, M.D.
Special Faculty Permit Review Committee	**Michelle Bholat, M.D., Chair** Neal Cohen, M.D. (UCSF) Daniel Giang, M.D. (LLU) Jonathan Hiatt, M.D. (UCLA) Laurence Katznelson, M.D. (Stanford) For-Shing Lui, M.D. (CNUCOM) Michael Nduati, M.D. (UCR) James Nuovo, M.D. (UCD) Andrew Ries, M.D. (UCSD) Frank Sinatra, M.D. (USC) Julianne Toohey, M.D. (UCI) Brenda Sutton-Wills
Public Outreach, Education, and Wellness Committee	**Randy Hawkins, M.D., Chair** Howard Krauss, M.D. Sharon Levine, M.D. Ronald Lewis, M.D. Denise Pines Brenda Sutton-Wills David Warmoth
Midwifery Advisory Council	**Carrie Sparrevohn, L.M., Chair** Anne Marie Adams, M.D. Jocelyn Dugan Tosi Marceline, L.M. Barbara Yaroslavsky

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

Attachment H

B&P Code Section and CCR Section for Application Review and Special Programs Committee

- B&P Code Section 2099
- B&P Code Section 2072
- B&P Code Section 2073
- B&P Code Section 2111
- B&P Code Section 2112
- B&P Code Section 2113
- B&P Code Section 2115
- B&P Code Section 2135.5
- Title 16, CCR, Section 1301

B&P Code Section and CCR Section for Applicant Review and Special Programs Committee

B&P Code Section 2099: Delegation of Authority
Notwithstanding any other provision of this chapter, the Division of Licensing may delegate to any member of the division its authority to approve the admission of candidates to examinations and to approve the issuance of physician's and surgeon's certificates to applicants who have met the specific requirements therefor. The division may further delegate to the executive director or other official of the board the authority to approve the admission of candidates to examinations and to approve the issuance of physician's and surgeon's certificates to applicants who have met the specific requirements therefor in routine cases to candidates and applicants who clearly meet the requirements of this chapter.

B&P Code Section 2072: Employment in state institutions of persons licensed in another state
Notwithstanding any other provision of law and subject to the provisions of the State Civil Service Act, any person who is licensed to practice medicine in any other state, who meets the requirements for application set forth in this chapter and who registers with and is approved by the Division of Licensing, may be appointed to the medical staff within a state institution and, under the supervision of a physician and surgeon licensed in this state, may engage in the practice of medicine on persons under the jurisdiction of any state institution. Qualified physicians and surgeons licensed in this state shall not be recruited pursuant to this section.

No person appointed pursuant to this section shall be employed in any state institution for a period in excess of two years from the date the person was first employed, and the appointment shall not be
extended beyond the two-year period. At the end of the two-year period, the physician shall have been issued a physician's and surgeon's certificate by the board in order to continue employment.
Until the physician has obtained a physician's and surgeon's certificate from the board, he or she shall not engage in the practice of medicine in this state except to the extent expressly permitted herein.

B&P Code Section 2073: Employment in county general hospitals of persons licensed in another state
Notwithstanding any other provision of law, any person who is licensed to practice medicine in any other state who meets the requirements for application set forth in this chapter, and who
registers with and is approved by the Division of Licensing, may be employed on the resident medical staff within a county general hospital and, under the supervision of a physician and surgeon

licensed in this state, may engage in the practice of medicine on persons within the county institution. Employment pursuant to this section is authorized only when an adequate number of qualified
resident physicians cannot be recruited from intern staffs in this state.

No person appointed pursuant to this section shall be employed in any county general hospital for a period in excess of two years from the date the person was first employed, and the employment shall not be extended beyond the two-year period. At the end of the two-year period, the physician shall have been issued a physician's and surgeon's certificate by the board in order to continue as a member of the resident staff. Until the physician has obtained a physician's and surgeon's certificate from the board, he or she shall not engage in the practice of medicine in this state except to the extent expressly permitted herein.

B&P Code Section 2111: Postgraduate medical school study by non-citizens

(a) Physicians who are not citizens but who meet the requirements of subdivision (b) and who seek postgraduate study in an approved medical school may, after receipt of an appointment from the dean of the California medical school and application to and approval by the Division of Licensing, be permitted to participate in the professional activities of the department or division in the medical school to which they are appointed. The physician shall be under the direction of the head of the department to which he or she is appointed, supervised by the staff of the medical school's medical center, and known for these purposes as a "visiting fellow." The visiting fellow shall wear a visible name tag containing the title "visiting fellow" when he or she provides clinical services.

(b) (1) Application for approval shall be made on a form prescribed by the division and shall be accompanied by a fee fixed by the division in an amount necessary to recover the actual application processing costs of the program. The application shall show that the person does not immediately qualify for a physician's and surgeon's certificate under this chapter and that the person has completed at least three years of postgraduate basic residency requirements. The application shall include a written statement of the recruitment procedures followed by the medical school before offering the appointment to the applicant.

(2) Approval shall be granted only for appointment to one medical school, and no physician shall be granted more than one approval for the same period of time.

(3) Approval may be granted for a maximum of three years and shall be renewed annually. The medical school shall submit a request for renewal on a form prescribed by the division, which shall be accompanied by a renewal fee fixed by the division in a amount necessary to recover the actual application processing costs of the program.

(c) Except to the extent authorized by this section, the visiting fellow may not engage in the practice of medicine. Neither the visiting fellow nor the medical school may assess any charge for the medical services provided by the visiting fellow, and the visiting fellow may not receive any other compensation therefor.

(d) The time spent under appointment in a medical school pursuant to this section may not be used to meet the requirements for licensure under Section 2102.

(e) The division shall notify both the visiting fellow and the dean of the appointing medical school of any complaint made about the visiting fellow.
The division may terminate its approval of an appointment for any act that would be grounds for discipline if done by a licensee. The division shall provide both the visiting fellow and the dean of the medical school with a written notice of termination including the basis for that termination. The visiting fellow may, within 30 days after the date of the notice of termination, file a written appeal to the division. The appeal shall include any documentation the visiting fellow wishes to present to the division.
(f) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country and recognized by the division from participating in any program established pursuant to this section.

B&P Code Section 2112: Participation in fellowship program by non-citizens

(a) Physicians who are not citizens and who seek postgraduate study, may, after application to and approval by the Division of Licensing, be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a hospital in this state which is approved by the Joint Committee on Accreditation of Hospitals and providing the service is satisfactory to the division. Such physicians shall at all times be under the direction and supervision of a licensed, board-certified physician and surgeon who is recognized as a clearly outstanding specialist in the field in which the foreign fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor is for a period of one year, but may be renewed annually upon application to and approval by the division. The approval may not be renewed more than four times. The division may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.

(b) Except to the extent authorized by this section, no such visiting physician may engage in the practice of medicine or receive compensation therefor. The time spent under appointment in a medical school pursuant to this section may not be used to meet the requirements for licensure under Section 2101 or 2102.

(c) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country from participating in any program established pursuant to this section.

B&P Code Section 2113: Certificate of registration to practice incident to duties as medical school faculty member

(a) Any person who does not immediately qualify for a physician's and surgeon's certificate under this chapter and who is offered by the dean of an approved medical school in this state a full-time faculty position may, after application to and approval by the Division of Licensing, be granted a certificate of registration to engage in the practice of medicine only to the extent that the practice is incident to and a necessary part of his or her duties as approved by the division in connection with the faculty position. A certificate of registration does not authorize a registrant to admit patients to a nursing or a skilled or assisted living facility unless that facility is formally affiliated with

the sponsoring medical school. A clinical fellowship shall not be submitted as a faculty service appointment.

(b) Application for a certificate of registration shall be made on a form prescribed by the division and shall be accompanied by a registration fee fixed by the division in a amount necessary to recover the actual application processing costs of the program. To qualify for the certificate, an applicant shall submit all of the following:

(1) If the applicant is a graduate of a medical school other than in the United States or Canada, documentary evidence satisfactory to the division that he or she has been licensed to practice medicine and surgery for not less than four years in another state or country whose requirements for licensure are satisfactory to the division, or has been engaged in the practice of medicine in the United States for at least four years in approved facilities, or has completed a combination of that licensure and training.

(2) If the applicant is a graduate of an approved medical school in the United States or Canada, documentary evidence that he or she has completed a resident course of professional instruction as required in Section 2089.

(3) Written certification by the head of the department in which the applicant is to be appointed of all of the following:

(A) The applicant will be under his or her direction.

(B) The applicant will not be permitted to practice medicine unless incident to and a necessary part of his or her duties as approved by the division in subdivision (a).

(C) The applicant will be accountable to the medical school's department chair or division chief for the specialty in which the applicant will practice.

(D) The applicant will be proctored in the same manner as other new faculty members, including, as appropriate, review by the medical staff of the school's medical center.

(E) The applicant will not be appointed to a supervisory position at the level of a medical school department chair or division chief.

(4) Demonstration by the dean of the medical school that the applicant has the requisite qualifications to assume the position to which he or she is to be appointed and that shall include a written statement of the recruitment procedures followed by the medical school before offering the faculty position to the applicant.

(c) A certificate of registration shall be issued only for a faculty position at one approved medical school, and no person shall be issued more than one certificate of registration for the same period of time.

(d) (1) A certificate of registration is valid for one year from its date of issuance and may be renewed twice.

A request for renewal shall be submitted on a form prescribed by the division and shall be accompanied by a renewal fee fixed by the division in an amount necessary to recover the actual application processing costs of the program.

(2) The dean of the medical school may request renewal of the registration by submitting a plan at the beginning of the third year of the registrant's appointment demonstrating the registrant's continued progress toward licensure and, if the registrant is a graduate of a medical school other than in the United States or Canada, that the registrant has been issued a certificate by the Educational Commission for Foreign Medical Graduates. The division may, in its discretion, extend the registration for a two-year period to facilitate the registrant's completion of the licensure process.

(e) If the registrant is a graduate of a medical school other than in the United States or Canada, he or she shall meet the requirements of Section 2102 or 2135, as appropriate, in order to obtain a physician's and surgeon's certificate. Notwithstanding any other provision of law, the division may accept clinical practice in an appointment pursuant to this section as qualifying time to meet the postgraduate training requirements in Section 2102, and may, in its discretion, waive the examination and the Educational Commission for Foreign Medical Graduates certification requirements specified in Section 2102 in the event the registrant applies for a physician's and surgeon's certificate. As a condition to waiving any examination or the Educational Commission for Foreign Medical Graduates certification requirement, the division in its discretion, may require an applicant to pass the clinical competency examination referred to in subdivision (d) of Section 2135. The division shall not waive any examination for an applicant who has not completed at least one year in the faculty position.

(f) Except to the extent authorized by this section, the registrant shall not engage in the practice of medicine, bill individually for medical services provided by the registrant, or receive compensation therefor, unless he or she is issued a physician's and surgeon's certificate.

(g) When providing clinical services, the registrant shall wear a visible name tag containing the title "visiting professor" or "visiting faculty member," as appropriate, and the institution at which the services are provided shall obtain a signed statement from each patient to whom the registrant provides services acknowledging that the patient understands that the services are provided by a person who does not hold a physician's and surgeon's certificate but who is qualified to participate in a special program as a visiting professor or faculty member.

(h) The division shall notify both the registrant and the dean of the medical school of a complaint made about the registrant. The division may terminate a registration for any act that would be grounds for discipline if done by a licensee. The division shall provide both the registrant and the dean of the medical school with written notice of the termination and the basis for that termination. The registrant may, within 30 days after the date of the notice of termination, file a written appeal to the division. The appeal shall include any documentation the registrant wishes to present to the division.

B&P Code Section 2115: Postgraduate study fellowship program in specialty or subspecialty in medically underserved area; Requirements; Supervision

(a) Physicians who are not citizens and who seek postgraduate study may, after application to and approval by the Division of Licensing, be permitted to participate in a fellowship program in a specialty or subspecialty field, providing the fellowship program is given in a clinic or hospital in a medically underserved area of this state that is licensed by the State Department of Health Services or is exempt from licensure pursuant to subdivision (b) or (c) of Section 1206 of the Health and Safety Code, and providing service is satisfactory to the division. These physicians shall at all times be under the direction and supervision of a licensed, board certified physician and surgeon who has an appointment with a medical school in California and is a specialist in the field in which the fellow is to be trained. The supervisor, as part of the application process, shall submit his or her curriculum vitae and a protocol of the fellowship program to be completed by the foreign fellow. Approval of the program and supervisor

is for a period of one year, but may be renewed annually upon application to and approval by the division. The approval may not be renewed more than four times. The division may determine a fee, based on the cost of operating this program, which shall be paid by the applicant at the time the application is filed.

(b) Except to the extent authorized by this section, no visiting physician may engage in the practice of medicine or receive compensation therefor. The time spent under appointment in a clinic pursuant to this section may not be used to meet the requirements for licensure under Section 2102.

(c) Nothing in this section shall preclude any United States citizen who has received his or her medical degree from a medical school located in a foreign country from participating in any program established pursuant to this section.

(d) For purposes of this section, a medically underserved area means a federally designated Medically Underserved Area, a federally designated Health Professional Shortage Area, and any other clinic or hospital determined by the board to be medically underserved. Clinics or hospitals determined by the board pursuant to this subdivision shall be reported to the Office of Statewide Health Planning and Development.

***B&P Code Section 2135.5:* Satisfaction of requirements.**

Upon review and recommendation, the Division of Licensing may determine that an applicant for a physician's and surgeon's certificate has satisfied the medical curriculum requirements of Section 2089, the clinical instruction requirements of Sections 2089.5 and 2089.7, and the examination requirements of Section 2170 if the applicant meets all of the following criteria:

(a) He or she holds an unlimited and unrestricted license as a physician and surgeon in another state and has held that license continuously for a minimum of four years prior to the date of application.

(b) He or she is certified by a specialty board that is a member board of the American Board of Medical Specialties.

(c) He or she is not subject to denial of licensure under Division 1.5 (commencing with Section 475) or Article 12 (commencing with Section 2220).

(d) He or she has not graduated from a medical school that has been disapproved by the division or that does not provide a resident course of instruction.

(e) He or she has graduated from a medical school recognized by the division. If the applicant graduated from a medical school that the division recognized after the date of the applicant's graduation, the division may evaluate the applicant under its regulations.

(f) He or she has not been the subject of a disciplinary action by a medical licensing authority or of an adverse judgment or settlement resulting from the practice of medicine that, as determined by the division, constitutes a pattern of negligence or incompetence.

Title 16, CCR, Section 1301: Delegation to Chief of Licensing

(a) The authority of the division to approve applications and issue certificates or licenses with or without an examination, to designate the location of and to administer examinations, and to approve applications for and issue fictitious name permits is hereby delegated to the chief of licensing of the division, or his or her designee.

(b) Applications for licensure and applications for participation in special programs and faculty appointments authorized in the Medical Practice Act may be referred in accordance with subsection (c) to the division's Application Review Committee or Special Programs Committee, as the case may be. Members appointed to the committees may advise the chief of licensing, or his or her designee on the disposition of the above-mentioned applications.

(c) An application accompanied by necessary supporting documentation may be referred to the applicable committee referred to in subsection (b) at the request of the applicant, at the request of a division member, or at the instance of the chief of licensing, or his or her designee.

Attachment I

B&P Code Section for Special Faculty Permit Review Committee

- B&P Code Section 2168.1

B&P Code Section for Special Faculty Permit Review Committee

B&P Code Section 2168.1(c): Eligibility requirements; Review Committee

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

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

Attachment J

B&P Code Section for Midwifery Advisory Council

- B&P Code Section 2509

B&P Code Section for Midwifery Advisory Council

B&P Code Section 2509: Midwifery Advisory Council

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

Attachment K

B&P Code Section for Panel A/B

- B&P Code Section 2008

B&P Code Section for Panel A and Panel B

B&P Code Section 2008: Formation of panels from membership
The board may appoint panels from its members for the purpose of fulfilling the obligations established in subdivision (c) of Section 2004. Any panel appointed under this section shall at no time
be comprised of less than four members and the number of public members assigned to the panel shall not exceed the number of licensed physician and surgeon members assigned to the panel. The president of the board shall not be a member of any panel unless there is a vacancy in the membership of the board. Each panel shall annually elect a chair and a vice chair.

Attachment L

Strategic Plan

Medical Board of California

Strategic Plan 2014

Mission:

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

Medical Board of California Members:

Sharon Levine, M.D. - President
David Serrano Sewell, J.D. - Vice President
Silvia Diego, M.D. - Secretary

Michael Bishop, M.D.
Dev GnanaDev, M.D.
Howard R. Krauss, M.D.
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Denise Pines
Gerrie Schipske, R.N.P., J.D.
Jamie Wright, Esq
Barbara Yaroslavsky
Felix C. Yip, M.D.

Kimberly Kirchmeyer, Executive Director

Medical Board of California
Strategic Plan -- 2014

Goals:

1. **Professional Qualifications:** Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and demonstrated competence.

2. **Regulations and Enforcement:** Protect the public by effectively enforcing laws and standards.

3. **Consumer and Licensee Education**: Increase Public and Licensee awareness of the Board, its mission, activities and services.

4. **Organizational Relationships:** Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.

5. **Organizational Effectiveness:** Evaluate and enhance organizational effectiveness and systems to improve service.

6. **Access to Care, Workforce, and Public Health:** Understanding the implications of Health Care Reform and evaluate how it may impact access to care and issues surrounding healthcare delivery, as well as promote public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.

