

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

MEDICAL BOARD OF CALIFORNIA

**Board and Committee
Meetings**

October 27-28, 2016



**MEDICAL BOARD OF CALIFORNIA
BOARD MEETING SCHEDULE**

Sheraton Mission Valley San Diego
1433 Camino Del Rio S.
San Diego, CA 92108

October 27-28, 2016

Thursday, October 27, 2016

- **9:00 am – 12:30 pm** **Panel A (Room: Connections Ballroom)**
(Members: Wright (Chair), Lewis, Bishop, Feinstein, Hawkins, Warmoth, Yip)
- **8:30 am – 12:30 pm** **Panel B (Room: Compass Ballroom)**
(Members: Krauss (Chair), Bholat, GnanaDev, Lawson, Levine, Pines, Sutton-Wills)
- **12:30 pm – 1:30 pm** **Lunch Break**
- **1:30 pm – 2:00 pm** **Application Review and Special Program Committee (Compass Ballroom)**
(Members: Bholat, Sutton-Wills)
- **2:00 pm – 5:30 pm** **Full Board Meeting (Room: Compass Ballroom)**
(All Members)

Friday, October 28, 2016

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



MEDICAL BOARD OF CALIFORNIA



PANEL A MEETING AGENDA

MEMBERS OF PANEL A

Chair

Jamie Wright, J.D.

Vice Chair

Ronald Lewis, M.D.

Michael Bishop, M.D.

Randy Hawkins, M.D.

Judge Katherine Feinstein (Ret.)

David Warmoth

Felix Yip, M.D.

Sheraton Mission Valley San Diego
1433 Camino Del Rio South
Compass Ballroom
San Diego, CA 92108
(619) 260-1111

Thursday, October 27, 2016

9:00 a.m. to 1:00 p.m.

(or until completion of business)

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

9:00 a.m. OPEN SESSION

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

BENZOR, Joanne Marian, M.D.

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

BENZOR, Joanne Marian, M.D.

10:15 a.m. OPEN SESSION

4. **Oral Argument on Proposed Decision**

EGTEDAR, Ascar, M.D.

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

EGTEDAR, Ascar, M.D.

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

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

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

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

6. **OPEN SESSION**

7. Adjournment

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

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

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



MEDICAL BOARD OF CALIFORNIA



PANEL B MEETING AGENDA

MEMBERS OF PANEL B

Chair

Howard Krauss, M.D.

Vice Chair

Michelle Bholat, M.D.

Dev GnanaDev, M.D.

Kristina Lawson, J.D.

Sharon Levine, M.D.

Denise Pines

Brenda Sutton-Wills, J.D.

Sheraton Mission Valley San Diego
Connections Ballroom
1433 Camino Del Rio South
San Diego, CA 92108
(619) 260-0111

Thursday, October 27, 2016

8:30 a.m. to 1:00 p.m.

(or until completion of business)

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

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

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

8:30 a.m. OPEN SESSION

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

NGUYEN, Li Quang

9:15 a.m.*CLOSED SESSION – Proposed Decision

NGUYEN, Li Quang

9:45 a.m. OPEN SESSION

4. **Oral Argument on Judicial Remand**

O'DORISIO, James Edward, M.D.

10:30 a.m.*CLOSED SESSION – Judicial Remand

O'DORISIO, James Edward, M.D.

11:00 OPEN SESSION

5. **Oral Argument on Proposed Decision**

THOMPSON, Christopher Thomas

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

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

11:45 a.m. *CLOSED SESSION – Proposed Decision

THOMPSON, Christopher Thomas

6. Deliberation on disciplinary matters, including proposed decisions and stipulations (Government Code §11126(c)(3))
7. **OPEN SESSION**
8. Adjournment

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MEDICAL BOARD OF CALIFORNIA
Licensing Program

APPLICATION REVIEW AND
SPECIAL PROGRAMS
COMMITTEE MEETING
AGENDA

MEMBERS OF THE COMMITTEE

Michael Bishop, M.D., Chair
Kristina D. Lawson, J.D.
Felix Yip, M.D.

Sheraton Mission Valley San Diego
Compass Ballroom Room
1433 Camino Del Rio S.
San Diego, CA 92108

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

Thursday, October 27, 2016
1:30 p.m. - 2:00 p.m.
(or until conclusion of business)

ALL TIMES ARE APPROXIMATE AND SUBJECT TO CHANGE

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

- 1. Call to Order/Roll Call/Establishment of Quorum
2. Public Comment on Items Not on Agenda
Note: The Committee may not discuss or take action on any matter raised during this public comment
section, except to decide whether to place the matter on the agenda of a future meeting [Government
Code Sections 11125, 11125.7(a)].
3. Application Review
A closed session will be held pursuant to Gov. Code §11126(c)(2) to consider applications for licensure.
4. Adjournment

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surgeons and certain allied healthcare professions and through the vigorous, objective enforcement of the Medical Practice Act, and to promote
access to quality medical care through the Board's licensing and regulatory functions.

NOTICE: The meeting is accessible to the physically disabled. A person who needs a disability-related accommodation or modification in order to
participate in the meeting may make a request by contacting Lisa Toof at (916)263-2389 or email lisa.toof@mbc.ca.gov or send a written request to
Ms. Toof at the Medical Board of California, 2005 Evergreen Street, Suite 1200, Sacramento, CA 95815.
Providing your request at least five (5) business days before the meeting will help ensure availability of the requested accommodation.

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

For additional information call (916) 263-2389.



MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING AGENDA



MEMBERS OF THE BOARD

President

Dev GnanaDev, M.D.

Vice President

Denise Pines

Secretary

Ronald Lewis, M.D.

Michelle Bholat, M.D.

Michael Bishop, M.D.

Judge Katherine Feinstein (ret.)

Randy Hawkins, M.D.

Howard Krauss, M.D.

Kristina Lawson, J.D.

Sharon Levine, M.D.

Brenda Sutton-Wills, J.D.

David Warmoth

Jamie Wright, J.D.

Felix Yip, M.D.

Sheraton Mission Valley – San Diego
1433 Camino Del Rio S.
San Diego, CA 92108

Thursday, October 27, 2016

2:00 p.m. – 5:30 p.m.

Friday, October 28, 2016

9:00 a.m. – 3:00 p.m.

(or until the conclusion of business)

Public Telephone Access – See Attached
Meeting Information

ORDER OF ITEMS IS SUBJECT TO CHANGE

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

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

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

Thursday October 27, 2016

2:00 p.m.

1. Call to Order/Roll Call/Establishment of a Quorum
2. Public Comments on Items not on the Agenda
*Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting.
[Government Code Sections 11125, 11125.7 (a)]*
3. Approval of Minutes from the July 28 – 29, 2016 Meeting
4. President's Report, including notable accomplishments and priorities – Dr. GnanaDev
5. Discussion and Consideration of Committees and Task Forces Make-Up – Dr. GnanaDev and Ms. Kirchmeyer
6. Board Member Communications with Interested Parties – Dr. GnanaDev

7. Executive Management Reports – Ms. Kirchmeyer
 - A. Administrative Summary, including budget, personnel, and technology updates
 - B. Enforcement Program Summary, including personnel, expert reviewer program, statistics, and enforcement unit updates
 - C. Licensing Program Summary, including personnel, statistics, and licensing unit updates
 - D. Update on the CURES Program, including registration and outreach information
 - E. Update on the Health Professions Education Foundation, including information on the Stephen M. Thompson Loan Repayment Program
 - F. Update on Coordination with State Agencies regarding Psychotropic Medications for Foster Children
 - G. Update on the Federation of State Medical Boards
8. Update from the Department of Consumer Affairs, which may include Updates pertaining to the Department’s Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory and Policy Matters – Ms. Lally
9. Review, Discussion, and Approval of the Sunset Review Report – Ms. Kirchmeyer and Ms. Robinson
10. Update on the Demographic Study, including progress and timeline – Ms. Robinson
11. Special Faculty Permit Review Committee Recommendations: Approval of Applicant – Dr. Bholat
12. Update from the Application Review and Special Program Committee – Dr. Bishop
13. Update on the Outreach Campaign – Dr. Hawkins
14. Update on the Physician Assistant Board – Dr. Bishop

Friday October 28, 2016

9:00 a.m.

15. Call to Order/Roll Call/Establishment of a Quorum
16. Public Comments on Items not on the Agenda
*Note: The Board may not discuss or take action on any matter raised during this public comment section, except to decide whether to place the matter on the agenda of a future meeting.
 [Government Code Sections 11125, 11125.7 (a)]*
17. 9:00 am REGULATIONS – PUBLIC HEARING – Consideration and Possible Action on Proposed Regulations amending Title 16, Division 13, CCR Sections 1364.10, 1364.11, 1364.13, and 1364.15 related to Citable Offenses, Citation Disclosure, and Citation and Fine Authority for Allied Health Professionals – Ms. Webb
18. 9:05 am REGULATIONS – PUBLIC HEARING – Consideration and Possible Action on Proposed Regulations on Requirements for Physicians on Probation, amending Title 16, Division 13, CCR Section 1358 – Ms. Webb

19. Presentation, Discussion, and Possible Action on the University of California, Los Angeles, International Medical Graduate Pilot Program – Dr. Bholat
20. Vertical Enforcement Program Update from Health Quality Investigation Unit – Mr. Chriss and Ms. Nicholls
21. Vertical Enforcement Program Update from Health Quality Enforcement Section – Ms. Castro
22. Update from the Attorney General’s Office – Ms. Castro
23. Update, Discussion and Possible Action of Recommendations from the Midwifery Advisory Council Meeting – Ms. Sparrevohn
24. Discussion and Possible Action on Midwifery Advisory Council Appointments – Mr. Worden
25. Discussion and Possible Action on Legislation/Regulations – Ms. Simoes
 - A. Implementation Plans for 2016 Legislation

AB 1244	SB 482	SB 1189
AB 2024	SB 1160	SB 1261
AB 2744	SB 1174	SB 1478
AB 2745	SB 1177	
 - B. Status of Regulatory Actions
 1. Physician and Surgeon Licensing Examinations Minimum Passing Scores, 16 CCR, section 1328.1
 2. Outpatient Surgery Setting Accreditation Agency Standards, 16 CCR, section 1313.4
 3. Disclaimers and Explanatory Information Applicable to Internet Postings, 16 CCR, section 1355.35
 4. Disciplinary Guidelines, 16 CCR, section 1361
 5. Midwife Assistants, 16 CCR, sections 1379.01, 1379.02, 1379.03, 1379.04, 1379.05, 1379.06, 1379.07, 1379.08, and 1379.09
 6. Physicians on Probation, 16 CCR, section 1358
 7. Citation and Fine, 16 CCR, section 1364.10, 1364.11, 1364.13, and 1364.15
26. Agenda Items for the January 2017 Meeting in the Sacramento Area
27. Adjournment

Meeting Information

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

The call-in number for teleconference comments is:

Thursday, October 27, 2016 1-800-288-8961

Friday, October 28, 2016 1-800-230-1096

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

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

During Agenda Item **2** and **16** – Public Comments on Items Not on the Agenda, the Board has limited the total public comment period via teleconference to 20 minutes. Therefore, after 20 minutes, no further comments will be accepted. Each person will be limited to three minutes per agenda item.

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

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

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MEDICAL BOARD OF CALIFORNIA

QUARTERLY BOARD MEETING



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

July 28-29, 2016

MEETING MINUTES

Thursday July 28, 2016

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

Members Present:

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

Members Absent:

Sharon Levine, M.D.
Denise Pines, Secretary
David Serrano Sewell, President

Staff Present:

Liz Amaral, Deputy Director
Christina Delp, Chief of Enforcement
Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
Susan Houston, Staff Services Manager II
Kimberly Kirchmeyer, Executive Director
Regina Rao, Associate Government Program Analyst
Elizabeth Rojas, Staff Services Analyst
Jennifer Saucedo, Business Services Officer
Jennifer Simoes, Chief of Legislation
Lisa Toof, Administrative Assistant II
Kerrie Webb, Legal Counsel
Curt Worden, Chief of Licensing

Medical Board of California
 Meeting Minutes from July 28-29, 2016
 Page 2

Members of the Audience:

Teresa Anderson, California Academy of Physician Assistants
 Andrew Angelantoni
 Emily Bentley
 Jessica Bucher
 Eric Carlile, Kaiser Permanente
 Gloria Castro, Senior Assistant Attorney General, Attorney General's Office
 David Chriss, Chief, Division of Investigation, Department of Consumer Affairs
 Genevieve Clavreul via Teleconference
 Long Do, California Medical Association
 Gene Dorio, M.D., via Teleconference
 Karen Ehrlich, Licensed Midwife
 Eileen Ellis
 Julie D'Angelo Fellmeth, Center for Public Interest Law
 Louis Galiano, Videographer, Department of Consumer Affairs
 Bridgette Gramme, Center for Public Interest Law
 David R. Grube, M.D., Compassion and Choices
 Christina Hildebrand, A Voice for Choice Advocacy
 Ralph Hughes, Investigator
 Kaleem Joy, Licensed Midwife
 Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
 Janice Miller
 Carole Moss, Consumers Union Safe Patient Project
 Ty Moss, Consumers Union Safe Patient Project
 Kathleen Nicholls, Deputy Chief, Department of Consumer Affairs
 Vic Sandoval, Supervising Investigator, Health Quality Investigation Unit
 Leonard Saputo, M.D.
 Jane Zack Simon, Supervising Deputy Attorney General, Attorney General's Office
 Marlene Smith

Agenda Item 1 Call to Order/Roll Call

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on July 28, 2016, at 3:15 p.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 2 Public Comments on Items not on the Agenda

Dr. Saputo discussed a law that effects all physicians who practice oncology. He noted that it is a felony in the state of California to practice any type of medicine to treat cancer with the exception of radiation, chemotherapy or surgery. So, with that, he stated the Department of Public Health has the right to come to any physician who is practicing any other types of approaches and make a criminal allegation.

Dr. Saputo referred the Members to a handout he had provided, a copy of Assembly Bill (AB) 592 that was put into law back in 2005. He noted the bill stated that any physician can practice any therapy they want as long as the mainstream approach is offered as a first choice, including the physician performing a proper physical exam and history and not doing any harm to the

patient. He noted that the means are there to regulate physicians who do anything wrong, in any field of medicine.

He stated the Department of Public Health law is unnecessary, and it interferes with physicians in California being able to practice the way they want to under the laws and regulations of the Board. He asked the Board to support legislation, to take that particular section out of Department of Public Health's jurisdiction. He noted he understands there is not a bill introduced yet, but, if the intent of the Board is there, he felt it would make it much easier to find someone in the Assembly to author this type of bill.

Ms. Miller stated that in June of last year, Senator Pan clarified the intent of Senate Bill (SB) 277 to the California State Senate before voting. The law included an amendment allowing California physicians to write medical exemptions for vaccinations. It stated that family medical history could be considered to determine if the vaccination is appropriate for the patient. Ms. Miller noted that even as the bill was pushed through the legislature, Senator Pan was aware of the CDC whistleblower who had come forward with the admission of fraud, eroding the public confidence in the vaccine program.

Ms. Miller stated that on a separate occasion, Senator Ben Allen had specifically said that physicians should not be sanctioned or impacted by using their discretion for granting a medical exemption for anyone who has a legitimate concern. She noted that SB 277 does not contain a provision that allows school districts, health departments or anyone else to reject a physician's medical judgment, however, it is happening. She stated these actions, not only violate SB 277, but may also be violating many other state and federal laws.

Ms. Bucher stated in June 2016, Dr. Dean sent out a letter to all schools, superintendents, principals and child care center directors, directing them to send all medical exemptions for a "comprehensive review" of each exemption for the purpose of data collection and compliance with SB 277 criteria. She noted that when Governor Brown signed SB 277 into law, he specifically stated the Legislature amended the bill to exempt a child from immunizations whenever a child's physician concludes that there are circumstances, including, but not limited to, family history for which the physician does not recommend immunization. With that information, Ms. Miller felt that there was no need for Dr. Dean to perform a comprehensive review of these exemptions as she was not the child's physician. She felt Dr. Dean should not be burdening the schools or anyone else with any additional steps, as the child's physician had already concluded that the medical exemption was warranted.

Ms. Hildebrand, A Voice for Choice Advocacy, stated often when one speaks to a physician about vaccinations, it becomes a taboo subject for a consumer or patient. She stated most physicians stated that vaccines are safe and effective, however, there are children and adults who are injured by vaccinations. She stated the CDC's vaccine schedule of 72 doses by the age of 18 had never been tested in its entirety to see if it was completely safe. Ms. Hildebrand stated there are two issues that are of great concern to her that she would like the Board to look into further. The first being that the insurance companies had been giving kick-backs to physicians to have children be fully vaccinated by the age of two. She noted there were upwards of \$400 dollars or more being kicked back to the physician for every child that was fully vaccinated by or before the age of two. She stated that fact tells her that the physician does not look at the risks or benefits of the vaccinations in many cases, but at their bottom financial line. Ms. Hildebrand stated her next area of concern was that there was no recourse for those who do get

injured, or have some reaction from vaccinations. Under the vaccine compensation act, one had to have had a anaphylactic shock or have died from the vaccine to qualify for any type of compensation. She noted another concern she had was there are many physician's practices who are now turning away patients because they are not fully vaccinated.

Mr. Angelentoni stated he had a bachelors in science degree and some experience in how to gather evidence for a hypothesis. He spoke of recent advances in the knowledge of how repeated immune activation due to aluminum adjuvanted vaccines may cause injury including autism. He noted that it was commonly thought that vaccination injury is limited to soreness of the arm, a slight fever, and in those rare cases some paralysis or even death. He stated that most people felt that autism is not caused by vaccines. He noted that the recent research by Cal Tech, UC Davis and other groups have provided the biological mechanism behind vaccine-induced autism. The work is showing how first maternal immune activation increases interleukin 6 (IL6), which is strongly pointing to the biological mechanism. Mr. Angelentoni noted that it had long been known that infection during pregnancy causes autism and schizophrenia, though it was not the actual infection, but the mother's immune reaction to the infection that caused it. In 2005, John's Hopkins showed that most brains of autistic individuals that were autopsied were inflamed. In 2009, Cal Tech tested the theory that purposely elevating IL6 would cause inflammation. It was found the mice exhibited autistic behavior. He stated that in 2014, Cal Tech partnered with UC Davis and performed the same experiments with monkeys, with the same end results.

Ms. Bentley stated that other groups corroborated the maternal immune activation work. UCLA published its work with mice and stated that IL6 is necessary and sufficient for producing autism in offspring. The New York Institute for Basic Research also performed the same type of experiments and found that IL6 caused autistic behavior in post-natal mice. She stated that the evidence showed that IL6 would cause autism. She noted that aluminum adjuvanted vaccines also raise IL6 levels, and up to 60% of vaccines on the CDC infant and childhood immunization vaccination schedule include aluminum adjuvant. The aluminum activates the immune system and without it, the body would not recognize the weakened antigens and would not create the necessary antibodies. She noted vaccine adverse reactions could stimulate enormous IL6 production in the brain in the same amount that has caused brain damage in experimental animals. The study supposedly disproving the link to autism considered only the Measles, Mumps and Rubella (MMR) vaccine. Aluminum vaccines have not been studied, with the exception of Hepatitis B, which is also strongly associated with autism. She stated vaccine promoters are using the MMR studies to argue that all vaccines have been proven safe, but this is dishonest and misuse of the science. She noted vaccines are different and the MMR does not contain aluminum.

Dr. Dorio, licensed physician, stated he has witnessed an HMO hospital not provide standard of care to their patients. The current chief medical officer (CMO) of this hospital, who is also a hospital administrator and a California licensed physician, changes policies and procedures resulting in the death of patients. In addition, he has witnessed physicians place their elder patients on hospice, just for the benefit of their organization's financial needs. He stated there is continual denial of patient care by California licensed physicians employed by insurance companies, and they have not been held accountable for their practice of medicine under the guise of utilization review. He stated he sensed the Board might recognize that utilization review would fall under the practice of medicine, but noted it seemed to him that the Board is awaiting the Legislature to define its legal jurisdiction. Since the highest priority of the Board is

to protect the public, the Board should not be waiting for the slow legislative process. Dr. Dorio noted any new laws will have fingerprints of lobbyists and special interest groups forcing the Board to continually clarify complicated wording through legal counsel. He noted the Medical Practice Act might provide a legal tool to fulfill the Board's fiduciary responsibilities for the purpose of appropriate patient care. He stated that section 2718 may allow oversight of licensed physicians who are not practicing the standard of care. He requested the issue be discussed as the public confidence in physician medical decision making is deteriorating due to business intervention. The unscrupulous and often immoral practice of medicine influenced by profit must be deterred. Other than the Board, there is no other agency that wields the power to make this happen. He noted he would like to see the Board put this item on a future agenda for discussion or for a committee to work on this particular issue.

Ms. Ellis stated she would like to see SB 277 be reformed, as the rights of her children and her rights as a mother are being violated. She noted her family has significant history of auto immune dysfunction as well as neurological dysfunction. Because of this history, they are concerned about aluminum vaccines, the body's challenges in processing it, and the effects it has on children's developing bodies when given multiple vaccines at one physician's visit. Due to these concerns, the family made a decision to vaccinate their children on a delayed, one at a time schedule. Ms. Ellis noted that by maintaining SB 277 in its current form, the state of California is violating her children's rights. Ms. Ellis asked the Board to work to adjust SB 277 in consideration of families like hers.

Agenda Item 3 Approval of Minutes from the May 5-6, 2016 Meetings

Dr. Lewis made a motion to approve the May 5-6, 2016 meeting minutes as written; s/Dr. Krauss. Motion carried unanimously. (12-0.)

Agenda Item 4 Presentation on the End of Life Option Act

Dr. Grube gave a presentation on the End of Life Option Act (Act). His presentation included the goals of ABX2-15, the sources, the end of life care and the role licensees play. Dr. Grube explained the physician components and responsibilities, as well as a comparison between the California Act and Oregon's Death with Dignity Act.

Dr. GnanaDev thanked Dr. Grube for his presentation and then asked if a poll had ever been taken to see what percentage of physicians would be willing to participate in this option.

Dr. Grube stated there had been many polls taken on similar subjects, but in Oregon, none have been done on this particular subject matter.

Dr. GnanaDev also asked if Dr. Grube had heard of any incidents where someone else used the drugs rather than the patient.

Dr. Grube responded that the drugs that are used are not opioid-type drugs, so they had not had an issue with that.

Ms. Wright asked how one would reconcile the ethical duty that the physician has as to ensure that the patient is truly terminal with no chance of survival, when there is a possibility they may actually survive.

Dr. Grube stated there is no way for a physician to say exactly how long a patient will live, and these patients are very, very sick. In addition, they most often have three physicians involved in the decision. Sadly, often times, the physician tends to over predict how long a patient has to live. He noted that if a physician has any doubt whatsoever about a patient's severity, a prescription should not be written.

Mr. Warmoth thanked Dr. Grube for coming and giving this very helpful presentation. He then asked if Dr. Grube knew of any mistakes in the California or Oregon law that the Board should watch for and be aware of.

Dr. Grube stated his response to the question was a personal response, not one of the Oregon Medical Board. He stated he felt that the inability of citizens of Oregon to access this law in some areas needed to be reviewed. There are some patients that are suffering terribly but the areas they live in have no sources to assist them with this law, which means they would have to travel to a different town to find a source to assist them, which is often difficult.

Dr. Krauss asked if Dr. Grube had seen any unexpected issues in any of the states where this Act was practiced.

Dr. Grube stated there were six in Oregon over the past 18 years, many years ago. He stated there were six individuals who had taken the fatal medication, but did not die. Each of the cases were looked at to discover what happened. Dr. Grube stated, for example one person had taken the fatal medication incorrectly; in another case, it was taken with a dairy product; and another person had taken it while taking a high dose of laxatives. He noted that in Oregon, there had not been any other issues, such as coercion, misuse of the medication, etc.

Dr. Lewis stated there were two hospitals in Palm Springs. One of those hospitals has informed staff they will not permit anyone on staff to participate in such a program. He noted he is having trouble understanding why someone might feel that way.

Dr. Grube stated he felt that many physicians think about themselves over what a patient's needs are. He had seen that same reaction in several of the medical facilities in Oregon where they had been against the program, but they now hold a neutral stance. Dr. Grube felt that more physicians are seeing that seriously ill patients get to the point where they have no dignity left and intolerable suffering, so they are starting to understand better.

Dr. GnanaDev stated that The California Hospital Association (CHA) is advising its members to not participate in the program, however, he felt it is because California is one state where physicians cannot be directly employed by the hospitals, unless they are a public entity like a federal, state or county hospital. He noted that hospitals cannot participate in the program, but physicians in independent practice can.

Dr. Grube mentioned that Compassion and Choices has a platform called Doc to Doc, where a physician in California can call a 1-800 number and ask questions about the Act.

Dr. Grube's full presentation can be viewed on the Board's website under July 2016 Board Meeting, Agenda Item 4.

Agenda Item 5 President's Report, including notable accomplishments and priorities

Dr. GnanaDev noted that Mr. Serrano Sewell was unable to attend the meeting due to a longstanding commitment, so he would be providing the President's Report. He noted that since Mr. Serrano Sewell could not be attend the meeting, Mr. Serrano Sewell provided a written report that could be found on pages BRD 5-1 and 5-2. Dr. GnanaDev noted that some of the highlights of Mr. Serrano Sewell's report included a few of the Board's accomplishments over the past two years, including the Board's Legislative Day, which he stated, he had the privilege of being a part of. He stated that on May 11, 2016, he and seven other Board Members visited with a variety of Legislators to educate them on the Board and its roles and functions. Several of them agreed to provide outreach about the Board to constituents via their social media and websites. Dr. GnanaDev thanked the Members for their participation.

Dr. GnanaDev noted that Mr. Serrano Sewell also talked about his three top priorities in his report, which included interim suspension orders, a physician health program, and public outreach.

Finally, Mr. Serrano Sewell discussed the Patient Notification Task Force and how the Board will move forward on the issue of patient notification of physician's on probation. He noted that Ms. Kirchmeyer would provide more information during her report and that it is also in her written report.

Mr. Serrano Sewell stated the Board takes this issue very seriously and that the Board will take up different issues and ideas that have come from the task force in the appropriate standing committee.

Regarding Board committees, Mr. Serrano Sewell stated in his report that he felt it would be prudent to await the election of new officers prior to assigning members to any of the committees. He noted the new Board president would work with Ms. Kirchmeyer to review committees that needed appointments and would make assignments within the next month. If any member was interested in a certain committee or in changing committees, he told them to let Ms. Kirchmeyer know.

Dr. GnanaDev then stated that over the last quarter, he and Mr. Serrano Sewell had had several calls with Board staff to discuss issues and projects at the Board as well as the Board's agenda.

Agenda Item 6 Board Member Communications with Interested Parties

There were no Board member communications with interested parties reported.

Agenda Item 7 Executive Management Reports

Ms. Kirchmeyer stated she would not be going over the reports in detail unless members had any questions, but would bring a few items to their attention. She referred the members to pages BRD 7A-5 in their packets, which was the Governor's budget that passed in June and included the Board's budget for FY 16/17. She noted on page BRD 7A-6, the Board's fund condition indicated the Board's fund reserve was projected to be at 3.6 months at the end of the fiscal year and below the mandate in FY 17/18. She noted the Board had not received month 13 reports, so the budget had not been finalized for FY 15/16. She stated once those reports are completed, they will identify where the Board's fund reserve is at the end of the fiscal year. She stated she was happy to report the Board's Budget Change Proposals (BCPs) to hire additional staff in the Central Complaint Unit (CCU) and to increase the Board's expert reviewer funding had been approved in the Governor's budget. Ms. Kirchmeyer then noted the fund condition shown on page BRD 7A-6 identified the additional BCPs that were approved and showed a loan repayment of \$6 million dollars in the next fiscal year.

Ms. Kirchmeyer then noted pages BRD 7A-18 and 7A-19 provided an update from the executive officer of the Board of Pharmacy. Ms. Kirchmeyer stated she had recently given a Medical Board update at the Board of Pharmacy meeting and that they would continue their collaborative efforts and continue to update each other's boards.

Ms. Kirchmeyer referred the Members to pages 7B-8 to 7B-17, where they could locate the finalized enforcement reports, and the updated vertical enforcement (VE) reports. She noted these reports would now be included in each of the enforcement report updates at each quarterly Board meeting. She noted that staff tried to use the same data markers for the reports from the Board's old database system to the BreEZe system. However, she noted her concern that the report is not pulling the same data markers, which was why there was a jump on the report on page 7B-8 in the packets. She felt that was one of the reasons for the increased time frames, but also noted that there was also an increased number of complaints, as well, since the transition to the new system. Ms. Kirchmeyer stated the reports are gathering the information they want to show and that is the time in the CCU, from the time a complaint is received to the time it is closed. She noted the difference between the data on page 7B-9 versus the data on 7B-10 and 7B-11 is due to the fact that staff now wants to measure the investigation process time frame separately for sworn staff through the Health Quality Investigation Unit (HQIU) versus the time frames for the non-sworn staff at the Board. Ms. Kirchmeyer stated the report also shows the length of time it takes to file an accusation. She noted that this report is not comparing the same data pre and post BreEZe because staff could now look at cases that are truly AG referrals for accusation, where before BreEZe, staff would also look at cases that went for a public letter of reprimand (PLR) to the Board for processing. These reports truly show just AG timeframes.

Ms. Kirchmeyer noted on the licensing side, the Board issued 222 more licenses this fiscal year, than in the prior fiscal year. In addition, the Board received 913 more applications in the same time frame.

Ms. Kirchmeyer stated the Board had made a major push at the end to get individuals registered for CURES. Staff had sent weekly emails to physicians who had not registered and even had a countdown clock on the Board's website. She noted that staff had received a significant number of calls the last two weeks leading up to the deadline. Staff assisted where they could and contacted DOJ directly in order to assist those they were unable to help. Ms. Kirchmeyer stated that as of Monday, July 25, 2016, there were 71,491 individual physicians registered in the CURES 2.0 system. In addition, there are approximately 32,000 prescribers and dispensers who were in CURES 1.0, but had not yet updated their systems to the newest 2.0 system. Ms. Kirchmeyer noted these numbers showed the outreach by the Board and other interested parties truly had an impact on registrants. She thanked the California Medical Association (CMA) for their extra push in these last days to get individuals registered. Ms. Kirchmeyer stated she was currently working with the DOJ to identify those who have a DEA to prescribe, but were not yet registered. She noted, once those individuals were identified, an email and possibly a post card would be sent to them informing them of the need to register into the CURES 2.0 system. She stated the Board had also included a CURES FAQ section in the most recent Newsletter, based on many of the calls that had been received by staff. Ms. Kirchmeyer added that from June 25, 2016 – July 25, 2016, there were over 161,400 patient activity reports requested from the CURES system. She stated this number showed that registration into CURES had made a huge impact on the physicians who have been using it.

Ms. Kirchmeyer stated that, as reported at the last Board Meeting, she had been working with the University California, Davis (UCD) and the DOJ to send a survey regarding the CURES 2.0 system to all physicians whose licenses expired in November, 2016. The survey would be attached to the November renewal notice being sent out in August. She stated the survey will be asking how the CURES 2.0 system is working and any problems they are experiencing, as well as any suggestions for improvement. She reminded the Board this survey is part of a study on opioids and grant work being done by the California Department of Public Health (CDPH) and the DOJ.

Ms. Kirchmeyer then referred the Members to pages BRD 7E-1 – 7E-15, which included not only an update from the executive director of the Health Professions Education Foundation, but also the Stephen M. Thompson Loan Repayment Program Annual report.

Ms. Kirchmeyer stated in regard to the update on the issue of prescribing psychotropic medication for foster children, the Board had received additional information from DHCS and DSS on June 13, 2016. She stated the additional information received was not exactly what the Board had requested based upon the expert's review and request, but it was the only information that was able to be provided from the two systems. She stated that additional information had been provided to the Board's expert pediatric psychiatrist and hoped to have a response from that expert in August. Staff is hopeful that the additional information provided will allow the expert to identify if there are any physicians who are inappropriately prescribing, so the Board can continue through the enforcement process and obtain medical records. Ms. Kirchmeyer again encouraged those physicians who are working within the system to contact the Board right away if they see someone who is inappropriately prescribing to foster children. She noted that Ms. Delp was scheduled to do a 15-minute presentation at the next Quality Improvement Project meeting on the Board's enforcement process and how to make a complaint. Board staff have established a shortened version of a complaint to where someone working within the system can contact Ms. Delp or Ms. Romero directly to file a complaint rather than the standard process with all of the documentation. This process was established to encourage those working within the system to file a complaint when appropriate.

Ms. Kirchmeyer stated that as of that morning, the ability to subscribe to a change in a licensee's primary license status was activated. This means an individual can go into the BreEZe system and sign up to receive notification when a licensee's primary status changes. This was a subject of discussion at the Patient Notification Task Force meetings.

As for the Federation of State Medical Board (FSMB) update, Ms. Kirchmeyer noted that the Board's FSMB representative had changed to Dr. Steingard, who is from the Arizona Osteopathic Medical Board and will be the Board's new liaison.

Ms. Kirchmeyer then referred the members to pages 7A-3 and 7A-4 regarding the Patient Notification Task Force. She noted that after discussions with the board president and vice president, it was determined that the issues from the task force would be pursued under the appropriate standing committee. She stated the information regarding these issues are listed on the two pages. She noted the outreach and website changes will be pursued within the Public Outreach, Education, and Wellness Committee. The signage and changes in legislation to allow the Board to require more information on the sign a physician must post will be pursued through the Board's sunset report. She then stated the possible change to the disciplinary guidelines to have an optional condition that would require a physician to notify their patients that they are on

probation will be studied under the Board's Enforcement Committee. She noted that while the change to add this condition could be done through the standard regulatory process, the mechanics of how that notification would occur is something that needs to be looked into and fully discussed with all interested parties.

Ms. Clavreul stated she feels that many physicians do not know how to use CURES.

Agenda Item 8 Discussion on Collaboration with the Osteopathic Medical Board of California, Board of Registered Nursing, Board of Pharmacy and Physician Assistant Board.

Ms. Kirchmeyer noted that at the last Board meeting, a member requested that Board staff look into meeting with the Board of Registered Nursing (BRN) and the Board of Pharmacy (BOP) on issues of mutual concern. She stated this collaboration is very similar to what is occurring at the national level, where they are looking at successful team building, new practice models and communication ethics. Ms. Kirchmeyer stated she felt that not only should the Board collaborate with the BRN and the BOP, but also with the Osteopathic Medical Board and the Physician Assistant Board. She stated this would be a great opportunity to bring the boards together to work on issues that impact each one of the boards. Ms. Kirchmeyer stated she had already contacted the executive officers of each of the boards and they are excited to meet. She was in the process of setting up a meeting for some time in August. She noted that some of the issues up for discussion are collaborative care, telemedicine, CURES usage and the opioid epidemic. Ms. Kirchmeyer stated once these boards get the communication amongst themselves started, she thought it would be a good idea for a couple of members from each of the boards to meet. She felt some outcomes of these meetings could be education on certain issues and the united front on such issues as opioid misuse and abuse. She stated that once the initial meeting takes place, she would provide the members with an update. She stated this is an exciting opportunity and noted the director of the Department of Consumer Affairs had also offered to attend and assist in any way necessary to move this collaboration forward. Ms. Kirchmeyer noted that working together would also enhance consumer protection.

Ms. Clavreul stated she would like to be kept informed of the team approach and would like to be part of the public participation, if appropriate.

Agenda Item 9 Update on the Sunset Review Process

Ms. Kirchmeyer noted that on July 8, 2016, the Board received the sunset report questionnaire, which could be found on pages BRD 9-1 through 9-15. She noted that per a memo from the legislature, this process allows the legislature to review the laws and regulations pertaining to the Board and evaluate its programs and policies and to also determine if the Board operates and enforces its regulatory responsibilities and is carrying out its statutory duties. The memo stated this process also ensures the fiscal management practices and financial relations with other agencies are being met. It stated that boards are also evaluated on key performance measures and targets related to the timeliness of enforcement actions and other necessary efforts to serve the needs of California consumers while promoting regulatory efficiency and effectiveness. Ms. Kirchmeyer stated the report form must be completed by December 1, 2016. She stated the first part of the report will provide an overview of the Board's current regulatory program and the latter sections focus on responses by the Board to particular issues raised by the Board or issues raised during the sunset oversight review. The report serves as a basis for the background paper

legislative staff will prepare. She stated the Board was informed that the Senate Business and Professions Committee will announce the dates for sunset oversight review hearings in early 2017. Board staff has put together a matrix identifying who is responsible within the staff for the questions within the report and their due dates. Ms. Kirchmeyer stated Ms. Robinson will lead the drafting and compiling of all of the information in order to complete the document.

Ms. Kirchmeyer stated she would be working with the Board president to identify a two-member task force to assist staff with the completion of the sunset review report. She hoped to present a draft report at the October Board meeting. However, it may be necessary to hold an interim teleconference meeting in November to finalize the report, due to the lateness of the report and the later due date. She noted that since many of the questions from the 2012 sunset report just need updated information added, this interim meeting may not be necessary. She wanted to provide the members plenty of time to review the report and provide comments.

Ms. Moss recommended the Board raise the following issues with the legislators in the sunset review report: improvements to patient safety in outpatient surgery settings (OSS); outreach by the Board related to physician discipline needs to be changed; changes to the Board's statute of limitations laws and increasing reports of actions taken by hospitals and clinics in the Business and Professions Code section 805:1 reporting. In addition, when the OSSs were removed from reporting to the Office of Statewide Health Planning and Development (OSHPD), data regarding procedures was eliminated. She recommended that the OSSs under the Board's jurisdiction report a standard and robust set of data to OSHPD. OSSs are required by law to report adverse events to the Board and the law authorizes the Board to fine physicians who fail to report these events in a timely manner. Ms. Moss recommended the Board post the adverse event reports that are received from OSSs, along with any fines assessed, on the Board's website. Ms. Moss requested that on the revised signs for physicians' offices, the Board add notification of who the Board is and how they can be reached, as not many people know that this Board is the governing body.

Agenda Item 10 Update from the Department of Consumer Affairs, which may include Updates pertaining to the Department's Administrative Services, Human Resources, Enforcement, Information Technology, Communications and Outreach, as well as Legislative, Regulatory and Policy Matters

Ms. Lally announced a change in the DCA's executive team. She noted that in late June, Governor Brown appointed Jeffrey Mason as DCA's new chief deputy director. Mr. Mason had been with DCA since 2013 serving as Chief of the Bureau of Security and Investigative Services and most recently he served as Deputy Commissioner for the Bureau of Real Estate.

Ms. Lally added that in May, Governor Brown appointed a new Deputy of Legislation, Mr. Adam Quinonez, who previously served as Deputy Director of Legislation for DCA. She noted that DCA is excited to have them both on board in their new positions.

Ms. Lally stated the SOLID training and planning solutions unit is specifically dedicated to the DCA's organizational development and offers a wide array of services to all of DCA's boards and bureaus. SOLID recently held their second brown bag gathering on July 20, 2016. She noted these meetings provide an opportunity to strengthen networking among the DCA's executives as well as time to discuss crosscutting issues and receive peer input on challenges

facing the workplace. She noted these meetings also provide DCA with feedback on other leadership activities they can provide their executives. Ms. Lally stated at the last brown bag gathering, they announced a new program, titled, Future Leadership Development Program. They believe it is critical to enhance the skills of the next generation of executives at DCA. She noted this program has three components: the first being specialized training, the second being mentoring opportunities from the executive team as well as other executive officers, and a group project to assist boards and bureaus in addressing common challenges. The group project gives staff the ability to build new skills and knowledge as well as interact and collaborate with higher peers from other boards. Ms. Lally noted there would be a steering committee of executive officers that will assist the DCA with this new program. They look forward to implementing this program by the end of 2016.

Ms. Lally stated DCA had already launched the program titled “The Employee Career Empowerment and Mentorship Pilot.” The pilot mentors submit profiles that include short biographies, their availability for mentorship, and the topics they are willing to discuss. The SOLID team posted the profiles on the intranet and staff review the profiles and schedule meetings with the mentors. Ms. Lally stated in early 2017, SOLID would conduct an evaluation of the pilot program to look for possible improvements and to determine if it should be expanded. She stated there were currently eight DCA boards and programs participating in this pilot.

Ms. Lally then announced that SOLID had also launched a “lunch and learn” class series. This is a new component of the DCA Connect training series to encourage staff within various classifications to engage one another in interesting topics. These sessions are held once a month during one hour lunch breaks. She noted that in a roundtable setting, DCA employees learn from one another through active listening, effective communication and understanding another’s view point. Topics have included, “What Does Professionalism Mean to You,” and, “Change Your Perspective, Change Your Life.” Ms. Lally added the next lunch and learn is scheduled for August 2, 2016, and is titled, “Honoring Cultural Diversity.”

Ms. Lally stated that SOLID was also assisting Director Kidane and staff on DCA’s new strategic plan that will cover the years 2017 through 2019. She announced that they would be soliciting input from stakeholders, board members, executive officers and all employees of the DCA to help identify DCA’s goals for the next two years. Ms. Lally stated an electronic survey would be sent out to all in late August, and she would appreciate everyone’s feedback to assist in improving DCA’s services and oversight.

Ms. Lally stated the Board continued to see a high volume of online applications submitted in May and June 2016, where the Board received over 8,886 applications online. For applications requiring payment, this represents approximately 58% of the total Board application volume for that period. She added that renewals continue to make up a majority of the Board’s applications received online. In May and June 2016, there were 8,251 renewals received online and 98% of those renewals were renewed the same day, which she stated showed incredible efficiency. Ms. Lally noted that as of that week, DCA had processed over \$208 million dollars via the BreZE online system since the Board went live in October of 2013. She added since the Board went live, it had processed over \$1 million dollars via the BreZE system.

In regard to BreZE maintenance, Ms. Lally stated for calendar year 2015, there was an average of 73 fixes that were deployed in the BreZE scheduled maintenance releases and since the

launch of release two of the system in January 2016, there have been an average of 167 fixes deployed in each scheduled maintenance release. She noted that scheduled maintenance releases occur every 6-7 weeks for the boards and bureaus and 161 changes occurred just recently. The next scheduled maintenance release will happen in September 2016.

Ms. Lally gave an update on the BreZE license lookup survey. She noted DCA is currently conducting a survey to collect public feedback on the “verify a license” feature that is available on the BreZE page. She requested that Board members share this feature with stakeholders and encourage them to participate to assist DCA in potential needed updates to the feature. The survey began on July 1 and is scheduled to end on August 31. Currently, DCA had received over 5,000 responses to the survey. The responses received so far have been very positive and are providing constructive criticism.

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

Dr. Yip stated at the Enforcement Committee Meeting, Ms. Delp provided an enforcement update stating that training with the Office of Administrative Hearings (OAH) will be held in September, October and November 2016, regarding emergency room procedures, co-morbid patients and fitness for duty violations. At the conclusion of the training, Board staff will have provided six training sessions to the administrative law judges. Ms. Delp reported that the Central Complaint Unit (CCU) has decreased the average number of days to process complaints from 162 days to 146 days and management continues to identify ways to streamline the complaint process. Dr. Yip noted that Ms. Delp also reported that the Enforcement Program currently has six vacancies and plans to hire new staff are ongoing. Vacancies should be filled by September 30, 2016.

Dr. Yip added that Ms. Robinson gave an update on the Demographic Study reporting that she and Ms. Kirchmeyer met with the California Research Bureau (CRB), who is conducting the study. The CRB stated they should be ready to present findings of the study at the October Board meeting, and that Dr. Krauss had been actively involved in the process. Dr. Yip noted that Ms. Delp also gave a presentation on the Expert Reviewer Program’s Recruitment Plan to recruit more experts. The plan included a 3-stage plan that includes updating the Board’s website and newsletter as well as creating a recruitment brochure and public service announcement to entice more physicians to participate in the program. Dr. Yip noted that Ms. Delp announced two expert reviewer trainings are scheduled, one on October 8, at UC San Francisco, and another on November 5, 2016, at UCLA.

Dr. Yip reported that Ms. Castro from the Attorney General’s, Health Quality Enforcement (HQE) Section gave an update on the VE process, and the committee was pleased to hear that her staff works tirelessly, and with passion.

Dr. Yip noted that Mr. Chriss and Ms. Nicholls from the HQIU provided an update on what efforts are being made to hire more sworn investigators. They are in the process of hiring non-sworn investigators and investigator assistants to handle the less complex cases. He noted the Board of Psychology and Osteopathic Board cases will be investigated by the staff in the Investigation and Enforcement Unit on a temporary basis until additional staff is hired.

Dr. Yip continued stating Ms. Delp and Ms. Houston gave a thorough presentation on the actions the probation staff takes when a probationer violates a condition of his or her probation and the time frames that staff has to act on those violations.

Dr. Yip stated Committee members requested a presentation on quality indicators and quality assurance efforts and how to improve the process.

Ms. Wright requested the Enforcement Committee ask staff to look into the comments made in regard to physicians receiving kickbacks for vaccinations, and also requested that someone from Senator Pan's office come and speak on some of the issues that were heard from the public at the meeting in regard to SB 277.

Ms. Moss stated she had spoken earlier at the Enforcement Committee in regard to the Board amending the guidelines to require physicians on probation for serious issues to inform their patients of their probationary status. She recommended that the patient notification requirement include physicians who are ordered on probation more than one time. She also recommended that the Board demonstrate its commitment to public safety by amending its disciplinary guidelines to require, as a standard condition, a physician whose probation is associated with a certain serious violation and practice restrictions be required to disclose their probationary and practice restrictions to their patients. She felt the Board should amend the current disciplinary guidelines to make patient notification an optional condition in all probation cases. An effective process should be developed to ensure the enforcement of the disclosure of this requirement.

Agenda Item 12 Update from the Attorney General's Office

Ms. Castro announced the San Francisco office has a new deputy attorney general (DAG), Mr. Keith Shaw comes from the Sonoma County District Attorney's Office.

Ms. Castro stated she continues to meet with Ms. Delp and Ms. Kirchmeyer regularly to discuss possible improvements in all of the processes. She stated she and her staff were there to assist in any way they can with the Sunset Review Report as it pertains to their role in the Board's enforcement and licensing functions.

Ms. Castro noted that SB 467 had been enacted into law in B&P code section 312.2 and would require the AG's office to file annual reports with the legislature regarding their performance metrics. She noted the metrics that will be measured include subsequent averages for important milestones in the life of the administrative cases they work. She noted they welcome the transparency and accountability and the report will apply to every DCA client and agency, commission, board and also apply to the licensing section in their office. Ms. Castro noted the first report will be filed in January 2017 for statistics related to FY 15/16. With the enactment of SB 467, the AG's office joined with the OAH in their mutually beneficial responsibilities in the process of consumer protection.

Agenda Item 13 Update on the Physician Assistant Board

Dr. Bishop noted that recently Governor Brown appointed Jennifer Carlquist to the Physician Assistant Board (PAB). He added Ms. Carlquist had been an emergency room physician assistant (PA) at the Community Hospital of the Monterey Peninsula since 2013 and at other locations since 2009.

Dr. Bishop stated the online version of the PA application for licensure had been added to BreZE on June 17, 2016. He noted the new licensing application had enhancements and features that would streamline the process for applicants.

In regard to CURES, Dr. Bishop noted that all practitioners had been required to register by July 1, 2016. In order to obtain that, the PAB had updated its website with a countdown calendar and also sent an email notification blast to all subscribers reminding them of the CURES registration deadline.

Dr. Bishop stated that the California End of Life Option Act (Act), had become effective June 9, 2016. The PAB has developed an information bulletin for PAs regarding the Act. The bulletin stated that specific requirements of the Act could only be performed by the patient's attending physician and not delegated to a PA. The bulletin had been posted to the PAB's website.

In regard to the rulemaking to repeal Title 16, California Code of Regulations (CCR) section 1399.531 and 1399.532, at the April 18, 2016 Board meeting, there was general consensus that the PAB may wish to examine repealing regulations addressing the *curriculum requirements for an approved program for primary care physician assistants* and *requirements for an approved program for the specialty training of physician assistants*.

The PAB currently delegates authority to the Accreditation Review Commission on Education for the Physician Assistants (ARCPA) to approve PA training programs. Dr. Bishop added post-graduate specialty PA training programs approved under section 1399.532 provided training to licensed PAs to enhance their current skills. The PAB does not issue an additional license to individuals who participate in specialty PA training programs.

Additionally, he noted, since post-graduate specialty PA training programs are training licensed PAs and those students are subject to the same requirements as licensees who had not participated in a post-graduate specialty program, the PAB believed that there was no need to continue to approve those types of programs. After discussion on this item, the PAB voted to repeal these sections.

In regard to another regulation, 16 CCR section 1399.540(b), *Delegation of Services Agreement, Electronic Signatures*, the PAB continued to discuss the now wide-spread practice of the use of electronic signatures in patient records and other documents utilized in the medical environment. The PAB recognized that electronic signatures allowed for the more efficient use of medical practitioners, thus improving patient care.

Dr. Bishop noted that at the PAB's April meeting, members voted to request that staff develop proposed amendments that would include the use of electronic signatures in the Delegations of Services Agreement for possible initiation of a rulemaking file to amend the regulation. Legal counsel reported that they continue to research the use of electronic signatures to assist in drafting amendments.

Dr. Bishop stated that though this seems like a simple process, it is actually very complicated, especially in emergency departments where a single PA might be supervised by more than one physician. It can become very complex to clearly identify who the responsible physician is.

Dr. Bishop noted at the Enforcement Committee meeting, there was a presentation by the Health Professions Education Foundation (HPEF) regarding scholarship and loan repayment programs offered to health care students and recent graduates, including PAs.

Dr. Bishop stated at a recent PAB meeting it was noted that the State of Georgia had recently passed legislation providing tax deductions for physicians who served as a community based faculty physician for a medical core clerkship provided by the community based faculty. In other words, physicians who served as a preceptor for the education of mid-level health care providers such as PAs. The PAB discussed the possible need for tax incentives for PA preceptors. This clinical instruction may come from other PAs or physicians who are not generally paid for their time, but may receive CME credit for being preceptors. Therefore, it is often difficult to find health care providers to be preceptors because they are not financially reimbursed. He noted to further explore this concept, the PAB would hold stakeholder meetings to determine if there was a need to seek legislation.

Dr. Bishop stated the next PAB meeting was scheduled for October 24, 2016.

Agenda Item 14 Election of Officers

Dr. GnanaDev asked for nominations for Board secretary. Dr. Krauss nominated Dr. Lewis. No other nominations were made. Dr. Lewis agreed to act as Secretary of the Board. ***Motion carried unanimously. (12-0)***

Dr. GnanaDev then asked for nominations for vice president. Dr. Krauss nominated Denise Pines. No other nominations were made. ***Motion carried unanimously. (12-0)***

Dr. GnanaDev then asked for nominations for president. Dr. Krauss nominated Dr. GnanaDev. No other nominations were made. Dr. GnanaDev agreed to act as President of the Board. ***Motion carried unanimously. (12-0)***

Dr. GnanaDev adjourned the meeting at 5:35 p.m.

Friday, July 29, 2016

Members Present:

Dev GnanaDev, M.D., Vice President
 Michelle Bholat, M.D.
 Michael Bishop, M.D.
 Judge Katherine Feinstein, (ret.)
 Randy Hawkins, M.D.
 Howard Krauss, M.D.
 Kristina Lawson, J.D.
 Ronald Lewis, M.D.
 Brenda Sutton-Wills, J.D.
 David Warmoth
 Felix Yip, M.D.

Members Absent:

Sharon Levine, M.D.
 Denise Pines
 David Serrano Sewell
 Jamie Wright, J.D.

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Staff Present:

Liz Amaral, Deputy Director
 Christina Delp, Chief of Enforcement
 Dianne Dobbs, Legal Counsel, Department of Consumer Affairs
 Susan Houston, Staff Services Manager II
 Kimberly Kirchmeyer, Executive Director
 James Nuovo, M.D., Medical Consultant
 Regina Rao, Associate Government Program Analyst
 Elizabeth Rojas, Staff Services Analyst
 Jennifer Saucedo, Business Services Officer
 Jennifer Simoes, Chief of Legislation
 Lisa Toof, Administrative Assistant II
 Kerrie Webb, Legal Counsel
 Curt Worden, Chief of Licensing

Members of the Audience:

Lorraine Amel, M.D., Dean of International Affairs, UNIBE
 Teresa Anderson, California Academy of Physician Assistants
 Eric Carlile, Kaiser Permanente
 David Chriss, Chief, Division of Investigation, Department of Consumer Affairs
 Long Do, California Medical Association
 Karen Ehrlich, Licensed Midwife
 Julie D'Angelo Fellmeth, Center for Public Interest Law
 Louis Galiano, Videographer, Department of Consumer Affairs
 Fred Gardner, O'Shaughnessy's Journal of Cannabis in Clinical Practice
 Bridgette Gramme, Center for Public Interest Law
 Faith Gibson, Licensed Midwife, California College of Midwives
 Christina Hildebrand, A Voice for Choice Advocacy
 Craig Leader, Investigator, Health Quality Investigation Unit
 Carole Moss, Consumers Union Safe Patient Project
 Ty Moss, Consumers Union Safe Patient Project
 Marcos Nunez, M.D., Dean, UNIBE
 Christine Lally, Deputy Director of Board and Bureau Relations, Department of Consumer Affairs
 Catherine Nation, M.D., University of California, Office of the President
 Kathleen Nicholls, Deputy Chief, Health Quality Investigation Unit
 Stephen S. Robinson, M.D., Society of Cannabis Clinician
 Mark Scarlett, Supervising Investigator, Health Quality Investigation Unit
 Carrie Sparrevohn, Licensed Midwife, Midwifery Advisory Counsel
 Jane Zack Simon, Supervising Deputy Attorney General, Attorney General's Office

Agenda Item 15 Call to Order/Roll Call

Dr. GnanaDev called the meeting of the Medical Board of California (Board) to order on July 29, 2016 at 9:04 a.m. A quorum was present and due notice was provided to all interested parties.

Agenda Item 16 Public Comments on Items not on the Agenda

Ms. Hildebrand stated she was concerned about a medical exemption pilot program that had been introduced by the Santa Barbara County public health director, which was also being copied by both Sacramento and Marin counties. She noted the program consisted of them collecting all of the medical exemptions from all of the schools and reviewing them. She stated there had been a teleconference on May 13, 2016, which the Board staff attended, to identify suspicious medical exemptions and how to report those suspicious physicians. She added that her concern was in Governor Brown's signing statement, he specifically stated that it was at the discretion of the physician to give vaccination exemptions. She asked the Board to put a stop to those who are seeking out the physicians who are giving exemptions and realize there is a logical, legitimate reason for them to give those exemptions.

Agenda Item 17 Regulations – Public Hearing – Consideration and Possible Action on Proposed Regulations: Midwife Assistants

Dr. GnanaDev stated this was the time and place set by the Board to conduct a public hearing on proposed regulations to implement, interpret, or make specific section 2516.5 of the Business and Professions (B&P) Code related to midwife assistants. The Board was considering changes to Division 13 of Title 16 of the CCR as described in the notice published in the California Regulatory Notice Register and sent by mail or electronic mail to those on the Board's mailing and subscribers' lists.

The Legislature adopted B&P Code section 2516.5 to permit licensed midwives and certified nurse-midwives to use midwife assistants in their practices. 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 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, did not specify such details as what the training entails, who could conduct the training, and who could certify that a midwife assistant meets the minimum requirements. These details had been left to the Board to establish via regulations. Additionally, the section authorized midwife assistants to "perform additional midwife technical support services under regulations and standards established by the Board."

Dr. GnanaDev stated accordingly, the purpose of the proposed rulemaking was 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 were necessary for consumer protection to ensure that midwife assistants had the proper training and supervision.

He noted for the record, the current date was July 29, 2016, and the hearing was beginning at approximately 9:14 a.m.

Dr. GnanaDev asked that persons who wished to testify please fill out a speaker's slip, available at the table in the back of the room.

He noted the purpose of the hearing was to receive oral testimony concerning the regulatory proposals described in the notice.

He added the regulations must comply with six legal review standards and testimony should address only these six standards.

Dr. Gnanadev asked the Board's Staff Counsel, Kerrie Webb, to offer opening comments.

Ms. Webb noted the Board had not received any comments on the proposed regulations, however, she did have one small non-substantive change, which was under section 1379.04 related to training in infection control. She recommended that the Center for Disease Control (CDC) Guidelines for Infection Control in Healthcare Personnel be identified as from 1998 and be incorporated by reference, so that the document being referenced is clarified.

Dr. GnanaDev then called on Ms. Sparrevohn who completed a request to testify concerning this proposed regulation.

Ms. Sparrevohn waived her request to speak.

Dr. GnanaDev stated that since no one else wished to speak, the hearing concerning midwife assistants was closed at 9:19 a.m.

Dr. Lewis made a motion to adopt the language with the proposed amendment to clarify the guidelines from the CDC and authorize staff to make any non-substantive changes that are needed to complete the rulemaking file for submission to the Office of Administrative Law (OAL) for formal adoption; s/Dr. Krauss. Motion carried unanimously. (11-0.)

Agenda Item 18 Presentation on Medical School Curriculum and Changes

Dr. Nation provided a high level overview on medical education for the State of California. She began by noting that California has a relatively small medical education system when compared to its population and geography, and that per capita, California has a statewide medical school enrollment that is the third lowest in the nation. She added there were approximately 7,000 students enrolled in the state's 12 medical schools. Dr. Nation stated there are three additional entities scheduled to open medical schools in California within the next three to four years.

Dr. Nation noted the Accreditation Council for Graduate Medical Education (ACGME) is responsible for the accreditation of GME programs throughout the U.S. There are 27 ACGME accredited specialty programs that lead to initial board eligibility and certification, and that roughly 100 accredited subspecialty programs are recognized by the ACGME.

Dr. Nation stated that California has 878 ACGME accredited residency training programs. She added 375 of them are specialty programs and have 8,800 residents, and the remaining 503 of them are subspecialty programs and have 2,100 fellows. She stated these programs are run by 84 different sponsored institutions, such as Kaiser Permanente, University of California (UC), and private medical schools and centers, and Children's Hospitals and community-based programs.

Dr. Nation also discussed challenges for GME, such as fiscal, workforce, access to GME training and resident well-being. She also talked about some recently established medical education initiatives, such as innovative educational tracks that supplement core curriculum,

new global health and clinical research academic tracks, and new curriculum integrating the student into a healthcare team emphasizing team-based training to address health disparities.

Dr. Nation's full presentation can be viewed on the Board's website under the July 2016 Board Meeting, Agenda Item 18.

Dr. GnanaDev thanked Dr. Nation for her presentation. He stated his concern was that the last UC school was created back in 1967, so it took 45 years to create another UC school. He added there are still only 36% primary care physicians at UC schools and in many community hospitals, like San Bernardino, they are 40% over the cap. Dr. GnanaDev asked if by doing so are the programs losing talent because students end up in medical schools or training programs all over the world. He stated in Chicago and New York about 30% of those students are California students. He further asked what the UC system will do to increase medical school and postgraduate positions to take care of the California population.

Dr. Nation stated there is not a simple answer for this question. She stated the practical reality is that California has had a very long reliance on migration and it had been a strategy at a state level to save resources. She added that the state relied on students returning for their families and communities. She stated that there were devastating budget cuts and the professional degree programs were disproportionately cut. Not just health professions, but business, law, etc. She stated the UC had a plan to grow the enrollment within the existing schools. The UC's first effort was to call for enrollment growth through PRIME, by adding about a 10% increase as a strategy for expanding access. She added about one-third of the 350 PRIME slots receive support. The other two-thirds were not funded. Rather than close those programs, the UC got into state funded enrollments, different strategies by different campuses. She said that now that they have moved forward with Riverside, they will look at the central valley. She said they have PRIME enrolled and UC Riverside started, but not at the pace or the size they would have wished.

Agenda Item 19 Discussion and Possible Action on Legislation/Regulations

Ms. Simoes referred the members to their legislative packets and the tracker list. She noted on the tracker list, the bills in blue were bills the Board had already taken positions on and even if the bill had been amended, the amendments would not affect the Board's position. She stated these bills would not need to be discussed at this time. The bills in pink were the Board's sponsored bills, and the bills in green would require discussion and a position.

Before moving on to the tracker bills, Ms. Simoes mentioned some bills that had died since the last meeting. AB 2507 (Gordon), the telehealth access bill, died on the Assembly Appropriations suspense file. The two scope bills, SB 323 (Hernandez) related to nurse practitioners, and SB 622 (Hernandez) related to optometrists, both died in the Assembly B&P Committee. SB 1033 (Hill), regarding patient notification for physicians on probation, died on the Senate Floor.

AB 2745 (Hill) Ms. Simoes began with the Board's sponsored clean-up bill. She noted that this was the bill that would make clarifying changes to existing law to assist the Board in its licensing and enforcement functions. She noted this bill was moving along with no opposition and would be heard in Senate Appropriations the following week and would probably be put on consent, so it was moving forward.

SB 1039 (Hill) Ms. Simoes stated this was the bill that included provisions to clarify that the Board of Podiatric Medicine (BPM) is its own board and is completely separate from the Board. Ms. Simoes stated the BPM revisions had been removed from the bill, but per Senator Hill, this issue would be addressed in the Board's Sunset Review.

SB 1478 (Sen. B&P Comm.) Ms. Simoes stated this bill was the health omnibus bill that would delete outdated sections of the B&P Code that were related to the Board and that it is moving forward with no opposition.

AB 1244 (Gray). Ms. Simoes stated this was a new bill for the Board and would specify the circumstances in which a medical provider must be suspended from participating in the workers' compensation system. Upon suspension, the administrative director (AD) of the Division of Workers' Compensation (DWC) must notify the relevant licensing, certification, or registration board, including the Medical Board. She noted this bill would also require the director of Department of Health Care Services (DHCS) to notify the AD of the DWC if a medical provider is suspended from the Medi-Cal program. She noted that this notification from DHCS was already required to be provided to the Medical Board.

Ms. Simoes noted the bill would create a suspension process for medical providers who commit serious crimes or are involved in fraudulent activity that was modeled after the suspension process for Medi-Cal, including requiring notification to the appropriate licensing board. She stated this bill would ensure that the Board is notified when a physician is suspended by the DWC, which would help to ensure consumer protection. The bill would also provide for communication between the DWC and DHCS, which would also help to protect consumers.

Dr. Lewis made a motion to support this bill; s/Dr. Krauss. Motion carried (9-0-2 Bholat and Lawson).

AB 1306 (Burke) – Ms. Simoes noted this bill would subject certified nurse-midwives (CNMs) to the anti-kickback and referral prohibitions in B&P Code section 650.01 and the exemptions in 650.02 and would add an exemption for a referral to a licensed alternative birth center or nationally accredited alternative birth center.

She added the bill would now require the BRN to create and appoint a Nurse-Midwifery Advisory Committee (Committee), similar to the Board's Midwifery Advisory Council (MAC), which would consist of CNMs in good standing with experience in hospital settings, alternative birth center settings, and home settings; a nurse-midwife educator, as specified; a consumer of midwifery care; and at least two qualified physicians, including an obstetrician that has experience working with nurse-midwives.

Ms. Simoes stated the bill would authorize a CNM to manage a full range of primary gynecological and obstetric care services for women from adolescence to beyond menopause. She noted these services include, but are not limited to: primary health care; gynecologic and family planning services; preconception care; care during pregnancy, childbirth, and postpartum period; immediate care of the newborn; and treatment of male partners for sexually transmitted infections, utilizing consultation, collaboration, or referral to appropriate levels of health care services.

She noted the bill specified the settings that a CNM can practice in without physician supervision. Most of those settings are the ones overseen by the CDPH.

Ms. Simoes noted the bill would allow a CNM to be employed in these settings; however the entity shall not interfere with, control, or otherwise direct the professional judgment of a CNM.

She added the bill would only allow a CNM to attend normal and low-risk pregnancy and childbirth in the home setting when certain conditions apply.

Ms. Simoes stated that if a potential CNM client meets all of the conditions, but has had a prior caesarean delivery, and the woman still desires to be a client of the CNM, the CNM shall provide the woman with a referral for an examination by a physician trained in obstetrics and gynecology. A CNM may assist the woman in pregnancy and childbirth only if an examination by a physician trained in obstetrics and gynecology is obtained and, based upon review of the client's medical file, the CNM determines that the risk factors presented by the woman's condition do not increase the woman's risk beyond that of a normal, low-risk pregnancy and birth. A CNM may continue care of the client during a reasonable interval between the referral and the initial appointment with the physician.

Ms. Simoes again stated the bill has been significantly amended and the amendments address the concerns previously raised by the Board. The bill now would require two physician members on the Committee, is very restricted on what types of patients a CNM can accept, and requires a physician examination for patients that have had a prior caesarean delivery. She added that although the CNM is allowed to make the determination regarding the risk factors for patients that have had a prior caesarean delivery, the CNM is still held to the standard of care and subject to discipline if that standard is not met. Although this bill does not include a ban on the corporate practice of medicine for CNMs, the type of settings where CNMs are allowed to work without physician supervision are limited, and for the most part they are licensed facilities overseen by the CDPH. She added that although this bill now includes parameters on independent CNM practice, this bill does expand the scope of a CNM to include primary health care as part of the gynecological and obstetric care services that a CNM can provide. Ms. Simoes noted if the reference to primary health care is removed, Board staff believes this bill has the necessary protections in place to ensure consumer protection.

Dr. Hawkins asked Ms. Simoes about scope of practice and what primary care involves.

Ms. Simoes stated it includes primary health care and does not define what primary health care involves, but before it was more related to CNM functions, and primary health care was not included. Staff had read it as there is a broader range of services than what a CNM could provide now.

Dr. Lewis made a motion to oppose the bill unless amended with the clarification of primary care and including the corporate ban practice; s/Dr. Bholat.

Ms. Kirchmeyer stated that in looking at the bill language, the only amendment staff feels strongly about is the primary health care addition. She stated that staff recommended taking a neutral if amended position, and only go neutral if they remove the primary health care notation out of the bill.

Dr. GnanaDev asked Ms. Simoes where in the bill is the corporate bar protected.

Ms. Simoes stated one of the things that had been mentioned to her is that licensed midwives do not have physician supervision, nor do they have the corporate ban on practice of medicine.

Ms. Sparrevohn stated she is not certain how the language around prior caesarean sections for a home birth serves anyone. It looked like it required the CNM to send the woman for a referral with a

physician, but then the CNM still determines whether or not that woman is eligible based on her risk factors for a VBAC, and with that it puts an additional burden on the woman to pay for and obtain the physician consultation. In addition it puts a burden on the physician when it is not his client and yet it would still ultimately be determined by the CNM as to whether or not this particular woman's risk factors are such that she could still safely attempt a vaginal birth at home. She stated the licensed midwife bill, AB 1308 did not specifically state that they had to get a physician consultation for a prior caesarean delivery. Ms. Sparrevohn stated she was really questioning the language in the CNM bill as to whether it would actually help anyone.

Ms. Kirchmeyer added that from the licensee population, the OB/GYN's, the reason they would want them to go to a physician is that at least then, they would have education as to the risks of VBAC, even though the CNM gets to make that final determination.

Dr. Bishop stated he agrees with Ms. Kirchmeyer and that also offers a second opinion from someone who has more training and education in that specific field.

Motion carried. (10-1, Ms. Sutton-Wills)

SB 482 (Lara) Ms. Simoes stated this bill would require a prescriber to access and consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, III or IV controlled substance for the first time to that patient and at least once every four months thereafter, if the prescribed controlled substance remains part of the patient's treatment. She added the bill would require a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. This bill would define "first time" to mean the initial occurrence in which a health care practitioner intends to prescribe, order, administer, furnish or dispense a controlled substance to a patient and has not previously prescribed a controlled substance to that patient.

Ms. Simoes stated the bill would specify that the requirement to consult the CURES database does not apply to a health care practitioner in certain circumstances as specified in the bill.

Ms. Simoes noted the bill would specify if CURES is not consulted by the health care practitioner because one of the exemptions applies, the practitioner shall document the reason he or she did not consult CURES in the patient's medical record.

She stated it would specify that if a health care practitioner knowingly fails to consult the CURES database, he or she shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

She stated the bill would specify that is not operative until six months after DOJ certifies that the CURES database is ready for statewide use. DOJ would be required to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

Ms. Simoes stated the Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent "doctor shopping." Requiring all prescribers to consult the CURES system will allow prescribers to make informed decisions about their patient's care. The bill would also ensure that the CURES system will have the capacity to handle this workload before the bill becomes operative.

Ms. Simoes noted, however, that the bill was amended and now includes one very broad exemption, which weakens the requirements in the bill. In addition, this bill would make it very hard for the Board to take any administrative action for physicians who do not comply with the requirements of this bill.

Dr. GnanaDev stated he felt the biggest problem with the opioid abuse and overdose issue is the chronic pain management. He noted that people should not have to put up with pain. It needs to be balanced. He noted concern with the two broad exemptions in the bill, knowingly and exceptional.

Dr. Bishop stated that those two words end up being the “dueling experts.” He stated he did not feel any legislation can anticipate every possible circumstance, so there has to be some sort of word to give some flexibilities. Yet it could allow someone to avoid discipline if the Board could not prove it. Dr. Bishop recommended leaving that determination to the executive director and/or the Board’s enforcement chief if those words would be detrimental when it comes to case processing time, or requiring many more expert analysis.

Ms. Kirchmeyer noted that her opinion as well as legal counsel’s opinions are that those words would cause a lot of problems with cases and they felt they should be clarified.

Dr. Bholat stated that there is no way to possibly know all of the circumstances, but to keep in mind that as busy primary care physicians, who would be seeing a lot of patients, they have to realize that the emergency room serves as the primary care homes for many people. She stated that in general, she supports the comments of her colleagues.

Dr. Krauss stated he would really like to see this bill pass during this legislative session, so he wished the Board could take a position of support, with suggested amendments. He added he thought it would be best to give Ms. Simoes some leeway to work with the authors to change the language without jeopardizing the passage of the bill.

Dr. Lewis made a motion to support the bill with suggested amendments; s/Dr. Bholat.

Mr. Do, CMA, stated their position on the bill is oppose unless amended. He noted there are other parts of the bill that they have issues with, however, the exemptions is not one of them. They felt the bill must avoid creating barriers to appropriate care for the many conditions treated by Schedules II, III, and IV drugs and felt the exemptions as drafted meet that balance. Mr. Do stated there are many regulations that can get in the way of appropriate medical care and the exemption of “exceptional circumstances” would cover the broad array of situations where a duty to consult could get in the way of necessary medical care. The Board staff suggestion was to delete the exceptional circumstances exemption, but that does not seem to coincide with the comments that staff has made, that there is some clarity needed over the words exceptional exemption. He felt those words could be teased out through the enforcement process and/or other means, so he felt it was not necessary to delete the entire exemption, especially when that exemption serves as a useful function as many of the Board members have recognized. Mr. Do suggested the Board reject any staff recommendation to suggest that that exemption be deleted.

Ms. Gibson stated that CURES is a web based program and that everyone knows what happens when the internet stops working or cell phone service does not work. She suggested maybe making the language more specific for example, if one cannot get on-line for more than 30 minutes.

Ms. Simoes stated that the Board would continue to be in support of the bill, and the author would not necessarily take all of the suggestions that the Board had however, she would continue to work with the author's office, but felt the word "exceptional" as discussed was pretty broad. She stated her plan was to work with the author to see what type of language can be used to make it easier for the Board to implement if they were to have to enforce it.

Ms. Clavreul stated many physicians do not know what the CURES system is and/or how to use it.

Motion carried unanimously. (11-0)

SB 1174 (McGuire) Ms. Simoes stated this is the bill related to prescribing psychotropic medications to foster children and the data being provided to the Board through the existing data usage agreement (DUA). She stated the last version of the bill had been more broad and that the information requested through the DUA would eventually be added. She noted that Dr. Levine had requested a sunset date be added to the bill to ensure the Board would not continue this information on an on-going basis if it was not useful to the Board. The amendment in the bill to address this request was that the Board could work with DSS and DHCS to revise the type of data needed, if necessary.

Judge Feinstein noted that she felt the way the bill was currently written, it was not going to produce any information that was going to be helpful in identifying physicians who either should not be prescribing psychotropic medication or who are abusing the right to prescribe it to children. She felt as if this was a county issue that had been put on the Board and the data being collected is not going to be of any assistance. Judge Feinstein said she felt it should have a sunset date of three years as she believed that nobody will be satisfied with the outcome of this data in the end. She felt the Board should take an oppose position unless there is a sunset added to the language, but she did agree with the need for this area to be looked at closer.

Ms. Sutton-Wills asked if the Board could ask for the report itself to have a sunset, rather than the whole bill.

Ms. Simoes stated she could certainly offer that option. The data report would be part of the Board's annual report to the Legislature. She also noted that the author wanted to make the sunset date of 20 years, as they state that it would take quite a bit of time to determine the importance of the data. Ms. Simoes stated that maybe a five year sunset would give staff time to see if any red flags are found and actually result in disciplinary actions.

Ms. Sutton-Wills also asked if the report would include the opportunity to address the effectiveness of the data.

Ms. Simoes noted the number of disciplinary actions would give the Board an idea of the effectiveness of the data, because the expert reviewer finds red flags in the data, the complaint process would begin and proceed accordingly from there.

Ms. Webb suggested the Board set a short sunset date, even with the understanding that it will take time to go through the court process to get medical records on foster care children. Staff does not even know if they will be able to identify practitioners that should be looked at more closely, based on the data being received. Ms. Webb stated that so far, the little bit of data that had been received was not helpful in the ways they had hoped. She added that the sunset date would not have to put an end to the whole process, but would at least give staff the opportunity to see if it had been successful.

Judge Feinstein stated she was not certain if when Ms. Simoes spoke of the court process, she was referring to the confidentiality of the needed records.

Ms. Simoes stated that staff had been told by DSS that because the foster parents are not the custodian of those medical records, staff would have to go through the court process to get those records.

Judge Feinstein stated that the department in each county should have those records, and wondered if perhaps an artificial obstacle is being created to getting the records. A legislative bill should authorize the release of medical records. The DSS should not be putting the burden elsewhere, because everyone that is in foster care is a dependent of a particular county.

Ms. Kirchmeyer stated that the Board had the de-identified patient information for the child, in the reports that staff received. Then, once the expert identifies that they believe a particular child is being inappropriately prescribed to, that is when staff would have to go back through the court process to obtain those medical records. Ms. Kirchmeyer added the Board does not have the authority, in any statute currently to be able to gather medical records. Staff would have to have patient authorization, or guardian approval to get any medical records in the state. According to DSS, the state, or perhaps the county that child is in, owns those medical records and staff would have to go through the court process to petition to obtain copies of them. She stated the Board should not oppose the bill since we are getting data. The bigger concern is that we do not want to receive data that will take a lot of staff time and then not be useful.

Dr. Lewis made a motion for the Board to take a support position if amended to include a sunset date of 3-5 years; s/Dr. Hawkins. Motion carried unanimously. (10-0 Krauss absent)

SB 1177 (Galgiani) Ms. Simoes stated the Board took a support position on this bill previously. This bill would authorize establishment of a physician health and wellness program (PHWP) within the Board. It would be administered by a third party administrative entity. Ms. Simoes stated this bill had been amended several times in hopes to make it stronger and more in compliance with the Uniform Standards to address the opposition's concerns.

Ms. Simoes noted that pursuant to the request of a Board member at the last meeting, a legal review of the provisions in the bill was completed regarding the bill's compliance with the Uniform Standards. It was found that a clarifying amendment may be needed in B&P Code Section 2340.6(c) to make it clear that confidentiality shall not apply if a physician is not in compliance with the conditions and procedures in the agreement. This technical amendment will ensure that the bill is in compliance with the Uniform Standards. Board staff can work with the author's office and committee staff to ensure this technical amendment is made.

Ms. Simoes stated this bill needs to have the following language added to 2340.6(c); any oral or written information reported to the Board shall remain confidential and shall not constitute a waiver of any existing evidentiary privileges under any provision or rule of law, however, confidentiality regarding the physician's and surgeon's participation in the program and related records, shall not apply if the Board has referred a participant as a condition of probation or if the physician or surgeon withdraws or is not in compliance with the conditions and procedures in the agreement.

Dr. Lewis made a motion for the Board to keep their support position on SB 1177, with the understanding that Ms. Simoes would work with the author and sponsors to make the amendments discussed; s/Dr. Krauss.

Mr. Do, CMA, stated that CMA is the sponsor of SB 1177 and appreciates the Board's support position as well as staff's recognition that the concerns that remain are technical in nature and are hopeful that they can address any of those concerns over any technical issues with the bill.