Medical Board of California
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Goal 1: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and demonstrated competence.			
1.1	**Define what is necessary to demonstrate competency and promote safe re-entry into medical practice after extended absences, including looking at the current difference between the requirement for retraining for re-entry (5 years) and the disciplinary re-entry (18 months).**		**HIGH - 1**
Activities		**Date**	**Responsible Parties**
a.	Examine and identify other states' definitions and requirements for re-entry into practice.	Jan-2015	Licensing Outreach Manager
b.	Compare the elements with California's existing practices for re-entry and determine if there are differences.	Jan-2015	Licensing Outreach Manager
c.	Consult with experts in the field of professional skills and competency.	May-2015	Licensing Outreach Manager
d.	Draft a report based upon this research, then propose appropriate length of non-practice to Board for review and approval.	Oct-2015	Chief of Legislation
e.	Make recommendations to the Business and Professions Committees and seek legislation.	Nov-2015	Chief of Legislation

Goal 1: Professional Qualifications: Promote the professional qualifications of medical practitioners by setting requirements for licensure and relicensure, including education, experience, and demonstrated competence.			
1.2	**Examine the Federation of State Medical Boards' (FSMB) Maintenance of Licensure (MOL) and the American Board of Medical Specialties' (ABMS) Maintenance of Certification (MOC) initiatives to determine if changes are needed to existing requirements in California (continuing medical education) in order to ensure maintenance of competency of California physicians.**		**HIGH - 2**
Activities		**Date**	**Responsible Parties**
a.	Review the FSMB MOL and the ABMS MOC documents and identify the various components.	Jan-2015	Licensing Outreach Manager
b.	Compare the elements with California's laws and regulations regarding continuing medical education and determine if there are differences.	Apr-2015	Licensing Outreach Manager
c.	Staff will draft changes to laws and regulations as necessary.	May-2015	Licensing Outreach Manager
d.	Hold an interested parties meeting to discuss the proposed changes.	Jun-2015	Chief of Legislation
e.	Present the final changes to the laws and regulations to the Board for consideration.	Jul-2015	Chief of Legislation
f.	Based on the discussion by the Board, if legislative changes are needed, find an author and initiate the legislative process.	Oct-2015	Chief of Legislation
g.	Based on the discussion by the Board, if regulatory changes are needed, have staff initiate the rule-making process.	Oct-2015	Licensing Outreach Manager

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.1	**Effectively transition the investigators from the Board to Department of Consumer Affairs in order to improve investigative time frames.**		**High - 1**
Activities		**Date**	**Responsible Parties**
a.	Identify existing investigative timeframes.	Dec-2013	Executive Director and Chief of Enforcement
b.	Hold regular meetings with DCA to discuss the transition of the investigators.	Oct-2013 and ongoing	Executive Director and Chief of Enforcement
c.	Review and approve the Memorandum of Understanding to identify how the transition will be implemented and DCA/Board responsibilities.	Mar-2014	Executive Director, Chief of Enforcement and Senior Staff Counsel
d.	Update the Board on the transition of staff.	Quarterly	Executive Director and Chief of Enforcement
e.	Meet with labor relations to discuss transition issues.	Apr-2014	Executive Director and Chief of Enforcement
f.	Meet with staff to discuss the transition.	Ongoing	Executive Director and Chief of Enforcement
g.	Finalize the transition and movement of staff.	Jul-2014	Executive Director and Chief of Enforcement
h.	Gather and review investigative timeframes.	Monthly	Executive Director and Enforcement Manager
i.	Report investigative timeframes to the Board.	Quarterly	Executive Director and Enforcement Manager

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.2	**Review the laws and regulations pertaining to the Board's responsibility to regulate outpatient surgery centers and suggest amendments.**		**High - 2**
Activities		**Date**	**Responsible Parties**
a.	Review existing laws to determine which laws/regulations need to be revised to meet the current needs for consumer protection and medical education.	Oct-2013	Chief of Licensing
b.	Provide a summary of the proposed changes to the interested parties.	Jan-2014	Chief of Licensing
c.	Determine which changes can be done with regulations versus legislation.	Jan-2014	Senior Staff Counsel
d.	Hold an interested parties meeting to discuss the proposed changes.	Jan-2014	Chief of Licensing
e.	Present the proposed changes to the Board to initiate the legislative process, if needed.	Oct-2014	Chief of Legislation
f.	Initiate the rule-making process.	Oct-2014	Chief of Licensing and Senior Staff Counsel
g.	Work with the stakeholders to facilitate implementation of regulatory and statutory changes.	Jan-2015 and Jan-2016	Chief of Licensing and Senior Staff Counsel
2.3	**Identify methods to help ensure the Board is receiving all the mandated reports.**		**High - 3**
Activities		**Date**	**Responsible Parties**
a.	Send individual notifications to all mandated reporters regarding the reporting requirements.	Annually	Enforcement Manager
b.	Obtain a list of reports from the National Practitioner Databank to cross check with the Board's information.	May annually	Research Program Specialist
c.	Identify opportunities for placement of articles on mandatory reporting in professional newsletters/publications and provide content to be used.	July-2014 and ongoing	Public Information Officer
d.	Conduct outreach on reporting requirements to all mandated reporters, as resources allow.	July-2014 and ongoing	Public Information Officer

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.4	**Determine whether the Registered Dispensing Optician (RDO) Program should remain within the authority of the Board.**		**High - 4**
Activities		**Date**	**Responsible Parties**
a.	Initiate discussions with the DCA, Board of Optometry, stakeholders, professional groups, and consumer representatives to discuss the potential transfer of the RDO program.	Aug-2014	Chief of Legislation; Executive Director
b.	Write a summary report of the discussions for the Board's review and approval.	Oct-2014	Chief of Legislation; Executive Director
c.	Make recommendations to the Business and Professions Committees and seek legislation if necessary.	Nov-2014	Chief of Legislation; Executive Director

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.5	**Examine the Expert Reviewer Program and policies to determine how it may be improved, including recruitment, evaluation of experts, opportunities for education, and policies governing the Board's use of experts.**		**High - 5**
Activities		**Date**	**Responsible Parties**
a.	Continue to evaluate, revise, and update the training program and materials for experts.	Ongoing	Enforcement Manager
b.	Require the Deputies Attorney General who use the experts to provide evaluations on each expert report and each expert that testifies.	Within 30 days of completion of each expert task	Enforcement Manager
c.	Examine the evaluations to determine if there is a need for remediation or elimination of the experts.	Within 30 days of the evaluation	Enforcement Manager
d.	Continue to provide statewide trainings for the expert reviewers.	Provide two trainings	Enforcement Manager
e.	Provide a status report to the Board on the Expert Reviewer Program.	Quarterly	Enforcement Manager

Goal 2: Regulations and enforcement: Protect the public by effectively enforcing laws and standards.			
2.6	**Partner with the Office of Administrative Hearings (OAH) and Health Quality Enforcement Section (HQES) of the Attorney General's (AG) office to identify opportunities, and design curriculum, for the ongoing education of judges.**		**Med - 6**
Activities		**Date**	**Responsible Parties**
a.	Examine recent disciplinary decisions to identify any training needed for the Administrative Law Judges.	Monthly	Enforcement Manager
b.	Identify subject matter experts and arrange OAH training at least every other month.	Six times annually	Enforcement Manager
c.	Provide OAH with updates on the Board issues and changes to disciplinary guidelines.	Annually	Executive Director and Enforcement Manager
2.7	**Study disciplinary and administrative cases, including looking at physicians in training, to identify trends or issues that may signal dangerous practices or risks.**		**Med - 7**
Activities		**Date**	**Responsible Parties**
a.	Identify the metrics to be used to examine disciplinary cases within last five years.	Aug-2014	Research Program Specialist
b.	Identify the red flags that could be used to predict patterns before serious harm occurs.	Nov-2014	Research Program Specialist
c.	Draft a report based upon the findings to present to the Board for possible action.	Jan-2015	Research Program Specialist

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
3.1	**Review the Board's public disclosure laws regarding posting postgraduate information and move forward with rescinding the 10- year time limit for posting disciplinary information/documents.**		**High - 1**
Activities		**Date**	**Responsible Parties**
a.	Seek legislation to rescind the 10-year time limit for posting disciplinary information/documents.	Feb-2014	Chief of Legislation
b.	Discuss the proposal to remove the posting of postgraduate training information with interested parties, specifically consumer interest groups.	Aug-2014	Chief of Legislation and Chief of Licensing
c.	Provide the recommendation on postgraduate training information to the Board for approval.	Oct-2014	Chief of Legislation and Chief of Licensing
d.	Make recommendations to the Business and Professions Committees and seek legislation.	Nov-2014	Chief of Legislation
3.2	**Expand all outreach efforts to educate physicians, medical students, and the public, regarding the Board's laws, regulations, and responsibilities.**		**High - 2**
Activities		**Date**	**Responsible Parties**
a.	Engage in two or more consumer outreach events with area organizations, as travel permits.	Quarterly	Public Information Officer
b.	Continue to provide articles and information in the Newsletter regarding potential violations to assist physicians in understanding the laws and regulations.	Quarterly	Public Information Officer
c.	Launch a Twitter account to provide stakeholders with updates on best practices, changes in laws and regulations, and recent Board activities.	Aug-2014	Public Information Officer
d.	Provide two or more articles to appropriate media outlets regarding laws and regulations and what they mean to stakeholders.	Quarterly	Public Information Officer

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
3.3	**Examine opportunities for the Board to provide training to licensees via the internet, including hosting webinars on subjects of importance to public protection and public health.**		**High - 3**
Activities		**Date**	**Responsible Parties**
a.	Work with DCA to establish webinar protocol and the tools needed to hold successful webinars.	Jun-2014	Public Information Officer
b.	Work with healthcare agencies and organizations regarding topics of interest for training purposes.	Sep-2014	Public Information Officer
c.	Develop interactive webinar content for licensees to promote public protection.	Jan-2015	Public Information Officer
d.	Conduct webinars to promote public protection.	Apr-2015 and bi-annually	Public Information Officer

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
3.4	**Establish a proactive approach in communicating via the media, and other various publications, to inform and educate the public, including California's ethnic communities, regarding the Board's role in protecting consumers through its programs and disciplinary actions.**		**High - 4**
Activities		**Date**	**Responsible Parties**
a.	Expand and continue to cultivate relationships with various ethnic communities through their individual media outlets by providing information and education on the Board's role and responsibilities. Provides updates to the Board.	Quarterly	Public Information Officer
b.	Engage in television and radio interviews promoting transparency and providing needed information as requested.	Ongoing	Public Information Officer
c.	Create PSAs and videos that can be placed online for viewing that address topics of interest as well as educate stakeholders.	Aug-2014 and ongoing	Public Information Officer
d.	Promote the Board's website and provide consumer friendly information on how to file a complaint.	Ongoing	Public Information Officer

Goal 3: Consumer and Licensee Education: Increase Public and Licensee awareness of the Board, its mission, activities and services.			
3.5	**Establish a method for hosting public seminars taught by legal or enforcement personnel on disciplinary cases, laws violated, and other issues of importance to the profession and the public.**		**Med - 5**
Activities		**Date**	**Responsible Parties**
a.	Develop a list of groups who have shown interest for Board speakers in the past, in order to identify similar groups that the Board can reach out to for potential seminars.	Sep-2014	Public Information Officer
b.	Cultivate relationships with groups not previously engaged, in order to provide seminars.	Sep-2014	Public Information Officer
c.	Revise and update presentations already developed for the purpose of providing seminars.	Jan-2015	Public Information Officer, Senior Staff Counsel, and Enforcement Manager
d.	Conduct and record the seminar and post it on the Board's website.	Mar-2015 and ongoing	Public Information Officer, Senior Staff Counsel, and Enforcement Manager

Goal 4: Organizational Relationships: Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.			
4.1	**Build collaborative relationships with elected officials and their staffs to work toward shared interests in consumer protection and advancing the profession.**		**High - 1**
Activities		**Date**	**Responsible Parties**
a.	Develop a plan to visit Senate and Assembly Business and Professions Committee members and staff with Board members.	Oct-2014	Chief of Legislation
b.	Invite legislative members and staff to Board meetings.	Quarterly	Chief of Legislation
c.	Continue to reach out to new legislative members to inform them of the Board's roles and responsibilities.	Ongoing	Chief of Legislation
4.2	**Improve educational outreach to hospitals, health systems, and similar organizations about the Board and its programs.**		**High - 2**
Activities		**Date**	**Responsible Parties**
a.	Arrange licensing fairs and orientations at teaching facilities to educate applicants on the Board and its application and licensing processes.	Monthly	Licensing Outreach Manager
b.	Provide presentations on the Board's roles, responsibilities, mandatory reporting requirements, and processes at hospitals, health systems, and similar organizations, as travel permits.	Quarterly	Public Information Officer and Appropriate Subject Matter Expert

Goal 4: Organizational Relationships: Improve effectiveness by building relationships with related organizations to further the Board's mission and goals.		
4.3	**Optimize relationships with the accreditation agencies, associations representing hospitals and medical groups, consumer organizations, professional associations and societies, the Federation of State Medical Boards, federal government agencies, and other state agencies, including the Department of Consumer Affairs and the Business, Consumer Services and Housing Agency.**	**High - 3**

Activities		**Date**	**Responsible Parties**
a.	Develop a contact list of representatives for stakeholder organizations.	Mar-2014 and update annually	Public Information Officer
b.	Offer to make presentations to all stakeholder organizations to provide educational information and updates on the Board's current activities, as travel permits.	May-2014 and ongoing	Public Information Officer
c.	Maintain regular communication with stakeholders, including attending stakeholder meetings as appropriate, as travel permits.	Ongoing	Public Information Officer
d.	Invite stakeholders to participate in the Board's Newsletter with articles and information, approved by the Editorial Committee, pertinent to licensees.	Mar-2014 and ongoing	Public Information Officer
e.	Provide activity reports to the Education and Wellness Committee.	At each committee meeting	Public Information Officer

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.			
5.1	**Review licensing applications within 45 days. Reduce complaint processing, investigations, and discipline timelines by 10% from prior fiscal year; reduce complaint processing median to less than 70 days, with 50-60% less than 50 days.**		**High - 1**
Activities		**Date**	**Responsible Parties**
a.	Gather and evaluate statistics regarding the Board's application review timeframes.	Quarterly	Chief of Licensing
b.	Determine if the Board is reviewing applications within 45 days, and if not, identify possible problems and solutions.	Quarterly	Chief of Licensing
c.	Implement the possible solutions for licensing process enhancement.	As Necessary	Chief of Licensing
d.	Gather and evaluate statistics regarding the Board's enforcement timeframes.	Quarterly	Enforcement Manager
e.	Determine if the Board is meeting enforcement timeframes goals, and if not, identify possible problems and solutions.	Quarterly	Enforcement Manager
f.	Implement the possible solutions for enforcement process enhancements.	As Necessary	Enforcement Manager

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.			
5.2	**Obtain and monitor feedback from those who access Board services and provide a report to the Board.**		**High - 2**
Activities		**Date**	**Responsible Parties**
a.	Evaluate consumer satisfaction statistics.	Quarterly	Research Program Specialist
b.	Evaluate applicant satisfaction statistics.	Quarterly	Research Program Specialist
c.	Evaluate web user satisfaction statistics.	Quarterly	Research Program Specialist
d.	Evaluate Newsletter reader satisfaction statistics.	Quarterly	Research Program Specialist
e.	Create a summary report of satisfaction statistics and present them to the Board.	Quarterly	Research Program Specialist and Executive Director
f.	Implement changes as needed based upon the feedback received.	As Necessary	Research Program Specialist and Executive Director

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.			
5.3	**Establish a consistent approach to educating staff about the Board's activities and priorities set by Board Members, including but not limited to facilitating staff attendance at meetings and Board Member attendance at staff meetings.**		**Med - 3**
Activities		**Date**	**Responsible Parties**
a.	Send an email to all staff after each Board meeting indicating the action taken by the Board and any projects that will need to be completed.	Quarterly	Executive Director
b.	Send emails to all staff updating them on projects of the Board.	Monthly	Executive Director
c.	Hold regular staff meetings and provide a Q and A time for staff.	Quarterly	Executive Director
d.	Send an email to staff notifying them of upcoming meetings where they may attend.	Quarterly	Executive Director
e.	Invite Board Members to all staff meetings.	Quarterly	Executive Director

Goal 5: Organizational Effectiveness: Evaluate and enhance organizational effectiveness and systems to improve service.			
5.4	**Conduct a review every two years of each of the Committees established by the Board to determine if they are still needed, if they are fulfilling the purpose for which they were established, and determine if they should continue, be reconfigured, or eliminated.**		**Med - 4**
Activities		**Date**	**Responsible Parties**
a.	Add an agenda item to the Board's October meeting to review the Committees.	Oct-2014 and Biennially	Executive Director
b.	Review the Committee Roster in October and identify Committees that may no longer be needed or may need reconfigured.	Oct-2014 and Biennially	Executive Director
c.	Prepare a memo for the Board Meeting Packet identifying the purpose of every committee and making staff recommendations.	Oct-2014 and Biennially	Executive Director
d.	Discuss the Committee Roster at the Board meeting.	Oct-2014 and Biennially	Executive Director
e.	Update the Committee Roster as approved by the Board.	Oct-2014 and Biennially	Executive Director

Goal 6: Access to Care, Workforce, and Public Health: Understanding the implications of Health Care Reform and evaluating how it may impact access to care and issues surrounding healthcare delivery, as well as promoting public health, as appropriate to the Board's mission in exercising its licensing, disciplinary and regulatory functions.			
6.1	**Inform the Board and stakeholders on the Affordable Care Act (ACA) and how it will impact the physician practice, workforce, and utilization of allied healthcare professionals, and access to care for patients.**		**High**
Activities		**Date**	**Responsible Parties**
a.	Continue to invite appropriate speakers to inform the Board about the ACA.	Bi-annually	Chief of Legislation and Executive Director
b.	Identify and obtain ACA articles to print in the Board's Newsletter.	Bi-annually	Public Information Officer
c.	Educate physicians on opportunities to assist patients not within the ACA in obtaining access to care.	Bi-annually	Public Information Officer

Attachment M

Performance Measures

Department of Consumer Affairs

Medical Board of California

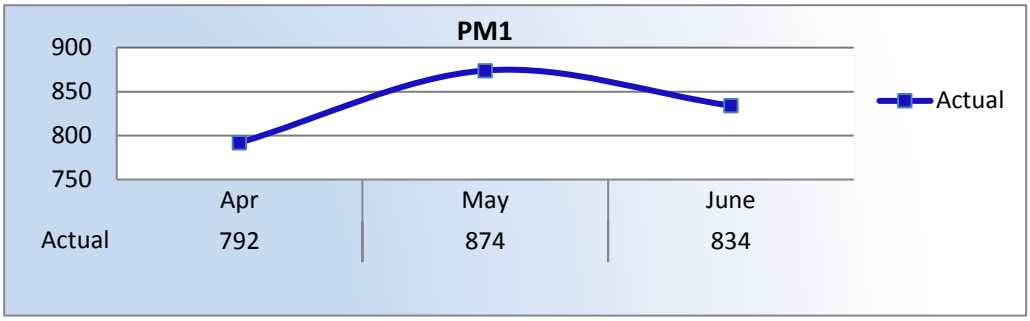
Performance Measures

Q4 Report *(April - June 2016)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

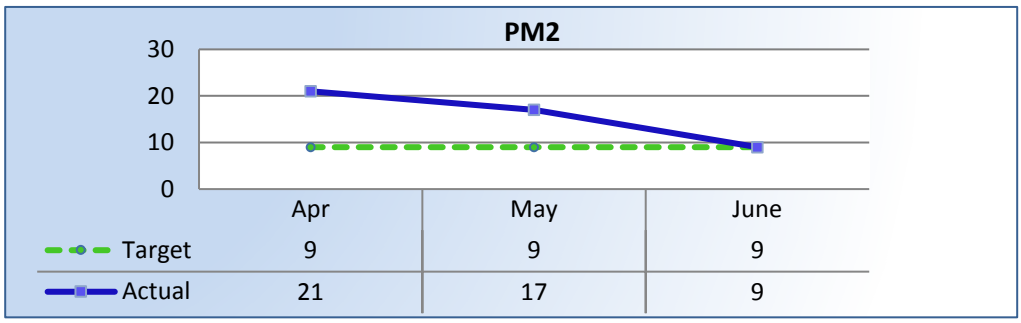


Total Received: 2,500 **Monthly Average**: 833

Complaints: 2,409 | **Convictions**: 91

PM2 | Intake

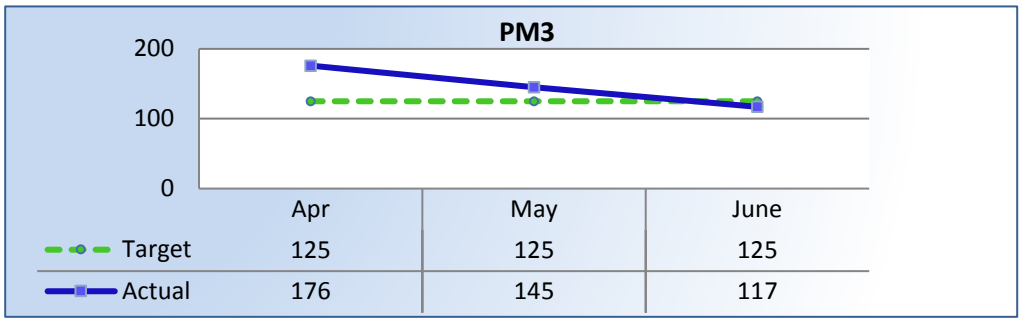
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 15 Days

PM3 | Intake & Investigation

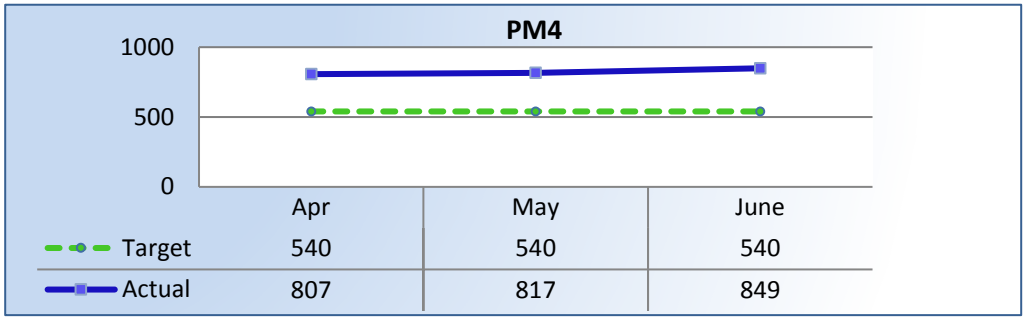
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



Target Average: 125 Days | **Actual Average:** 147 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



Target Average: 540 Days | **Actual Average:** 825 Days

Department of Consumer Affairs

Medical Board of California

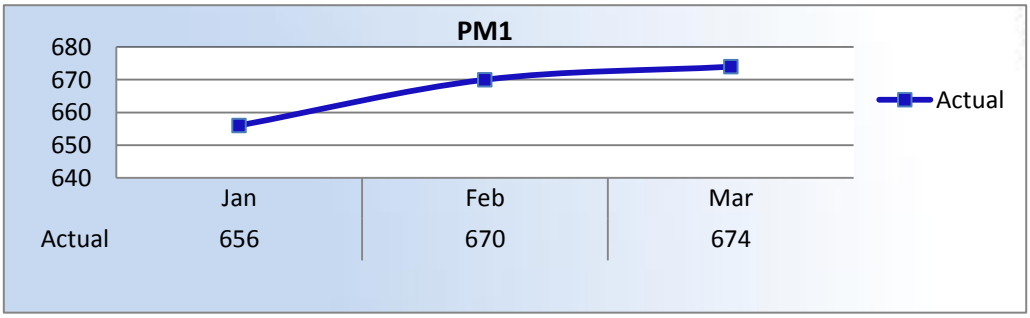
Performance Measures

Q3 Report *(January – March 2016)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

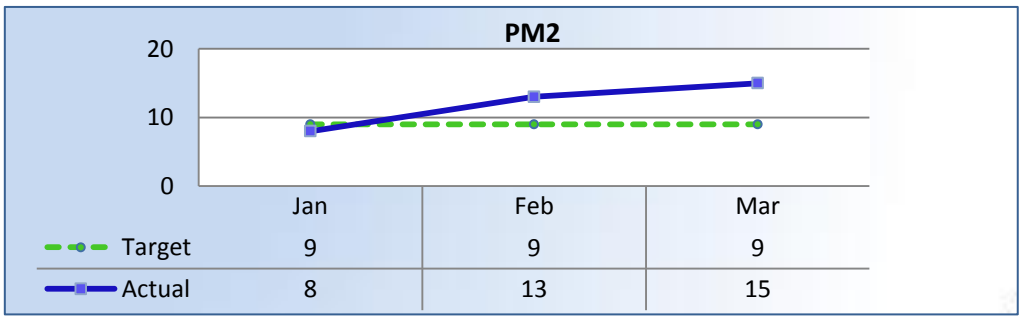


Total Received: 2,000 **Monthly Average**: 667

Complaints: 1,929 | **Convictions**: 71

PM2 | Intake

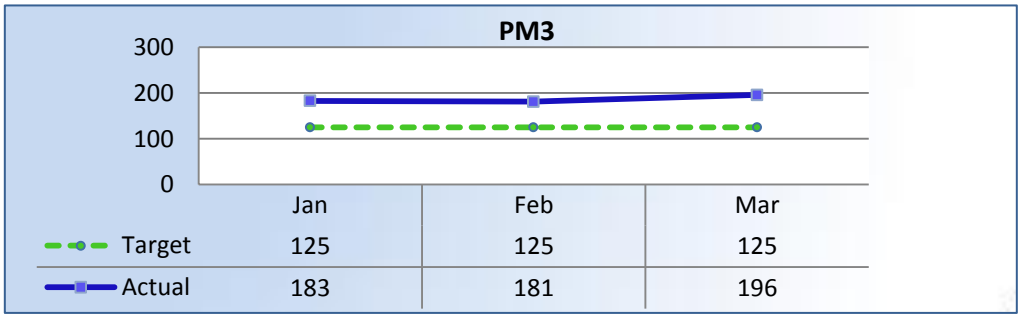
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 12 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

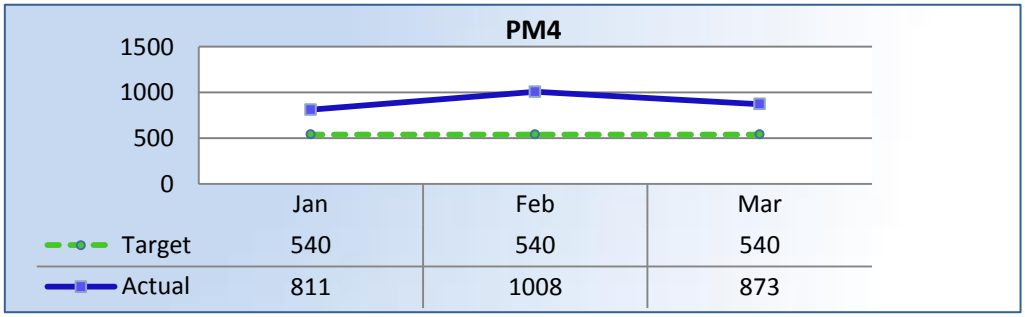


	Jan	Feb	Mar
Target	125	125	125
Actual	183	181	196

Target Average: 125 Days | **Actual Average:** 188 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	Jan	Feb	Mar
Target	540	540	540
Actual	811	1008	873

Target Average: 540 Days | **Actual Average:** 890 Days

Department of Consumer Affairs

Medical Board of California

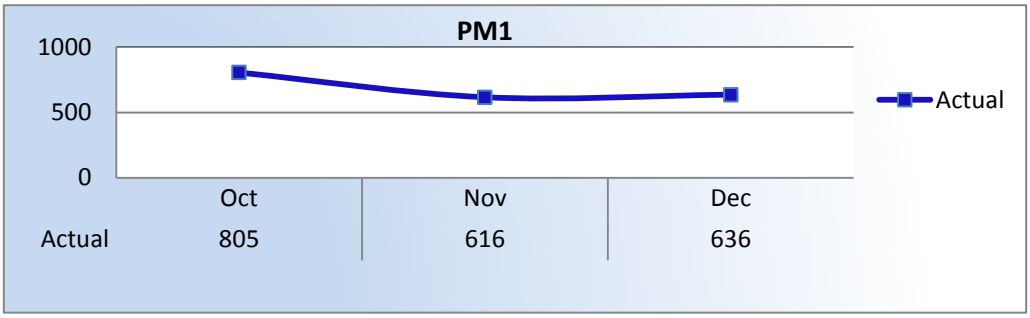
Performance Measures

Q2 Report *(October - December 2015)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

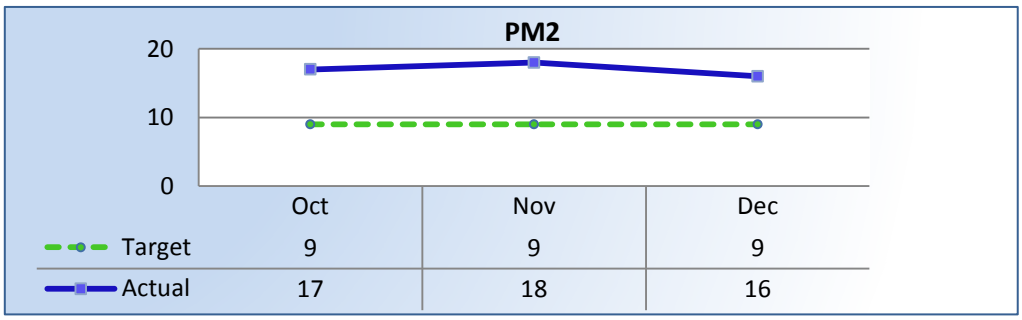


Total Received: 2,057 **Monthly Average**: 686

Complaints: 1,976 | **Convictions**: 81

PM2 | Intake

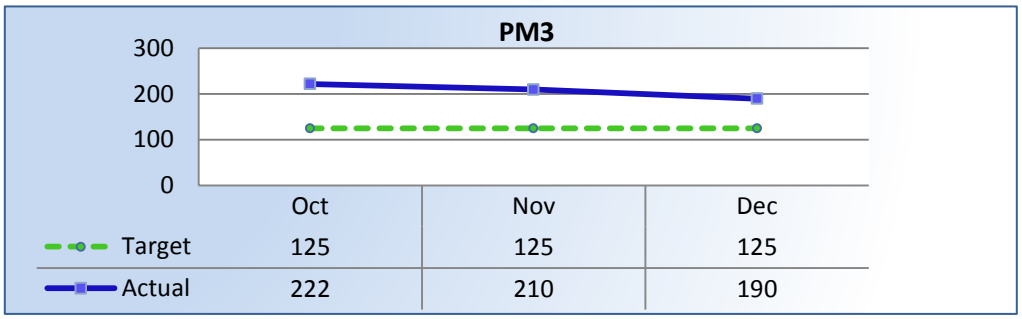
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 17 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

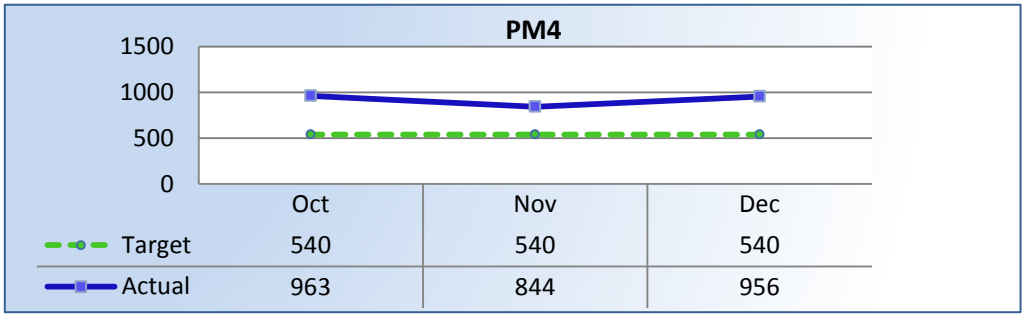


	Oct	Nov	Dec
Target	125	125	125
Actual	222	210	190

Target Average: 125 Days | **Actual Average:** 206 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	Oct	Nov	Dec
Target	540	540	540
Actual	963	844	956

Target Average: 540 Days | **Actual Average:** 914 Days

Department of Consumer Affairs

Medical Board of California

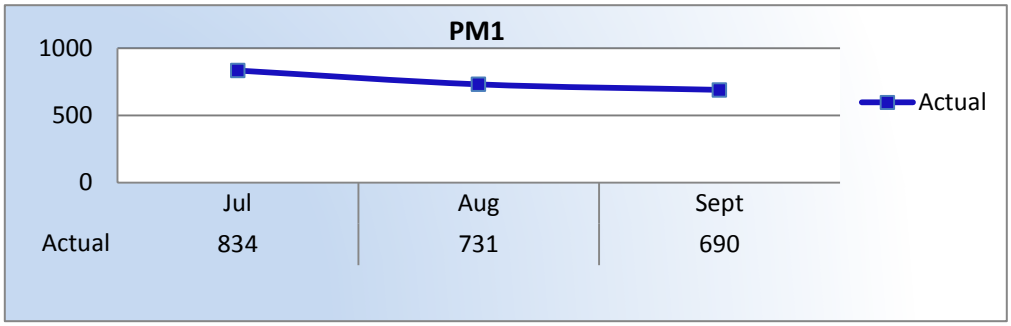
Performance Measures

Q1 Report *(July - September 2015)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

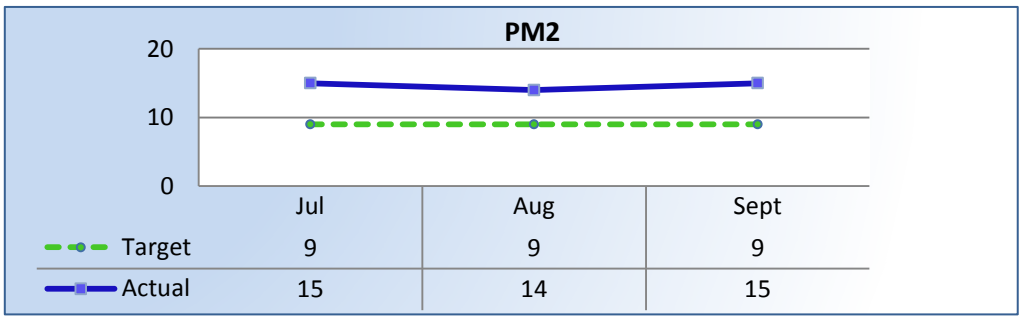


Total Received: 2,255 **Monthly Average**: 752

Complaints: 2,149 | **Convictions**: 106

PM2 | Intake

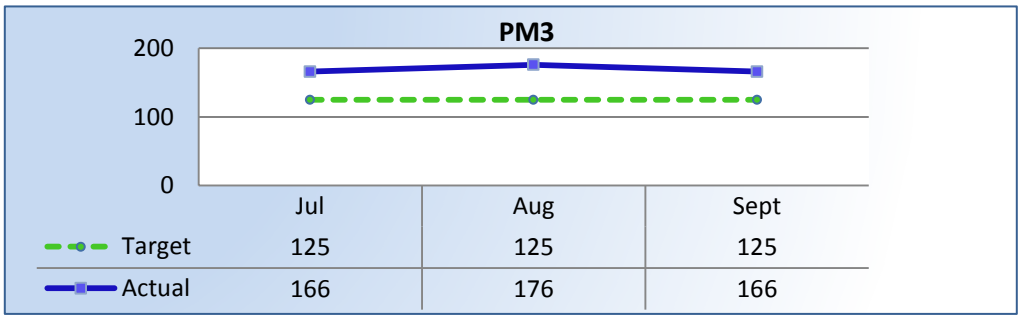
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 14 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

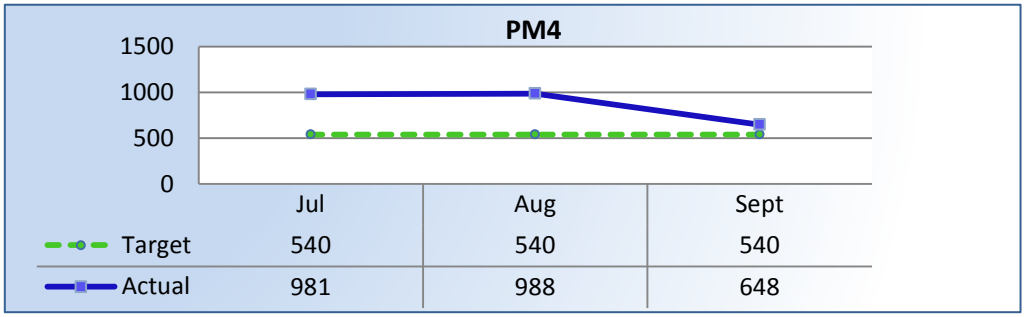


	Jul	Aug	Sept
Target	125	125	125
Actual	166	176	166

Target Average: 125 Days | **Actual Average:** 169 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	Jul	Aug	Sept
Target	540	540	540
Actual	981	988	648

Target Average: 540 Days | **Actual Average:** 897 Days

Department of Consumer Affairs

Medical Board of California

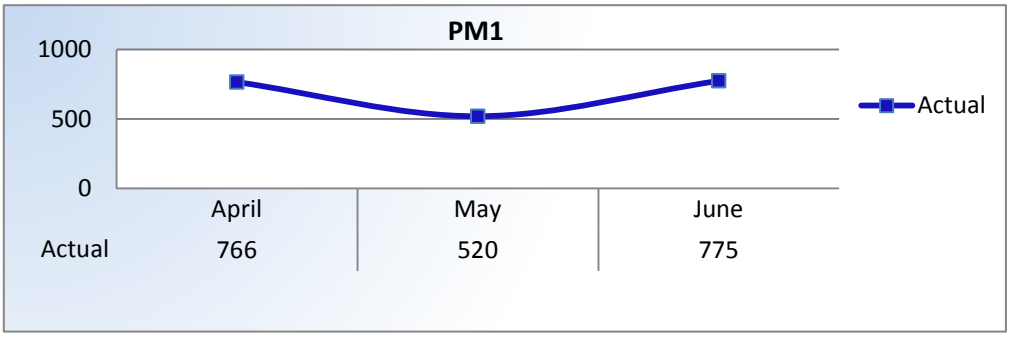
Performance Measures

Q4 Report *(April – June 2015)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

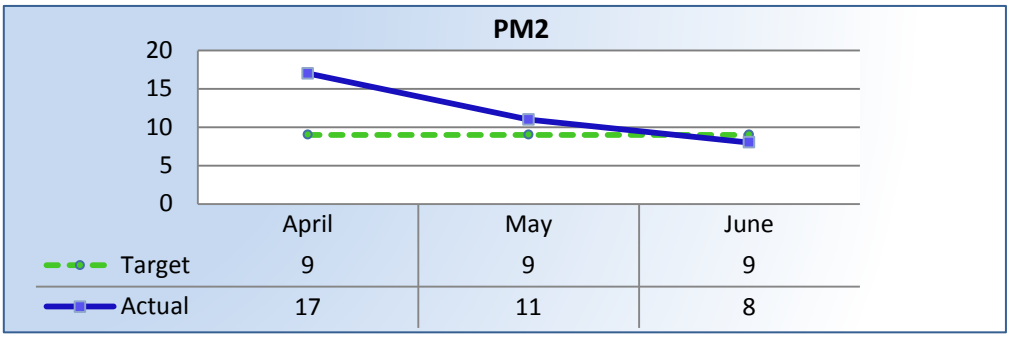


Total Received: 2,061 Monthly Average: 687

Complaints: 1,975 | **Convictions**: 86

PM2 | Intake

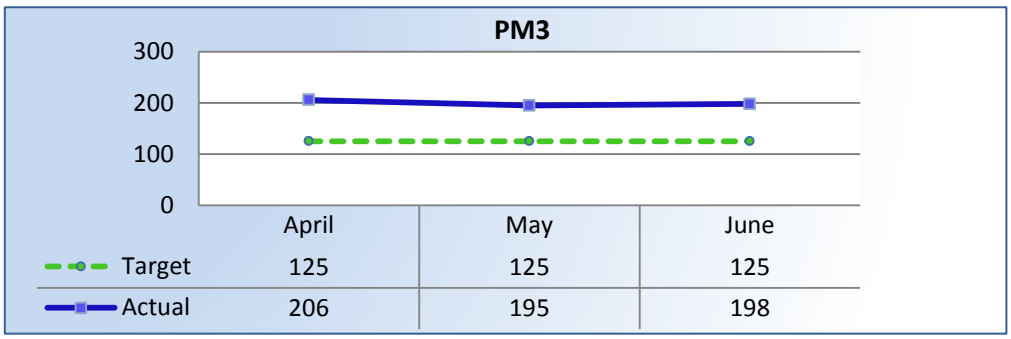
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 12 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