Ms. Gramme, CPIL, stated that several pieces of reform legislation had been enacted and mirrored many of CPIL's recommendations. She noted CPIL continues to oppose SB 1177, as they believe it is not necessary, and felt that a substance-abusing physician who is having problems and truly wants to be reformed is not going to seek assistance from the Board that could take their license away. She stated they really believe there are additional concerns and did not feel that SB 1177 complied with all elements of the Uniform Standards. She stated CPIL strongly urged the Board to take a closer look at the bill and oppose the bill unless it is amended appropriately.

Motion carried. (7-0-4 Feinstein, Hawkins, Warmoth, Yip)

Agenda Item 19 B. – Federal Legislation – Enhancement of Use of Telehealth Services in the Military Health System. Ms. Simoes referred the members to the handout under tab 19 in the Board packets. She stated the bill would, for the purposes of reimbursement, licensure, and professional liability, redefine the practice of medicine for providers serving veterans, as occurring at the location of the provider, rather than the location of the patient. She stated the Board has always believed that the practice of medicine occurs where the patient is located, rather than where the provider is located. This patient-centered model is the nationwide standard that ensures that state medical boards have the legal capacity and practical capability to regulate physicians treating patients within the borders of their state. She noted the Board had previously opposed similar legislation and had written letters to Congress expressing the Board's opposition.

Dr. GnanaDev stated the Board's belief had been where the patient is located is where the physician should be licensed. There should be no telehealth from a physician in another state as there is no consumer protection in that method.

Dr. Krauss made a motion to approve staff to write letters expressing the Board's opposition and concerns regarding this federal legislation; s/Dr. Lewis. Motion carried unanimously. (11-0.)

Agenda Item 19 D. - Status of Regulatory Actions. Ms. Simoes referred the Members to the matrix in the Board packet.

Dr. Krauss thanked Ms. Simoes for the excellent work that she has been doing on behalf of the Board. He added that she has been an exceptional voice representing the Board as well as the people of California.

Agenda Item 20 Discussion and Possible Action on the Universidad Iberoamericana (UNIBE) Medical School Application for Recognition

Mr. Worden stated that at the November 2015 Board meeting, the Board had approved staff to do a site visit to the UNIBE medical school. He noted the site team consisted of Dr. Lewis, Dr. Nuovo, Ms. Dobbs and himself. He referred the members to pages 20-1 through 20-14 to review the reports. Mr. Worden stated there were two representatives from the school, Dr. Marcos Nunez, Dean of the Medical School, and Dr. Lorraine Amel, Dean of International Affairs in the audience should the Board have any questions for them.

Dr. Nuovo, Associate Dean of Graduate Medical Education at UC Davis, and Board medical consultant stated site visits are a lot of work, not just for the site team, but for the school, as well. It requires the school to conduct intensive background work to get all of the documents together. It also entails organizing the right people for the site team to meet with during the visit. Dr. Nuovo thanked the site team and the school personnel for participating in the visit and for doing an outstanding job.

Dr. Nuovo then gave a PowerPoint presentation of photos taken during the site visit that included pictures of several of the school's senior members of leadership that they met with and a brief description of the topics that were discussed with those members. The presentation also included photos of the site team's six-hour tour of the hospital/clinical facilities.

Dr. Nuovo stated that after review of the information and documentation provided by the school during the site visit, the team determined that UNIBE was in substantial compliance with the requirements of B&P Code sections 2089 and 2089.5 and CCR, Title 16, Division 13, Section 1314.1. The site visit team recommended recognition of the UNIBE program by the Board, retroactive for UNIBE students who matriculated on or after January 1, 2009.

Dr. Hawkins asked Dr. Nuovo's opinion on the school's cultural competence.

Dr. Nuovo stated it was very impressive - one of the most impressive he has seen at any site visit.

Dr. Bholat asked, in terms of the graduating classes, where did the percentage of students go for residency and what percentage is primary care and what percentage goes into specialty care.

Dr. Nunez stated that 80% of their students wanted to come to the United States. He noted some stay in the country, and some go to Europe and South America. Dr. Nunez stated that about 20% of those who graduated would choose family medicine, surgery or OB/GYN. He noted they were trying to promote family medicine with the government due to the salary issues. He noted that approximately 70-80% go into specialty care.

Dr. Hawkins made a motion for the Board to recognize UNIBE to be in substantial compliance with the requirements of B&P Code sections 2089 and 2089.5 and CCR, Title 16, Division 13, Section 1314.1, and extend recognition to students who matriculated UNIBE on or after January 1, 2009; s/Dr. Lewis. Motion carried unanimously. (10-0 Yip Absent)

Agenda Item 21 Update from the Application Review and Special Program Committee

Dr. Lewis gave the update on Dr. Yip's behalf stating the Application Review and Special Program Committee held a teleconference meeting on June 22, 2016, at 8:30 a.m., and reviewed the Kaiser Permanente Oakland Medical Center's request for a spine surgery fellowship program pursuant to B&P Code section 2112. He stated he and Dr. Yip were present during this meeting. Mr. Worden presented Kaiser Oakland's request for the fellowship program to the committee. After discussion of the request, a motion was passed to recommend to the Chief of licensing approval of the request for one fellow per year.

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

Ms. Webb stated this agenda item consists of a regulatory package that was reviewed and approved at the last Board meeting. However while under review, staff decided it was important to add another citable offense, which is under Health and Safety Code section 120370(a). This code relates to a physician providing a parent or guardian of a child a written statement indicating that the physical condition of the child or the medical circumstances relating to the child are such that immunization is not considered safe.

Dr. Hawkins made a motion to direct staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend Title 16, Division 13, Chapter 2, Article 6, CCR Sections 1364.10, 1364.11, 1364.13 and 1364.15 to include Health and Safety Code 120307(a) in addition to those changes already approved by the Board; s/ Mr. Warmoth. Motion carried unanimously. (10-0)

Agenda Item 23 Discussion and Possible Action of Proposed Regulations Update the Manual of Model Disciplinary Orders and Disciplinary Guidelines, amending Title 16, Division 13, CCR Section 1361

Ms. Webb stated this agenda item consists of a rulemaking package the Board had already approved, and in working to finalize it, staff found some issues that needed to be resolved for internal language consistency throughout and some provisions that are in the current language were left out of the noticed language in error. Ms. Webb noted that for transparency purposes, it needed to be noticed for a 15-day comment period.

Dr. Krauss made a motion to allow the Board to make the corrections that are outlined in the Board Packet memo, to send it out for a 15-day comment period and if no substantive, or negative comments are received on these specific re-noticed items, that the Board authorizes staff to make non-substantive changes and finalize the rulemaking package for submission to the Office of Administrative Law; s/Dr. Bholat. Motion carried unanimously. (10-0)

Agenda Item 24 Update on the Interim Suspension Order (ISO) Study

Ms. Kirchmeyer stated that at the last Board meeting, Mr. Serrano Sewell had requested an update on the ISO study and recommended policy changes. She noted that on pages BRD 24-1 through 24-4 was an update on actions taken to date. She noted that several of these recommended improvements had either been completed or started. She stated a few of the recommendations were still being worked on before being implemented. Ms. Kirchmeyer noted that although all of the recommendations had not been implemented, there had been several significant improvements from fiscal year 14/15 to fiscal year 15/16. She highlighted a few of those improvements, including the number of ISOs increased 157% from 14 to 36 between those two years. In addition, the length of time it takes to obtain an ISO decreased by 150 days. Also, the overall suspensions or restriction orders increased from a total of 52 to 84 for all types of restrictions.

Ms. Kirchmeyer stated that Board staff would continue to work with the AG's Office and the HQIU to implement all of the recommendations and an update will be provided at a future Board meeting.

Agenda Item 25 Update on the Outreach Campaign

Dr. Lewis provided an update on the "Check Up On Your Doctor's License" campaign. He noted the activities update could be found on pages BRD 25-3 through BRD 25-7. He stated the Board's Office of Public Affairs had been busy working on the outreach campaign and had been very successful in getting the word out to patients in the entire State of California. Dr. Lewis stated that at a prior meeting, he had announced that a tutorial was being prepared, which was now completed and on the Board's website, as well as on You Tube. He added this tutorial walks the patient through the steps needed to check on a physician's license.

Dr. Lewis noted that the "Check up on Your Doctor's License" brochure had been translated in to Spanish and would be available soon.

Dr. Lewis added that a message encouraging state employees, vendors and contractors to "Check up on Your Doctor's License" appeared on the bottom of all state warrants for the month of June 2016, which had reached nearly 439,000 individuals. He also noted that in April 2016, an issue of the California State Retiree Publication featured an article and an image of the Board's brochure and had reached nearly 34,000 state retirees. Dr. Lewis announced that in May 2016, the County of San Bernardino posted the same information on its website which had reached nearly 2.2 million individuals. Also, in May, Tulare County's health department had agreed to post the Board's message on a Twitter account and also on Facebook throughout the year and that this same information would be added to the "Spotlight" section of their website. In addition, the county of Tulare had created a network of digital signs that would appear throughout the county on buildings and the Family Resource Center as well as family clinics. They stated they would carry the Board's message and a small article would be appearing in Tulare County Newsletter in the future and had the potential to reach nearly 466,000 individuals.

Dr. Lewis stated that also in May, Monterey County Health Department had posted an article about the Board's outreach campaign on its website and had also promised to post on social media as well, which would potentially reach over 430,000 individuals. He added that in Orange County, the health care agency published a ½ page write up in its June employees newsletter which reached 3,000 agency employees. He noted that in June, Contra Costa County had started running the Board's message on its cable TV bulletin board which was available to all county residents and had the potential to reach 11 million individuals. Also in June, the Los Angeles County Department of Health Services had begun posting the Board's information on its patient resources section which would potentially reach 10.12 million individuals. Kern County indicated they would immediately start sharing the Board's information on its social media sites. Stanislaus County Health Services posted the same information on its website. Fresno County had begun to run a feature on its internet for the Board's outreach campaign targeting a readership of 7,000 county employees. He added that in San Francisco, the Department of Public Health had also posted the Board's information on its website and through social media. He noted that CalPERS would soon be running an article about the Board's outreach campaign in its next quarterly newsletter, "Perspective," which was mailed out to members' homes and was posted on its website, which would include an audience of 1.7 million

members. CalPERS would also be posting a bulletin on its intranet site, which had the potential to reach 2.9 million CalPERS employees.

Dr. Lewis noted that Board staff wrote an article for CalSTRS which would be published in several of their publications with a readership of 900,00 people.

Dr. Lewis stated that based on the successful outreach by the Board, it's messaging had been placed in publications that had a capacity to reach 17 million Californians. He noted that he was very pleased with the work that had been done by staff and that they would continue to do outreach to various cities, counties, unions and other large community organizations. He added that staff was working on completing another public service announcements and hoped to have it completed by the October 2016 Board meeting.

Dr. Hawkins asked Ms. Kirchmeyer if there was a count of how many hits the website had seen.

Ms. Kirchmeyer referred the members to the public affairs outreach update that was emailed to them previously, but also stated that ISB is implementing a QR code soon that would assist the Board in knowing where the hits are specifically coming from on the website. She added that in May there had been 160,000 hits on the Board's website, but in June, there had been 220,000 hits, so it had increased by 60,000 hits between May and June, and there had been an increase of about 20,000 hits on the licensing verification part of the website.

Agenda Item 26 Discussion on the Process to Revise the Statement on Marijuana for Medical Purposes, Marijuana Recommendation Guidelines, and a Policy on Physician Use of Marijuana

Ms. Kirchmeyer reminded the members that as of January 1, 2016, Senate Bill (SB) 643 required the Board to consult with the California Marijuana Research Program, known as the Center for Medical Cannabis Research (CMCR) on developing and adopting medical guidelines for the appropriate administration and use of cannabis. She noted that at the last Board meeting, a member requested that the Board review the two policies that were adopted by the Federation of State Medical Board. (FSMB). The first being the Model Guidelines for the Recommendation of Marijuana in Patient Care, and the other regarding a physician's use of marijuana. Ms. Kirchmeyer referred the members to pages 26-1 and 26-2 in their Board packet where they would find the Board's most recent statement on recommending marijuana for medical purposes. This statement had been used as the Board's guidelines for recommending marijuana. Additionally, on pages BRD 26-3 through BRD 26-16, were the FSMB's recently adopted model guidelines. Ms. Kirchmeyer stated that in order to implement SB 643, the Board would need to begin to review the current statement or guidelines to determine if changes needed to be made. She noted the best way to begin this process was to develop a two-member task force to review the FSMB's guidelines and the Board's current statement and see if any changes were necessary. Ms. Kirchmeyer added that this task force could hold interested parties meetings to discuss the issue and work with the CMCR to obtain their input on the guidelines. She asked that if any member were interested in being on this task force, to let her know so she could discuss it with the Board president. Ms. Kirchmeyer stated once the Board President identifies the two-member task force, meetings would be scheduled to discuss the next steps to proceed further on the issue.

Ms. Kirchmeyer stated the other issue that had been raised at the previous Board meeting was a physician's use of marijuana and a policy on that issue. She noted that on pages BRD 26-17 through BRD 26-50, members would find the FSMB's Essentials of a State Medical and Osteopathic Act. She stated the FSMB uses this document to guide states and to amend existing medical practice acts for the development of consistent standards. Based on discussion of the FSMB's marijuana workgroup, it was determined that rather than have a separate policy on a physician's use of marijuana, that subsection D of the Essentials document would be amended. This subsection pertains to actions where a board should be able to take disciplinary action against a licensee. Section 19 of subsection 19 had been amended to add marijuana to the list of substances that impair a physician's ability and could lead to disciplinary action. Although the task force may want to look into the issue of a physician's use of marijuana, in looking at the FSMB's handling of the issue, and looking into the B&P Code Section 2239, she felt the Board already had a law that would allow it to take action should a physician's ability to practice be impaired by the use of marijuana. Therefore, the task force may want to use the existing law regarding this issue, similar to what the FSMB recommended rather than develop a new policy. She noted once this task force is developed, more information will be provided on future steps for this task force and future interested parties meetings will be scheduled.

Ms. Kirchmeyer stated she had received one written comment that morning, that she was unable to print out, in regard to this agenda item. It was regarding the in-person evaluation prior to the recommendation of marijuana for medicinal purposes. She added that this comment would be forwarded to all of the members.

Dr. Robinson, Member of the Society of Cannabis Clinicians (SCC), read a statement that his board submitted to the editors of the Journal of American Medical Association (JAMA) in response to the FSMB's publication of their guidelines. The statement was in response to an online version of a JAMA article, that had been published on June 16, 2016, by Dr. Chaudhry, et al., entitled "Medical Board Expectations for Physicians Recommending Marijuana." Dr. Robinson stated that the SCC members had monitored cannabis use by tens of thousands of patients treating numerous medical conditions. He noted the SCC had two concerns; one concern was regarding conflicts of interest. The article stated that physicians should "not be associated, in any way," with a dispensary or cultivation center. He added this wording was far more restrictive than the actual policy ratified by the FSMB. He noted it would impede physicians wishing to collaborate with dispensaries to research which specific cannabinoid-terbinoid ratios were effective. He stated an association, for research purposes, would not involve a financial interest on the physician's part, and should not be prohibited.

Dr. Robinson stated another concern SCC has was that the article states "state medical and osteopathic boards advise their licensees to abstain from the use of marijuana for medical or recreational purposes while actively engaged in the practice of medicine." He stated that provision did not appear in the model guidelines developed by the FSMB workgroup adopted as policy by the FSMB House of Delegates in April, 2016. He noted that the use of medical cannabis has a lower addiction potential than alcohol or opiates. The proposed policy to disallow such usage is scientifically unsupportable.

Mr. Gardner commented on Ms. Kirchmeyer's statement in regard to physicians inappropriately prescribing psychotropic meds for foster kids, and that the Board's mantra is that a complaint from someone in the loop such as a social worker is obviously a better basis for pursuing an investigation than an algorithm of the kinds being proposed by the FSMB. These algorithms

involve a number of patients a physician approves marijuana use for and the number of plants approved. He stated there is an ongoing stigma around cannabis. Physicians receive no training about it in medical school and a majority are very reluctant to recommend or discuss it with their patients. The physicians who are willing to recommend it are a relatively small group. They get an inordinate number of patients. With the use of the algorithm, they get investigated. Sometimes the investigator wants to make a case and pursues it with great zeal, so it is a very dangerous, slippery slope. Mr. Gardner urged the Board to take a close look at what its approving. He stated the Board should be asking the Federation why this campaign is being pushed and why time and money is being spent on this.

Dr. Perry Solomon stated one of the proposals in the FSMB's model, under the patient evaluation section, the first few words are "a documented in-person medical evaluation." As a chief medical officer at a telehealth platform organization that provides remote live HIPAA-compliant cannabis evaluations to patients from all over California, he has seen this modality help thousands of patients. These physicians are able to perform evaluations of patients who are housebound and unable to obtain transportation to see physicians. He stated he had been thanked many times for offering this type of service. He noted that telehealth had opened the door for so many people all across the country that previously had no access to health care or treatment. He stated telehealth care is now mainstream health care and there should be no reason that cannabis evaluations should be excluded.

Agenda Item 27 Update on Improvements and Potential Changes to the Vertical Enforcement Program

Ms. Kirchmeyer noted that at the last meeting, a member had requested an update on the implementation on the VE report findings and recommendations. She referred the members to page BRD 27-1 to BRD 27-3 in the Board packet, which included a copy of the report that had been adopted in February and released in March 2016. She stated page 27-11 showed the Board's four recommendations for the VE model. She added that recommendations one through three would require legislation in order to make the changes and implement them. She noted that recommendation number one pertains to the section of law that states that the investigator shall be "under the direction but not the supervision of the Deputy Attorney General." The Board felt this language could interfere with the investigators and attorneys being a true team and therefore the language should be amended. However, it could only be done through a legislative change. She noted that recommendation number two would allow some of the Board's cases that do not get sent to the HQUI to be worked in a VE model which would include cases that are completed by the Board's non-sworn in-house investigators within the Complaint Investigation Office (CIO). Although there may be a way to do this without legislation, to make it clear to the AG's Office, the language would need to be amended.

Ms. Kirchmeyer added the third requirement also would need a legislative change due to the fact that the investigators are no longer employed by the Board. The entire VE model is outside the Board's specific authority as it is now overseen at the AG's Office and the DCA, therefore the law should be changed to state that the DCA shall perform the duties required by the Government Code section 12529.6(e). She added the report was provided to the Legislature along with the recommendations. She noted that she had testified at the sunset hearing regarding VE and had gone over the recommendations.

Ms. Kirchmeyer noted that she and Ms. Simoes had met with the Business and Professions committee staff to discuss VE and the Board's recommendations. She added, to date, no language had been introduced to change the language that was requested to be amended. However, she stated that meetings were still being arranged and there was a possibility that changes to the language could be made this year. She noted that if no language was brought forward this year, this issue could be part of the sunset process.

Ms. Kirchmeyer stated that recommendation four states the DCA and the AG's Office should utilize the joint VE manual and develop additional strategies and procedures to assist the investigators and attorneys to further improve the VE model. She noted that DCA and the AG's Office had recently done joint training on 805 peer review investigations for both attorneys and investigators. The AG's Office and the HQUI will also be setting up subject interview training. She noted in addition, a new case disposition form had been developed that had been assisting in the investigation closure and/or transmittal process. She added Board staff would continue to meet with legislative staff and DCA to seek the legislative changes need to implement the recommendations in the report.

Judge Feinstein asked if there were any statistics available about who the investigator might be and who the DAG might be on complaint cases and whether or not that stays consistent throughout the whole process.

Ms. Kirchmeyer stated that are no statistics available in that area, however, she stated that the way the VE model has been implemented is there is a lead prosecutor who is out in the field and handles a lot of work on the case, and there is the primary deputy, that actually tries the case.

Ms. Fellmeth stated in the spirit of full disclosure, in her November 2004 report, as the enforcement monitor for the Board, she and her team had recommended the Board use the VE model of investigating and prosecuting its complex cases. She noted she had submitted a letter to the Board registering several concerns about the report and the data in the report that had resulted in the four recommendations in the report, and those concerns had not been addressed. She noted the first concern is that the report only uses data that comes from the BreEZe system, which has not proven reliable. Secondly, the report only shows median case processing times, and the reporting of median case processing time does not fully reflect long problematic delays, nor does it adequately measure quickly resolved matters. She added the language in the current report did not correct that problem. Ms. Fellmeth stated that the third concern is the report states that the VE has not sped up the enforcement process. That complaint ignores the fact that the earlier involvement of the DAG is necessarily going to result in the early closure of minor or non-meritorious cases. The data presented in the report does not reflect what may be higher quality decision making about which cases to pursue and which cases to drop. She noted the VE model is being blamed for problems that have occurred since the transfer of the investigators to DCA. She stated that since 1990, they have felt that the proper place for the investigators is in the AG's Office, Health Quality Enforcement Section so that they can truly function as a team with the attorneys, who specialize in the Board's complex matters. She noted they would oppose any changes to the statute if it affects the ability of the prosecutor to direct the investigation.

Agenda Item 28 Agenda Items for the October 27-28, 2016 Meeting in the San Diego Area

Dr. GnanaDev announced that the October meeting may require the Board to meet on Wednesday afternoon, October 26 in order to review the Sunset Report.

In addition, there would be two regulatory hearings, a presentation by Dr. Bholat on the UCLA International Medical Graduate Pilot Program, and any updates from committees and task forces.

Agenda Item 29 Adjournment

Dr. GnanaDev adjourned the meeting at 12:55 p.m.

 Dr. GnanaDev, President

 Date

 Dr. Lewis, Secretary

 Date

 Kimberly Kirchmeyer, Executive Director

 Date

The full meeting can be viewed at <http://www.mbc.ca.gov/AboutUs/Meetings/2016/>



MEDICAL BOARD OF CALIFORNIA

Executive Office



Committees of the Board

Executive Committee

- Membership:** President of the Board, Chair
 Vice President of the Board
 Secretary of the Board
 Immediate Past President of the Board
 Chair of the Enforcement Committee
 Chair of the Licensing Committee
 Chair of the Public Outreach, Education, and Wellness Committee
 (The president may select additional members at his/her discretion.)
- Responsibility:** Oversees various administrative functions of the Board, such as budgets and personnel, and reviews legislation, as needed; 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) when the full Board cannot be convened.
- Staff:** Executive Director
- List of Issues:**
- Legislation discussions and positions
 - Executive director evaluation
 - Strategic planning
 - Administrative issues
 - Assessment regarding effectiveness and efficiency of Board
- Meeting Schedule:** Meets on an as needed basis, usually during quarterly Board meetings, but may also meet off-cycle of quarterly Board meetings.

Enforcement Committee

- Membership:** Determined by the President
- Responsibility:** Serves 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; identifies program improvements in order to enhance protection of health care consumers; and reviews the Board's Vertical Enforcement/Prosecution (VE/P) Program.
- Staff:** Chief of Enforcement

Committees of the Board

October 2016

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List of Issues: - Time lines for processing complaints, investigations, and disciplinary actions in an effort to determine efficiencies and identify where changes can be made
 - VE/P evaluation report recommendations
 - Probation Program enhancements

Meeting Schedule: Meets on an as needed basis during quarterly Board meetings; but may also need to meet off-cycle of quarterly Board meetings.

Licensing Committee

Membership: Determined by the President

Responsibility: Serves 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; identifies program improvements; and reviews licensing regulations, policies, and procedures.

Staff: Chief of Licensing

List of Issues: - Maintenance of licensure (MOL)
 - Postgraduate training
 - Physician re-entry
 - Other programs of the Board related to licensing:
 ➢ Fictitious name permits
 ➢ Research psychoanalyst
 ➢ Continuing medical education and audits
 ➢ Polysomnography program
 ➢ Outpatient setting accreditation agencies

Meeting Schedule: Meets on an as needed basis during quarterly Board meetings, but may also need to meet off-cycle of quarterly Board meetings.

Public Outreach, Education and Wellness Committee

Membership: Determined by the President

Responsibility: Develops various informational materials for publication and internet posting; develops plans and strategies to provide outreach to physicians and patients; monitors the Board’s strategic plan pertaining to communication; develops physician wellness information by identifying available activities and resources, which renew and balance a physician’s life, both personal and professional.

Staff: Chief of Legislative and Public Affairs and the Public Information Officer

Committees of the Board

October 2016

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List of Issues: - Education of physicians and consumers
 - Ensuring the Board's message is disseminated

Meeting Schedule: Meets on an as needed basis, during quarterly Board meetings, but may also need to meet off-cycle or quarterly Board meetings.

Application Review and Special Programs Committee

(Business and Profession Code sections 2072, 2073, 2099, 2111-2113, 2115, 2135.5 and 16 CCR section 1301)

Membership: Determined by the President (normally limited to three members with minimum of one physician)

Responsibility: Evaluates the credentials of licensure applicants where statute provides the Board to exercise discretion; and makes recommendations to the Licensing Program regarding eligibility for licensure (for example, postgraduate training hardship petitions per 16 CCR section 1321(d) and written licensing exam waiver requests per Business and Professions Code section 2113).

Staff: Chief of Licensing

Meeting Schedule: Meets on an as needed basis during Quarterly Board Meetings

Special Faculty Permit Review Committee

(Business and Professions Code section 2168.1(c)(1))

Membership: A physician member and public member of the Board determined by the President and one representative from each California medical school nominated by the school dean.

Responsibility: Evaluates the credentials of applicants proposed by a California medical school to meet the requirements of Section 2168.1; determines whether the candidate meets the requirements of an academically eminent physician, or an outstanding physician in an identified area of need; and submits a recommendation to the Board for each proposed candidate for final approval or denial.

Staff: Chief of Licensing

List of Issues: - Periodic examination of the performance and status of all 2168 special faculty permit holders based upon information from their institutions and elsewhere.

Meeting Schedule: Meets off-cycle of quarterly Board meetings on an as needed basis.

Committees of the Board

October 2016

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Midwifery Advisory Council

(Business and Professions Code section 2509)

- Membership: Determined by the Board as specified in law
- Responsibility: Develops solutions to various regulatory, policy, and procedure issues regarding the midwifery program, including challenge mechanisms and examinations, as specified by the Board.
- Staff: Chief of Licensing
- List of Issues:
- Barriers to care
 - Mandatory annual reporting
 - Midwife assistants
 - Enforcement of midwives – licensed or unlicensed
 - Outreach to physician groups regarding midwifery
- Meeting Schedule: Meets three times per year, usually off-cycle of quarterly Board meetings.

Subcommittees/Task Forces of the Board

Editorial Committee

- Membership: Determined by the President
- Responsibility: Reviews the Newsletter articles to ensure they are appropriate for publication and provides necessary edits to the articles.
- Staff: Executive Director

Marijuana Task Force

- Membership: Determined by the President
- Responsibility: Reviews and updates the Board’s guidelines pertaining to the recommendation for marijuana for medicinal purposes, identifies best practices, and performs communication and outreach by engaging all stakeholders in the endeavor.
- Staff: Executive Director

Committees of the Board
October 2016
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Midwifery Task Force

Membership: Determined by the President
Responsibility: Discusses solutions to pending regulatory issues pertaining the practice of midwifery.
Staff: Executive Director

Prescribing Task Force

Membership: Determined by the President
Responsibility: Identifies ways to proactively approach and find solutions to the epidemic of prescription drug overdoses through education, prevention, best practices, communication and outreach by engaging all stakeholders in the endeavor.
Staff: Executive Director

Sunset Review Task Force

Membership: Determined by the President
Responsibility: Reviews the sunset review questions and responses to provide input and guidance to staff.
Staff: Executive Director

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

<i>Committee</i>	<i>Members</i>
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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 12, 2016
 ATTENTION: Members, Medical Board of California
 SUBJECT: Administrative Summary
 STAFF CONTACT: Kimberly Kirchmeyer, Executive Director

REQUESTED ACTION:

This report is intended to provide the Members with an update on the staffing, budget, and other administrative functions/projects occurring at the Medical Board of California (Board). No action is needed at this time.

Administrative Updates

Board staff has had several meetings with interested parties regarding the Board.

- Regular meetings were held with Chief Deputy Director Jeffrey Mason and Deputy Director Christine Lally of the Department of Consumer Affairs (DCA) and other DCA Executive staff.
- Regular meetings continue to be held with Gloria Castro, Senior Assistant Attorney General.
- Regular meetings were held with David Chriss, Chief of Enforcement, and Kathleen Nicholls, Deputy Chief of Enforcement, Division of Investigation, Health Quality Investigation Unit, regarding the Board's investigations, staffing, and retention concerns.
- Board staff continues to meet with DCA and the Department of Justice (DOJ) to discuss the Controlled Substance Utilization Review and Evaluation System (CURES) database.
- Board staff met with the California Medical Association (CMA) on issues of interest to both parties.
- Board staff attends monthly meetings with the California Department of Public Health (CDPH) and other entities regarding safe injection practices.
- Board staff attended meetings with the Psychotropic Medication Implementation (PMI) Workgroup, which is a workgroup to improve the safe and appropriate use of psychotropic medication for children and youth in foster care.
- Board staff has met with legislative offices to provide updates, discuss pending legislation, and provide education on the Board's functions.
- Board staff attended the first National Governors' Association *Opioid State Action Network* call.
- Board staff had a meeting with Governor's Office, Department of Finance, and DCA staff as well as interested parties on the implementation of Business and Profession Code section 853, which is the Licensed Physicians and Dentists from Mexico Pilot Program.
- Board staff met with the Governor's Office Deputy Appointments Secretary. The Secretary was provided a tour of the Board facilities and an overview of the Board.
- Board staff met with staff from the Business, Consumer Services, and Housing Agency to discuss the Board's outreach plan.
- Board staff provided a presentation on the CURES system and the Board's *Guidelines for Prescribing Controlled Substances for Pain* to physicians at St. Mary's Hospital in San Francisco.
- Board staff had a call with the Medical Director at the California Primary Care Association (CPCA) and discussed partnership between the two organizations in the dissemination of information and the Board providing presentations to the CPCA.
- Board staff met with staff from CDPH, Healthcare-Associated Infections Program to discuss dissemination of information pertinent to physicians.
- Board staff met with staff from the Department of Social Services to identify a process to obtain the medical records for foster care children who may have been inappropriately prescribed psychotropic medications.
- Board staff had a call with the California Hospital Association to discuss sharing of data and possible future presentations.
- Board staff met with staff from CDPH to discuss outpatient surgery settings and oversight.
- Board staff provided a presentation at a Board of Psychology meeting regarding the End of Life Option Act.
- Board staff provided a presentation at the California Ambulatory Surgery Association regarding adverse event reports and the Board's enforcement process.

- Board staff met with the California Research Bureau to receive an update on the demographic study.
- Board staff attended webinars and teleconferences with staff from the Federation of State Medical Boards and the International Association of Medical Regulatory Authorities.
- Board staff continues to meet with representatives from the CDPH, the Board of Pharmacy, Dental Board, the Department of Health Care Services (DHCS), DOJ, the Emergency Medical Services Authority, DCA, and other interested parties regarding prescription opioid misuse and overdose. The group is identifying ways all the entities can work together to educate prescribers, dispensers, and patients regarding this issue of serious concern.
- Board Executive Director attended the Administrators in Medicine (AIM) Executive Director Workshop where several interactive case studies were presented and best practices identified. The Executive Director also provided a presentation at the AIM Executive Academy.
- Board Executive Director attended the United States Medical Licensing Examination (USMLE) State Board Advisory Panel meeting in Philadelphia and discussed updates on the USMLE and toured the testing facility.

Staffing Update

The Board has 160.6 permanent full-time positions (in addition to temporary staff). The Board is at a 7% vacancy rate which equates to 12 vacant positions. This is 2% higher than the vacancy rate that was provided in the last administrative summary, which was 5%. The Board anticipates several retirements at the end of the fiscal year and will be reviewing the Board's budget in conjunction with the need to fill vacant positions.

Budget Update

The Board's budget documents are attached, beginning on page BRD 7A-4 and continuing to page BRD 7A-17. BRD 7A-4 is the Board's fund condition, which identifies the Board's fund reserve at 4.7 months at the end of FY 16/17. However, this reserve level is dependent upon the partial repayment of the Board's outstanding general fund loan. If this loan were to not be repaid in this FY (as identified in BRD 7A-5), the Board's fund reserve would be at 3.6 months at the end of this FY.

Page BRD 7A-6 provides the final year-end budget document for FY 15/16. It is important to note that the Board spent approximately \$3 million more in FY 15/16 than in FY 14/15. These increased costs were associated with an increase in spending at the Attorney General's (AG) Office, an increase in DCA pro rata, and an increase in personal services. Page BRD 7A-7 identifies the HQIU final expenditures for FY 15/16.

With the partial repayment of the outstanding loans, and taking into consideration future anticipated costs, the Board's fund reserve will be within its mandated level in FY 17/18. Board staff will be closely monitoring the Board's budget to determine whether future changes are needed. As indicated by both fund conditions, it would not be prudent at this time to consider any reduction in licensing fees as previously recommended by the Bureau of State Audits because the Board anticipates being within its mandatory level at the end of FY 15/16. In addition, the Board has future costs that could impact the Board's budget should they be approved.

The Board's overall actual expenditures for FY 16/17 through August 31, 2016 can be found on page BRD 7A-8. Pages BRD 7A-9 to 7A-13 show the budget report, specifically for licensing, enforcement, the HQIU, and the AG expenditures. Page BRD 7A-17 provides the Board Members' expenditure report as of September 26, 2016.

BreEZe Update

Board staff continues to submit requests for changes/fixes to DCA for the BreEZe system. Requests designed to streamline the physician and surgeon renewal process for licensees renewing online and Board staff processing deficiencies are pending an Impact Analysis (resource/cost estimate) from the vendor before a final

vote by the BreEZe Change Control Board. Currently, staff is working on requests to redesign the physician and surgeon postgraduate training authorization letter and initial applications based on the modifications to the paper applications recently finalized by licensing staff. These improvements will make these online functions more user-friendly to applicants and licensees as well as make deficiency processing and resolution clearer to the applicants and licensees and more efficient for Board staff.

Controlled Substance Utilization Review and Evaluation System (CURES) Update

The Board is still working with DOJ to identify physicians who have DEA certificates and should have been registered in the CURES system by July 1, 2016, as required by law. As previously stated, once those individuals who have not registered are identified, the Board will send out notices via email for those who have an email on file with the Board. For those that do not have an email, the Board may be sending them a postcard notification.

As of September 15, 2016, there were 73,455 physicians registered in the CURES 2.0 system. There are additional physicians who are registered in CURES 1.0 that have not updated their information into the CURES 2.0, however, DOJ cannot identify how many registered in that system are physicians. In addition, between August 15 – September 15, 2016, physicians requested 198,176 patient activity reports from the CURES 2.0 system.

The Board provided a CURES FAQ in the Summer Newsletter to assist physicians on understanding CURES and what information is available. However, based upon the telephone calls received by the Board, more educational information needs to be provided to physicians, especially in light of the passage of Senate Bill (SB) 482 (Lara). Therefore, Board staff will meet with staff from DOJ and other DCA boards to develop some educational tools for physicians. The DOJ CURES website does include tutorial videos to assist physicians.

Prescribing Psychotropic Medications to Foster Children

In August, the Board received the findings of the Board's expert pediatric psychiatrist reviewer after review of the data that was received by the Department of Health Care Services (DHCS) and the Department of Social Services (DSS). As previously stated, the data included a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more, a list of the medications prescribed, the start and stop date for each medication, and the child's date of birth. Additional data received included the diagnosis associated with the medication, dosage of medication prescribed, schedule of dosage, and weight of the child/adolescent.

The expert reviewer identified numerous patients who may have been inappropriately prescribed psychotropic medications that needed further investigation. Based upon this information, the Board requested the assistance of the DHCS and the DSS in obtaining the medical records for the patients identified. The Board is currently working with the DSS to identify the appropriate party to authorize release of these medical records.

In addition, on August 23, 2016, the Bureau of State Audits (BSA) released an audit report concerning the oversight of psychotropic medications prescribed to California's foster children. The report concluded that the state and counties have failed to adequately oversee the prescribing of these medications. The report mostly focused on the counties, DHCS and DSS; however, the audit also had a portion related to the Board. The portion regarding the Board and the findings and recommendations can be found in 7F of the Board packet. The Board will provide a 60-day response on October 23, 2016. With the passage of SB 1174 (McGuire), and with the proactive steps the Board has already taken, the Board has either implemented or is in the process of implementing all of the recommendations.

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

(Dollars in Thousands)

Fund Condition with General Fund Loan Repayments

	ACTUAL 2015-16	CY 2016-17	BY 2017-18	BY+1 2018-19	BY+2 2019-20
BEGINNING BALANCE	\$ 28,087	\$ 27,001	\$ 25,327	\$ 25,779	\$ 15,758
Prior Year Adjustment	\$ 282	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,369	\$ 27,001	\$ 25,327	\$ 25,779	\$ 15,758
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
Revenues:					
125600 Other regulatory fees	\$ 385	\$ 388	\$ 388	\$ 388	\$ 388
125700 Other regulatory licenses and permits	\$ 7,388	\$ 7,194	\$ 7,194	\$ 7,194	\$ 7,194
125800 Renewal fees	\$ 48,728	\$ 47,828	\$ 48,799	\$ 48,799	\$ 48,799
125900 Delinquent fees	\$ 124	\$ 136	\$ 136	\$ 136	\$ 136
131700 Miscellaneous revenue from local agencies	\$ 2	\$ -	\$ -	\$ -	\$ -
141200 Sales of documents	\$ 25	\$ 10	\$ 10	\$ 10	\$ 10
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 139	\$ 52	\$ 53	\$ 53	\$ 53
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
160800 Escheat of unclaimed property	\$ 1	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 23	\$ 10	\$ 10	\$ 10	\$ 10
161400 Miscellaneous revenues	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1
Totals, Revenues	\$ 56,816	\$ 55,619	\$ 56,591	\$ 56,591	\$ 56,591
Transfers and Other Adjustments:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ 6,000	\$ -	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ -	\$ 9,000	\$ -	\$ -
TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS	\$ 56,816	\$ 61,619	\$ 65,591	\$ 56,591	\$ 56,591
TOTAL RESOURCES	\$ 85,185	\$ 88,620	\$ 90,918	\$ 82,369	\$ 72,349
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1111 Program Expenditures (State Operations)	\$ 55,516	\$ 59,956	\$ 63,631	\$ 64,921	\$ 64,921
<u>2016-17 and Ongoing Approved Costs</u>					
BreEZe Costs	\$ 2,403	\$ 2,403	\$ -	\$ -	\$ -
BreEZe Costs	\$ 158	\$ -	\$ -	\$ -	\$ -
Staff Augmentation	\$ -	\$ 113	\$ 105	\$ 105	\$ 105
Expert Reviewer	\$ -	\$ 206	\$ 206	\$ 206	\$ 206
Registered Dispensing Opticians	\$ -	\$ (39)	\$ (39)	\$ (39)	\$ (39)
Department of Justice	\$ -	\$ 577	\$ 577	\$ 577	\$ 577
<u>Anticipated Future Costs</u>					
Staff Augmentation - Enforcement	\$ -	\$ -	\$ 206	\$ 206	\$ 206
Staff Augmentation - Licensing	\$ -	\$ -	\$ 339	\$ 279	\$ 279
Implement SB 1177	\$ -	\$ -	\$ 114	\$ 356	\$ 356
BreEZe Costs	\$ -	\$ -	\$ 2,403	\$ 2,403	\$ 2,403
1111 Program Expenditures (State Operations) Subtotal	\$ 58,077	\$ 63,216	\$ 65,139	\$ 66,611	\$ 66,611
Expenditure Adjustments:					
0840 State Controller (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
8880 Financial Information System for California (State Operations)	\$ 107	\$ 77	\$ -	\$ -	\$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	\$ 58,184	\$ 63,293	\$ 65,139	\$ 66,611	\$ 66,611
Unscheduled Reimbursements	\$ 900	\$ 900	\$ 900	\$ 900	\$ 900
FUND BALANCE					
Reserve for economic uncertainties	\$ 27,001	\$ 25,327	\$ 25,779	\$ 15,758	\$ 5,738
Months in Reserve	5.1	4.7	4.6	2.8	0.1

NOTES:

- A. Assumes workload and revenue projections are realized for FY 16/17 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$6 million was loaned to the General Fund in FY 08/09 and \$9 million was loaned to the General Fund by the Board in FY 11/12. \$6 million will be repaid in FY 16/17 and \$9 million in FY 17/18. If partial payment is made, the remainder will be paid when the fund is nearing its minimum mandated level.
- D. The Financial Information System for California is a direct assessment which reduces the fund balance but is not reflected in the Medical Board of California's state operational budget.
- E. Unscheduled reimbursements result in a net increase in the fund balance.

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

(Dollars in Thousands)

Fund Condition without General Fund Loan Repayments

	ACTUAL 2015-16	CY 2016-17	BY 2017-18	BY+1 2018-19	BY+2 2019-20
BEGINNING BALANCE	\$ 28,087	\$ 27,001	\$ 19,327	\$ 10,779	\$ 758
Prior Year Adjustment	\$ 282	\$ -	\$ -	\$ -	\$ -
Adjusted Beginning Balance	\$ 28,369	\$ 27,001	\$ 19,327	\$ 10,779	\$ 758
REVENUES, TRANSFERS AND OTHER ADJUSTMENTS					
Revenues:					
125600 Other regulatory fees	\$ 385	\$ 388	\$ 388	\$ 388	\$ 388
125700 Other regulatory licenses and permits	\$ 7,388	\$ 7,194	\$ 7,194	\$ 7,194	\$ 7,194
125800 Renewal fees	\$ 48,728	\$ 47,828	\$ 48,799	\$ 48,799	\$ 48,799
125900 Delinquent fees	\$ 124	\$ 136	\$ 136	\$ 136	\$ 136
131700 Miscellaneous revenue from local agencies	\$ 2	\$ -	\$ -	\$ -	\$ -
141200 Sales of documents	\$ 25	\$ 10	\$ 10	\$ 10	\$ 10
142500 Miscellaneous services to the public	\$ -	\$ -	\$ -	\$ -	\$ -
150300 Income from surplus money investments	\$ 139	\$ 52	\$ 53	\$ 53	\$ 53
160400 Sale of fixed assets	\$ -	\$ -	\$ -	\$ -	\$ -
160800 Escheat of unclaimed property	\$ 1	\$ -	\$ -	\$ -	\$ -
161000 Escheat of unclaimed checks and warrants	\$ 23	\$ 10	\$ 10	\$ 10	\$ 10
161400 Miscellaneous revenues	\$ 1	\$ 1	\$ 1	\$ 1	\$ 1
Totals, Revenues	\$ 56,816	\$ 55,619	\$ 56,591	\$ 56,591	\$ 56,591
Transfers and Other Adjustments:					
Proposed GF Loan Repayment (Budget Act of 2008)	\$ -	\$ -	\$ -	\$ -	\$ -
Proposed GF Loan Repayment (Budget Act of 2011)	\$ -	\$ -	\$ -	\$ -	\$ -
TOTALS, REVENUES, TRANSFERS AND OTHER ADJUSTMENTS	\$ 56,816	\$ 55,619	\$ 56,591	\$ 56,591	\$ 56,591
TOTAL RESOURCES	\$ 85,185	\$ 82,620	\$ 75,918	\$ 67,369	\$ 57,349
EXPENDITURES AND EXPENDITURE ADJUSTMENTS					
Expenditures:					
1111 Program Expenditures (State Operations)	\$ 55,516	\$ 59,956	\$ 63,631	\$ 64,921	\$ 64,921
<u>2016-17 and Ongoing Approved Costs</u>					
BreEZe Costs	\$ 2,403	\$ 2,403	\$ -	\$ -	\$ -
BreEZe Costs	\$ 158	\$ -	\$ -	\$ -	\$ -
Staff Augmentation	\$ -	\$ 113	\$ 105	\$ 105	\$ 105
Expert Reviewer	\$ -	\$ 206	\$ 206	\$ 206	\$ 206
Registered Dispensing Opticians	\$ -	\$ (39)	\$ (39)	\$ (39)	\$ (39)
Department of Justice	\$ -	\$ 577	\$ 577	\$ 577	\$ 577
<u>Anticipated Future Costs</u>					
Staff Augmentation - Enforcement	\$ -	\$ -	\$ 206	\$ 206	\$ 206
Staff Augmentation - Licensing	\$ -	\$ -	\$ 339	\$ 279	\$ 279
Implement SB 1177	\$ -	\$ -	\$ 114	\$ 356	\$ 356
BreEZe Costs	\$ -	\$ -	\$ 2,403	\$ 2,403	\$ 2,403
1111 Program Expenditures (State Operations) Subtotal	\$ 58,077	\$ 63,216	\$ 65,139	\$ 66,611	\$ 66,611
Expenditure Adjustments:					
0840 State Controller (State Operations)	\$ -	\$ -	\$ -	\$ -	\$ -
8880 Financial Information System for California (State Operations)	\$ 107	\$ 77	\$ -	\$ -	\$ -
TOTALS, EXPENDITURES AND EXPENDITURE ADJUSTMENTS	\$ 58,184	\$ 63,293	\$ 65,139	\$ 66,611	\$ 66,611
Unscheduled Reimbursements	\$ 900	\$ 900	\$ 900	\$ 900	\$ 900
FUND BALANCE					
Reserve for economic uncertainties	\$ 27,001	\$ 19,327	\$ 10,779	\$ 758	\$ (9,262)
Months in Reserve	5.1	3.6	1.9	0.1	-0.1

NOTES:

- A. Assumes workload and revenue projections are realized for FY 16/17 and beyond.
- B. Interest on fund estimated at .361%.
- C. \$6 million was loaned to the General Fund in FY 08/09 and \$9 million was loaned to the General Fund by the Board in FY 11/12. \$6 million will be repaid in FY 16/17 and \$9 million in FY 17/18. If partial payment is made, the remainder will be paid when the fund is nearing its minimum mandated level.
- D. The Financial Information System for California is a direct assessment which reduces the fund balance but is not reflected in the Medical Board of California's state operational budget.
- E. Unscheduled reimbursements result in a net increase in the fund balance.

Medical Board of California
Fiscal Year 2015-16
Budget Expenditure Report
(As of June 30, 2016)
(100% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	9,446,564	8,575,522	90.8	871,042
Board Members	31,500	98,400	312.4	(66,900)
Temp Help	755,880	161,601	21.4	594,279
BL 12-03 Blanket	0	636,462	0.0	(636,462)
Overtime	44,441	121,923	274.3	(77,482)
Staff Benefits	5,213,036	4,848,471	93.0	364,565
TOTALS, PERS SERVICES	15,491,421	14,442,379	93.2	1,049,042
OPERATING EXP & EQUIP				
Fingerprint Reports	333,448	383,190	114.9	(49,742)
General Expense	204,206	317,733	155.6	(113,527)
Printing	194,755	280,053	143.8	(85,298)
Communications	106,190	131,724	124.0	(25,534)
Postage	149,511	107,036	71.6	42,475
Insurance	2,053	8,056	392.4	(6,003)
Travel In-State	130,298	193,886	148.8	(63,588)
Travel Out-of-State	0	7,361	0.0	(7,361)
Training	54,895	13,569	24.7	41,326
Facilities Operation (Rent)	928,140	1,010,125	108.8	(81,985)
Consult/Prof Services	1,317,088	954,687	72.5	362,401
Departmental Prorata	6,473,849	6,490,970	100.3	(17,121)
HQIU	16,871,000	16,335,960	96.8	535,040
Consolidated Data Center	650,230	224,769	34.6	425,461
Data Processing	117,492	251,269	213.9	(133,777)
Central Admin Svcs (Statewide Prorata)	2,912,000	2,912,283	100.0	(283)
Major Equipment	8,500	0	0.0	8,500
Other Items of Expense	0	0	0.0	0
Vehicle Operations	31,925	25,340	79.4	6,585
Attorney General Services	13,347,280	13,140,243	98.4	207,037
Office of Administrative Hearings	1,750,080	1,515,808	86.6	234,272
Evidence/Witness	1,893,439	1,822,396	96.2	71,043
Court Reporter Services	225,000	251,494	111.8	(26,494)
Minor Equipment	35,200	64,712	183.8	(29,512)
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	47,736,579	46,442,665	97.3	1,293,914
TOTALS, EXPENDITURES	63,228,000	60,885,044	96.3	2,342,956
Scheduled Reimbursements	(384,000)	(397,739)	103.6	13,739
Distributed Costs	(780,000)	(538,978)	69.1	(241,022)
TOTAL, STATE OPERATIONS	62,064,000	59,948,327	96.6	2,115,673
Unscheduled Reimbursements*	0	(1,871,752)		
		58,076,575		

* no authority to spend

Health Quality Investigation Unit (HQIU)
Fiscal Year 2015-16
Budget Expenditure Report
(As of June 30, 2016)
(100% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,177,000	6,544,758	80.0	1,632,242
Temp Help	1,074,000	1,590,266	148.1	(516,266)
Overtime	6,000	34,064	567.7	(28,064)
Staff Benefits	4,644,000	3,942,158	84.9	701,842
BL 12-03 Blanket	0	7,397	0.0	(7,397)
TOTALS, PERS SERVICES	13,901,000	12,118,642	87.2	1,782,358
OPERATING EXP & EQUIP				
General Expense	214,000	293,774	137.3	(79,774)
Printing	69,000	57,282	83.0	11,718
Communications	172,000	122,931	71.5	49,069
Postage	36,000	46,727	129.8	(10,727)
Insurance	38,000	45,099	118.7	(7,099)
Travel In-State	222,000	156,137	70.3	65,863
Travel Out-of-State	7,000	0	0.0	7,000
Training	27,000	27,548	102.0	(548)
Facilities Operation (Rent)	1,574,000	2,052,178	130.4	(478,178)
Consult/Prof Services	91,000	438,015	481.3	(347,015)
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	241,475	1609.8	(226,475)
Data Processing	0	61,401	0.0	(61,401)
Central Admin Svcs (Statewide Prorata)	0	0	0.0	0
Major Equipment	199,000	154,612	77.7	44,388
Other Items of Expense	28,000	96,015	342.9	(68,015)
Vehicle Operations	216,000	215,414	99.7	586
Attorney General Services	0	2,532	0.0	(2,532)
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	46,663	0.0	(46,663)
Court Reporter Services	0	0	0.0	0
Minor Equipment	8,000	153,609	1920.1	(145,609)
Special Items of Expense	0	5,907	0.0	(5,907)
TOTALS, OE&E	2,916,000	4,217,318	144.6	(1,301,318)
TOTALS, EXPENDITURES	16,817,000	16,335,960	97.1	481,040
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	0	0	0.0	0
NET TOTAL, EXPENDITURES	16,817,000	16,335,960	97.1	481,040
Unscheduled Reimbursements*	0	0	0.0	0

* no authority to spend

Medical Board of California
Fiscal Year 2016-17
Budget Expenditure Report
(As of August 31, 2016)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages				
(Staff & Exec Director)	9,605,000	1,416,816	14.8	8,188,184
Board Members	32,000	10,800	33.8	21,200
Temp Help	142,600	13,251	9.3	129,349
BL 12-03 Blanket	613,400	140,683	22.9	472,717
Overtime	44,000	8,927	20.3	35,073
Staff Benefits	5,290,000	829,154	15.7	4,460,846
TOTALS, PERS SERVICES	15,727,000	2,419,630	15.4	13,307,370
OPERATING EXP & EQUIP				
General Expense	82,000	26,548	32.4	55,452
Fingerprint Reports	333,000	0	0.0	333,000
Printing	196,000	35,611	18.2	160,389
Communications	107,000	2,114	2.0	104,886
Postage	151,000	22,259	14.7	128,741
Insurance	2,000	0	0.0	2,000
Travel In-State	131,000	7,789	5.9	123,211
Travel Out-of-State	0	1,203	0.0	(1,203)
Training	57,000	0	0.0	57,000
Facilities Operation (Rent)	932,000	955,376	102.5	(23,376)
Consult/Prof Services	1,581,000	1,014,304	64.2	566,696
Departmental Prorata	6,277,000	1,033,168	16.5	5,243,832
HQIU	17,058,000	3,640,310	21.3	13,417,690
Consolidated Data Center	650,000	11,999	1.8	638,001
Data Processing	117,000	106	0.0	116,894
Central Admin Svcs (Statewide Prorata)	2,993,000	0	0.0	2,993,000
Major Equipment	163,000	0	0.0	163,000
Other Items of Expense	0	0	0.0	0
Vehicle Operations	32,000	751	2.3	31,250
Attorney General Services	13,924,000	2,317,415	16.6	11,606,585
Office of Administrative Hearings	1,750,000	306,032	17.5	1,443,968
Evidence/Witness	1,893,000	125,333	6.6	1,767,667
Court Reporter Services	167,000	12,261	7.3	154,739
Minor Equipment	115,000	9,581	8.3	105,419
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	48,711,000	9,522,160	19.5	39,188,840
TOTALS, EXPENDITURES	64,438,000	11,941,790	18.5	52,496,210
Scheduled Reimbursements	(384,000)	(64,562)	16.8	(319,438)
Distributed Costs	(838,000)	(25,216)	3.0	(812,784)
TOTAL, STATE OPERATIONS	63,216,000	11,852,012	18.7	51,363,988
Unscheduled Reimbursements*	0	(211,472)		
		11,640,539		

* no authority to spend

Medical Board of California
Fiscal Year 2016-17
Budget Expenditure Report - Licensing
(As of August 31, 2016)
 (17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF	UNENCUMBERED BALANCE
			BUDGET EXPEND / ENCUMB	
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	2,761,700	413,879	15.0	2,347,821
Board Members	0	0	0.0	0
Temp Help	38,300	1,380	3.6	36,920
BL 12-03 Blanket	113,200	25,431	22.5	87,769
Overtime	14,400	4,796	33.3	9,604
Staff Benefits	1,488,400	253,704	17.0	1,234,696
TOTALS, PERS SERVICES	4,416,000	699,191	15.8	3,716,809
OPERATING EXP & EQUIP				
General Expense	7,600	1,205	15.8	6,395
Fingerprint Reports	333,000	0	0.0	333,000
Printing	73,000	17,390	23.8	55,610
Communications	19,100	123	0.6	18,977
Postage	82,700	10,124	12.2	72,576
Insurance	0	0	0.0	0
Travel In-State	18,000	390	2.2	17,610
Travel Out-of-State	0	0	0.0	0
Training	18,900	0	0.0	18,900
Facilities Operation (Rent)	271,800	321,749	118.4	(49,949)
Consult/Prof Services	1,122,000	732,929	65.3	389,071
Departmental Prorata	2,055,900	342,702	16.7	1,713,198
HQIU	0	0	0.0	0
Consolidated Data Center	0	0	0.0	0
Data Processing	3,900	0	0.0	3,900
Central Admin Svcs (Statewide Prorata)	980,300	0	0.0	980,300
Major Equipment	0	0	0.0	0
Other Items of Expense	0	0	0.0	0
Vehicle Operations	0	0	0.0	0
Attorney General Services	39,500	11,787	29.8	27,713
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	0	0.0	0
Court Reporter Services	0	0	0.0	0
Minor Equipment	0	0	0.0	0
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	5,025,700	1,438,399	28.6	3,587,301
TOTALS, EXPENDITURES	9,441,700	2,137,589	22.6	7,304,111
Scheduled Reimbursements	(384,000)	(64,562)	16.8	(319,438)
Distributed Costs	(28,000)	0	0.0	(28,000)
TOTAL, STATE OPERATIONS	9,029,700	2,073,027	23.0	6,956,673
Unscheduled Reimbursements*	0	(138)		
		2,072,890		

* no authority to spend

Medical Board of California
Fiscal Year 2016-17
Budget Expenditure Report - Enforcement
(As of August 31, 2016)
 (17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF	
			BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages (Staff & Exec Director)	2,710,600	392,480	14.5	2,318,120
Board Members	0	0	0.0	0
Temp Help	47,500	3,885	8.2	43,615
BL 12-03 Blanket	481,500	111,034	23.1	370,466
Overtime	12,300	457	3.7	11,843
Staff Benefits	1,652,400	249,047	15.1	1,403,353
TOTALS, PERS SERVICES	4,904,300	756,903	15.4	4,147,397
OPERATING EXP & EQUIP				
General Expense	32,600	8,247	25.3	24,353
Fingerprint Reports	0	0	0.0	0
Printing	50,000	10,711	21.4	39,289
Communications	34,800	308	0.9	34,492
Postage	65,100	12,082	18.6	53,018
Insurance	0	0	0.0	0
Travel In-State	43,300	2,781	6.4	40,519
Travel Out-of-State	0	0	0.0	0
Training	15,000	0	0.0	15,000
Facilities Operation (Rent)	246,700	264,179	107.1	(17,479)
Consult/Prof Services	1,000	375	37.5	625
Departmental Prorata	1,758,900	283,914	16.1	1,474,986
HQIU	17,058,000	3,640,310	21.3	13,417,690
Consolidated Data Center	0	0	0.0	0
Data Processing	4,200	98	0.0	4,102
Central Admin Svcs (Statewide Prorata)	838,600	0	0.0	838,600
Major Equipment	0	0	0.0	0
Other Items of Expense	0	0	0.0	0
Vehicle Operations	0	0	0.0	0
Attorney General Services	13,884,500	2,305,628	16.6	11,578,872
Office of Administrative Hearings	1,750,000	306,032	17.5	1,443,968
Evidence/Witness	1,761,800	119,408	6.8	1,642,392
Court Reporter Services	167,000	12,261	7.3	154,739
Minor Equipment	0	0	0.0	0
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	37,711,500	6,966,332	18.5	30,745,168
TOTALS, EXPENDITURES	42,615,800	7,723,235	18.1	34,892,565
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	(800,100)	(25,216)	3.2	(774,884)
TOTAL, STATE OPERATIONS	41,815,700	7,698,019	18.4	34,117,681
Unscheduled Reimbursements*	0	(21,819)		
		7,676,200		

* no authority to spend

Health Quality Investigation Unit (HQIU)
Fiscal Year 2016-17
Budget Expenditure Report
(As of August 31, 2016)
(17% of fiscal year completed)

OBJECT DESCRIPTION	BUDGET ALLOTMENT	EXPENDITURES / ENCUMBRANCES	PERCENT OF BUDGET EXPEND / ENCUMB	UNENCUMBERED BALANCE
PERSONAL SERVICES				
Salary & Wages	8,112,000	1,012,213	12.5	7,099,787
Temp Help	1,074,000	133,523	12.4	940,477
Overtime	6,000	12,188	203.1	(6,188)
Staff Benefits	4,679,000	618,524	13.2	4,060,476
BL 12-03 Blanket	0	7,773	0.0	(7,773)
TOTALS, PERS SERVICES	13,871,000	1,784,220	12.9	12,086,780
OPERATING EXP & EQUIP				
General Expense	214,000	15,563	7.3	198,437
Printing	69,000	100,441	145.6	(31,441)
Communications	172,000	12,112	7.0	159,888
Postage	36,000	5,093	14.1	30,907
Insurance	38,000	0	0.0	38,000
Travel In-State	222,000	1,843	0.8	220,157
Travel Out-of-State	7,000	0	0.0	7,000
Training	27,000	7,378	27.3	19,622
Facilities Operation (Rent)	1,574,000	1,388,855	88.2	185,145
Consult/Prof Services	91,000	32,283	35.5	58,717
Departmental Prorata	0	0	0.0	0
Consolidated Data Center	15,000	19,646	131.0	(4,646)
Data Processing	0	3,403	0.0	(3,403)
Central Admin Svcs (Statewide Prorata)	0	0	0.0	0
Major Equipment	363,000	0	0.0	363,000
Other Items of Expense	28,000	24,681	88.1	3,319
Vehicle Operations	216,000	21,239	9.8	194,761
Attorney General Services	0	0	0.0	0
Office of Administrative Hearings	0	0	0.0	0
Evidence/Witness	0	0	0.0	0
Court Reporter Services	0	218,356	0.0	(218,356)
Minor Equipment	115,000	5,196	4.5	109,804
Special Items of Expense	0	0	0.0	0
TOTALS, OE&E	3,187,000	1,856,090	58.2	1,330,910
TOTALS, EXPENDITURES	17,058,000	3,640,310	21.3	13,417,690
Scheduled Reimbursements	0	0	0.0	0
Distributed Costs	0	0	0.0	0
NET TOTAL, EXPENDITURES	17,058,000	3,640,310	21.3	13,417,690
Unscheduled Reimbursements*	0	0	0.0	0

* no authority to spend

**MEDICAL BOARD OF CALIFORNIA
 ATTORNEY GENERAL EXPENDITURES - FY 2016-17
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)**

Page 1 of 2

		<u>Number of Hours</u>	<u>Rate</u>	<u>Amount</u>
July	Attorney Services	5863.00	\$170.00	\$996,710.00
	Paralegal Services	300.25	\$120.00	\$36,030.00
	Auditor/Analyst Services	171.50	\$99.00	\$16,978.50
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$1,049,718.50
August	Attorney Services	7021.00	\$170.00	\$1,193,570.00
	Paralegal Services	278.50	\$120.00	\$33,420.00
	Auditor/Analyst Services	271.50	\$99.00	\$26,878.50
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$1,828.35
				<hr/>
				\$1,255,696.85
September	Attorney Services	1.25	\$170.00	\$212.50
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$212.50
October	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
November	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00
December	Attorney Services	0.00	\$170.00	\$0.00
	Paralegal Services	0.00	\$120.00	\$0.00
	Auditor/Analyst Services	0.00	\$99.00	\$0.00
	Special Agent	0.00	\$120.00	\$0.00
	Cost of Suit			\$0.00
				<hr/>
				\$0.00

Total July-Dec = \$2,305,627.85
FY 2016-17 Budget = \$13,347,280.00
 BRD 7A - 12

**MEDICAL BOARD OF CALIFORNIA
 ATTORNEY GENERAL EXPENDITURES - FY 2016-17
 DOJ AGENCY CODE 003573 - ENFORCEMENT (6303)**

page 2 of 2

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

FYTD Total = \$2,305,627.85
FY 2016-17 Budget = \$13,347,280.00

ENFORCEMENT/PROBATION RECEIPTS													
MONTHLY PROFILE: JULY 2014 - JUNE 2017													
	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	FYTD Total
Invest Cost Recovery	0	50	50	850	0	850	800	500	100	50	1,963	600	5,813
Criminal Cost Recovery	844	29,175	4,060	13,683	15,041	1,185	1,133	6,184	1,499	7,009	1,194	3,284	84,291
Probation Monitoring	64,316	41,643	52,840	73,499	56,938	146,603	414,557	227,809	117,226	60,897	46,859	47,974	1,351,161
Exam	9,061	3,048	7,438	13,718	26,715	8,551	13,313	7,060	6,755	8,796	3,273	600	108,328
Cite/Fine	3,000	3,000	1,000	5,000	0	0	0	0	2,500	0	0	2,500	17,000
MONTHLY TOTAL	77,221	76,916	65,388	106,750	98,694	157,189	429,803	241,553	128,080	76,752	53,289	54,958	1,566,593
FYTD TOTAL	77,221	154,137	219,525	326,275	424,969	582,158	1,011,961	1,253,514	1,381,594	1,458,346	1,511,635	1,566,593	
	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16	FYTD Total
Invest Cost Recovery	50	50	50	50	0	100	0	50	100	0	100	50	600
Criminal Cost Recovery	451	4,851	7,581	1,100	1,400	2,400	3,188	4,607	551	4,789	551	27,916	59,385
Probation Monitoring	74,221	54,139	42,860	44,930	62,069	102,916	359,823	222,613	91,728	64,230	68,510	46,889	1,234,928
Exam	9,593	5,778	1,922	16,948	5,721	11,506	10,926	16,650	6,225	10,617	8,165	8,705	112,756
Cite/Fine	0	0	0	0	0	0	2,500	700	5,000	2,850	1,050	6,850	18,950
MONTHLY TOTAL	84,315	64,818	52,413	63,028	69,190	116,922	376,437	244,620	103,604	82,486	78,376	90,410	1,426,619
FYTD TOTAL	84,315	149,133	201,546	264,574	333,764	450,686	827,123	1,071,743	1,175,347	1,257,833	1,336,209	1,426,619	
	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17	Jun-17	FYTD Total
Invest Cost Recovery	0	100											100
Criminal Cost Recovery	181	6,225											6,406
Probation Monitoring	57,451	50,482											107,933
Exam	5,087	7,610											12,697
Cite/Fine	3,500	1,400											4,900
MONTHLY TOTAL	66,219	65,817	0	0	0	0	0	0	0	0	0	0	132,036
FYTD TOTAL	66,219	132,036	132,036	132,036	132,036	132,036	132,036	132,036	132,036	132,036	132,036	132,036	

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

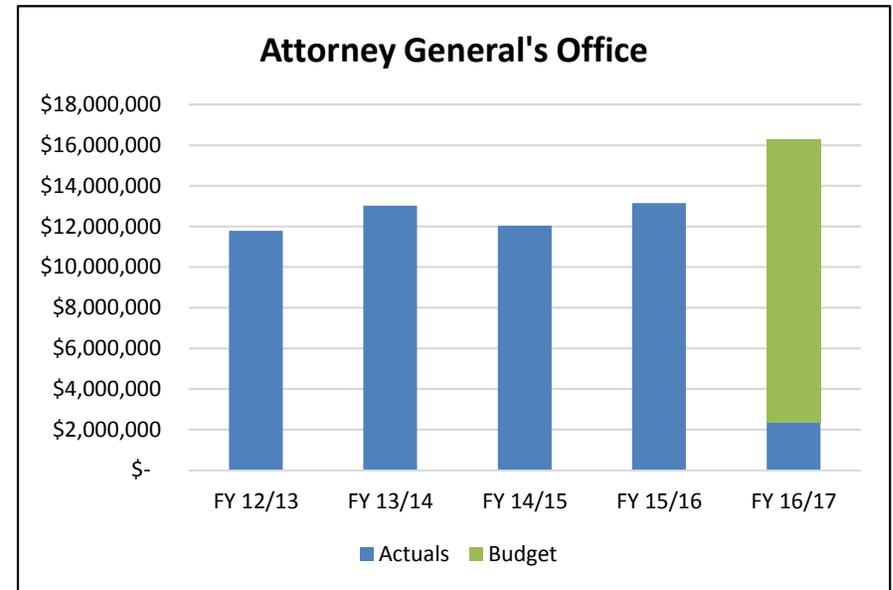
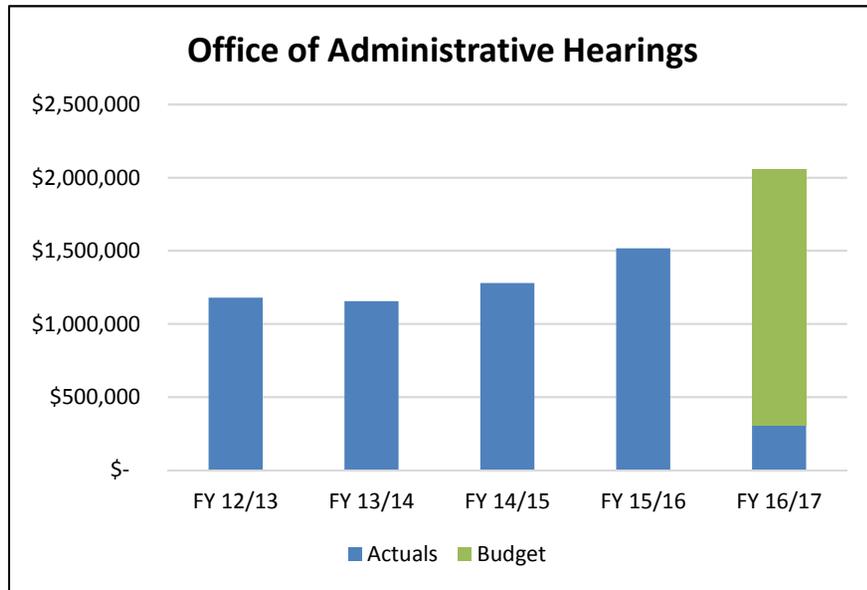
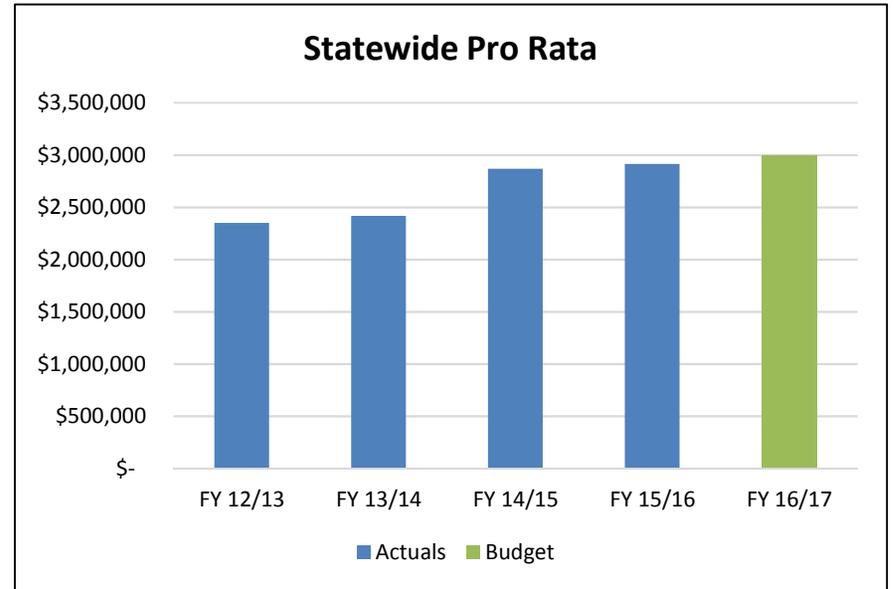
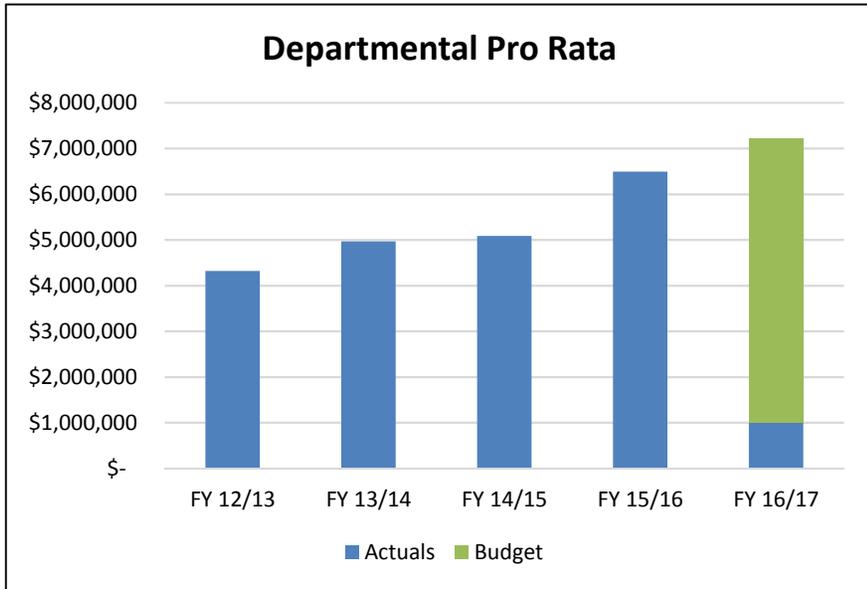
MEDICAL BOARD OF CALIFORNIA BUDGET OVERVIEW BY BOARD COMPONENT

	EXEC	ENFORCE	OPERATION SAFE MEDICINE	LICENSING	ADMIN SERVICES	INFO SYSTEMS	PROBATION MONITORING	BOARD TOTAL
FY 13/14								
\$ Budgeted	2,304,466	40,127,776	716,147	8,386,914	1,833,855	3,363,720	2,281,227	59,014,105
\$ Spent*	1,427,599	40,148,898	879,418	6,023,718	1,650,434	3,166,541	1,424,973	54,721,581 *
Positions Authorized	8.8	147.0	6.0	53.3	14.0	17.0	25.0	271.1
FY 14/15								
\$ Budgeted	1,909,018	45,230,270		6,502,878	1,576,586	3,154,922	2,065,009	60,438,683
\$ Spent*	1,517,922	40,108,425		8,845,645	1,413,056	2,745,722	2,276,725	56,907,495 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1
FY 15/16								
\$ Budgeted	2,000,070	41,624,123		8,551,071	2,312,598	3,969,970	3,606,168	62,064,000
\$ Spent*	2,027,741	40,082,824		8,855,159	2,298,695	3,309,798	3,374,110	59,948,327 *
Positions Authorized	8.0	44.0		53.1	14.0	17.0	24.0	160.1
FY 16/17								
\$ Budgeted **	2,510,400	41,815,700		9,029,700	2,398,300	3,942,900	3,519,000	63,216,000
\$ Spent thru 8/31*	668,984	7,698,019		2,073,027	412,576	497,836	501,570	11,852,012 *
Positions Authorized	8.0	45.0		52.6	14.0	17.0	24.0	160.6

* net expenditures (excludes unscheduled reimbursements)

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

External Agencies' Spending



FY 16/17 actual expenditures through 8/31/16

NAMES	JULY	AUG	SEPT	OCT	NOV	DEC	JAN	FEB	MAR	APRIL	MAY	JUNE	YTD
DR. BHOLAT - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Bholat	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. BISHOP - Per diem	\$ 900	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 900
Travel	\$ 848	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 848
Total-Dr. Bishop	\$ 1,748	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,748
JUDGE FEINSTEIN - Per diem	\$ 1,300	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,100
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Judge Feinstein	\$ 1,300	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,100
DR. GNANADEV - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Gnanadev	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. HAWKINS - Per diem	\$ 2,100	\$ 1,800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,900
Travel	\$ 1,010	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,010
Total-Dr. Hawkins	\$ 3,110	\$ 1,800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,910
DR. KRAUSS - Per diem	\$ 1,100	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,100
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Krauss	\$ 1,100	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,100
MS. LAWSON - Per diem	\$ 900	\$ 700	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,600
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms. Lawson	\$ 900	\$ 700	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,600
DR. LEVINE - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Levine	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. LEWIS - Per diem	\$ 900	\$ 700	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,600
Travel	\$ 2,535	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,535
Total-Dr. Lewis	\$ 3,435	\$ 700	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 4,135
MS. PINES - Per diem	\$ 600	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,600
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms. Pines	\$ 600	\$ 1,000	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,600
MR. SERRANO SEWELL- Per diem	\$ 300	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 300
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Mr. Serrano Sewell	\$ 300	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 300
MS. SUTTON-WILLS - Per diem	\$ 1,500.00	\$ 1,500.00	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,000
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms. Sutton-Wills	\$ 1,500	\$ 1,500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 3,000
MR. WARMOTH - Per diem	\$ 900	\$ 500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,400
Travel	\$ 1,075	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 1,075
Total-Mr. Warmoth	\$ 1,975	\$ 500	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,475
MS. WRIGHT - Per diem	\$ 1,200	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,000
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms. Wright	\$ 1,200	\$ 800	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ 2,000
MS. YAROSLAVSKY - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Ms. Yaroslavsky	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
DR. YIP - Per diem	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Travel	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
Total-Dr. Yip	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -

As of: 9/26/16

TOTAL PER DIEM BUDGETED \$ 32,000
TOTAL PER DIEM \$ 19,500
TOTAL TRAVEL \$ 5,467
TOTAL \$ 24,967

[REDACTED]
 Santa Rosa, CA
 License Surrendered
 March 18, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=81587>

[REDACTED]
 Decatur, GA
 License Revoked
 February 12, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=93821>

[REDACTED]
 Hercules, CA
 License Surrendered
 March 11, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=34612>

[REDACTED]
 Santa Monica, CA
 Revoked, stayed, placed on 3 years' probation with terms and conditions
 April 8, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=34474>

[REDACTED]
 San Diego, CA
 Public Reprimand
 April 8, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=89937>

[REDACTED]
 Cerritos, CA
 Revoked, stayed, placed on 3 years' probation with terms and conditions
 March 11, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=30411>

[REDACTED]
 Poway, CA
 Public Reprimand
 April 18, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=127144>

[REDACTED]
 Santa Barbara, CA
 Public Letter of Reprimand issued pursuant to Business and Professions Code section 2233
 February 29, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=69796>

[REDACTED]
 Carlsbad, CA
 Public Letter of Reprimand issued pursuant to Business and Professions Code section 2233
 March 15, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=C&licenseNumber=53195>

[REDACTED]
 Vancouver, WA
 License Revoked
 March 18, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=68294>

[REDACTED]
 San Diego, CA
 License Revoked
 February 12, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=G&licenseNumber=45636>

[REDACTED]
 Chatsworth, CA
 Public Reprimand
 February 5, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=C&licenseNumber=42572>

[REDACTED]
 San Diego, CA
 License Revoked
 March 11, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=34709>

[REDACTED]
 San Diego, CA
 Revoked, stayed, placed on 5 years' probation with terms and conditions including a condition precedent to the practice of medicine
 April 28, 2016
<http://www2.mbc.ca.gov/BreezePDL/default.aspx?licenseType=A&licenseNumber=95063>

- Convicted of DUI. Attempted to overpower an officer during arrest and refused to take a breath or blood test.
- Attempted to steal merchandise from a grocery store and was charged with one count of Second Degree Commercial Burglary.
- Committed dishonest acts in completing an application for hospital privileges and making material representations and omissions relating to the reasons for a leave of absence from a training program, disciplinary action at a facility, the circumstances related to leaving that facility, and ongoing monitoring.
- Committed sexual misconduct against a patient who was a minor.
- Convicted of 92 counts related to the unlawful dispensation of Schedule II, III, and IV controlled substances and money laundering in transactions over \$10,000.
- Convicted of a felony count of unlawfully obtaining and attempting to obtain and procure controlled substances and a felony count of unlawfully entering a building with the intent to commit a felony. Also, took the prescription pad of a nurse practitioner, an employee, forged the nurse practitioner's signature and wrote two prescriptions for hydrocodone for personal use.
- Convicted of crimes involving prescribing oxycodone to persons without a legitimate medical purpose.
- Convicted of driving with a blood alcohol content (BAC) of 0.08 percent or more.
- Convicted of one felony count of Conspiracy to Engage in Health Care Fraud, 10 felony counts of Health Care Fraud and Aiding and Abetting Health Care Fraud and one felony count of Conspiracy to Solicit and Receive Kickbacks Involving a Federal Health Care Program for submitting more than \$2,400,000 in fraudulent claims to Medicare for power wheelchairs for Medicare beneficiaries who did not need them.
- Convicted of possession of a controlled substance in 2014 and battery and possession of methamphetamine in 2015.
- Convicted of three felony counts of forcible sexual penetration, one felony count of sexual exploitation of a patient and must register as a sex offender.
- Delayed going to the hospital to deliver a baby which resulted in the death of the infant.
- Delayed signing a medical chart until almost four months after the initial visit and failed to diagnose acute cholecystitis.
- Demonstrated a lack of knowledge and skill in failing to identify the hip fracture in an elderly patient, failing to recognize the poor image quality of the x-rays and not ordering a new x-ray or other test, such as CT or MRI exam, and relying on a personal laptop computer not properly certified for use in teleradiology.
- Departed from the standard of care in the treatment of several chronic pain patients.
- Disciplined by another state for an alleged delay in the treatment of a patient resulting in permanent brain damage.
- Disciplined by another state for a Class 1 misdemeanor conviction of DWI.
- Disciplined by another state based on a conviction of reckless driving and failing to report the conviction on the license renewal application.
- Disciplined by another state based on a felony conviction of unlawful surveillance.
- Disciplined by another state based on a felony conviction of aiding and abetting the unauthorized practice of medicine and submitting a dishonest response on his medical license renewal application regarding the criminal charges that were pending.
- Disciplined by another state based on findings the physician is unable to engage in a clinical practice due to being diagnosed with Parkinson's disease.
- Disciplined by another state based on the denial of a license in a different state for omitting and/or misrepresenting information about past discipline in other states.
- Disciplined by another state due to concerns of substance abuse, a history of arrests, and mental/physical impairment.
- Disciplined by another state for dispensing numerous tablets of Vicodin under the Drug Enforcement Agency (DEA) registration of another health care provider who was under the contract with the same dispensing management company and from a location that was not registered with the DEA or state board.
- Disciplined by another state for engaging in a sexual relationship with a patient while prescribing and administering narcotics to the patient.
- Disciplined by another state for excessively or inappropriately prescribing controlled substances to known drug addicts, at least one of whom died of a drug overdose, and self-prescribing multiple Schedule III controlled substances.
- Disciplined by another state for failing to adequately review a patient's records and test results prior to recommending spinal anesthesia and communicating the anesthesia plan to a colleague during the transfer of a patient's care.
- Disciplined by another state for failing to diagnose compartment syndrome in an emergency room patient.