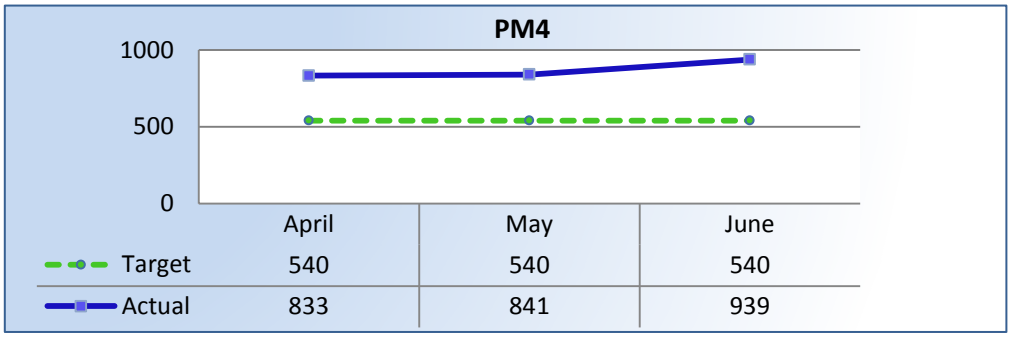


	April	May	June
Target	125	125	125
Actual	206	195	198

Target Average: 125 Days | **Actual Average:** 200 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	April	May	June
Target	540	540	540
Actual	833	841	939

Target Average: 540 Days | **Actual Average:** 871 Days

Department of Consumer Affairs

Medical Board of California

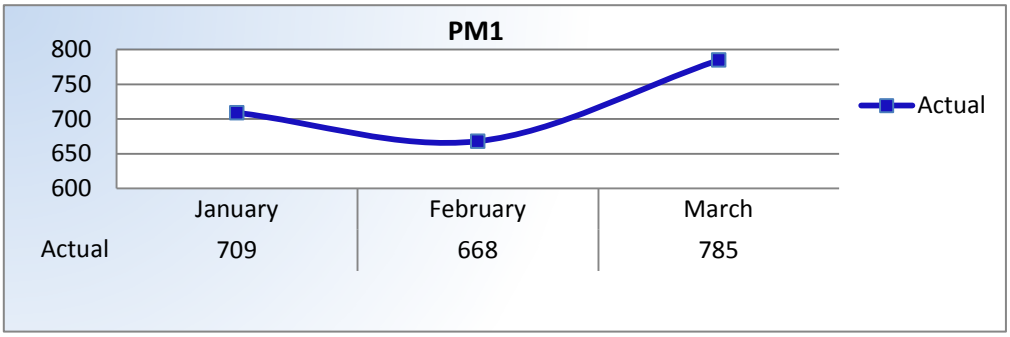
Performance Measures

Q3 Report *(January – March 2015)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

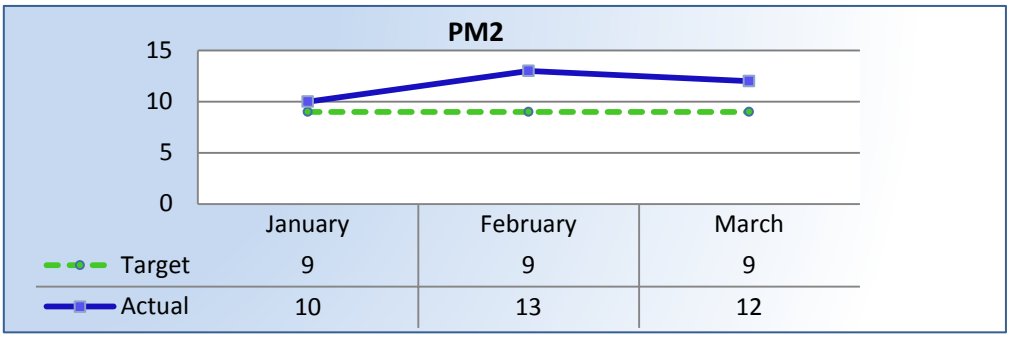


Total Received: 2,162 Monthly Average: 721

Complaints: 2,073 | **Convictions**: 89

PM2 | Intake

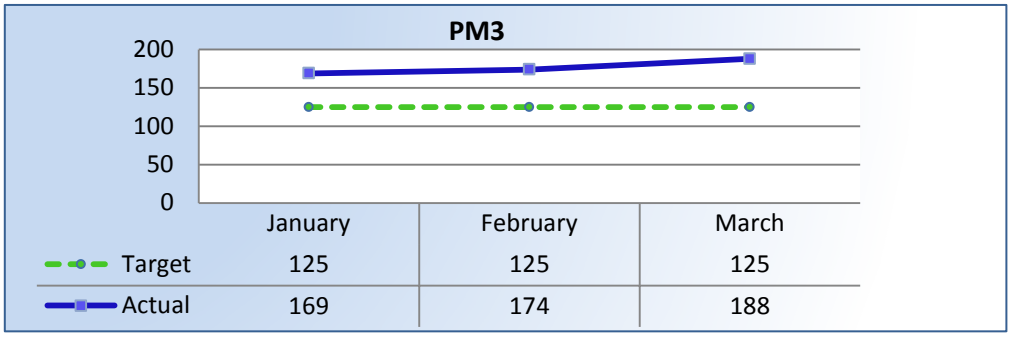
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 12 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

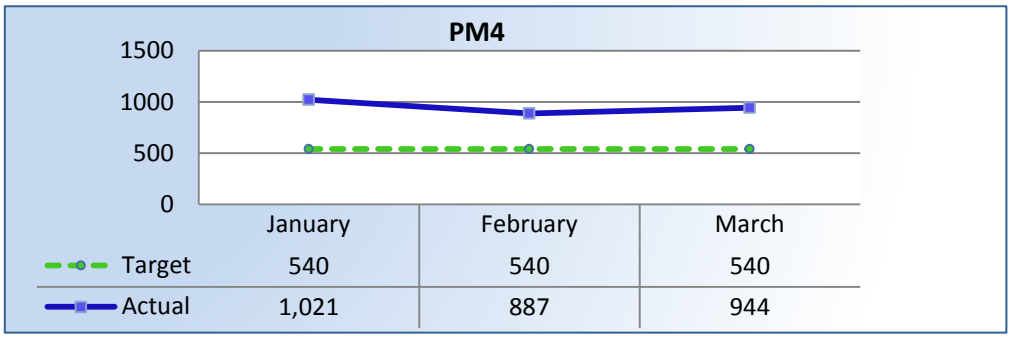


	January	February	March
Target	125	125	125
Actual	169	174	188

Target Average: 125 Days | **Actual Average:** 177 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)



	January	February	March
Target	540	540	540
Actual	1,021	887	944

Target Average: 540 Days | **Actual Average:** 946 Days

Department of Consumer Affairs

Medical Board of California

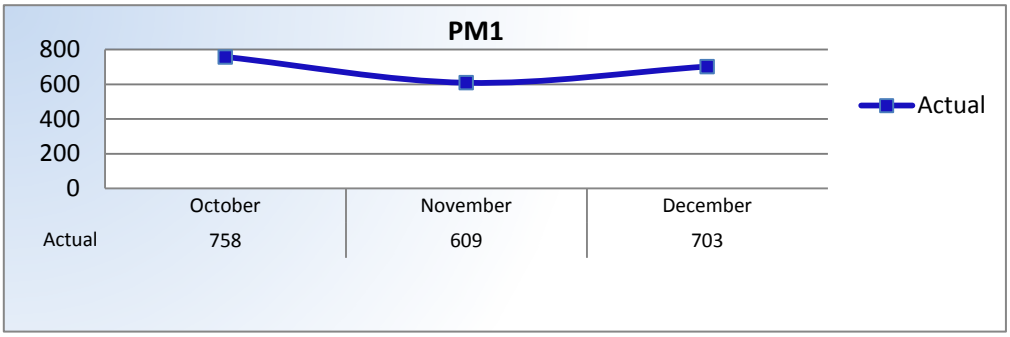
Performance Measures

Q2 Report *(October - December 2014)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.



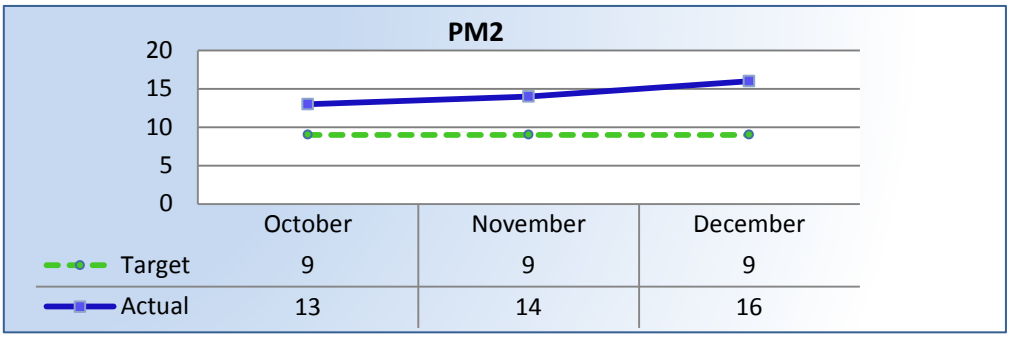
	October	November	December
Actual	758	609	703

Total Received: 2,070 Monthly Average: 690

Complaints: 1,994 | **Convictions**: 76

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



	October	November	December
Target	9	9	9
Actual	13	14	16

Target Average: 9 Days | **Actual Average:** 14 Days

PM3 | Intake & Investigation

Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).

Data Currently Unavailable.

Target Average: 125 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases transmitted to the AG for formal discipline. (Includes intake, investigation, and transmittal outcome)

Data Currently Unavailable.

Target Average: 540 Days | **Actual Average:** N/A

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Data Currently Unavailable.

Target Average: 25 Days | **Actual Average:** N/A

PM8 |Probation Violation Response

Average number of days from the date a violation of probation is reported, to the date the assigned monitor initiates appropriate action.

Data Currently Unavailable.

Target Average: 10 Days | **Actual Average:** N/A

Department of Consumer Affairs

Medical Board of California

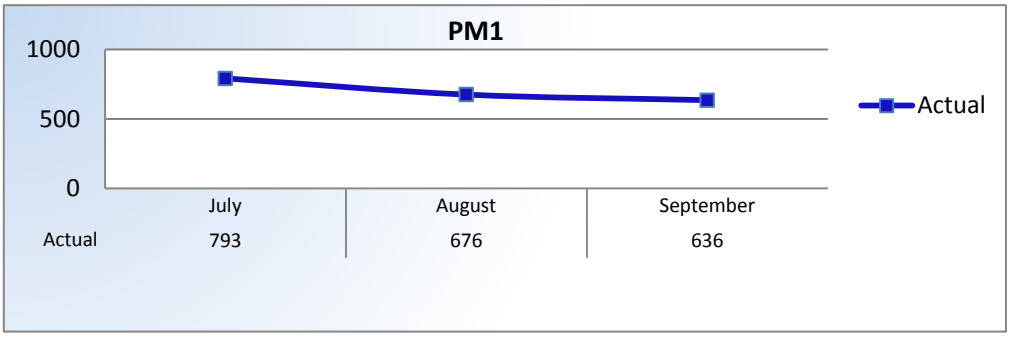
Performance Measures

Q1 Report *(July - September 2014)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

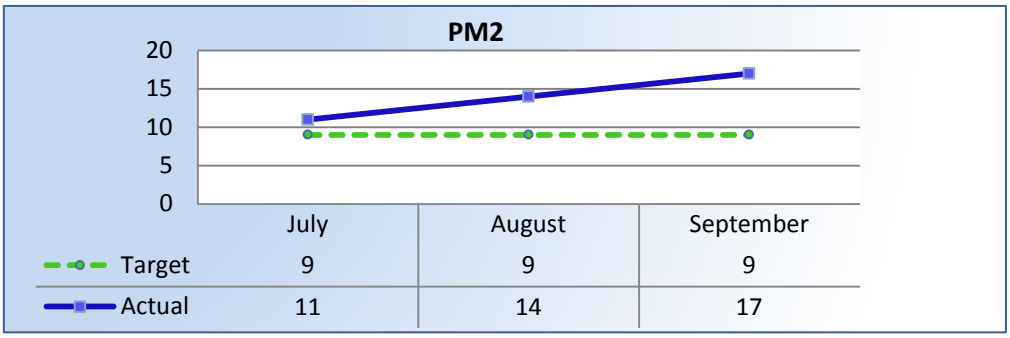


Total Received: 2,105 Monthly Average: 702

Complaints: 2,011 | **Convictions**: 94

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 14 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Consistent data not yet available from BreEZe.

Target Average: 125 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Consistent data not yet available from BreEZe.

Target Average: 540 Days | **Actual Average:** N/A

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Consistent data not yet available from BreEZe.

Target Average: 25 Days | **Actual Average:** N/A

Department of Consumer Affairs

Medical Board of California

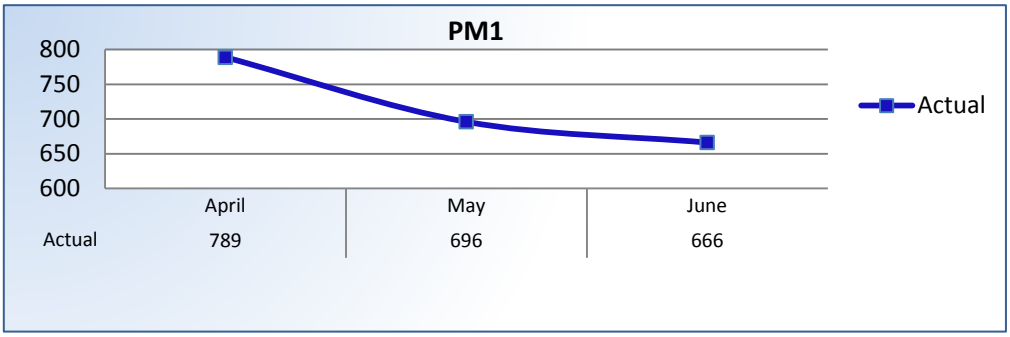
Performance Measures

Q4 Report *(April - June 2014)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

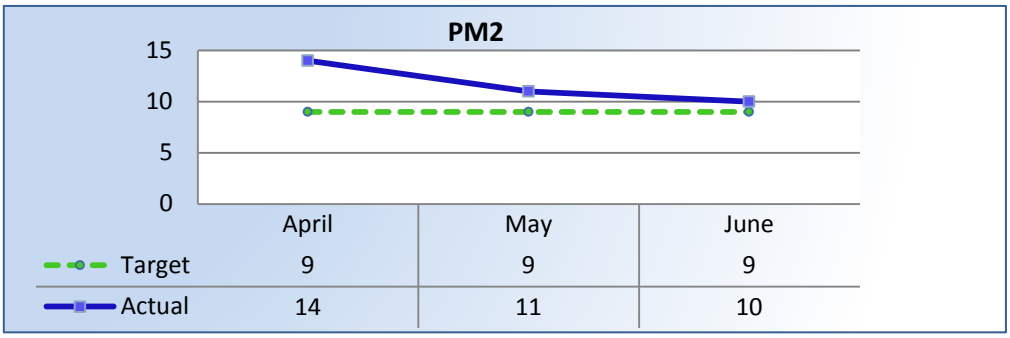


Total Received: 2,151 Monthly Average: 717

Complaints: 2,041 | **Convictions**: 110

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 12 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Consistent data not yet available from BreEZe.

Target Average: 125 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Consistent data not yet available from BreEZe.

Target Average: 540 Days | **Actual Average:** N/A

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

At this time, this information is not available from BreEZe.

Target Average: 25 Days | **Actual Average:** N/A

Department of Consumer Affairs

Medical Board of California

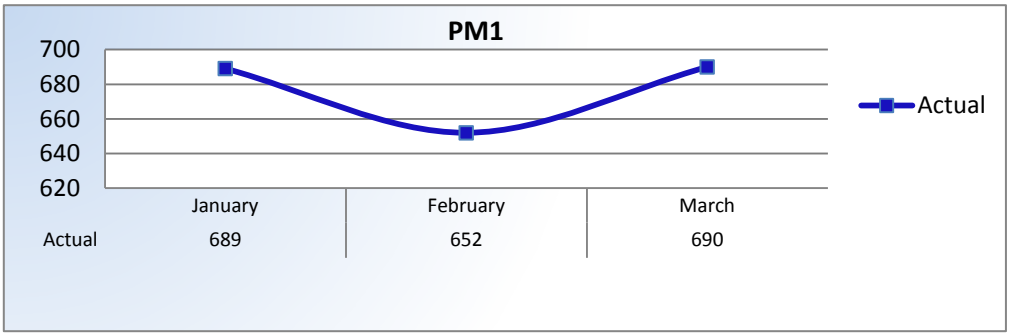
Performance Measures

Q3 Report *(January - March 2014)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

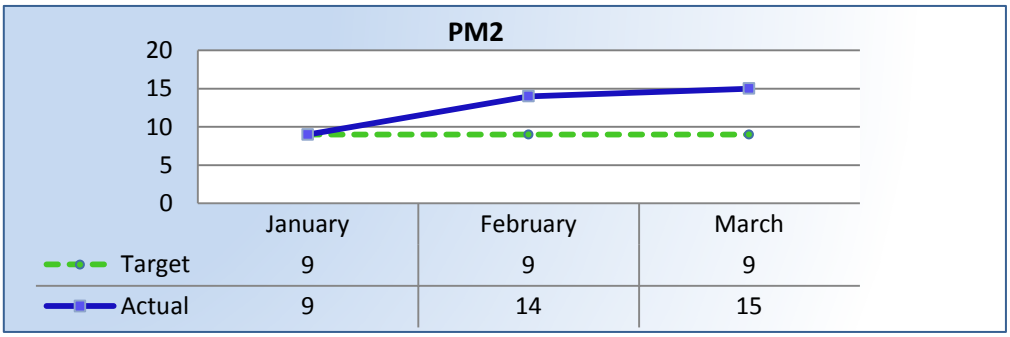


Total Received: 2,031 Monthly Average: 677

Complaints: 1,944 | **Convictions**: 87

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 13 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Consistent data not yet available from BreEZe.

Target Average: 125 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Consistent data not yet available from BreEZe.

Target Average: 540 Days | **Actual Average:** N/A

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 25 Days | **Actual Average:** N/A

Department of Consumer Affairs

Medical Board of California

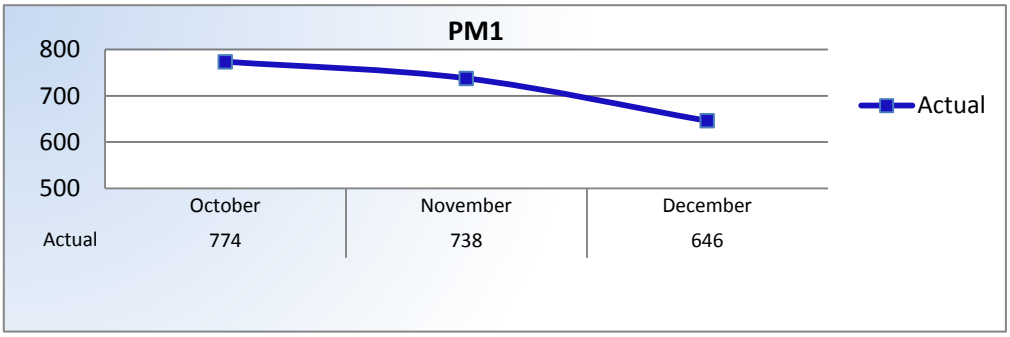
Performance Measures

Q2 Report *(October - December 2013)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

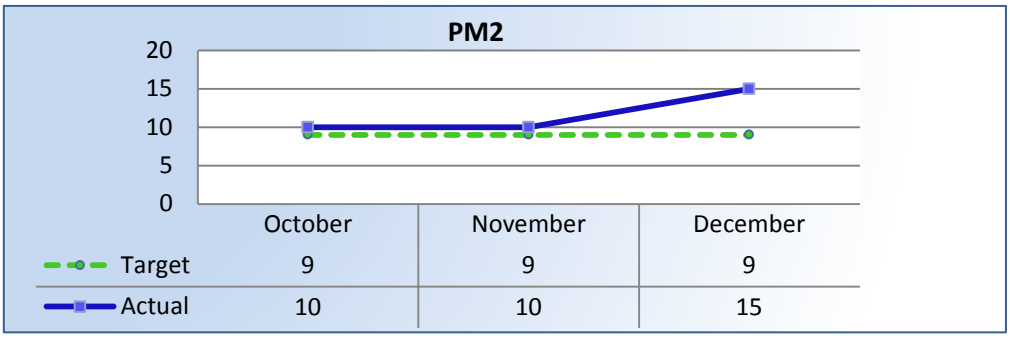


Total Received: 2,158 Monthly Average: 719

Complaints: 2,078 | **Convictions**: 80

PM2 | Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 12 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Due to incorrect data with the BreEZe report, this information is not being reported.