San Diego, CA

Stipulated Decision. No admissions but charged with repeated negligent acts and failure to maintain adequate and accurate medical records in the care and treatment of three ophthalmology patients, convicted of two misdemeanors for driving under the influence of alcohol, battery, and violating state laws regulating drugs in that he made, created, and signed a fraudulent prescription. Revoked, stayed, placed on 3 years probation with terms and conditions including, but not limited to, completing an educational course, a prescribing practices course, a medical record keeping course, an ethics course, and a clinical training program. November 23, 2011

San Jose, CA

Public Letter of Reprimand issued pursuant to Business and Professions Code Section 2233 for failing to document the standard indications for placement of an Implantable Cardioverter-Defibrillator device in a 54 year old patient and failed to maintain completed records of ICD follow-up visits. Public Letter of Reprimand. November 29, 2011

Default Decision. Disciplined by Texas for prescribing medication, including controlled substances, to a patient with a 30 year history of pain, without adequate examination and indication. Revoked. December 1, 2011

, San Diego, CA

Committed repeated negligent acts in the care and treatment of three radiation therapy patients. Public Reprimand. November 18, 2011

Foothill Ranch, CA

Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts, incompetence and failure to maintain adequate and accurate medical records in his care and treatment of a patient for failing to recognize symptoms of a cervical esophageal or hypopharyngeal perforation, failing to refer the patient for emergency treatment, and failing to adequately interpret x-rays. Revoked, stayed, placed on 5 years probation with terms and

conditions including, but not limited to, completing an educational course, a medical record keeping course, a clinical training program, obtaining a practice monitor, and restricted from performing any gastroenterological procedure until he has successfully completed a clinical training program. November 18, 2011

Albuquerque, NM

Disciplined by New Mexico for failing to maintain timely, accurate, legible and complete medical records. Physician must complete a prescribing practices course. Public Reprimand. November 18, 2011

San Dimas, CA

Stipulated Decision. No admissions but charged with gross negligence, repeated negligent acts and failure to maintain adequate and accurate medical records in providing anesthetic care to two patients. Surrender of License. November 11, 2011

Long Beach, CA

Public Letter of Reprimand issued pursuant to Business and Professions Code Section 2233. Disciplined by Colorado for failing to adequately interpret a CT angiogram for a patient who reported to the emergency room with complaints of chest pain and shortness of breath. The patient was discharged from the emergency room and died from a pulmonary embolism after his discharge. November 3, 2011

Albany, GA

Stipulated Decision. Disciplined by Georgia for failing to conform to the minimal standards of an acceptable and prevailing medical practice when he performed a bilateral subpectoral MP memory gel breast augmentation on a 30-year old female patient, failed to have appropriate assistance during the surgical procedure, failed to prepare accurate consent forms and failed to maintain accurate medical records. Physician must complete a medical record keeping course and an educational course of 8 hours relating to providing/obtaining/documenting informed consent. Public Reprimand. January 13, 2012

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 12, 2016
 ATTENTION: Members, Medical Board of California
 SUBJECT: Enforcement Program Summary
 STAFF CONTACT: Christina Delp, Chief of Enforcement

Requested Action:

This report is intended to provide the Members with an update on the Enforcement Program at the Medical Board of California (Board). No action is needed at this time.

Expert Reviewer Program:

There are currently 1091 active experts in the Board's expert database. 228 experts were utilized to review 389 cases from January 1, 2016 through September 30, 2016. **Attachment A** provides the Expert Reviewer Program statistics. Additional experts are needed in the following specialties:

- Addiction Medicine with additional certification in Family or Internal Medicine, or Psychiatry
- Colon and Rectal Surgery
- Dermatology
- Family Medicine
- Midwives
- Neurological Surgery
- Neurology
- Pathology
- Pain Medicine
- Pediatric Surgery
- Pediatric Cardiac Surgery
- Pediatric Pulmonology
- Psychiatry (general and addiction)
- Surgery
- Urology
- Vascular Surgery

Since the July Board Meeting, the Expert Reviewer Program finalized details to conduct two Expert Reviewer training sessions. Training was held on October 8, 2016, at University of California San Francisco. Forty-three participants attended this training (33 physicians and surgeons, 2 osteopathic physicians, and 3 podiatrists). The agenda included speakers from the Board, the Health Quality Investigation Unit, the Health Quality Enforcement Section of the Attorney General's Office, defense counsel and a retired administrative law judge (ALJ). Training at the University of California Los Angeles will be held on November 5, 2016, and there are 65 individuals registered to attend this event.

Staff began recruitment efforts according to the plan that was presented to the Board at the July Meeting. Staff is on track to complete Phase I of the recruitment plan by the end of Fall and staff will present a formal update regarding its recruitment efforts at the next Enforcement Committee meeting.

Office of Administrative Hearing Training

At the July Board meeting, the Enforcement Committee heard a report that training with ALJs from the Office of Administrative Hearing (OAH) was going to resume in Fall. On September 30, 2016, the ALJs

received emergency medicine training. According to OAH Presiding Judge Alvord, “the ALJs were unanimously pleased with the depth and breadth of material covered and loved the presentation.” Two more training sessions are scheduled to take place on October 28 and November 18, 2016, and the training will focus on co-morbid conditions, physician impairment, and how fitness for duty evaluations can measure impaired physicians.

Central Complaint Unit:

Staff in the Central Complaint Unit (CCU) continues to focus all efforts on reducing initiation and complaint processing timeframes, and improving efficiency.

CCU intake staff reduced the complaint initiation timeframe to an average of 11 days for the first quarter of fiscal year 2016/2017. While still one day over the timeframe mandated by Business and Professions Code section 129(b), CCU management is confident this number will be within the statutory timeframe as soon as newly hired staff becomes more proficient in performing the job duties.

The average time to process a complaint is currently 154 days. In August and September all CCU managers conducted case reviews with their individual staff persons to review pending caseloads and provide guidance regarding any issues staff may have encountered that could be delaying timely completion of their work. Management has also instituted weekly statistical reporting to ensure all aspects of each analyst’s caseload, i.e., new complaints, pending complaints, and the drafting of closing letters, is receiving adequate attention. Gathering these statistics will also enable the CCU managers to determine the number of complaints being received by case type in each geographical region to ensure even distribution of caseloads.

A new management services technician began work on July 18, 2016, and is currently being trained on complaint initiation and processing of medical malpractice reports. CCU elected not to move forward with a limited term staff services analyst (SSA) for the Medical Consultant Program as the previous incumbent returned to work on September 12, 2016. The employee has received refresher training on the process for referring complaints for medical consultant review and has been instructed on new policies and procedures implemented during her absence. Also, a new associate governmental program analyst (AGPA) will report to work on October 17, 2016. This employee will be responsible for the review and analysis of adverse event reports from accredited outpatient surgery settings, and other mandatory reporting involving patient transfers and patient deaths occurring in outpatient surgery settings. The CCU currently has one vacant office technician position. This vacancy has been advertised and recruitment efforts are underway. Interviews are expected to be scheduled by the end of October and the position filled by the first of December.

Discipline Coordination Unit:

Staff in the Discipline Coordination Unit (DCU) continues to focus their efforts on restoring public disciplinary documents to the Board’s website to ensure compliance with Assembly Bill 1886. Since the enforcement summary provided at the July 2016 Board meeting, a retired annuitant and two student assistants continue to make progress on restoring the documents to the website.

The DCU has two vacant positions: an SSA and an AGPA. Both positions were advertised and interviews were held in September. Two job offers were made and are pending hire clearance.

Complaint Investigation Office:

The Complaint Investigation Office (CIO) non-sworn special investigators continue to monitor a case load of approximately 51 cases. Since the last enforcement summary provided at the July 2016 Board meeting, CIO has closed 78 cases and has transmitted 25 cases to the Attorney General’s Office – 2 malpractice, 9 criminal/conviction cases, 2 petitions for reinstatement of licensure, and 12 petitions for early termination/modification of probation.

CIO’s average case processing timeframe to process each case type is as follows: reinstatement is 291 days, sub-arrest convictions is 193-days, mandated settlement reports are 358-days, and petitions for early termination is 143 days. Management is evaluating case procedures with the goal of reducing overall processing timeframes.

The petitions for modification and/or early termination of probation requests were redirected back to the Probation Unit effective June 1, 2016, now that the Probation Unit has filled its vacant analyst position. The CIO is fully staffed.

Probation Unit:

Effective July 1, 2016, the Probation Unit implemented two new performance measures (PM); PM07 and PM08. PMs are statistical measures that are reported to the Department of Consumer Affairs and are intended to capture how long it takes staff to complete workload activities. PM07 and PM08 are specific to probation. PM07 will capture the timeframe of when a probation inspector is assigned a case to when the inspector makes the initial telephone call to the probationer to set up the face-to-face intake interview.

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

During the first quarter of fiscal year 2016/2017, 13 Cease Practice Orders have been issued. This demonstrates the efforts of staff to take swift action to address violations of probation. Additionally, during this same reporting period, 10 petitions to revoke probation or accusations/petitions to revoke probation have been filed.

	Fiscal Year 14/15	Fiscal Year 15/16	Fiscal Year 16/17 (July 1-September 30)
Cease Practice Orders	9	14	13
PTR/Accusation and PTR	21	34	10

The Probation Unit filled one vacant inspector position in September. A tentative job offer was made to fill the vacant inspector position in the San Dimas Office however, the candidate unfortunately declined. The position has been re-advertised and the Enforcement Program anticipates hiring interviews will be conducted in November. In addition, two inspector supervisors have been out on extended leave since the beginning of the year and their anticipated return is unknown; for the time being, the probation managers have resumed the responsibilities carried out by the supervisors.

The petitions for modification and/or early termination of probation requests were redirected back to the Probation Unit effective June 1, 2016. Since June 1, 2016, three petitions for early termination were transmitted to the Attorney General’s Office.

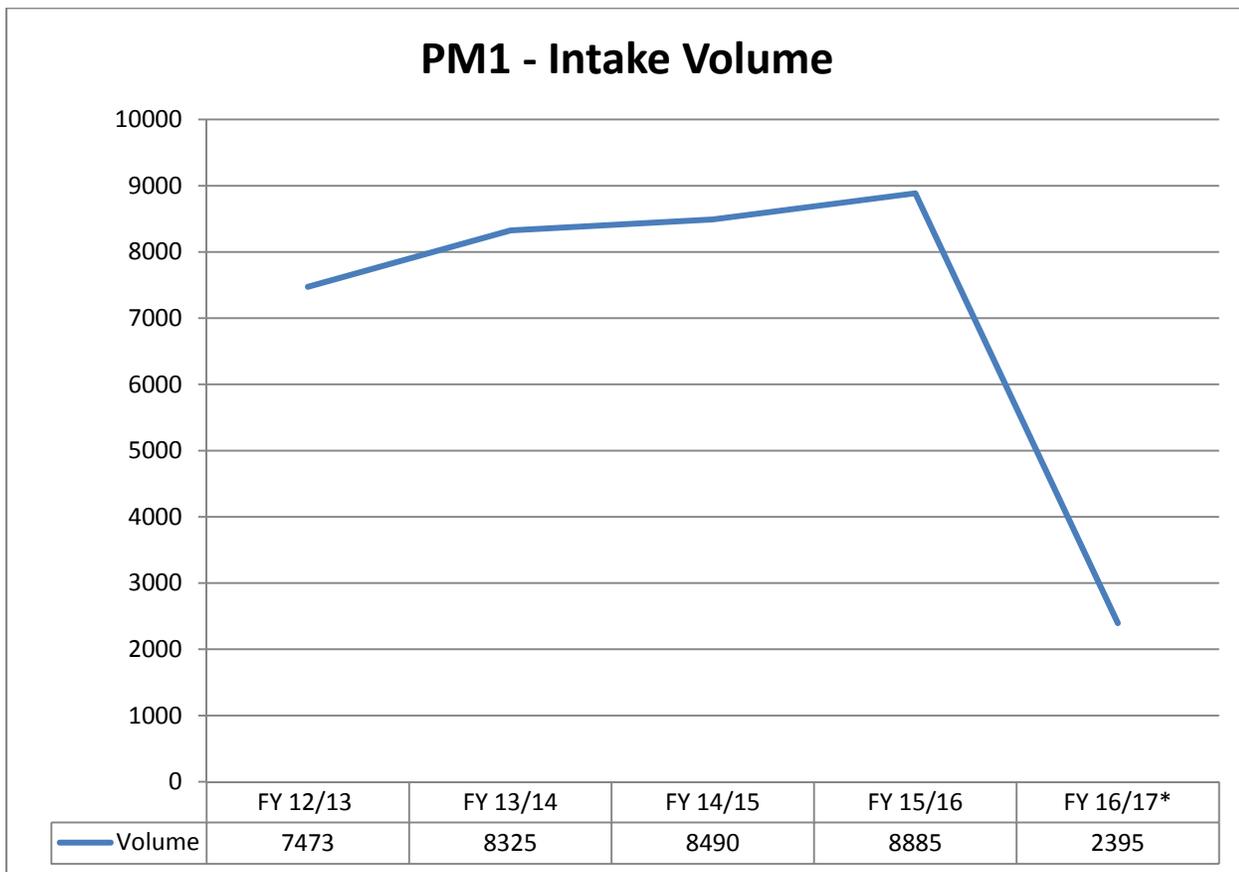
Executive Office Analyst

The Board received approval to reclassify the executive assistant position that reported to the chief of enforcement and to the chief of legislation to an SSA position. This position will assist the chiefs with performing research to identify and develop recommendations for process improvements and will be the Board’s regulation coordinator. Interviews were conducted and a tentative offer was made pending background clearance.

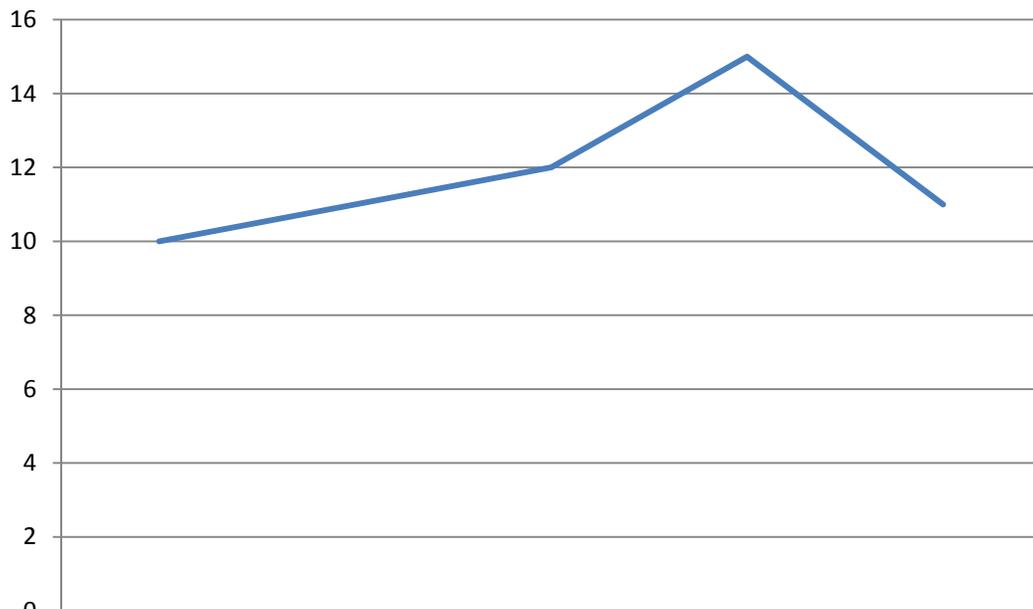
Enforcement Performance Measures

The charts below depict workload statistics regarding the number of complaints received (PM 1, which includes complaints and arrest notifications), processing times to initiate a complaint and assign to a desk analyst (PM 2), complete an investigation (PM 3), and the average number of days it takes to complete a case that has been transmitted to the Attorney General’s Office for disciplinary action (PM 4).

*The FY 16/17 numbers are only for the first quarter, July 1, 2016 to September 30, 2016.

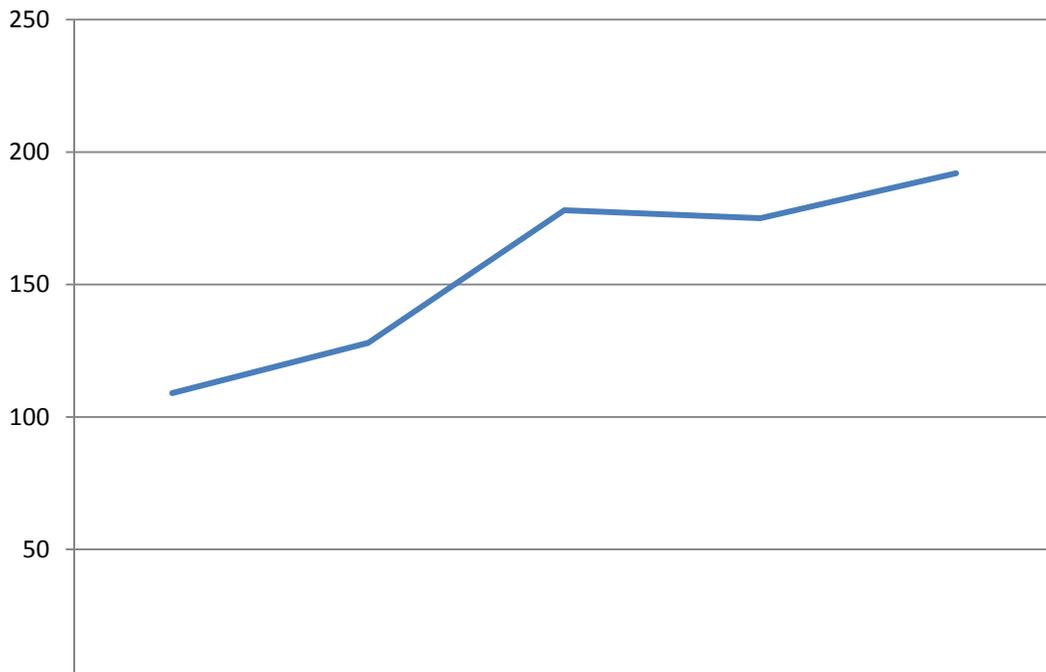


PM2 - Intake Cycle Time

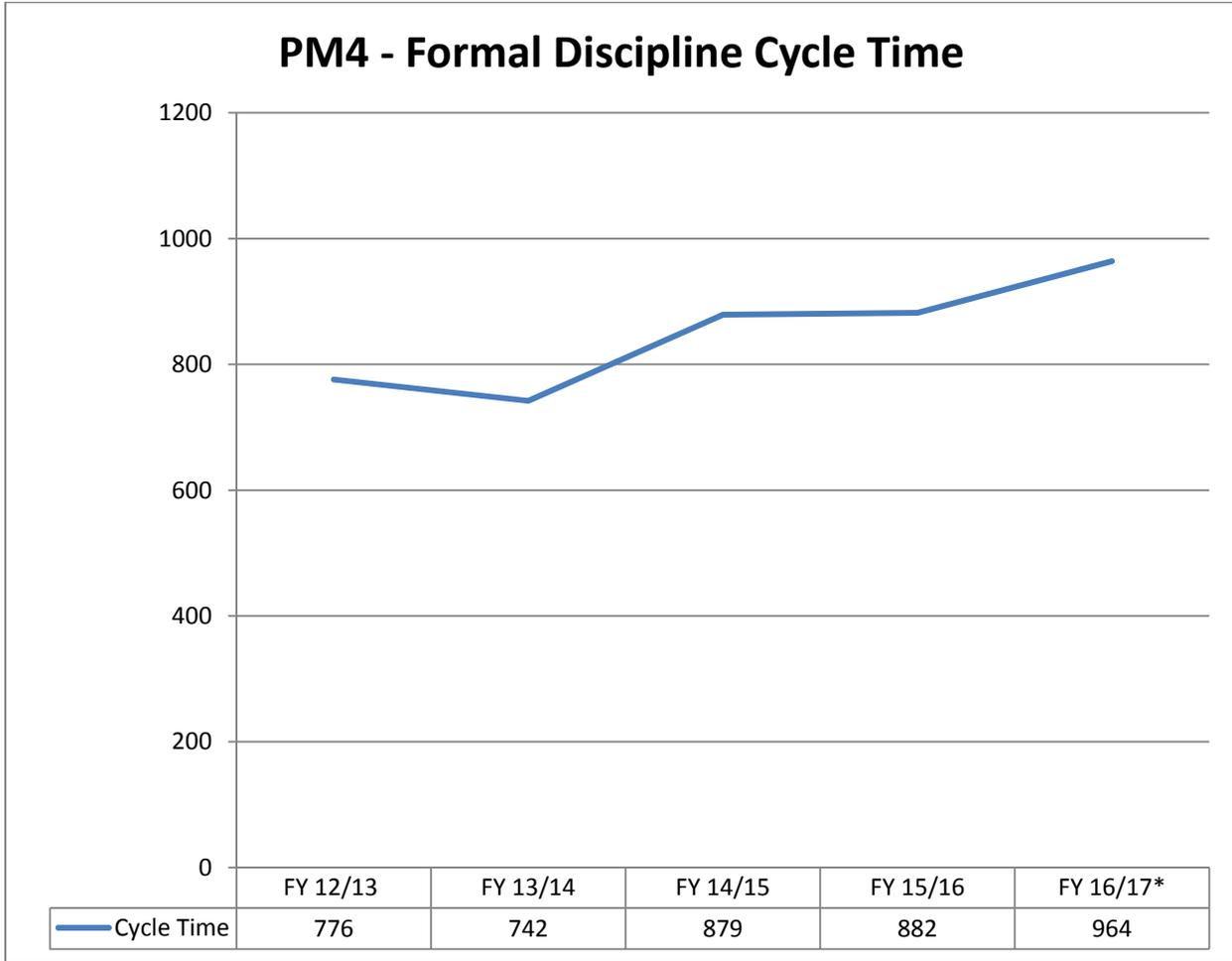


	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17*
Cycle Time	10	11	12	15	11

PM3 - Intake and Investigation Cycle Time



	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17*
Cycle Time	109	128	178	175	192



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

Attachment A

October 1, 2016

SPECIALTY	Number of Cases reviewed by Experts January 1 through September 30, 2016	Number of Experts and how often Utilized from January 1 through September 30, 2016	Active List Experts 1,091 ↑
<i>ADDICTION</i>	8	3 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 5 CASES	11
ALLERGY & IMMUNOLOGY (A&I)			3
ANESTHESIOLOGY (Anes)	7	5 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	76 ↓
COLON & RECTAL SURGERY (CRS)	5	2 EXPERTS 1 LIST EXPERT REVIEWED 2 CASES 1 LIST EXPERT REVIEWED 3 CASES	2
<i>COMPLEMENTARY/ALTERNATIVE MEDICINE</i>	5	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 3 CASES	17
DERMATOLOGY (D)	3	2 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	11 ↓
EMERGENCY (EM)	6	6 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH	44 ↓
FAMILY (FM)	75	27 EXPERTS 11 LIST EXPERTS REVIEWED 1 CASE EACH 6 LIST EXPERTS REVIEWED 2 CASES EACH 4 LIST EXPERTS REVIEWED 3 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES 2 LIST EXPERTS REVIEWED 5 CASES EACH 2 LIST EXPERTS REVIEWED 6 CASES EACH 1 LIST EXPERT REVIEWED 15 CASES	59 ↓
<i>HAND SURGERY</i>			11
<i>HOSPICE & PALLIATIVE MEDICINE</i>			14
INTERNAL (General Internal Med)	62	42 EXPERTS 29 LIST EXPERTS REVIEWED 1 CASE EACH 6 LIST EXPERTS REVIEWED 2 CASES EACH 6 LIST EXPERTS REVIEWED 3 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES	154
Cardiovascular Disease (Cv)	5	5 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EACH	31 ↓
Endocrinology, Diabetes and Metabolism (EDM)	1	1 EXPERT 1 LIST EXPERT	6
Gastroenterology (Ge)		4 EXPERTS	

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

Attachment A

October 1, 2016

SPECIALTY	Number of Cases reviewed by Experts January 1 through September 30, 2016	Number of Experts and how often Utilized from January 1 through September 30, 2016	Active List Experts 1,091 ↑
	5	3 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	19
Infectious Disease (Inf)			8
Medical Oncology (Onc)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	11
Nephrology (Nep)	2	2 EXPERTS 2 LIST EXPERT	11
Pulmonary Disease (Pul)			16
Rheumatology (Rhu)			6
MIDWIFE REVIEWER	2	1 EXPERT 1 LIST EXPERT REVIEWED 2 CASES	4
NEUROLOGICAL SURGERY (NS)	4	3 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	10
NEUROLOGY (N)	9	9 EXPERTS 9 LIST EXPERTS REVIEWED 1 CASE EACH	19 ↓
NEUROLOGY with Special Qualifications in Child Neurology (N/ChiN)			2
NUCLEAR MEDICINE (NuM)			4
OBSTETRICS & GYNECOLOGY (ObG)	23	14 EXPERTS 8 LIST EXPERTS REVIEWED 1 CASE EACH 3 LIST EXPERTS REVIEWED 2 CASES EACH 2 LIST EXPERTS REVIEWED 3 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES	70 ↑
OCCUPATIONAL MEDICINE	1	1 EXPERT 1 LIST EXPERT	8
OPHTHALMOLOGY (Oph)	4	2 EXPERTS 2 LIST EXPERTS REVIEWED 2 CASES EACH	26 ↓
ORTHOPAEDIC SURGERY (OrS)	12	9 EXPERTS 8 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 4 CASES	29 ↓
OTOLARYNGOLOGY (Oto)	1	1 EXPERT 1 LIST EXPERT	18

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

Attachment A

October 1, 2016

SPECIALTY	Number of Cases reviewed by Experts January 1 through September 30, 2016	Number of Experts and how often Utilized from January 1 through September 30, 2016	Active List Experts 1,091 ↑
PAIN MEDICINE (PM)	35	14 EXPERTS 7 LIST EXPERTS REVIEWED 1 CASE EACH 3 LIST EXPERTS REVIEWED 3 CASES EACH 2 LIST EXPERTS REVIEWED 4 CASES EACH 1 LIST EXPERT REVIEWED 5 CASES 1 LIST EXPERT REVIEWED 6 CASES	23 ↓
PATHOLOGY (Path)	2	2 EXPERTS 2 LIST EXPERTS REVIEWED 1 CASE EACH	11
PEDIATRICS (Ped)	5	5 EXPERTS 4 LIST EXPERTS REVIEWED 1 CASE EACH 1 LIST EXPERT REVIEWED 2 CASES	47
Pediatric Cardiology (Cd)	1	1 EXPERT 1 LIST EXPERT	5
Pediatric Emergency Medicine (PEM)			3
Pediatric Endocrinology (En)			1
Pediatric Gastroenterology (Ge)			5
Pediatric Hematology-Oncology (HO)			3
Pediatric Infectious Diseases (Inf)			4
Pediatric Nephrology (Ne)			2
Pediatric Pulmonology (Pul)			0
Pediatric Rheumatology (Rhu)			0
PHYSICAL MEDICINE & REHABILITATION (PMR)			11
PLASTIC SURGERY (PIS)	18	12 EXPERTS 6 LIST EXPERTS REVIEWED 1 CASE EACH 3 LIST EXPERTS REVIEWED 2 CASES EACH 3 LIST EXPERTS REVIEWED 3 CASES EACH	45 ↑
PSYCHIATRY (Psyc)	95	42 EXPERTS 23 LIST EXPERTS REVIEWED 1 CASE EACH 6 LIST EXPERTS REVIEWED 2 CASES EACH 5 LIST EXPERTS REVIEWED 3 CASES EACH 4 LIST EXPERTS REVIEWED 4 CASES EACH 2 LIST EXPERTS REVIEWED 8 CASES EACH 1 LIST EXPERT REVIEWED 10 CASES 1 LIST EXPERT REVIEWED 12 CASES	70 ↑

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

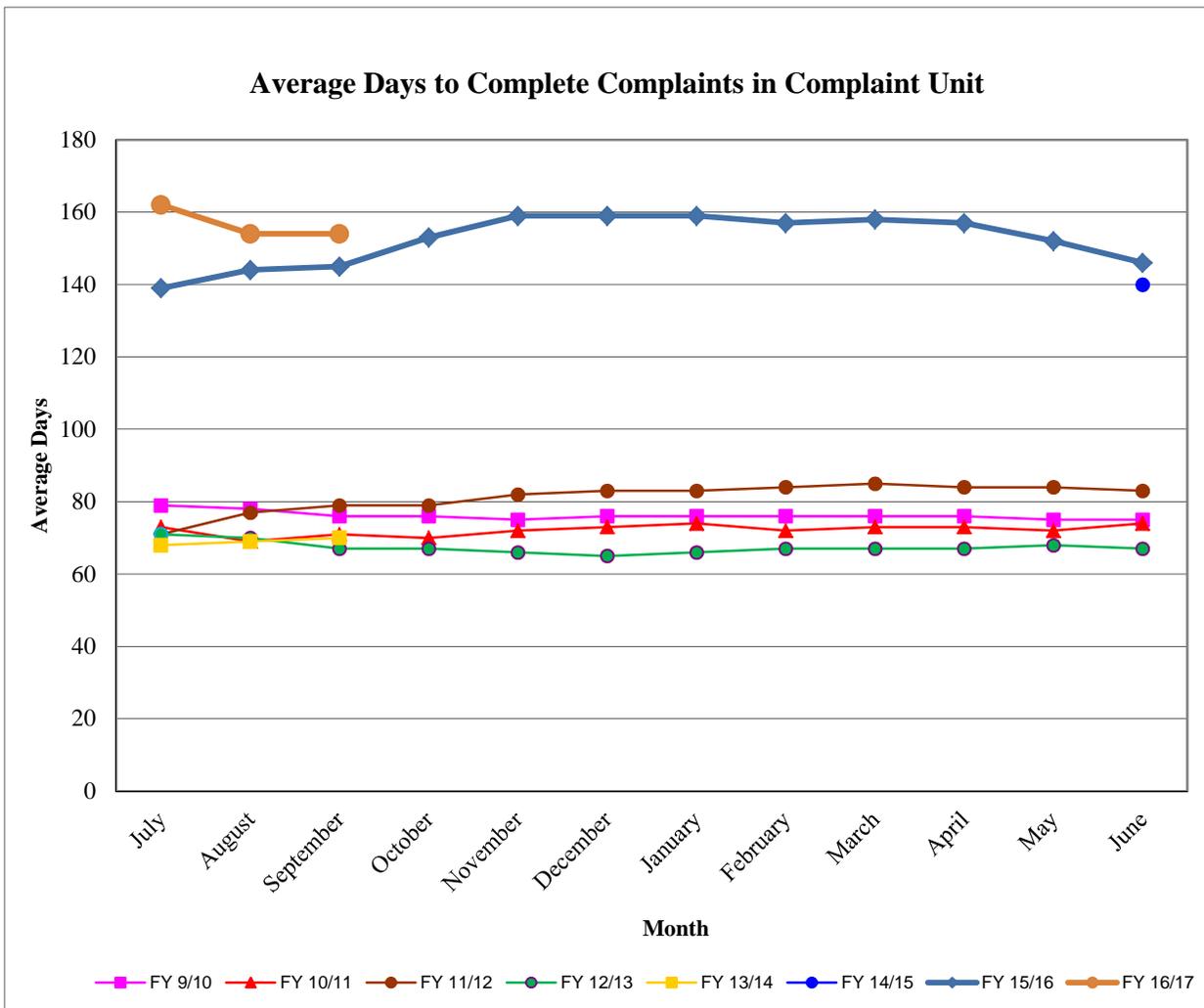
Attachment A**October 1, 2016**

SPECIALTY	Number of Cases reviewed by Experts January 1 through September 30, 2016	Number of Experts and how often Utilized from January 1 through September 30, 2016	Active List Experts 1,091 ↑
RADIOLOGY (Rad)	4	3 EXPERT 2 LIST EXPERTS REVIEWED 2 CASES EACH 1 LIST EXPERT REVIEWED 2 CASES	31 ↑
Radiation Oncology (Rad RO)			5
SLEEP MEDICINE (S)			8
SURGERY (S)	17	10 EXPERTS 5 LIST EXPERTS REVIEWED 1 CASE EACH 4 LIST EXPERTS REVIEWED 2 CASES EACH 1 LIST EXPERT REVIEWED 4 CASES	28 ↑
Pediatric Surgery (PdS)	1	1 EXPERT 1 LIST EXPERT	2
Vascular Surgery (VascS)	3	2 EXPERTS 1 LIST EXPERT REVIEWED 1 CASE 1 LIST EXPERT REVIEWED 2 CASES	6
THORACIC SURGERY (TS)	1	1 EXPERT 1 OFF-LIST EXPERT	10 ↑
<i>Pediatric Cardiothoracic Surgery</i>	1	1 EXPERT 1 OFF-LIST EXPERT	0
<i>(MEDICAL) TOXICOLOGY</i>	1	1 EXPERT 1 OFF-LIST EXPERT	7
UROLOGY (U)	7	5 EXPERTS 3 LIST EXPERTS REVIEWED 1 CASE EACH 2 LIST EXPERTS REVIEWED 2 CASES EACH	13 ↑
TOTAL CASES REVIEWED (Jan. – Sept. 2016)			389
TOTAL EXPERTS UTILIZED (Jan. – Sept. 2016)			228
TOTAL ACTIVE LIST EXPERTS (10/1/2016)			1091

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

Fiscal Year

Month	FY 9/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17
July	79	73	71	71	68		139	162
August	78	69	77	70	69		144	154
September	76	71	79	67	70		145	154
October	76	70	79	67			153	
November	75	72	82	66			159	
December	76	73	83	65			159	
January	76	74	83	66			159	
February	76	72	84	67			157	
March	76	73	85	67			158	
April	76	73	84	67			157	
May	75	72	84	68			152	
June	75	74	83	67		140	146	

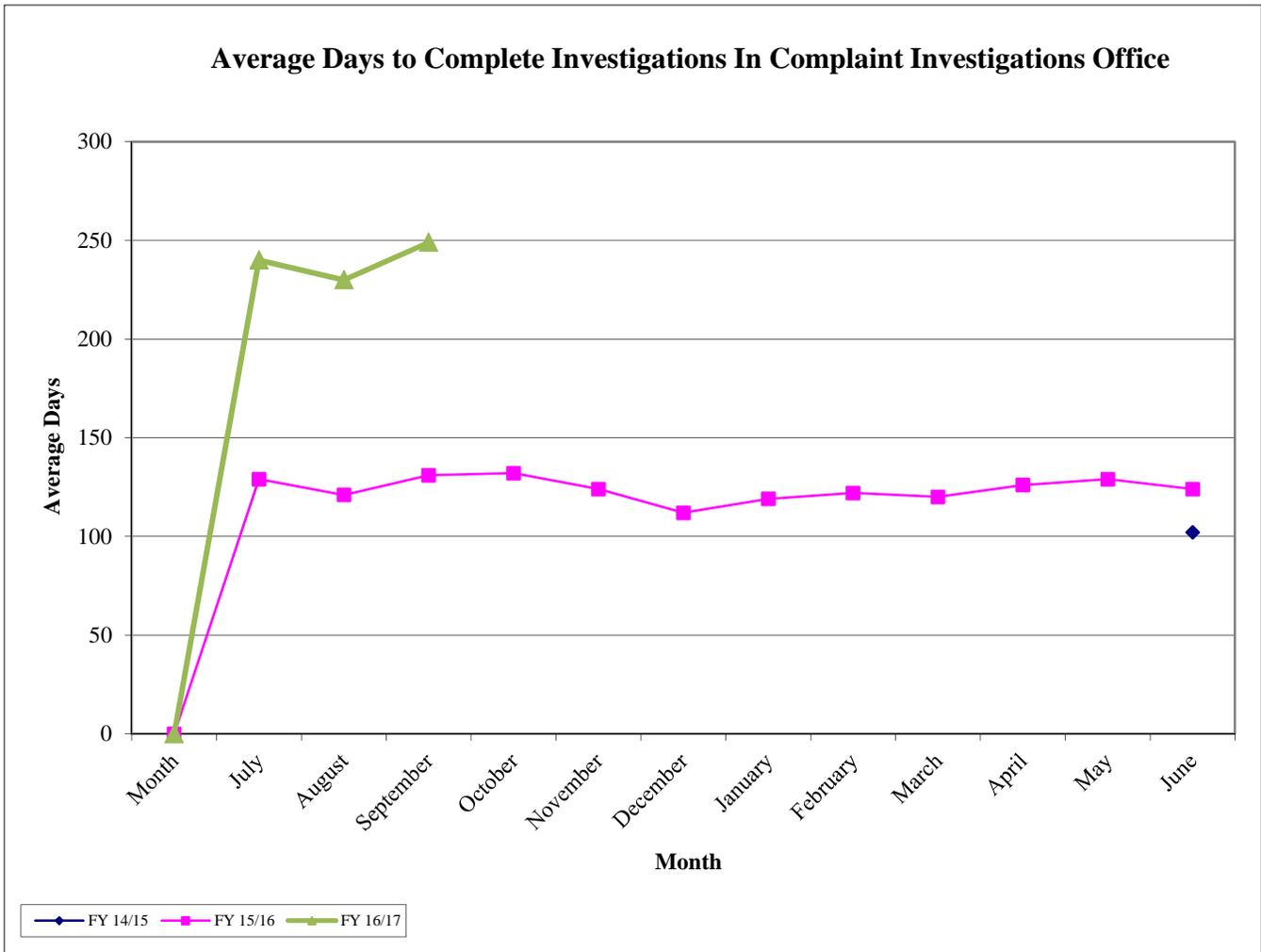


Average Days to Complete Complaints in Complaint Unit includes complaints resolved by Complaint Unit and Complaint Unit processing days for cases completed at field investigation.

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

Fiscal Year

Month	FY 14/15	FY 15/16	FY 16/17
July		129	240
August		121	230
September		131	249
October		132	
November		124	
December		112	
January		119	
February		122	
March		120	
April		126	
May		129	
June	102	124	

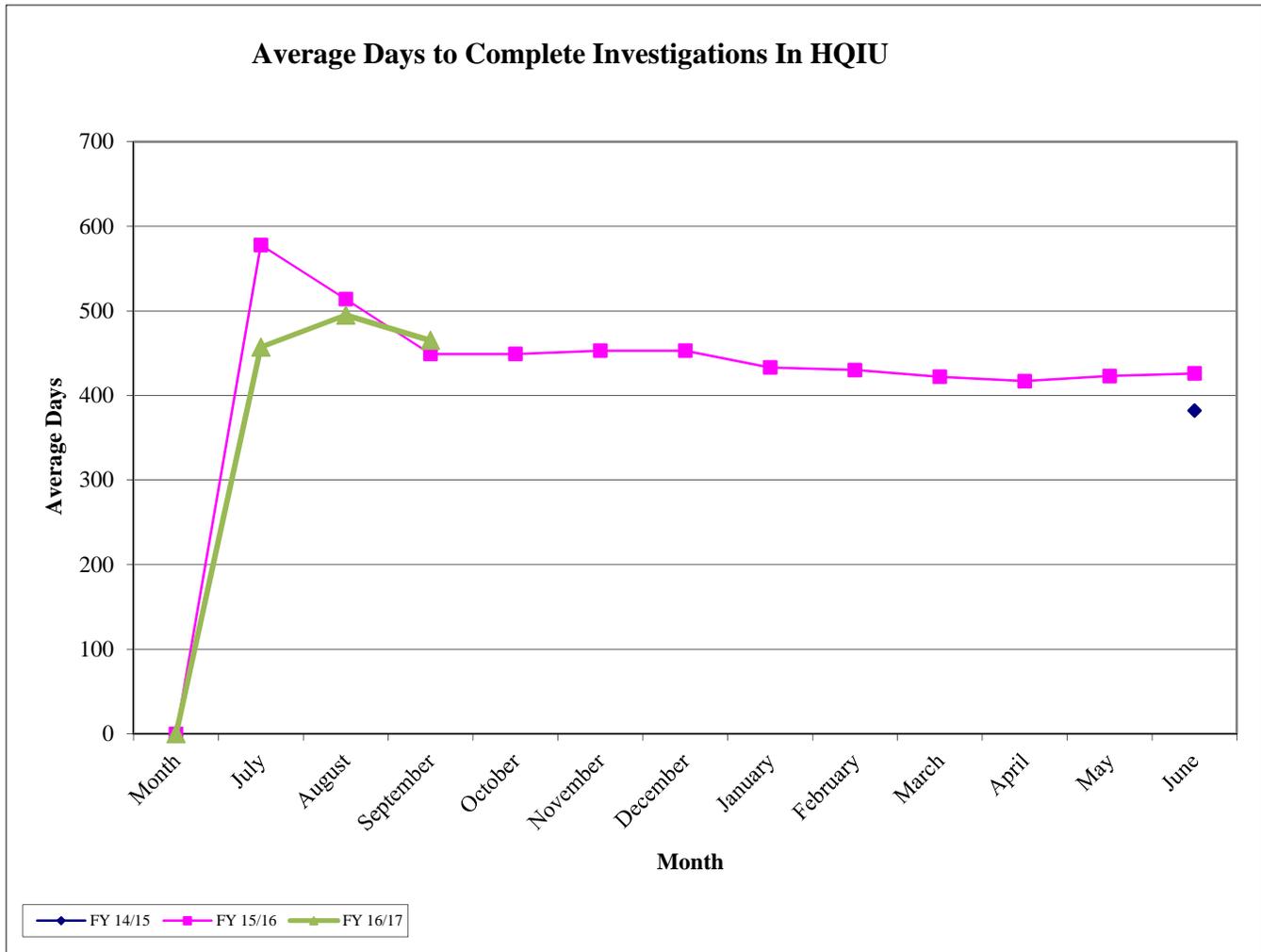


Investigation processing days are from the date case was assigned to Complaint Investigation Office (CIO) Investigator by Complaint Unit until closure or referral (does not include Complaint Unit processing days for complaints completed at CIO).

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

Fiscal Year

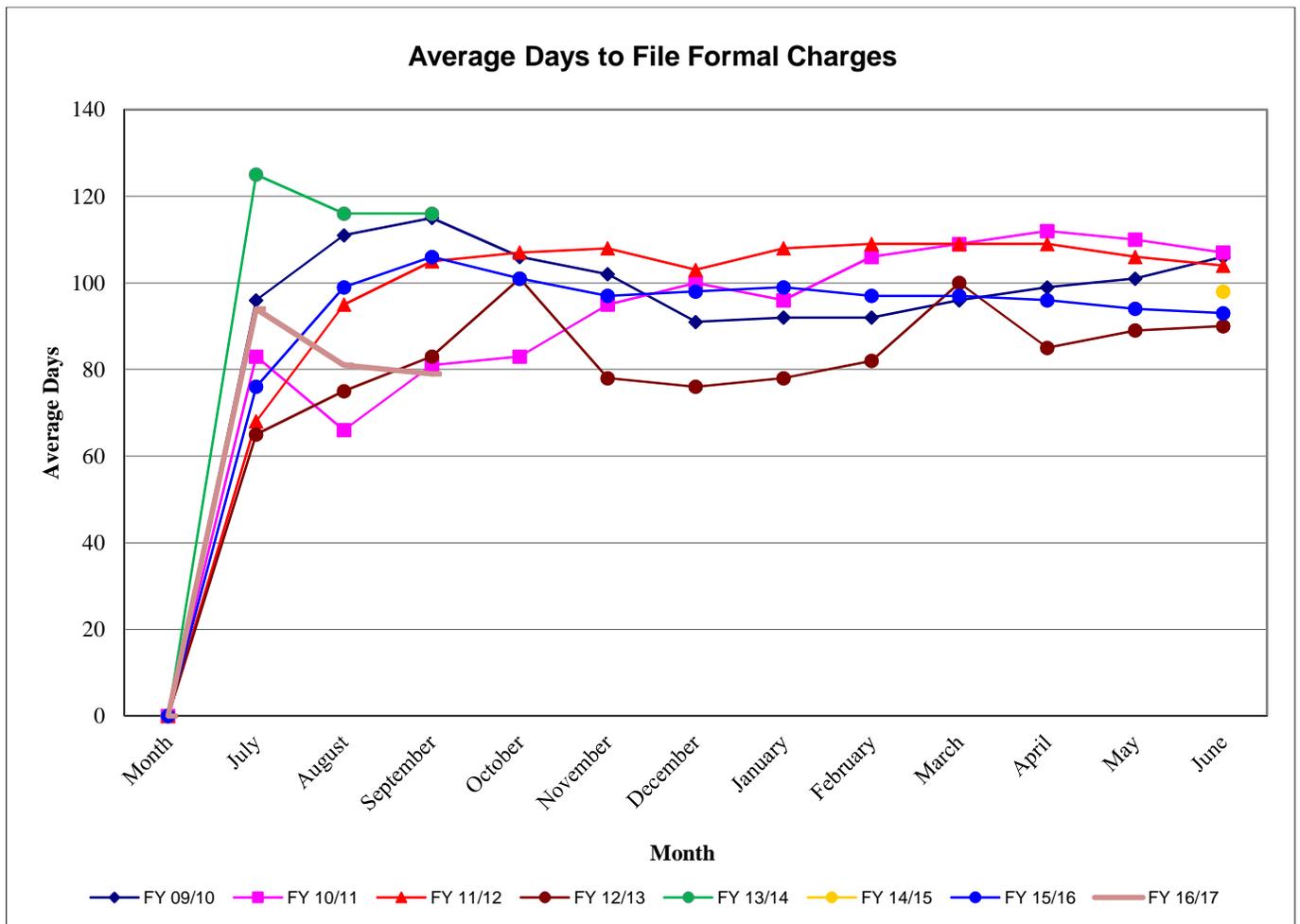
Month	FY 14/15	FY 15/16	FY 16/17
July		578	457
August		514	495
September		449	465
October		449	
November		453	
December		453	
January		433	
February		430	
March		422	
April		417	
May		423	
June	382	426	



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

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

Month	Fiscal Year							
	FY 09/10	FY 10/11	FY 11/12	FY 12/13	FY 13/14	FY 14/15	FY 15/16	FY 16/17
July	96	83	68	65	125		76	94
August	111	66	95	75	116		99	81
September	115	81	105	83	116		106	79
October	106	83	107	101			101	
November	102	95	108	78			97	
December	91	100	103	76			98	
January	92	96	108	78			99	
February	92	106	109	82			97	
March	96	109	109	100			97	
April	99	112	109	85			96	
May	101	110	106	89			94	
June	106	107	104	90		98	93	



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

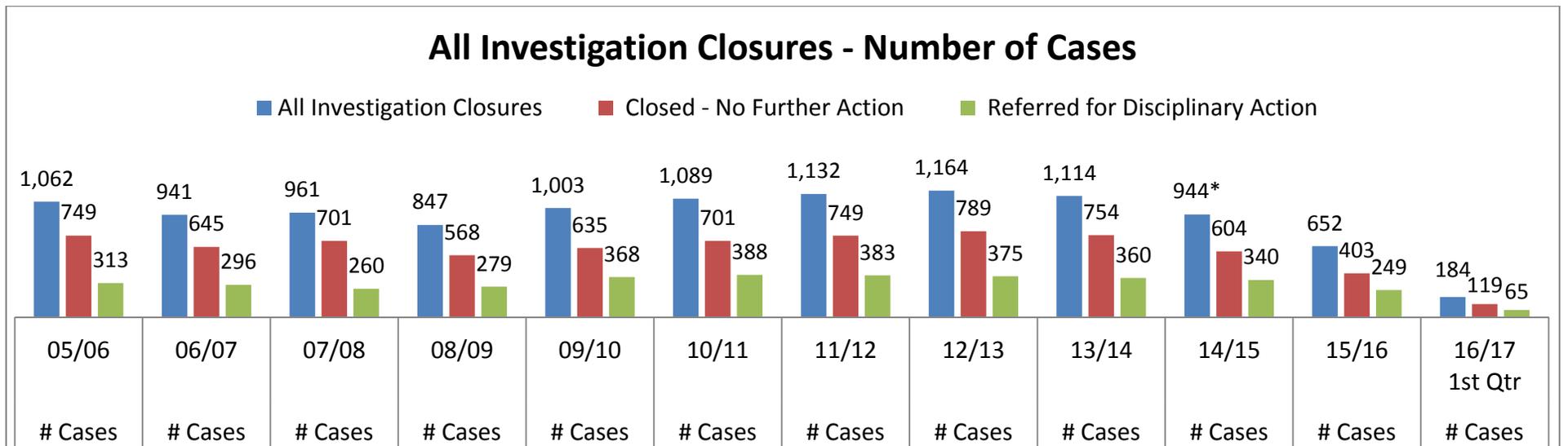
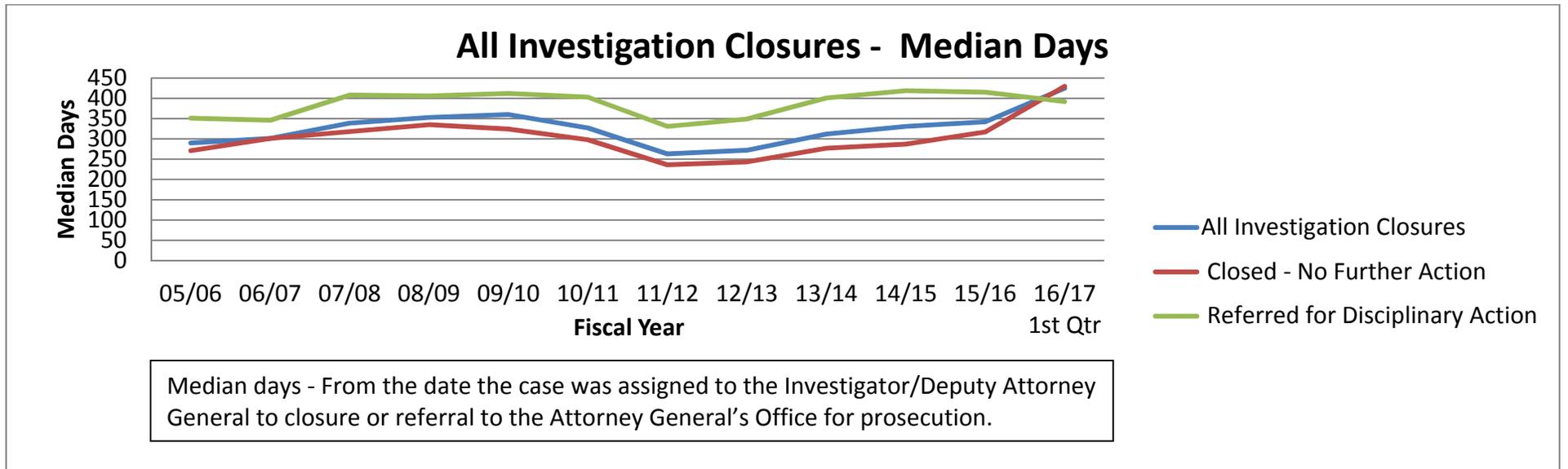
ENFORCEMENT TIMEFRAMES

FISCAL YEARS	2008 - 2009		2009 - 2010		2010 - 2011		2011 - 2012		2012 - 2013		2013 - 2014		2014 - 2015 ¹		2015 - 2016 ¹		2016 - 2017 ²	
	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN	AVERAGE	MEDIAN										
COMPLAINT PROCESSING	75	63	76	63	74	77	83	64	67	54	67	43	140	113	146	119	154	125
INVESTIGATION PROCESSING - MBC-CIO													102	57	124	52	249	199
INVESTIGATION PROCESSING - HQUI													382	352	426	367	465	430
INVESTIGATION PROCESSING - ALL	349	309	328	292	312	283	264	225	268	245	245	205						
TOTAL MBC & HQUI																		
DAYS	424	372	404	355	386	360	347	289	335	299	312	248	228	150	230	155	174	140
YEARS	1.16	1.02	1.11	0.97	1.06	0.99	0.95	0.79	0.92	0.82	0.85	0.68	0.62	0.41	0.63	0.42	0.48	0.38
AG PREP FOR ACC/PTR/ACC&PTR/SOI	103	63	106	66	107	72	104	78	90	75	110	86	98	68	93	67	79	63
POST ACCUSATION/PTR/SOI	381	311	368	312	417	324	396	350	435	366	443	402	459	392	453	378	456	418
ACCUSATION DECLINED BY AG													44	23	56	31	19	19
TOTAL AG																		
DAYS	484	374	474	378	524	396	500	428	525	441	553	488	473	413	479	393	456	418
YEARS	1.33	1.02	1.30	1.04	1.44	1.08	1.37	1.17	1.44	1.21	1.52	1.34	1.30	1.13	1.31	1.08	1.25	1.15
TOTAL MBC & AG																		
DAYS	908	746	878	733	910	756	847	717	860	740	865	736	956	927	967	919	965	955
YEARS	2.49	2.04	2.41	2.01	2.49	2.07	2.32	1.96	2.36	2.03	2.37	2.02	2.62	2.54	2.65	2.52	2.64	2.62

Years calculated using 365 days per year

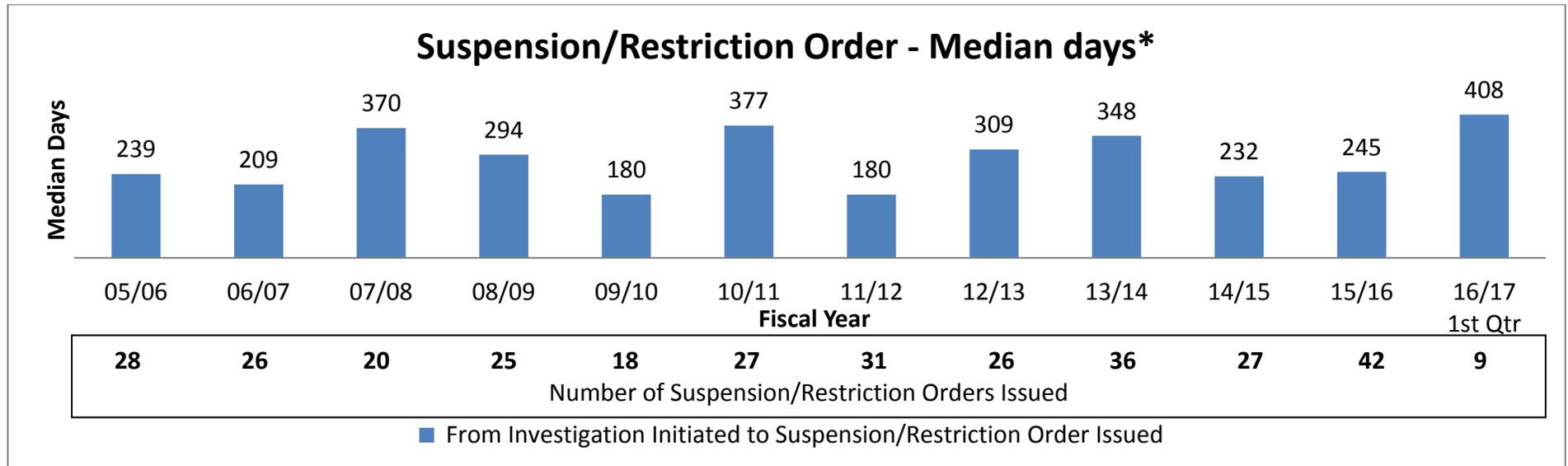
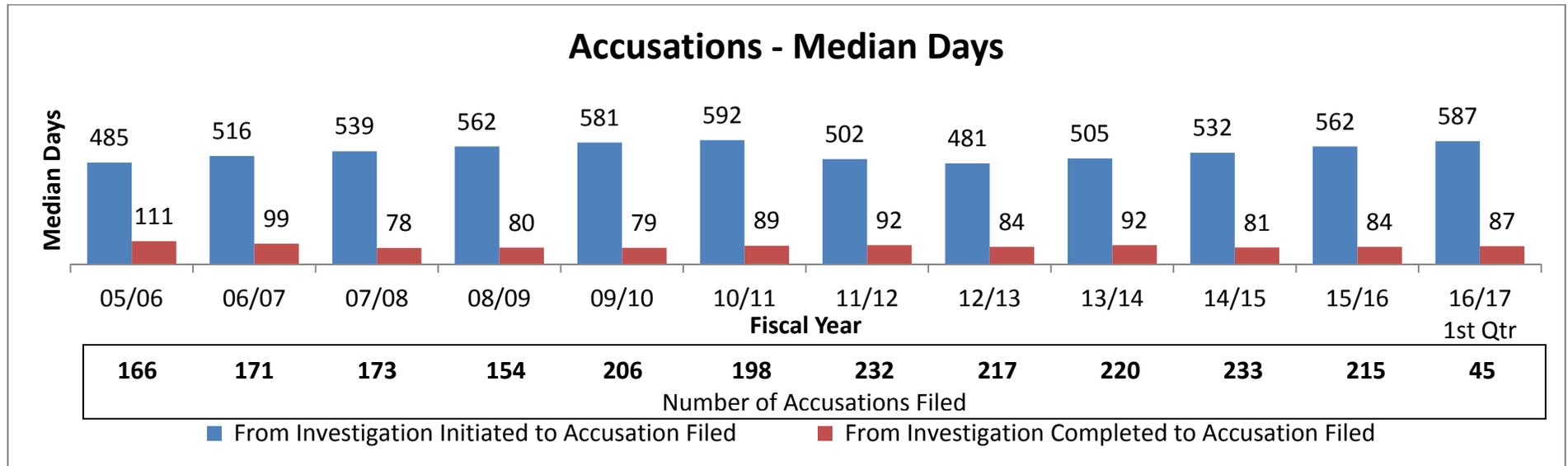
¹ "Total" Days prior to FY 14-15 were the averages per unit added together. Beginning in FY 14-15, reports were run that show true averages for the Total timeframes.

² Data through 9/30/16



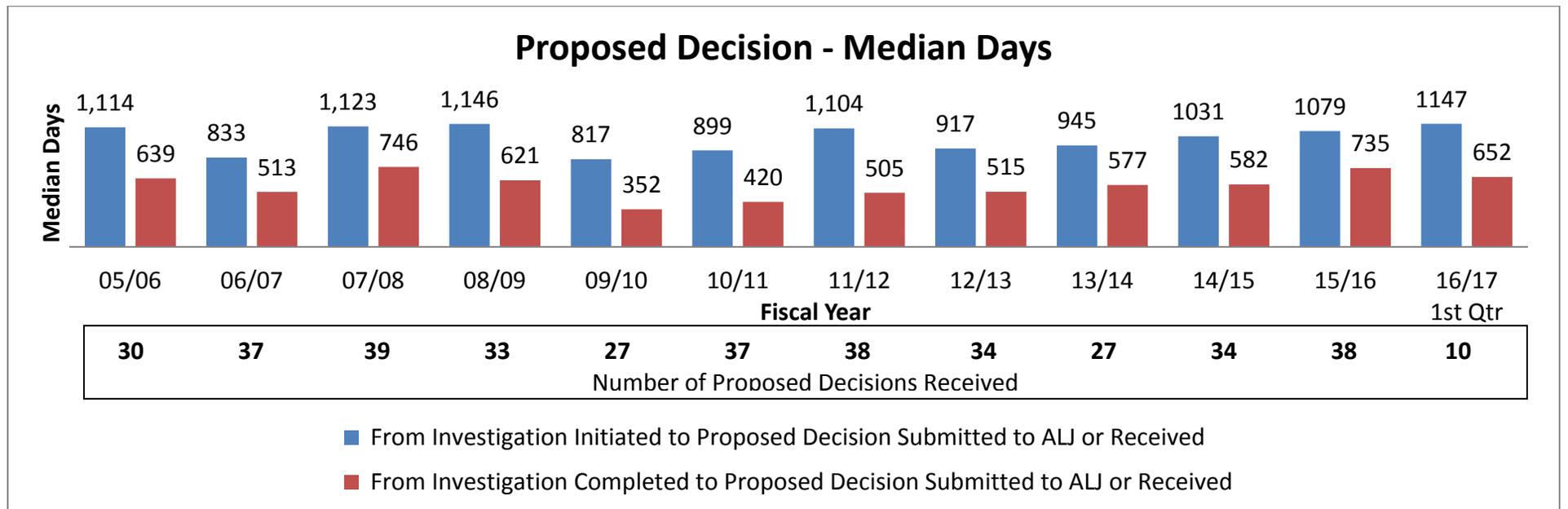
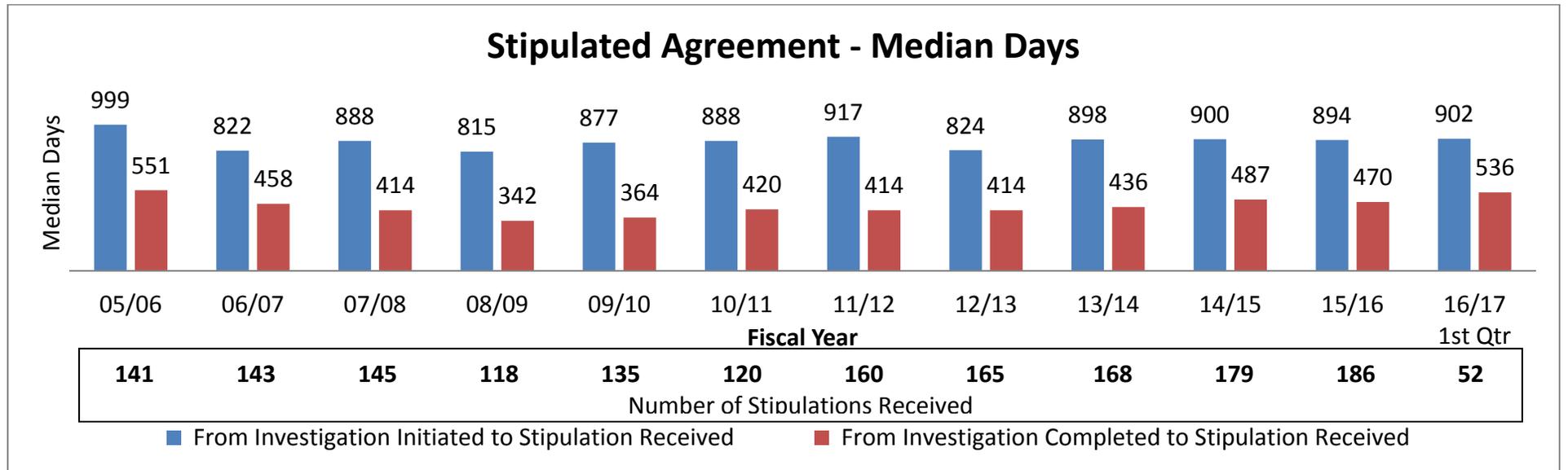
* This decrease is due to the Board initiating, in July 2014, a complaint investigation office of non-sworn special investigators who began investigating cases that would have been sent to HQIU.

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

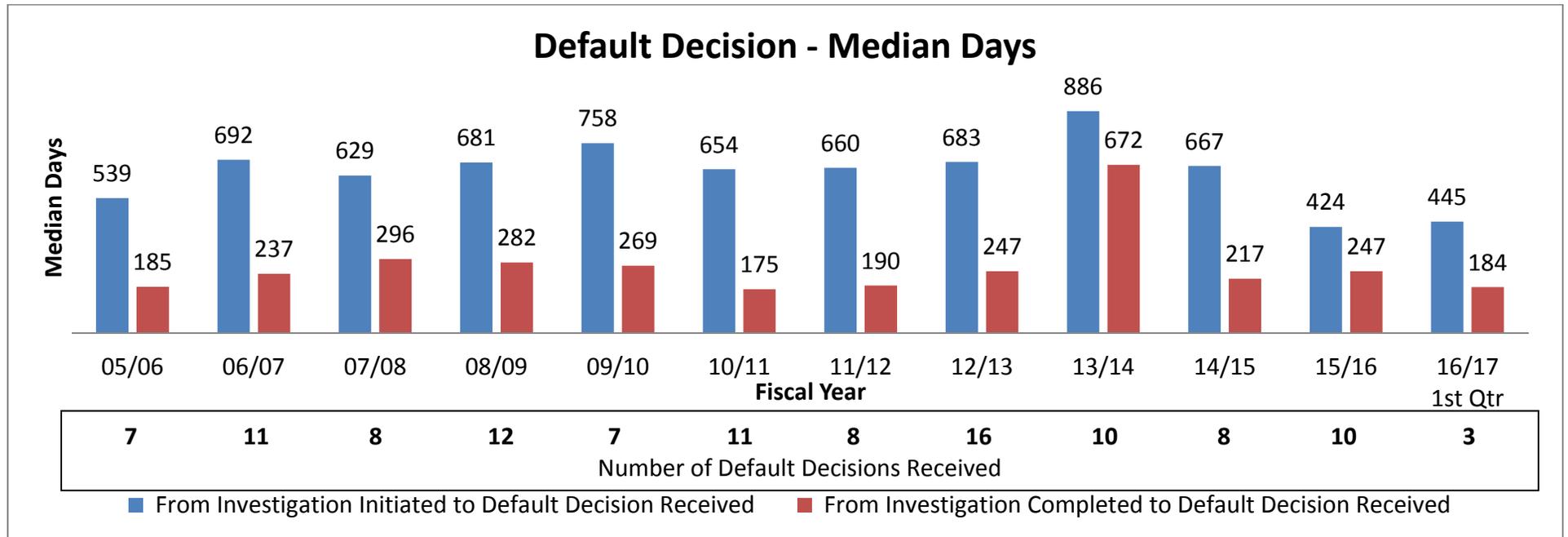


* This data includes: interim suspension orders, Penal Code section 23 restrictions, stipulated agreements to restrictions/suspension, and temporary restraining orders. It does not include out-of-state suspension orders, automatic suspension orders, or orders to cease practice while on probation.

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



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

MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 11, 2016
 ATTENTION: Members, Medical Board of California (Board)
 SUBJECT: Licensing Program Summary
 STAFF CONTACT: Curtis J. Worden, Chief of Licensing

STAFFING:

The Licensing Program was not fully staffed and several staff scheduled vacations in the first quarter of fiscal year (FY) 2016-17. Staff continued to work hard in the first quarter of FY 2016-17 to meet the needs of applicants for physician's and surgeon's (P&S) licenses or postgraduate training authorization letters (PTAL), licensees and consumers.

Two Licensing Managers are retiring by the end of the year. Both positions have been advertised and interviews will be scheduled in November.

Licensing currently has the following vacancies:

- Office Technician (Call Center)
- Office Technician (P&S Application File Setup)
- Management Services Technician (US/CAN P&S Application Review)
- Associate Governmental Program Analyst (Senior Review)

Staff in training:

- 2 - Staff Services Analysts (IMG P&S Application Review)
- 1 - Staff Services Manager I
- Office Technician (Cashing)

STATISTICS:

The statistics are on pages BRD 7C - 3 through BRD 7C - 10. The statistics have been obtained from the call center phone system, tracked manually, or from the BreEZe system.

Notable statistics include:

- Consumer Information Unit telephone calls answered: 18,359
 - 1,026 less calls answered than the previous quarter
- Consumer Information Unit telephone calls requesting a call back: 6,288
 - 2,210 less call back requests than the previous quarter
- Consumer Information Unit telephone calls abandoned: 6,111
 - 2,284 less abandon calls than the previous quarter

Note: The phone system was down for several hours one day.

- P&S applications received in FY 2016-17 to date: 2,178
 - 13 more than the previous quarter
- P&S applications initial review completed: 2,105
 - 60 less applications reviewed than the previous quarter
- P&S licenses issued: 1,801
 - 137 less licenses issued than the previous quarter
 - 564 more licenses issued than in the first quarter of FY 15/16

Licensing met its goal of performing initial reviews of all new P&S applications within 45 days of receipt by the Board for all 13 weeks in the first quarter of FY 2016-17.

INTERNATIONAL MEDICAL SCHOOLS:

The statistics for the international medical school reviews are on page BRD 7C - 5. The review of international medical schools continues to be a significant workload for the Board. The Board received one new Self-Assessment Report and there are currently seven Self-Assessment Reports that are pending.

SPECIALTY BOARD APPLICATIONS:

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

OUTREACH:

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

License Fairs:

- July 28: San Joaquin General Hospital: 30 residents
- July 29: UC Davis: 40 residents
- Aug 16-17: UCLA, Olive View, and affiliated hospitals/clinics: approximately 75 residents
- Aug 23-24: UCSF, Zuckerberg General Hospital, and affiliated hospitals/clinics: approximately 80 residents
- Aug 31: Highland Hospital/Alameda County: approximately 45 residents
- Sept 8: California Pacific Medical Center (SF): approximately 40 residents
- Sept 13: USC: approximately 30 residents
- Sept 16: Cedars Sinai: approximately 45 residents
- Sept 20: Kaiser Permanente, Fontana (with some from Arrowhead and UCR): approximately 30 residents
- Sept 21: St Mary's Long Beach: approximately 20 residents
 California Hospital: approximately 20 residents
- Sept 22: Kaiser Permanente, San Diego: approximately 10 residents
 UCSD: approximately 45 residents
- Sept 23: UCSD: approximately 30 residents
- Sept 30: UCI: approximately 90 residents

Resident Orientation:

- July 1: Loma Linda: 60 residents
 UCI: 75 residents
 UCLA: 100 residents

CONSUMER INFORMATION UNIT FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Total Calls Answered	18,359	18,359			
Calls Requesting Call Back	6,288	6,288			
Calls Abandoned	6,111	6,111			
Address Changes Completed	1,229	1,229			

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

PHYSICIAN & SURGEON DATA FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
*Applications Received	2,178	2,178			
Initial Reviews Completed	2,105	2,105			
Pending	N/A				
Reviewed	N/A				
Not Reviewed	N/A				
(SR2s Pending)	N/A	55			
Licenses Issued	1,801	1,801			
Renewals Issued	16,717	16,717			

*The Applications Received stat does not include applications received with monies not cleared as this process may take several weeks.

PHYSICIAN & SURGEON DATA FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Applications Received	7,763	2,262	1,732	2,094	1,675
Initial Reviews Completed	7,687	1,645	1,975	1,902	2,165
Total Pending	N/A				
Reviewed	N/A				
Not Reviewed	N/A				
(SR2s Pending)	N/A	35	38	51	53
Licenses Issued	6,316	1,237	1,425	1,716	1,938
Renewals Issued	66,778	17,123	16,237	16,712	16,706

Unrecognized and Disapproved Medical School Applicants (2135.7) - FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Beginning	3	3			
Received	0	0			
Reviewed	0	0			
Not Eligible	0	0			
Licensed	0	0			

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

SR 2 - CATEGORIES FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Alcohol/Drugs	6	6			
PG/Medical Knowledge	22	22			
Convictions	17	17			
Other	61	61			

SR 2 - CATEGORIES FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Alcohol/Drugs	29	7	8	10	4
PG/Medical Knowledge	61	16	23	16	6
Convictions	41	17	8	11	5
Other	128	31	32	31	34

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	N/A	123			
Pending Self-Assessment Reports (included pending above)	N/A	7			
New Self-Assessment Reports Received (included pending above)	0	0			
New Unrecognized Schools Received	31	31			
School Recognized Pursuant to CCR 1314(a)(1)	17	17			
School Recognized Pursuant to CCR 1314(a)(2)	2	2			
TOTAL Schools Pending Recognition at End of Quarter	N/A	135			

INTERNATIONAL MEDICAL SCHOOL APPLICATIONS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
Schools Pending Recognition at Beginning of Quarter	N/A	107	114	123	122
Pending Self-Assessment Reports	N/A	7	7	7	7
New Self-Assessment Reports Received	1	0	0	0	1
New Unrecognized Schools Received	45	13	13	7	12
School Recognized Pursuant to CCR 1314(a)(1)	29	6	4	8	11
School Recognized Pursuant to CCR 1314(a)(2)	0	0	0	0	0
TOTAL Schools Pending Recognition at End of Quarter	N/A	114	123	122	124

SPECIALTY BOARD APPLICATIONS FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Applications Received		0	0	0	0
Applications Pending	N/A	1	0	0	0

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

RESEARCH PSYCHOANALYST FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
RP Applications Received	4	4			
RP Licenses Issued	4	4			

RESEARCH PSYCHOANALYST FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
RP Applications Received	6	1	2	3	0
RP Licenses Issued	9	3	1	4	1

Licensing Program Report

WORKLOAD REPORT
 as of September 30, 2016

Fiscal Year 2016-2017

LICENSED MIDWIVES FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Applications Received	4	4			
Applications Pending	N/A	4			
Applications Withdrawn	1	1			
Licenses Issued	3	3			
Licenses Renewed	47	47			

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

FICTITIOUS NAME PERMITS FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
P&S - FNP Received	330	330			
P&S - FNP Issued	304	304			
P&S - FNP Pending	N/A	361			
P&S - FNP Renewed	1,657	1,657			
Podiatric FNP Received	3	3			
Podiatric FNP Issued	0	0			
Podiatric FNP Pending	N/A	7			
Podiatric FNP Renewed	28	28			

FICTITIOUS NAME PERMITS FY 15/16					
	FY 15/16	Q1	Q2	Q3	Q4
P&S - FNP Received	1289	375	295	318	301
P&S - FNP Issued	1,243	324	268	337	314
P&S - FNP Pending	N/A	N/A	N/A	N/A	N/A
P&S - FNP Renewed	5,104	1,337	1,121	1,357	1,289
Podiatric FNP Received	18	6	7	1	4
Podiatric FNP Issued	26	6	9	6	5
Podiatric FNP Pending	N/A	N/A	N/A	N/A	N/A
Podiatric FNP Renewed	156	36	35	44	41

POLYSOMNOGRAPHY FY 16/17					
	FY 16/17	Q1	Q2	Q3	Q4
Trainee					
Applications Received	4	4			
Registrations Issued	4	4			
Registrations Renewed	1	3			
Technician					
Applications Received	3	3			
Registrations Issued	15	15			
Registrations Renewed	7	7			
Technologist					
Applications Received	16	16			
Registrations Issued	2	2			
Registrations Renewed	121	121			

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

Licensing Program Report

WORKLOAD REPORT
as of September 30, 2016

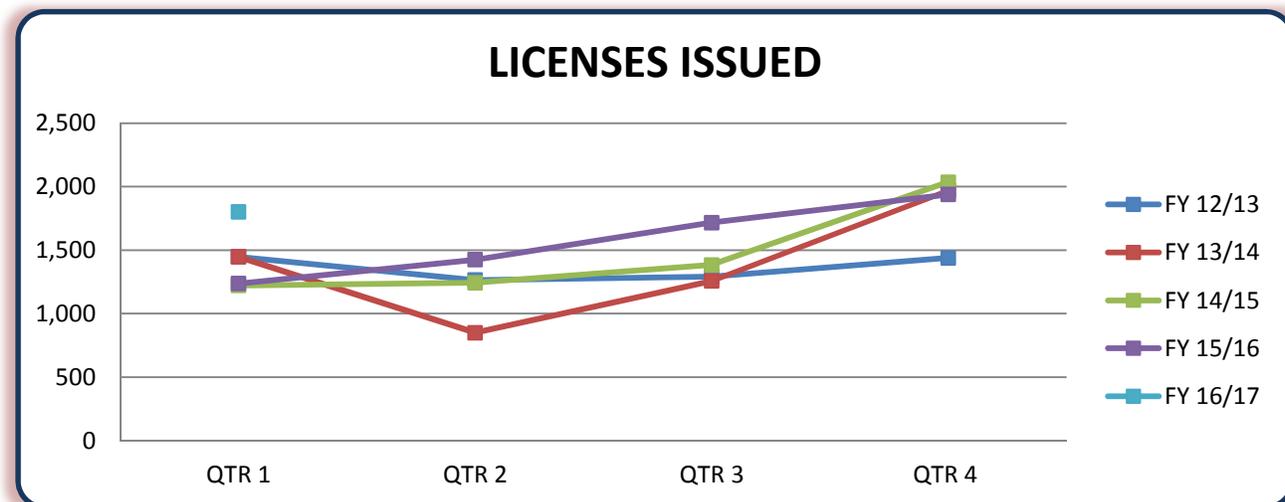
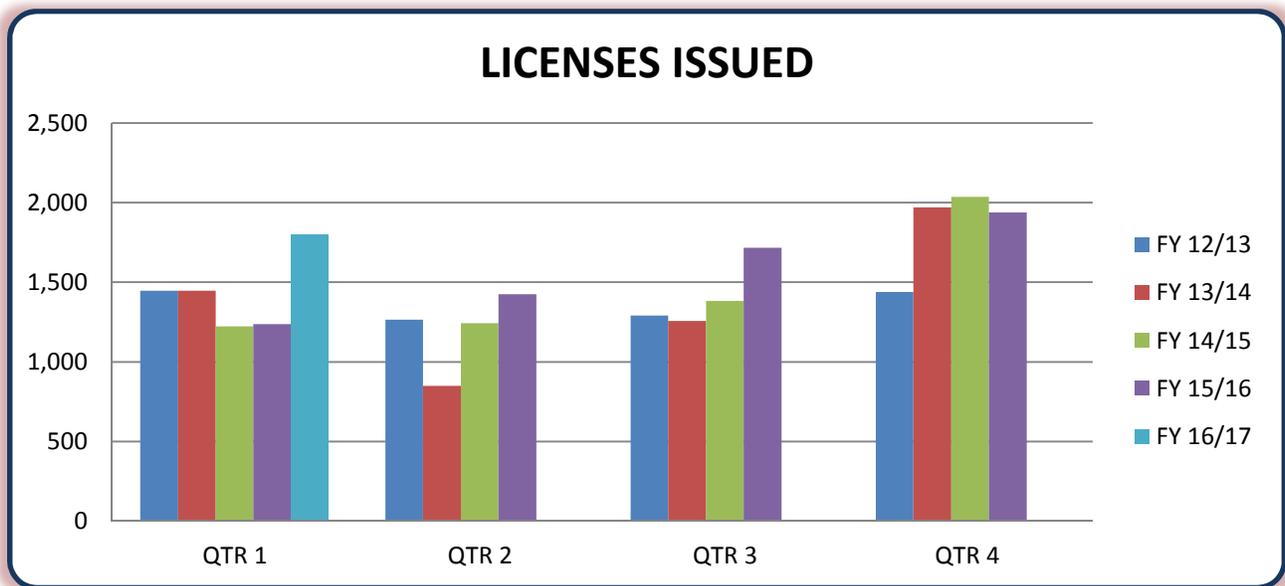
Fiscal Year 2016-2017

SPECIAL PROGRAMS																								
FY 16/17																								
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	10				10				11				20				10				0			
2112	0				0				1				0				0				0			
2113	4				3				9				15				15				0			
2168	0				0				0				1				4				0			
2072	0				0				0				0				0				0			
1327	0				0				0				0				0				0			

SPECIAL PROGRAMS																								
FY 15/16																								
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	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	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	
1327	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	

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

PHYSICIAN'S AND SURGEON'S LICENSES ISSUED					
Five Fiscal Year History					
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
FY 16/17	1,801				1,801
FY 15/16	1,237	1,425	1,716	1,938	6,316
FY 14/15	1,222	1,243	1,383	2,035	5,883
FY 13/14	1,447	849	1,257	1,969	5,522
FY 12/13	1,447	1,264	1,291	1,438	5,440



Licensing Program Report

WORKLOAD REPORT
as of September 30, 2016

Fiscal Year 2015-2016

*PHYSICIAN'S AND SURGEON'S LICENSE AND PTAL APPLICATIONS RECEIVED					
Five Fiscal Year History					
Fiscal Year	QTR 1	QTR 2	QTR 3	QTR 4	TOTAL
			BRD 7C - 10		
FY 16/17	2,178				2,178
FY 15/16	2,262	1,732	2,094	1,675	7,763
FY 14/15			1,967	1,516	6,850
FY 13/14					6,308
FY 12/13	1,722	1,715	1,708	1,552	6,697

*The Applications Received stat does not include applications received with monies not cleared as this process may take several weeks.

Fiscal Year - 2016/2017					
Strategic Plan Goal 5: Organizational Effectiveness					
Objective 5.1: Licensing Applications to be Reviewed Within 45 Days					
	FY 16/17	Q1	Q2	Q3	Q4
Number of Weeks 45 Day Initial Review Goal Not Met	0	0			
Number of Weeks	52	13	13	13	13
Highest # of Days Goal Exceeded	N/A	N/A			

Fiscal Year - 2015/2016

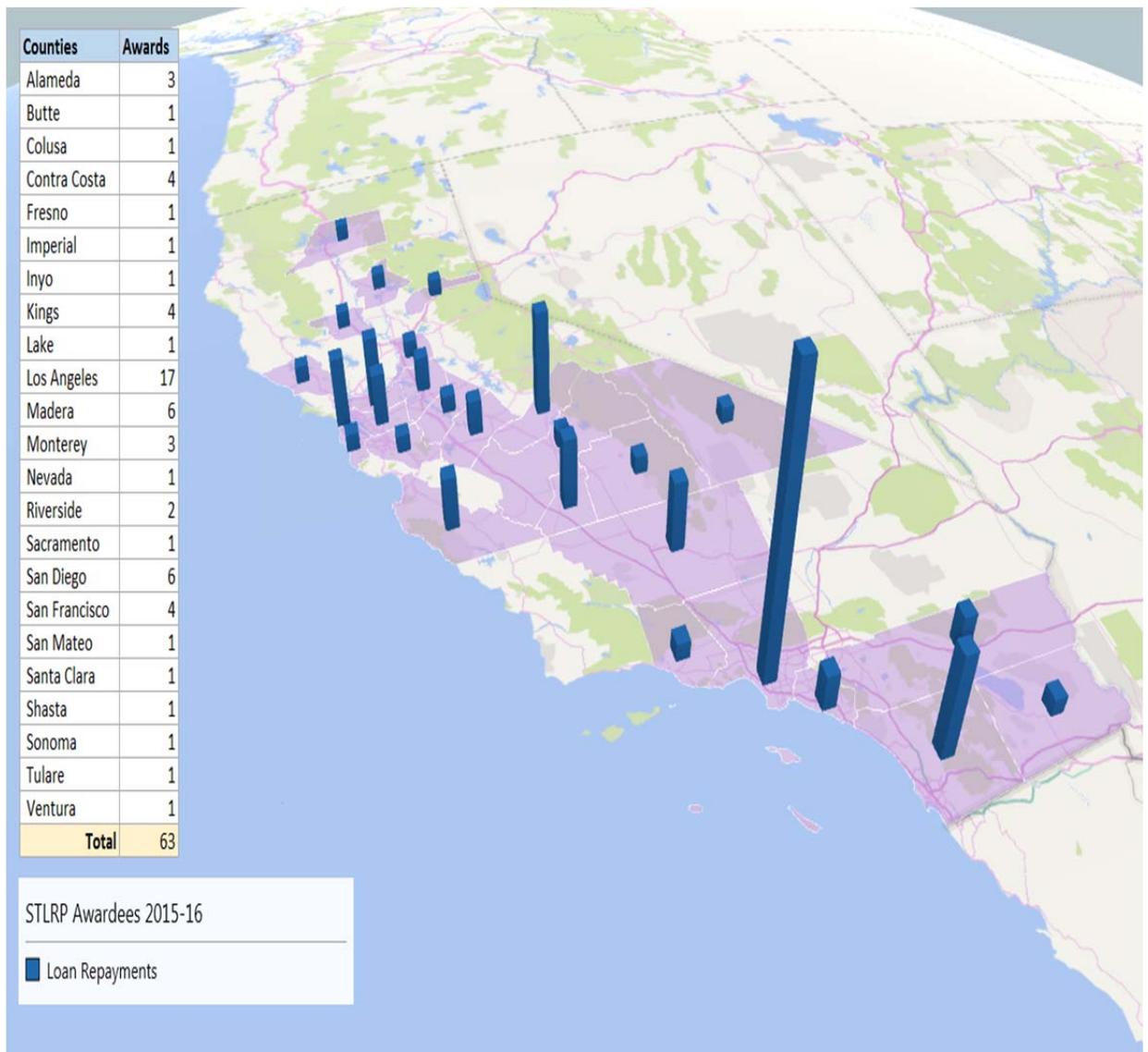
Strategic Plan Goal 5: Organizational Effectiveness					
Objective 5.1: Licensing Applications to be Reviewed Within 45 Days					
	FY 15/16	Q1	Q2	Q3	Q4
Number of Weeks 45 Day Initial Review Goal Not Met	38	10	9	13	6
Number of Weeks	52	13	13	13	13
Highest # of Days Goal Exceeded	N/A	19	23	13	11



**Health Professions Education Foundation (HPEF)
Update for California Medical Board
October 12, 2016**

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

- Based on the number of applicants and the amount of funds available each year, the process of selecting STLRP recipients continues to be competitive. HPEF is currently monitoring a total of 285 STLRP recipients.
- Below is a map of the 63 STLRP awardees from the 2015-16 cycle.



- The STLRP 2016-17 cycle will open on December 1, 2016.
 - HPEF staff worked with the advisory committee to better clarify STLRP application questions.
- The 2017 Annual STLRP Report will be drafted in December and released in February.

Application Cycles

- HPEF’s 2016-17 application cycle for the six loan repayment programs is currently open. Deadline to apply is November 18, 2016.
- For the 2016-17 loan repayment cycle, there is currently a total of 4,516 applications in process and a total of 717 applications have been submitted. Below is a breakdown of the number of applications in process for the six loan repayment programs:

Loan Repayment Program	2016-2017 Applications in Process
LMH	960
MHLAP	2,367
AH	253
LVN	107
BSN	490
APH	339

- The six scholarship programs will open January 3, 2017.

Other Pertinent Information

- On September 28, 2016, the Governor signed SB 1139 (Lara). This law will allow applicants to apply to Office of Statewide Health Planning and Development (OSHPD) scholarship and loan repayment programs regardless of their citizenship or immigration status. The new law would require that OSHPD accept individual taxpayer identification numbers (ITINs) that have or will be submitted in lieu of a social security number (SSN) for scholarship and loan repayment programs. The law will go into effect on January 1, 2017.
 - HPEF is currently in the process of updating its application on CalREACH to implement the new law.
 - The Steven M. Thompson Loan Repayment Program Application Cycle opening December 1, 2016 will reflect this change in the law.

Outreach

- Over the last few months, HPEF staff and Board members visited campuses, conferences, and workshops to promote all HPEF programs. HPEF has launched its own Facebook page: <https://www.facebook.com/HealthProfessionsEdFoundation>.

- HPEF posts daily updates on Facebook and Twitter. HPEF also hosts webinars, application workshops, and conference calls for potential applicants.
 - Events where HPEF provides outreach to physicians and future physicians:

Table 1: Calendar Year 2016 Events and Outreach	
Event Name	Location
Mt. San Antonio College 10 th Annual Health Professions Conference	Walnut
CareerMD Career Fair	San Francisco
National Medical Association Conference	Los Angeles
California Primary Care Association – Webinar Presentation	Sacramento
CareerMD Career Fair	Los Angeles
Network of Ethnic Physicians Organization Conference	Newport Beach
Osteopathic Board Meeting – Presentation	Vallejo
CareerMD Career Fair	Palo Alto
14th UC Davis Pre-Health Professions National Conference/Presentation	UC Davis
California Primary Care Association Conference	Long Beach
CareerMD Career Fair	Orange County
California Primary Care Association Conference	Long Beach
CareerMD Career Fair	Fresno
CareerMD Career Fair	San Diego

Summary

Results in Brief

Psychotropic medications such as antidepressants, mood stabilizers, and antipsychotics can provide significant benefits in the treatment of psychiatric illnesses, but they can also cause serious adverse side effects. Although the American Psychological Association has mentioned that studies since the 1970s have found that children in foster care (foster children) often have a greater need for mental health treatment, public and private entities have expressed concerns about the higher prescription rates of psychotropic medication among foster children than among nonfoster children. This issue is of particular importance to California, which has the largest population of foster children in the country. In fact, our analysis of the available state data found that nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014–15, whereas studies suggest that only about 4 to 10 percent of nonfoster children are prescribed these medications.

To examine the oversight of psychotropic medications prescribed to foster children, we reviewed case files for a total of 80 foster children in Los Angeles, Madera, Riverside, and Sonoma counties and analyzed available statewide data. We found that many foster children had been authorized to receive psychotropic medications in amounts and dosages that exceeded the State's recommended guidelines (state guidelines), circumstances that should have prompted the counties responsible for their care to follow up with the children's prescribers. For example, 11 of the 80 children whose files we reviewed had been authorized to take multiple psychotropic medications within the same drug class. Further, 18 of the 80 children had been authorized to take psychotropic medications in dosages that exceeded the State's recommended maximum limits. Medications that exceed the State's recommended guidelines may be appropriate under some circumstances, and we are not questioning prescribers' medical expertise. However, in the instances above, the counties did not contact the prescribers to ensure the safety and necessity of the medications in question, as the state guidelines recommend.

Compounding these concerns is the fact that many of these children do not appear to have received follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications. The American Academy of Child and Adolescent Psychiatry recommends that children should receive follow-up visits with their health care providers ideally within two weeks, but at least within a month, after they start psychotropic medications. Nonetheless, one-third of the 67 foster children who started at least one psychotropic medication during our audit period did not receive follow-up appointments with their prescriber or

Audit Highlights . . .

Our audit concerning the oversight of psychotropic medications prescribed to California's foster children revealed the following:

- » *Nearly 12 percent of California's more than 79,000 foster children were prescribed psychotropic medications during fiscal year 2014–15.*
- » *Some foster children were prescribed psychotropic medications in amounts and dosages that exceeded state guidelines and counties did not follow up with prescribers to ensure the appropriateness of these prescriptions.*
- » *Many foster children did not receive follow-up visits or recommended psychosocial services in conjunction with their prescriptions for psychotropic medications.*
- » *Counties did not always obtain required court or parental approval for psychotropic medications prescribed to foster children as required by law.*
- » *The State's fragmented oversight structure of its child welfare system has contributed to weaknesses in the monitoring of foster children's psychotropic medications.*
- » *The California Department of Social Services' and the Department of Health Care Services' data systems together cannot completely identify which foster children are prescribed psychotropic medications.*
- » *Foster children's Health and Education Passports—documents summarizing critical health and education information—contained inaccurate and incomplete mental health data.*

to collaborate, the State's overall approach has exerted little system-level oversight to help ensure that these entities' collective efforts actually work as intended and produce desirable results.

The State's fragmented oversight structure has also contributed to its failure to ensure it has the data necessary to monitor the prescription of psychotropic medications to foster children. The two state entities most directly involved in overseeing foster children's mental health care are the California Department of Social Services (Social Services) and the Department of Health Care Services (Health Care Services). Even when combined, results from data systems these two departments operate still contain inaccurate and incomplete data related to foster children who are prescribed psychotropic medications. Consequently, neither agency can completely identify which foster children statewide are prescribed psychotropic medications or which medications those children are prescribed.

Further, the inaccurate and incomplete information in Social Services' data system is used to produce Health and Education Passports, which are critical documents that are meant to follow foster children should their placement change. We found that all 80 of the Health and Education Passports we reviewed contained instances of incorrect start dates for psychotropic medications. Moreover, 13 of these 80 Health and Education Passports did not identify all the psychotropic medications that the courts authorized, and all 80 were missing information about the corresponding psychosocial services the foster children should have received for at least one psychotropic medication. These errors and omissions appear to have been caused in large part by a lack of county staff to enter foster children's health information into Social Services' data system and an unwillingness of some county departments to share foster children's information with each other. However, caretakers, health care providers, social workers, and others rely on the Health and Education Passports to make decisions about foster children's care; without accurate information, they may inadvertently make decisions that do not reflect the children's best interests.

Also, the State has missed opportunities to ensure that the counties have reasonable processes for overseeing the prescription of psychotropic medications to foster children. For example, Social Services' California Child and Family Services Reviews of the counties only recently began examining in more depth psychotropic medications prescribed to foster children. Because Social Services and Health Care Services have not historically examined the prescription of psychotropic medications to foster children in their periodic reviews, they have missed opportunities for in-depth, county-by-county reviews of this issue. However, as of March 2016, both departments had begun collecting from the counties certain information about these medications.

services as well as the quality of their outcomes under county mental health care plans and county Medi-Cal managed care plans (Medi-Cal managed care plans). Health Care Services contracts with two organizations to conduct these external reviews and includes links to the organizations' reports on its website. However, the reports for the most recent annual external reviews for the Medi-Cal mental health plans and Medi-Cal managed care plans for the four counties we visited did not include substantive information regarding psychotropic medications prescribed to foster children.

Although external reviews annually examine the counties' Medi-Cal mental health plans and Medi-Cal managed care plans, the assistant chief of the Medical Review Branch within Health Care Services' Audits and Investigations Division indicated that the State has no similar oversight mechanism in place for health professionals who provide psychosocial services and then bill Medi-Cal via the fee-for-service approach. While more Medi-Cal beneficiaries are enrolling in managed care plans, foster children have the option to receive health care services from fee-for-service providers instead. Health Care Services is responsible for signing up and screening these providers. However, according to the assistant chief of the Medical Review Branch, the only oversight Health Care Services performs related to this type of provider involves identifying appropriate billing based on medical necessity criteria and federal and state reimbursement guidelines.

The three types of county-level reviews that Social Services and Health Care Services perform present an opportunity to gather first-hand information regarding the counties' administration of psychotropic medications to foster children.

The three types of county-level reviews that Social Services and Health Care Services perform present an opportunity for the departments to gather first-hand information regarding the counties' administration of psychotropic medications to foster children. These reviews could allow Social Services and Health Care Services to identify relevant deficiencies in this area and work with counties to resolve those deficiencies. Further, using the relevant results of these reviews in conjunction with complete and accurate state data, Social Services, Health Care Services, and their county partners could consider whether to modify their oversight structures to better ensure that providers only prescribe psychotropic medications to foster children when reasonably necessary.

The State Has Not Proactively Overseen Physicians Who Prescribe Psychotropic Medications for Foster Children

Although the State has mechanisms in place for reacting to complaints about physicians who may have inappropriately prescribed psychotropic medications to foster children, it does not currently take routine proactive steps to identify and correct inappropriate prescribing practices. The State oversees physicians through the Medical Board, which is responsible for issuing

physicians' licenses, investigating complaints, and imposing discipline. Its disciplinary actions may include administrative citations, fines, or license revocation. However, as of February 2016, its executive director stated that the Medical Board had not received any complaints against physicians for inappropriately prescribing psychotropic medications to foster children. Given the nature and extent of the issues we identified in Chapter 1 related to psychotropic medications, we believe that the lack of complaints to the Medical Board may suggest that this reactive approach alone is not sufficient to help ensure that physicians properly prescribe psychotropic medications to foster children.

Although the State also has other reactive methods through which it can monitor physicians who prescribe psychotropic medications to foster children, it is unclear whether these methods provide adequate oversight. For instance, state law requires Social Services to establish a foster care ombudsman's office to disseminate information on the rights of foster children and to investigate and attempt to resolve complaints made by or on behalf of foster children related to their care, placement, or services. Nonetheless, according to a consultant in the foster care ombudsman's office, a review of a sample of child welfare complaints over a four-year period showed that the office had not received complaints regarding children being overprescribed psychotropic medications. Similarly, state regulations allow Health Care Services to designate a Medi-Cal managed care ombudsman to investigate and resolve complaints between Medi-Cal beneficiaries and their managed care health plans. However, the chief of Health Care Services' Managed Care Operations Division told us that the managed care ombudsman's office does not investigate complaints regarding inappropriate prescribing of psychotropic medications to foster children and would refer any such complainants to another appropriate program.

Consequently, we believe that the State's reactive approach for overseeing physicians should be supplemented by more proactive steps to better ensure that physicians who prescribe psychotropic medications to foster children adhere to applicable guidelines. Although the Medical Board is trying to take proactive steps, its progress has been slow. Specifically, in April 2015 the Medical Board entered into an agreement with Health Care Services and Social Services to obtain pharmacy claims data for all foster children who were or had been on three or more psychotropic medications for 90 days or longer. The Medical Board's executive director stated that her staff had planned to analyze these data and investigate those physicians who exhibited inappropriate patterns of prescribing psychotropic medications to foster children. However, even though the Medical Board received these data in May 2015,

We believe the State's reactive approach for overseeing physicians should be supplemented by more proactive steps to better ensure that physicians who prescribe psychotropic medications to foster children adhere to applicable guidelines.

the executive director explained in February 2016 that the board had not yet been able to use it to identify physicians with potentially inappropriate prescribing habits.

The executive director attributed the delay to a number of causes. Specifically, she stated that the Medical Board was unable to contract with a consultant to analyze the data until November 2015 because it took longer than expected to identify an appropriate, available expert in the Sacramento area. She further stated that in late January 2016, the consultant reported to the Medical Board that the data were inadequate to perform the desired assessment. The consultant presented a list of additional information necessary to perform the desired analysis, such as each child's targeted diagnosis and weight, and each medication's dosage and frequency. In February 2016, the Medical Board met with Health Care Services and Social Services to request the additional information. Health Care Services responded in March 2016, stating that its claims system does not capture data for the targeted diagnoses, dosages, or frequency of the medications but that it could provide other data fields as substitutes. Health Care Services also said that Social Services could provide each child's weight to the extent its data system captured that information. The Medical Board requested these substitute data fields but, according to the executive director, was still waiting as of April 2016 to hear from the two departments.

Off-label Use of Prescription Medications by Children

According to studies and other documents that we examined, physicians may prescribe medications for *off-label uses*, which are any uses that are not indicated on the medications' approved drug labels. Federal regulations state that any prescription medication approved by the U.S. Food and Drug Administration (FDA) must contain a drug label that identifies its approved uses, including the target population, diagnosis, dosages, and method of administration. According to the FDA, most medicines prescribed for children have not been tested in children and, by necessity, doctors have routinely prescribed medications for off-label use in children. However, the safety and effectiveness of a medication may or may not extend to all age groups or diagnoses that were not tested, which could pose additional risks to a patient prescribed a medication for off-label purposes. Nevertheless, according to the American Academy of Child and Adolescent Psychiatry, it is ethical, appropriate, and consistent with general medical practice to prescribe medication off-label when clinically indicated.

Sources: California State Auditor's review of the FDA's regulations and website and of studies and other documents related to off-label use of medications.

Because the Medical Board has not yet received the necessary information from Health Care Services and Social Services, it does not know when it will be able to complete this project. However, its executive director asserted that if this project is successful in identifying physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board will continue working with Health Care Services and Social Services to review their data on a regular basis.

Health Care Services Does Not Ensure That Pharmacists Obtain Its Approval Before They Dispense Psychotropic Medications to Foster Children for Off-Label Uses

Health Care Services has not consistently ensured that pharmacists obtain its approval before they dispense psychotropic medications to foster children for purposes other than those indicated on the medications' product labels. As the text box describes, such uses of prescription medications

The chief of pharmacy benefits agreed that Health Care Services should consider programming its claims system to trigger TAR requirements for these psychotropic medications based on the patients' ages. He also stated that Health Care Services should evaluate alternative tools and procedures to identify off-label use of medications and better enforce compliance with TAR requirements. For example, he stated Health Care Services could consider developing a process through which its Audits and Investigations Division could include off-label TARs in its retail pharmacy audits.

Finally, as discussed earlier, the Judicial Council recently adopted new and revised forms to request court authorization of psychotropic medications prescribed to foster children. These forms now require physicians to describe why they prescribed psychotropic medications not approved for a child this age. County staff can use this information to better ensure that foster children were properly prescribed psychotropic medications.

Recommendations

Legislature

To improve the State's and counties' oversight of psychotropic medications prescribed to foster children, the Legislature should require Social Services to collaborate with its county partners and other relevant stakeholders to develop and implement a reasonable oversight structure that addresses, at a minimum, the concerns identified in this audit report.

To improve the State's oversight of physicians who prescribe psychotropic medications to foster children, the Legislature should require the Medical Board to analyze Health Care Services' and Social Services data in order to identify physicians who may have inappropriately prescribed psychotropic medications to foster children. If this initial analysis successfully identifies such physicians, the Legislature should require the Medical Board to periodically perform the same or similar analyses in the future. Further, the Legislature should require Health Care Services and Social Services to provide periodically to the Medical Board the data necessary to perform these analyses.

California Department of Social Services

To improve the oversight of psychotropic medications prescribed to foster children, Social Services should collaborate with the counties and other relevant stakeholders—including Health Care Services, as

necessary—to develop and implement a reasonable oversight structure that ensures the coordination of the State’s and counties’ various oversight mechanisms as well as the accuracy and completeness of the information in Social Services’ data system. This structure should include at least the following items:

- Identification of the specific oversight responsibilities to be performed by the various state and local government agencies.
- An agreement on how county staff such as social workers, probation officers, and public health nurses will use printed Health and Education Passports to obtain foster children’s necessary mental health information—including psychotropic medications and psychosocial services—for inclusion in Social Services’ data system.
- A plan to ensure that counties have sufficient staff available to enter foster children’s mental health information into Social Services’ data system and the resources to pay for those staff.
- An agreement on the specific information related to psychotropic medication—including but not limited to the medication name, maximum daily dosage, and court authorization date—and psychosocial services and medication follow-up appointment information that county staff must enter into Social Services’ data system for inclusion in foster children’s Health and Education Passports.
- Specific directions from Social Services regarding the correct medication start dates and court authorization dates counties should include in its data system and foster children’s Health and Education Passports.
- An agreement on the training or guidance Social Services should provide to county staff members working with Social Services’ data system to ensure that they know how to completely and accurately update foster children’s Health and Education Passports.
- An agreement on how the counties will use information on the new authorization forms that the Judicial Council approved to better oversee the prescription of psychotropic medications to foster children.
- An agreement regarding how counties will implement, use, or disseminate the educational and informational materials the Quality Improvement Project has produced, including the *California Guidelines for the Use of Psychotropic Medication with Children and Youth in Foster Care*, *Questions to Ask About Medications*, and the *Foster Youth Mental Health Bill of Rights*.

- An agreement on the specific measures and the best available sources of data the State and counties will use to oversee foster children prescribed psychotropic medications, including psychosocial services and medication follow-up appointments.
- An agreement on how the State and counties will oversee psychotropic medications prescribed to foster children by fee-for-service providers who are not affiliated with county Medi-Cal mental health plans.
- An agreement on the extent of information related to psychotropic medications prescribed to foster children that counties will include in the self-assessments, system improvement plans, and annual progress reports they develop as part of Social Services' California Child and Family Services Reviews.
- An agreement on the extent of the information related to psychotropic medications prescribed to foster children that counties will include in their responses to Health Care Services' reviews, including its county Medi-Cal mental health plan compliance reviews and external quality reviews.

California Department of Social Services and the Department of Health Care Services

To ensure that the Medical Board can promptly complete its analysis to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, Social Services and Health Care Services should continue to work with the Medical Board and its consultant to meet their data needs. If the Medical Board's analysis is able to identify these physicians, Social Services and Health Care Services should enter into an agreement with the Medical Board to provide the information the Medical Board needs to perform similar analyses in the future.

Department of Health Care Services

To increase the State's assurance that foster children do not receive medically inappropriate or unnecessary psychotropic medications, Health Care Services should devise and implement within six months methods to better enforce its prior authorization requirement for the off-label use of psychotropic medications. For example, Health Care Services should revise its claims system to automatically prompt pharmacists to submit treatment authorization requests when filling prescriptions for Medi-Cal beneficiaries under age 18 when the prescribed psychotropic medications have no FDA-approved pediatric uses. Furthermore,

as part of its collaboration with Social Services and the counties to develop and implement a reasonable oversight structure, Health Care Services should determine whether information from the Judicial Council's revised court authorization forms would help it better enforce its prior authorization requirements.

Medical Board of California

To ensure that physicians do not inappropriately prescribe psychotropic medications to foster children, the Medical Board should take the following steps:

- Within 60 days, obtain and analyze the data from Health Care Services and Social Services to identify physicians who may have inappropriately prescribed psychotropic medications for foster children.
- Following the completion of this analysis, take the appropriate follow-up actions that it deems necessary, including the investigation of physicians identified in its analysis.
- To the extent that its analysis is able to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board should enter into an agreement with Health Care Services and Social Services within six months of completing its initial review to periodically obtain the data necessary to perform the same or similar analyses.

BUSINESS, CONSUMER SERVICES, AND HOUSING AGENCY - *Department of Consumer Affairs* EDMUND G. BROWN JR, *Governor*



MEDICAL BOARD OF CALIFORNIA
Executive Office



June 6, 2016

Elaine M. Howle
California State Auditor
Bureau of State Audits
621 Capitol Mall, Suite 1200
Sacramento, CA 95814

Re.: Draft Audit Report 2015-131 – California’s Oversight of Psychotropic Medications Prescribed to Children in Foster Care

Dear Ms. Howle:

The Medical Board of California (Board) is in receipt of your draft audit report regarding California’s oversight of psychotropic medications prescribed to children in foster care. The Board received the portions of the draft audit related to the Medical Board. I would like to thank the Bureau of State Audits for conducting this audit and for allowing the Board to respond to the issues presented in the audit report. The Board agrees that a proactive approach to this issue is essential in order to ensure appropriate prescribing to foster children. The Board has been working on this issue and, as stated in the report, is currently under a data usage agreement (DUA) with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) to obtain specified prescribing information for foster children. The Board is currently waiting for additional information that is necessary for the Board’s consultant to perform the desired data analysis assessment. This additional information was originally requested from DHCS and DSS by the Board in February 2016.

In addition, the Board has been working closely with Senator McGuire on his bill, SB 1174. This bill would add to the Board’s priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill would require the Board to confidentially collect and analyze data submitted by DHCS and DSS, related to physicians prescribing psychotropic medications to children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the Board has received under the existing DUA is only a snapshot in time, for a six-month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. Once a possible inappropriate prescriber is identified, the Board will still have to go through its normal complaint and investigation process. The Board believes this bill responds to the draft audit recommendations to the Legislature.

The Board would like to respond to the recommended steps the draft report suggests that the Board should take:

Recommendation: Within 60 days, obtain and analyze the data from DHCS and DSS to identify physicians who may have inappropriately prescribed psychotropic medications for foster children.

Response: The Board does plan on having the Board’s consultant analyze the additional data that has been requested from DHCS and DSS as soon as it is received. The Board will commit to requiring the Board’s consultant to perform an analysis of the data within 60 days of receipt.

Elaine M. Howle
June 6, 2016
Page 2

Recommendation: Following the completion of its analysis, take the appropriate follow-up actions, including the investigation of physicians identified in its data analysis, that it deems necessary.

Response: Once the Board's consultant identifies physicians that need further review, the Board will begin its complaint and investigation process. The first step will involve asking assistance from DSS, as the data provided to the Board does not include names of foster children. Per the DUA, DSS will provide technical assistance, which includes, but is not limited to, facilitating contact with county child welfare agencies, the juvenile courts, county counsel, children's attorneys and other relevant entities to assist the Board in securing a court order authorizing it to obtain child-specific information, including relevant medical records. Once the child-specific medical records are obtained, the Board will follow its normal complaint and investigation process, which is confidential.

Recommendation: To the extent that its analysis is able to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board should enter into an agreement with DHCS and DSS within six months of completing its initial review to periodically obtain the data necessary to perform the same or similar analysis.

Response: If SB 1174 passes and is signed into law, similar prescribing data will be provided to the Board on an on-going basis. If SB 1174 is not signed into law, the Board will work with DHCS and DSS to revise the existing DUA to ensure that the Board receives the most current data and that the Board receives this data on an on-going basis. However, this revised DUA will have to be agreed upon by all parties involved.

The Board greatly appreciates the opportunity to respond to the draft report and its recommendations. The Board takes the recommendations in the draft report very seriously and believes that the issues raised are very important, as consumer protection is the Board's primary mission. If you have any questions regarding this response, please contact me at (916) 263-2389.

Sincerely,



Kimberly Kirchmeyer
Executive Director

cc: Alexis Podesta, Acting Secretary, Business, Consumer Services and Housing Agency
Awet Kidane, Director, Department of Consumer Affairs

Audit Report 2015-131 – California’s Foster Care System – The State and Counties Have Failed to Adequately Oversee the Prescription of Psychotropic Medications to Children in Foster Care

Medical Board of California’s Recommendations and Responses

Recommendation 34:

Within 60 days, obtain and analyze the data from DHCS and DSS to identify physicians who may have inappropriately prescribed psychotropic medications for foster children.

Response – Fully Implemented as of August 2016:

The Medical Board of California's (Board's) consultant has analyzed the additional data that has been requested from the Department of Health Care Services (DHCS) and the Department of Social Services (DSS) and has identified physicians who may have inappropriately prescribed psychotropic medications to foster children. The Board provided DSS with a listing of the patient de-identifiers on August 8, 2016. Per the DUA, the Board requested assistance from DSS in obtaining authorizations for medical records for these foster children. DSS is currently working on obtaining feedback from each county in order to determine the best process to get the authorizations the Board needs to continue its investigations.

Recommendation 35:

Following the completion of its analysis, take the appropriate follow-up actions, including the investigation of physicians identified in its data analysis, that it deems necessary.

Response – Not Fully Implemented, Estimated Completion Date – April 1, 2017

The Medical Board of California (Board) has completed the first step of requesting assistance from the Department of Social Services (DSS), as the data provided to the Board does not include names of foster children. Per the DUA, DSS will provide technical assistance, which includes, but is not limited to, facilitating contact with county child welfare agencies, the juvenile courts, county counsel, children's attorneys and other relevant entities to assist the Board in securing a court order authorizing it to obtain child-specific information, including relevant medical records. Once the child-specific medical records are obtained, the Board will follow its normal complaint and investigation process to determine if discipline is warranted.

Recommendation 36:

To the extent that its analysis is able to identify physicians who may have inappropriately prescribed psychotropic medications to foster children, the Medical Board should enter into an agreement with DHCS and DSS within six months of completing its initial review to periodically obtain the data necessary to perform the same or similar analysis.

Response – Fully Implemented as of October 2016

Although the Medical Board of California (Board) has not entered into a new agreement with the Department of Health Care Services (DHCS) and the Department of Social Services (DSS), however, this is no longer necessary as SB 1174 (McGuire, Chapter 840, Statutes of 2016) was signed into law by the Governor.

SB 1174 requires DHCS and DSS to provide data to the Board on an annual basis, pursuant to a data-sharing agreement, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. For each foster child who falls into this category, the following information shall be submitted to the Board: a list of the psychotropic medications prescribed; the start and stop dates, if any, for each psychotropic medication prescribed; the prescriber's name and contact information; the child or adolescent's year of birth; the unit and quantity of the medication and the number of days' supply of the medication; and any other information that is de-identified and necessary to the Board to allow the Board to exercise its statutory authority as an oversight entity.

This bill requires the Board to review this data on a quarterly basis to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, conduct an investigation. If the Board investigates a physician for inappropriate prescribing and concludes that there is a violation of law, the Board must take appropriate disciplinary action. This bill requires the Board to report this data annually to the Legislature in its annual report.

Since SB 1174 has been signed into law, this prescribing data will now be provided to the Board on an on-going basis.

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*

Edmund G. Brown Jr., Governor
Dev GnanaDev, M.D., President, Medical Board of California
Kimberly Kirchmeyer, Executive Director, Medical Board of California



STATE OF CALIFORNIA

EDMUND G. BROWN JR., GOVERNOR
ALEXIS PODESTA, ACTING SECRETARY, BUSINESS, CONSUMER SERVICES AND HOUSING AGENCY
AWET KIDANE, DIRECTOR, DEPARTMENT OF CONSUMER AFFAIRS

MEDICAL BOARD OF CALIFORNIA

DEV GNANADEV, M.D., PRESIDENT
DENISE PINES, VICE PRESIDENT
RONALD LEWIS M.D., SECRETARY
KIMBERLY KIRCHMEYER, EXECUTIVE DIRECTOR

Additional copies of this report can be obtained from: www.mbc.ca.gov

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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

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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 licensing¹ 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.)

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 HQUI, 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.

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.

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.

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.

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 meetings 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

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. Serrano Sewell made public outreach and increased awareness of the Board a major goal, as well as increasing the use of Interim

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.

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

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

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.

➤ *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

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

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

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

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

have all of the sites inspected. 16 CCR section 1313.4 said 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.

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-RjFWJcl> (provider PSA) and <https://www.youtube.com/watch?v=7Rk3oVwpgk> (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

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

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

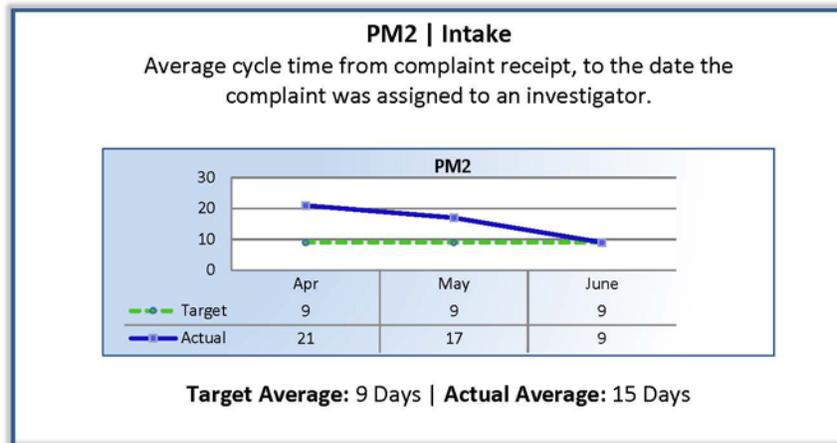
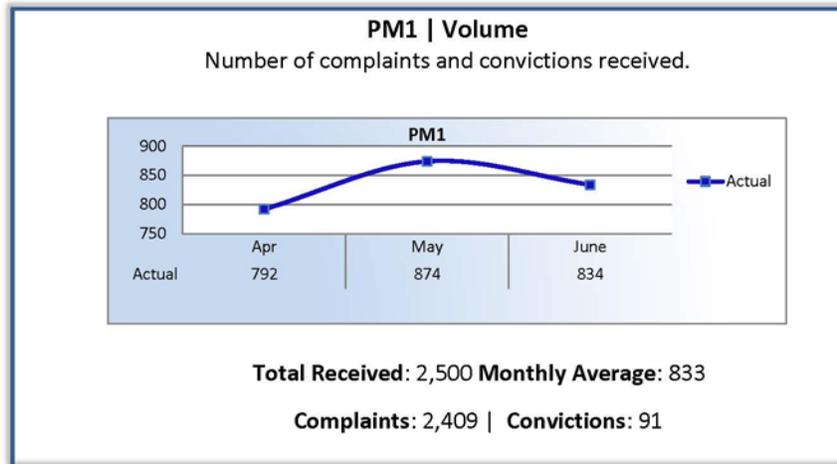
All quarterly and annual performance measure reports for FY 12/13, FY 13/14, and quarterly reports for FY 14/15, and FY 15/16 as published on the Department of Consumer Affairs (DCA) website are in [Section 12, Attachment M](#). The DCA discontinued publishing an annual performance measure report after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

DRAFT

Performance Measures

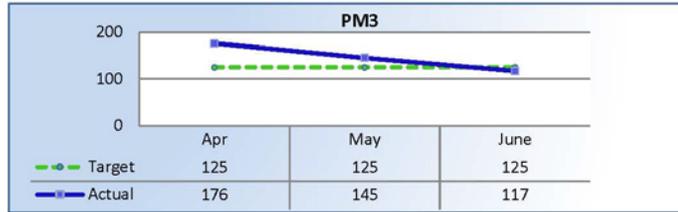
Q4 Report (April - June 2016)

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.



PM3 | Intake & Investigation

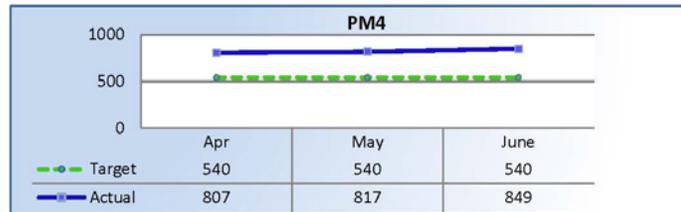
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



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



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

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.

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

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

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

FY 2015-2016	Q1	Q2	Q3	Q4
	132	174	224	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	Q2	Q3	Q4
	132	174	224	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	Q2	Q3	Q4
	132	174	224	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%

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%

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.

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%

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.

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.

	FY 2012/13		FY 2013/14		FY 2014/15		FY 2015/16	
	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.

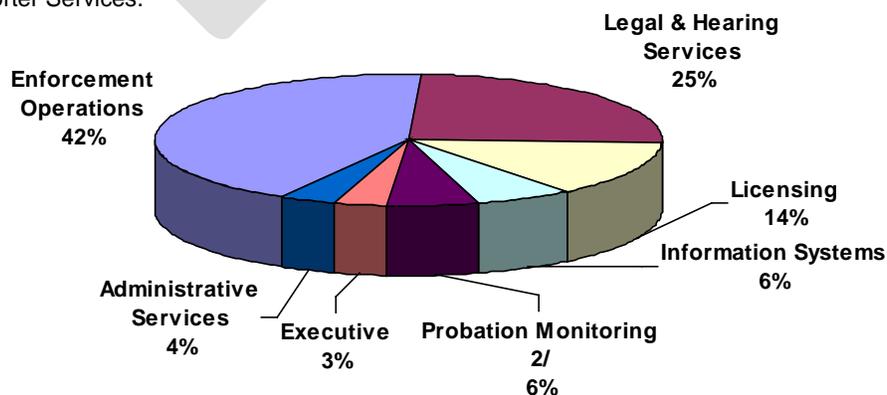
² In FY 14/15, Pro Rata includes Health Quality Investigation Unit expenditures of \$16,313,540. In FY 15/16, the amount was \$16,335,960.

³ Totals exclude both scheduled and unscheduled reimbursements.

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

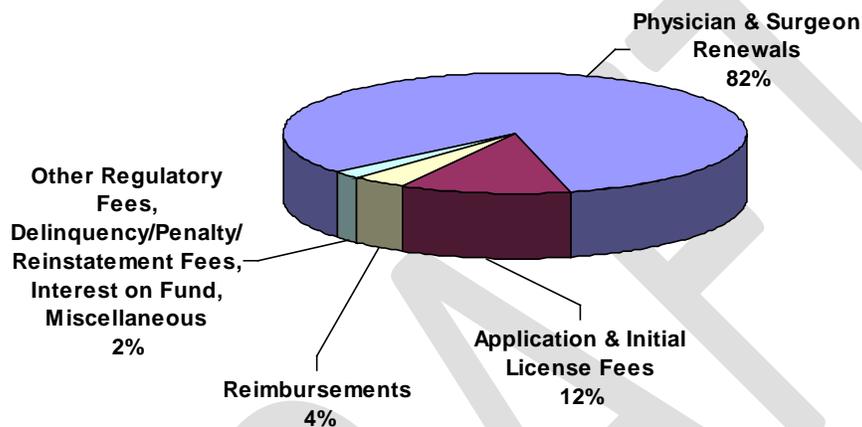
The Board's main source of revenue is from the physician's renewal fees. This is illustrated below in the Revenues and Reimbursements chart, which is included in the Board's Annual Report. Both the fees for the allied health programs and physician's renewal fee have remained the same since the last Sunset 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%

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).

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

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.

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.

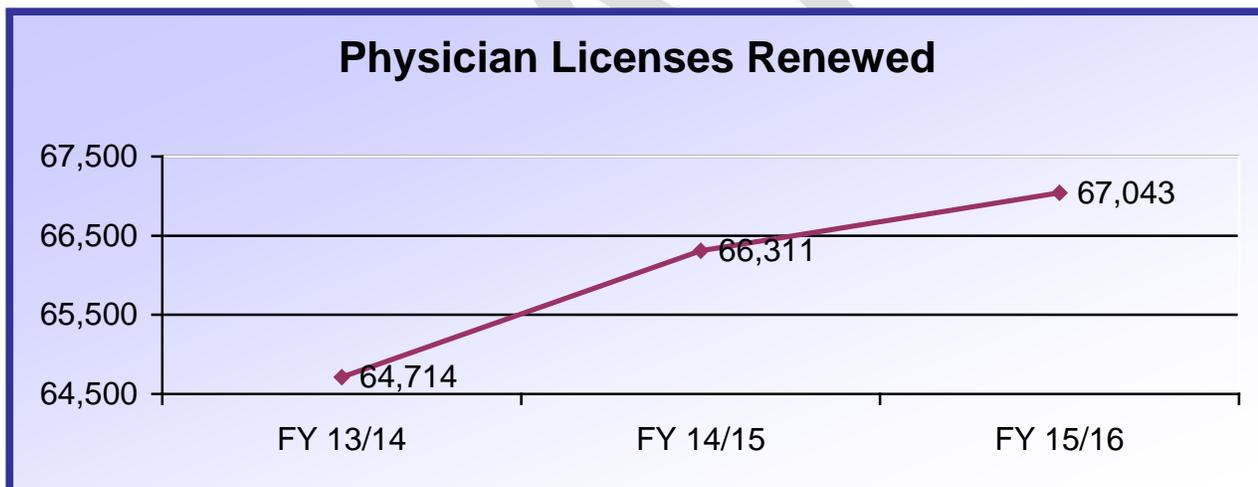
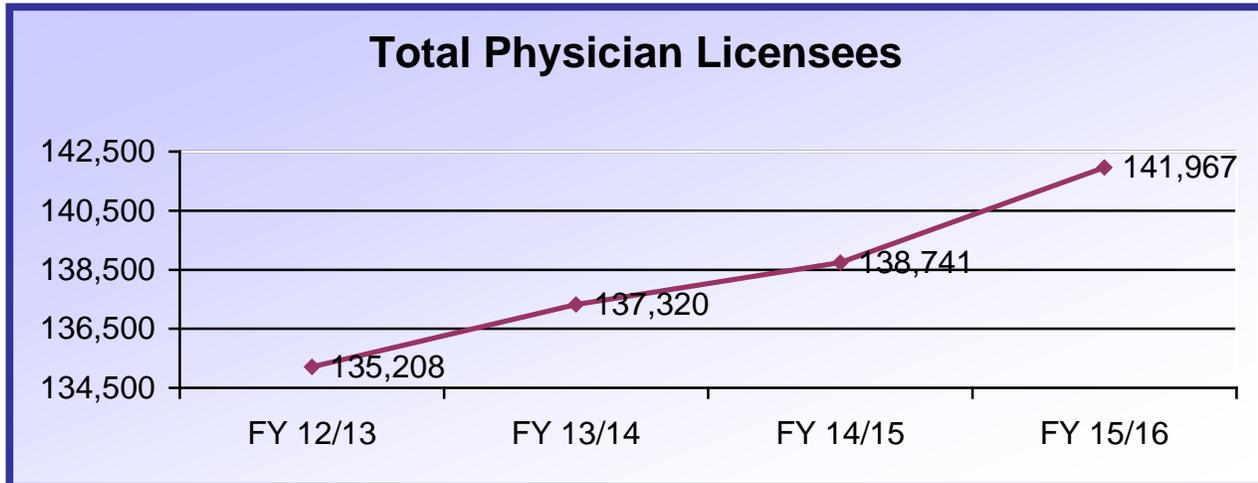
In addition, the Board evaluates physician specialty boards that are not affiliated with, or certified by, the ABMS but believe they have equivalent requirements.

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.

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.

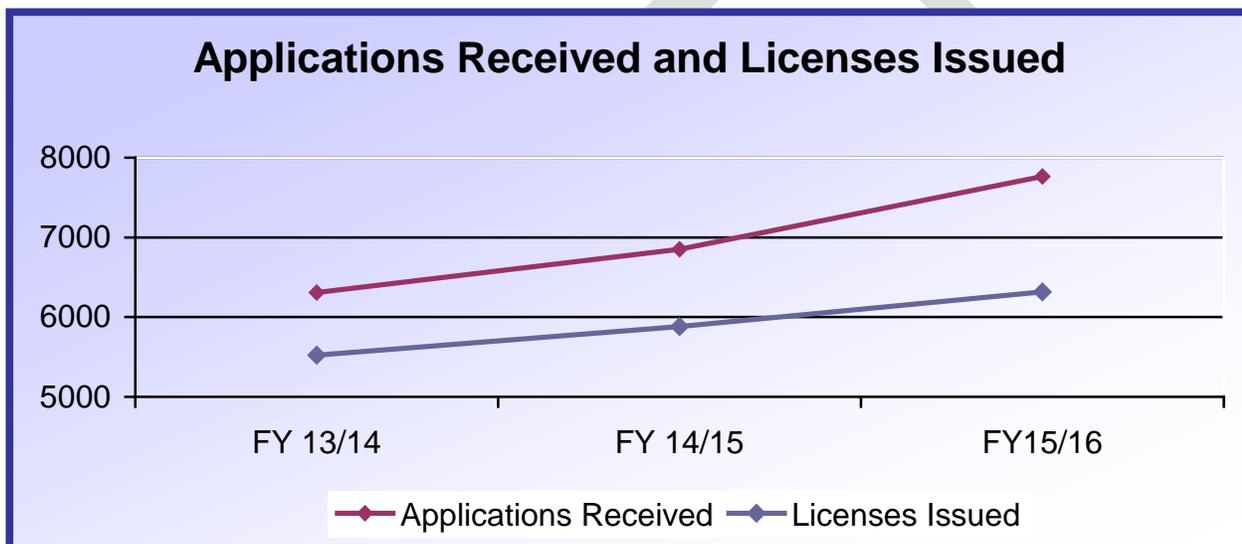
Although timeframes are defined in regulations (60 working days, approximately 90 calendar days), the Board has set expectations and a Strategic Plan objective that U.S./Canadian, international, and Postgraduate Training Authorization Letter (PTAL) applications be reviewed

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.

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.

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
<p>* 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</p>			

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,

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,

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

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

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.

- 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

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 a 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)TM*;

- 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

- 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.

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

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.

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.)

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 reinstated 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.

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.

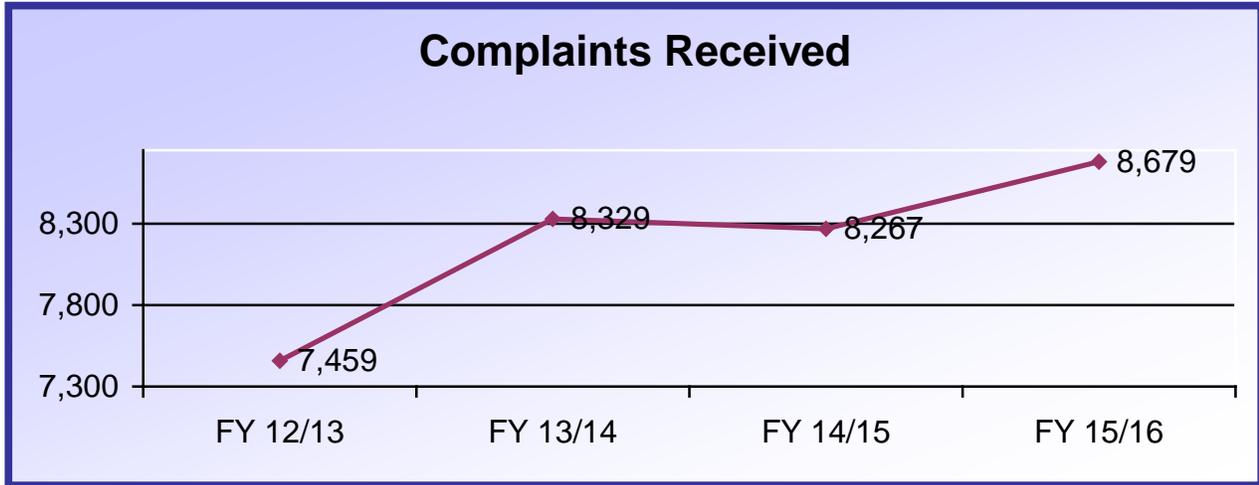
Lastly, a new cloud based content sharing solution was implemented by HQIU and the AG's Office to share confidential evidentiary materials regarding case investigations among the VE/P team in real-time. This development has helped to reduce the time it took for team members to receive important information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

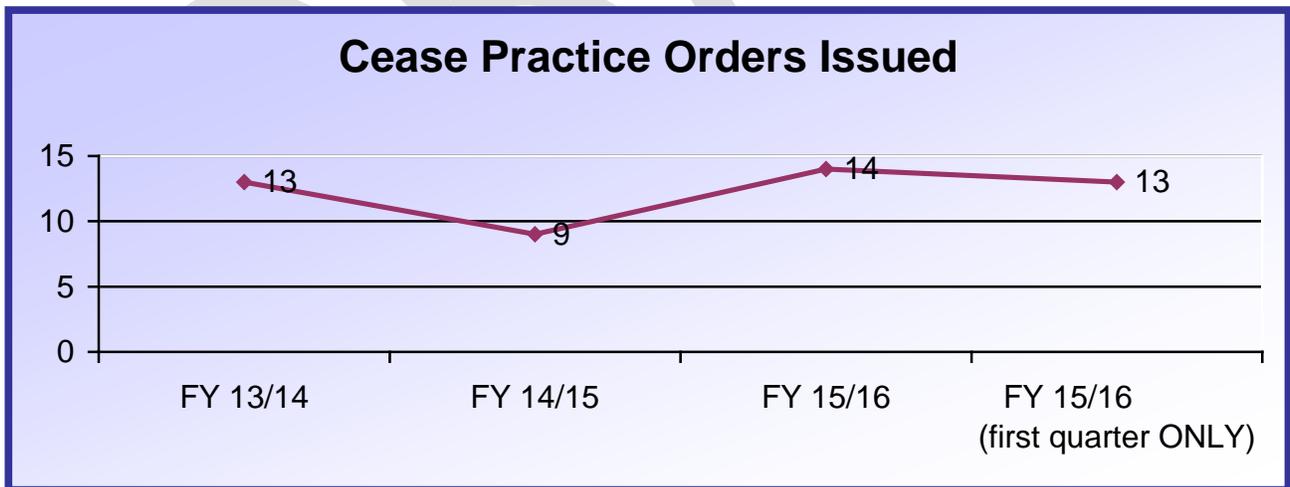
During FY 2015/2016, parallel prosecution guidelines were developed by the HQIU and the AG's Office to ensure that public protection is achieved in cases that are being submitted to the District Attorney's (DA) Office for criminal prosecution. The guidelines lay out a process for dual referrals to the 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.

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, HQUI, 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

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, HQUI. 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.

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.

Fiscal Year	Prior Sunset Review Report			Three Year Average	Current Sunset Review Report			Three Year Average
	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 extent or in such a manner as to be dangerous or injurious to the licensee, or any other persons, or the public, or to the extent that such use impairs the ability of the licensee 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

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

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.

- 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).

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

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

DRAFT

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.

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.

- 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;

- 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.

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.

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 *website* 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

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.

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.

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.

Section 9

Current Issues

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



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.

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.

DRAFT

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.

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.

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.

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.

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.

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

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.

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.

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.

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.

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.

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 BreZE 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.

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;

- 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.

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, Statutes 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.

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.

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.

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.

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.

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 pursue 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

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.

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

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.

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).

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

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.

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

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 midwives 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

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.*

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?*

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 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 (HQUES) prosecutors to work together from the beginning of an investigation to the conclusion of legal proceedings. The MBC and the HQUES 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 licensee'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 licensee 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 statute is amended to give the MBC the authority to issue a cease practice order in cases where the licensee 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?

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.

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 BReZE implementation by the MBC?

Background: The BreZE Project will provide DCA boards, bureaus, and committees with a new enterprise-wide enforcement and licensing system. BreZE will replace the existing outdated legacy systems and multiple “work around” systems with an integrated solution based on updated technology.

BreZE 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, BreZE will improve DCA’s service to the public and connect all license types for an individual licensee. BreZE 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 BreZE solution will be maintained at a three-tier State Data Center in alignment with current State IT policy.

BreZE 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 BreZE Project. Due to increased costs in the BreZE 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 BreZE project costs.

The MBC is scheduled to begin using BreZE in the “Early Spring” of 2013. It would be helpful to update the Committee about MBC’s current work to implement the BreZE project.

Prior to the DCA BreZE 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.

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

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, professional 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.

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 of electives) 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

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.

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

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.

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.

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 1014².

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.

DRAFT

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.

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.

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.

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.

(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.

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,

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)								
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
1110-19	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

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.

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

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 three-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 midwives.

The majority of the complaints received regarding licensed midwives 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 midwives 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

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			

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

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2016 Medical Board Sunset Report

Section 11 – New Issues

None

DRAFT

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.

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

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.

		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.

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

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

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

DRAFT

Part IV

Research Psychoanalyst

- Background and Description of Research Psychoanalyst Program
- Licensing Program
- Enforcement Program



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

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.

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

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 its investigative resources to pursue and prosecute, if appropriate, individuals providing psychoanalysis services without the proper registration.

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

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

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

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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Board Member Administrative Procedure Manual

Updates to Manual – April 2013

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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.
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

(Government Code section 11120 et seq.)

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

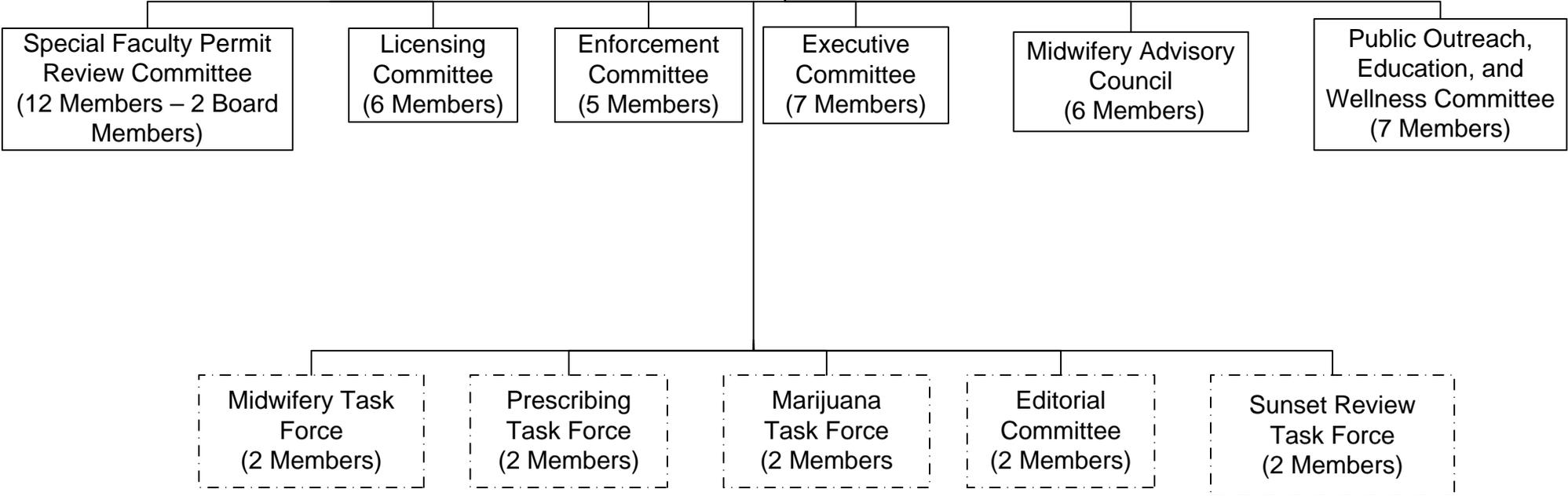
DCA Orientation: July 27, 2010

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)



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



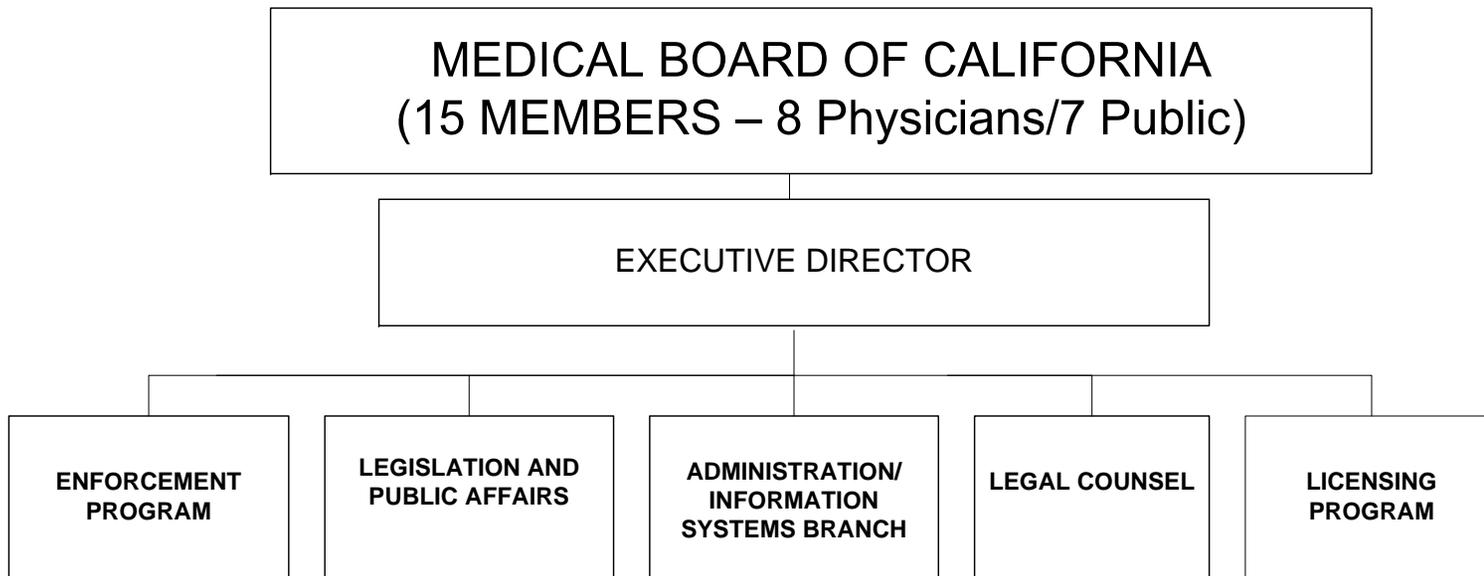
Major Studies Conducted by the Board and Major Publications Prepared by the Board

- **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-RjFWJcl>
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

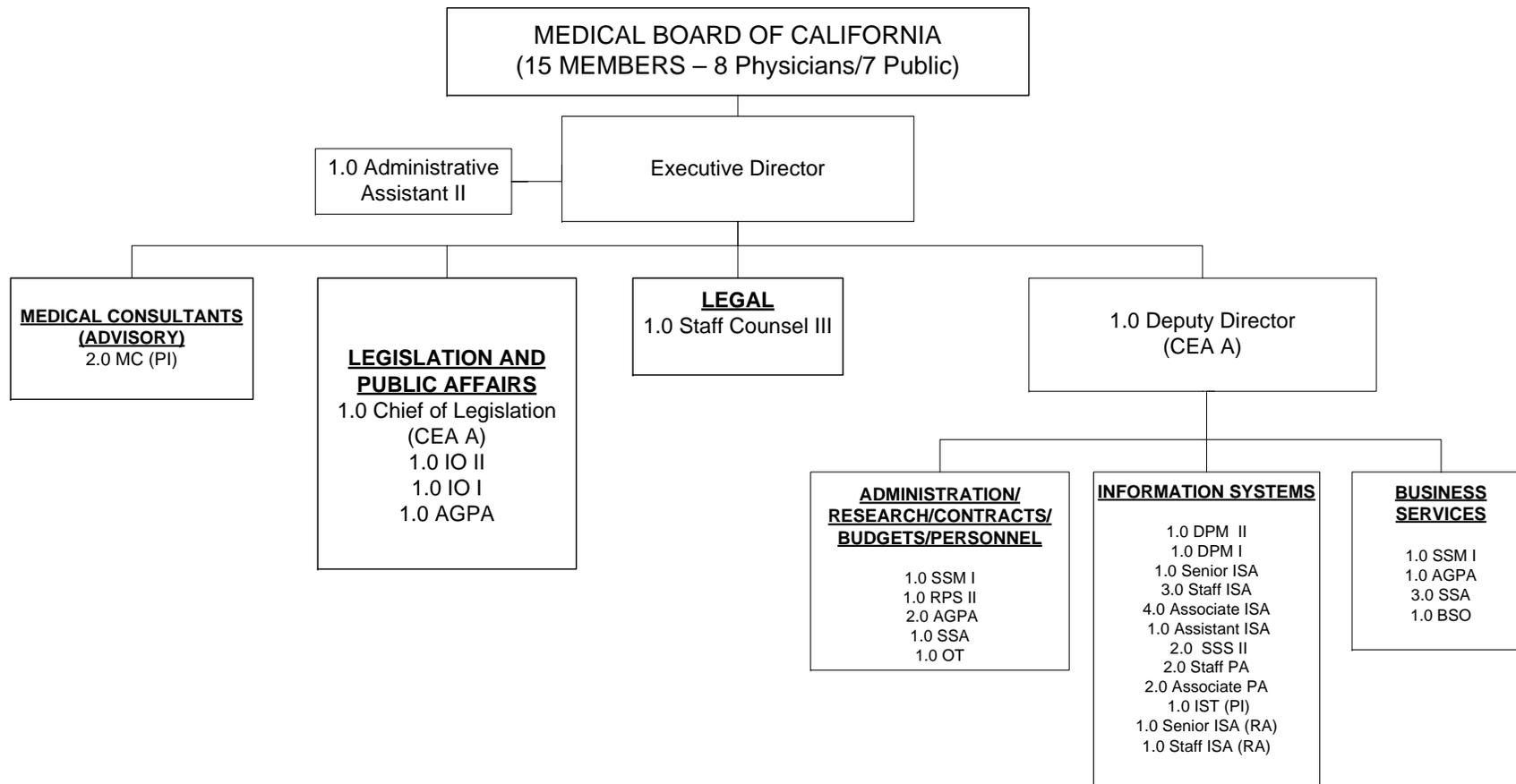




FY 2015/2016

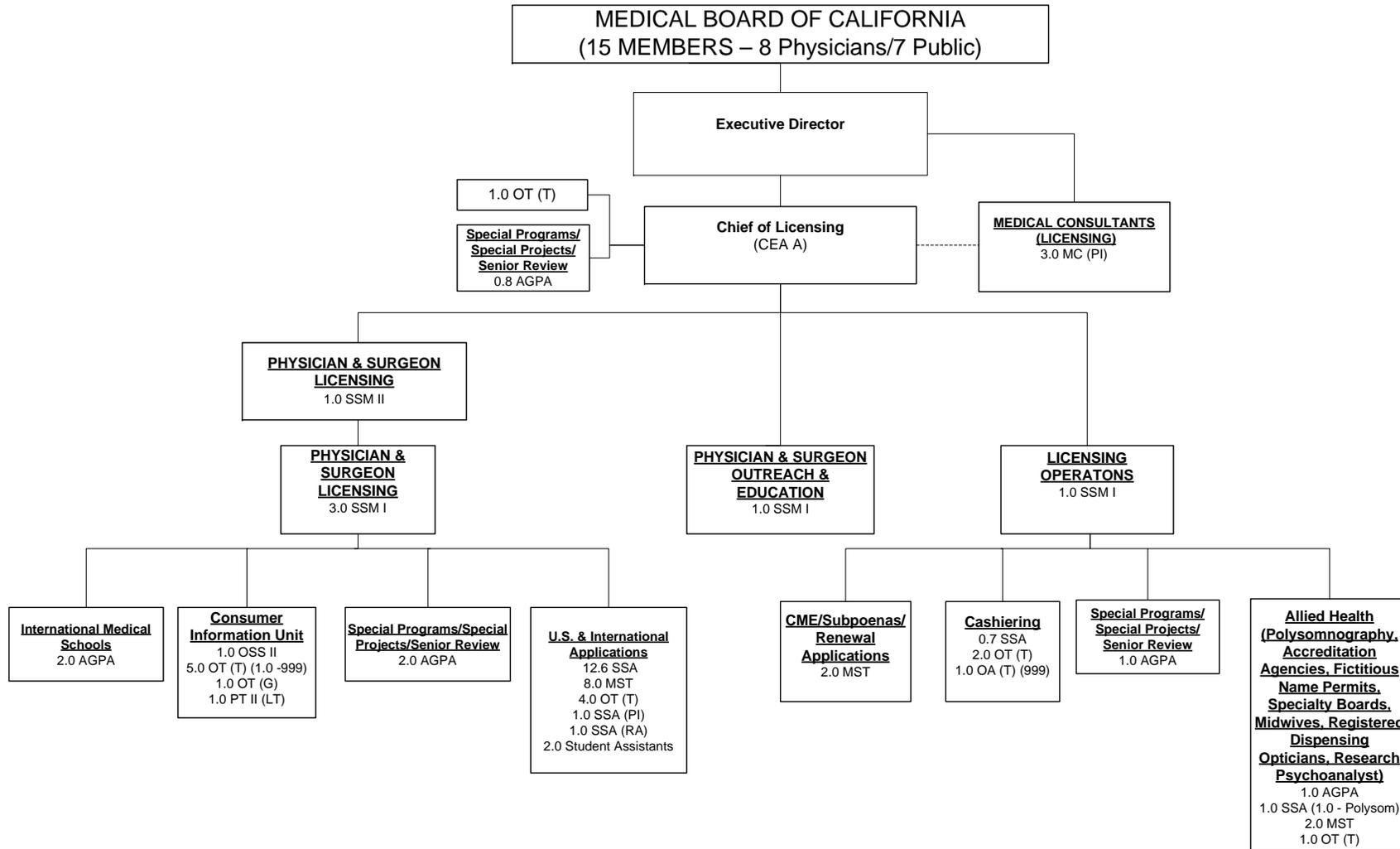
160.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Administrative and Executive Programs
 FY 2015/2016



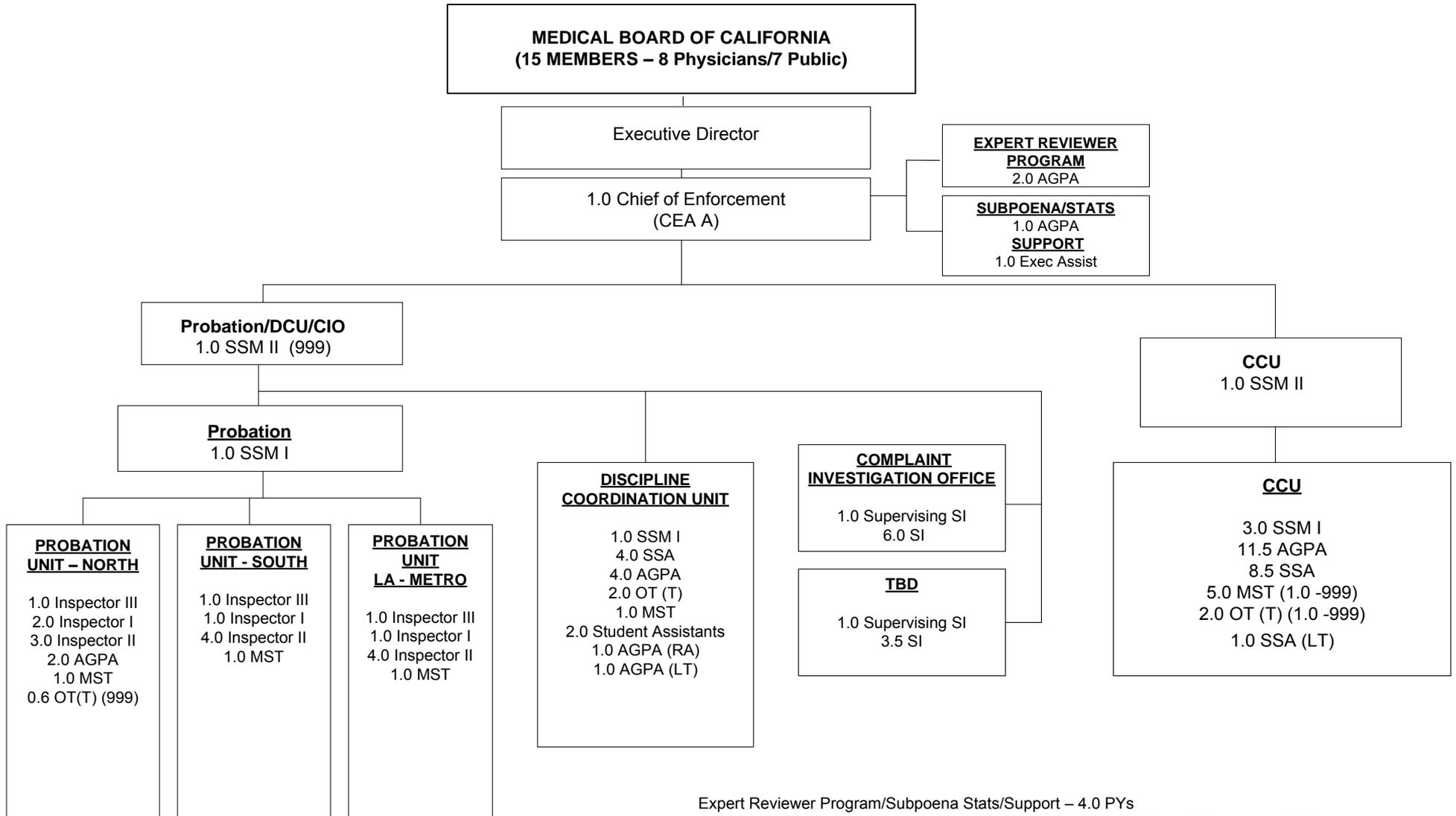
Information Systems Branch – 17.0 PYs plus 1.0 permanent intermittent (IST) and 2.0 retired annuitants (Sr. ISA & SISA)
 Administrative Services including Research Program Specialist II – 6.0 PYs
 Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Licensing Program
 FY 2015/2016