Target Average: 125 Days | **Actual Average:** N/A

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

Due to incorrect data with the BreEZe report, this information is not being reported.

Target Average: 540 Days | **Actual Average:** N/A

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board did not contact any new probationers this quarter.

Target Average: 25 Days | **Actual Average:** N/A

Department of Consumer Affairs

Medical Board of California

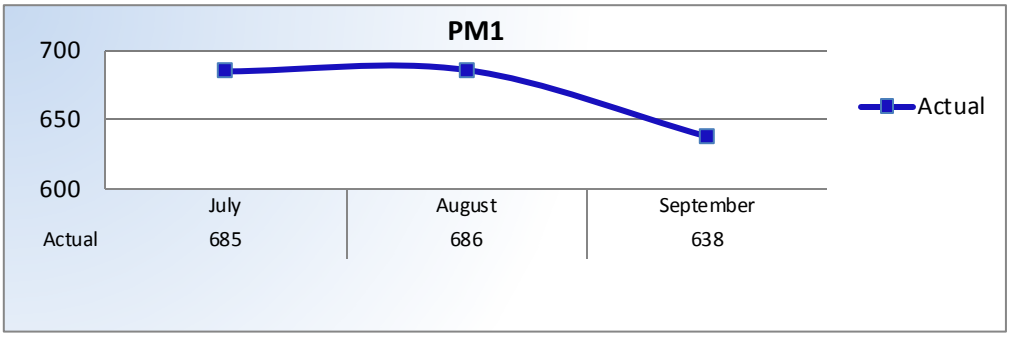
Performance Measures

Q1 Report *(July - September 2013)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

PM1 | Volume

Number of complaints and convictions received.

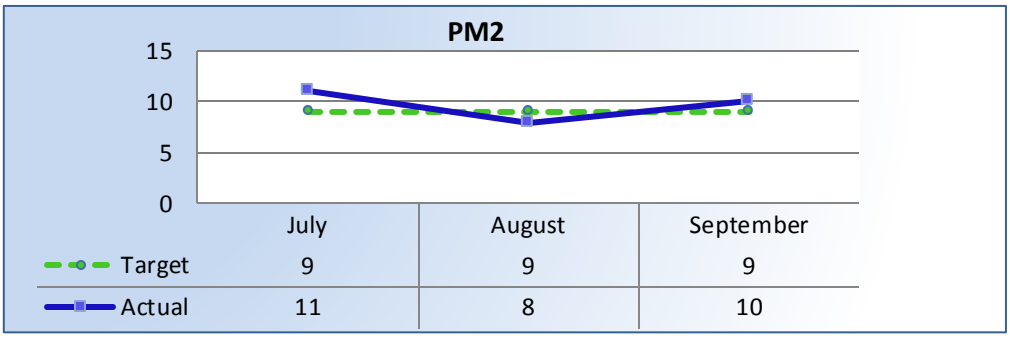


Total Received: 2,009 Monthly Average: 670

Complaints: 1,920 | **Convictions**: 89

PM2 | Intake

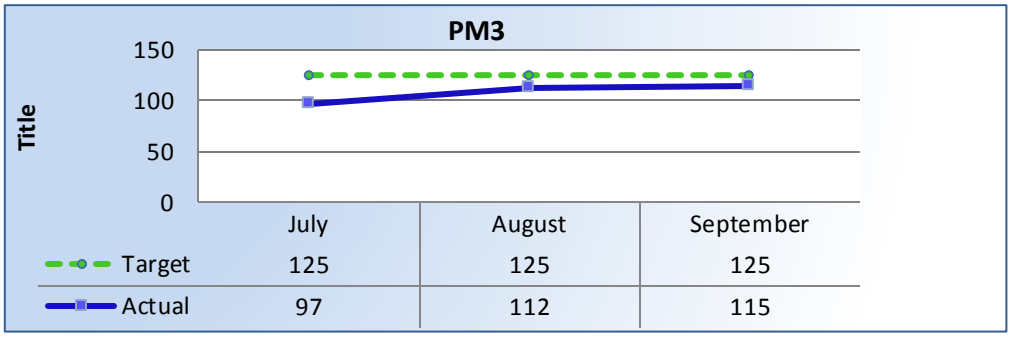
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | **Actual Average:** 10 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

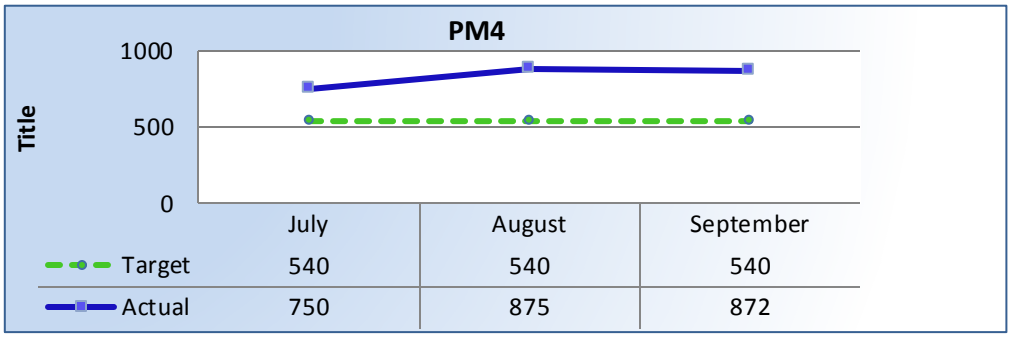


	July	August	September
Target	125	125	125
Actual	97	112	115

Target Average: 125 Days | **Actual Average:** 108 Days

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

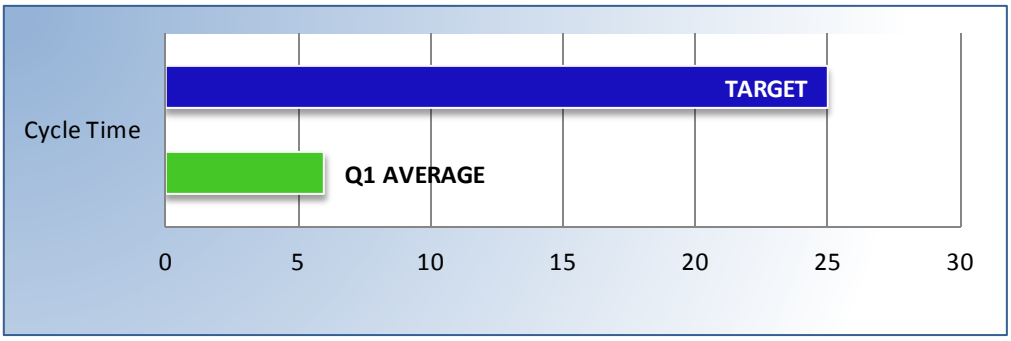


	July	August	September
Target	540	540	540
Actual	750	875	872

Target Average: 540 Days | **Actual Average:** 811 Days

PM7 | Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 25 Days | **Actual Average:** 6 Days

Department of Consumer Affairs

Medical Board of California

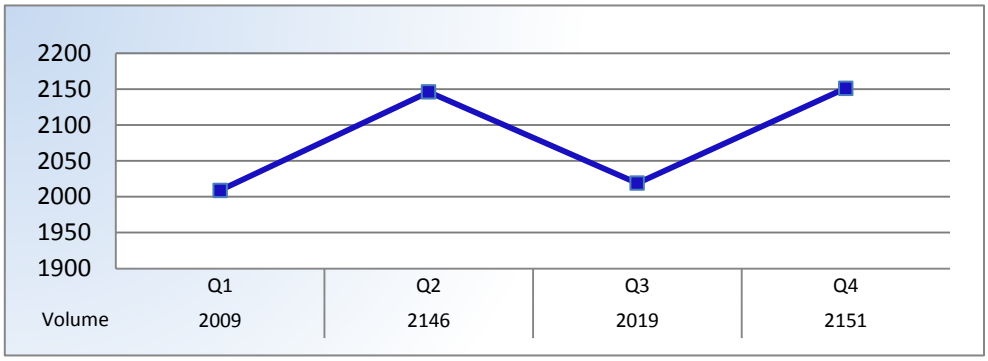
Performance Measures

Annual Report *(2013 – 2014 Fiscal Year)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly and annual basis.

PM1 | Volume

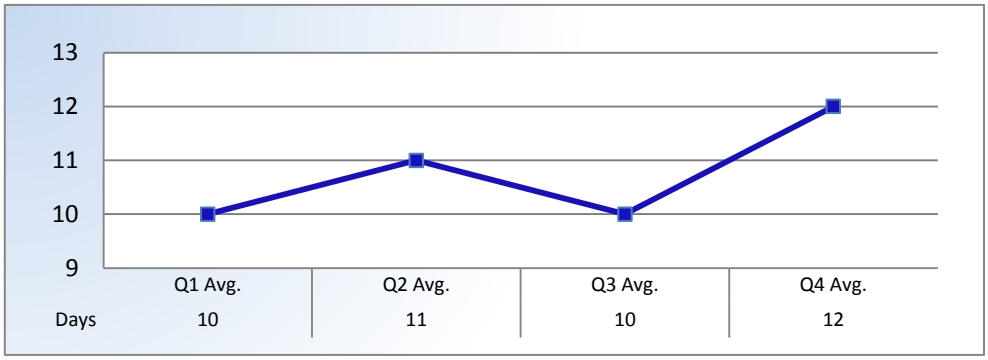
Number of complaints and convictions received.



Fiscal Year Total: 8,325

PM2 | Intake

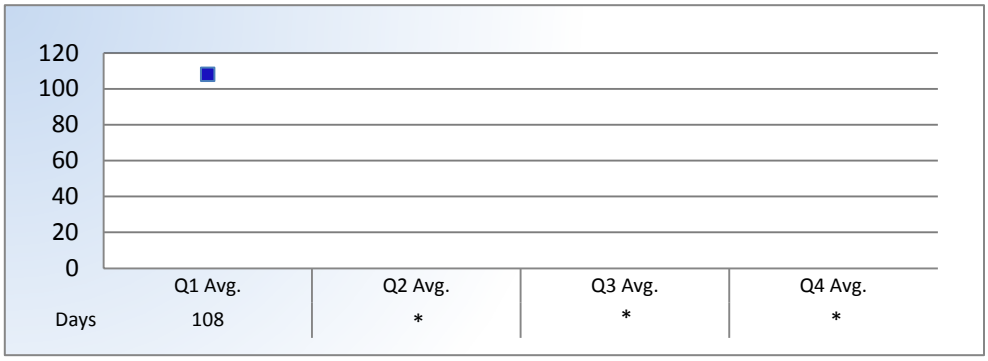
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days

PM3 | Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

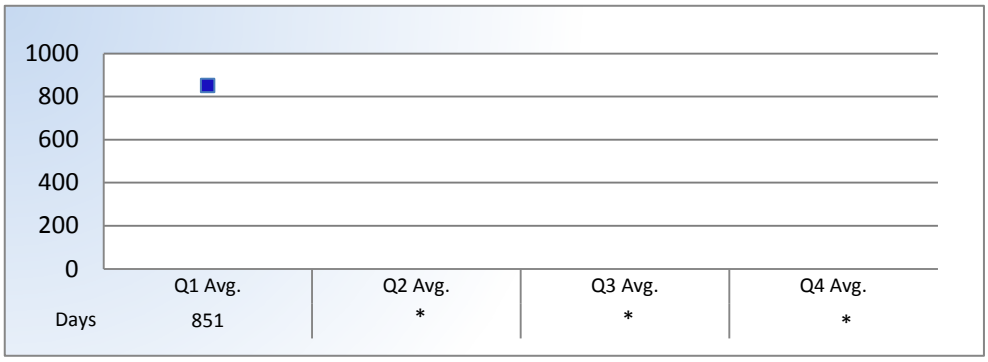


Target Average: 125 Days

**Consistent data not yet available from BreEZe.*

PM4 | Formal Discipline

Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).

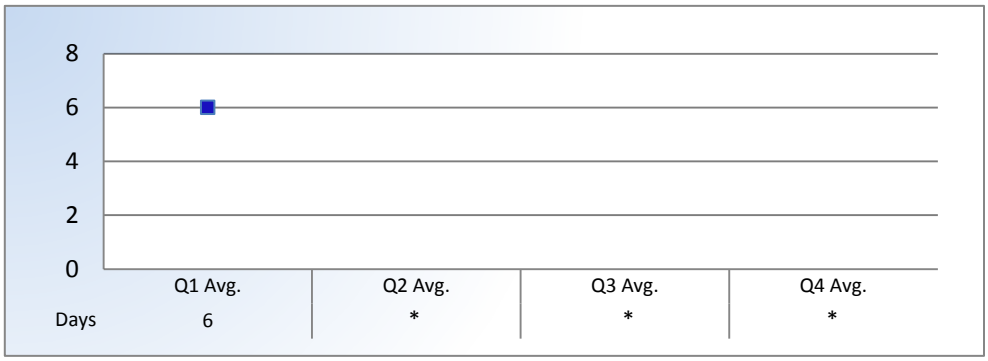


Target Average: 540 Days

**Consistent data not yet available from BreEZe.*

PM7 |Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.



Target Average: 25 Days

**Consistent data not yet available from BreEZe.*

Department of Consumer Affairs

Medical Board of California

Performance Measures

Q4 Report (*April - June 2013)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

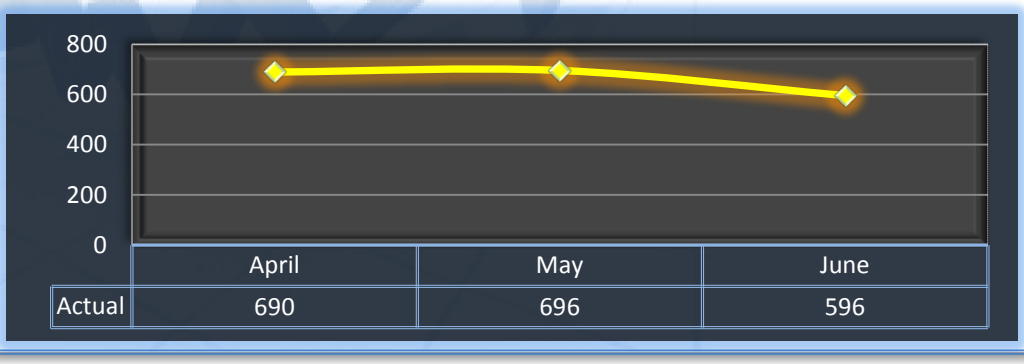
Volume

Number of complaints and convictions received.

Q4 Total: 1,982

Complaints: 1,886 Convictions: 96

Q4 Monthly Average: 661



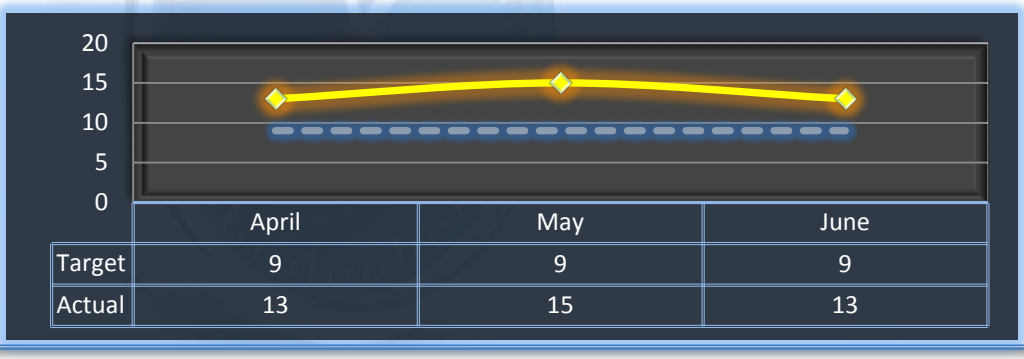
	April	May	June
Actual	690	696	596

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q4 Average: 14 Days



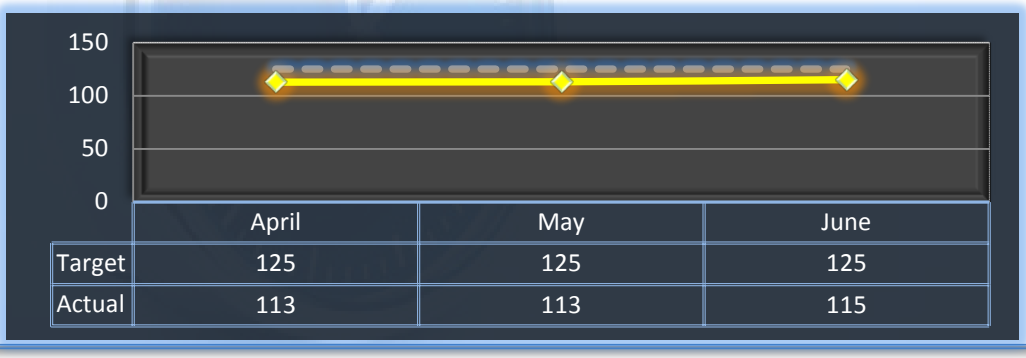
	April	May	June
Target	9	9	9
Actual	13	15	13

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q4 Average: 114 Days



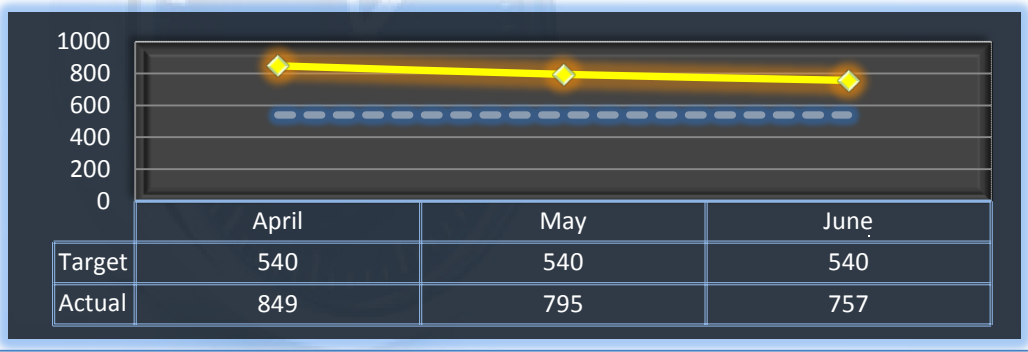
	April	May	June
Target	125	125	125
Actual	113	113	115

Formal Discipline/ Administrative Action

Average cycle time to complete the entire enforcement process for those cases closed by the AG's office after referral by the program. Does not include declined, withdrawn or dismissed cases.