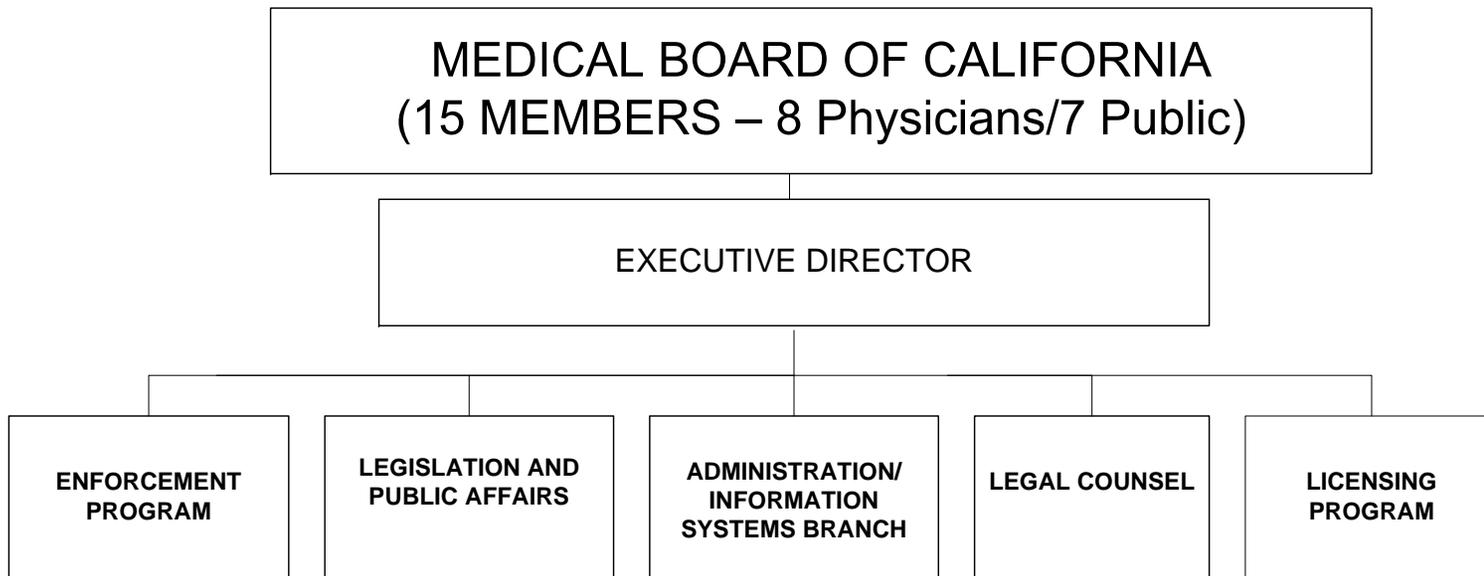


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 3.0 re-established BL 12-03 (999) (1.0 SSM II, 1.0 OT-T, 1.0 OA-T), 4.0 permanent intermittent (1.0 SSA, 3.0 MC), 1.0 retired annuitant (SSA), 1.0 limited term (PT II)

Department of Consumer Affairs
 MEDICAL BOARD OF CALIFORNIA
 Enforcement Program
 Discipline Coordination Unit
 Complaint Investigation Office
 Central Complaint Unit
 Probation Unit
 FY 2015/2016



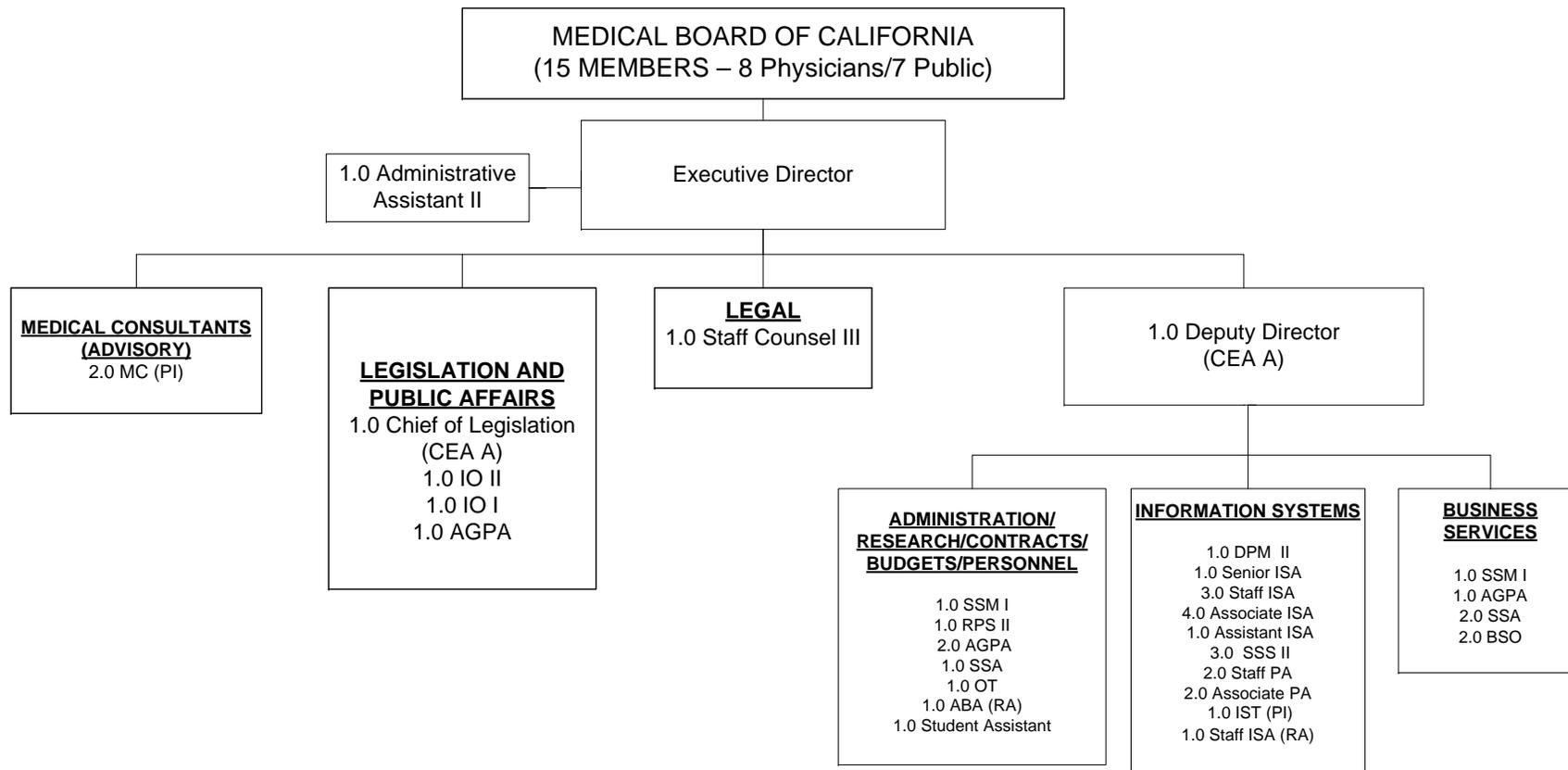
Expert Reviewer Program/Subpoena Stats/Support – 4.0 PYs
 Probation – 24.0 PYs plus 1.6 re-established BL 12-03 staff (999) (1.0 SSM II and 0.6 OT-T)
 Discipline Coordination Unit – 12.0 PYs plus 2.0 student assistants, 1.0 retired annuitant (AGPA),
 1.0 limited term (AGPA)
 Complaint Investigation Office – 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 SSM II, 1.0 OT-T) and
 1.0 limited term (SSA)



FY 2014/2015

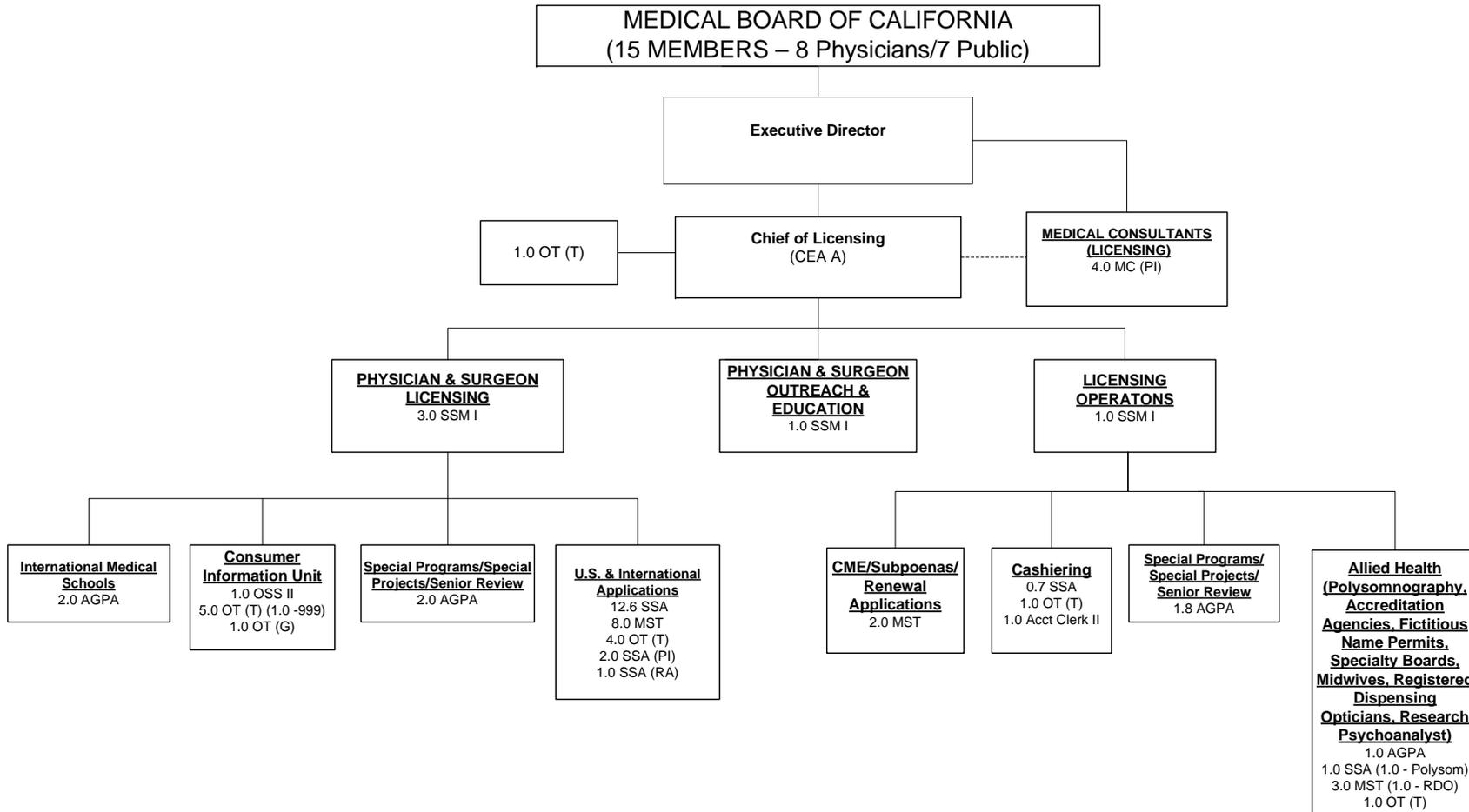
160.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Administrative and Executive Programs
 FY 2014/2015



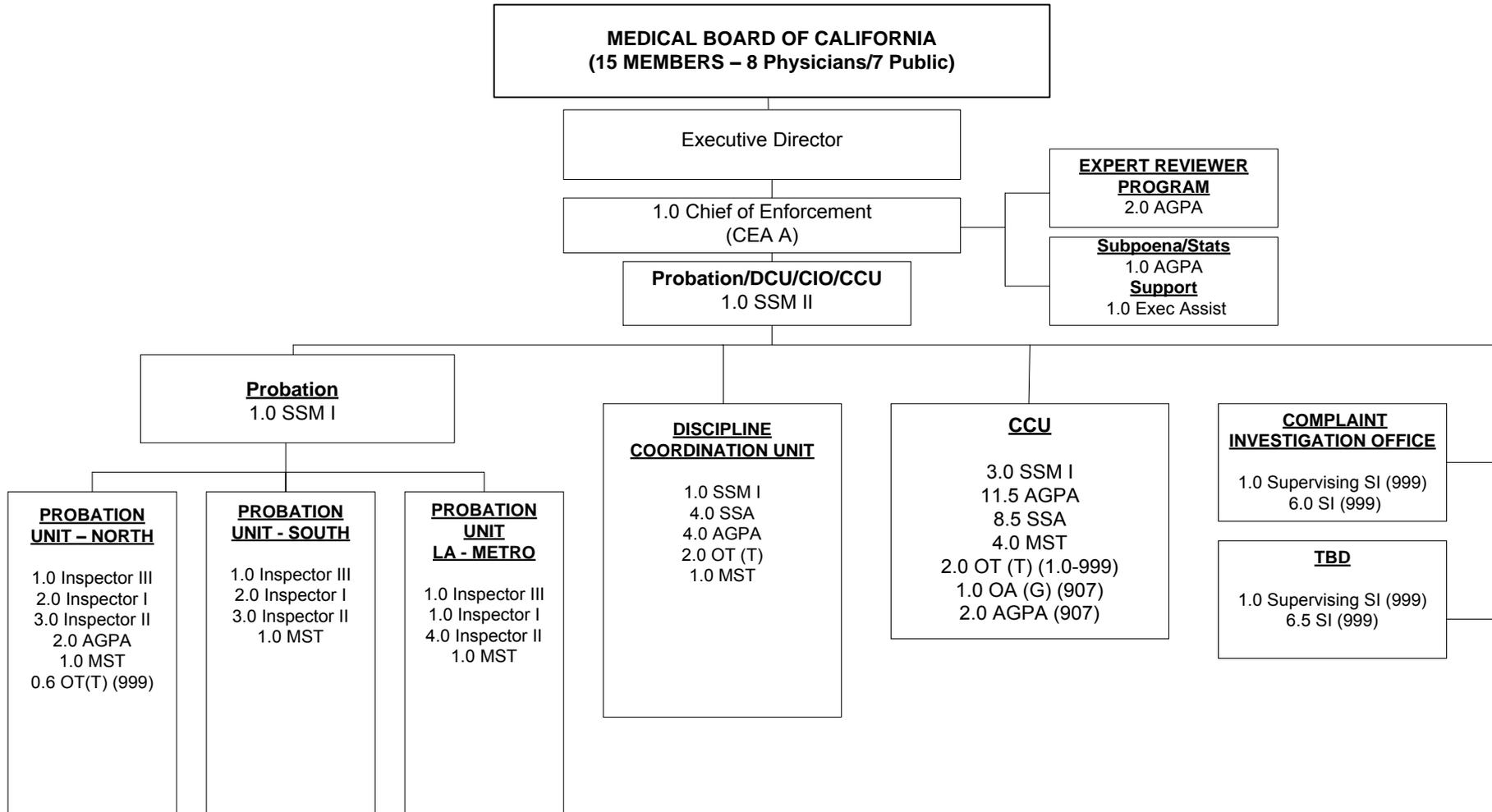
Information Systems Branch – 17.0 PYs plus 1.0 permanent intermittent (IST) and 1.0 retired annuitant (SISA)
 Administrative Services including Research Program Specialist II – 6.0 PYs, plus 1.0 retired annuitants (ABA) and 1.0 Student Asst.
 Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Licensing Program
 FY 2014/2015

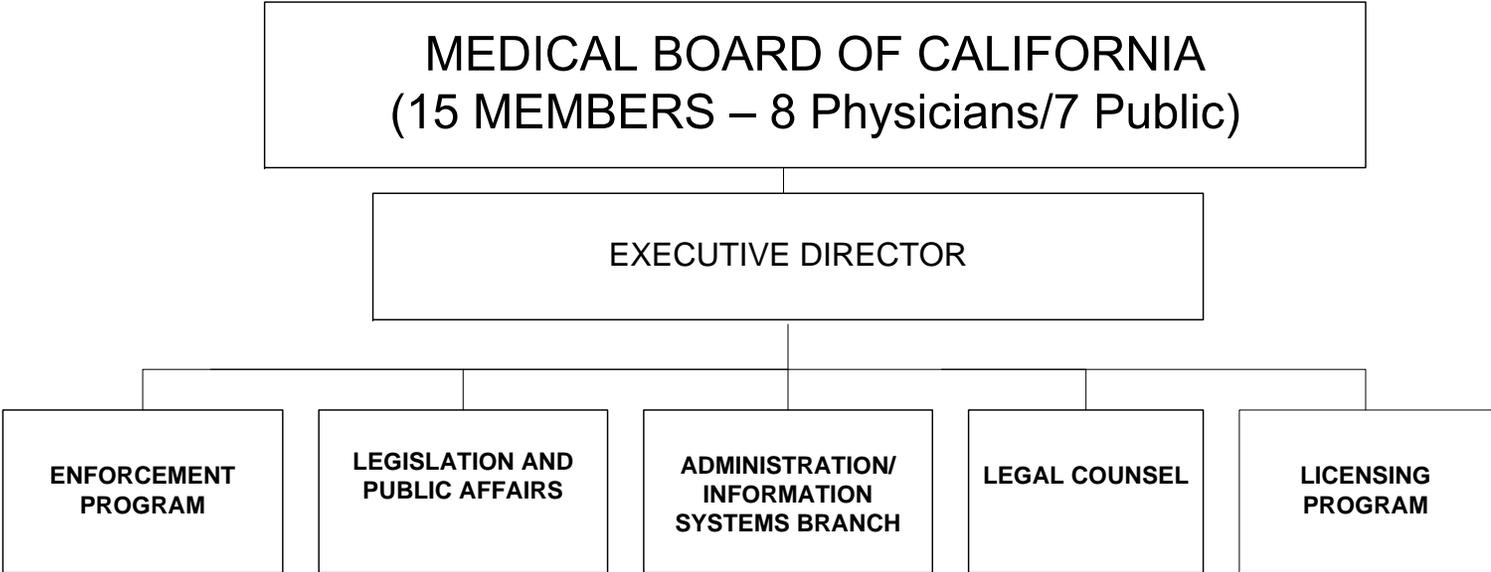


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 1.0 re-established BL 12-03 (999) (OT-T), 6.0 permanent intermittent (2.0 SSA, 4.0 MC), 1.0 retired annuitant (SSA), Registered Dispensing Opticians Program (Agency Code 599) 1.0 (MST)

Department of Consumer Affairs
 MEDICAL BOARD OF CALIFORNIA
 Enforcement Program
 Discipline Coordination Unit
 Complaint Investigation Office
 Central Complaint Unit
 Probation Unit
 FY 2014/2015

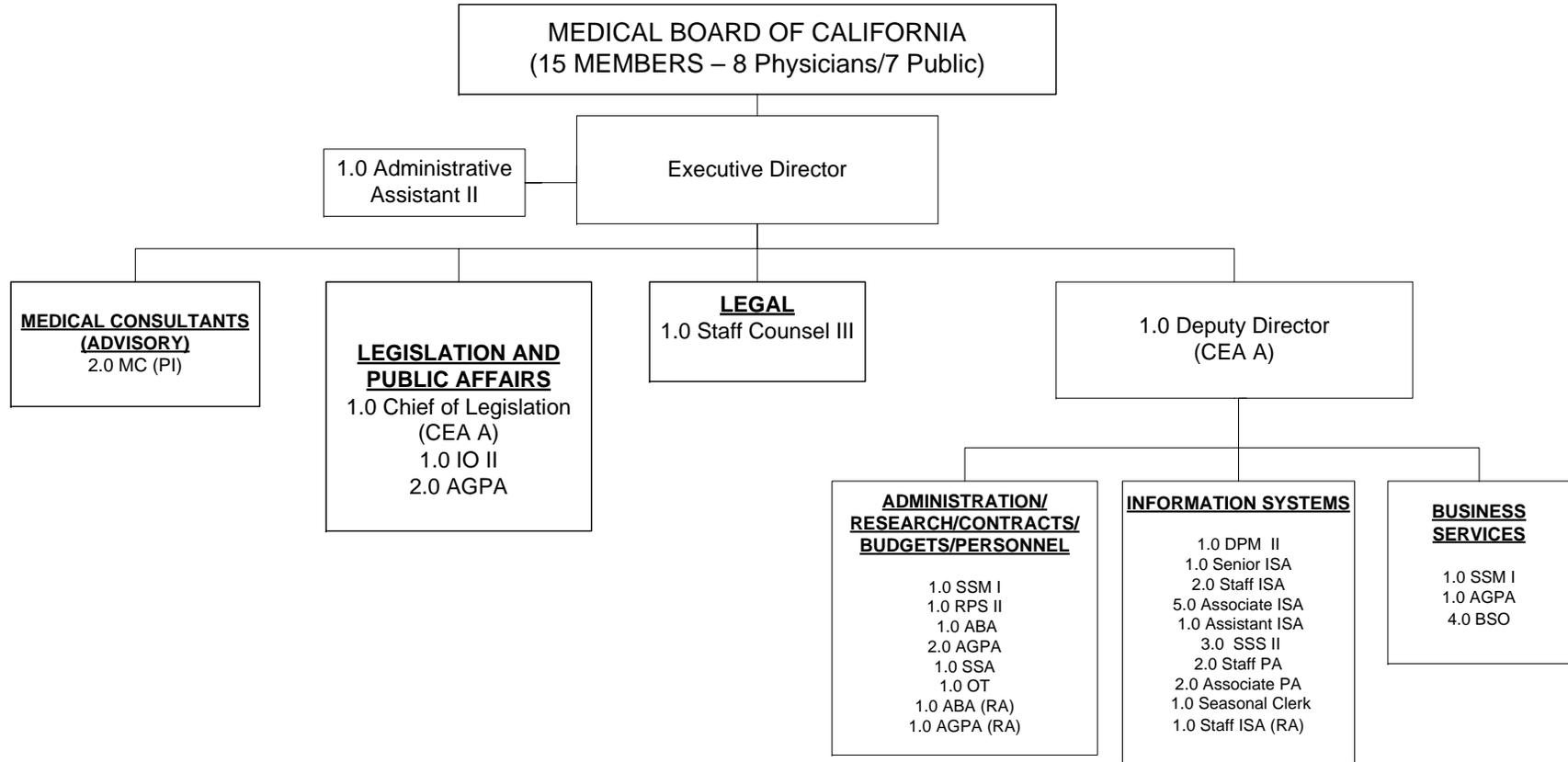


Expert Reviewer Program/Subpoena Stats/Support – 4.0 PY
 Probation – 24.0 PYs plus 0.6 re-established BL 12-03 staff (999) (1.0 SSM II and 1.0 OT-T)
 Discipline Coordination Unit – 12.0 PYs
 Complaint Investigation Office – 7.0 re-established BL 12-03 staff (999), 7.5 vacant
 Central Complaint Unit – 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)
 Section 12 Page 287



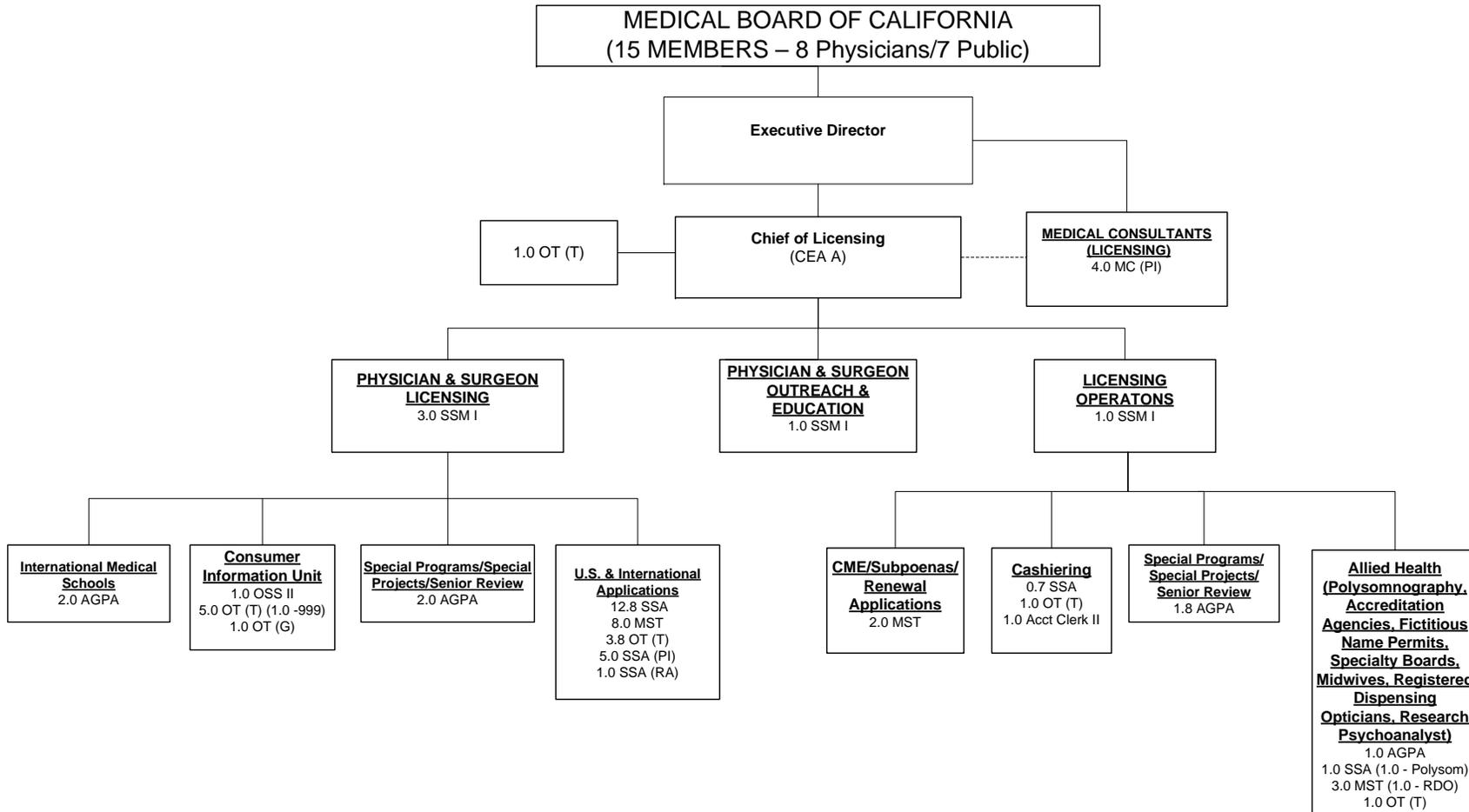
FY 2013/2014
271.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Administrative and Executive Programs
 FY 2013/2014



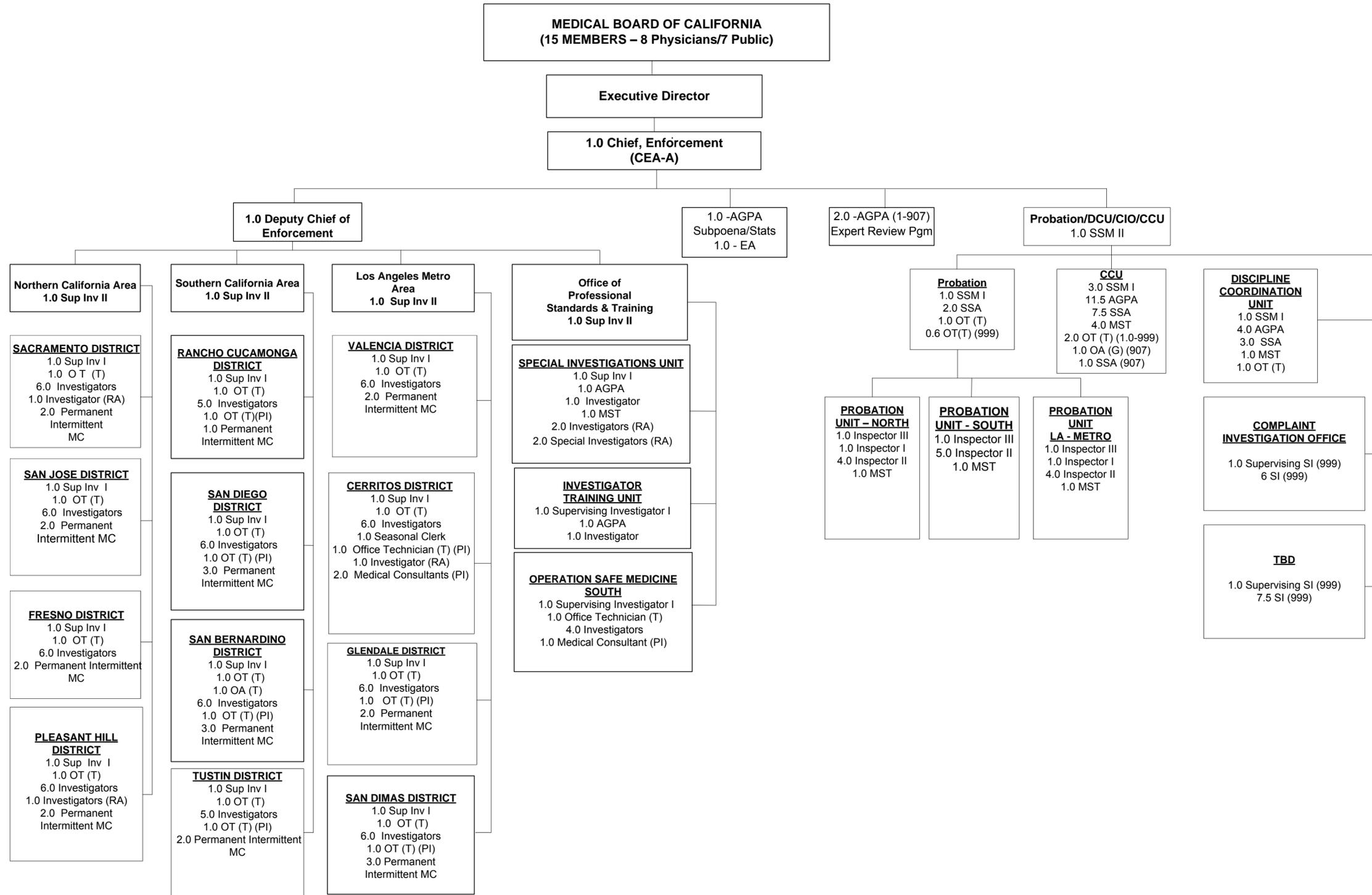
Information Systems Branch – 17.0 PYs plus 1.0 seasonal clerk and 1.0 retired annuitant (SISA)
 Administrative Services including Research Program Specialist II – 7.0 PYs, plus 2.0 retired annuitants (1.0 -ABA, 1.0 -AGPA)
 Business Services – 6.0 PYs

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Licensing Program
 FY 2013/2014

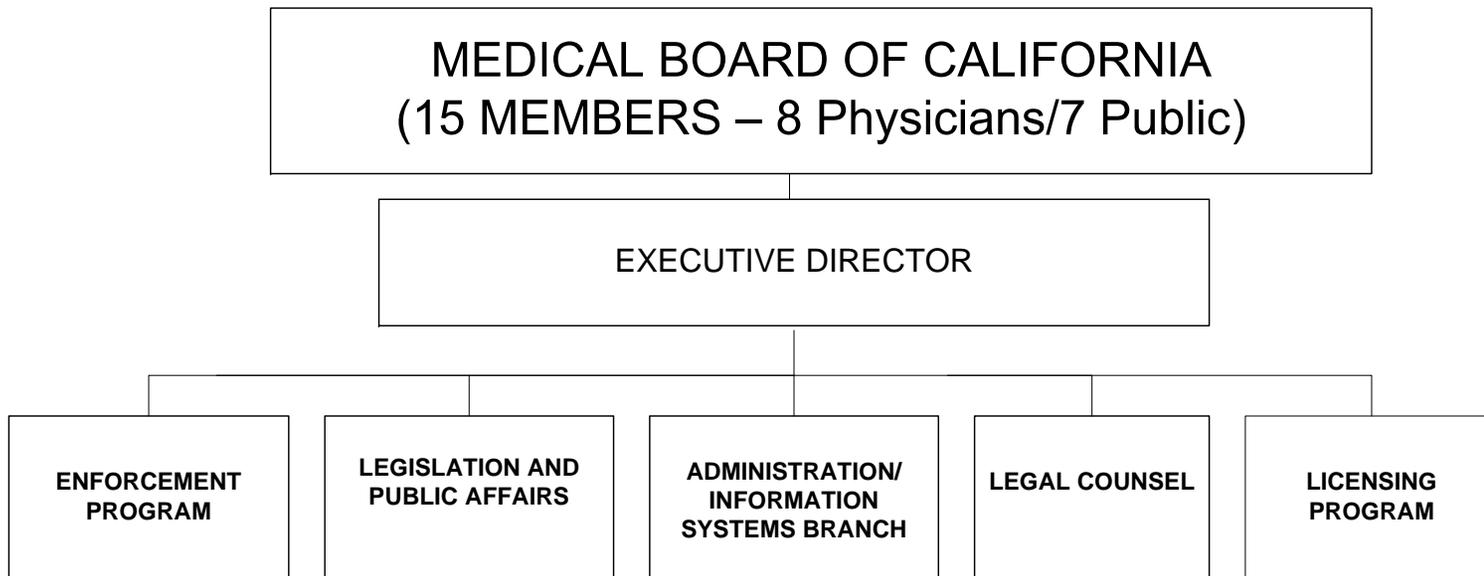


Licensing 52.1 PYs plus Polysomnography 1.0 (SSA), 1.0 re-established BL 12-03 (999) (OT-T), 9.0 permanent intermittent (5.0 SSA, 4.0 MC), 1.0 retired annuitant (SSA), Registered Dispensing Opticians Program (Agency Code 599) 1.0 (MST)

Department of Consumer Affairs
 Medical Board of California
 Enforcement Program
 FY 2013/2014



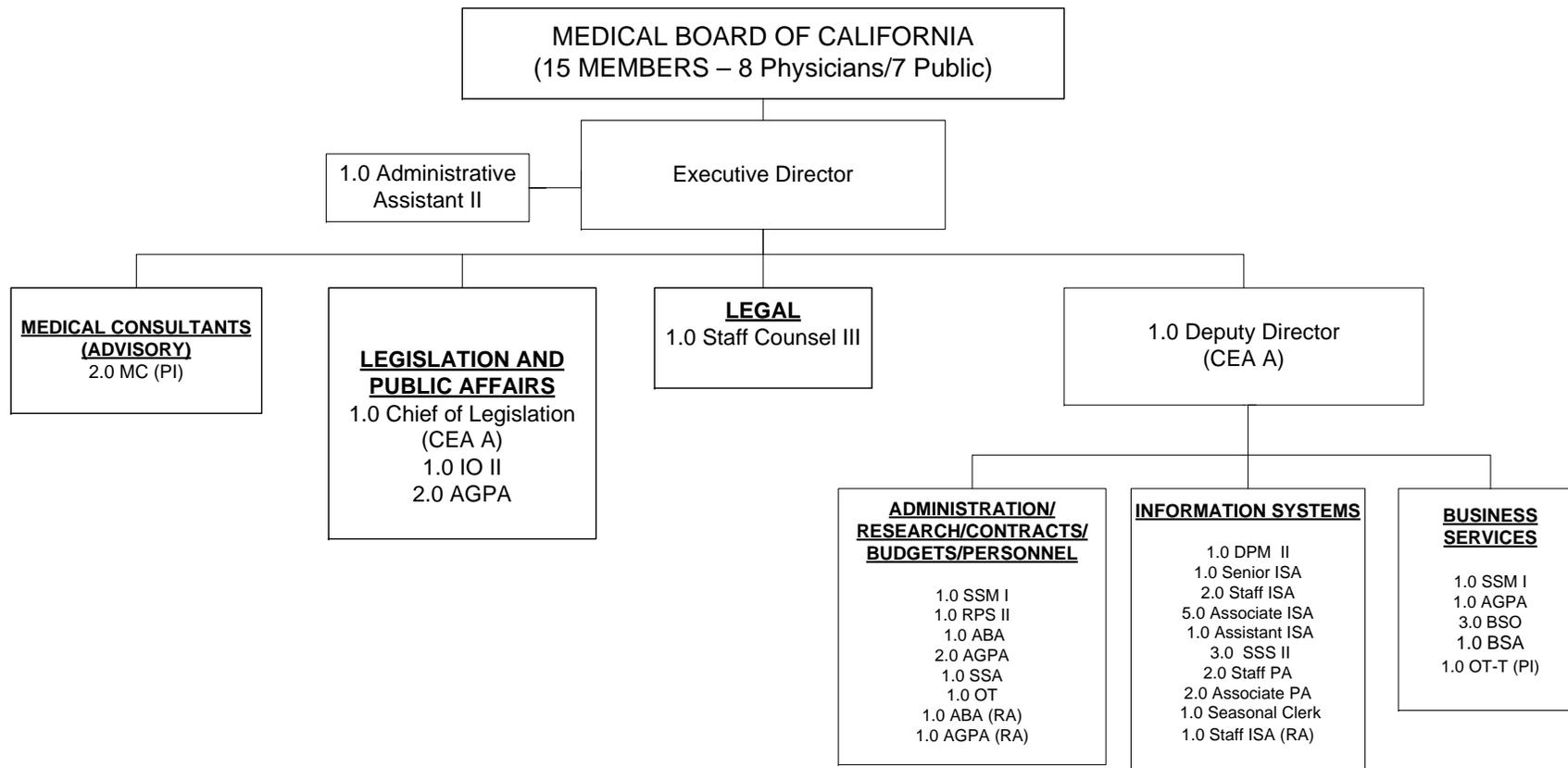
Subpoena Stats/Exec Assist /Expert Reviewer Program – 3.0 PY plus 1.0 temp help blanket (907) (AGPA)
 Investigations – 100.0 PYs (Total includes chief, deputy chief) plus retired annuitants,
 permanent intermittents and a seasonal clerk)
 Office of Standards and Training/OSM – 14.0 PYs plus 4.0 retired 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

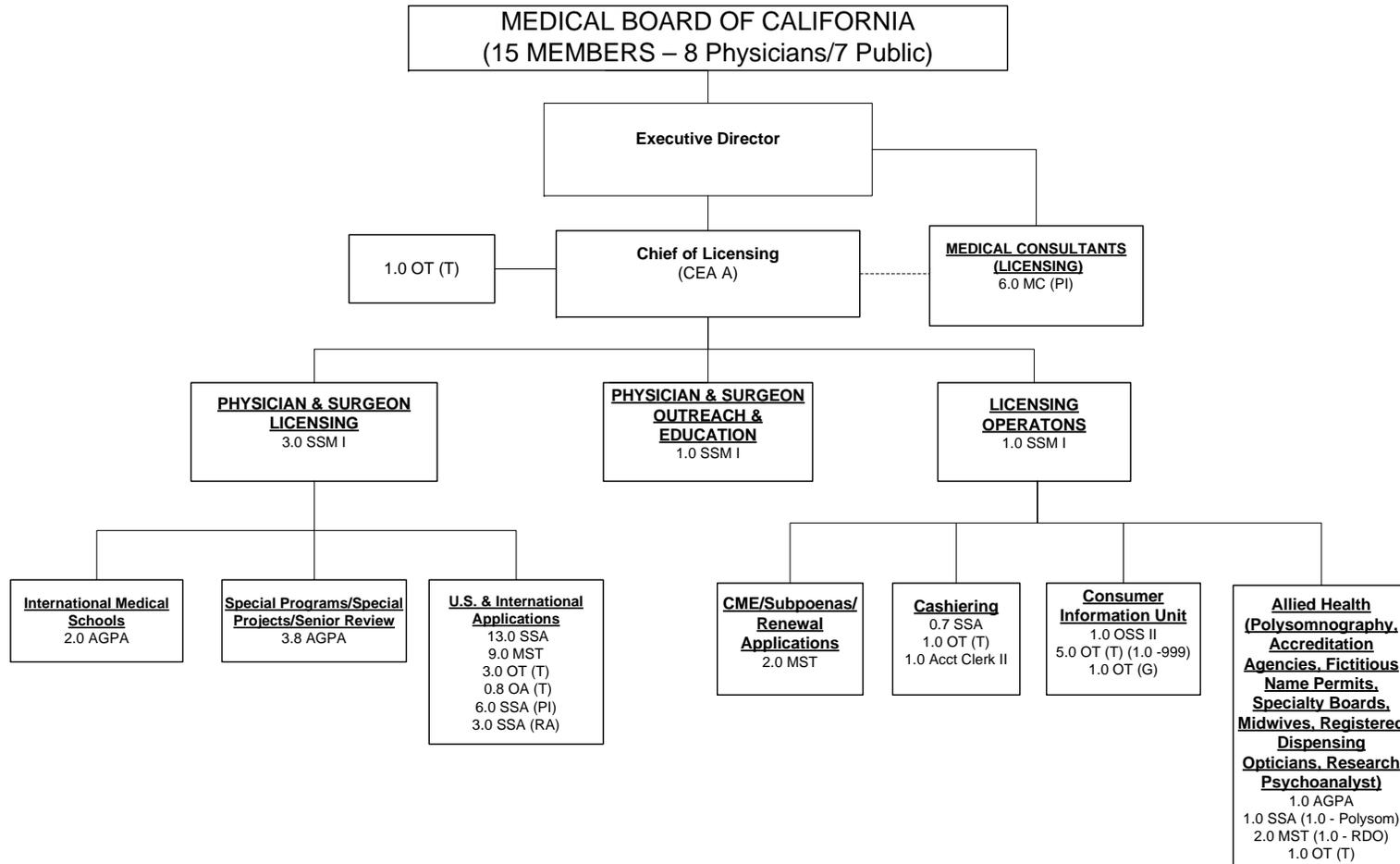
271.1 PYs plus permanent intermittents, retired annuitants, seasonal clerks, temporary help

Department of Consumer Affairs
MEDICAL BOARD OF CALIFORNIA
 Administrative and Executive Programs
 FY 2012/2013



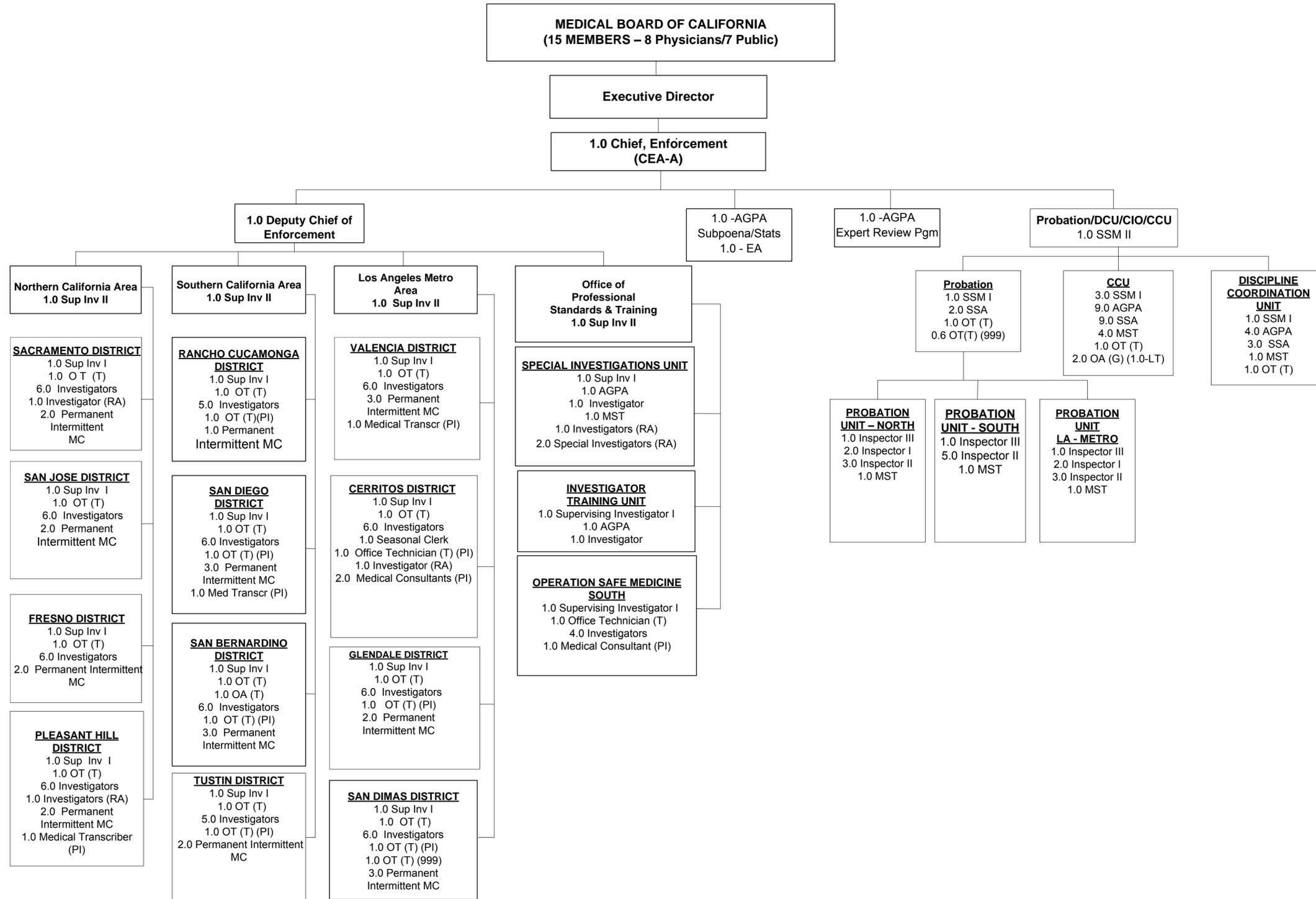
Information Systems Branch – 17.0 PYs plus 1.0 seasonal clerk and 1.0 retired annuitant (SISA)
 Administrative Services including Research Program Specialist II – 7.0 PYs, plus 2.0 retired annuitants (1.0 -ABA, 1.0 -AGPA)
 Business Services – 6.0 PYs plus 1.0 permanent intermittent (OT-T)

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)

¹The 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						

- 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?
- 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							
Enforcement									
Examination									
Licensing									
Administration *									
DCA Pro Rata									
Diversion (if applicable)									
TOTALS	\$	\$	\$	\$	\$	\$	\$	\$	

*Administration includes costs for executive staff, board, administrative support, and fiscal services.

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

- 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 licensing² 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?
- What process does the board use to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?
 - Does the board fingerprint all applicants?
 - Have all current licensees been fingerprinted? If not, explain.
 - Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?
 - 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.
- Does the board identify or track applicants who are veterans? If not, when does the board expect to be compliant with BPC § 114.5?
 - 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?
 - What regulatory changes has the board made to bring it into conformance with BPC § 35?
 - 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?
 - 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 1 st Time Candidates		
	Pass %		
FY 2013/14	# of 1 st Time Candidates		
	Pass %		
FY 2014/15	# of 1 st Time Candidates		
	Pass %		
FY 2015/16	# of 1 st time Candidates		
	Pass %		
	Date of Last OA		
	Name of OA Developer		

Target OA Date				
National Examination (include multiple language) if any:				
License Type				
Exam Title				
FY 2012/13	# of 1 st Time Candidates			
	Pass %			
FY 2013/14	# of 1 st Time Candidates			
	Pass %			
FY 2014/15	# of 1 st Time Candidates			
	Pass %			
FY 2015/16	# of 1 st 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.
- How does the board verify CE or other competency requirements?
 - Does the board conduct CE audits of licensees? Describe the board's policy on CE audits.
 - What are consequences for failing a CE audit?
 - 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?
- What is the dollar threshold for settlement reports received by the board?
 - 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.
- 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?
 - 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?
 - 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 do 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 DEC?
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.			
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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*

<i>Committee</i>	<i>Members</i>
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 an 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 an 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.
Ronald H. Lewis, M.D.
Elwood Lui
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.

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

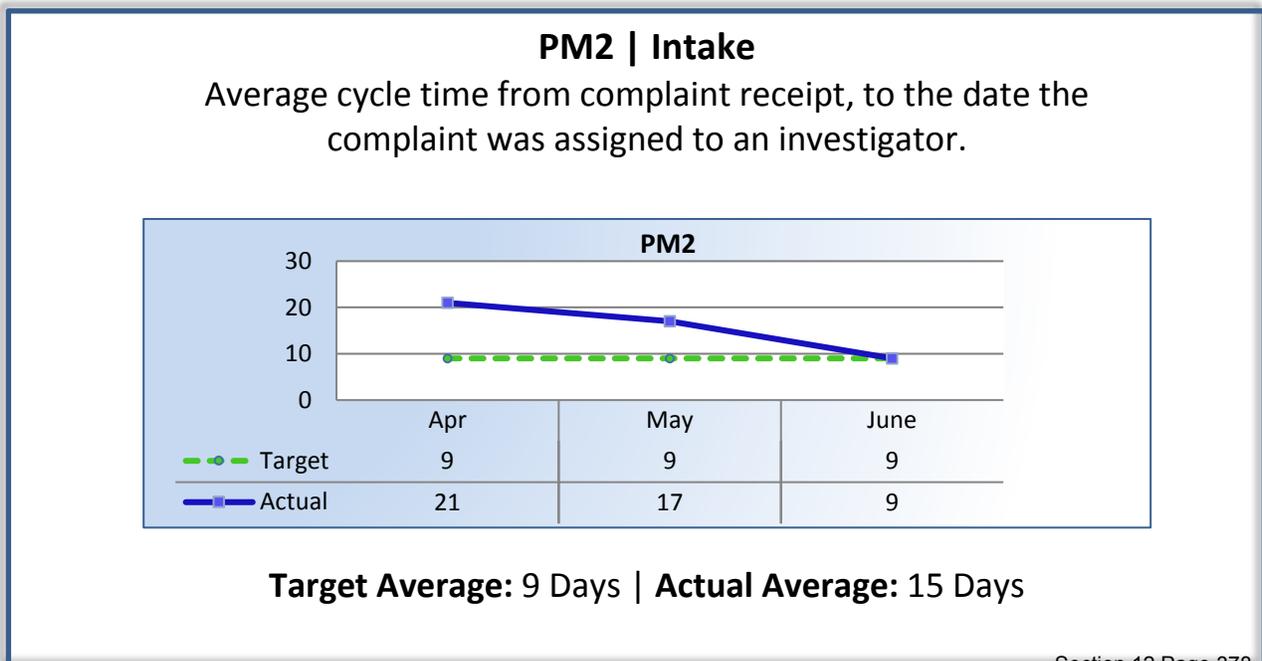
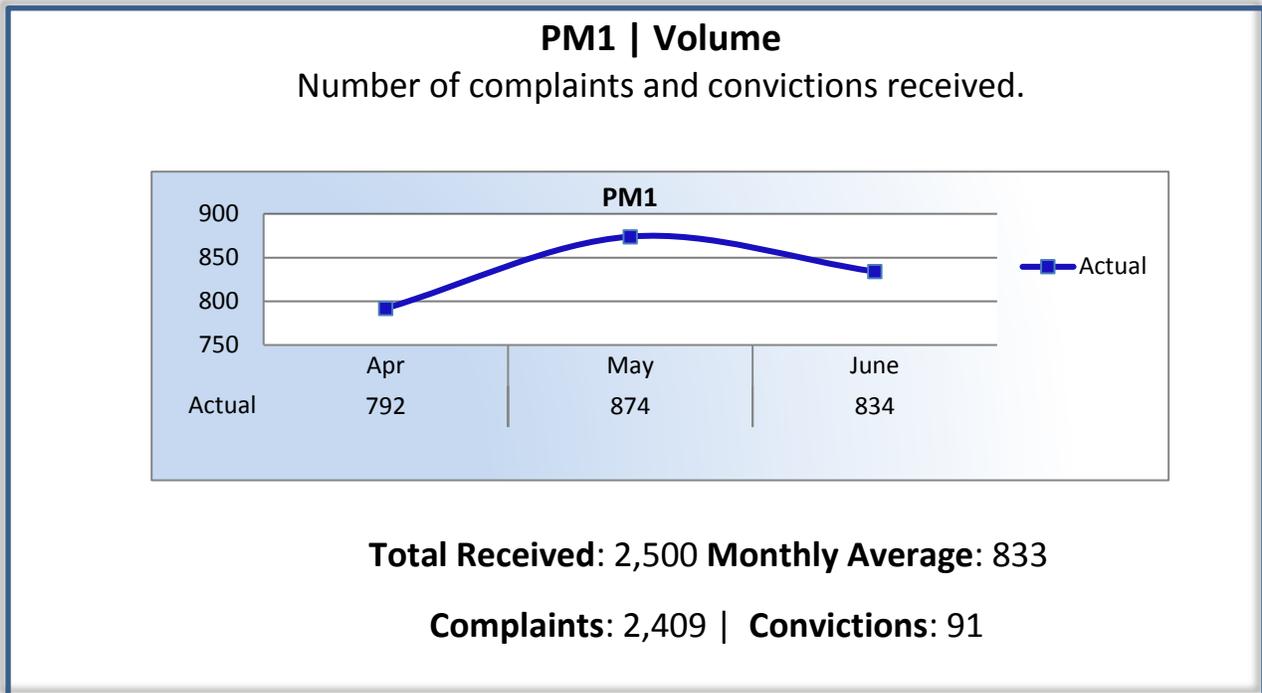


Medical Board of California

Performance Measures

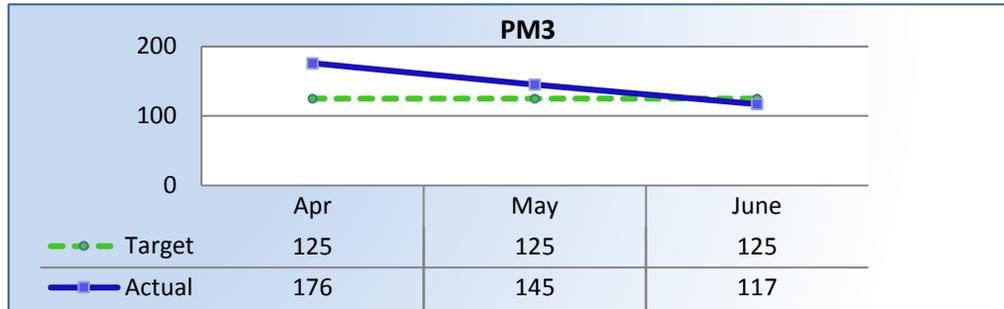
Q4 Report (April - June 2016)

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.



PM3 | Intake & Investigation

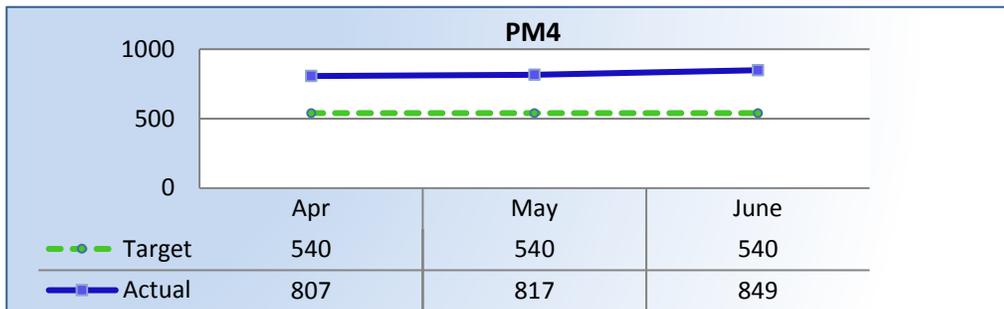
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



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)



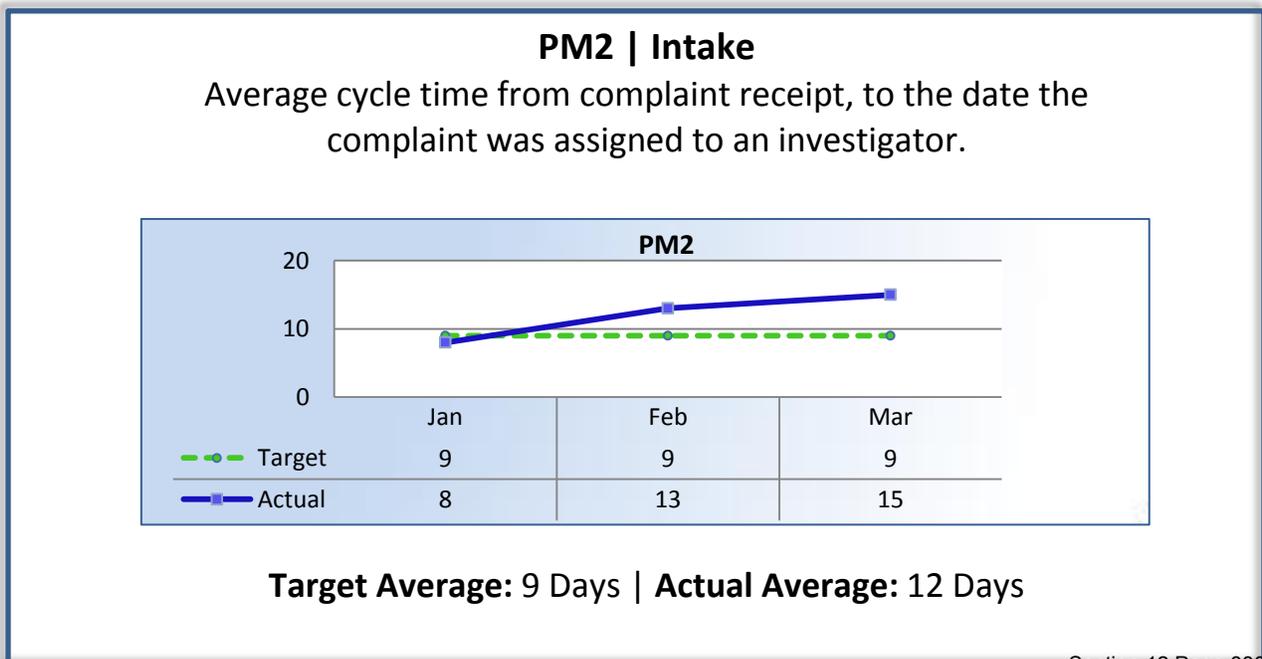
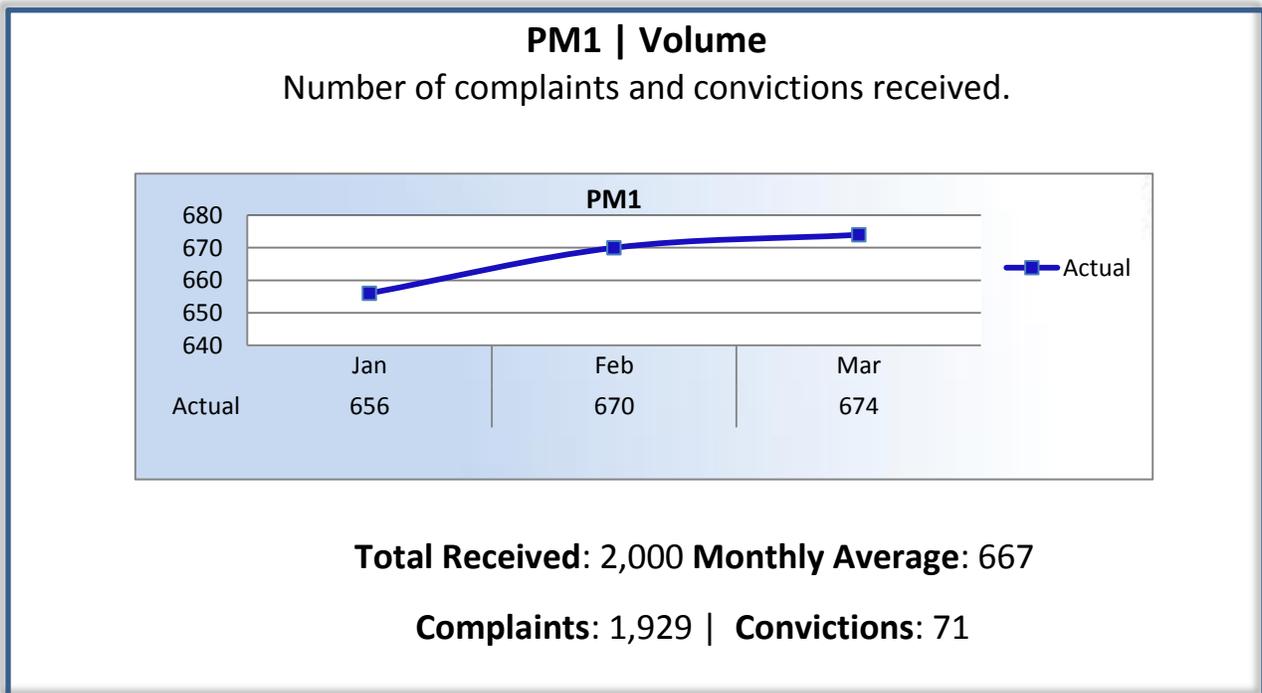
Target Average: 540 Days | Actual Average: 825 Days

Medical Board of California

Performance Measures

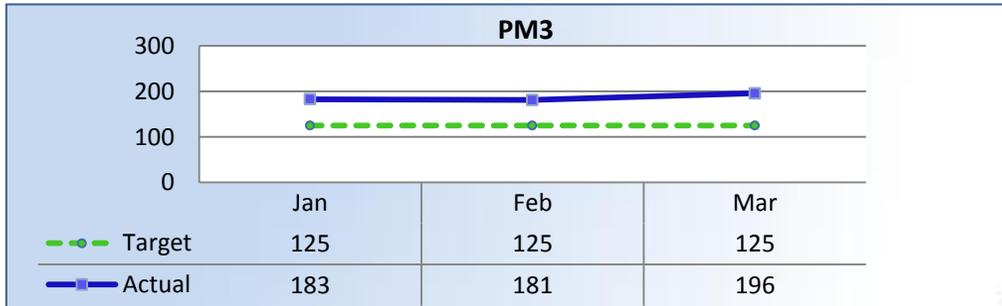
Q3 Report (January – March 2016)

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.



PM3 | Intake & Investigation

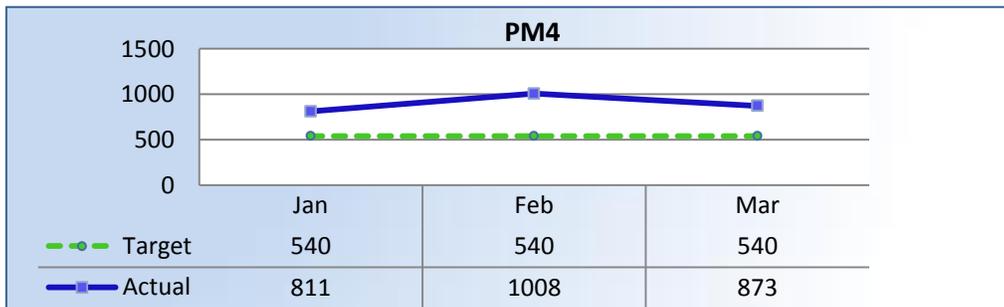
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



Target Average: 125 Days | Actual Average: 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)



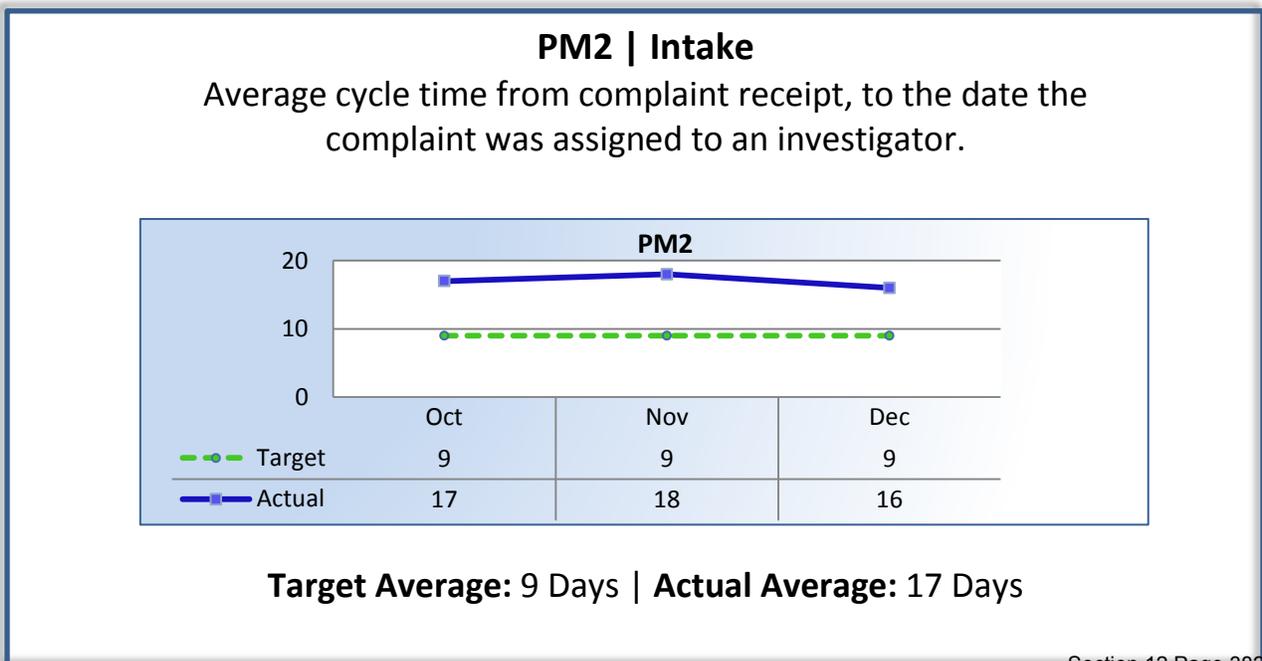
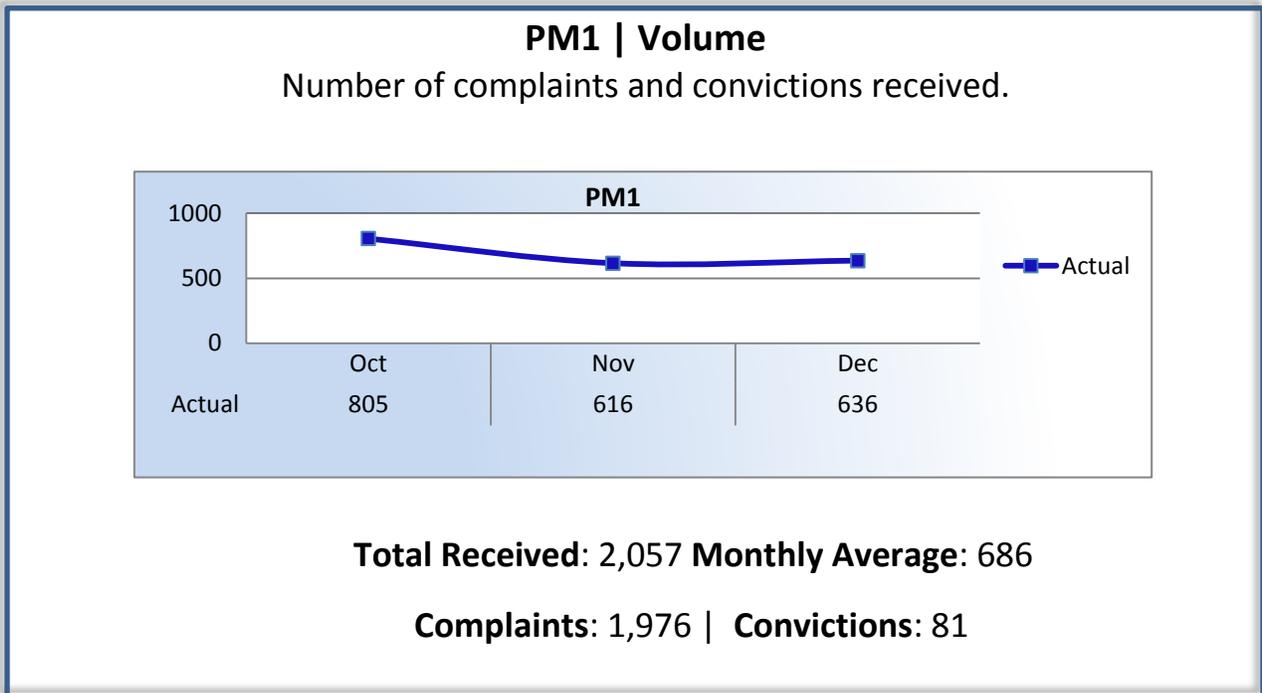
Target Average: 540 Days | Actual Average: 890 Days

Medical Board of California

Performance Measures

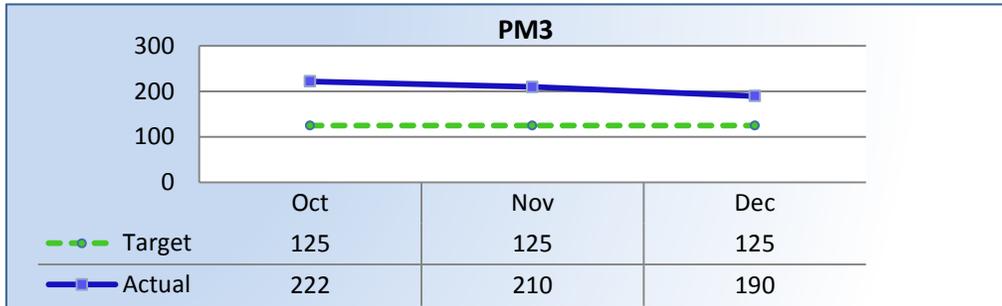
Q2 Report (October - December 2015)

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.



PM3 | Intake & Investigation

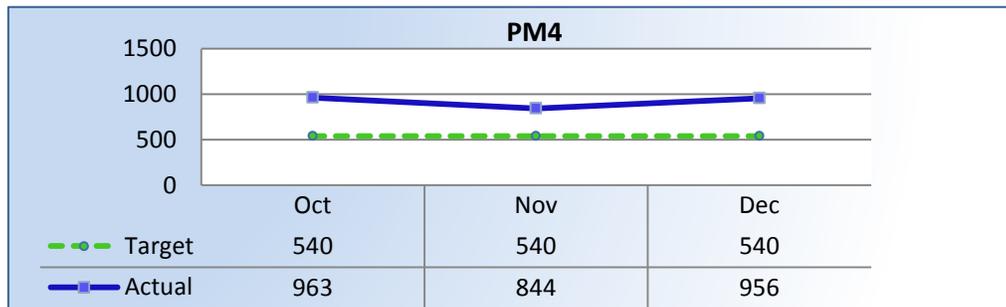
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



Target Average: 125 Days | Actual Average: 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)



Target Average: 540 Days | Actual Average: 914 Days

Medical Board of California

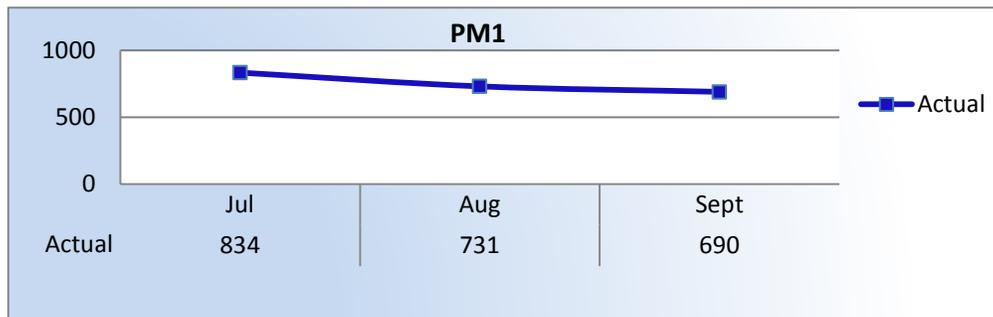
Performance Measures

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.

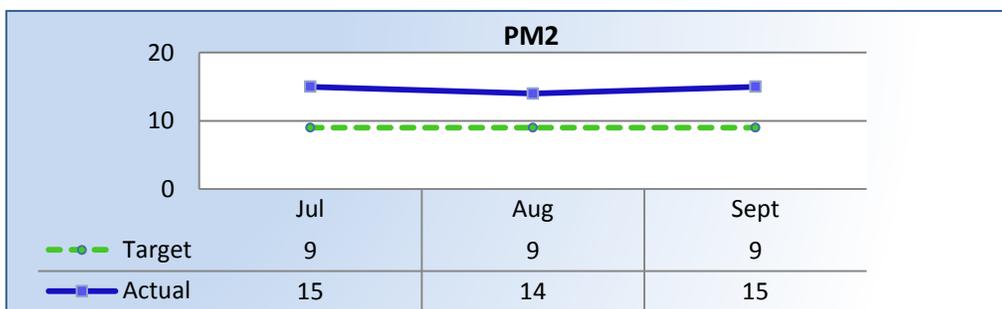


Total Received: 2,255 Monthly Average: 752

Complaints: 2,149 | Convictions: 106

PM2 | Intake

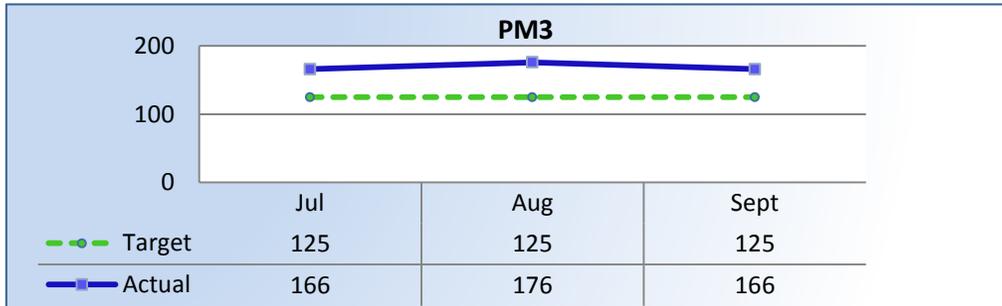
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | Actual Average: 14 Days

PM3 | Intake & Investigation

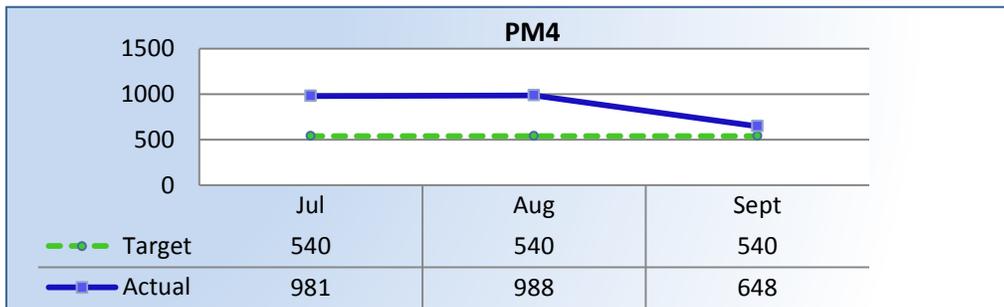
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



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)



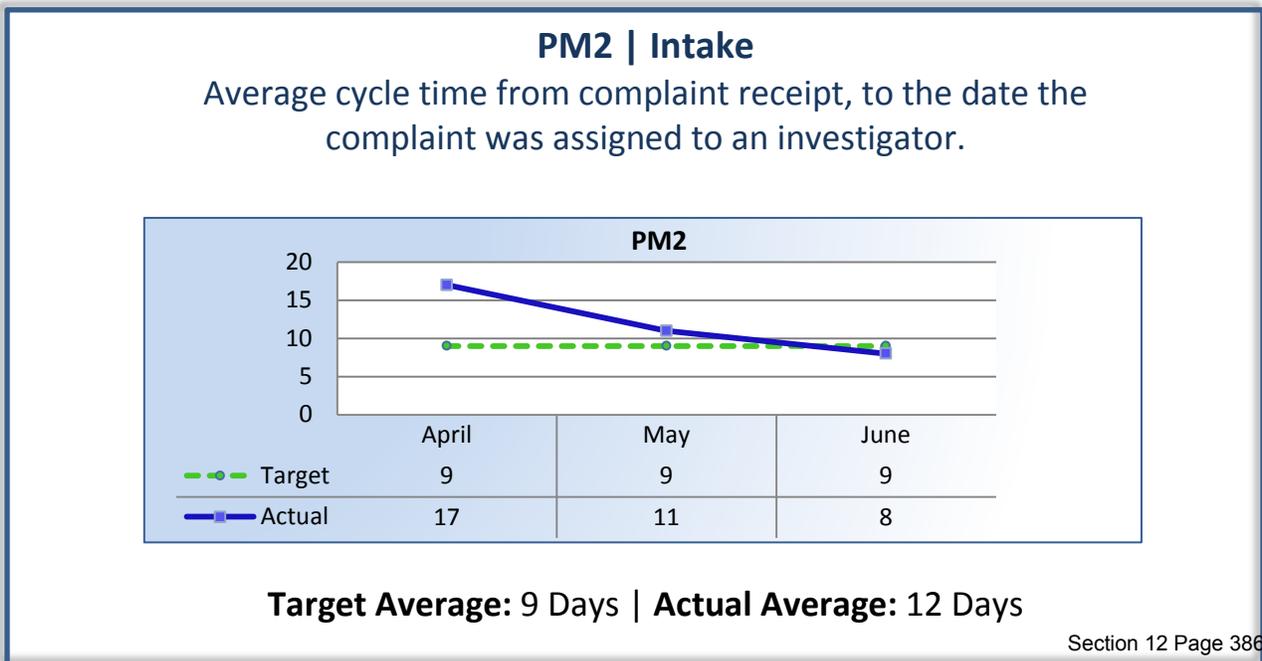
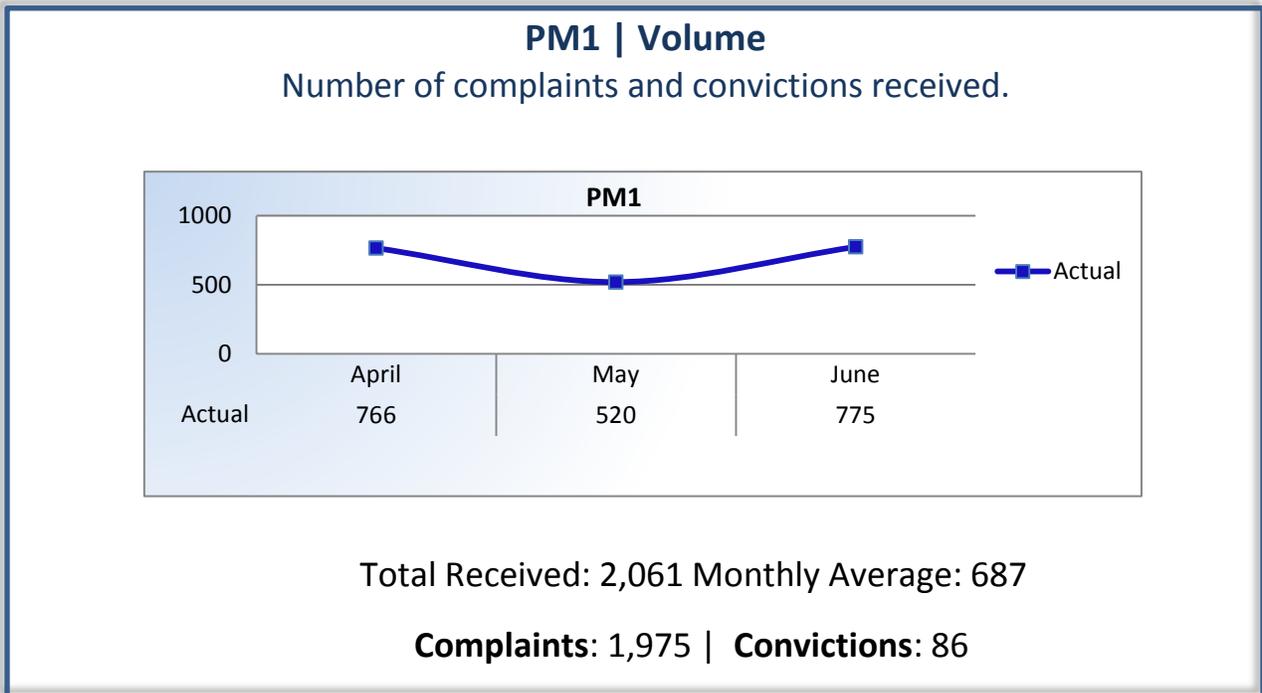
Target Average: 540 Days | Actual Average: 897 Days

Medical Board of California

Performance Measures

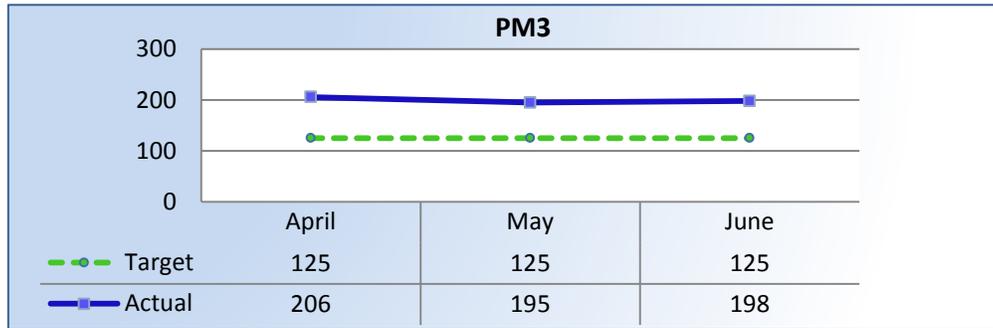
Q4 Report (April – June 2015)

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.



PM3 | Intake & Investigation

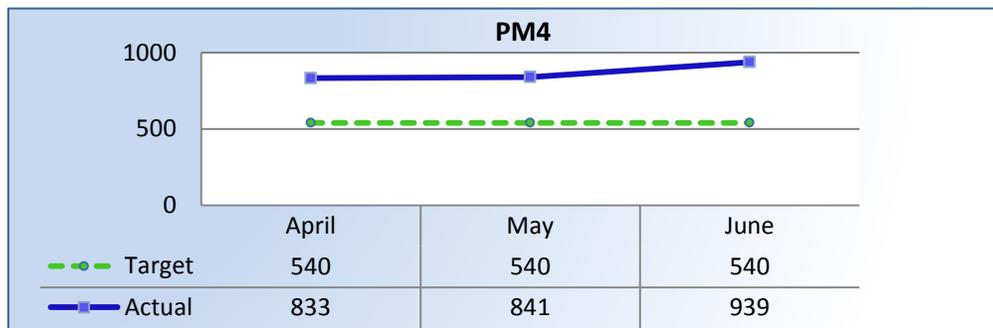
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



Target Average: 125 Days | Actual Average: 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)



Target Average: 540 Days | Actual Average: 871 Days

Medical Board of California

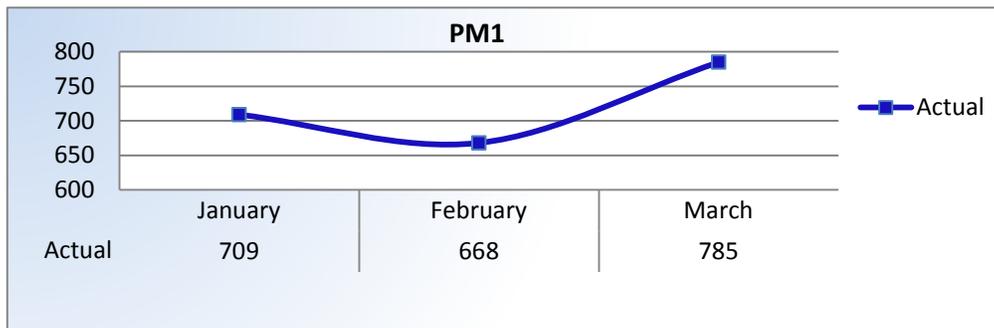
Performance Measures

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.

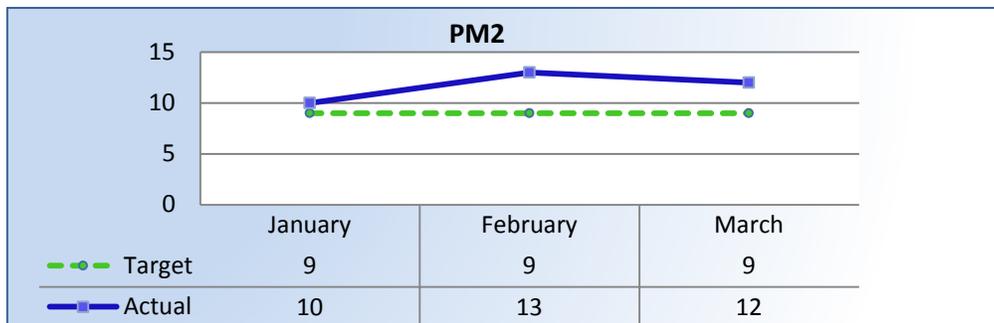


Total Received: 2,162 Monthly Average: 721

Complaints: 2,073 | Convictions: 89

PM2 | Intake

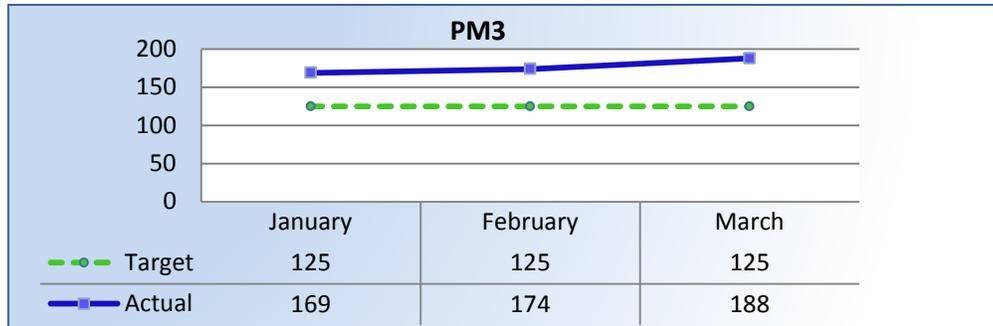
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



Target Average: 9 Days | Actual Average: 12 Days

PM3 | Intake & Investigation

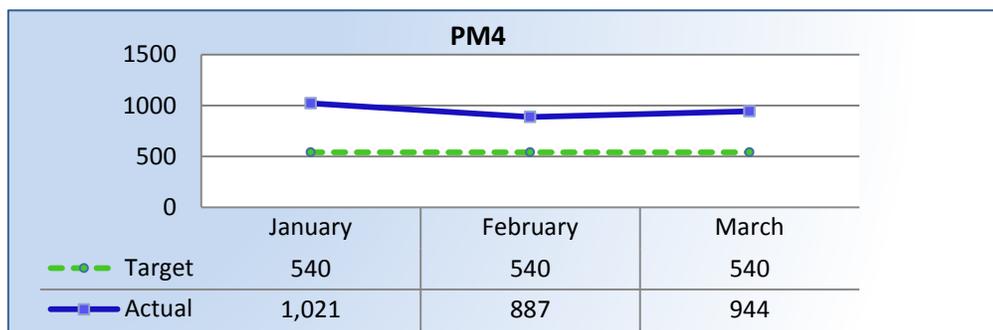
Average number of days to complete the entire enforcement process for cases not transmitted to the AG. (Includes intake and investigation).



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)



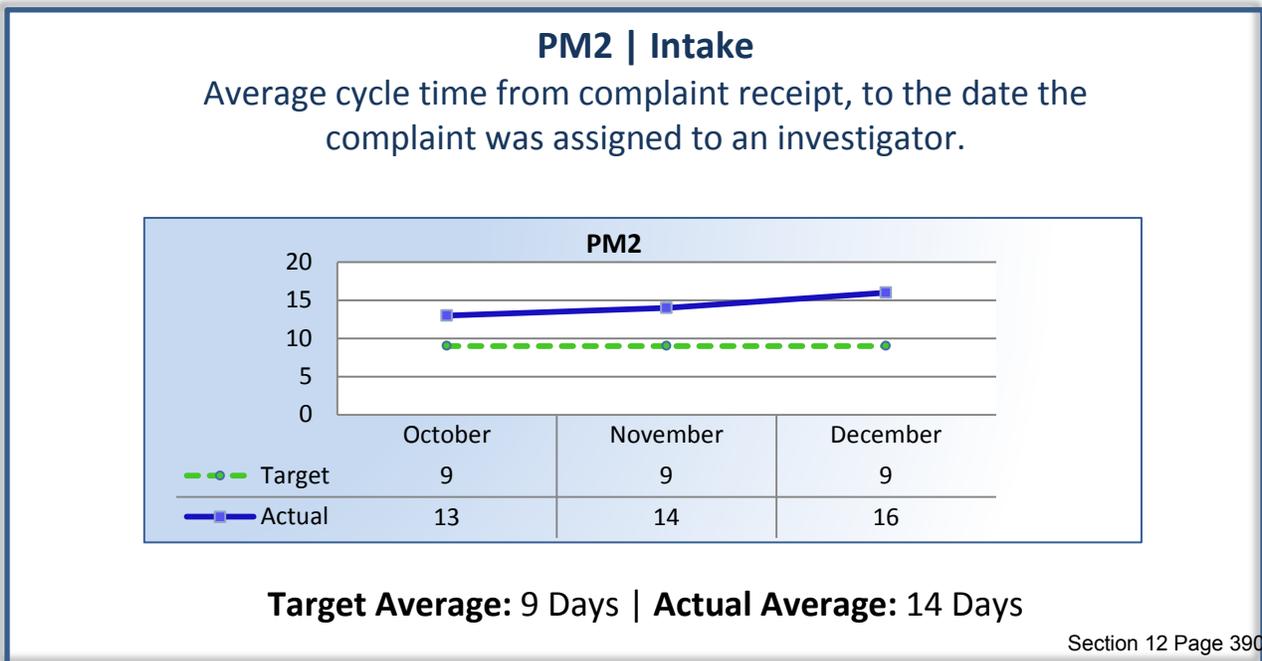
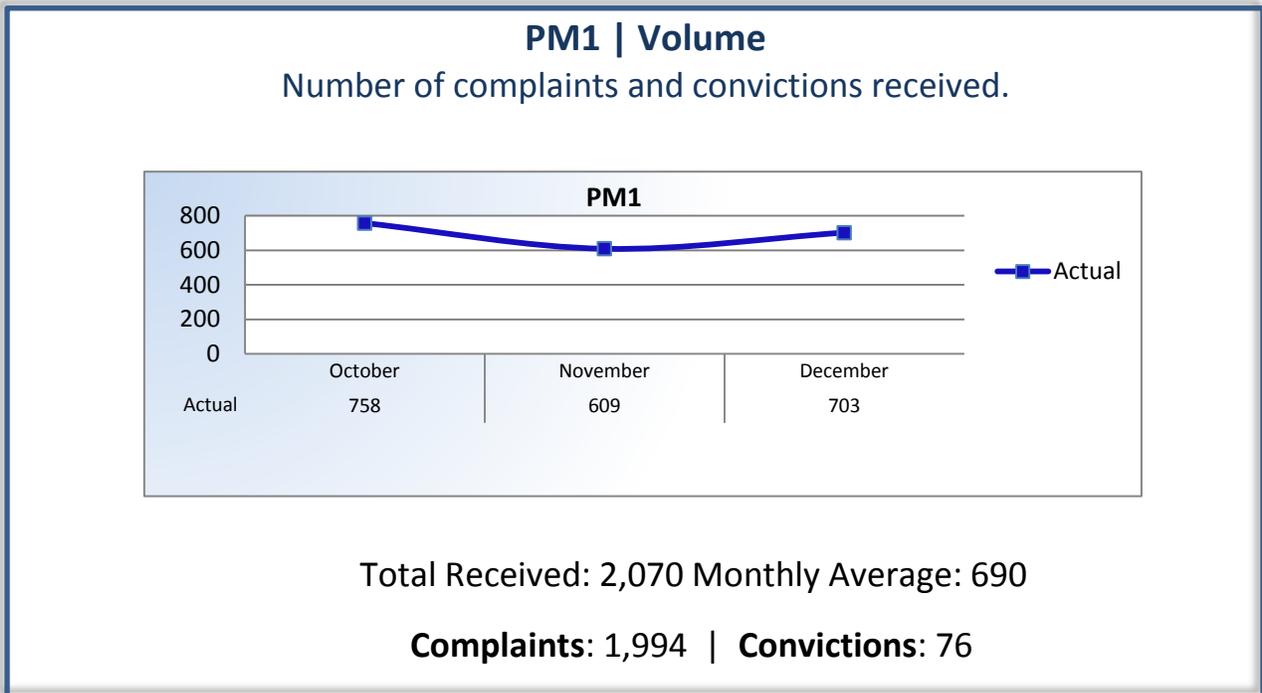
Target Average: 540 Days | Actual Average: 946 Days

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.



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

Medical Board of California

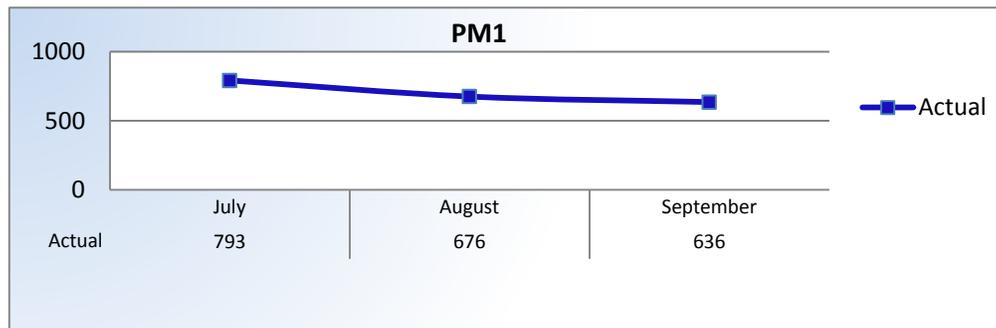
Performance Measures

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.

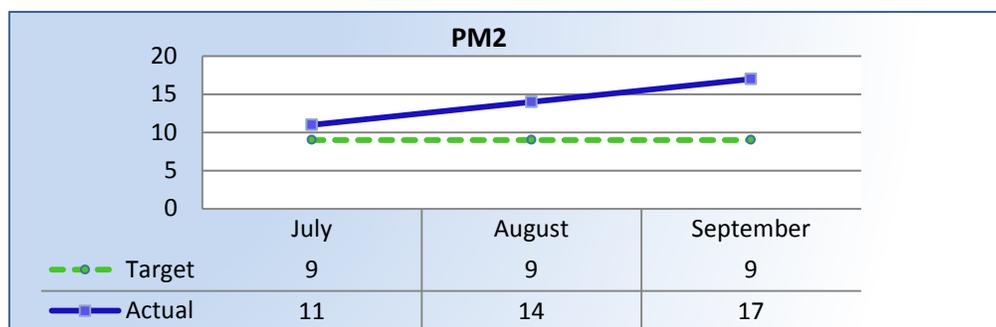


Total Received: 2,105 Monthly Average: 702

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

Medical Board of California

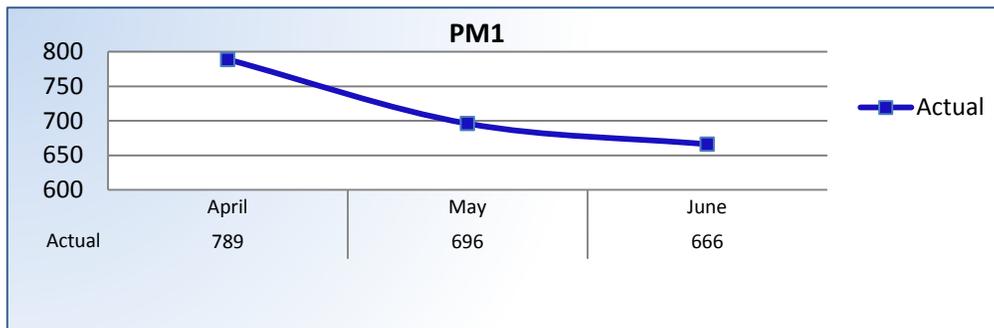
Performance Measures

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.

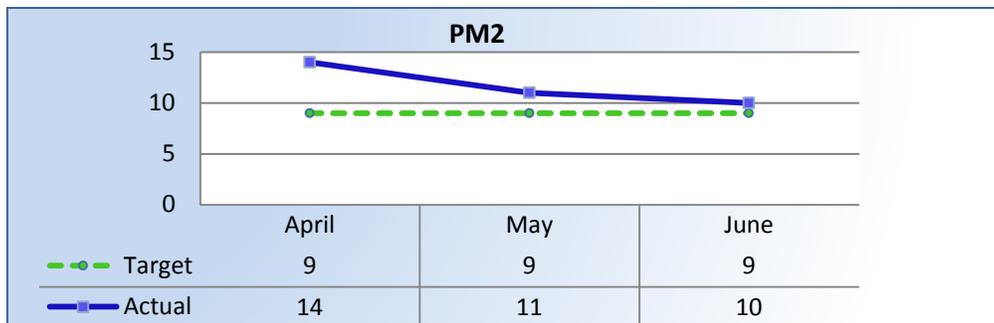


Total Received: 2,151 Monthly Average: 717

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 BreZE.

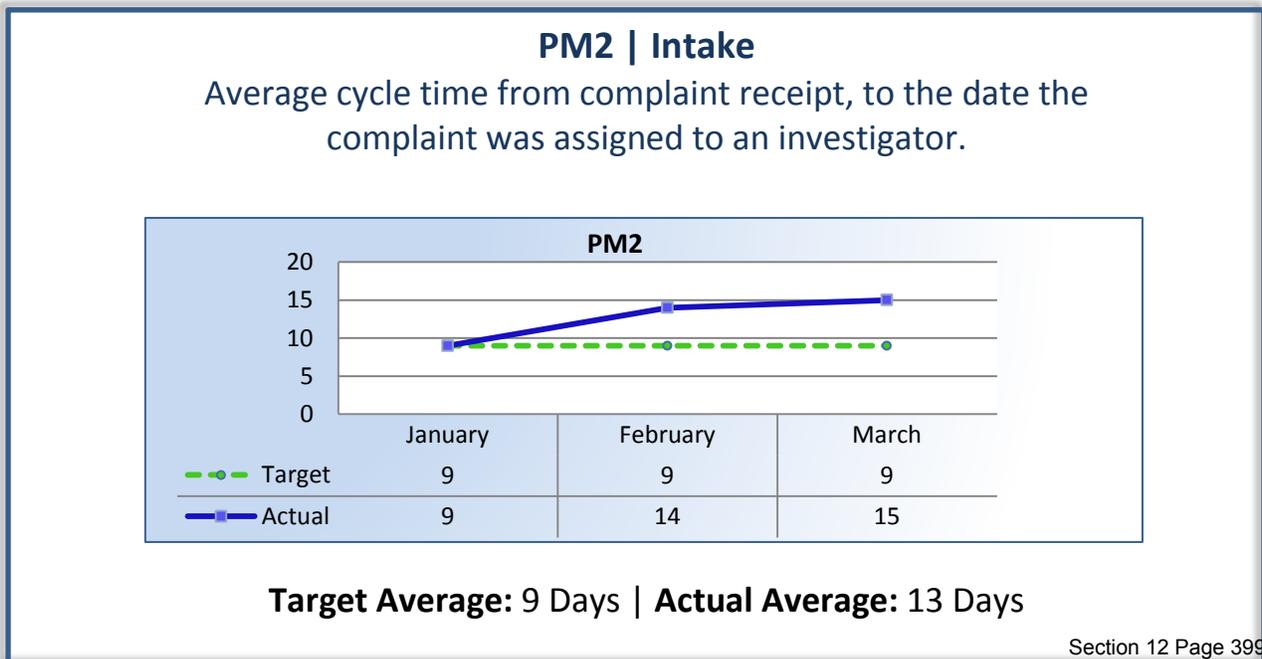
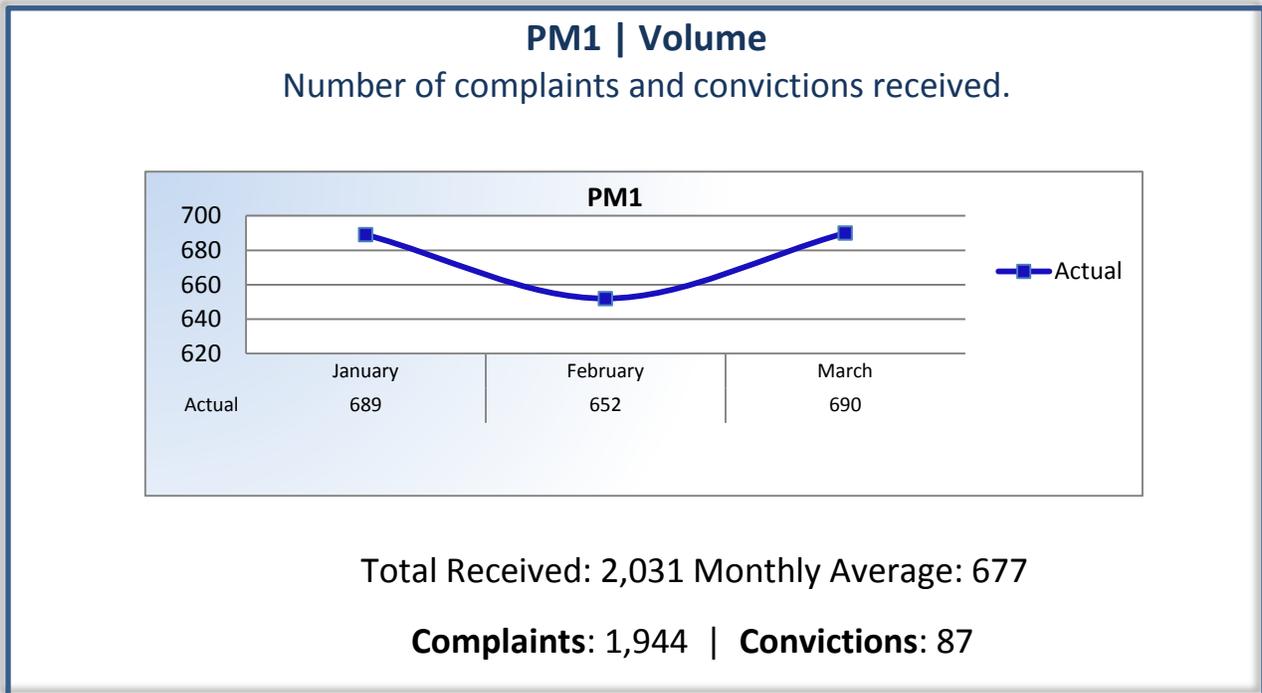
Target Average: 25 Days | Actual Average: N/A

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.



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.*

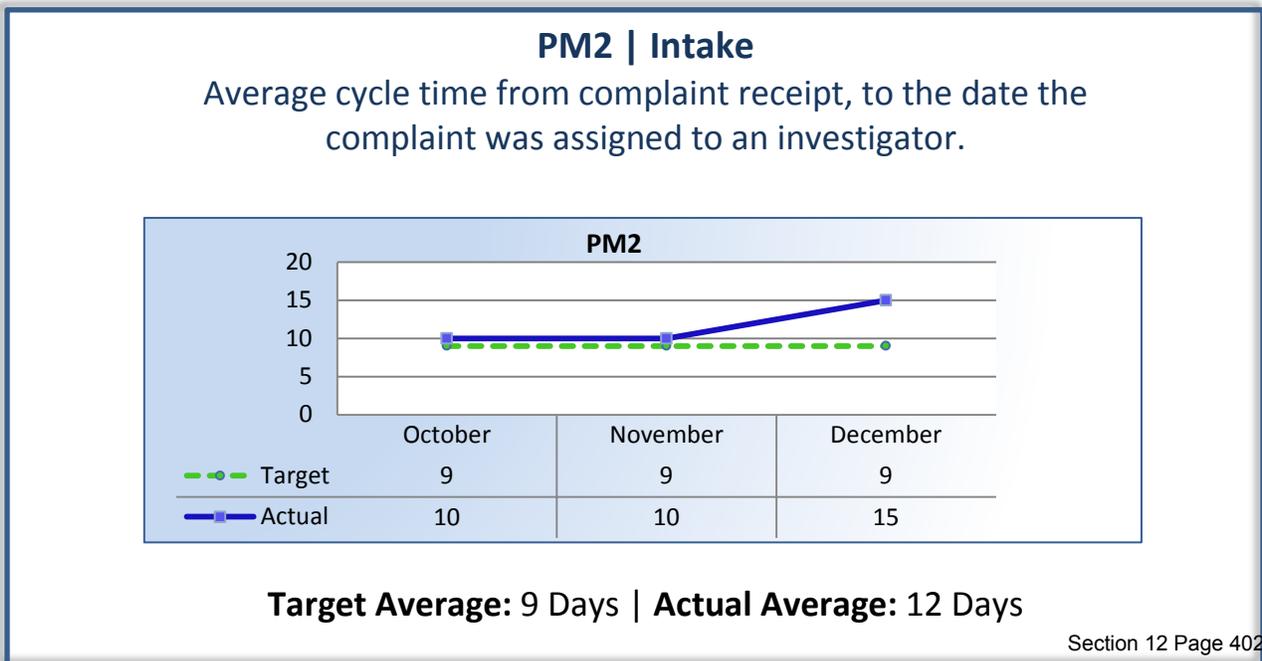
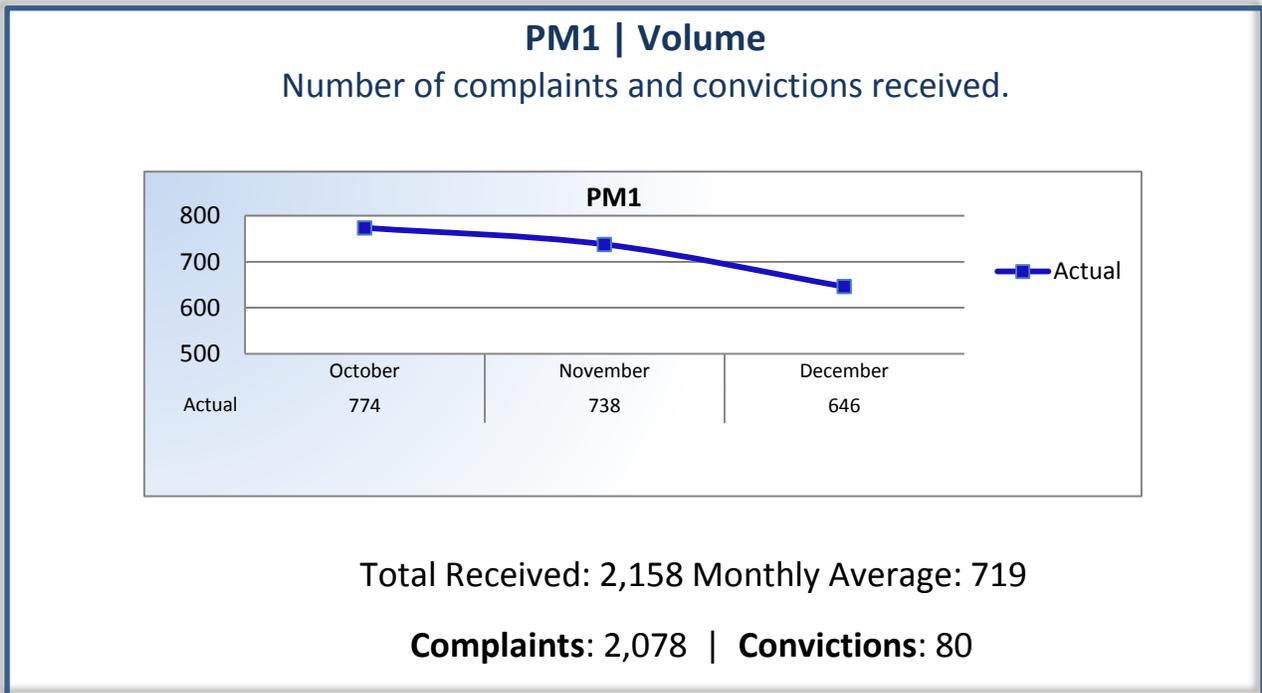
Target Average: 25 Days | Actual Average: N/A

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.



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.*

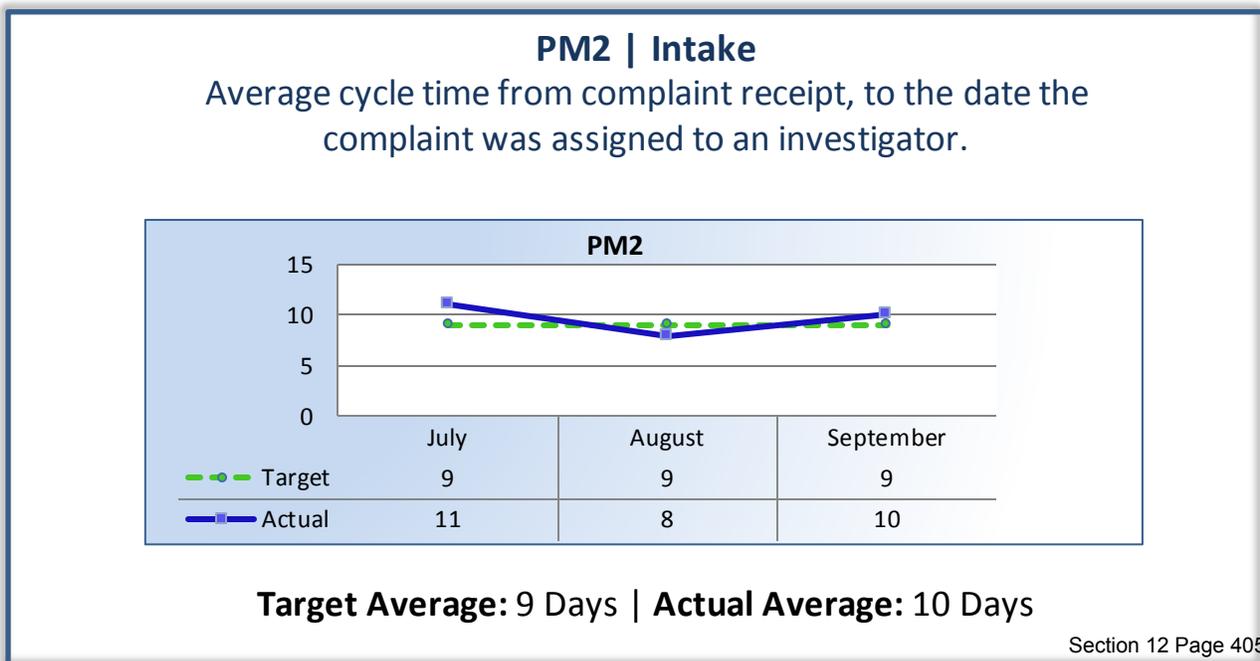
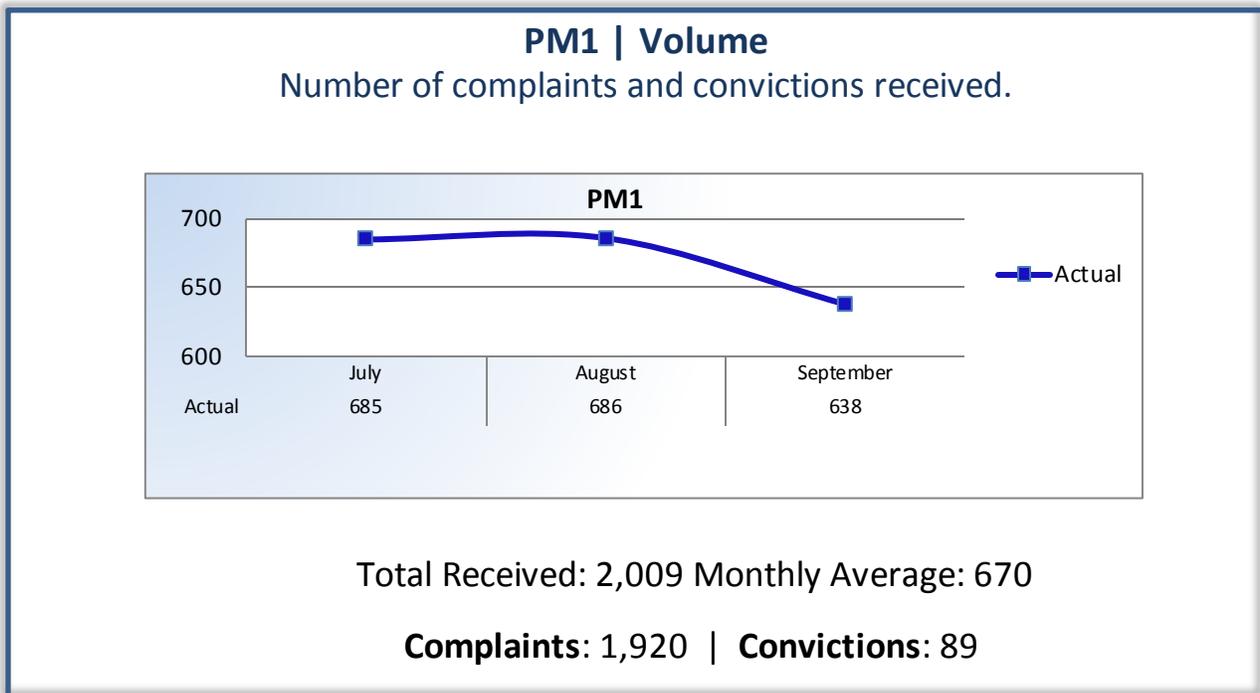
Target Average: 25 Days | Actual Average: N/A

Medical Board of California

Performance Measures

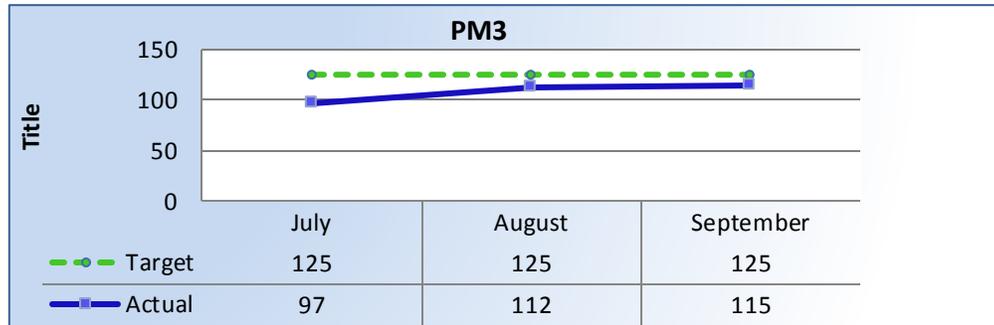
Q1 Report (July - September 2013)

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.



PM3 | Intake & Investigation

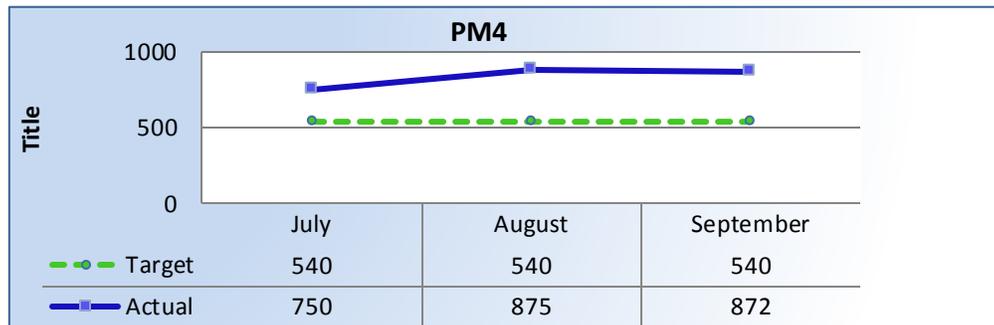
Average cycle time from complaint receipt to closure of the investigation process. Does not include cases sent to the Attorney General or other forms of formal discipline.



Target Average: 125 Days | Actual Average: 108 Days

PM4 | Formal Discipline

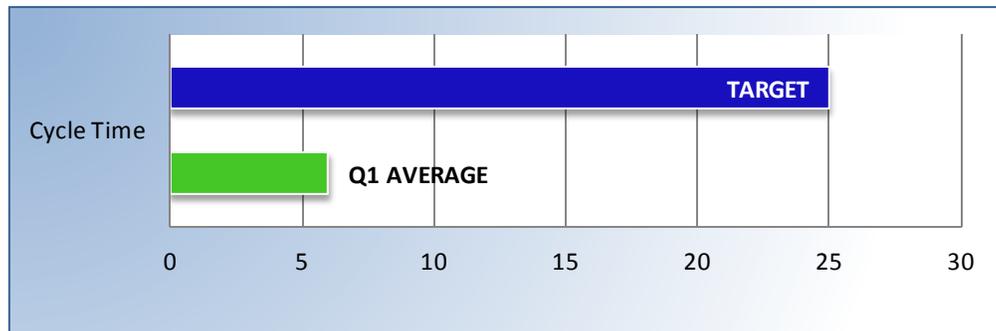
Average number of days to complete the entire enforcement process for cases resulting in formal discipline. (Includes intake and investigation by the Board and prosecution by the AG).



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

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

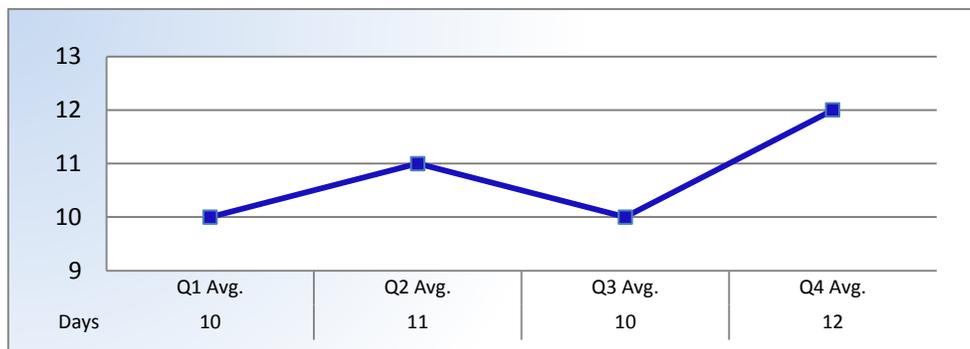
Number of complaints and convictions received.



Fiscal Year Total: 8,325

PM2 | Intake

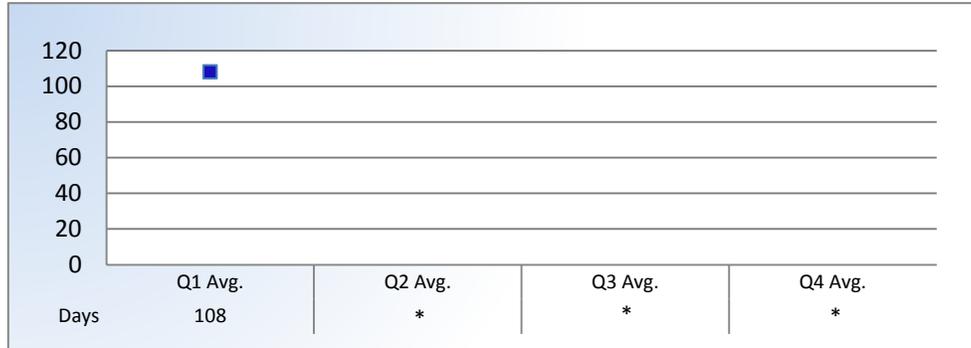
Average cycle time from complaint receipt, to the date the complaint was assigned to an investigator.



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.

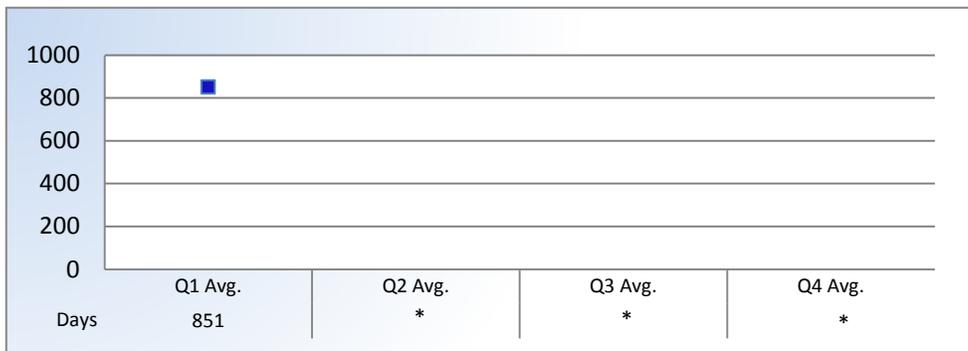


Target Average: 125 Days

**Consistent data not yet available from BreZE.*

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).

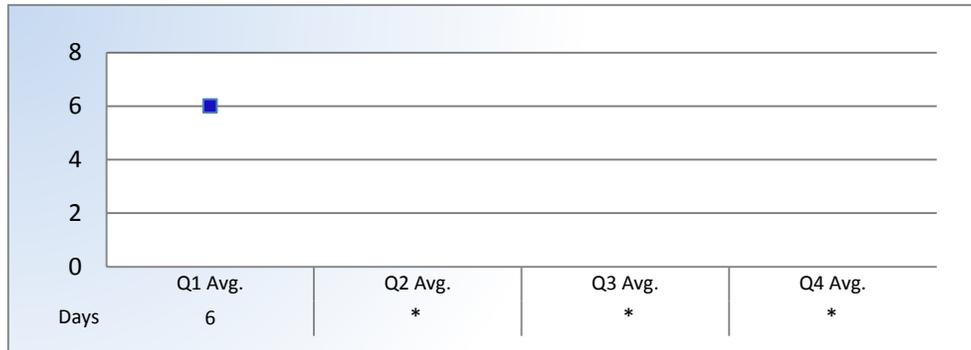


Target Average: 540 Days

**Consistent data not yet available from BreZE.*

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 BreZE.*

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

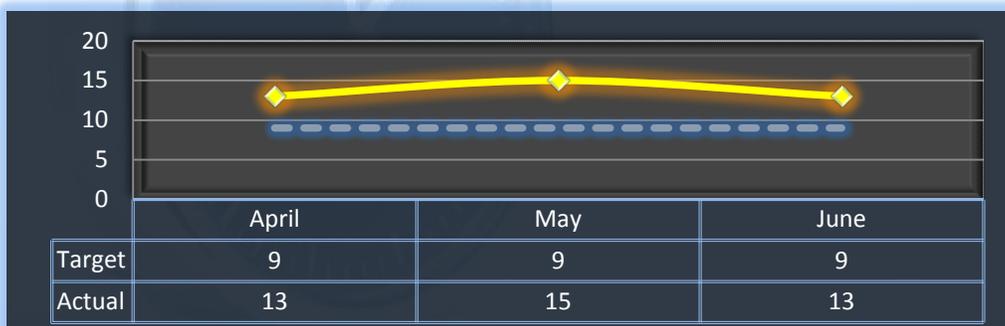


Intake

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

Target: 9 Days

Q4 Average: 14 Days

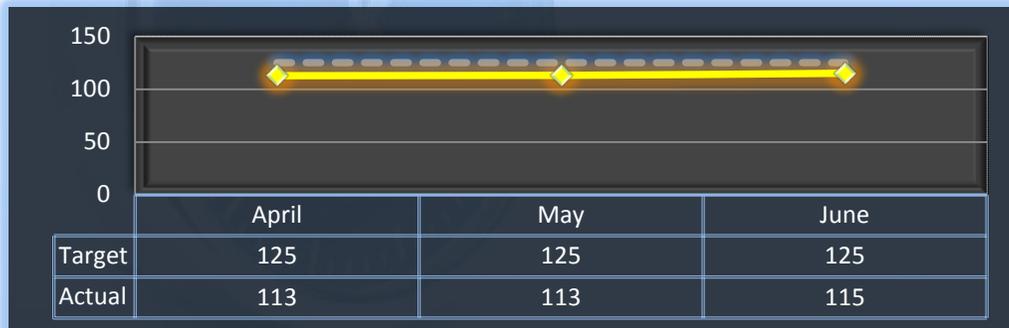


Intake & Investigation

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



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



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



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.

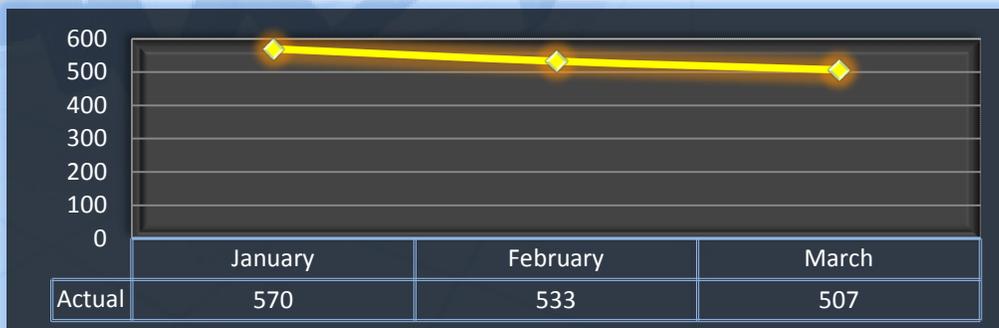
Volume

Number of complaints and convictions received.

Q3 Total: 1,610

Complaints: 1,493 Convictions: 117

Q3 Monthly Average: 537

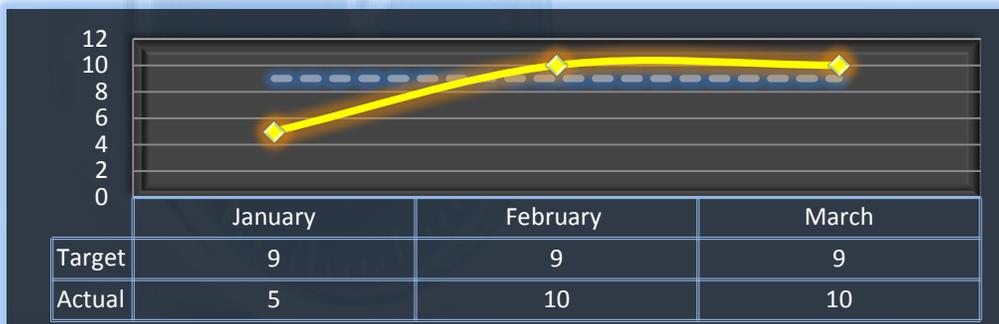


Intake

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

Target: 9 Days

Q3 Average: 8 Days

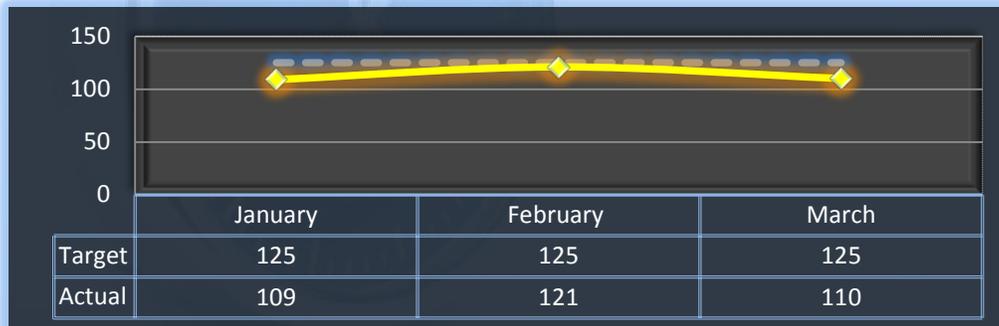


Intake & Investigation

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

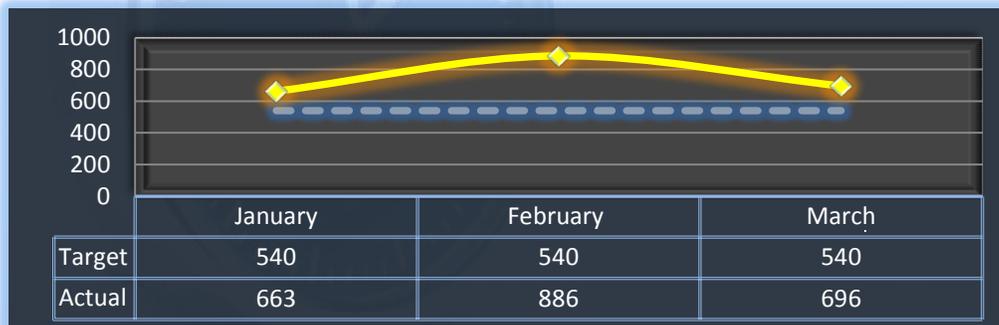


Formal Discipline/ Administrative Action

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



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



Medical Board of California

Performance Measures

Q2 Report (October - December 2012)

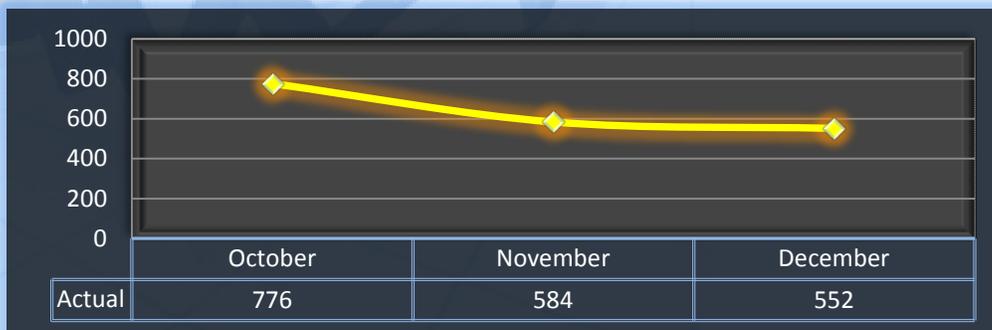
To ensure stakeholders can review the Board's progress toward meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures will be posted publicly on a quarterly basis.

Number of complaints and convictions received.

Q2 Total: 1,912

Complaints: 1,823 Convictions: 89

Q2 Monthly Average: 637



Intake

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

Target: 9 Days

Q2 Average: 8 Days

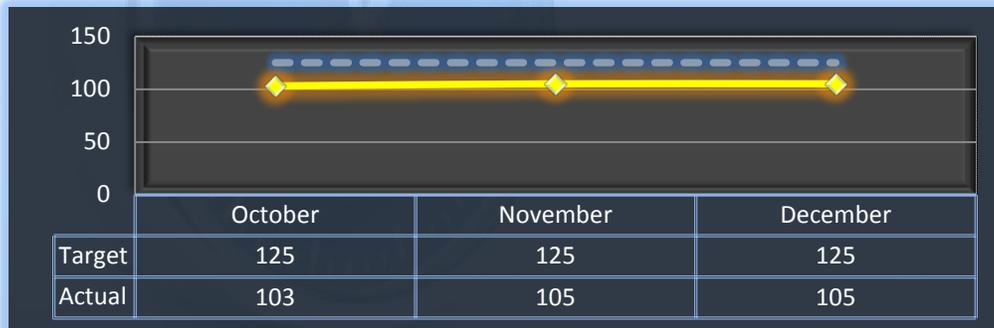


Intake & Investigation

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

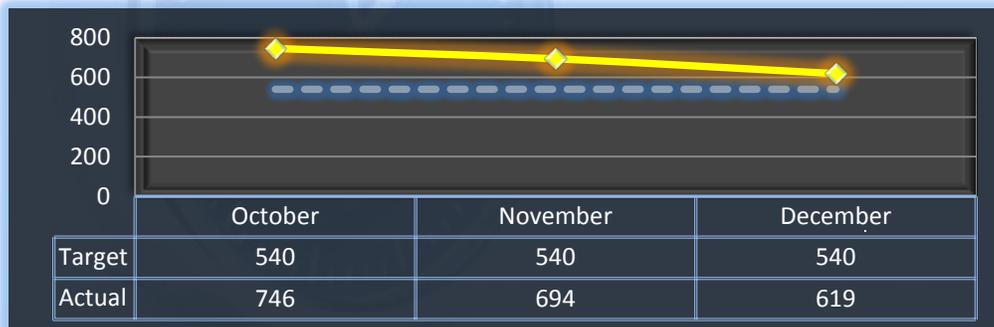


Formal Discipline/ Administrative Action

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

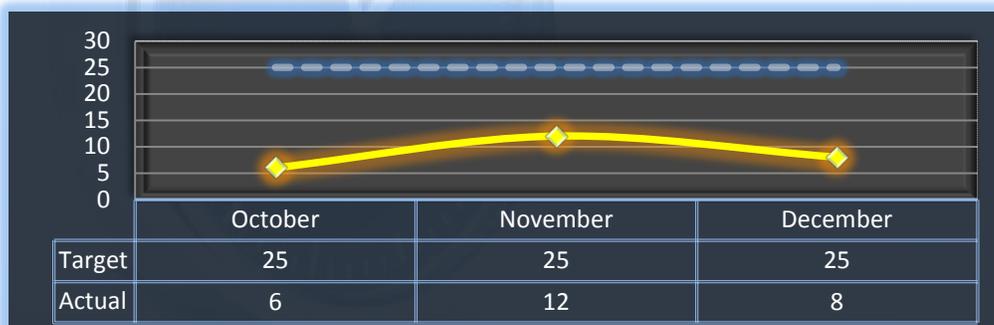


Probation Intake

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



Medical Board of California

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

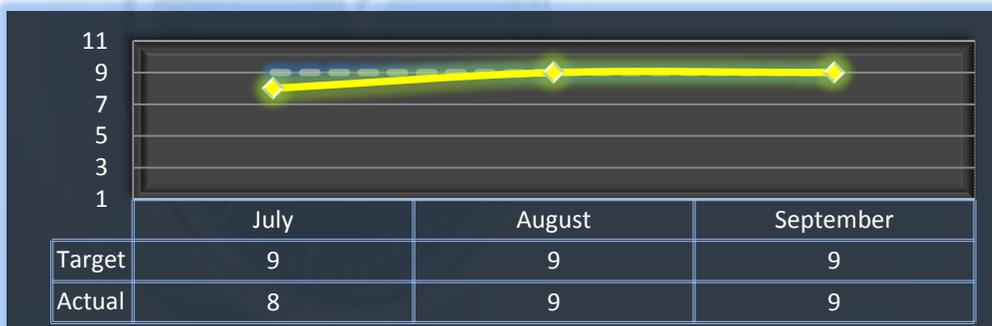


Intake

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

Target: 9 Days

Q1 Average: 9 Days

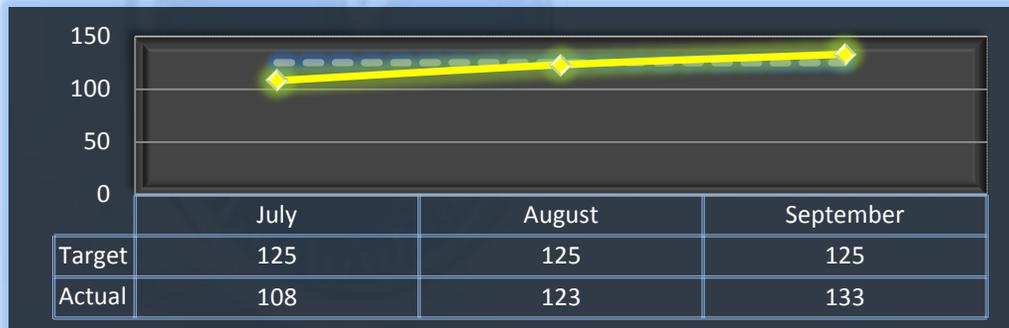


Intake & Investigation

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



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

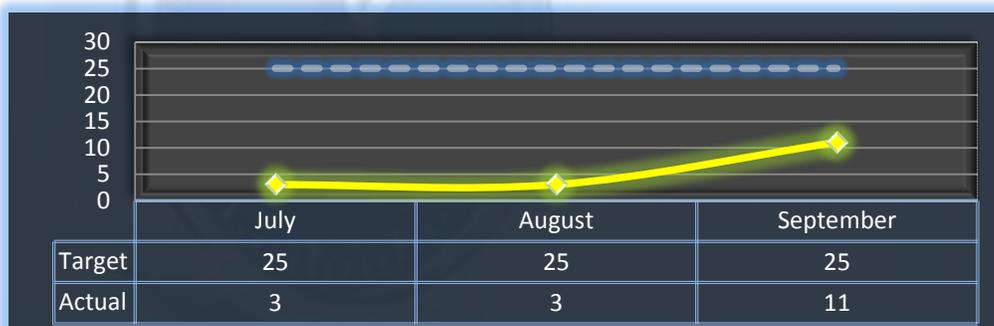


Probation Intake

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



Performance Measures

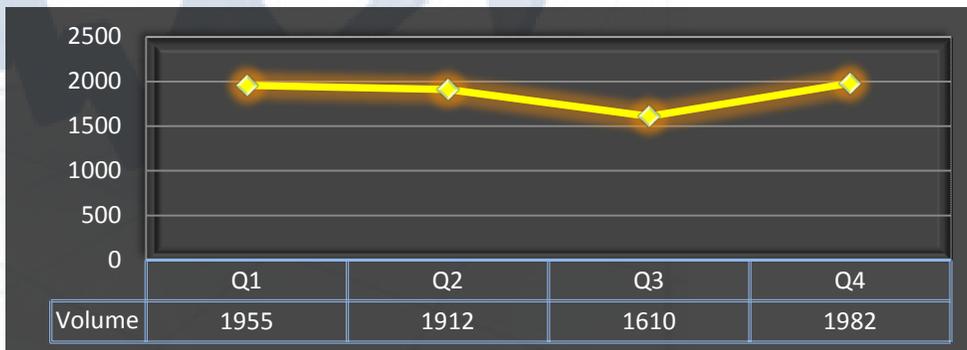
Annual Report (2012 – 2013 Fiscal Year)

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.

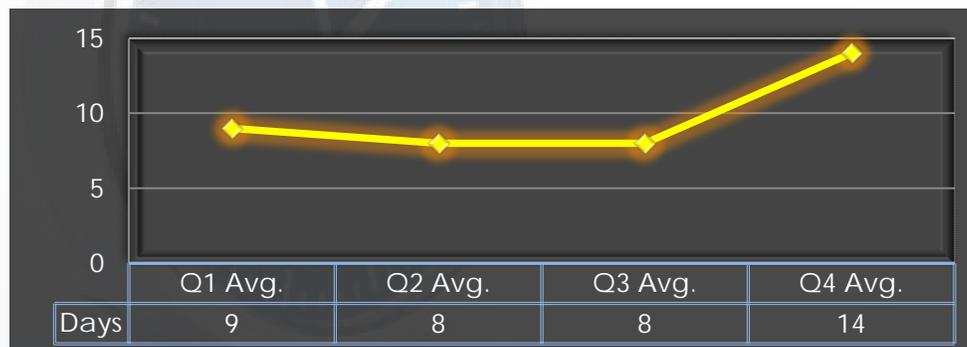
The Board had an annual total of 7,459 this fiscal year.



Intake

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

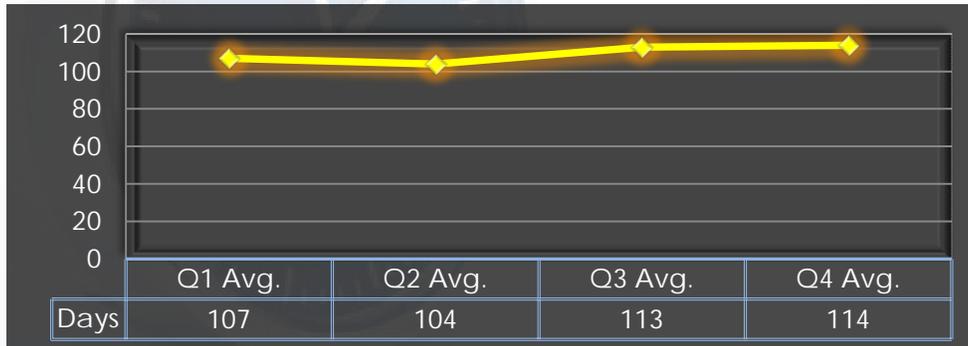
The Board has set a target of 9 days for this measure.



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.

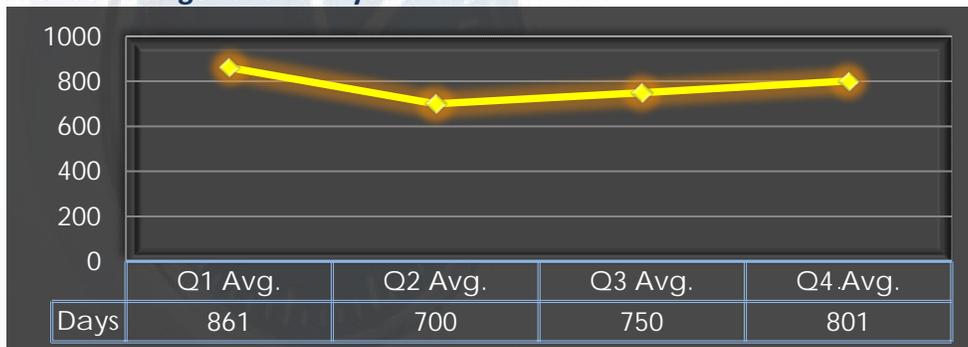
The Board has set a target of 125 days for this measure.



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.

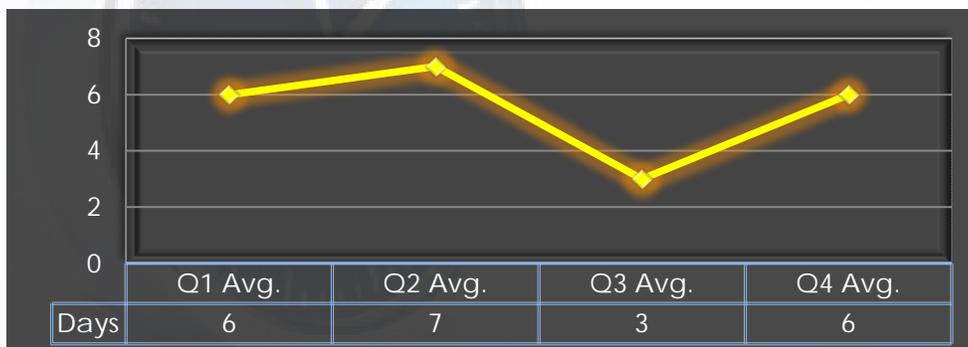
The Board has set a target of 540 days for this measure.



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

	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
How satisfied were you with our response to your initial correspondence?						
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

	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
How satisfied were you with the time it took to speak to a representative of our Board/Bureau?						
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

	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
How satisfied were you with our representative's ability to address your complaint?						
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

	FY 2012/13		FY 2013/14		FY 2014/15	
	% of Total	Count	% of Total	Count	% of Total	Count
How satisfied were you with the time it took for us to resolve your complaint?						
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 BreZE 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 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -
	0	9	14	14	38	9	4	8	25	8	7	6	12	19	26	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 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -
	0	9	14	14	38	9	4	8	24	7	7	6	10	17	23	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 describes 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 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -
	0	0	0	71	110	76	48	43	35	27	24	27	24	15	7	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 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -	Q1 -	Q2 -	Q3 -	Q4 -
	0	0	0	71	110	76	48	43	35	27	24	27	24	15	7	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.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 10, 2016
ATTENTION: Members, Medical Board of California
SUBJECT: Special Faculty Permit Review Committee
Recommendation
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

RECOMMENDED ACTION:

Shunji Sano, M.D., Ph.D.

Approve the Special Faculty Permit Review Committee (SFPRC) recommendation for a Special Faculty Permit (SFP) appointment for Shunji Sano, M.D., Ph.D., pursuant to California Business and Professions Code (BPC) section 2168.1(a)(1)(B).

BACKGROUND AND ANALYSIS:

The Medical Board of California (Board) is authorized to issue an SFP to a physician who is academically eminent and meets all of the other requirements pursuant to BPC section 2168.1.

An individual who holds a valid SFP is authorized to practice medicine only within the medical school itself and any affiliated institutions in which the SFP holder is providing instruction as part of the medical school's educational program, and for which the medical school has assumed direct responsibility.

The SFPRC is comprised of two Board members, one who is a physician and one who is a public member, and one representative from each of the 10 allopathic medical schools in California for a total of 12 members. The SFPRC reviews and makes recommendations to the Board regarding the applicants applying pursuant to BPC section 2168.1.

At the SFPRC's September 29, 2016 meeting, the SFPRC reviewed the qualifications of one applicant from the University of California San Francisco (UCSF).

Shunji Sano, M.D., Ph.D. - UCSF:

Neal Cohen, M.D., M.S., M.P.H., Vice Dean, UCSF, presented UCSF's request for Shunji Sano, M.D., Ph.D., to receive an SFP and provided the SFPRC with Dr. Sano's qualifications.

Dr. Sano's area of expertise is pediatric cardiac surgery.

Dr. Sano has held the following positions: Consultant Cardiac Surgeon, Victoria Pediatric Cardiac Surgical Unit at Royal Children's Hospital, Melbourne, Australia; Assistant Professor, Surgical Department at Okayama University Medical School, Okayama, Japan; Assistant Professor, Department of Cardiovascular Surgery at Okayama University Medical School, Okayama, Japan; Professor and Chairman, Department of Cardiovascular Surgery at Okayama University Medical School, Okayama, Japan; Professor, Functional Physiology, Bio-physiological Science, Okayama University Graduate School of Medicine and Dentistry, and Chairman, Department of Cardiovascular Surgery, Okayama University Hospital, Okayama,

Japan; Vice President, Okayama University Hospital, Japan; and Professor, Functional Physiology, Bio-physiological Science, Okayama University Graduate School of Medicine and Dentistry and Pharmaceutical Science Chairman. Dr. Sano has extensive experience in the surgical care of patients with life threatening cardiac abnormalities and is regarded internationally as a leader in the field and a pioneer in the development of new surgical techniques. Dr. Sano is responsible for transforming Okayama University Medical School cardiovascular program into the leading pediatric cardiac surgery program in Japan, performing over 500 cases per year. He also teaches local surgeons in pediatric cardiac surgery procedures.

Dr. Sano has given approximately 150 invited lectures internationally and has participated in many surgical symposia in Asia, Europe and the United States. Dr. Sano is internationally renowned for his contributions to the surgical treatment of congenital heart disease including the development of the “Sano Procedure” for hypoplastic left heart syndrome. Dr. Sano has performed more than 7000 pediatric cardiac surgeries in Japan and has pioneered research on cardiac regeneration therapy. Dr. Sano and his research team have developed a progenitor cell therapy for patients with single ventricle heart failure.

Dr. Sano will hold a full-time faculty appointment as a Professor of Surgery at UCSF, if approved for an SFP appointment by the Board. Dr. Sano will engage in the practice of pediatric cardiac surgery at UCSF, teaching cardiothoracic surgery fellows, participating in teaching conferences and resident rounding. Dr. Sano will serve as the principal investigator of a multi-center trial of stem cell auto transplants in pediatrics patients at UCSF. Dr. Sano is an extraordinarily accomplished surgeon who has the credentials to guide the UCSF pediatric cardiac surgery program to international recognition in the treatment of heart failure patients. A great need exists to expand pediatric cardiac surgical services and to develop the capability to provide innovative surgical repairs for the most complex cardiac abnormalities at UCSF.

Dr. Sano’s application is complete except for the copy of his U.S. social security card, a copy of his U.S. visa, and the final fee for the permit. The file is ready to present for discussion and recommendation by the Committee. The copy of his U.S. social security card, U.S. visa, and the final fee for the permit will be required prior to issuing the SFP, should the Board approve an SFP appointment for Dr. Sano.

Education:

Medical School:

Okayama University Medical School	Japan	1971 - 1977
Graduated March 25, 1977		

Postgraduate Training:

- | | | |
|---|-------|-----------|
| ➤ Hiroshima City Hospital
General Surgery | Japan | 1977-1978 |
| ➤ Okayama University Medical School
Cardiovascular Surgery (Doctor of Philosophy in Medical Science) | Japan | 1978-1982 |

**Check Up on Your Doctor’s License Campaign
Priority One Outreach Activities Update**

Outreach Activity	Status Update
<p>Develop a tutorial for the Medical Board of California’s (Board’s) website on how to lookup a physician’s license and what the information means on the website</p>	<p>The tutorial was completed in June 2016 and is available on YouTube and posted on the Board’s website’s main page http://www.mbc.ca.gov/ “Check Up On Your Doctor’s License – Tutorial”</p> <p>The Board has completed the tutorial in Spanish and it is available on You Tube and on the Board’s website. https://www.youtube.com/watch?v=rzVpikwUFy8&feature=youtu.be</p>
<p>Develop a PSA that can be provided to entities to air</p>	<p>Board staff will begin work on the PSA now that the Spanish version of the tutorial is complete. The estimated completion deadline for the PSA is January 2017.</p>
<p>Include information about the Board on utility bills throughout the state</p>	<p>The Public Affairs Manager will be working to launch the partnership with Tammi Watt’s (nurse practitioner) and PG&E’s proposed Health Center for employees before the end of the year. The Board would provide brochures, newsletters, Op-Ed’s and presentations at their staff outreach events.</p>
<p>Include information about the Board on city, county, and state employee paystubs</p>	<p>A message encouraging state employees, vendors and contractors to “Check Up On Their Doctor’s License” appeared at the bottom of all State Warrants for June 2016, reaching 439,916 individuals.</p> <p>The Board has made arrangements to have another global message like this on the March 1, 2017 State Warrants, in addition to a flier that will be placed in the March 31, 2017 state warrants. March is National Consumer Protection Month.</p> <p>The April 2016 issue (pg. 8) of the “California State Retiree” publication featured an image of the Board’s “Check Up On Your Doctor” brochure, reaching 34,000 state retirees.</p> <p>The Orange County Health Care Agency published a ½ page write-up in its June employee newsletter “What’s Up” titled “Have</p>

**Check Up on Your Doctor’s License Campaign
Priority One Outreach Activities Update**

Outreach Activity	Status Update
<p>Include information about the Board on city, county, and state employee paystubs (cont.)</p>	<p>You Done a Checkup on your Doctor’s License?” reaching 3,000 agency employees.</p> <p>On May 17, 2016, San Bernardino County posted the Board’s information on the San Bernardino County website, reaching potentially 2,139,570 individuals.</p> <p>On May 25, 2016, the Tulare County Health Department agreed to schedule the Board’s messaging on Twitter and Facebook pages throughout the year. In addition the information was added on the “Spotlight” section of its website. In addition they have created a network of digital signs that appear throughout its county buildings and Area Family Resource Centers/County Clinics that will carry the Board’s messaging and a small article will appear in the County Newsletter in the future, reaching potentially 466,339 individuals.</p> <p>On May 31, 2016, the Monterey County Health Department posted an article about the campaign on its website. They have also promised to post social media as well, reaching 431,344 individuals. They have asked for brochures in Spanish, which the Board has developed and ordered.</p> <p>On July 6, 2016, the San Francisco Department of Public Health published the Board’s information on its website as well as through social media, reaching potentially 852,469 individuals.</p> <p>On June 7, 2016, the Los Angeles County Department of Health Services began posting the Board’s information on the Patient Resources section of its website, reaching potentially 10.12 million individuals.</p> <p>On June 7, 2016, Contra Costa County started running the Board’s message on its cable TV bulletin board which is available to all county</p>

**Check Up on Your Doctor’s License Campaign
Priority One Outreach Activities Update**

Outreach Activity	Status Update
<p>Include information about the Board on city, county, and state employee paystubs (cont.)</p>	<p>residents, reaching potentially up to 1.11 million individuals.</p> <p>On June 7, 2016, the Kern County Department of Public Health indicating they would immediately start to share the Board’s information on all its social media sites (Twitter and Facebook), reaching potentially 875,589 individuals.</p> <p>On June 8, 2016, Stanislaus County Health Services posted the Board’s message in its various facilities, reaching 525,491 individuals.</p> <p>On June 13, 2016 Fresno County began to run a feature on its intranet for the “Check Up On Your Doctor” campaign, targeting Fresno County readership, reaching 7,000 employees.</p> <p>On July 28, 2016, the Long Beach Health and Human Services Department posted an article, “Do a Check Up on Your Doctor’s License” with the picture on their website, reaching 300 employees.</p> <p>On August 19, 2016 the California Department of Consumer Affairs posted an article about Check up on Your Doctor’s License on their DCA Blog, reaching an undetermined number of viewers.</p> <p>CalPERS ran a short article on the campaign in its <i>Perspective</i> newsletter’s Fall 2016 version, which is delivered to members’ homes and is available on the internet, reaching 1.7 million members.</p> <p>CalPERS will be posting a bulletin on its intranet site reaching 2,900 CalPERS employees.</p> <p>CalPERS also provided a link to the Board’s website on its open enrollment page from September through the end of October 2016.</p>

**Check Up on Your Doctor’s License Campaign
Priority One Outreach Activities Update**

Outreach Activity	Status Update
<p>Work with the AARP to provide Board information at their conferences, in their publications, and on their website</p>	<p>The Board’s Public Affairs Manager has reached out to Charee Gillins who handles media for AARP in Southern California and Mark Beach who handles media in Northern California. Board staff has heard from Ms. Gillins who is going to look into the issue of promoting the Board’s messaging in Southern California regarding AARP. Board staff is waiting to hear back from Mr. Beach who represents Northern California.</p>
<p>Reach out to unions so they can provide their members information about the Board and a link to the Board’s website on union materials</p>	<p>CalSTRS ran a news brief on the “Check Up On Your Doctor” campaign in their Retired Educator publication in the Summer 2016 edition. A similar article ran in their Connections publication in the Fall 2016 issue. Together, both publications have the potential of reaching 900,000 current and retired California teachers.</p> <p>The American Federation of State, County, and Municipal Employees (AFSCME) is a national union and has two District Councils, #36 serves Southern California and #57 serves Northern California. The Board’s Public Affairs Manager has spoken with Erica Lichtman from District 36, and on April 4, an email was sent to Ms. Lichtman providing a copy of the Board’s brochure and a short write up detailing the campaign. Board staff is still working on this. Potential target readership is 120,000 California members.</p>
<p>Provide an interview and PSA to iHeart Radio with Board staff and/or with Board Members</p> <p>Interview/PSA on NPR and Capitol Public Radio</p>	<p>The Board’s Public Affairs Manager will work to get these interviews scheduled after the Board’s PSA is completed.</p>
<p>Encourage Legislative Members, Congressional Members, and local government to include information and a link to the Board’s website in their newsletters and to Tweet the Board’s link and post the Board’s link on their websites</p> <p>Hold a Legislative Day (possibly two) at the</p>	<p>The Board’s Legislative Day was held on May 11, 2016. Board Members met with legislators who are members of policy committees that impact the Board (such as the Senate Business, Professions and Economic Development Committee and the Assembly Business and Professions Committee). Additionally, 20 copies of the California State Retiree Article and the</p>

**Check Up on Your Doctor’s License Campaign
Priority One Outreach Activities Update**

Outreach Activity	Status Update
<p>Capitol where Board staff passes out brochures and Members meet with key Legislators</p>	<p>Board’s outreach brochure were handed out to legislators at the State Capitol.</p>
<p>Encourage Legislative Members, Congressional Members, and local government to include information and a link to the Board’s website in their newsletters and to Tweet the Board’s link and post the Board’s link on their websites (cont.)</p>	<p>On May 17, 2016 the Board tweeted “Be an informed patient – check up on your doctor’s license status” accompanied by the graphic on the cover of the brochure. On May 23, 2016, Assembly Member Sebastian Ridley-Thomas re-tweeted the Board’s May 17 tweet.</p> <p>Senator Richard Pan, M.D. agreed to display and give out the Board’s “Check Up on your Doctor’s License” brochures in his office.</p>
<p>General Outreach activity</p>	<p>“Check up on your Doctor’s License” brochures have been translated into Spanish and are now available.</p> <p>On May 11, 2016, the Board had an exhibit at the Department of Consumer Affairs (DCA) Earth, Safety and Wellness Day at DCA headquarters, passing out the “Check Up On Your Doctor’s License” brochures, as well as instructing attendees on how to look up a license and what the information on the website means. There were approximately 300 attendees.</p> <p>On June 17, 2016, the Public Affairs Manager gave a presentation on the importance of “Checking on Your Doctor’s License” at a Town Hall event with Assemblyman Jim Cooper in Sacramento at the ACC Senior Services Center. There were approximately 100 attendees.</p> <p>On October 13, 2016 the public affairs manager along with the Yolo County District Attorney’s Office (and several other stakeholders) gave a presentation and set up an informational booth at the Senior Resource and Crime Prevention Fair in Woodland.</p>



PERSPECTIVE

Fall 2016

Know Your Choices for
2016 Health Open Enrollment



Summary of Benefits and Coverage Notice

Choosing your health plan is an important decision. To assist you with this process, each health plan available through CalPERS has produced a Summary of Benefits and Coverage (SBC). In addition, the federal government has compiled a glossary of common health insurance terms. Together, these documents provide important information to help you better understand your health benefit coverage and more easily compare health plan options.