Target: 540 Days

Q4 Average: 801 Days



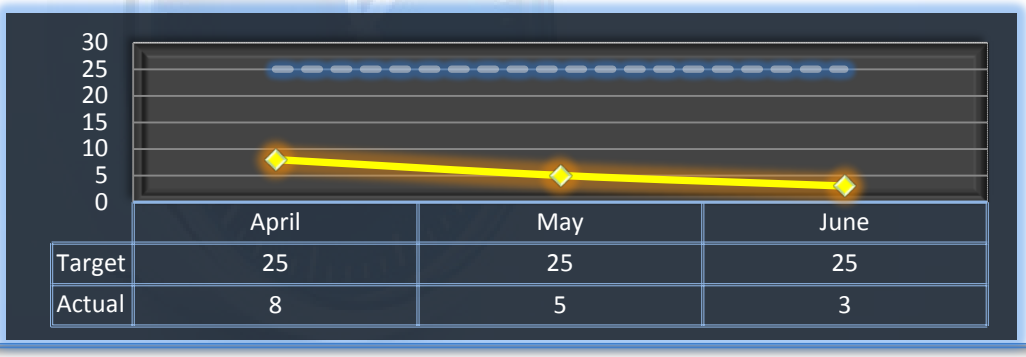
	April	May	June
Target	540	540	540
Actual	849	795	757

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q4 Average: 6 Days



	April	May	June
Target	25	25	25
Actual	8	5	3

Department of Consumer Affairs

Medical Board of California

Performance Measures

Q3 Report *(January - March 2013)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

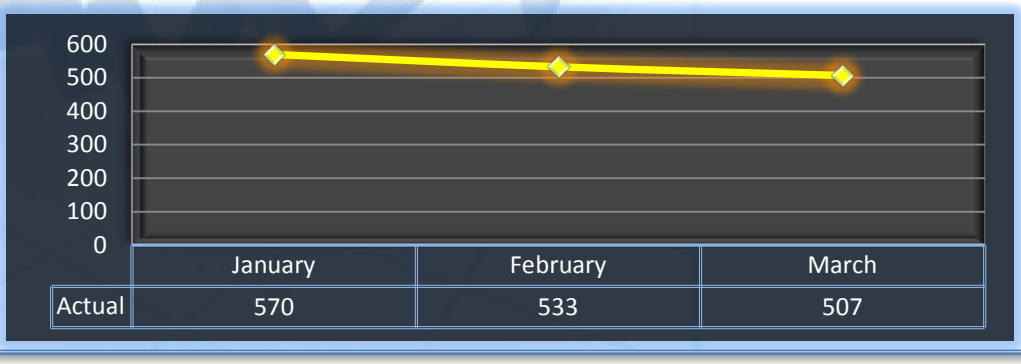
Volume

Number of complaints and convictions received.

Q3 Total: 1,610

Complaints: 1,493 Convictions: 117

Q3 Monthly Average: 537



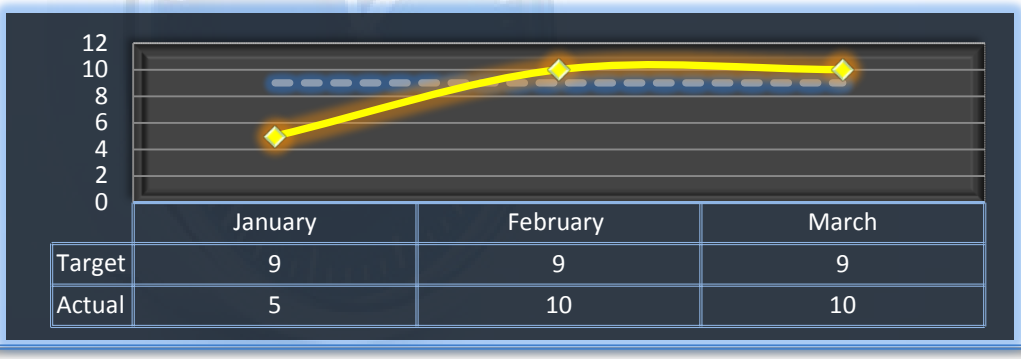
	January	February	March
Actual	570	533	507

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q3 Average: 8 Days



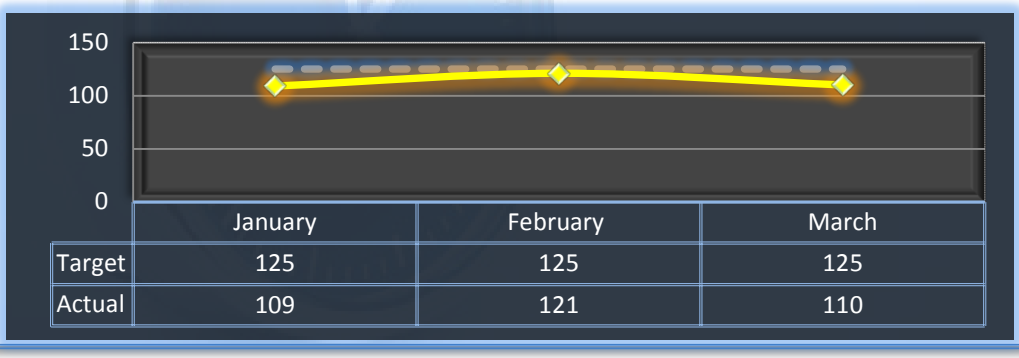
	January	February	March
Target	9	9	9
Actual	5	10	10

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q3 Average: 113 Days



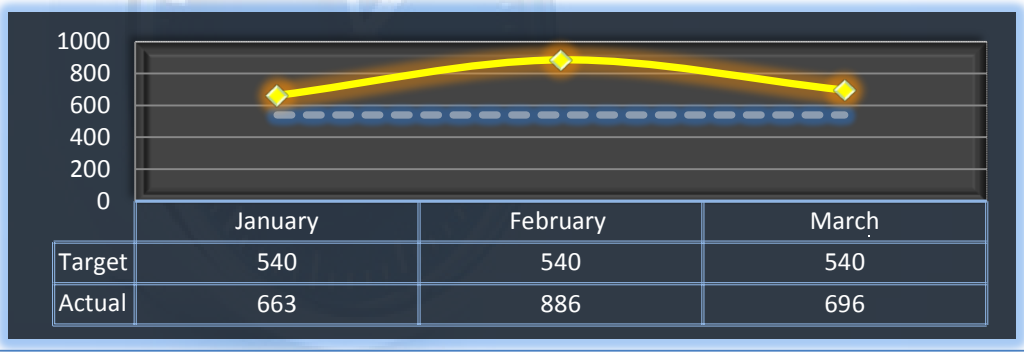
	January	February	March
Target	125	125	125
Actual	109	121	110

Formal Discipline/ Administrative Action

Average cycle time to complete the entire enforcement process for those cases closed by the AG's office after referral by the program. Does not include declined, withdrawn or dismissed cases.

Target: 540 Days

Q3 Average: 750 Days



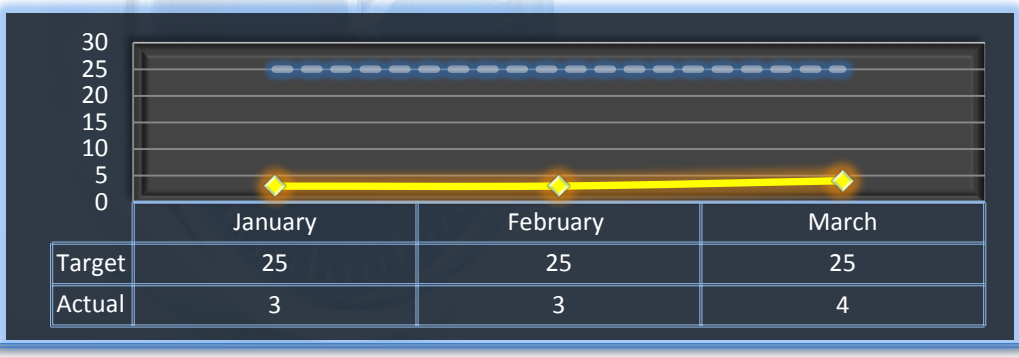
	January	February	March
Target	540	540	540
Actual	663	886	696

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q3 Average: 3 Days



	January	February	March
Target	25	25	25
Actual	3	3	4

Department of Consumer Affairs

Medical Board of California

Performance Measures

Q2 Report *(October - December 2012)*

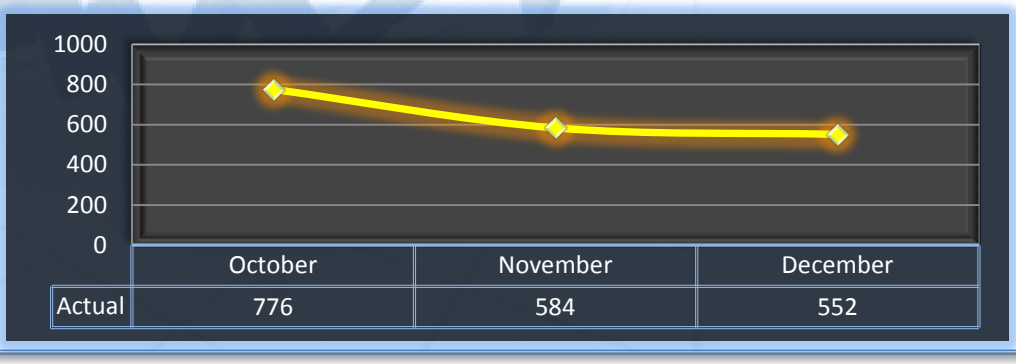
To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

Number of complaints and convictions received.

Q2 Total: 1,912

Complaints: 1,823 Convictions: 89

Q2 Monthly Average: 637



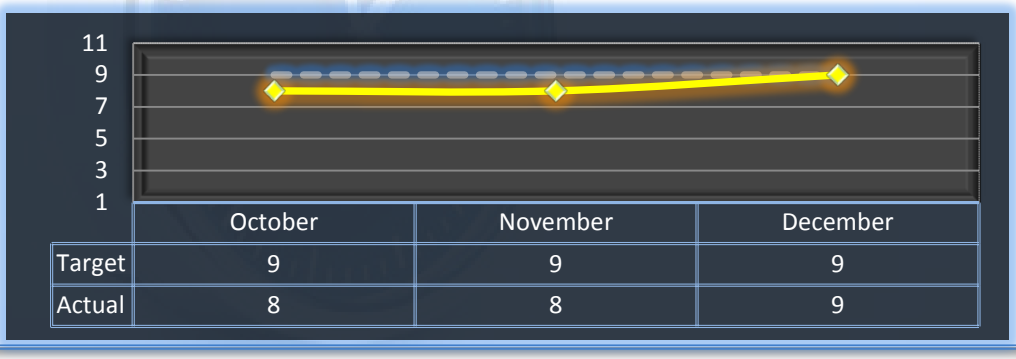
	October	November	December
Actual	776	584	552

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q2 Average: 8 Days



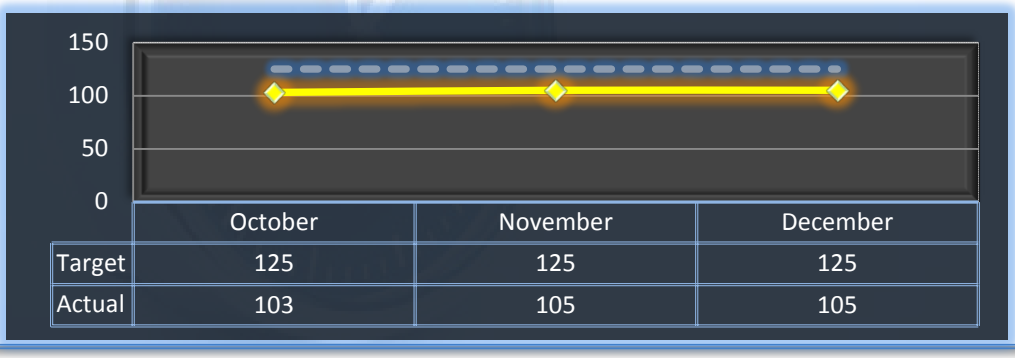
	October	November	December
Target	9	9	9
Actual	8	8	9

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q2 Average: 104 Days



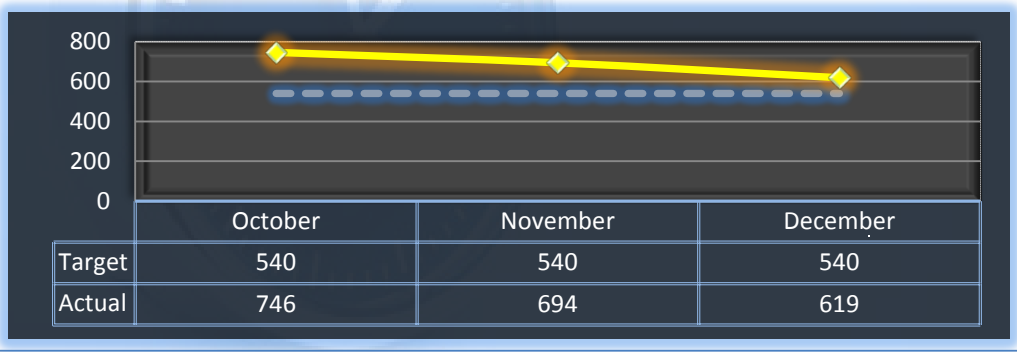
	October	November	December
Target	125	125	125
Actual	103	105	105

Formal Discipline/ Administrative Action

Average cycle time to complete the entire enforcement process for those cases closed by the AG's office after referral by the program. Does not include declined, withdrawn or dismissed cases.

Target: 540 Days

Q2 Average: 700 Days



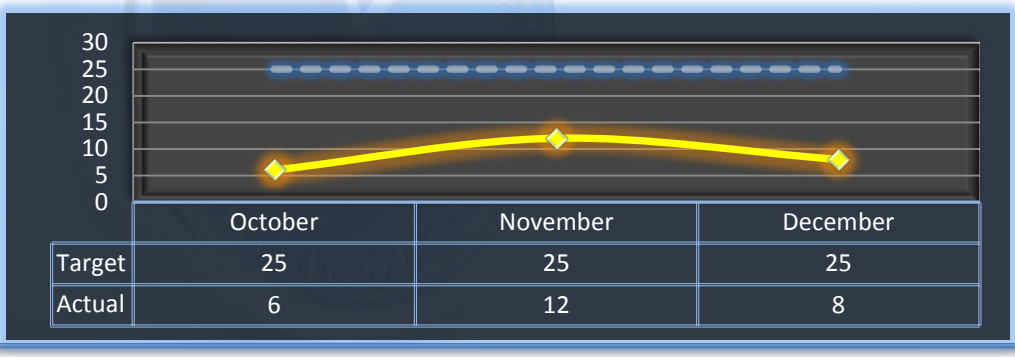
	October	November	December
Target	540	540	540
Actual	746	694	619

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q2 Average: 7 Days



	October	November	December
Target	25	25	25
Actual	6	12	8

Performance Measures

Q1 Report *(July - September 2012)*

To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

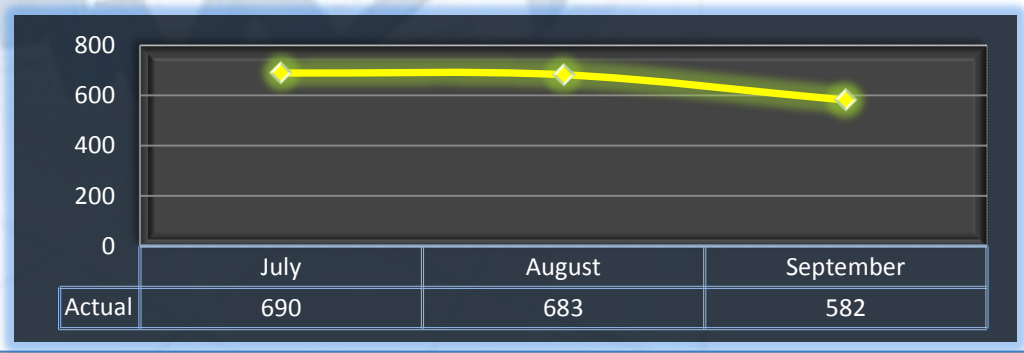
Volume

Number of complaints and convictions received.

Q1 Total: 1,955

Complaints: 1,867 Convictions:88

Q1 Monthly Average: 652



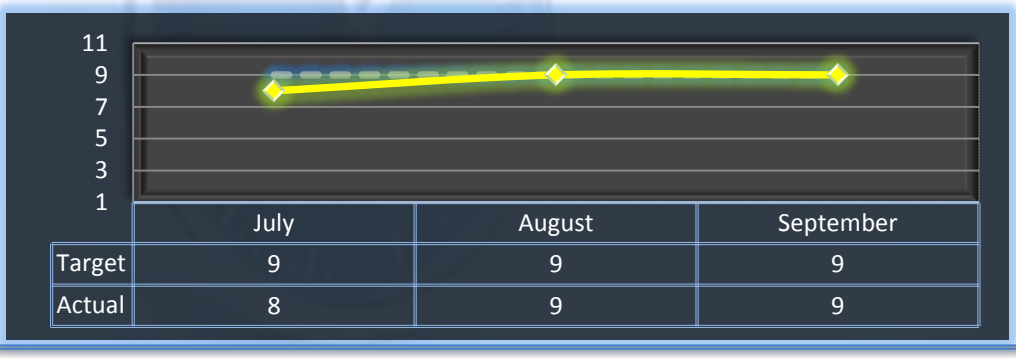
	July	August	September
Actual	690	683	582

Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

Target: 9 Days

Q1 Average: 9 Days



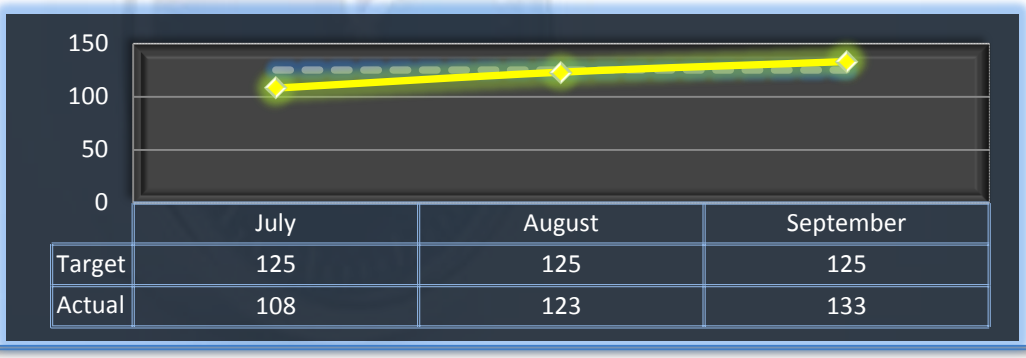
	July	August	September
Target	9	9	9
Actual	8	9	9

Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

Target: 125 Days

Q1 Average: 107 Days

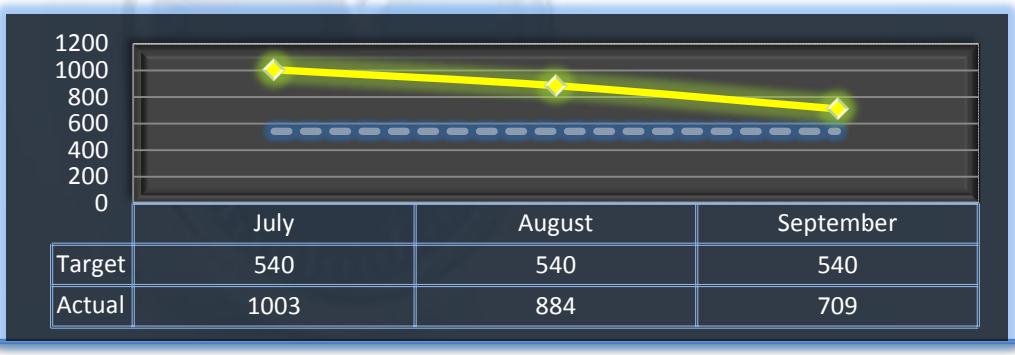


	July	August	September
Target	125	125	125
Actual	108	123	133

Formal Discipline/ Administrative Action

Average cycle time to complete the entire enforcement process for those cases closed by the AG's office after referral by the program. Does not include declined, withdrawn or dismissed cases. **Target: 540 Days**

Q1 Average: 861 Days



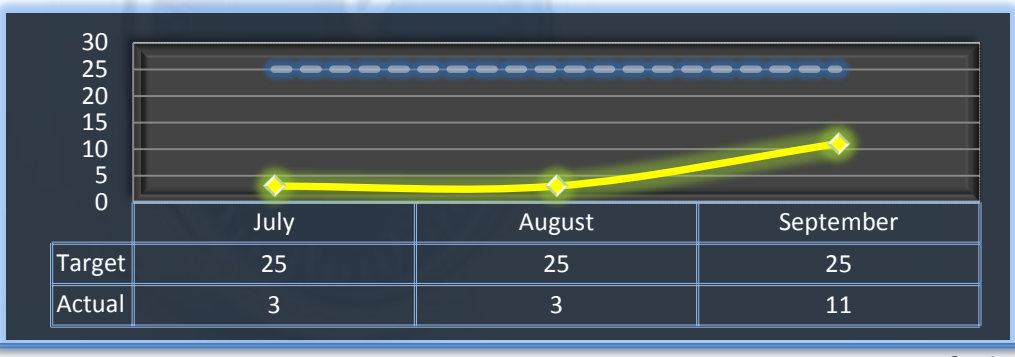
	July	August	September
Target	540	540	540
Actual	1003	884	709

Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

Target: 25 Days

Q1 Average: 6 Days



	July	August	September
Target	25	25	25
Actual	3	3	11

Department of Consumer Affairs

Medical Board of California

Performance Measures

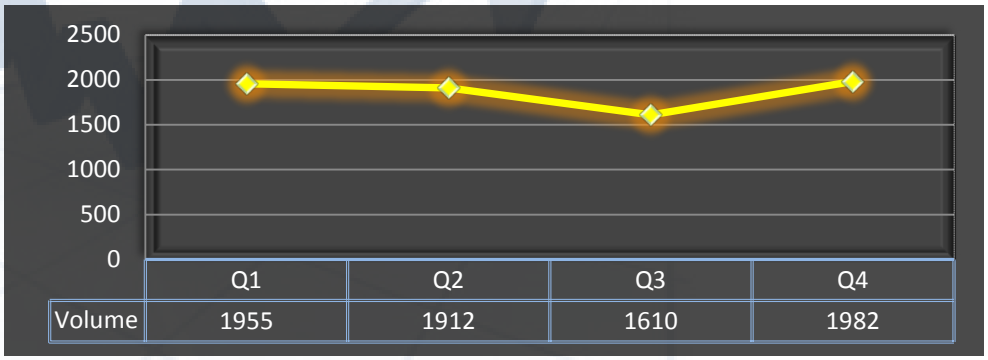
Annual Report *(2012 – 2013 Fiscal Year)*

To ensure stakeholders can review the Board's progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

Volume

Number of complaints and convictions received.

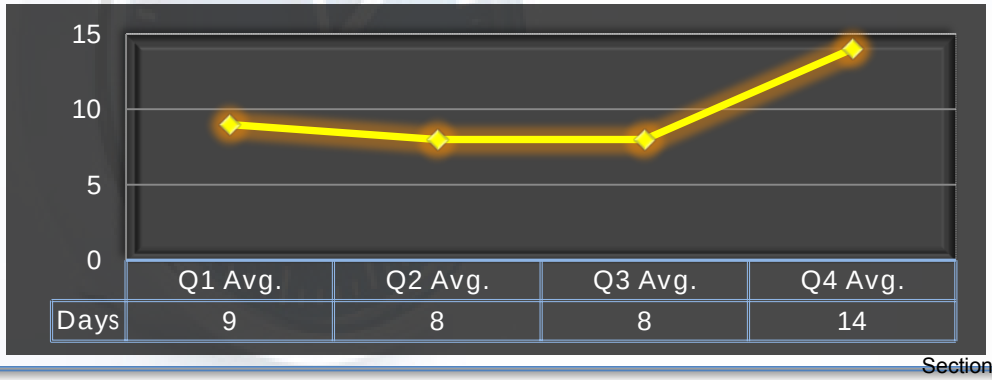
The Board had an annual total of 7,459 this fiscal year.



Intake

Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.

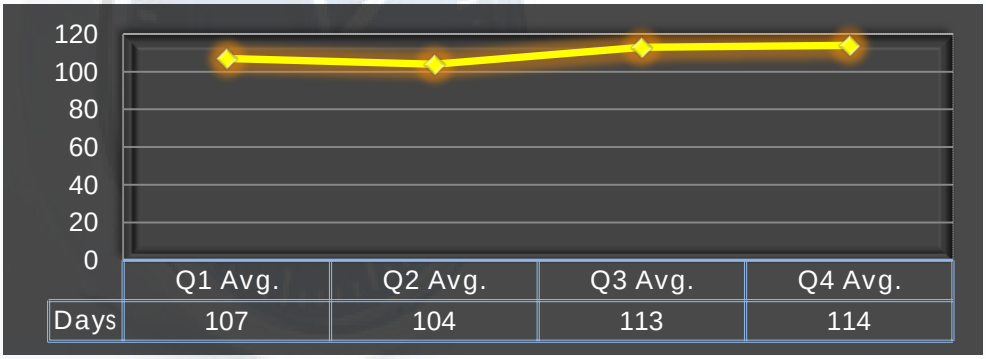
The Board has set a target of 9 days for this measure.



Intake & Investigation

Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.

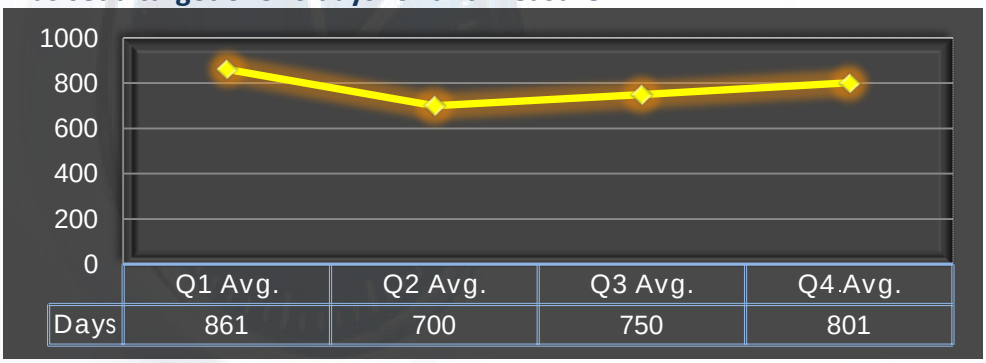
The Board has set a target of 125 days for this measure.



Formal Discipline/Administrative Actions

Average cycle time to complete the entire enforcement process for those cases closed by the Attorney General's office after referral by the program. Does not include declined, withdrawn or dismissed cases.

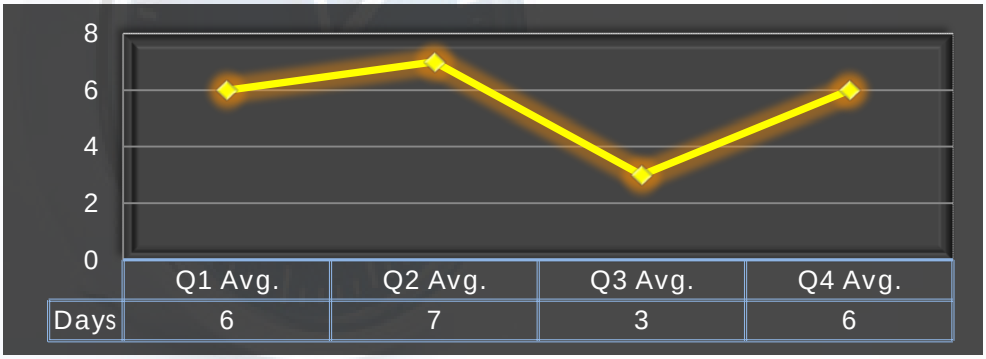
The Board has set a target of 540 days for this measure.



Probation Intake

Average number of days from monitor assignment, to the date the monitor makes first contact with the probationer.

The Board has set a target of 25 days for this measure.



Attachment N

Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs

Consumer Satisfaction Survey
Conducted by the Department of Consumer Affairs

How did you contact our Board/Bureau?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
In-person	59%	54	55%	12	0%	0
Email	16%	15	9%	2	0%	0
Phone	10%	9	0%	0	0%	0
Regular mail	8%	7	23%	5	0%	0
Web Site	2%	2	5%	1	0%	0
No response	5%	5	9%	2	0%	0
	100%	**92**	**100%**	**22**	**0%**	**0**

How satisfied were you with the format and navigation of our website?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	100%	1	0%	0	0%	0
Somewhat dissatisfied	0%	0	0%	0	0%	0
Neither satisfied nor dissatisfied	0%	0	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	0%	0	0%	0	0%	0
	100%	**1**	**0%**	**0**	**0%**	**0**

How satisfied were you with information pertaining to your complaint available on our website?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	100%	1	0%	0	0%	0
Somewhat dissatisfied	0%	0	0%	0	0%	0
Neither satisfied nor dissatisfied	0%	0	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	0%	0	0%	0	0%	0
	100%	**1**	**0%**	**0**	**0%**	**0**

How satisfied were you with the time it took to respond to your initial correspondence?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	50%	5	25%	1	0%	0
Somewhat dissatisfied	30%	3	25%	1	0%	0
Neither satisfied nor dissatisfied	0%	0	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	20%	2	50%	2	0%	0
	100%	**10**	**100%**	**4**	**0%**	**0**

Consumer Satisfaction Survey
Conducted by the Department of Consumer Affairs

How satisfied were you with our response to your initial correspondence?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	80%	8	50%	1	0%	0
Somewhat dissatisfied	0%	0	50%	1	0%	0
Neither satisfied nor dissatisfied	10%	1	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	10%	1	0%	0	0%	0
	100%	10	**100%**	2	**0%**	**0**

How satisfied were you with the time it took to speak to a representative of our Board/Bureau?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	0%	0	0%	0	0%	0
Somewhat dissatisfied	0%	0	0%	0	0%	0
Neither satisfied nor dissatisfied	0%	0	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	100%	1	0%	0	0%	0
	100%	**1**	**0%**	**0**	**0%**	**0**

How satisfied were you with our representative's ability to address your complaint?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	100%	1	0%	0	0%	0
Somewhat dissatisfied	0%	0	0%	0	0%	0
Neither satisfied nor dissatisfied	0%	0	0%	0	0%	0
Somewhat satisfied	0%	0	0%	0	0%	0
Very satisfied	0%	0	0%	0	0%	0
	100%	**1**	**0%**	**0**	**0%**	**0**

How satisfied were you with the time it took for us to resolve your complaint?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	64%	56	47%	8	0%	0
Somewhat dissatisfied	8%	7	18%	3	0%	0
Neither satisfied nor dissatisfied	14%	12	12%	2	0%	0
Somewhat satisfied	8%	7	0%	0	0%	0
Very satisfied	7%	6	24%	4	0%	0
	100%	88	**100%**	17	**0%**	**0**

Consumer Satisfaction Survey
Conducted by the Department of Consumer Affairs

How satisfied were you with the explanation you were provided regarding the outcome of your complaint?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	70%	62	41%	7	0%	0
Somewhat dissatisfied	8%	7	29%	5	0%	0
Neither satisfied nor dissatisfied	5%	4	0%	0	0%	0
Somewhat satisfied	13%	11	0%	0	0%	0
Very satisfied	5%	4	29%	5	0%	0
	100%	**88**	**100%**	**17**	**0%**	**0**

Overall, how satisfied were you with the way in which we handled your complaint?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Very dissatisfied	73%	64	35%	6	0%	0
Somewhat dissatisfied	9%	8	24%	4	0%	0
Neither satisfied nor dissatisfied	9%	8	0%	0	0%	0
Somewhat satisfied	3%	3	12%	2	0%	0
Very satisfied	6%	5	29%	5	0%	0
	100%	**88**	**100%**	**17**	**0%**	**0**

Would you contact us again for a similar situation?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Absolutely not	42%	36	35%	6	0%	0
Probably not	24%	21	18%	3	0%	0
Maybe	12%	10	6%	1	0%	0
Probably	6%	5	18%	3	0%	0
Definitely	16%	14	24%	4	0%	0
	100%	**86**	**100%**	**17**	**0%**	**0**

Would you recommend us to a friend or family member experiencing a similar situation?	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
Absolutely not	58%	50	47%	8	0%	0
Probably not	16%	14	12%	2	0%	0
Maybe	9%	8	6%	1	0%	0
Probably	7%	6	12%	2	0%	0
Definitely	9%	8	24%	4	0%	0
	100%	**86**	**100%**	**17**	**0%**	**0**

Attachment O

Consumer Satisfaction Survey Conducted by the Medical Board

Medical Board of California
Applicant Satisfaction Survey - Quarterly Results

1. Did the application instructions clearly state how to complete the application?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 61	Q2 - 167	Q3 - 142	Q4 - 173	Q1 - 180	Q2 - 25	Q3 - 0	Q4 - 0	Q1 - 0	Q2 - 0	Q3 - 125	Q4 - 258	Q1 - 132	Q2 - 174	Q3 - 224	Q4 - 231
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Yes	88%	93%	94%	94%	89%	96%	n/a	n/a	n/a	n/a	86%	88%	91%	88%	91%	91%
No	12%	7%	6%	6%	11%	4%	n/a	n/a	n/a	n/a	14%	12%	9%	12%	9%	9%

2. If you visited the Medical Board's website for assistance, was the information helpful?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 61	Q2 - 167	Q3 - 142	Q4 - 173	Q1 - 180	Q2 - 25	Q3 - 0	Q4 - 0	Q1 - 0	Q2 - 0	Q3 - 125	Q4 - 258	Q1 - 132	Q2 - 174	Q3 - 224	Q4 - 231
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Yes	87%	90%	94%	90%	87%	92%	n/a	n/a	n/a	n/a	80%	81%	86%	85%	89%	89%
No	13%	10%	6%	10%	13%	8%	n/a	n/a	n/a	n/a	20%	19%	14%	15%	11%	11%

3. If you used the BreEZe online system, how satisfied were you with the information it provided?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 61	Q2 - 167	Q3 - 142	Q4 - 173	Q1 - 180	Q2 - 25	Q3 - 0	Q4 - 0	Q1 - 0	Q2 - 0	Q3 - 125	Q4 - 258	Q1 - 132	Q2 - 174	Q3 - 224	Q4 - 231
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Very satisfied	33%	31%	37%	41%	35%	44%	n/a	n/a	n/a	n/a	25%	28%	30%	29%	34%	32%
Somewhat satisfied	34%	36%	37%	35%	32%	24%	n/a	n/a	n/a	n/a	36%	36%	25%	32%	37%	39%
Somewhat dissatisfied	16%	8%	6%	12%	9%	4%	n/a	n/a	n/a	n/a	10%	11%	9%	9%	7%	6%
Very dissatisfied	5%	7%	6%	2%	7%	8%	n/a	n/a	n/a	n/a	10%	7%	10%	6%	2%	7%
Not Applicable, I did not use the Web Applicant Access System.	12%	18%	13%	11%	17%	20%	n/a	n/a	n/a	n/a	19%	18%	26%	24%	20%	16%

Medical Board of California
Applicant Satisfaction Survey - Quarterly Results

4. How satisfied were you with the courteousness, helpfulness, and responsiveness of the staff person who processed your application?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 61	Q2 - 167	Q3 - 142	Q4 - 173	Q1 - 180	Q2 - 25	Q3 - 0	Q4 - 0	Q1 - 0	Q2 - 0	Q3 - 125	Q4 - 258	Q1 - 132	Q2 - 174	Q3 - 224	Q4 - 231
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Very satisfied	53%	60%	53%	56%	50%	52%	n/a	n/a	n/a	n/a	44%	41%	44%	48%	53%	52%
Somewhat satisfied	12%	16%	20%	19%	22%	16%	n/a	n/a	n/a	n/a	22%	22%	23%	21%	20%	21%
Somewhat dissatisfied	12%	5%	5%	7%	4%	0%	n/a	n/a	n/a	n/a	14%	14%	13%	10%	8%	11%
Very dissatisfied	10%	5%	6%	6%	7%	12%	n/a	n/a	n/a	n/a	12%	16%	15%	12%	12%	10%
Not applicable; I did not have any communication with the staff person who processed my application.	14%	13%	16%	12%	17%	20%	n/a	n/a	n/a	n/a	8%	7%	5%	9%	7%	6%

5. How satisfied were you with the application process?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 61	Q2 - 167	Q3 - 142	Q4 - 173	Q1 - 180	Q2 - 25	Q3 - 0	Q4 - 0	Q1 - 0	Q2 - 0	Q3 - 125	Q4 - 258	Q1 - 132	Q2 - 174	Q3 - 224	Q4 - 231
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Very satisfied	44%	49%	50%	42%	44%	44%	n/a	n/a	n/a	n/a	30%	31%	35%	37%	38%	36%
Somewhat satisfied	23%	26%	24%	31%	26%	44%	n/a	n/a	n/a	n/a	33%	29%	26%	35%	36%	35%
Somewhat dissatisfied	15%	11%	13%	17%	19%	4%	n/a	n/a	n/a	n/a	19%	21%	23%	13%	14%	18%
Very dissatisfied	18%	14%	14%	9%	11%	8%	n/a	n/a	n/a	n/a	18%	19%	16%	15%	12%	11%

Medical Board of California
Newsletter Satisfaction Survey - Quarterly Results

1. My overall satisfaction about the content of the Medical Board's Newsletter is:

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 9	Q3 - 14	Q4 - 14	Q1 - 38	Q2 - 9	Q3 - 4	Q4 - 8	Q1 - 25	Q2 - 8	Q3 - 7	Q4 - 6	Q1 - 12	Q2 - 19	Q3 - 26	Q4 - 5
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Excellent	n/a	33%	0%	43%	21%	11%	0%	25%	16%	25%	14%	33%	20%	32%	13%	20%
Very Good	n/a	45%	29%	21%	18%	33%	50%	38%	24%	38%	29%	17%	30%	28%	35%	40%
Good	n/a	11%	29%	36%	34%	22%	25%	13%	28%	13%	29%	33%	30%	17%	26%	40%
Average	n/a	0%	36%	0%	16%	34%	0%	13%	20%	13%	14%	0%	0%	6%	9%	0%
Disappointed	n/a	11%	6%	0%	11%	0%	25%	11%	12%	11%	14%	17%	20%	17%	17%	0%

2. Please rate the usefulness of the Annual Report (fall issue):

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 9	Q3 - 14	Q4 - 14	Q1 - 38	Q2 - 9	Q3 - 4	Q4 - 8	Q1 - 24	Q2 - 7	Q3 - 7	Q4 - 6	Q1 - 10	Q2 - 17	Q3 - 23	Q4 - 5
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Very Useful	n/a	22%	29%	36%	27%	22%	0%	13%	13%	14%	14%	17%	30%	18%	9%	40%
Informative	n/a	67%	43%	21%	34%	22%	75%	38%	42%	43%	57%	50%	30%	41%	48%	60%
Somewhat Informative	n/a	11%	21%	43%	34%	56%	0%	38%	33%	43%	15%	16%	30%	41%	30%	0%
Not Useful At All	n/a	0%	7%	0%	5%	0%	25%	11%	12%	0%	14%	17%	10%	0%	13%	0%

Medical Board of California
Newsletter Satisfaction Survey - Quarterly Results

3. I prefer to receive the Newsletter:

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 9	Q3 - 14	Q4 - 14	Q1 - 36	Q2 - 9	Q3 - 4	Q4 - 8	Q1 - 23	Q2 - 7	Q3 - 7	Q4 - 6	Q1 - 10	Q2 - 17	Q3 - 22	Q4 - 4
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Via Email	n/a	78%	79%	64%	61%	67%	100%	75%	66%	71%	29%	66%	60%	82%	63%	100%
Hard copy via Regular Mail	n/a	22%	21%	36%	28%	33%	0%	25%	30%	29%	71%	17%	30%	18%	32%	0%
Social Media (when it becomes available)	n/a	0%	0%	0%	11%	0%	0%	0%	4%	0%	0%	17%	10%	0%	5%	0%