To view the SBCs and glossary online, visit www.calpers.ca.gov or any of the health plan websites below. To request a free paper copy of the SBC and glossary, please contact each health plan directly.

Anthem Blue Cross HMO
(855) 839-4524
www.anthem.com/ca/calpers/hmo

Kaiser Permanente
(800) 464-4000
www.kp.org/calpers

Blue Shield of California
(800) 334-5847
www.blueshieldca.com/calpers

Peace Officers Research Association of California*
(800) 288-6928
www.ibtoporac.org

California Association of Highway Patrolmen*
(800) 734-2247
www.thechap.org

PERS Select, PERS Choice, and PERSCare
(877) 737-7776
www.anthem.com/ca/calpers

California Correctional Peace Officers Association*
(800) 257-6213
www.ccpoabtf.org

Sharp Health Plan
(855) 995-5004
www.sharphealthplan.com/calpers

Health Net of California
(888) 926-4921
www.healthnet.com/calpers

UnitedHealthcare
(877) 359-3714
www.uhc.com/calpers

*To enroll in these health plans, you must belong to the specific employee association and pay applicable dues.

Long-Term Care Expanded Eligibility

Did you know that CalPERS Long-Term Care Program eligibility extends to more than just California public employees and retirees?

You and many of your immediate family members are all eligible to apply for coverage. Family members such as spouses, siblings, and adult children can apply, even if the public employee who makes an individual eligible does not apply.

Now, CalPERS Long-Term Care eligibility criteria has been expanded further to include former California public employees, as well as grandparents, grandchildren, nieces, nephews, aunts, uncles, sons-in-law, daughters-in-law, brothers-in-law, and sisters-in-law of current and former California public employees. This expansion provides an opportunity for even more people to find the peace of mind available with CalPERS Long-Term Care.

If you have any questions about applying for coverage or to find out if you or someone you know is eligible to apply, please call the CalPERS Long-Term Care Program toll free at (800) 908-9119, Monday through Friday, 8:00 a.m. to 5:00 p.m. Pacific Time or visit our website anytime at www.calperslongtermcare.com.



Have You Checked Your Doctor's License?

The Medical Board of California encourages consumers to check their doctor's license. Such a checkup is simple and helps you make an informed choice when choosing a doctor. To determine a doctor's status, go to the Medical Board's website at www.mbc.ca.gov or call (800) 633-2322.

CalSTRS Medicare Premium Payment Program—Are You Eligible?

You may be eligible for CalSTRS to pay your Medicare Part A (hospital) premiums through our Medicare Premium Payment Program if you retired or started receiving a disability benefit on or before June 30, 2012, and meet all the other requirements. Under the program, if you don't qualify for premium-free Medicare Part A, CalSTRS will pay your Part A premium directly to Medicare.

Your eligibility also depends on the time period during which you were employed and whether or not your employer held a Medicare Division election—and if your employer did hold an election, when it occurred, your vote and your age at the time of the election. Learn more about the eligibility requirements in the *Member Handbook* or at CalSTRS.com/medicare-premium-payment-program.

In addition, you must enroll in Medicare Parts A and B to participate in the Medicare Premium Payment Program. Call the Social Security Administration toll free at 800-772-1213 to determine your eligibility for, and to enroll in, Medicare.

We will send you information in advance of your 65th birthday if you may meet the minimum requirements, or you can download the *Medicare Payment Authorization* packet at CalSTRS.com/forms.

If you have any questions about the program, send us a secure online message at CalSTRS.com/contact or through your *myCalSTRS* account, or call us at 800-228-5453.



Good to Know: Check Up on Your Doctor's License

The Medical Board of California encourages consumers to check up on their doctors' licenses to help make an informed choice when selecting a medical professional. To determine a doctor's status, review license details and verify any disciplinary actions, go to mbc.ca.gov and click on *License Search*. You can also sign up to be notified by email of disciplinary actions taken against a physician's license, including probationary status, suspension or revocation. Encouraging patients to check up on their doctors' license is part of the Medical Board's ongoing mission of consumer protection. For more information, call 800-633-2322.



Update Your One-Time Death Benefit Recipient Information Online at *myCalSTRS*

If you've gone through a divorce, remarried or your family has grown since your retirement account was established, make sure to update your recipient designation information. Log on to myCalSTRS.com for secure and convenient access to your CalSTRS accounts and select *Manage Your Beneficiary Selections*.

TITLE 16. MEDICAL BOARD OF CALIFORNIA

NOTICE IS HEREBY GIVEN that the Medical Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held on October 28, 2016, at 9:00 a.m., at the Sheraton Mission Valley San Diego located at 1433 Camino Del Rio South, San Diego, California.

Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office no later than 5:00 p.m. on October 25, 2016, or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Sections 125.9, 148, and 2018 of the Business and Professions Code, and to implement, interpret or make specific section(s) 125.9, 148, 2027, 2227, 2228, 2229, and 2234 of said Code, the Board is considering amendments to Sections 1364.10, 1364.11, 1364.13 and 1364.15 of Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST

A. Informative Digest

This rulemaking action seeks to amend Division 13 of Title 16 of the California Code of Regulations (CCR) sections 1364.10, 1364.11, 1364.13 and 1364.15.

Proposed Amendments to 16 CCR 1364.10(b)

Under existing law, CCR section 1364.10, states that a Board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in section 1364.11.

Licensed midwives and polysomnographic technologists, technicians, and trainees are licensed/registered and regulated by the Board, but are not currently covered by the Board's citation and fine regulations. This proposed rulemaking will add licensed midwives and polysomnographic technologists, technicians, and trainees under CCR section 1364.10(b) as licensees/registrants to whom the Board may issue citations with orders of abatement and fines when these allied health care professionals violate statutes or regulations referenced in CCR

section 1364.11.

These amendments are necessary to provide the Board with an administrative tool to bring licensed midwives, and polysomnographic technologists, technicians, and trainees into compliance if they commit a violation of the specified statutes. This supports the Board's mission of public protection.

Further, CCR section 1364.10(b) currently states that citations containing orders of abatement and fines may be issued for violations of the statutes referred to in Section 1364.11. Because CCR section 1364.11 also lists regulations as citable offenses, an amendment to 1364.10(b) is necessary to clarify that citations containing orders of abatement and fines may be issued for violations of regulations, as well as statutes, referred to in Section 1364.11.

Proposed Amendments to 16 CCR 1364.11

Under existing law, CCR section 1364.11(a) states that a Board official may issue a citation under section 1364.10 for a violation of the provisions listed in this section. This proposed rulemaking will add additional provisions of the Business and Professions (B&P) and Health and Safety (H&S) Codes and the CCR to the list of citable offenses to authorize the Board to issue citations with orders of abatement and fines to licensees found in violation of those statutes or regulations, furthering consumer protection.

The proposed additions to 16 CCR section 1364.11(a) include the following statutes and regulation:

- B&P Code section 2234(h), relating to the repeated failure of a certificate holder, in the absence of good cause, to attend and participate in an interview by the board;
- B&P Code section 2507, relating to the practice of midwifery, the midwifery scope of practice, and the requirement for physician referral under certain circumstances;
- B&P Code section 2508, relating to required disclosures by licensed midwives to their clients;
- B&P Code section 2510, relating to requirements for a licensed midwife upon transfer of a client to a hospital;
- B&P Code section 2514, relating to requirements for midwifery students practicing midwifery as part of his or her course of study;
- B&P Code section 2519, relating to grounds for suspension or revocation of a midwifery license;
- B&P Code section 3575, relating to requirements for engaging in polysomnography as a polysomnographic technologist, technician, or trainee;
- B&P Code section 3576, relating to grounds for denial, suspension, or revocation of a registration as a polysomnographic technologist,

- technician, or trainee;
- B&P Code section 4172, relating to any prescriber who dispenses drugs and fails to store all drugs to be dispensed in an area that is secure;
 - H&S Code section 11165.1(a)(1)(A)(i), requiring health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances to submit an application before July 1, 2016, to the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient maintained in the CURES database;
 - H&S Code section 120370(a), relating to physicians providing a parent or guardian of a child a written statement indicating that the physical condition of a child, or the medical circumstances relating to the child, are such that immunization is not considered safe; and
 - 16 CCR section 1355.4, relating to any licensee that practices medicine and fails to provide proper notice to each patient of the fact that the licensee is licensed and regulated by the Board.

Adding these sections of law and regulation as citable offenses is necessary to provide the Board with an administrative tool to bring licensees into compliance with these sections, furthering consumer protection.

Additionally, this proposed rulemaking reorganizes and renumbers section 1364.11(a) so that it is easier for interested parties to locate citable offenses, and also makes technical changes as follows:

- B&P Code sections 655.6 and 2265 have been repealed in statute, and these sections will be deleted as citable offenses.
- B&P Code section 802(b) is currently listed as a citable offense, but subsection (b) falls under the jurisdiction of the Board of Behavioral Sciences. The citable offense has been corrected to reflect B&P Code section 802(a) in the proposed amendments, as this subsection applies to physicians and surgeons.
- B&P Code section 2630 now falls under the Physical Therapy Board's jurisdiction, and will be stricken as a citable offense by this rulemaking.
- B&P Code section 2097 was renumbered by the legislature to B&P Code section 2426, and that change will be reflected in the amendment to this section.

These technical changes are necessary to improve the clarity of this section.

Finally, this proposed rulemaking adds a subsection (e) to specify that a citation issued under this section is separate from and in addition to any other administrative, civil, or criminal remedies. This change is necessary to improve

the clarity of the section.

Proposed Amendments to 16 CCR 1364.13

Under existing law, CCR 1364.13 authorizes a Board official to issue citations containing orders of abatement and fines against individuals, partnerships, corporations or associations, who are performing or who have performed services for which licensure as a physician and surgeon is required under the Medical Practice Act. However, individuals, partnerships, corporations or associations who are performing or who have performed services as unlicensed midwives and polysomnographic technologists, technicians, and trainees are not currently covered by the Board's citation and fine regulations.

This proposed rulemaking will amend this section to indicate that a Board official is authorized to issue citations with orders of abatement and fines to individuals, partnerships, corporations or associations, who are performing, or who have performed, services for which licensure as a licensed midwife or registration as a polysomnographic technologist, technician, or trainee is required. These amendments are necessary for the Board to be able to issue citations with orders of abatement and fines to these individuals and entities who practice without obtaining the required license or registration. Such authority furthers the Board's mission of consumer protection.

Thus, this proposed rulemaking specifies that a Board official is authorized to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon licensed under Chapter 5 of the code (commencing with section 2000) or as a licensed midwife licensed under Chapter 5 of the code (commencing with section 2505), or registration as a polysomnographic technologist, technician, or trainee registered under Chapter 7.8 (commencing with section 3575) is required.

Additionally, this rulemaking proposes to strike the reference to the Medical Practice Act from CCR section 1364.13, since allied health care providers are being added, and each licensee's or registrant's authorizing code section under the B&P Code is specified. CCR section 1364.13 will be further clarified by indicating that the provisions of CCR sections 1364.10 and 1364.12 apply to the issuances of citations for unregistered as well as unlicensed activity, since polysomnographic technologists, technicians, and trainees are required to be registered, not licensed.

Finally, existing law under CCR section 1364.13 indicates that any sanction under this section is separate and in addition to any other civil or criminal remedies. This rulemaking will add administrative remedies to that list to clarify that any sanction under this section is separate and in addition to any other administrative, civil, or criminal remedies.

This proposed rulemaking is necessary to amend CCR section 1364.13 to allow the Board to issue citations with orders of abatement and fines to these unlicensed/unregistered individuals and entities who violate the law, thereby giving the Board an administrative tool to further its mission of consumer protection.

Proposed Amendments to 16 CCR 1364.15

Under existing law, CCR section 1364.15 states every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public, and citations that have been resolved by payment of the administrative fine or compliance with the order of abatement shall be purged five (5) years from the date of resolution.

Effective January 1, 2015, pursuant to amendments to B&P Code section 2027(b)(9), the Board shall post on its website all historical information in its possession, custody, or control regarding all current and former licensee to include citations issued within the last three (3) years that have been resolved by payment of the administrative fine or compliance with the order of abatement.

This proposed rulemaking will change the citation purge date from five years to three years to be consistent with B&P Code section 2027(b)(9). This proposed amendment is necessary to make CCR section 1364.15 consistent with the three-year time period set forth by B&P Code section 2027(b)(9).

Board Authorization

On May 6, 2016, at the Board's quarterly meeting, Board staff requested the Board authorize staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking. The Board granted the request to initiate the rulemaking process to amend CCR sections 1364.10, 1364.11, 1364.13 and 1364.15 and authorized a hearing to be held after the 45-day comment period.

At the July 29, 2016, quarterly Board meeting, Board staff readdressed its May 6, 2016, request to authorize staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendment and schedule a hearing on the rulemaking. The purpose of the proposal was to add H&S Code section 120370(a) to the list of citable offenses due to the recent enactment of Senate Bill 277 relating to medical exemptions for vaccinations.

B. Policy Statement Overview/Anticipated Benefits of Proposal

The proposed amendments will authorize the Board to issue citations containing orders of abatement and fines to licensed midwives and polysomnographic technicians, technicians, and trainees, in addition to licensed physicians and

surgeons, and to unlicensed or unregistered individuals performing services that require a license or registration. Moreover, the proposed amendments add additional statutes for which the Board is authorized to issue citations containing orders of abatement and fines to California health care professionals who violate specified provisions of the B&P Code, the H&S Code, and the CCR, and will align the timeframe for retaining citations with current statute. Such amendments give the Board necessary tools to bring individuals into compliance with the law, and further the Board's mission of consumer protection pursuant to B&P Code section 2001.1. It also furthers the Board's goal of rehabilitation of licensees, when rehabilitation is not inconsistent with the Board's priority of public protection pursuant to B&P Code section 2229.

C. Consistency and Compatibility with Existing State Regulations

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

FISCAL IMPACT ESTIMATES

Fiscal Impact on Public Agencies Including Costs or Savings to State Agencies or Costs/Savings in Federal Funding to the State:

Additional provisions of the B&P and H&S Codes and CCR have been added to the list of citable offenses to authorize the Board to issue citations with orders of abatement and fines to licensees found in violation of those sections. The proposed amendments also give the Board the authority to issue citations with orders of abatement and fines to licensed midwives and polysomnographic technologists, technicians, and trainees. The cost and workload to the Board is minimal and absorbable. It is anticipated that licensed midwives, polysomnographic technologists, technicians, and trainees will generate an average of \$5,872 in annual revenue to the Board from citations and fines. Over the life of this regulation, the Board anticipates receiving approximately \$58,720 in revenue from citations and fines issued to allied health professions, and for those practicing in these areas without the required license or registration.

Further, the Board anticipates collecting approximately \$107,216 in annual citation and fine revenue from physicians and surgeons, which include citations and fines for violations of the proposed additional code sections. Over the life of this regulation, the Board anticipates receiving approximately \$1,072,160 in revenue from citations and fines issued to physicians and surgeons, and for those practicing medicine without a license. The Board's attachment to the STD 399 outlines the estimated revenue anticipated.

The Board has determined that this proposed rulemaking will not cause a cost or savings in federal funding to the state, since the regulation of the licenses and registrations of health care providers is a state function.

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

Business Impact:

The Board has made an initial determination that the proposed regulatory action will have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for fiscal year (FY) 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.

Cost Impact on Representative Private Person or Business:

The cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action and that are known to the Board are:

There may be minimal cost impact to licensed physicians and surgeons, midwives and polysomnographic technologists, technicians, and trainees and unlicensed individuals and entities performing services for which a license or registration is required as a result of a citation and fine being issued for violating a provision(s) listed in section 1364.11(a) of the CCR. Individuals who are in compliance with the law will not be impacted. Based on data over a two year period, the average citation and fine amount is \$979.

Effect on Housing Costs: None

RESULTS OF ECONOMIC IMPACT ASSESSMENT/ANALYSIS:

The Board has made an initial determination that the proposed regulatory action will have no significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the following facts:

- Analysis of creation/elimination of jobs: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of jobs or the elimination of jobs in the State of California. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for FY 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.
- Analysis of creation/elimination of businesses: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of new businesses or the elimination existing businesses or the expansion of businesses in the State of California. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for FY 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.
- Analysis of expansion of business: This proposal is not expected to lead to the expansion of new businesses within California. This initial determination is based on the fact that this proposal gives the Board a tool to bring licensees into compliance with the law if they violate certain

specified statutes or regulations, and it impacts a very small percentage of licensees and unlicensed or unregistered individuals or entities.

- Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment: The Board has determined that this regulatory proposal will benefit the health and welfare of California residents because the proposed additions to the list of citable offenses under CCR section 1364.11(a) provides further consumer protection. Additionally, authorizing the Board to issue citations with orders of abatement and fines to licensed midwives and polysomnographic technologists, technicians, and trainees and unlicensed individuals and entities performing services as midwives and polysomnographic technologists, technicians, and trainees, provides an administrative tool to the Board to address consumer complaints that do not warrant formal disciplinary action. This assists in bringing the licensee or unlicensed individual or entity into compliance, furthering consumer protection.

This proposed rulemaking is not anticipated to have an impact on worker safety or the state's environment.

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for fiscal year (FY) 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposal described in this Notice, or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

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

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

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

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

CONTACT PERSON

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

Name: Christina Delp, Chief of Enforcement
Address: 2005 Evergreen Street, Ste. 1200
Sacramento, CA 95815
Telephone No.: 916-263-2389
Fax No.: 916-263-2387
E-Mail Address: Christina.delp@mbc.ca.gov

The backup contact person is:

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

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

**MEDICAL BOARD OF CALIFORNIA
CITE AND FINE AUTHORITY – ALLIED HEALTH PROFESSIONALS**

Specific Language of Proposed Changes

Underlined **Indicates proposed additions to the existing regulation.**

~~Strikeout~~ **Indicates proposed deletions to the existing regulation**

Amend Sections 1364.10, 1364.11, 1364.13 and 1364.15 in Article 6 of Chapter 2, Division 13, of Title 16 of the California Code of Regulations to read as follows:

§1364.10. Citations and Fines.

(a) For purposes of this article, “board official” shall mean the executive director of the board or his or her designee.

(b) A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon, licensed midwife, or polysomnographic technologist, technician, or trainee of the statutes and regulations referred to in Section 1364.11.

(c) A citation shall be issued whenever any fine is levied or any order of abatement is issued. Each citation shall be in writing and shall describe with particularity the nature and facts of the violation, including a reference to the statute or regulations alleged to have been violated. The citation shall be served upon the individual personally or by certified mail.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.
Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1364.11. Citable Offenses.

The amount of any fine to be levied by a board official shall take into consideration the factors listed in subdivision (b)(3) of Section 125.9 of the code and shall be within the range set forth below.

(a) In his or her discretion, a board official may issue a citation under Section 1364.10 for a violation of the provisions listed in this section.

- (1) Business and Professions Code Section 119
- (2) Business and Professions Code Section 125
- (3) Business and Professions Code Section 125.6
- (4) Business and Professions Code Section 475(a)(1)
- (5) Business and Professions Code Section 496
- (6) Business and Professions Code Section 650
- (7) Business and Professions Code Section 650.1
- (8) Business and Professions Code Section 654

- (9) Business and Professions Code Section 654.1
- (10) Business and Professions Code Section 654.2
- (11) Business and Professions Code Section 655.5
- ~~(12) Business and Professions Code Section 655.6~~
- ~~(13)~~(12) Business and Professions Code Section 702
- ~~(14)~~(13) Business and Professions Code Section 730
- ~~(15)~~(14) Business and Professions Code Section 732
- (15) Business and Professions Code Section 802(a)
- (16) Business and Professions Code Section 802.1
- ~~(16)~~(17) Business and Professions Code Section 810
- ~~(17)~~(18) Business and Professions Code Section 2021
- ~~(18)~~(19) Business and Professions Code Section 2052
- ~~(19)~~(20) Business and Professions Code Section 2054
- ~~(20)~~(21) Business and Professions Code Section 2065
- ~~(21)~~(22) Business and Professions Code Section 2066
- ~~(22)~~(23) Business and Professions Code Section 2072
- ~~(23)~~(24) Business and Professions Code Section 2073
- ~~(24) Business and Professions Code Section 2097~~
- (25) Business and Professions Code Section 2168
- (26) Business and Professions Code Section 2168.4
- (27) Business and Professions Code Section 2216.1
- (28) Business and Professions Code Section 2221.1
- (29) Business and Professions Code Section 2234(h) ~~only for a violation of one of the following:~~
- ~~(A) Business and Professions Code Section 802(b)~~
- ~~(B) Business and Professions Code Section 802.1~~
- ~~(C) Health and Safety Code Section 102795~~
- ~~(D) Health and Safety Code Section 102800~~
- ~~(E) Health and Safety Code Section 103785~~
- ~~(F) Health and Safety Code Section 109275~~
- ~~(G) Health and Safety Code Section 109277~~
- ~~(H) Health and Safety Code Section 109278~~
- ~~(I) Health and Safety Code Section 109282~~
- ~~(J) Health and Safety Code Section 120250~~
- ~~(K) Health and Safety Code Section 121362~~
- ~~(L) Health and Safety Code Section 121363~~
- ~~(M) Title 17 California Code of Regulations Section 2500~~
- (30) Business and Professions Code Section 2236
- (31) Business and Professions Code Section 2238
- (32) Business and Professions Code Section 2240
- (33) Business and Professions Code Section 2244 (maximum fine \$1000 pursuant to section 2244)
- (34) Business and Professions Code Section 2243
- (35) Business and Professions Code Section 2250
- (36) Business and Professions Code Section 2255
- (37) Business and Professions Code Section 2256
- (38) Business and Professions Code Section 2257
- (39) Business and Professions Code Section 2259
- (40) Business and Professions Code Section 2261
- (41) Business and Professions Code Section 2262
- (42) Business and Professions Code Section 2263
- (43) Business and Professions Code Section 2264

- ~~(44)~~ ~~Business and Professions Code Section 2265~~
- ~~(45)~~ (44) Business and Professions Code Section 2266
- ~~(46)~~ (45) Business and Professions Code Section 2271
- ~~(47)~~ (46) Business and Professions Code Section 2272
- ~~(48)~~ (47) Business and Professions Code Section 2273
- ~~(49)~~ (48) Business and Professions Code Section 2274
- ~~(50)~~ (49) Business and Professions Code Section 2285
- ~~(51)~~ (50) Business and Professions Code Section 2286
- ~~(52)~~ (51) Business and Professions Code Section 2305
- ~~(53)~~ (52) Business and Professions Code Section 2400
- ~~(54)~~ (53) Business and Professions Code Section 2415
- (54) Business and Professions Code Section 2426
- (55) Business and Professions Code Section 2439
- (56) Business and Professions Code Section 2440
- (57) Business and Professions Code Section 2441
- (58) Business and Professions Code Section 2507
- (59) Business and Professions Code Section 2508
- (60) Business and Professions Code Section 2510
- (61) Business and Professions Code Section 2514
- (62) Business and Professions Code Section 2519
- ~~(58)~~ ~~Business and Professions Code Section 2630~~
- ~~(59)~~ (63) Business and Professions Code Section 3516
- (64) Business and Professions Code Section 3575
- (65) Business and Professions Code Section 3576
- ~~(60)~~ (66) Business and Professions Code Section 4080
- ~~(64)~~ (67) Business and Professions Code Section 4081(a)
- (68) Business and Professions Code Section 4172
- ~~(62)~~ (69) Business and Professions Code Section 17500
- ~~(65)~~ (70) Civil Code Section 56.10
- ~~(66)~~ (71) Health and Safety Code Section 1248.15
- (72) Health and Safety Code Section 11165.1(a)(1)(A)(i)
- (73) Health and Safety Code Section 102795
- (74) Health and Safety Code Section 102800
- (75) Health and Safety Code Section 103785
- (76) Health and Safety Code Section 109275
- (77) Health and Safety Code Section 109277
- (78) Health and Safety Code Section 109278
- (79) Health and Safety Code Section 109282
- (80) Health and Safety Code Section 120250
- (81) Health and Safety Code Section 120370(a)
- (82) Health and Safety Code Section 121362
- (83) Health and Safety Code Section 121363
- ~~(67)~~ (84) Health and Safety Code Section 123110(a), (b)
- ~~(68)~~ (85) Health and Safety Code Section 123148
- ~~(69)~~ (86) Penal Code Section 11166
- ~~(63)~~ (87) Title 16 California Code of Regulations Section 1338(c)
- (88) Title 16 California Code of Regulations Section 1355.4
- ~~(64)~~ (89) Title 16 California Code of Regulations Section 1399.545
- (90) Title 17 California Code of Regulations Section 2500

(b) In his or her discretion, a board official may issue a citation under Section 1364.10 to a licensee for a violation of a term or condition contained in the decision placing that licensee on probation.

(c) A citation may include a fine from \$100 to \$2500. However, a citation may include a fine up to \$5,000 if one or more of the following circumstances apply:

- (1) The cited person has received two or more prior citations for the same or similar violations;
- (2) The citation involves multiple violations that demonstrate a willful disregard for the law.
- (d) In his or her discretion, a board official may issue a citation with an order of abatement without levying a fine for the first violation of any provision set forth above.
- (e) The sanction authorized under this section shall be separate from and in addition to any other administrative, civil, or criminal remedies.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.

Reference: Sections 125.9, 148, 2227, 2228, 2229 and 2234, Business and Professions Code.

§ 1364.13. Citations for Unlicensed Practice.

A board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon licensed under Chapter 5 of the code (commencing with section 2000) or as a licensed midwife licensed under Chapter 5 of the code (commencing with section 2505), or registration as a polysomnographic technologist, technician, or trainee registered under Chapter 7.8 (commencing with section 3575) is required. ~~under the Medical Practice Act.~~ Each citation issued shall contain an order of abatement. Where appropriate, a board official shall levy a fine for such unlicensed activity in accordance with subdivision (b)(3) of Section 125.9 of the code. The provisions of Sections 1364.10 and 1364.12 shall apply to the issuance of citations for unlicensed or unregistered activity under this subsection. The sanction authorized under this section shall be separate from and in addition to any other administrative, civil, or criminal remedies.

Note: Authority cited: Sections 125.9, 148 and 2018, Business and Professions Code.

Reference: Sections 125.9 and 148, Business and Professions Code.

§ 1364.15. Public Disclosure; Record Retention.

Every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public. Citations that have been resolved, by payment of the administrative fine or compliance with the order of abatement, shall be purged ~~five (5)~~ three (3) years from the date of resolution. A citation that has been withdrawn or dismissed shall be purged immediately upon being withdrawn or dismissed.

Note: Authority cited: Sections 125.9, 148, ~~and 2018,~~ and 2027, Business and Professions Code. Reference: Sections 125.9, ~~and 148,~~ and 2027, Business and Professions Code.

MEDICAL BOARD OF BOARD
INITIAL STATEMENT OF REASONS

Hearing Date: October 28, 2016

Subject Matter of Proposed Regulations: Citation and Fine Authority – Allied Health Professionals

Section(s) Affected: Title 16, Division 13, Chapter 2, Article 6, California Code of Regulations (CCR), Section(s) 1364.10, 1364.11, 1364.13 and 1364.15

Introduction:

The Medical Board of California (Board) licenses and regulates physicians and surgeons and certain allied health care professionals, including licensed midwives and polysomnographic technologists, technicians, and trainees.

The Board is currently authorized to issue administrative citations with orders of abatement and fines to physicians and surgeons, but the Board's regulations do not currently include an authorization for the Board to issue citations with orders of abatement and fines to allied health care professionals.

Through this proposed rulemaking, the Board seeks to amend the identified regulations to include the authority to issue citations with orders of abatement and fines to licensed midwives and polysomnographic technologists, technicians, and trainees, and to add additional statutes and an additional regulation as citable offenses. This proposed rulemaking also proposes additional conforming changes, and some technical changes to improve the clarity of the regulations at issue, as described below. These changes support the Board's mission of consumer protection.

Specific Purpose of Each Adoption, Amendment, or Repeal and Factual Basis/Rationale:

1. Proposed Amendments to 16 CCR section 1364.10(b)

Under existing law, CCR section 1364.10, states that a Board official is authorized to determine when and against whom a citation will be issued and to issue citations containing orders of abatement and fines for violations by a licensed physician or surgeon of the statutes referred to in section 1364.11.

Business and Professions (B&P) Code section 125.9 authorizes the Board to establish a system by regulation for the issuance of a citation which may contain

an order of abatement or fine to licensees within the Board's jurisdiction. Pursuant to B&P Code section 23.7, "license" means license, certificate or registration. Licensed midwives and polysomnographic technologists, technicians, and trainees are licensed/registered and regulated by the Board, but are not currently covered by the Board's citation and fine regulations.

This rulemaking adds licensed midwives and polysomnographic technologists, technicians, and trainees under CCR section 1364.10(b) as individuals to whom the Board may issue citations containing orders of abatement and fines.

The proposed amendments are necessary for the Board to be able to issue citations with orders of abatement and fines when these allied health care professionals violate statutes or regulations referenced in CCR section 1364.11.

Further, CCR section 1364.10(b) currently states that citations containing orders of abatement and fines may be issued for violations of the statutes referred to in Section 1364.11. Because CCR section 1364.11 also lists regulations as citable offenses, an amendment to 1364.10(b) is necessary to clarify that citations containing orders of abatement and fines may be issued for violations of regulations, as well as statutes, referred to in Section 1364.11.

This amendment is necessary to provide clarity to this section, which furthers the Board's mission of consumer protection.

2. Proposed Amendments to 16 CCR section 1364.11

Under existing law, CCR section 1364.11(a) states that a Board official may issue a citation under section 1364.10 for a violation of the provisions listed in this section. Additional provisions of the B&P and Health and Safety (H&S) Codes and the CCR need to be added to the list of citable offenses to authorize the Board to issue citations with orders of abatement and fines to licensees found in violation of those statutes or regulations, furthering consumer protection.

The proposed additions to 16 CCR section 1364.11(a) include the following statutes and regulation:

- B&P Code section 2234(h), relating to the repeated failure of a certificate holder, in the absence of good cause, to attend and participate in an interview by the board;
- B&P Code section 2507, relating to the practice of midwifery, the midwifery scope of practice, and the requirement for physician referral under certain circumstances;
- B&P Code section 2508, relating to required disclosures by licensed midwives to their clients;

- B&P Code section 2510, relating to requirements for a licensed midwife upon transfer of a client to a hospital;
- B&P Code section 2514, relating to requirements for midwifery students practicing midwifery as part of his or her course of study;
- B&P Code section 2519, relating to grounds for suspension or revocation of a midwifery license;
- B&P Code section 3575, relating to requirements for engaging in polysomnography as a polysomnographic technologist, technician, or trainee;
- B&P Code section 3576, relating to grounds for denial, suspension, or revocation of a registration as a polysomnographic technologist, technician, or trainee;
- B&P Code section 4172, relating to any prescriber who dispenses drugs and fails to store all drugs to be dispensed in an area that is secure;
- H&S Code section 11165.1(a)(1)(A)(i), requiring health care practitioners authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances to submit an application before July 1, 2016, to the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient maintained in the CURES database;
- H&S Code section 120370(a), relating to physicians providing a parent or guardian of a child a written statement indicating that the physical condition of a child, or the medical circumstances relating to the child, are such that immunization is not considered safe; and
- 16 CCR section 1355.4, relating to any licensee that practices medicine and fails to provide proper notice to each patient of the fact that the licensee is licensed and regulated by the Board.

Adding these statutes and regulation as citable offenses is necessary to provide the Board with the administrative authority to bring licensees and registrants into compliance with these sections, furthering consumer protection.

Additionally, under existing law, CCR section 1364.11(a) is not organized by code and section in a logical way that makes citable offenses easy to find. Under the proposed rulemaking, section 1364.11(a) will be reorganized and renumbered so that it is easier for interested parties to locate citable offenses.

Further, technical changes to section 1364.11(a) are proposed in this rulemaking as follows:

- B&P Code sections 655.6 and 2265 have been repealed in statute, and these sections will be deleted as citable offenses.
- B&P Code section 802(b) is currently listed as a citable offense, but

subsection (b) falls under the jurisdiction of the Board of Behavioral Sciences. The citable offense has been corrected to reflect B&P Code section 802(a) in the proposed amendments, as this subsection applies to physicians and surgeons.

- B&P Code section 2630 now falls under the Physical Therapy Board's jurisdiction, and will be stricken as a citable offense by this rulemaking.
- B&P Code section 2097 was renumbered by the legislature to B&P Code section 2426, and that change will be reflected in the amendment to this section.

These technical changes are necessary to improve the clarity of this section.

Existing law under CCR section 1364.11 does not make it clear that citations with orders of abatement and fines are separate from and in addition to any other administrative, civil, or criminal remedies. Thus, the proposed rulemaking adds subsection (e) to CCR section 1364.11 to make it clear that a citation issued under this section is separate from and in addition to any other administrative, civil, or criminal remedies. These changes are necessary to improve the clarity of the section, and to remind recipients of citations that all other remedies to address the wrongful conduct remain available.

3. Proposed Amendments to 16 CCR section 1364.13

Under existing law, CCR section 1364.13 authorizes a Board official to issue citations containing orders of abatement and fines against individuals, partnerships, corporations or associations, who are performing, or who have performed, services for which licensure as a physician and surgeon is required under the Medical Practice Act. However, individuals, partnerships, corporations or associations who are performing, or who have performed, services as unlicensed midwives or unregistered polysomnographic technologists, technicians, and trainees are not currently covered by the Board's citation and fine regulations.

B&P Code section 148 authorizes the Board to establish a system by regulation for the issuance of a citation which may contain an order of abatement or fine to an unlicensed person acting in the capacity of a licensee or registrant within the Board's jurisdiction. Thus, this proposed rulemaking specifies that a Board official is authorized to issue citations containing orders of abatement and fines against persons, partnerships, corporations or associations who are performing or who have performed services for which licensure as a physician and surgeon licensed under Chapter 5 of the code (commencing with section 2000) or as a licensed midwife licensed under Chapter 5 of the code (commencing with section 2505), or registration as a polysomnographic technologist, technician, or trainee

registered under Chapter 7.8 (commencing with section 3575) is required.

Additionally, this rulemaking proposes to strike the reference to the Medical Practice Act from CCR section 1364.13, since allied health care providers are being added, and each licensee's or registrant's authorizing code section under the B&P Code is specified. CCR section 1364.13 will be further clarified by indicating that the provisions of CCR sections 1364.10 and 1364.12 apply to the issuances of citations for unregistered as well as unlicensed activity, since polysomnographic technologists, technicians, and trainees are required to be registered, not licensed.

Finally, existing law under CCR section 1364.13 indicates that any sanction under this section is separate and in addition to any other civil or criminal remedies. This rulemaking will add administrative remedies to that list to clarify that any sanction under this section is separate and in addition to any other administrative, civil, or criminal remedies.

This proposed rulemaking is necessary to amend CCR section 1364.13 to allow the Board to issue citations with orders of abatement and fines to these unlicensed/unregistered individuals and entities who violate the law, thereby giving the Board an administrative tool to further its mission of consumer protection.

4. Proposed Amendments to 16 CCR section 1364.15

Existing law under 16 CCR section 1364.15 states that every citation that is issued pursuant to this article shall be disclosed to an inquiring member of the public, and citations that have been resolved by payment of the administrative fine or compliance with the order of abatement shall be purged five (5) years from the date of resolution. However, effective January 1, 2015, pursuant to amendments to B&P Code section 2027(b)(9), the Board shall post on its website all historical information in its possession, custody, or control regarding all current and former licensee to include citations issued within the last three (3) years that have been resolved by payment of the administrative fine or compliance with the order of abatement.

This proposed rulemaking will change the citation purge date from five years to three years to be consistent with the time period specified by B&P Code section 2027(b)(9).

This proposed amendment is necessary to make CCR section 1364.15 consistent with the three-year time period set forth by B&P Code section 2027(b)(9).

Underlying Data

At the May 6, 2016 quarterly Board meeting, Board staff requested the Board to authorize staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendment and schedule a hearing on the rulemaking.

The Board adopted a motion to approve staff to begin the regulatory process to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend Title 16, Division 13, Chapter 2, Article 6, California Code of Regulations, sections 1364.10, 1364.11, 1364.13 and 1364.15.

At the July 29, 2016 quarterly Board meeting, Board staff readdressed its May 6, 2016 request to authorize staff to prepare the necessary regulatory documents to submit to the Office of Administrative Law (OAL) to formally notice the proposed regulatory amendment and schedule a hearing on the rulemaking. The purpose of the proposal was to expand the list of citable offenses to include H&S Code section 120370(a) to the list due to the recent enactment of Senate Bill 277 relating to medical exemptions for vaccinations.

Business Impact

The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for fiscal year (FY) 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.

Economic Impact Assessment

The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the following facts:

- Analysis of creation/elimination of jobs: The Board has made an initial

determination that this regulatory proposal will not likely have any impact on the creation of jobs or the elimination of jobs in the State of California. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for FY 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.

- Analysis of creation/elimination of businesses: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of new businesses or the elimination existing businesses or the expansion of businesses in the State of California. This initial determination is based on the fact that individuals who are in compliance with the law will not be impacted by the proposed amendments. Further, very few individuals are issued citations with orders of abatement and fines. For example, the Board issued 158 citations and fines for FY 2012/2013 to physicians and surgeons, which was approximately .002% of the California licensed physician and surgeon population. In FY 2013/2014, the Board issued 50 citations and fines to physicians and surgeons, which was approximately .0004% of the California licensed physician and surgeon population. The Board's allied health care professionals comprise less than 1% of the total population of the Board's licensees, and the Board anticipates issuing only one to two citations per year for allied health professionals, and fewer for unlicensed individuals and entities.
- Analysis of expansion of business: This proposal is not expected to lead to the expansion of new businesses within California. This initial determination is based on the fact that this proposal gives the Board a tool to bring licensees into compliance with the law if they violate certain specified statutes or regulations, and it impacts a very small percentage of licensees.
- Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment: The Board has determined that this regulatory proposal will benefit the health and welfare of California residents because the proposed additions to the list of citable

offenses under CCR section 1364.11(a) provides further consumer protection. Moreover, authorizing the Board to issue citations with orders of abatement and fines to licensed midwives and polysomnographic technologists, technicians, and trainees and unlicensed individuals performing services as midwives and polysomnographic technologists, technicians, and trainees, provides an administrative tool to the Board to address consumer complaints that do not warrant formal disciplinary action. This assists in bringing the licensee or unlicensed individual or entity into compliance, furthering consumer protection.

This proposed rulemaking is not anticipated to have an impact on worker safety or the state's environment.

Economic Impact for “Major Regulations” (If applicable)

Non-Applicable.

Specific Technologies or Equipment

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

Consideration of Alternatives

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

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

1. Do not seek a change. This alternative was rejected because the amendments are necessary for consumer protection and support the Board's mission to regulate physicians and certain allied health care professionals. Additionally amendments are needed to delete repealed or incorrect references to law, and to provide clarity.
2. Adopt the proposed regulatory amendments. This alternative was determined to be the most appropriate because the proposed changes align with the Board's mission to protect consumers by bringing licensees and registrants into compliance with the law, and taking action against unlicensed or unregistered individuals and entities performing services requiring a license or registration. The proposed changes also improve clarity to the sections at issue.

TITLE 16. MEDICAL BOARD OF CALIFORNIA

NOTICE IS HEREBY GIVEN that the Medical Board of California (Board) is proposing to take the action described in the Informative Digest. Any person interested may present statements or arguments orally or in writing relevant to the action proposed at a hearing to be held on October 28, 2016, at 9:05 a.m., at the Sheraton Mission Valley San Diego located at 1433 Camino Del Rio South, San Diego, California.

Written comments, including those sent by mail, facsimile, or e-mail to the addresses listed under Contact Person in this Notice, must be received by the Board at its office no later than 5:00 p.m. on October 25, 2016, or must be received at the hearing. The Board, upon its own motion or at the instance of any interested party, may thereafter adopt the proposals substantially as described below, or may modify such proposals if such modifications are sufficiently related to the original text. With the exception of technical or grammatical changes, the full text of any modified proposal will be available for 15 days prior to its adoption from the person designated in this Notice as contact person and will be mailed to those persons who submit written or oral testimony related to this proposal or who have requested notification of any changes to the proposal.

Authority and Reference: Pursuant to the authority vested by Section 2018 of the Business and Professions Code, and to implement, interpret or make specific section(s) 2227, 2228, and 2229 of said Code, the Board is considering changes to Division 13 of Title 16 of the California Code of Regulations as follows:

INFORMATIVE DIGEST**A. Informative Digest**

This rulemaking action seeks to amend Division 13 of Title 16 of the California Code of Regulations (CCR) section 1358.

Existing law under CCR section 1358 provides the following:

Each physician and surgeon who has been placed on probation by the division shall be subject to the division's Probation Surveillance Compliance Program and shall be required to fully cooperate with representatives of the division and its investigative personnel. Such cooperation shall include, but is not necessarily limited to, submission to laboratory testing for the purpose of determining the existence of alcohol, narcotics, other controlled substances and/or dangerous drugs in his or her system. Such tests shall be made at the times and places required by the division or its duly authorized representative. Any monetary fees incurred as a result of such laboratory tests shall be borne by the physician-probationer.

Reference to the terms "division," "Probation Surveillance Compliance Program," and "laboratory testing" are obsolete, and are no longer used by the Board. Moreover, this section indicates that physicians on probation are required to fully cooperate with the "division" and personnel, and indicates that cooperation shall

include submission to “laboratory testing” for the purpose of determining the existence of alcohol or drugs in the physician’s system. The requirement for cooperation is more expansive, and extends to all terms and conditions in the order placing the physician on probation.

Accordingly, this proposed rulemaking seeks to remove obsolete language referencing the “division” and the “Probation Surveillance Compliance Program” and replace it with current references to the “Board” and “Probation Program.” It also replaces “laboratory” with “biological fluid” testing, which is the term currently used by the Board. The proposed amendments further specify that probationers are required to bear the costs and be in compliance with all of the terms and conditions of the Order placing them on probation, in addition to referrals for biological fluid testing. These are existing requirements for probationers pursuant to the Board’s Manual of Model Disciplinary Orders and Disciplinary Guidelines incorporated by reference into 16 CCR section 1361.

The proposed changes are necessary to eliminate obsolete language and to clarify the Board’s requirements for probationers.

At the Board’s quarterly meeting held on May 6, 2016, Board staff requested the Board to authorize staff to prepare the necessary regulatory documents to formally notice the proposed regulatory amendment, to submit the documents to the Office of Administrative Law (OAL) for approval, and to schedule a hearing on the rulemaking. The Board granted the request to initiate the rulemaking process and authorized a hearing to be held after the 45-day comment period.

B. Policy Statement Overview/Anticipated Benefits of Proposal

The proposed amendments will eliminate obsolete language within CCR section 1358 and prevent confusion to the reader of the regulation, as the existing language in this section referencing the “division” and the “Probation Surveillance Compliance Program” is not currently used by staff, stakeholders, or the public in written or verbal communications. It further updates the term “laboratory” with “biological fluid” testing.

Moreover, the proposed amendments specify that probationers are required to bear the costs and be in compliance with all of the terms and conditions of the order placing them on probation, in addition to referrals for biological fluid testing. These are existing requirements for probationers pursuant to the Board’s Manual of Model Disciplinary Orders and Disciplinary Guidelines incorporated by reference into 16 CCR section 1361. This provides clarity to the Board’s requirements for probationers.

C. Consistency and Compatibility with Existing State Regulations

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

FISCAL IMPACT ESTIMATES

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

Nondiscretionary Costs/Savings to Local Agencies: None

Local Mandate: None

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

Business Impact:

The Board has made an initial determination that the proposed regulatory action would have no significant statewide adverse economic impact directly affecting business, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the fact that no additional requirements are being created by the proposed amendments, as they are simply clarifying changes.

Cost Impact on Representative Private Person or Business:

The Board is not aware of any cost impacts that a representative private person or business would necessarily incur in reasonable compliance with the proposed action, since no additional requirements are being created by the proposed amendments, as they are simply clarifying changes.

Effect on Housing Costs: None

RESULTS OF ECONOMIC IMPACT ASSESSMENT/ANALYSIS:

The Board has made an initial determination that the proposed regulatory action will have no significant statewide adverse economic impact directly affecting businesses, including the ability of California businesses to compete with businesses in other states. This initial determination is based on the following facts:

- Analysis of creation/elimination of jobs: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of jobs or the elimination of jobs in the State of California. This initial determination is based on the fact that the proposed changes simply eliminate obsolete language from CCR section 1358, and clarify the Board's requirements for physicians on probation. They do not add any new requirements not already in existence.
- Analysis of creation/elimination of businesses: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of new businesses or the elimination existing businesses or the expansion of businesses in the State of California. This initial determination is based on the fact that the proposed changes simply

eliminate obsolete language from CCR section 1358, and clarify the Board's requirements for physicians on probation. They do not add any new requirements not already in existence.

- Analysis of expansion of business: This proposal is not expected to lead to the expansion of new businesses within California. This initial determination is based on the fact that the proposed changes simply eliminate obsolete language from CCR section 1358, and clarify the Board's requirements for physicians on probation. They do not add any new requirements not already in existence.
- Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State's Environment: The Board has determined that this regulatory proposal will benefit the health and welfare of California residents because the proposed amendments eliminate obsolete language from CCR section 1358, and clarify the Board's requirements for physicians on probation. Improved clarity in the Board's regulations furthers consumer protection.

This proposed rulemaking is not anticipated to have an impact on worker safety or the state's environment.

EFFECT ON SMALL BUSINESS

The Board has determined that the proposed regulations would not affect small businesses, since no additional requirements are being created by the proposed amendments, as they are simply clarifying changes.

CONSIDERATION OF ALTERNATIVES

The Board must determine that no reasonable alternative it considered or that has otherwise been identified and brought to its attention would be more effective in carrying out the purpose for which the action is proposed, would be as effective and less burdensome to affected private persons than the proposal described in this Notice, or would be more cost effective to affected private persons and equally effective in implementing the statutory policy or other provision of law.

Any interested person may present statements or arguments orally or in writing relevant to the above determinations at the above-mentioned hearing.

INITIAL STATEMENT OF REASONS AND INFORMATION

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

TEXT OF PROPOSAL

Copies of the exact language of the proposed regulations, and any document incorporated by reference, the initial statement of reasons, and all of the information

upon which the proposal is based, may be obtained at the hearing or prior to the hearing upon request from the person designated in this Notice under Contact Person, or by accessing the Board's website at [http://www.mbc.ca.gov/About Us/Laws/Proposed Regulations](http://www.mbc.ca.gov/About_Us/Laws/Proposed_Regulations).

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

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

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

CONTACT PERSON

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

Name: Christina Delp, Chief of Enforcement
Address: 2005 Evergreen Street, Ste. 1200
Sacramento, CA 95815
Telephone No.: 916-263-2389
Fax No.: 916-263-2387
E-Mail Address: Christina.delp@mbc.ca.gov

The backup contact person is:

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

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

**MEDICAL BOARD OF CALIFORNIA
REQUIREMENTS FOR PHYSICIANS ON PROBATION
Specific Language of Proposed Changes**

Underlined Indicates proposed additions to the existing regulation.

~~Strikeout~~ Indicates proposed deletions to the existing regulation

Amend Section 1358 in Article 3, of Chapter 2, Division 13, of Title 16 of the California Code of Regulations to read as follows:

§1358. Requirements for Physicians on Probation

Each physician and surgeon who has been placed on probation by the ~~division~~ Board shall be subject to the ~~division's~~ Board's Probation ~~Surveillance Compliance~~ Program and shall be required to fully cooperate with representatives of the ~~division~~ Board and its ~~investigative~~ personnel. Such cooperation shall include, but is not necessarily limited to, compliance with each term and condition in the order placing the physician and surgeon on probation, and submission to laboratory biological fluid testing for the purpose of determining the existence of alcohol, narcotics, other controlled substances and/or dangerous drugs in his or her system. Such biological fluid tests shall be made at the times and places required by the division Board or its duly authorized representative. Any monetary fees incurred as a result of such laboratory tests a term or condition of probation, or biological fluid testing, shall be borne by the physician-probationer.

NOTE: Authority cited: Section 2018, Business and Professions Code. Reference: Section(s) 2227, 2228, and 2229, Business and Professions Code.

MEDICAL BOARD OF BOARD

INITIAL STATEMENT OF REASONS

Hearing Date: October 28, 2016

Subject Matter of Proposed Regulations: Requirements for Physicians on Probation

Section(s) Affected: Title 16, Division 13, Chapter 2, Article 3, California Code of Regulations (CCR), Section 1358

Introduction:

The Medical Board of California (Board) licenses and regulates physicians and surgeons. Through this proposed rulemaking, the Board seeks to amend CCR section 1358 to improve the clarity of the regulation, as described below. These changes support the Board's mission of consumer protection.

Specific Purpose of Each Amendment and Factual Basis/Rationale:

Existing law under CCR section 1358 provides the following:

Each physician and surgeon who has been placed on probation by the division shall be subject to the division's Probation Surveillance Compliance Program and shall be required to fully cooperate with representatives of the division and its investigative personnel. Such cooperation shall include, but is not necessarily limited to, submission to laboratory testing for the purpose of determining the existence of alcohol, narcotics, other controlled substances and/or dangerous drugs in his or her system. Such tests shall be made at the times and places required by the division or its duly authorized representative. Any monetary fees incurred as a result of such laboratory tests shall be borne by the physician-probationer.

Reference to the terms "division," "Probation Surveillance Compliance Program," and "laboratory testing" are obsolete, and are no longer used by the Board. Moreover, this section indicates that physicians on probation are required to fully cooperate with the "division" and personnel, and indicates that cooperation shall include submission to "laboratory testing" for the purpose of determining the existence of alcohol or drugs in the physician's system. The requirement for cooperation is more expansive, and extends to all terms and conditions in the order placing the physician on probation.

Accordingly, this proposed rulemaking seeks to remove obsolete language referencing the "division" and the "Probation Surveillance Compliance Program" and replace it with current references to the "Board" and "Probation Program." It also replaces "laboratory" with "biological fluid" testing, which is the term currently used by the Board. The proposed amendments further specify that probationers are required to bear the costs

and be in compliance with all of the terms and conditions of the order placing them on probation, in addition to referrals for biological fluid testing. These are existing requirements for probationers pursuant to the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines incorporated by reference into 16 CCR section 1361.

The proposed changes are necessary to eliminate obsolete language and to clarify the Board's requirements for probationers.

Anticipated benefits from this regulatory action:

The proposed language will eliminate confusion to the reader of the regulation, as the current language referencing the "division" and the "Probation Surveillance Compliance Program" is not used by staff or stakeholders in written or verbal communication. It further updates the term "laboratory" with "biological fluid" testing. Moreover, the proposed amendments specify that probationers are required to bear the costs and be in compliance with all of the terms and conditions of the order placing them on probation, in addition to referrals for biological fluid testing. These are existing requirements for probationers pursuant to the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines incorporated by reference into 16 CCR section 1361. This provides clarity and consistency to the Board's requirements for probationers.

Underlying Data

At the May 6, 2016 quarterly Board meeting, Board staff requested the Board to authorize staff to prepare the necessary regulatory documents to formally notice the proposed regulatory amendment to submit the documents to the Office of Administrative Law (OAL) for approval, and to schedule a hearing on the rulemaking. The Board adopted a motion to approve staff to begin the regulatory process to formally notice the proposed regulatory amendments and schedule a hearing on the rulemaking to amend Title 16, Division 13, Chapter 2, Article 3, California Code of Regulations, section 1358.

Business Impact

This regulation will not have any adverse economic impact on businesses. This initial determination is based on the following facts: The proposed changes do not affect businesses within the State of California, as the proposed amendments merely change obsolete language and create consistency with the requirements for physicians on probation. No additional requirements are being created by the proposed amendments.

Economic Impact Assessment

This regulatory proposal will have the following effects:

- Analysis of creation/elimination of jobs: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of jobs or the elimination of jobs in the State of California. This initial determination is based on the fact that the proposed changes simply eliminate obsolete language from CCR section 1358, and clarify the Board’s requirements for physicians on probation. They do not add any new requirements not already in existence.
- Analysis of creation/elimination of businesses: The Board has made an initial determination that this regulatory proposal will not likely have any impact on the creation of new businesses or the elimination existing businesses or the expansion of businesses in the State of California. This initial determination is based on the fact that the proposed changes simply eliminate obsolete language from CCR section 1358, and clarify the Board’s requirements for physicians on probation. They do not add any new requirements not already in existence.
- Analysis of expansion of business: This proposal is not expected to lead to the expansion of new businesses within California. This initial determination is based on the fact that the proposed changes simply eliminate obsolete language from CCR section 1358, and clarify the Board’s requirements for physicians on probation. They do not add any new requirements not already in existence.
- Benefits of the Regulation to the Health and Welfare of California Residents, Worker Safety, and the State’s Environment: The Board has determined that this regulatory proposal will benefit the health and welfare of California residents because the proposed amendments eliminate obsolete language from CCR section 1358, and clarify the Board’s requirements for physicians on probation. Improved clarity in the Board’s regulations furthers consumer protection.

This proposed rulemaking is not anticipated to have an impact on worker safety or the state’s environment.

Economic Impact for “Major Regulations” (If applicable)

Non-Applicable.

Specific Technologies or Equipment

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

Consideration of Alternatives

No reasonable alternative to the regulatory proposal would be either more effective in carrying out the purpose for which the action is proposed, or would be as effective or less burdensome to affected private persons and equally effective in achieving the purposes of the regulation in a manner that ensures full compliance with the current law.

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

1. Do not seek a change. This alternative was rejected because the language in the regulation is outdated and not consistent with the terminology used by the Board, stakeholders, and the public. Further, the requirements for physicians on probation needed to be clarified to specify they are required to be in compliance with all of the terms and conditions of the order placing them on probation, in addition to referrals for biological fluid testing.
2. Adopt the proposed regulatory amendments. This alternative was determined to be the most appropriate, because the proposed language will eliminate confusion to the reader of the regulation, as the language in the regulation referencing the “division,” “Probation Surveillance Compliance Program,” and “laboratory testing” is not currently used by the Board, stakeholders, or the public in written or verbal communications. It will also clarify requirements for physicians on probation.

UCLA I.M.G.



INTERNATIONAL MEDICAL GRADUATE PROGRAM





Celebrating 10 years! 2006-2016

- **Trains and provides** Spanish-speaking International Medical Graduates with an intensive course of **professional instruction** and **clinical training** to pass the *US Medical Licensing Examinations (USMLE)*
- IMGs compete successfully for Family Medicine residency program positions in California (*National Resident Matching Program – NRMP*)
- In return, IMGs commit to practicing medicine for two to three years in **medically underserved communities** in urban and rural California, where bicultural and bilingual skills are critically needed

In the State of California:

- 200+ languages spoken
- 1 in 5 residents is Limited-English Proficient
- 13 million Hispanics – 38% of total population
- 35% live in medically underserved areas (MUSA)
- ~ 6% of doctors are Hispanic

*At UCLA, the IMG Program is pursuing an **innovative strategy** to increase the number of bilingual, bicultural family physicians committed to practicing in California's largely minority, medically underserved communities.*



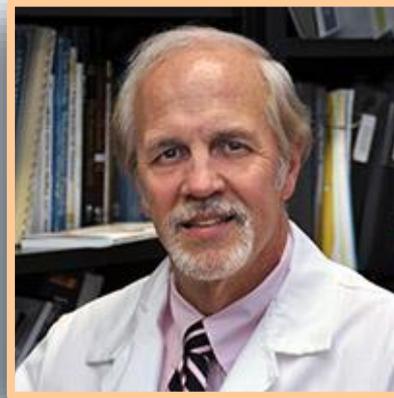
“The paramount objective of the UCLA IMG Program is to increase the number of well-trained Family Medicine physicians practicing in California's underserved rural and inner urban communities, with the ability to meet the cultural and linguistic needs of the patients they serve.”

Michelle Bholat, MD, MPH
*Co-founder and Executive Director,
UCLA International Medical Graduate Program*

Co-founded in 2006 at UCLA



Michelle Anne Bholat, MD, MPH
Executive Director
Professor & Executive Vice Chair
UCLA Dept. of Family Medicine



Patrick T. Dowling, MD, MPH
Associate Director
Professor & Chair
UCLA Dept. of Family Medicine

Keeping IMGs as observers was like “...being a student driver but only allowed to sit in the passenger seat.”

Patrick Dowling, MD, MPH *Co-founder and Associate Director, UCLA IMG Program*

AB 1533 – A collaborative partnership

- The Honorable Holly Mitchell
- David Geffen School of Medicine at UCLA
- UC Office of the President
- Medical Board of California

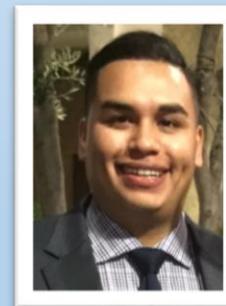


TEAM: UCLA IMG



Drs. Michelle Bholat, Patrick Dowling, and Blanca Campos

Program mentors include **world-class faculty and physicians** from the UCLA Department of Family Medicine and associated facilities.



Fernando Murillo
UCLA IMG Associate
Program Coordinator

Blanca Campos, MD

Alumna, 2007 UCLA, family physician and teacher-mentor for the scholars.

Our Diverse and Experienced Scholars

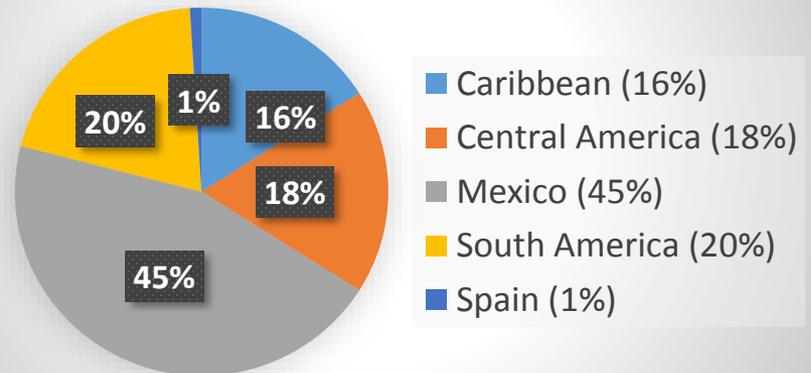
Our IMGs come from all over Latin America and bring their expertise and experience to serve patients in California.



IMGs celebrating Match Day 2016



IMGs by Geographic Area



The UCLA IMG Program at a Glance

Program A

Basic Sciences / USMLE Step 1 Preparation
English for Health Professionals

Program B

Clinical Sciences / USMLE Step 2 CK/CS Preparation
English for Health Professionals

Program C

Clinical Rotations at UCLA and UCLA affiliates
English for Health Professionals

Program D

Volunteer and Clinical Trial Opportunities

Match successfully into a Family Medicine Residency Program in California
(National Resident Matching Program – NRMP)

Didactic Sessions & Grand Rounds



Program participants meet weekly to present cases and discuss medical conditions and treatments



Participants attend weekly Grand Rounds



Participants receive 'hands-on' training in class and as part of clinical rotations at UCLA hospitals and clinics

UCLA and Affiliated Health Centers

UCLA Family Health Center



Santa Monica UCLA Medical Center and Orthopaedic Hospital

UCLA Health



Olive View-UCLA Medical Center



Mid-Valley Comprehensive Health Center



IMG Program

UCLA International Medical Graduate (IMG) Program

IMGs Matched (2007-16) Agenda Item 19

Central Valley	38
Southern California	48
Coachella Valley	14
Outside California	4
Total	104



Central Valley

Clinica Sierra Vista Bakersfield	10
Clinica Sierra Vista Fresno	1
Contra Costa	1
Kaweah Delta	1
Kern Medical Center	2
Hanford	8
Mercy Merced	1
Natividad Medical Center	3
San Joaquin General Hospital	2
Sutter Health Sacramento	1
UC San Francisco Fresno	6
Valley Family Medicine of Modesto	2

Outside California

Jackson Memorial Hospital (FL)	1
St. Joseph Family Medicine (NY)	1
Texas Tech University El Paso (TX)	1
University of Texas Houston (TX)	1

Southern California

Camp Pendleton Naval Hospital	1
Family Health Centers of San Diego	1
Glendale Adventist Medical Center	5
Kaiser Permanente Fontana	2
Northridge Family Medicine	4
PIH Family Health Medicine	2
Pomona Valley Hospital	7
UC Los Angeles	15
UC San Diego	3
USC California Hospital	8

Coachella Valley

Eisenhower Medical Center	2
UC Riverside Regional	12



Outcomes: Commitment to Medically Underserved Areas (MUSA)

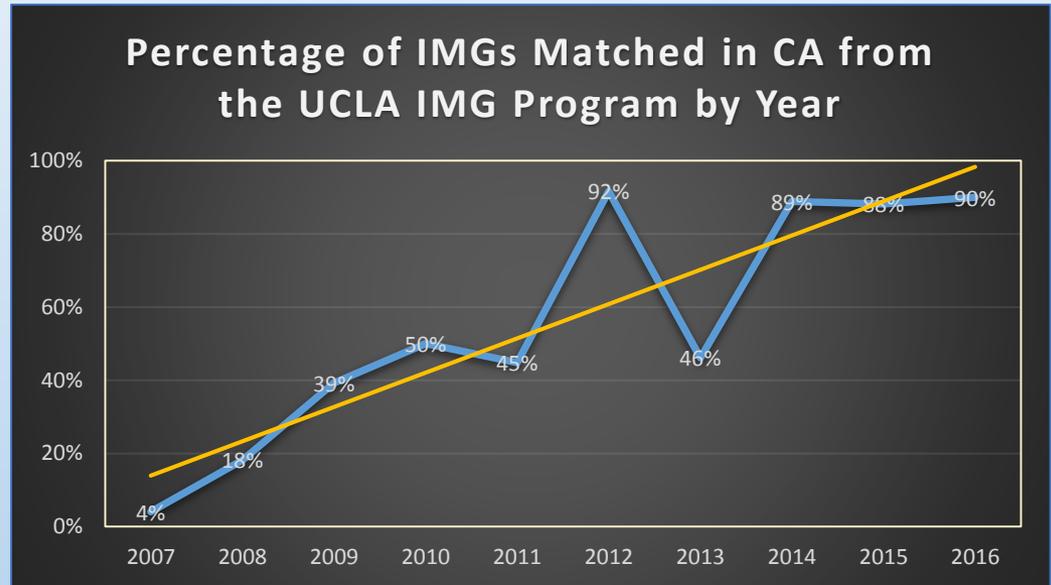
- 52 of 64 alumni (81.3%) continue to work in MUSAs
- 65 of those 66 (98.5%) fulfilled the program's mission
- 66 of 104 alumni (63%) have graduated while 37% are currently enrolled in a Family Medicine training program



Outcomes: IMGs by Year

IMGs Matched into a Family Medicine Program in California

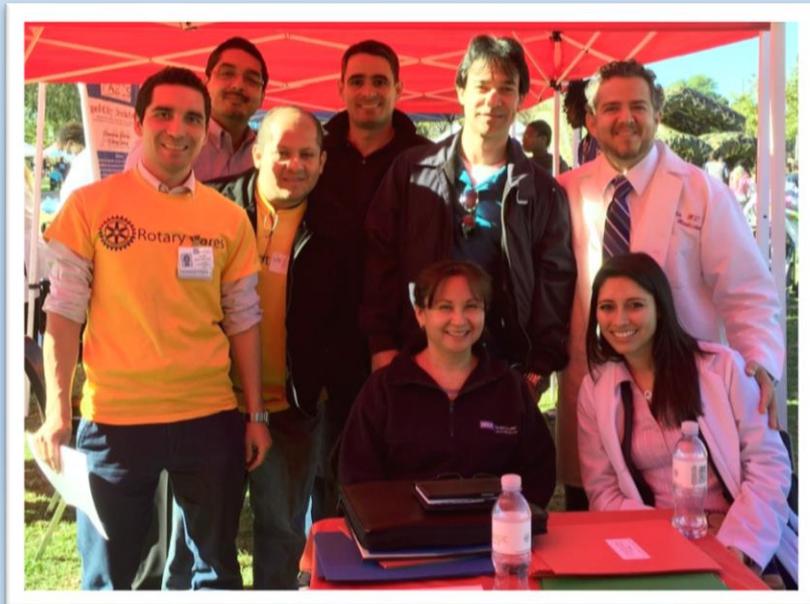
Year	# of IMGs	# of UCLA IMGs	%
2007	50	2	4%
2008	33	6	18%
2009	28	11	39%
2010	22	11	50%
2011	29	13	45%
2012	12	11	92%
2013	26	12	46%
2014	18	16	89%
2015	17	15	88%
2016	10	9	90%
Total IMGs	104		



The UCLA IMG Program's strategy has been an effective model in training Family Medicine physicians and placing them in under-resourced communities in California

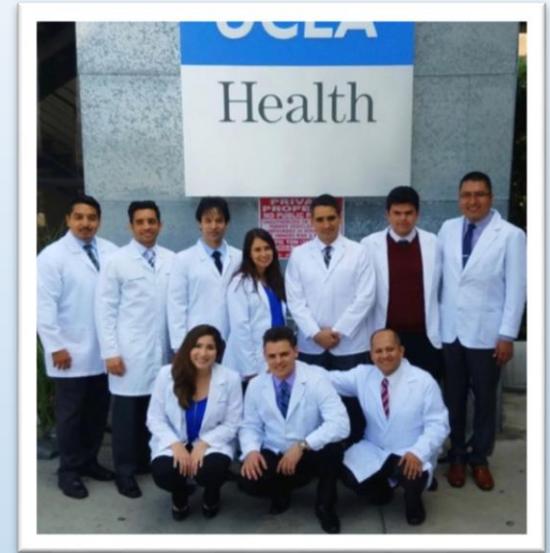
Our Future Family Physicians and Community Leaders

- Community Impact
 - Rotary Club - Angel City Celebration
 - American Heart Association LA Heart Walk
 - UCLA Employee Volunteer Interpretation Program (EVIP)
 - *Live Well, Eat Smart* Program



UCLA IMG Alumni Association

- Promotes the program to candidates and the general public
- Professional networking
- Leadership development



UCLA IMG Match 2017 Roster



Dr. Jaime Acosta
Universidad Evangélica
de El Salvador
El Salvador



**Dr. Silvia
Buenrostro**
Universidad de
Ciencias Médicas
Costa Rica



Dr. Fausto J. Castillo
Universidad Nacional
Autónoma de Nicaragua
Nicaragua



**Dr. Karen Yberico
Fourie**
Universidad de San
Martín de Porres
Perú



Dr. Eric Gama
Universidad Autónoma
de Guadalajara
México



Dr. Luis García
Universidad Autónoma
de Baja California
México



**Dr. Gustavo J.
Gutiérrez-Colin**
Universidad de
Guanajuato
México



**Dr. Francisco
Ordaz-Chávez**
Universidad
Michoacana de San
Nicolás de Hidalgo
México



Dr. José Rodríguez-García
Universidad Autónoma
de Guadalajara
México



Dr. Felipe Saavedra
Universidad de Chile
Chile



Dr. Gladys Valdéz
Universidad Autónoma
de Santo Domingo
República Dominicana



Dr. Estefania Way
Universidad Científica del Sur
Perú

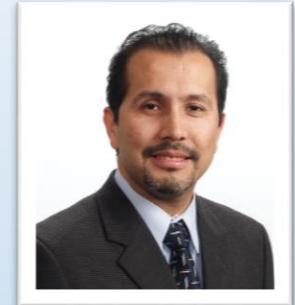
Pilot Program: Retention/Expansion Strategies

- UME/GME: PRIME & Family Medicine Training

Inspired Leadership

Faculty Development

Building Programs



*Gerardo Moreno, MD,
MSHS*

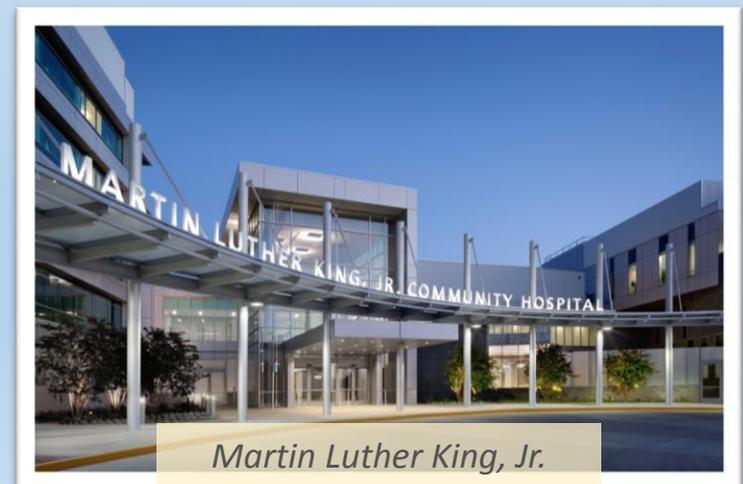
Director of the PRIME
program at DGSOM

Rio Bravo (UC affiliate)

- First class began training in 2014

- New program in Central LA

- Professional development of alumni



*Martin Luther King, Jr.
Community Hospital*



Celebrating 10 years! 2006-2016

CONTACT INFORMATION

UCLA IMG Program

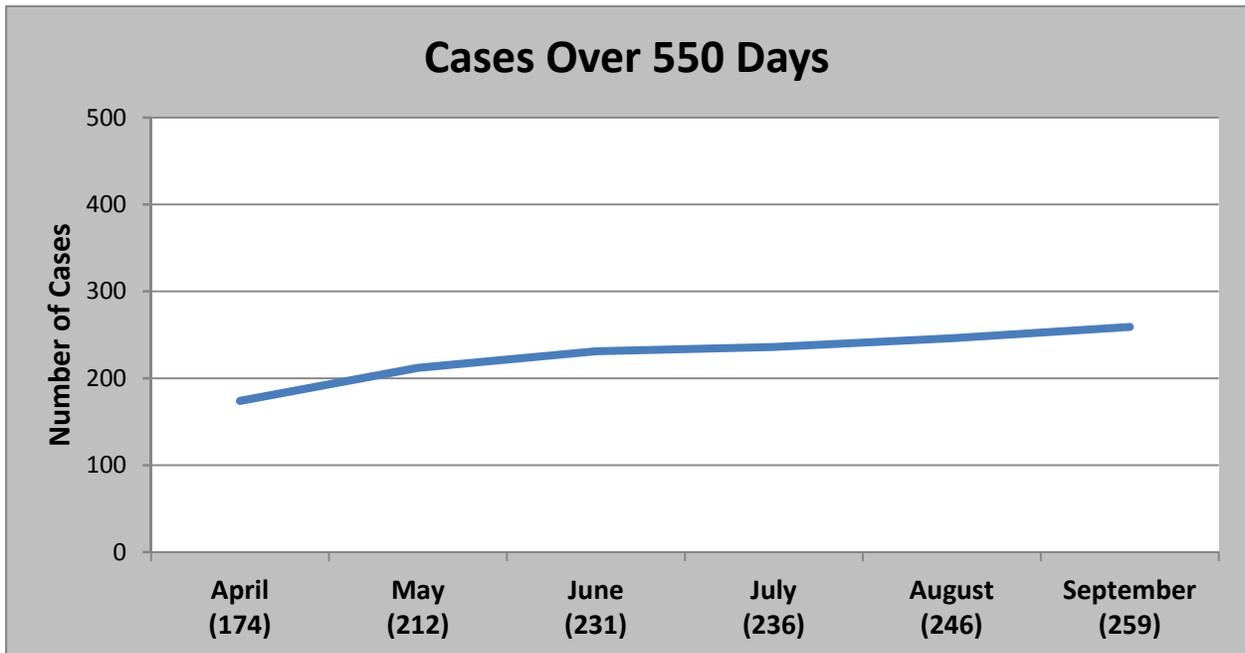
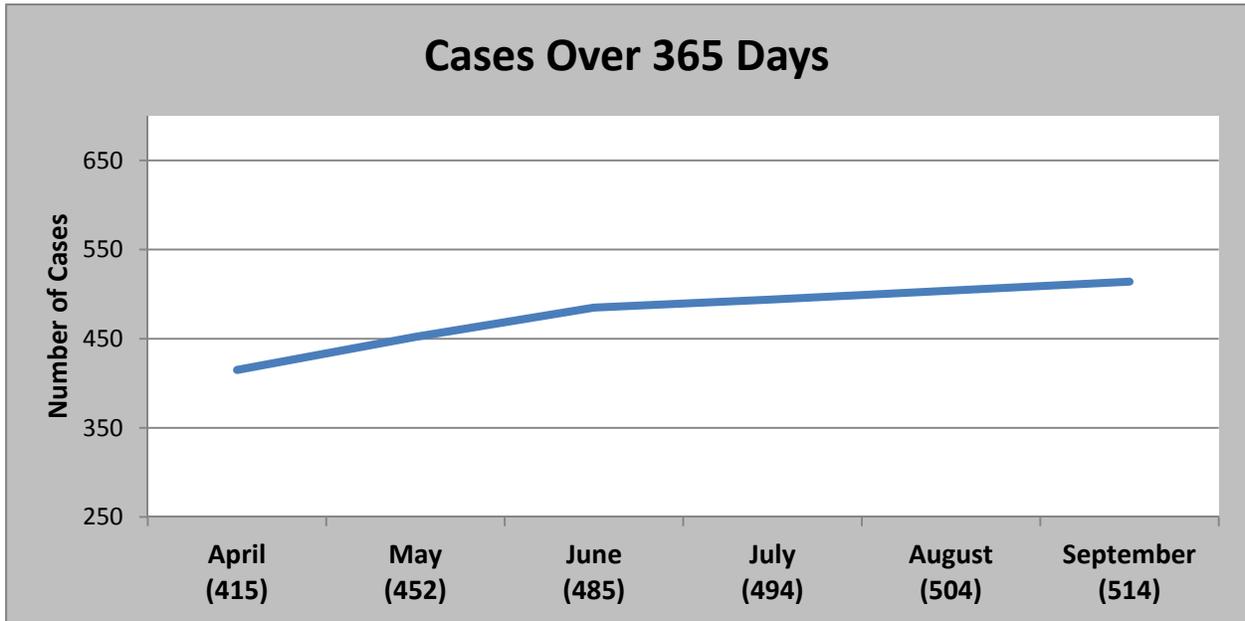
1920 Colorado Ave

Santa Monica, CA

Website: fm.mednet.ucla.edu/img/img_program.asp

Email: MBholat@mednet.ucla.edu

HQIU ACTIVE CASE STATISTICS April 2016 – September 2016



MEDICAL BOARD OF CALIFORNIA

DATE REPORT ISSUED: October 10, 2016
ATTENTION: Medical Board of California, Members
SUBJECT: Midwifery Advisory Council (MAC) Chair Report
CONTACT: Carrie Sparrevohn, L.M., Chair

REQUESTED ACTION:

Approval of the following agenda items is requested for the next MAC meeting:

- Task Force Update:
 - Update on Revisions to Licensed Midwife Annual Report (LMAR)
- Update on continuing regulatory efforts required by Assembly Bill (AB) 1308
- Update on Hospital Transfer Form
- Update on Midwifery Task Force
- Update on midwifery related legislation expected to be introduced or followed next year
- Update on the midwifery program
- Update on progress of midwifery assistant regulations
- Report from California Association of Licensed Midwives on new Quality Care Program
- Discussion and decision on 2017 MAC meeting dates

BACKGROUND:

The last MAC meeting was held on August 18, 2016. At this meeting, the MAC was updated by Staff regarding recommendations for changes to the Licensed Midwife Annual Report (LMAR). This process continues to move forward.