4. My main interest in the Newsletter is as a:

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 9	Q3 - 14	Q4 - 14	Q1 - 36	Q2 - 9	Q3 - 4	Q4 - 8	Q1 - 23	Q2 - 7	Q3 - 7	Q4 - 6	Q1 - 10	Q2 - 17	Q3 - 22	Q4 - 4
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Physician / Surgeon	n/a	67%	86%	86%	78%	100%	100%	88%	91%	71%	86%	50%	80%	100%	95%	100%
Associated Medical Professional	n/a	0%	0%	0%	11%	0%	0%	0%	0%	0%	14%	17%	0%	0%	0%	0%
Interested Reader	n/a	11%	7%	14%	8%	0%	0%	0%	9%	14%	0%	0%	20%	0%	0%	0%
Member of the Media	n/a	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%	0%
Government Member	n/a	11%	0%	0%	3%	0%	0%	0%	0%	0%	0%	17%	0%	0%	5%	0%
Other	n/a	11%	7%	0%	0%	0%	0%	12%	0%	15%	0%	16%	0%	0%	0%	0%

Medical Board of California
Website Satisfaction Survey - Quarterly Results

1. Which of the following best decribes you?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 0	Q3 - 0	Q4 - 71	Q1 - 110	Q2 - 76	Q3 - 48	Q4 - 43	Q1 - 35	Q2 - 27	Q3 - 24	Q4 - 27	Q1 - 24	Q2 - 15	Q3 - 7	Q4 - 15
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Consumer/Patient	n/a	n/a	n/a	1%	2%	16%	17%	23%	29%	15%	42%	33%	42%	27%	57%	27%
Applicant (applying for licensure)	n/a	n/a	n/a	3%	6%	8%	10%	2%	6%	11%	8%	11%	12%	27%	14%	0%
Current Licensee	n/a	n/a	n/a	82%	89%	40%	52%	47%	29%	33%	38%	33%	17%	33%	29%	46%
Educator	n/a	n/a	n/a	1%	0%	1%	2%	2%	9%	4%	0%	0%	0%	0%	0%	0%
Employer/Recruiter	n/a	n/a	n/a	3%	0%	5%	10%	0%	2%	7%	0%	8%	0%	0%	0%	7%
Media	n/a	n/a	n/a	0%	0%	0%	2%	0%	2%	0%	0%	0%	0%	0%	0%	13%
Other (please specify)	n/a	n/a	n/a	10%	4%	30%	6%	26%	23%	30%	12%	15%	29%	13%	0%	7%

2. During your most recent visit to the Board's website, which of the following best describes the seeking? [1/]

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 0	Q3 - 0	Q4 - 71	Q1 - 110	Q2 - 76	Q3 - 48	Q4 - 43	Q1 - 35	Q2 - 27	Q3 - 24	Q4 - 27	Q1 - 24	Q2 - 15	Q3 - 7	Q4 - 15
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
License Renewal	n/a	n/a	n/a	82%	83%	26%	38%	28%	40%	30%	17%	22%	12%	7%	29%	27%
Application for Licensure	n/a	n/a	n/a	7%	4%	13%	15%	5%	0%	7%	4%	7%	12%	33%	14%	0%
Verifying a License	n/a	n/a	n/a	4%	6%	41%	29%	23%	23%	15%	29%	18%	12%	20%	29%	27%
Filing a Complaint	n/a	n/a	n/a	1%	4%	5%	6%	14%	20%	15%	29%	18%	29%	27%	14%	33%
Public Documents	n/a	n/a	n/a	6%	2%	15%	8%	7%	14%	4%	8%	0%	8%	7%	0%	47%
Name/Address Change	n/a	n/a	n/a	3%	4%	3%	6%	9%	9%	4%	8%	4%	4%	7%	14%	7%
Board Publications/Media	n/a	n/a	n/a	4%	3%	7%	2%	2%	3%	7%	0%	0%	0%	0%	0%	7%
Continuing Education	n/a	n/a	n/a	4%	1%	1%	2%	0%	3%	4%	4%	0%	0%	0%	0%	7%
Legislation/Regulation	n/a	n/a	n/a	1%	2%	3%	0%	5%	3%	0%	0%	0%	0%	0%	0%	7%
Other (please specify)	n/a	n/a	n/a	11%	11%	25%	19%	23%	37%	41%	42%	52%	33%	20%	43%	27%

[1/] Results exceeding 100% is attributed to raters having the option to choose multiple answers.

Medical Board of California
Website Satisfaction Survey - Quarterly Results

3. Were you successful in finding the information you were seeking?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 0	Q3 - 0	Q4 - 71	Q1 - 110	Q2 - 76	Q3 - 48	Q4 - 43	Q1 - 35	Q2 - 27	Q3 - 24	Q4 - 27	Q1 - 24	Q2 - 15	Q3 - 7	Q4 - 15
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Yes	n/a	n/a	n/a	86%	84%	50%	31%	21%	14%	22%	21%	11%	37%	40%	29%	60%
No	n/a	n/a	n/a	14%	16%	50%	69%	79%	86%	78%	79%	89%	63%	60%	71%	40%

4. Overall, how satisfied are you with the Board's website?

Answer Options	FY 2012 - 2013				FY 2013 - 2014				FY 2014 - 2015				FY 2015 - 2016			
	Q1 - 0	Q2 - 0	Q3 - 0	Q4 - 71	Q1 - 110	Q2 - 76	Q3 - 48	Q4 - 43	Q1 - 35	Q2 - 27	Q3 - 24	Q4 - 27	Q1 - 24	Q2 - 15	Q3 - 7	Q4 - 15
	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%	%
Extremely satisfied	n/a	n/a	n/a	24%	26%	9%	2%	9%	9%	11%	0%	11%	21%	13%	0%	34%
Somewhat satisfied	n/a	n/a	n/a	45%	40%	30%	13%	14%	11%	15%	12%	4%	17%	33%	29%	13%
Neither satisfied nor dissatisfied	n/a	n/a	n/a	9%	16%	5%	10%	2%	17%	18%	17%	7%	17%	0%	0%	13%
Somewhat dissatisfied	n/a	n/a	n/a	14%	11%	16%	17%	19%	20%	15%	4%	26%	8%	7%	14%	7%
Extremely dissatisfied	n/a	n/a	n/a	9%	8%	40%	58%	56%	43%	41%	67%	52%	37%	47%	57%	33%

Attachment P

DCA BreEZe Funding Chart

Department of Consumer Affairs
BreEZe Costs and Funding
FY 2009-10 through FY 2018-19
(amounts in whole $s)

	PROJECT								MAINTENANCE	
	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Budget	FY 2017-18 Budget	FY 2018-19 Budget
BreEZe Costs										
Solution Vendor - Accenture LLP*	-	-	869,926	387,607	4,478,770	4,136,552	12,380,258	11,750,441	14,683,000	14,559,000
DCA Staff and OE&E**	372,732	1,096,247	3,199,363	4,655,450	7,979,320	9,506,388	11,904,786	7,046,014	6,882,000	6,749,000
Data Center Services**	-	-	147,645	138,410	137,472	156,096	182,610	156,096	164,000	172,000
Other Contracts	44,151	53,169	645,011	1,178,588	1,751,269	2,383,841	2,635,696	4,544,449	727,000	50,000
Oversight	10,168	345,993	488,034	393,232	478,328	475,033	364,804	-	-	-
Total Costs	**427,051**	**1,495,409**	**5,349,979**	**6,753,287**	**14,825,159**	**16,657,910**	**27,468,154**	**23,497,000**	**22,456,000**	**21,530,000**
BreEZe Funding Needs										
Total Costs	427,051	1,495,409	5,349,979	6,753,287	14,825,159	16,657,910	27,468,154	23,497,000	22,456,000	21,530,000
Redirected Resources	427,051	1,495,409	3,198,486	4,818,002	5,806,881	7,405,427	7,430,456	2,080,000	2,080,000	2,080,000
Total BreEZe BCP	**-**	**-**	**2,151,493**	**1,935,285**	**9,018,278**	**9,252,483**	**20,037,698**	**21,417,000**	**20,376,000**	**19,450,000**

Board / Bureau Name	FY 2009-10 Actual	FY 2010-11 Actual	FY 2011-12 Actual	FY 2012-13 Actual	FY 2013-14 Actual	FY 2014-15 Actual	FY 2015-16 Actual	FY 2016-17 Budget	FY 2017-18 Budget	FY 2018-19 Budget
Medical Board	27,112	110,597	214,860	340,725	736,524	808,545	1,723,838	1,668,524	1,638,524	1,535,524

* Includes maintenance and financing costs. Financing payments will continue through 2022
** Staff and data center costs will be permanent and ongoing

Attachment Q

Revenue and Fee Schedule

Table 4.	Fee Schedule and Revenue						
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
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA							
Physician Application Fee (B&P 2435)	442	442	3,014,113	3,080,185	3,124,490	3,515,776	6.20%
Physician Initial License Fee (B&P 2435, 16 CCR 1351.5)	783	790	1,545,747	1,672,396	1,706,565	1,881,288	3.32%
Physician Initial License Fee (Reduced) (B&P 2435)	391.50	395	1,471,360	1,624,546	1,589,553	1,751,187	3.09%
Suspended Revenue	various	various	50	584,593	346,592	180,576	0.32%
Out-of-State Volunteer Physician	25		-	25	-	800	0.00%
Physician Oral Re-exam Fee	100		-	1,705	31,696	-	0.00%
SB 2036 Application Fee	4,030		-	-	49,860	30,560	0.05%
Physician Biennial Renewal Fee (B&P 2435, 16 CCR 1352)	783	790	45,739,732	48,637,896	46,961,910	48,477,654	85.51%
Physician Biennial Renewal (B&P 2435)	783	790	20,930	1,610	-	10	0.00%
Physician Biennial Renewal Fee One-Time Reduction	761		25,107	4,566	-	-	0.00%
Physician Delinquency Fee (B&P 2435)	78	79	83,994	83,180	116,674	108,735	0.19%
Physician Delinquency Fee (B&P 2435)	80.50		1,288	81	-	-	0.00%
Physician Delinquency Fee: 10% of Biennial Renewal Fee (B&P 2435)	various	various	-	146,146	-	-	0.00%
Physician Penalty Fee (B&P 2424, 16 CCR 1352.2)	391.50		6,440	403	-	-	0.00%
Physician Penalty Fee (B&P 2424, 16 CCR 1352.2)	391.50	391.50	104,556	29,832	267,673	269,240	0.47%
Physician Duplicate License/Certification Fee (B&P 2435)	10	50	1,290	240	-	-	0.00%

Table 4.	Fee Schedule and Revenue						
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
Physician Duplicate Certificate Fee (B&P 2435)	50	50	39,600	30,350	27,833	26,950	0.05%
Physician Letter of Good Standing (B&P 2435)	10	10	59,080	48,590	27,620	70,660	0.12%
Reinstatement Fee - A physician may "reinstate" by paying an amount equivalent to the total of renewal fees & delinquent fees which have accrued (B&P 125.3)	various	various	88,166	17,600	-	-	0.00%
Citations and Fines (B&P 125.9)	various	5,000	68,186	32,050	21,100	18,400	0.03%
Citation/Fine FTB Collection (B&P 125.9)	various	various	277	298	296	228	0.00%
Special Faculty Permit Application Fee (B&P 2168.4 & 2435)	442	442	442	578	1,021	1,768	0.00%
Special Faculty Permit Initial License Fee (B&P 2435, 16 CCR 1351.5)	783	790	-	1,568	2,349	1,566	0.00%
Special Faculty Permit Biennial Renewal Fee (B&P 2168.4 & 2435, 16 CCR 1352.1)	783	790	4,698	5,481	9,396	7,047	0.01%
Special Faculty Permit Delinquency Fee (B&P 2168.4 & 2435)	78	79	-	-	-	-	0.00%
Special Faculty Permit Penalty Fee (B&P 2168.4, 16 CCR 1352.2)	391.50	391.50	-	392	-	-	0.00%
Special Programs Initial Application Fee (B&P 2111 & 2113, 16 CCR 1351.5)	86	86	3,784	1,290	86	86	0.00%
Special Programs Annual Renewal Fee (B&P 2111 & 2113, 16 CCR 1351.1)	43.00	43.00	2,537	602	602	344	0.00%

Table 4.	Fee Schedule and Revenue						
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
Special Programs Delinquency Fee (B&P 163.5)	25	25	-	-	-	-	0.00%
Fictitious Name Permit Application and Initial Permit Fee (B&P 2443)	50	50	68,638	62,718	70,802	65,983	0.12%
Fictitious Name Permit Biennial Renewal Fee (B&P 2443)	40	40	314,840	260,798	222,172	215,988	0.38%
Fictitious Name Permit Delinquency Fee (B&P 2443)	20	20	9,080	8,030	12,620	12,810	0.02%
Fictitious Name Permit Duplicate Cert (B&P 2443)	30	50	-	780	840	1,260	0.00%
Research Psychoanalyst Registration Fee (B&P 2529.5, 16 CCR 1377)	100	100	300	500	700	475	0.00%
Research Psychoanalyst Reduced Registration Fee (B&P 2529.5, 16 CCR 1377)	75	75	-	-	75	75	0.00%
Research Psychoanalyst Biennial Renewal Fee (B&P 2529.5, 16 CCR 1377)	50	50	150	3,150	350	3,950	0.01%
Research Psychoanalyst Delinquency Fee (B&P 2529.5)	25	25	25	150	50	100	0.00%
Polysomnography Trainee Application Fee (B&P 3577, 16 CCR 1379.78)	100	100	9,800	1,500	3,200	2,700	0.00%
Polysomnography Trainee Registration Fee (B&P 3577, 16 CCR 1379.78)	100	100	2,600	1,200	2,400	2,800	0.00%
Polysomnography Trainee Biennial Renewal Fee (B&P 3577, 16 CCR 1379.78)	150	150	-	-	900	1,650	0.00%
Polysomnography Trainee Delinquency Fee (B&P 163.5, 16 CCR 1379.78)	75	75	-	-	-	75	0.00%
Polysomnography Technician Application Fee (B&P 3577, 16 CCR 1379.78)	100	100	7,600	2,400	1,400	1,800	0.00%

Table 4.	Fee Schedule and Revenue						
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
Polysomnography Technician Registration Fee (B&P 3577, 16 CCR 1379.78)	100	100	5,500	3,000	1,900	1,700	0.00%
Polysomnography Technician Biennial Renewal Fee (B&P 3577, 16 CCR 1379.78)	150	150	-	-	3,600	4,200	0.01%
Polysomnography Technician Delinquency Fee (B&P 163.5, 16 CCR 1379.78)	75	75	-	-	75	150	0.00%
Polysomnography Technologist Application Fee (B&P 3577, 16 CCR 1379.78)	100	100	50,600	4,300	4,600	6,500	0.01%
Polysomnography Technologist Registration Fee (B&P 3577, 16 CCR 1379.78)	100	100	51,600	6,400	4,550	6,404	0.01%
Polysomnography Technologist Biennial Renewal Fee (B&P 3577, 16 CCR 1379.78)	150	150	-	-	54,550	17,490	0.03%
Polysomnography Technologist Delinquency Fee (B&P 163.5, 16 CCR 1379.78)	75	75	-	-	1,050	1,725	0.00%
Specialty Board Application Fee (B&P 651, 16 CCR 1354)	4,030	4,030	805	-	-	-	0.00%
Dishonored Check Fee (B&P 206)	25	25	575	300	425	700	0.00%
Refunded - OSHP			-	276	125	-	0.00%

Attachment R

Budget Change Proposals

Table 5.		Budget Change Proposals (BCPs)						
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1110-05 [1]	12/13	Operation Safe Medicine	1.0 Sup Inv I 4.0 Investigators 1.0 OT	1.0 Sup Inv I 4.0 Investigators 1.0 OT	513,000	513,000	(513,000)	(513,000)
1110/1111-01	12/13	BreEZe System - Special Project Report Continuation and Credit Card Funding	N/A	N/A	N/A	N/A	1,278,000	1,278,000
1110/1111-01	13/14	BreEZe System - Special Project Support Continuation and Credit Card Funding	N/A	N/A	N/A	N/A	1,183,000	1,183,000
1110/1111-02 [2]	14/15	BreEZe System - Special Project Support Continuation and Credit Card Funding	N/A	N/A	N/A	N/A	1,531,000	1,531,000
1110/1111-03	14/15	Medical Expert Reviewer	N/A	N/A	N/A	N/A	476,000	0
1110/1111	14/15	Operation Safe Medicine - North	1.0 Sup Inv I 4.0 Investigators 1.0 OT	0	527,000	0	169,000	0
1110-16	14/15	Enforcement Enhancement - Workload request based on G.C. 13308.05	1.0 AGPA 2.0 SSA 1.0 Investigator 1.0 OT	1.0 AGPA 2.0 SSA 1.0 Investigator 1.0 OT	288,000	288,000	183,000	183,000
1110/11111-05L	14/15	SB 304 - Redirection of Investigative Staff	1.0 CEA A	1.0 CEA A	118,000	118,000	N/A	N/A
1110/1111-05L	14/15	SB 304 - Redirection of Investigative Staff	-1.0 Deputy Chief -1.0 CEA II -4.0 Sup Inv II -15.0 Sup Inv I -2.0 AGPA -76.0 Investigator -13.0 OT -1.0 MST -1.0 AGPA -1.0 OA -1.0 SSA	-1.0 Deputy Chief -1.0 CEA II -4.0 Sup Inv II -15.0 Sup Inv I -2.0 AGPA -76.0 Investigator -13.0 OT -1.0 MST -1.0 AGPA -1.0 OA -1.0 SSA	(12,797,000)	(12,797,000)	(2,701,000)	(2,701,000)
	15/16	BreEZe System - Revised Costs	N/A	N/A	N/A	N/A	2,403,000	2,403,000

Table 5.		Budget Change Proposals (BCPs)						
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	$ Requested	$ Approved	$ Requested	$ Approved
1110-002-BCP-BR-2015-MR	15/16	BreEZe System - Revised Costs	N/A	N/A	N/A	N/A	158,000	158,000
1111-014-BCP-BR-2016-GB	16/17	Staff Augmentation (Adverse Events – Outpatient Surgery Settings)	1.0 AGPA	1.0 AGPA	93,000	93,000	20,000	20,000
1111-015-BCP-BR-2016-GB	16/17	Medical Expert Reviewer	N/A	N/A	N/A	N/A	735,000	206,000
1110-XXX-BCP-BR-2016-GB	16/17	Staff Augmentation	2.0 OT 3.0 MST 1.0 Staff ISA 1.0 SSA 1.0 AGPA	0	579,000	0	163,000	0
1111-038-BCP-BR-2016-GB	16/17	Registered Dispensing Opticians (AB 684, Chapter 405, Statutes of 2015)	-0.5 OT	-0.5 OT	-36,000	-36,000	-3,000	-3,000
1111-007-BCP-BR-2016-GB	16/17	Department of Justice (SB 467, Chapter 656, Statutes of 2015)	N/A	N/A	N/A	N/A	577,000	577,000
1110/1111	16/17	Re-establish BL12-03 Blanket Positions	2.6 OT 6.0 Spec Investigator 1.0 Sup Spec Investigator 1.0 OA	0	N/A	N/A	N/A	N/A

[1] Position Authority only was approved. Funding was internally redirected from OE&E to Personal Services.

[2] FY 2014/15 Breeze BCP includes a current year component for 2013/14 funding of $26,000.