The MAC reviewed applications from a number of licensed midwives for the vacant position on the MAC. The MAC is pleased to recommend Diane Holzer, LM, PaC for this position. Ms. Holzer has worked throughout her career to further the profession of midwifery, in California, the US and globally, and she will be a great asset to the MAC.

Once again, the MAC heard updates on the continuing efforts to craft regulations required by AB 1308 (Bonilla, Chapter 665, Statutes of 2013); specifically language required by Business and Professions Code section 2507(b)(1)(A)(i) and (ii), essentially the development of a list of conditions requiring a referral to a physician for consultation and a determination that the risk factors presented by the woman's disease or condition are not likely to significantly affect the course of pregnancy or childbirth, prior to the midwife continuing care for a particular client. There continues to be disagreement regarding care for women who have had a prior cesarean. In an effort to further this conversation, a task force was formed so that members of the Board could be better informed regarding this discussion.

MEDICAL BOARD STAFF REPORT

DATE REPORT ISSUED: October 10, 2016
ATTENTION: Members, Medical Board of California (Board)
SUBJECT: Midwifery Advisory Council (MAC) Appointment
STAFF CONTACT: Curtis J. Worden, Chief of Licensing

REQUESTED ACTION:

Appoint one License Midwife (LM) member to the MAC.

STAFF RECOMMENDATION:

Staff recommends the Board approve the MAC's recommendation to appoint Diane Holzer, L.M., to the licensed midwife position.

EXECUTIVE SUMMARY:

Business and Professions Code section 2509 states that the Board shall create and appoint a MAC consisting of licensees of the Board in good standing, who need not be members of the Board, and members of the public who have an interest in midwifery practice, including but not limited to, home births. At least one-half of the MAC members shall be California licensed midwives. The MAC shall make recommendations on matters specified by the Board.

The MAC was established in 2007 to make recommendations to the Board on issues related to the practice of midwifery in California. The MAC consists of six members and is currently comprised of three California licensed midwives and three members of the public that include one California licensed physician and surgeon who is certified in obstetrics and gynecology by an affiliate board of the American Board of Medical Specialties, and two non-licensees of the Board.

A MAC Member Interest Form dated May 20, 2016, was mailed to all California licensed midwives and individuals on the interested parties mailing list for one vacant licensed midwife position, with a final filing date of June 30, 2016. An application was also posted on the Board's website. The vacant licensed midwife position is set to expire June 30, 2019.

The Board received nine licensed midwife applications for appointment to the MAC. Four of the applicants for the MAC member appointment were present at the August 18, 2016 MAC meeting. Each of the four applicants who were present at the meeting made presentations to the MAC members. The MAC members voted to recommend the Board appoint Diane Holzer, L.M., to the MAC.

MEDICAL BOARD OF CALIFORNIA - 2016 TRACKER LIST
October 13, 2016

BILL	AUTHOR	TITLE	STATUS	POSITION	AMENDED
AB 1244	Gray	Worker's Compensation: Providers	Chaptered, #852	Reco: Support	8/19/16
AB 2024	Wood	Critical Access Hospitals: Employment	Chaptered, #496	Neutral	8/15/16
AB 2744	Gordon	Healing Arts: Referrals	Chaptered, #360	Neutral	8/8/16
AB 2745	Holden	Healing Arts: Licensing and Certification	Chaptered, #303	Sponsor/Support	4/25/16
SB 482	Lara	Controlled Substances: CURES Database	Chaptered, #708	Support	8/19/16
SB 1160	Mendoza	Workers' Compensation	Chaptered, #868	Supported provisions contained in SB 563 (Pan) that are now in this bill.	8/29/16
SB 1174	McGuire	Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications	Chaptered, #840	Support if Amended	8/19/16
SB 1177	Galgiani	Physician and Suregon Health and Wellness Program	Chaptered, #591	Support	8/18/16
SB 1189	Pan & Jackson	Postmortem Examinations or Autopsies	Chaptered, #787	Support	8/19/16
SB 1261	Stone	Physicians and Surgeons: Licensure Exemption	Chaptered, #239	Neutral	5/3/16
SB 1478	Sen. B&P	Health Omnibus	Chaptered, #489	Sponsor/Support MBC Provisions	8/18/16

Pink – Sponsored Bills, Green – Chaptered

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 1244
Author: Gray
Chapter: 852
Bill Date: August 19, 2016, Amended
Subject: Workers' Compensation
Sponsor: Author
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill specifies the circumstances in which a medical provider must be suspended from participating in the workers' compensation system. This bill also ensures that the appropriate licensing board is notified of the suspension and provides for communication between various state agencies, among other provisions.

BACKGROUND

The workers' compensation system in California provides benefits to an employee who suffers from an injury or illness that arises out of, and in the course of employment, irrespective of fault. This system requires all employers to secure payment of benefits by either securing the consent of the Department of Industrial Relations to self-insure or by securing insurance against liability from an insurance company authorized by the state. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to utilization review (UR). UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

Existing law requires the director of the Department of Health Care Services (DHCS) to suspend any or all payments to a medical service provider if there is a credible allegation of fraud against the Medi-Cal system or if a provider has been convicted of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of medical services.

ANALYSIS

This bill requires the administrative director (AD) of the Division of Workers'

Compensation (DWC) to suspend medical service providers from participating in any capacity in the workers' compensation system if the provider:

- Is convicted of a felony or misdemeanor and that crime comes within any of the following descriptions:
 - Involves fraud or abuse of the Medi-Cal program, Medicare program, workers' compensation system, or fraud or abuse of any patient;
 - Relates to the conduct of the individual's medical practice as it pertains to patient care;
 - Is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system; and
 - Is substantially related to the qualifications, functions, or duties of a provider of services.
- Is suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.
- License, certificate, or approval to provide health care has been surrendered or revoked.

This bill would require the AD to provide written notice to the medical provider who has been identified as eligible for suspension. This bill would require the DWC to hold a hearing on the suspension of a medical provider within 30 days of a request. Such a request would stay any suspension of a medical provider. If, during the hearing, the AD finds that the medical provider is eligible for suspension due to the reasons listed above, the AD must suspend the medical provider immediately. Upon suspension, the AD must notify the relevant licensing, certification, or registration board, including the Medical Board. This bill would also require the director of DHCS to notify the AD of the DWC if a medical provider is added to the Suspended or Ineligible Provider List (this notification from DHCS is already required to be provided to the Medical Board).

This bill seeks to combat workers' compensation fraud by changing the incentives facing medical providers in the California workers' compensation system. Specifically, this bill would create a suspension process for medical providers who commit serious crimes or are involved in fraudulent activity that is modeled after the suspension process for Medi-Cal, including requiring notification to the appropriate licensing board. This bill will ensure that the Medical Board is notified when a physician is suspended by the DWC, which will help to ensure consumer protection. This bill also provides for communication between the DWC and DHCS, which will also help to protect consumers. For these reasons, the Board took a support position on this bill.

FISCAL: None to the Board

SUPPORT: American Insurance Association; Association of California Insurance Companies; California Association of Highway Patrolmen; California Chamber of Commerce; California Coalition on Workers' Compensation; California Conference Board of the Amalgamated Transit Union; California Conference of Machinists; California Labor Federation; California Professional Firefighters; California State

Association of Counties; California Teamsters Public Affairs Council; Engineers & Scientists of CA, IFPTE Local 20, AFL-CIO; International Longshore & Warehouse Union; Los Angeles County Professional Peace Officers Association; Medical Board of California; Organization of SMUD Employees; Professional & Technical Engineers, IFPTE Local 21, AFL-CIO; San Luis Obispo County Employees Association; Service Employees International Union; State Building and Construction Trades Council; UNITE-HERE, AFL-CIO; and Utility Workers Union of America, AFL-CIO

OPPOSITION:

California Neurological Society
California Society for Industrial Medicine and Surgery
California Society of Physical Medicine and Rehabilitation

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Reach out to the AD of the DWC to establish a process for the Board to receive suspension information from the DWC

Assembly Bill No. 1244

CHAPTER 852

An act to amend Section 4906 of, and to add Section 139.21 to, the Labor Code, and to amend Section 14123 of the Welfare and Institutions Code, relating to workers' compensation.

[Approved by Governor September 30, 2016. Filed with
Secretary of State September 30, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 1244, Gray. Workers' compensation.

Under existing law, the Director of Health Care Services is authorized, for purposes of administering the Medi-Cal program, to suspend a provider of service from further participation under the program for specified reasons, including conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service. Existing law requires the director, upon receipt of written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, to promptly suspend the practitioner from participation in the Medi-Cal program.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, that generally requires employers to secure the payment of workers' compensation for injuries incurred by their employees that arise out of, or in the course of, employment. Existing law requires an employer to provide all medical services reasonably required to cure or relieve the injured worker from the effects of the injury.

Existing law authorizes an insurer, employer, or entity that provides physician network services to establish or modify a medical provider network for the provision of medical treatment to injured employees and requires the administrative director to contract with individual physicians or an independent medical review organization to perform medical provider network independent medical reviews.

This bill would require the administrative director to promptly suspend any physician, practitioner, or provider from participating in the workers' compensation system if as a physician, practitioner, or provider the individual or entity meets specified criteria, including if that individual has been convicted of any felony or misdemeanor involving fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, if that individual's license, certificate, or approval to provide health care has been surrendered or revoked, or if that individual or entity has been

suspended, due to fraud or abuse, from participation in the Medicare or Medicaid programs. The bill would require the administrative director to adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system pursuant to these provisions, as specified, and would require the administrative director to furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request that hearing. The bill would also require the administrative director to promptly notify the appropriate state licensing, certifying, or registering authority of a physician's, practitioner's, or provider's suspension and to update the division's databases of qualified medical evaluators and medical provider networks. The bill would require the administrative director to notify the chief judge of the division of a suspension under these provisions, as specified, and post a notice on the department's Internet Web site. The bill would enact special lien proceedings for the adjudication of any liens of a physician, practitioner, or provider who has been suspended pursuant to these provisions because he or she has been convicted of a felony or misdemeanor that meets specified criteria.

The bill would also require the Director of Health Care Services to notify the administrative director of a suspension of a physician from participation in the Medi-Cal program imposed pursuant to the provisions described above authorizing the director to suspend a provider of service from participation.

Existing law establishes the Workers' Compensation Appeals Board to exercise all judicial powers vested in it, as specified, including workers' compensation proceedings for the recovery of compensation, or concerning any right or liability arising out of or incidental to the recovery of compensation. Existing law vests the appeals board with full power, authority, and jurisdiction to try and determine finally those matters, subject only to the review by the courts, as specified. Existing law authorizes the appeals board to determine, and allow as liens against any sum to be paid as compensation, as specified, a reasonable attorney's fee for legal services and disbursements in connection with those legal services. Existing law provides that a charge, claim, or agreement for those legal services or disbursements is not enforceable, valid, or binding in excess of a reasonable amount.

Existing law also requires an attorney to furnish to the employee a written disclosure form describing the procedures available to the injured employee or his or her dependents and specified information regarding attorney's fees. Existing law requires that a copy of the disclosure form be signed by the employee and the attorney and sent to the employer, or insurer or 3rd-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution of the form. Existing law also requires the employee, the insurer, the employer, and the attorneys for each party to sign and file with the board a statement, signed under penalty of perjury, attesting that the signatories have not violated specified laws prohibiting conflicts of interest.

Existing law authorizes the appeals board, a workers' compensation judge, or any party to the action or proceeding, as specified, to cause the deposition of witnesses in any investigation or hearing before the appeals board, and provides that the deponent is entitled to receive specified benefits, such as reasonable expenses of transportation, meals, and lodging, as specified.

This bill would prohibit payment for legal services or disbursements in connection with those legal services, or expenses relating to the deposition of witnesses, incurred under the provisions described above, as specified, prior to the filing of the disclosure form with the appeals board and the sending of that form to the employer, or to the insurer or 3rd-party administrator, if either is known, by the attorney. The bill would require the disclosure form described above to contain a paragraph setting forth the exact location of the district office of the appeals board at which the employee's case will be filed and to include a specified statement. The bill would impose other requirements regarding the signing and content of the form, including that the form be signed under penalty of perjury by the attorney representing the employee, and would require the form to be filed with the appeals board.

The bill would also require an attorney who subsequently assumes the representation of the employee in the same action or proceeding to complete and sign under penalty of perjury a disclosure form that meets the above-described requirements and the statement attesting that the signatories have not violated specified laws prohibiting conflicts of interest. The bill would require the attorney to file the form and statement with the appeals board, and send them to the employer, or insurer or 3rd-party administrator, if either is known, within 15 days of the employee's and attorney's execution of the form and statement.

By expanding the scope of the crime of perjury under these provisions, this bill would impose a state-mandated local program.

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

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

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

SECTION 1. Section 139.21 is added to the Labor Code, immediately following Section 139.2, to read:

139.21. (a) (1) The administrative director shall promptly suspend, pursuant to subdivision (b), any physician, practitioner, or provider from participating in the workers' compensation system as a physician, practitioner, or provider if the individual or entity meets any of the following criteria:

(A) The individual has been convicted of any felony or misdemeanor and that crime comes within any of the following descriptions:

(i) It involves fraud or abuse of the Medi-Cal program, Medicare program, or workers' compensation system, or fraud or abuse of any patient.

(ii) It relates to the conduct of the individual's medical practice as it pertains to patient care.

(iii) It is a financial crime that relates to the Medi-Cal program, Medicare program, or workers' compensation system.

(iv) It is otherwise substantially related to the qualifications, functions, or duties of a provider of services.

(B) The individual or entity has been suspended, due to fraud or abuse, from the federal Medicare or Medicaid programs.

(C) The individual's license, certificate, or approval to provide health care has been surrendered or revoked.

(2) The administrative director shall exercise due diligence to identify physicians, practitioners, or providers who have been suspended as described in subdivision (a) by accessing the quarterly updates to the list of suspended and ineligible providers maintained by the State Department of Health Care Services for the Medi-Cal program at <https://files.medi-cal.ca.gov/pubsdoco/SandILanding.asp>.

(b) (1) The administrative director shall adopt regulations for suspending a physician, practitioner, or provider from participating in the workers' compensation system, subject to the notice and hearing requirements in paragraph (2).

(2) The administrative director shall furnish to the physician, practitioner, or provider written notice of the right to a hearing regarding the suspension and the procedure to follow to request a hearing. The notice shall state that the administrative director is required to suspend the physician, practitioner, or provider pursuant to subdivision (a) after 30 days from the date the notice is mailed unless the physician, practitioner, or provider requests a hearing and, in that hearing, the physician, practitioner, or provider provides proof that paragraph (1) of subdivision (a) is not applicable. The physician, practitioner, or provider may request a hearing within 10 days from the date the notice is sent by the administrative director. The request for the hearing shall stay the suspension. The hearing shall be held within 30 days of the receipt of the request. Upon the completion of the hearing, if the administrative director finds that paragraph (1) of subdivision (a) is applicable, the administrative director shall immediately suspend the physician, practitioner, or provider.

(3) The administrative director shall have power and jurisdiction to do all things necessary or convenient to conduct the hearings provided for in paragraph (2). The hearings and investigations may be conducted by any designated hearing officer appointed by the administrative director. Any authorized person conducting that hearing or investigation may administer oaths, subpoena and require the attendance of witnesses and the production of books or papers, and cause the depositions of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil cases in the superior court of this state under Title 4

(commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure.

(c) The administrative director shall promptly notify the physician's, practitioner's, or provider's state licensing, certifying, or registering authority of a suspension imposed pursuant to this section and shall update the division's qualified medical evaluator and medical provider network databases, as appropriate.

(d) Upon suspension of a physician, practitioner, or provider pursuant to this section, the administrative director shall give notice of the suspension to the chief judge of the division, and the chief judge shall promptly thereafter provide written notification of the suspension to district offices and all workers' compensation judges. The method of notification to all district offices and to all workers' compensation judges shall be in a manner determined by the chief judge in his or her discretion. The administrative director shall also post notification of the suspension on the department's Internet Web site.

(e) The following procedures shall apply for the adjudication of any liens of a physician, practitioner, or provider suspended pursuant to subparagraph (A) of paragraph (1) of subdivision (a), including any liens filed by or on behalf of the physician, practitioner, or provider or any clinic, group or corporation in which the suspended physician, practitioner, or provider has an ownership interest.

(1) If the disposition of the criminal proceeding provides for or requires, whether by plea agreement or by judgment, dismissal of liens and forfeiture of sums claimed therein, as specified in the criminal disposition, all of those liens shall be deemed dismissed with prejudice by operation of law as of the effective date of the final disposition in the criminal proceeding, and orders notifying of those dismissals may and shall be entered by workers' compensation judges.

(2) If the disposition of the criminal proceeding fails to specify the disposition to be made of lien filings in the workers' compensation system as set forth in paragraph (1), all liens pending in any workers' compensation case in any district office within the state shall be consolidated and adjudicated in a special lien proceeding as described in subdivisions (f) to (i), inclusive.

(f) After notice of suspension, pursuant to subdivision (d), and if subdivision (e) applies, the administrative director shall appoint a special lien proceeding attorney, who shall be an attorney employed by the division or by the department. The special lien proceeding attorney shall, based on the information that is available, identify liens subject to disposition pursuant to subdivision (e), and workers' compensation cases in which those liens are pending, and shall notify the chief judge regarding those liens. Based on this information, the chief judge shall identify a district office for a consolidated special lien proceeding to adjudicate those liens, and shall appoint a workers' compensation judge to preside over that proceeding.

(g) It shall be a presumption affecting the burden of proof that all liens to be adjudicated in the special lien proceeding, and all underlying bills for

service and claims for compensation asserted therein, arise from the conduct subjecting the physician, practitioner, or provider to suspension, and that payment is not due and should not be made on those liens because they arise from, or are connected to, criminal, fraudulent, or abusive conduct or activity. A lien claimant shall not have the right to payment unless he or she rebuts that presumption by a preponderance of the evidence.

(h) The special lien proceedings shall be governed by the same laws, regulations, and procedures that govern all other matters before the appeals board. The administrative director shall promulgate regulations for the implementation of this section.

(i) If it is determined in a special lien proceeding that a lien does not arise from the conduct subjecting a physician, practitioner, or provider to suspension, the workers' compensation judge shall have the discretion to adjudicate the lien or transfer the lien back to the district office having venue over the case in which the lien was filed.

(j) At any time following suspension, a physician, practitioner, or provider lien claimant may elect to withdraw or to dismiss his or her lien with prejudice, which shall constitute a final disposition of the claim for compensation asserted therein.

(k) The provisions of this section shall not affect, amend, alter, or in any way apply to the provisions of Section 139.2.

SEC. 2. Section 4906 of the Labor Code is amended to read:

4906. (a) A charge, claim, or agreement for the legal services or disbursements mentioned in subdivision (a) of Section 4903, or for the expense mentioned in subdivision (b) of Section 4903, is not enforceable, valid, or binding in excess of a reasonable amount. The appeals board may determine what constitutes a reasonable amount, but payment pursuant to subdivision (a) of Section 4903 or Section 5710 shall not be allowed for any services or expenses incurred prior to the filing of the disclosure form described in subdivision (e) with the appeals board and the sending of that form to the employer, or to the insurer or third-party administrator, if either is known, by the attorney.

(b) An attorney or agent shall not demand or accept any fee from an employee or dependent of an employee for the purpose of representing the employee or dependent of an employee in any proceeding of the division, appeals board, or any appellate procedure related thereto until the amount of the fee has been approved or set by the appeals board.

(c) Any fee agreement shall be submitted to the appeals board for approval within 10 days after the agreement is made.

(d) In establishing a reasonable attorney's fee, consideration shall be given to the responsibility assumed by the attorney, the care exercised in representing the applicant, the time involved, and the results obtained.

(e) At the initial consultation, an attorney shall furnish the employee a written disclosure form promulgated by the administrative director which shall clearly and prominently describe the procedures available to the injured employee or his or her dependents. The disclosure form shall describe this section, the range of attorney's fees customarily approved by the appeals

board, and the attorney's fees provisions of Section 4064 and the extent to which an employee may receive compensation without incurring attorney's fees. The disclosure form shall include the telephone number of the administrative director together with the statement that the employee may receive answers at that number to questions concerning entitlement to compensation or the procedures to follow to receive compensation. A copy of the disclosure form shall be signed by the employee and the attorney and filed with the appeals board and sent to the employer, or insurer or third-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution thereof.

(f) The disclosure form set forth in subdivision (e) shall contain, prominently stated, the following statement:

“Any person who makes or causes to be made any knowingly false or fraudulent material statement or representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.”

(g) (1) The disclosure form described in subdivision (e) shall also contain a paragraph setting forth the exact location of the district office of the appeals board at which the employee's case will be filed. This paragraph shall also contain, prominently displayed, the following statement:

“The employee has been advised of the district office at which his or her case will be filed and that he or she may be required to attend conferences or hearings at this location at his or her own expense.”

(2) The disclosure form may not be signed by the employee until he or she has been advised of the location at which his or her case will be filed, has met with or personally spoken with an attorney licensed by the State Bar of California who is regularly employed by the firm by which the employee will be represented, and has been advised of his or her rights as set forth in subdivision (e) and the provisions of paragraph (1). The name of this individual shall be clearly and legibly set forth on the disclosure form.

(3) The disclosure form shall include the actual date the disclosure form was signed by both the employee and the attorney and shall be signed under penalty of perjury by the attorney representing the employee, or an attorney licensed by the State Bar of California who is regularly employed by his or her firm. A copy of the disclosure form containing all of the required information shall be given to the employee when he or she signs the disclosure form.

(h) In addition to the disclosure form, the employee, the insurer, the employer, and the attorneys for each party shall sign under penalty of perjury and file with the board a statement, with the complete application or answer, and in addition to the disclosure required pursuant to subdivision (g), that they have not violated Section 139.3 and that they have not offered,

delivered, received, or accepted any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for any referred examination or evaluation.

(i) An attorney who subsequently assumes the representation of the employee in the same action or proceeding shall complete a disclosure form that meets all of the requirements of this section and the statement required by subdivision (h). Both the form and the statement shall be signed under penalty of perjury by the attorney or an attorney licensed by the State Bar of California who is regularly employed by his or her firm. Both the disclosure form and the statement shall be filed with the appeals board and sent to the employer, or insurer or third-party administrator, if either is known, by the attorney within 15 days of the employee's and attorney's execution of the form and statement. Payment pursuant to subdivision (a) of Section 4903 or Section 5710 shall not be allowed for any services or expenses incurred prior to the filing of the disclosure form described in subdivision (e) with the appeals board and the sending of that form to the employer, or to the insurer or third-party administrator, if either is known, by the attorney.

SEC. 3. Section 14123 of the Welfare and Institutions Code is amended to read:

14123. Participation in the Medi-Cal program by a provider of service is subject to suspension in order to protect the health of the recipients and the funds appropriated to carry out this chapter.

(a) (1) The director may suspend a provider of service from further participation under the Medi-Cal program for violation of any provision of this chapter or Chapter 8 (commencing with Section 14200) or any rule or regulation promulgated by the director pursuant to those chapters. The suspension may be for an indefinite or specified period of time and with or without conditions, or may be imposed with the operation of the suspension stayed or probation granted. The director shall suspend a provider of service for conviction of any felony or any misdemeanor involving fraud, abuse of the Medi-Cal program or any patient, or otherwise substantially related to the qualifications, functions, or duties of a provider of service.

(2) If the provider of service is a clinic, group, corporation, or other association, conviction of any officer, director, or shareholder with a 10 percent or greater interest in that organization, of a crime described in paragraph (1) shall result in the suspension of that organization and the individual convicted if the director believes that suspension would be in the best interest of the Medi-Cal program. If the provider of service is a political subdivision of the state or other government agency, the conviction of the person in charge of the facility of a crime described in paragraph (1) may result in the suspension of that facility. The record of conviction or a certified copy thereof, certified by the clerk of the court or by the judge in whose court the conviction is had, shall be conclusive evidence of the fact that the conviction occurred. A plea or verdict of guilty, or a conviction following

a plea of nolo contendere is deemed to be a conviction within the meaning of this section.

(3) After conviction, but before the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal, the director, if he or she believes that suspension would be in the best interests of the Medi-Cal program, may order the suspension of a provider of service. When the time for appeal has elapsed, or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending the imposition of sentence irrespective of any subsequent order under Section 1203.4 of the Penal Code allowing a person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, information, or indictment, the director shall order the suspension of a provider of service. The suspension shall not take effect earlier than the date of the director's order. Suspension following a conviction is not subject to the proceedings required in subdivision (c). However, the director may grant an informal hearing at the request of the provider of service to determine in the director's sole discretion if the circumstances surrounding the conviction justify rescinding or otherwise modifying the suspension provided for in this subdivision.

(4) If the provider of service appeals the conviction and the conviction is reversed, the provider may apply for reinstatement to the Medi-Cal program after the conviction is reversed. Notwithstanding Section 14124.6, the application for reinstatement shall not be subject to the one-year waiting period for the filing of a reinstatement petition pursuant to Section 11522 of the Government Code.

(b) Whenever the director receives written notification from the Secretary of the United States Department of Health and Human Services that a physician or other individual practitioner has been suspended from participation in the Medicare or Medicaid programs, the director shall promptly suspend the practitioner from participation in the Medi-Cal program and notify the Administrative Director of the Division of Workers' Compensation of the suspension, in accordance with paragraph (2) of subdivision (e). This automatic suspension is not subject to the proceedings required in subdivision (c). No payment from state or federal funds may be made for any item or service rendered by the practitioner during the period of suspension.

(c) The proceedings for suspension shall be conducted pursuant to Section 100171 of the Health and Safety Code. The director may temporarily suspend any provider of service prior to any hearing when in his or her opinion that action is necessary to protect the public welfare or the interests of the Medi-Cal program. The director shall notify the provider of service of the temporary suspension and the effective date thereof and at the same time serve the provider with an accusation. The accusation and all proceedings thereafter shall be in accordance with Section 100171 of the Health and Safety Code. Upon receipt of a notice of defense by the provider, the director shall set the matter for hearing within 30 days after receipt of the notice. The temporary suspension shall remain in effect until such time as the

hearing is completed and the director has made a final determination on the merits. The temporary suspension shall, however, be deemed vacated if the director fails to make a final determination on the merits within 60 days after the original hearing has been completed. This subdivision does not apply where the suspension of a provider is based upon the conviction of any crime involving fraud, abuse of the Medi-Cal program, or suspension from the federal Medicare program. In those instances, suspension shall be automatic.

(d) (1) The suspension by the director of any provider of service shall preclude the provider from submitting claims for payment, either personally or through claims submitted by any clinic, group, corporation, or other association to the Medi-Cal program for any services or supplies the provider has provided under the program, except for services or supplies provided prior to the suspension. No clinic, group, corporation, or other association which is a provider of service shall submit claims for payment to the Medi-Cal program for any services or supplies provided by a person within the organization who has been suspended or revoked by the director, except for services or supplies provided prior to the suspension.

(2) If the provisions of this chapter, Chapter 8 (commencing with Section 14200), or the regulations promulgated by the director are violated by a provider of service that is a clinic, group, corporation, or other association, the director may suspend the organization and any individual person within the organization who is responsible for the violation.

(e) (1) Notice of the suspension shall be sent by the director to the provider's state licensing, certifying, or registering authority, along with the evidence upon which the suspension was based.

(2) At the same time notice is provided pursuant to paragraph (1), the director shall provide written notification of the suspension to the Administrative Director of the Division of Workers' Compensation, for purposes of Section 139.21 of the Labor Code.

(f) In addition to the bases for suspension contained in subdivisions (a) and (b), the director may suspend a provider of service from further participation under the Medi-Cal dental program for the provision of services that are below or less than the standard of acceptable quality, as established by the California Dental Association Guidelines for the Assessment of Clinical Quality and Professional Performance, Copyright 1995, Third Edition, as periodically amended. The suspension shall be subject to the requirements contained in subdivisions (a) to (e), inclusive.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2024
Author: Wood
Chapter: 496
Bill Date: August 15, 2016, Amended
Subject: Critical Access Hospitals: Employment
Sponsor: Author
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes, until January 1, 2024, a federally certified critical access hospital (CAH) to employ physicians and charge for professional services. 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 requires 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 requires the CAHs to also submit reports to OSHPD on an annual basis.

BACKGROUND:

Current law (commonly referred to as the "ban on the corporate practice of medicine" – Business and Professions Code section 2400) generally prohibits corporations or other entities that are not controlled by physicians from practicing medicine, to ensure that lay persons are not controlling or influencing the professional judgment and practice of medicine by physicians.

Most states, including California, allow exemptions for some professional medical corporations to employ physicians. For example, California allows physician employees at teaching hospitals, some community clinics, and certain non-profit organizations. California is one of only a few states that prohibits the employment of physicians by hospitals.

SB 376 (Chesbro, Chapter 411, Statutes of 2003) directed the Board to establish a pilot program to provide for the direct employment of physicians by qualified district hospitals. The bill was sponsored by the Association of California Healthcare Districts to enable qualified district hospitals to recruit, hire, and employ physicians as full-time, paid staff in rural or underserved communities meeting specified criteria. The goal of the legislation was to improve the ability of district hospitals to attract physicians. However, participation in the pilot was very limited, with only five participating hospitals and six participating physicians, and the Board was

hindered in making a full evaluation due to lack of participation. The pilot expired on January 1, 2011.

ANALYSIS

This bill establishes a pilot program for federally certified CAHs to employ physicians and would require OSHPD to provide a report to the Legislature containing data about the impact of CAH’s employing physicians and their ability to recruit and retain physicians between January 1, 2017, and January 1, 2023, inclusive. The report would be due on or before July 1, 2023, and the pilot program would end on January 1, 2024. This bill would also require CAHs that are employing physicians to submit to OSHPD on an annual basis. The report must include data elements that are required by OSHPD and be submitted to OSHPD in the format they require. This bill would specify that the CAH shall not interfere with, control, or otherwise direct the professional judgment of a physician in a manner prohibited by the ban on the corporate practice of medicine.

The author states that he is sympathetic to the concerns about interference with the clinical judgment of any health care provider. There are a number of exceptions to the ban on the corporate practice of medicine currently allowed. The 26 CAHs are in rural communities that have difficulty recruiting and retaining physicians. Allowing these CAHs to employ physicians will help to provide economic security adequate to recruit physicians who will have to relocate to these rural communities where CAHs are located.

The Board has always believed that the ban on the corporate practice of medicine provides a very important protection for patients and physicians from inappropriate intrusions into the practice of medicine. That being said, CAHs are in remote, rural areas and this bill would help these hospitals to recruit and retain physicians, which will improve access to care in these rural communities. In addition, this bill is a pilot program that will be evaluated and the bill makes it clear that the CAH must not interfere with, control or otherwise direct the professional judgement of a physician. The Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: Adventist Health; Alliance of Catholic Health Care; Association of California Healthcare Districts; Banner Lassen Medical Center; California Hospital Association; California Special Districts Association; Catalina Island Medical Center; Eastern Plumas Health Care; Fairchild Medical Center; Glenn Medical Center; Health Access California; Jerold Phelps Community Hospital; Kern Valley Healthcare District; Loma Linda University Health; Mayers Memorial Hospital District; Mendocino Coast District Hospital; Modoc Medical Center; Northern Inyo Healthcare District; Rural County Representatives of California; San Bernardino Mountains Community Hospital; Santa Ynez Valley Cottage Hospital; Sutter Lakeside Hospital; Tehachapi Valley Healthcare District; and

Trinity Hospital

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website

Assembly Bill No. 2024

CHAPTER 496

An act to amend Section 2401 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 23, 2016. Filed with Secretary of State September 23, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2024, Wood. Critical access hospitals: employment.

Existing law, the Medical Practice Act, restricts the employment of physicians and surgeons or doctors of podiatric medicine by a corporation or other artificial legal entity to entities that do not charge for professional services rendered to patients and are approved by the Medical Board of California, subject to specified exemptions. Existing law establishes the Office of Statewide Health Planning and Development, which succeeds to and is vested with all the duties, powers, responsibilities, and jurisdiction of the State Department of Public Health relating to health planning and research development.

This bill, until January 1, 2024, would also authorize a federally certified critical access hospital to employ those medical professionals and charge for professional services rendered by those medical professionals if the medical staff concur by an affirmative vote that the professional's employment is in the best interest of the communities served by the hospital and the hospital does not direct or interfere with the professional judgment of a physician and surgeon, as specified. The bill would require the office, on or before July 1, 2023, to provide a report to the Legislature containing data on the impact of this authorization on federally certified critical access hospitals and their ability to recruit and retain physicians and surgeons, as specified. The bill would, on and after July 1, 2017, and until July 1, 2023, require a federally critical access hospital employing those medical professionals under this authorization to submit a report, on or before July 1 of each year, to the office as specified.

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

SECTION 1. Section 2401 of the Business and Professions Code is amended to read:

2401. (a) Notwithstanding Section 2400, a clinic operated primarily for the purpose of medical education by a public or private nonprofit university medical school, which is approved by the board or the Osteopathic Medical Board of California, may charge for professional services rendered to

teaching patients by licensees who hold academic appointments on the faculty of the university, if the charges are approved by the physician and surgeon in whose name the charges are made.

(b) Notwithstanding Section 2400, a clinic operated under subdivision (p) of Section 1206 of the Health and Safety Code may employ licensees and charge for professional services rendered by those licensees. However, the clinic shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(c) Notwithstanding Section 2400, a narcotic treatment program operated under Section 11876 of the Health and Safety Code and regulated by the State Department of Health Care Services, may employ licensees and charge for professional services rendered by those licensees. However, the narcotic treatment program shall not interfere with, control, or otherwise direct the professional judgment of a physician and surgeon in a manner prohibited by Section 2400 or any other law.

(d) Notwithstanding Section 2400, a hospital that is owned and operated by a licensed charitable organization, that offers only pediatric subspecialty care, that, prior to January 1, 2013, employed licensees on a salary basis, and that has not charged for professional services rendered to patients may, commencing January 1, 2013, charge for professional services rendered to patients, provided the following conditions are met:

(1) The hospital does not increase the number of salaried licensees by more than five licensees each year.

(2) The hospital does not expand its scope of services beyond pediatric subspecialty care.

(3) The hospital accepts each patient needing its scope of services regardless of his or her ability to pay, including whether the patient has any form of health care coverage.

(4) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(5) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(e) (1) Notwithstanding Section 2400, until January 1, 2024, a federally certified critical access hospital may employ licensees and charge for professional services rendered by those licensees to patients, provided both of the following conditions are met:

(A) The medical staff concur by an affirmative vote that the licensee's employment is in the best interest of the communities served by the hospital.

(B) The hospital does not interfere with, control, or otherwise direct a physician and surgeon's professional judgment in a manner prohibited by Section 2400 or any other law.

(2) (A) On or before July 1, 2023, the Office of Statewide Health Planning and Development shall provide a report to the Legislature containing data about the impact of paragraph (1) on federally certified critical access hospitals and their ability to recruit and retain physicians and

surgeons between January 1, 2017, and January 1, 2023, inclusive. This report shall be submitted in compliance with Section 9795 of the Government Code. The requirement for submitting a report imposed under this subparagraph is inoperative on July 1, 2027.

(B) The office shall determine the format of the report, as well as the methods and data elements to be utilized in the development of the report.

(C) On and after July 1, 2017, a federally certified critical access hospital that is employing licensees and charging for professional services rendered by those licensees to patients under this section shall submit to the office, on or before July 1 of each year, a report for any year in which that hospital has employed or is employing licensees and charging for professional services rendered by those licensees to patients. The report shall include data elements as required by the office and shall be submitted in a format as required by the office. The requirement for submitting reports imposed under this subparagraph shall be inoperative on July 1, 2023.

O

MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2744
Author: Gordon
Chapter: 360
Bill Date: August 8, 2016, Amended
Subject: Healing Arts: Referrals
Sponsor: The Internet Association
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill would specify that the payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients that is prohibited in existing law.

BACKGROUND

Existing law, Business and Professions Code Section 650, prohibits the offer of a commission as compensation for referring a patient. Existing law does allow payment for services other than the referral of a patient. This statute is several decades old, and was put into place before online advertising became available. In the past, if a physician wanted to advertise for his or her services, they could take out an advertisement in the yellow pages, a newspaper, a billboard, or run a commercial on radio or television. In these instances, the advertisement could include a coupon or special offer.

Now, physicians and other health care professionals can advertise online and offer purchase vouchers for service in online market places such as Groupon, Living Social, and others. For online voucher advertising companies, the health care professional decides whether to advertise and what service to make available for purchase (which is not an essential health benefit), the cost of the service, how many vouchers to offer, and for how long. The health care professional pays the online advertising network for making the offer available, generally a percentage of the price of the purchased service. Once a consumer purchases a voucher through this form of online advertising, the consumer contacts the health care professional to set an appointment, just as they would if responding to any other form of advertisement.

Per a 1994 Attorney General Opinion, a referral exists when a third party independent entity who individually has contact with a person in need of health care selects a professional to render the same. Online marketplaces do not select a health care professional, but rather make the advertisements and vouchers available on its website.

Currently, the Attorney General's Opinion Unit is in the process of researching and drafting a formal opinion on the question of whether a health care professional may offer

online discounts for their services through a third-party internet marketer. The opinion request, 13-1203, is currently pending completion in the AG's office. At this time, the completion date is unknown.

ANALYSIS

This bill would expressly provide that payment or receipt of consideration for advertising, where a licensee offers or sells services through a third-party advertiser, does not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. This bill would specify that the fee paid to the third-party advertiser must be commensurate with the service provided by the third-party advertiser. This bill would require the purchaser to receive a refund of the full purchase price, as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee, if the licensee determines, after consultation with the purchaser of the service, that the service is not appropriate for the purchaser. It must be disclosed in the advertisement that this consultation is required and the purchaser will receive a refund if not eligible to receive the service. This bill would specify that it does not apply to basic health care services or essential health benefits, as specified. This bill would require the entity that provides the advertising to demonstrate that the licensee consented in writing to the requirements of this bill. This bill would require a third-party advertiser to make advertisements available to prospective purchasers for all services of licensees in the applicable geographic region.

Board staff has already looked at the issue of Internet advertising for physicians with companies like Groupon and Living Social, and does not believe that these arrangements are in violation of existing referral law. This bill would make it clear that this type of advertising is not in violation of existing law and would add protections for consumers to be refunded if the service is not appropriate. For these reasons, the Board has taken a neutral position on this bill.

FISCAL: None

SUPPORT: The Internet Association (Sponsor)
Groupon

OPPOSITION: California Medical Association
California Society of Plastic Surgeons

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website

Assembly Bill No. 2744

CHAPTER 360

An act to amend Section 650 of the Business and Professions Code, relating to the healing arts.

[Approved by Governor September 14, 2016. Filed with Secretary of State September 14, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2744, Gordon. Healing arts: referrals.

Existing law provides for the licensure and regulation of various healing arts professions and vocations by boards within the Department of Consumer Affairs. Under existing law, it is unlawful for licensed healing arts practitioners, except as specified, to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person. Existing law makes a violation of this provision a public offense punishable upon a first conviction by imprisonment, as specified, or a fine not exceeding \$50,000, or by imprisonment and that fine.

This bill would provide that the payment or receipt of consideration for advertising, wherein a licensed healing arts practitioner offers or sells services through a third-party advertiser, does not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The bill would require that the fee paid to the third-party advertiser be commensurate with the service provided by the third-party advertiser. The bill would require the purchaser of the service to receive a refund of the full purchase price if the licensee determines, after consultation with the purchaser, that the service provided by the licensee is not appropriate for the purchaser, or if the purchaser elects not to receive the service for any reason and requests a refund, as specified. The bill would require that a licensee disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if not eligible to receive the service. The bill would specify that these provisions do not apply to basic health care services or essential health benefits, as defined. The bill would also provide that the entity that provides advertising is required to be able to demonstrate that the licensee consented in writing to these provisions. The bill would require a third-party advertiser to make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region and to disclose, in any advertisement offering a discount price for a service, the regular, nondiscounted price for that service.

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

SECTION 1. Section 650 of the Business and Professions Code is amended to read:

650. (a) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code, the offer, delivery, receipt, or acceptance by any person licensed under this division or the Chiropractic Initiative Act of any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for referring patients, clients, or customers to any person, irrespective of any membership, proprietary interest, or coownership in or with any person to whom these patients, clients, or customers are referred is unlawful.

(b) The payment or receipt of consideration for services other than the referral of patients which is based on a percentage of gross revenue or similar type of contractual arrangement shall not be unlawful if the consideration is commensurate with the value of the services furnished or with the fair rental value of any premises or equipment leased or provided by the recipient to the payer.

(c) The offer, delivery, receipt, or acceptance of any consideration between a federally qualified health center, as defined in Section 1396d(l)(2)(B) of Title 42 of the United States Code, and any individual or entity providing goods, items, services, donations, loans, or a combination thereof to the health center entity pursuant to a contract, lease, grant, loan, or other agreement, if that agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center, shall be permitted only to the extent sanctioned or permitted by federal law.

(d) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful for any person licensed under this division to refer a person to any laboratory, pharmacy, clinic (including entities exempt from licensure pursuant to Section 1206 of the Health and Safety Code), or health care facility solely because the licensee has a proprietary interest or coownership in the laboratory, pharmacy, clinic, or health care facility, provided, however, that the licensee's return on investment for that proprietary interest or coownership shall be based upon the amount of the capital investment or proportional ownership of the licensee which ownership interest is not based on the number or value of any patients referred. Any referral excepted under this section shall be unlawful if the prosecutor proves that there was no valid medical need for the referral.

(e) Except as provided in Chapter 2.3 (commencing with Section 1400) of Division 2 of the Health and Safety Code and in Sections 654.1 and 654.2 of this code, it shall not be unlawful to provide nonmonetary remuneration, in the form of hardware, software, or information technology and training

services, as described in subsections (x) and (y) of Section 1001.952 of Title 42 of the Code of Federal Regulations, as amended October 4, 2007, as published in the Federal Register (72 Fed. Reg. 56632 and 56644), and subsequently amended versions.

(f) “Health care facility” means a general acute care hospital, acute psychiatric hospital, skilled nursing facility, intermediate care facility, and any other health facility licensed by the State Department of Public Health under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

(g) Notwithstanding the other subdivisions of this section or any other provision of law, the payment or receipt of consideration for advertising, wherein a licensee offers or sells services through a third-party advertiser, shall not constitute a referral of patients when the third-party advertiser does not itself recommend, endorse, or otherwise select a licensee. The fee paid to the third-party advertiser shall be commensurate with the service provided by the third-party advertiser. If the licensee determines, after consultation with the purchaser of the service, that the service provided by the licensee is not appropriate for the purchaser or if the purchaser elects not to receive the service for any reason and requests a refund, the purchaser shall receive a refund of the full purchase price as determined by the terms of the advertising service agreement between the third-party advertiser and the licensee. The licensee shall disclose in the advertisement that a consultation is required and that the purchaser will receive a refund if not eligible to receive the service. This subdivision shall not apply to basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, or essential health benefits, as defined in Section 1367.005 of the Health and Safety Code and Section 10112.27 of the Insurance Code. The entity that provides the advertising shall be able to demonstrate that the licensee consented in writing to the requirements of this subdivision. A third-party advertiser shall make available to prospective purchasers advertisements for services of all licensees then advertising through the third-party advertiser in the applicable geographic region. In any advertisement offering a discount price for a service, the licensee shall also disclose the regular, nondiscounted price for that service.

(h) A violation of this section is a public offense and is punishable upon a first conviction by imprisonment in a county jail for not more than one year, or by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by a fine not exceeding fifty thousand dollars (\$50,000), or by both that imprisonment and fine. A second or subsequent conviction is punishable by imprisonment pursuant to subdivision (h) of Section 1170 of the Penal Code, or by that imprisonment and a fine of fifty thousand dollars (\$50,000).

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: AB 2745
Author: Holden
Chapter: 303
Bill Date: April 25, 2016, Amended
Subject: Healing Arts: Licensing and Certification
Sponsor: Medical Board of California (Board)
Position: Sponsor/Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill makes clarifying changes to existing law to assist the Board in its licensing and enforcement functions.

ANALYSIS

This bill clarifies the Board's authority for the allied health licensees/registrants overseen by the Board. It allows the Board to revoke or deny a license/registration for registered sex offenders, allows the Board to take disciplinary action for excessive use of drugs or alcohol, allows allied health licensees/registrants to petition the Board for license/registration reinstatement, and allows the Board to use probation as a disciplinary option for allied health licensees/registrants.

Existing law only allows new physician and surgeon applicants and disabled status licensees to apply for a limited practice license (LPL). This bill allows all physician and surgeon licensees to apply for an LPL at any time. This bill would ensure that physicians who have a disabled status license and want to change to an LPL meet the same requirements in existing law for an LPL.

This bill clarifies 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 clarifies existing law related to investigations of a deceased patient. Existing law allows the Board to obtain a copy of the medical records of a deceased patient without the approval of the next of kin if the Board is unsuccessful in locating or contacting the patients' next of kin after reasonable efforts. Existing law requires the Board to contact the physician that owns the records, however, in many cases the records do not reside with the physician. This bill allows the Board to send a written request for medical records to the facility where the care occurred or where the records are located. This will ensure that the Board's investigation is not hindered.

This bill cleans up existing law to ensure that the Board's authority to perform its

regulatory oversight of licensees/registrants is clearly defined and aligned with current law.
This is a Board-sponsored bill.

FISCAL: None

SUPPORT: Medical Board of California (Sponsor)
 AFSCME

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website
- Revise the LPL application
- Develop appropriate reinstatement forms
- Add violation codes to the BreZE system and make other necessary changes to BreZE related to probation fees

Assembly Bill No. 2745

CHAPTER 303

An act to amend Sections 2088, 2221, 2225, 2441, 2519, 2520, 2529, 3576, and 3577 of, and to add Sections 2522, 2523, 2529.1, 2529.6, 3576.1, 3576.2, and 3576.3 to, the Business and Professions Code, relating to healing arts, and making an appropriation therefor.

[Approved by Governor September 12, 2016. Filed with
Secretary of State September 12, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

AB 2745, Holden. Healing arts: licensing and certification.

(1) Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Existing law authorizes an applicant for a physician's and surgeon's license who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability to receive a limited license if the applicant pays the license fee and signs an agreement agreeing to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board. Existing law makes any person who knowingly provides false information in this agreement subject to any sanctions available to the board. Existing law authorizes the board to require the applicant to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving the limited license. Violation of specified provisions of the act is a crime. Existing law establishes the Contingent Fund of the Medical Board of California, a continuously appropriated fund.

This bill would specify that a licensee who is otherwise eligible for a license but is unable to practice some aspects of medicine safely due to a disability is authorized to receive the limited license if the above-described conditions are met, including payment of the appropriate fee. By adding fees for deposit into the Contingent Fund of the Medical Board of California, this bill would make an appropriation.

This bill would also authorize the board to deny a postgraduate training authorization to an applicant who is guilty of unprofessional conduct or of any cause for revocation or suspension of a license.

(2) Existing law authorizes a licensee who demonstrates that he or she is unable to practice medicine due to a disability to request a waiver of the license renewal fee. Under existing law, a licensee granted that waiver is prohibited from practicing medicine until he or she establishes that the disability no longer exists or signs an agreement, under penalty of perjury, agreeing to limit his or her practice in the manner prescribed by the reviewing physician.

This bill would require the board to agree to this limit, would authorize the board to require an independent clinical evaluation, and would subject a person who knowingly provides false information in the agreement to sanctions. By modifying the scope of the crime of perjury, this bill would impose a state-mandated local program.

(3) Existing law authorizes the board, in any investigation that involves the death of a patient, to inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely to determine the extent to which the death was the result of the physician and surgeon's violation of the Medical Practice Act, if the board provides a written request to the physician and surgeon that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts.

This bill would authorize the board to provide the written request to the facility where the medical records are located or the care to the deceased patient was provided.

(4) Existing law, the Licensed Midwifery Practice Act of 1993, provides for the licensing and regulation of midwives by the Medical Board of California. Under the act, the board is authorized to suspend or revoke the license of a midwife for specified conduct, including unprofessional conduct consisting of, among other things, incompetence or gross negligence in carrying out the usual functions of a licensed midwife. A violation of the act is a crime.

This bill would authorize the board to place a license on probation and establish a fee for monitoring a licensee on probation. The bill would also authorize a person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a license for a person required to register as a sex offender, except as specified.

(5) Existing law relating to research psychoanalysts authorizes certain students and graduates in psychoanalysis to engage in psychoanalysis under prescribed circumstances if they register with the Medical Board of California and present evidence of their student or graduate status. Existing law authorizes that board to suspend or revoke the exemption of those persons from licensure for unprofessional conduct, as specified.

The bill would include within the definition of unprofessional conduct, among other things, the use of any controlled substance, or the use of any dangerous drugs, as specified, or of alcoholic beverages, as specified. The bill would also require the revocation of a registration for a person required to register as a sex offender, except as specified.

(6) Existing law prohibits a person from using the title "certified polysomnographic technologist" or engaging in the practice of polysomnography unless he or she is registered as a certified polysomnographic technologist, is supervised and directed by a licensed

physician and surgeon, and meets certain other requirements. Existing law requires polysomnographic technologists to apply to and register with the Medical Board of California and to pay specified fees to be fixed by the board at no more than \$100 each, and to renew their registration biennially for a fee of no more than \$150. Existing law requires the deposit of those fees in the Contingent Fund of the Medical Board of California. Existing law authorizes a registration to be suspended, revoked, or otherwise subject to discipline for specified conduct.

This bill would also authorize a registration to be placed on probation if a registrant engages in that conduct and would establish a fee for monitoring a registrant on probation. By increasing fees for deposit into the Contingent Fund, this bill would make an appropriation. The bill would authorize a person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been suspended, revoked, or placed on probation to petition the board for reinstatement or modification of penalty, as specified. The bill would require the revocation of a registration for a person required to register as a sex offender, except as specified. The bill would authorize the suspension or revocation of a registration for unprofessional conduct, as defined.

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

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

Appropriation: yes.

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

SECTION 1. Section 2088 of the Business and Professions Code is amended to read:

2088. (a) An applicant for a physician's and surgeon's license or a physician's and surgeon's licensee who is otherwise eligible for that license but is unable to practice some aspects of medicine safely due to a disability may receive a limited license if he or she does both of the following:

(1) Pays the appropriate initial or renewal license fee.

(2) Signs an agreement on a form prescribed by the board in which the applicant or licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the applicant or licensee described in subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a limited license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to subdivision (a) shall be subject to any sanctions available to the board.

SEC. 2. Section 2221 of the Business and Professions Code is amended to read:

2221. (a) The board may deny a physician's and surgeon's certificate or postgraduate training authorization letter to an applicant guilty of unprofessional conduct or of any cause that would subject a licensee to revocation or suspension of his or her license. The board in its sole discretion, may issue a probationary physician's and surgeon's certificate to an applicant subject to terms and conditions, including, but not limited to, any of the following conditions of probation:

(1) Practice limited to a supervised, structured environment where the licensee's activities shall be supervised by another physician and surgeon.

(2) Total or partial restrictions on drug prescribing privileges for controlled substances.

(3) Continuing medical or psychiatric treatment.

(4) Ongoing participation in a specified rehabilitation program.

(5) Enrollment and successful completion of a clinical training program.

(6) Abstention from the use of alcohol or drugs.

(7) Restrictions against engaging in certain types of medical practice.

(8) Compliance with all provisions of this chapter.

(9) Payment of the cost of probation monitoring.

(b) The board may modify or terminate the terms and conditions imposed on the probationary certificate upon receipt of a petition from the licensee. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board.

(c) The board shall deny a physician's and surgeon's certificate to an applicant who is required to register pursuant to Section 290 of the Penal Code. This subdivision does not apply to an applicant who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(d) An applicant shall not be eligible to reapply for a physician's and surgeon's certificate for a minimum of three years from the effective date of the denial of his or her application, except that the board may, in its discretion and for good cause demonstrated, permit reapplication after not less than one year has elapsed from the effective date of the denial.

SEC. 3. Section 2225 of the Business and Professions Code is amended to read:

2225. (a) Notwithstanding Section 2263 and any other law making a communication between a physician and surgeon or a doctor of podiatric medicine and his or her patients a privileged communication, those provisions shall not apply to investigations or proceedings conducted under this chapter. Members of the board, the Senior Assistant Attorney General of the Health Quality Enforcement Section, members of the California Board of Podiatric Medicine, and deputies, employees, agents, and representatives of the board or the California Board of Podiatric Medicine and the Senior Assistant Attorney General of the Health Quality Enforcement Section shall keep in confidence during the course of investigations, the names of any

patients whose records are reviewed and shall not disclose or reveal those names, except as is necessary during the course of an investigation, unless and until proceedings are instituted. The authority of the board or the California Board of Podiatric Medicine and the Health Quality Enforcement Section to examine records of patients in the office of a physician and surgeon or a doctor of podiatric medicine is limited to records of patients who have complained to the board or the California Board of Podiatric Medicine about that licensee.

(b) Notwithstanding any other law, the Attorney General and his or her investigative agents, and investigators and representatives of the board or the California Board of Podiatric Medicine, may inquire into any alleged violation of the Medical Practice Act or any other federal or state law, regulation, or rule relevant to the practice of medicine or podiatric medicine, whichever is applicable, and may inspect documents relevant to those investigations in accordance with the following procedures:

(1) Any document relevant to an investigation may be inspected, and copies may be obtained, where patient consent is given.

(2) Any document relevant to the business operations of a licensee, and not involving medical records attributable to identifiable patients, may be inspected and copied if relevant to an investigation of a licensee.

(c) (1) Notwithstanding subdivision (b) or any other law, in any investigation that involves the death of a patient, the board may inspect and copy the medical records of the deceased patient without the authorization of the beneficiary or personal representative of the deceased patient or a court order solely for the purpose of determining the extent to which the death was the result of the physician and surgeon's conduct in violation of the Medical Practice Act, if the board provides a written request to either the physician and surgeon or the facility where the medical records are located or the care to the deceased patient was provided, that includes a declaration that the board has been unsuccessful in locating or contacting the deceased patient's beneficiary or personal representative after reasonable efforts. Nothing in this subdivision shall be construed to allow the board to inspect and copy the medical records of a deceased patient without a court order when the beneficiary or personal representative of the deceased patient has been located and contacted but has refused to consent to the board inspecting and copying the medical records of the deceased patient.

(2) The Legislature finds and declares that the authority created in the board pursuant to this section, and a physician and surgeon's compliance with this section, are consistent with the public interest and benefit activities of the federal Health Insurance Portability and Accountability Act (HIPAA).

(d) In all cases in which documents are inspected or copies of those documents are received, their acquisition or review shall be arranged so as not to unnecessarily disrupt the medical and business operations of the licensee or of the facility where the records are kept or used.

(e) If documents are lawfully requested from licensees in accordance with this section by the Attorney General or his or her agents or deputies, or investigators of the board or the California Board of Podiatric Medicine,

the documents shall be provided within 15 business days of receipt of the request, unless the licensee is unable to provide the documents within this time period for good cause, including, but not limited to, physical inability to access the records in the time allowed due to illness or travel. Failure to produce requested documents or copies thereof, after being informed of the required deadline, shall constitute unprofessional conduct. The board may use its authority to cite and fine a physician and surgeon for any violation of this section. This remedy is in addition to any other authority of the board to sanction a licensee for a delay in producing requested records.

(f) Searches conducted of the office or medical facility of any licensee shall not interfere with the recordkeeping format or preservation needs of any licensee necessary for the lawful care of patients.

SEC. 4. Section 2441 of the Business and Professions Code is amended to read:

2441. (a) Any licensee who demonstrates to the satisfaction of the board that he or she is unable to practice medicine due to a disability may request a waiver of the license renewal fee. The granting of a waiver shall be at the discretion of the board and may be terminated at any time. Waivers shall be based on the inability of a licensee to practice medicine. A licensee whose renewal fee has been waived pursuant to this section shall not engage in the practice of medicine unless and until the licensee pays the current renewal fee and does either of the following:

(1) Establishes to the satisfaction of the board, on a form prescribed by the board and signed under penalty of perjury, that the licensee's disability either no longer exists or does not affect his or her ability to practice medicine safely.

(2) Signs an agreement on a form prescribed by the board, signed under penalty of perjury, in which the licensee agrees to limit his or her practice in the manner prescribed by the reviewing physician and agreed to by the board.

(b) The board may require the licensee described in paragraph (2) of subdivision (a) to obtain an independent clinical evaluation of his or her ability to practice medicine safely as a condition of receiving a disabled status license under this section.

(c) Any person who knowingly provides false information in the agreement submitted pursuant to paragraph (2) of subdivision (a) shall be subject to any sanctions available to the board.

SEC. 5. Section 2519 of the Business and Professions Code is amended to read:

2519. The board may suspend, revoke, or place on probation the license of a midwife for any of the following:

(a) Unprofessional conduct, which includes, but is not limited to, all of the following:

(1) Incompetence or gross negligence in carrying out the usual functions of a licensed midwife.

(2) Conviction of a violation of Section 2052, in which event, the record of the conviction shall be conclusive evidence thereof.

(3) The use of advertising that is fraudulent or misleading.

(4) Obtaining or possessing in violation of law, or prescribing, or except as directed by a licensed physician and surgeon, dentist, or podiatrist administering to himself or herself, or furnishing or administering to another, any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code.

(5) The use of any controlled substance as defined in Division 10 (commencing with Section 11000) of the Health and Safety Code, or any dangerous drug as defined in Article 8 (commencing with Section 4210) of Chapter 9 of Division 2 of the Business and Professions Code, or alcoholic beverages, to an extent or in a manner dangerous or injurious to himself or herself, any other person, or the public or to the extent that this use impairs his or her ability to conduct with safety to the public the practice authorized by his or her license.

(6) Conviction of a criminal offense involving the prescription, consumption, or self-administration of any of the substances described in paragraphs (4) and (5), or the possession of, or falsification of, a record pertaining to, the substances described in paragraph (4), in which event the record of the conviction is conclusive evidence thereof.

(7) Commitment or confinement by a court of competent jurisdiction for intemperate use of or addiction to the use of any of the substances described in paragraphs (4) and (5), in which event the court order of commitment or confinement is prima facie evidence of such commitment or confinement.

(8) Falsifying, or making grossly incorrect, grossly inconsistent, or unintelligible entries in any hospital, patient, or other record pertaining to the substances described in subdivision (a).

(b) Procuring a license by fraud or misrepresentation.

(c) Conviction of a crime substantially related to the qualifications, functions, and duties of a midwife, as determined by the board.

(d) Procuring, aiding, abetting, attempting, agreeing to procure, offering to procure, or assisting at, a criminal abortion.

(e) Violating or attempting to violate, directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate any provision or term of this chapter.

(f) Making or giving any false statement or information in connection with the application for issuance of a license.

(g) Impersonating any applicant or acting as proxy for an applicant in any examination required under this chapter for the issuance of a license or a certificate.

(h) Impersonating another licensed practitioner, or permitting or allowing another person to use his or her license or certificate for the purpose of providing midwifery services.

(i) Aiding or assisting, or agreeing to aid or assist any person or persons, whether a licensed physician or not, in the performance of or arranging for

a violation of any of the provisions of Article 12 (commencing with Section 2221) of Chapter 5.

(j) Failing to do any of the following when required pursuant to Section 2507:

- (1) Consult with a physician and surgeon.
- (2) Refer a client to a physician and surgeon.
- (3) Transfer a client to a hospital.

SEC. 6. Section 2520 of the Business and Professions Code is amended to read:

2520. (a) (1) The fee to be paid upon the filing of a license application shall be fixed by the board at not less than seventy-five dollars (\$75) nor more than three hundred dollars (\$300).

(2) The fee for renewal of the midwife license shall be fixed by the board at not less than fifty dollars (\$50) nor more than two hundred dollars (\$200).

(3) The delinquency fee for renewal of the midwife license shall be 50 percent of the renewal fee in effect on the date of the renewal of the license, but not less than twenty-five dollars (\$25) nor more than fifty dollars (\$50).

(4) The fee for the examination shall be the cost of administering the examination to the applicant, as determined by the organization that has entered into a contract with the board for the purposes set forth in subdivision (a) of Section 2512.5. Notwithstanding subdivision (c), that fee may be collected and retained by that organization.

(b) The fee for monitoring a licensee on probation shall be the cost of monitoring, as fixed by the board.

(c) The fees prescribed by this article shall be deposited in the Licensed Midwifery Fund, which is hereby established, and shall be available, upon appropriation, to the board for the purposes of this article.

SEC. 7. Section 2522 is added to the Business and Professions Code, to read:

2522. (a) A person whose license has been voluntarily surrendered while under investigation or while charges are pending or whose license has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the license or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a license surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a license surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from midwives licensed in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section 11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the license was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a license or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 8. Section 2523 is added to the Business and Professions Code, to read:

2523. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the license of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a license pursuant to this section shall be conducted in accordance with chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 9. Section 2529 of the Business and Professions Code is amended to read:

2529. (a) Graduates of the Southern California Psychoanalytic Institute, the Los Angeles Psychoanalytic Society and Institute, the San Francisco

Psychoanalytic Institute, the San Diego Psychoanalytic Center, or institutes deemed equivalent by the Medical Board of California who have completed clinical training in psychoanalysis may engage in psychoanalysis as an adjunct to teaching, training, or research and hold themselves out to the public as psychoanalysts, and students in those institutes may engage in psychoanalysis under supervision, if the students and graduates do not hold themselves out to the public by any title or description of services incorporating the words “psychological,” “psychologist,” “psychology,” “psychometrists,” “psychometrics,” or “psychometry,” or that they do not state or imply that they are licensed to practice psychology.

(b) Those students and graduates seeking to engage in psychoanalysis under this chapter shall register with the Medical Board of California, presenting evidence of their student or graduate status. The board may suspend or revoke the exemption of those persons for unprofessional conduct as defined in Sections 726, 2234, 2235, and 2529.1

SEC. 10. Section 2529.1 is added to the Business and Professions Code, to read:

2529.1. (a) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(b) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 11. Section 2529.6 is added to the Business and Professions Code, to read:

2529.6. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex

offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 12. Section 3576 of the Business and Professions Code is amended to read:

3576. (a) A registration under this chapter may be denied, suspended, revoked, placed on probation, or otherwise subjected to discipline for any of the following by the holder:

(1) Incompetence, gross negligence, or repeated similar negligent acts performed by the registrant.

(2) An act of dishonesty or fraud.

(3) Committing any act or being convicted of a crime constituting grounds for denial of licensure or registration under Section 480.

(4) Violating or attempting to violate this chapter or any regulation adopted under this chapter.

(b) Proceedings under this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, and the board shall have all powers granted therein.

SEC. 13. Section 3576.1 is added to the Business and Professions Code, to read:

3576.1. (a) A person whose registration has been voluntarily surrendered while under investigation or while charges are pending or whose registration has been revoked or suspended or placed on probation, may petition the board for reinstatement or modification of penalty, including modification or termination of probation.

(b) The person may file the petition after a period of not less than the following minimum periods have elapsed from the effective date of the surrender of the registration or the decision ordering that disciplinary action:

(1) At least three years for reinstatement of a registration surrendered or revoked for unprofessional conduct, except that the board may, for good cause shown, specify in a revocation order that a petition for reinstatement may be filed after two years.

(2) At least two years for early termination of probation of three years or more.

(3) At least one year for modification of a condition, or reinstatement of a registration surrendered or revoked for mental or physical illness, or termination of probation of less than three years.

(c) The petition shall state any facts as may be required by the board. The petition shall be accompanied by at least two verified recommendations from polysomnographic technologists registered in any state who have personal knowledge of the activities of the petitioner since the disciplinary penalty was imposed.

(d) The petition may be heard by a panel of the board. The board may assign the petition to an administrative law judge designated in Section

11371 of the Government Code. After a hearing on the petition, the administrative law judge shall provide a proposed decision to the board, which shall be acted upon in accordance with Section 2335.

(e) The panel of the board or the administrative law judge hearing the petition may consider all activities of the petitioner since the disciplinary action was taken, the offense for which the petitioner was disciplined, the petitioner's activities during the time the registration was in good standing, and the petitioner's rehabilitative efforts, general reputation for truth, and professional ability. The hearing may be continued from time to time as the administrative law judge designated in Section 11371 of the Government Code finds necessary.

(f) The administrative law judge designated in Section 11371 of the Government Code reinstating a registration or modifying a penalty may recommend the imposition of any terms and conditions deemed necessary.

(g) No petition shall be considered while the petitioner is under sentence for any criminal offense, including any period during which the petitioner is on court-imposed probation or parole. No petition shall be considered while there is an accusation or petition to revoke probation pending against the person. The board may deny without a hearing or argument any petition filed pursuant to this section within a period of two years from the effective date of the prior decision following a hearing under this section.

SEC. 14. Section 3576.2 is added to the Business and Professions Code, to read:

3576.2. (a) Except as provided in subdivisions (b) and (c), the board shall revoke the registration of any person who has been required to register as a sex offender pursuant to Section 290 of the Penal Code for conduct that occurred on or after January 1, 2017.

(b) This section shall not apply to a person who is required to register as a sex offender pursuant to Section 290 of the Penal Code solely because of a misdemeanor conviction under Section 314 of the Penal Code.

(c) This section shall not apply to a person who has been relieved under Section 290.5 of the Penal Code of his or her duty to register as a sex offender, or whose duty to register has otherwise been formally terminated under California law.

(d) A proceeding to revoke a registration pursuant to this section shall be conducted in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

SEC. 15. Section 3576.3 is added to the Business and Professions Code, to read:

3576.3. (a) The board may suspend or revoke the registration of a polysomnographic technologist, polysomnographic technician, or polysomnographic trainee for unprofessional conduct as described in this section.

(b) The use of any controlled substance or the use of any of the dangerous drugs specified in Section 4022, or of alcoholic beverages, to the extent, or in such a manner as to be dangerous or injurious to the registrant, or to any other person or to the public, or to the extent that this use impairs the ability

of the registrant to practice safely or more than one misdemeanor or any felony conviction involving the use, consumption, or self-administration of any of the substances referred to in this section, or any combination thereof, constitutes unprofessional conduct. The record of the conviction is conclusive evidence of this unprofessional conduct.

(c) A plea or verdict of guilty or a conviction following a plea of nolo contendere is deemed to be a conviction within the meaning of this section. The board may order discipline of the registrant in accordance with Section 2227 or may order the denial of the registration when the time for appeal has elapsed or the judgment of conviction has been affirmed on appeal or when an order granting probation is made suspending imposition of sentence, irrespective of a subsequent order under the provisions of Section 1203.4 of the Penal Code allowing this person to withdraw his or her plea of guilty and to enter a plea of not guilty, or setting aside the verdict of guilty, or dismissing the accusation, complaint, information, or indictment.

SEC. 16. Section 3577 of the Business and Professions Code is amended to read:

3577. (a) Each person who applies for registration under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars (\$100).

(b) Each person to whom registration is granted under this chapter shall pay into the Contingent Fund of the Medical Board of California a fee to be fixed by the board at a sum not in excess of one hundred dollars (\$100).

(c) The registration shall expire after two years. The registration may be renewed biennially at a fee which shall be paid into the Contingent Fund of the Medical Board of California to be fixed by the board at a sum not in excess of one hundred fifty dollars (\$150).

(d) The fee for monitoring a registrant on probation shall be the cost of monitoring, as fixed by the board.

(e) The money in the Contingent Fund of the Medical Board of California that is collected pursuant to this section shall be used for the administration of this chapter.

SEC. 17. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 482
Author: Lara
Chapter: 708
Bill Date: August 19, 2016, Amended
Subject: Controlled Substances: CURES Database
Sponsor: Consumer Attorneys of California and
 California Narcotics Officers
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill 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.

BACKGROUND:

The CURES Program is currently housed in the Department of Justice (DOJ) and is a state database of dispensed prescription drugs that have a high potential for misuse and abuse. CURES provides for electronic transmission of specified prescription data to DOJ. In September 2009, DOJ launched the CURES Prescription Drug Monitoring Program (PDMP) system allowing pre-registered users, including licensed health care prescribers eligible to prescribe controlled substances, pharmacists authorized to dispense controlled substances, law enforcement, and regulatory boards, to access patient controlled substance history information through a secure website. SB 809 (DeSaulnier, Chapter 400) was signed into law in 2013 and included a provision to collect funds from boards that license individuals who prescribe and dispense, for purposes of funding and upgrading the CURES system. This bill also required all prescribers to register with CURES by January 1, 2016, but the law was amended to extend the registration deadline to July 1, 2016. The new CURES 2.0 system, which is a modernized system that has been updated to more efficiently serve prescribers, pharmacists and other entities, is now operational and available online, as long as the prescriber uses a compliant browser.

According to the Centers for Disease Control and Prevention, drug overdoses are the top cause of accidental death in the United States and nearly 23,000 people died from an overdose of pharmaceuticals in 2013, more than 70% of them from opiate prescription painkillers. According to the California Attorney General’s Office, if doctors and pharmacies have access to controlled substance history information at the point of care, it will help them make better prescribing decisions and cut down on prescription drug abuse in California.

According to the author’s office, other states that have required prescribers to check their drug monitoring systems have seen significantly improved public health outcomes. In 2012, Tennessee required prescribers to check the state’s PDMP before

prescribing painkillers, and, within one year, they saw a 36% drop in patients who were seeing multiple prescribers to obtain the same drugs. In Virginia, the number of doctor-shoppers fell by 73% after use of the database became mandatory. In Oklahoma, which requires mandatory checks for methadone, overdoses fell about 21% in one year. New York also requires prescribers to check their state drug monitoring systems and has seen dramatic decreases in drug overdoses and deaths.

ANALYSIS

This bill requires 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. This bill requires a health care practitioner to obtain a patient's controlled substance history from the CURES database no earlier than 24 hours before the medication is prescribed, ordered, administered, furnished or dispensed. If a health care practitioner is exempted from checking CURES before prescribing a controlled substance for the first time pursuant to this bill, they are required to consult CURES before subsequently prescribing a controlled substance to the patient at least every four months thereafter if the substance remains part of the treatment of the patient. This bill defines "first time" to mean the initial occurrence in which a health care practitioner intends to prescribe, order, administer, furnish or dispense a Schedule II, III, or IV controlled substance to a patient and has not previously prescribed a controlled substance to that patient.

This bill specifies that a prescriber, pharmacist, or any person acting on their behalf, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising from any false, incomplete, inaccurate or misattributed information submitted to, reported by or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

This bill specifies that the duty to consult CURES does not apply to veterinarians or pharmacists.

This bill specifies that the requirement to consult the CURES database does not apply to a health care practitioner in any of the following circumstances:

- If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:
 - A licensed clinic,
 - An outpatient setting,
 - A health facility, or
 - A county medical facility.
- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital if the quantity of the controlled substance does not exceed a non-

refillable seven-day supply of the controlled substance, to be used in accordance with the directions for use.

- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient’s treatment for a surgical procedure, if the quantity of the controlled substance does not exceed a non-refillable five-day supply and is in a licensed clinic, an outpatient setting, a health facility, a county medical facility or a place of practice.
- If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care.
- If all of the following circumstances are satisfied:
 - It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.
 - Another health care practitioner or designee authorized to access CURES is not reasonably available.
 - The quantity of controlled substance does not exceed a non-refillable five-day supply, to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

Note: If a health care practitioner falls under this exemption, he or she must document the reason CURES was not consulted in the patient’s medical record.
- If the CURES database is not operational, as determined by DOJ, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the failure that is reasonably within his or her control.
- If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of the health care practitioner.
- If consultation of the CURES database would, as determined by the health care practitioner, result in a patient’s inability to obtain a prescription in a timely manner and thereby adversely impact the patient’s medical condition, provided that the quantity of the controlled substance does not exceed a non-refillable five-day supply if the controlled substance were used in accordance with the directions for use.

This bill specifies that if a health care practitioner fails to consult the CURES database, he or she shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

This bill specifies that it does not create a private cause of action against a health care practitioner and does not limit a health care practitioner’s liability for the negligent failure to diagnose or treat a patient.

This bill specifies that it is not operative until six months after DOJ certifies that the CURES database is ready for statewide use and that DOJ has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in the Budget Act of 2016. This bill requires DOJ to notify the Secretary of State and the Office of Legislative Counsel of the date of that certification.

This bill specifies that the provisions of the bill are severable and if any provision is held invalid, that invalidity shall not affect other provisions of this bill.

This bill specifies that a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

The Board believes CURES is a very important enforcement tool and an effective aid for physicians to use to prevent “doctor shopping.” Requiring all prescribers to consult the CURES system will allow prescribers to make informed decisions about their patient’s care. This bill also ensures that the CURES system will have the capacity to handle this workload before the bill becomes operative. For these reasons, the Board took a support position on this bill.

FISCAL: Minimal and absorbable fiscal impact

SUPPORT: Consumer Attorneys of California and California Narcotics Officers’ Association (co-sponsors); Acclamation Insurance Management Services; American Insurance Association; Blue Shield of California; California Chamber of Commerce; California Dental Association; California Pharmacists Association; California Teamsters; Center for Public Interest Law; Children’s Advocacy Institute; Consumer Watchdog; Medical Board of California; National Alliance on Mental Illness; Pacific Business Group on Health; Peace Officers Research Association of California; PRIUM; Small Business California and Teamsters

OPPOSITION: Association of Northern California Oncologists
Doctor’s Company
The US Oncology Network

IMPLEMENTATION:

- Newsletter article(s), including a stand-alone article
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General’s Office, Health Quality Enforcement Section
- Update the Board’s website
- Send an email blast to all physicians before the bill becomes effective
- Work with physician associations/organizations to provide information to physicians

Senate Bill No. 482

CHAPTER 708

An act to amend Sections 11165 and 11165.1 of, and to add Section 11165.4 to, the Health and Safety Code, relating to controlled substances.

[Approved by Governor September 27, 2016. Filed with
Secretary of State September 27, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 482, Lara. Controlled substances: CURES database.

Existing law classifies certain controlled substances into designated schedules. Existing law requires the Department of Justice to maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, administer, furnish, or dispense these controlled substances. Existing law requires dispensing pharmacies and clinics to report specified information for each prescription of a Schedule II, Schedule III, or Schedule IV controlled substance to the department.

This bill would require a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance to consult the CURES database to review a patient's controlled substance history no earlier than 24 hours, or the previous business day, before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every 4 months thereafter if the substance remains part of the treatment of the patient. The bill would exempt a veterinarian and a pharmacist from this requirement. The bill would also exempt a health care practitioner from this requirement under specified circumstances, including, among others, if prescribing, ordering, administering, or furnishing a controlled substance to a patient receiving hospice care, to a patient admitted to a specified facility for use while on facility premises, or to a patient as part of a treatment for a surgical procedure in a specified facility if the quantity of the controlled substance does not exceed a nonrefillable 5-day supply of the controlled substance that is to be used in accordance with the directions for use. The bill would require, if a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient pursuant to one of those exemptions, the health care practitioner to consult the CURES database before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every 4 months thereafter if the substance remains part of the treatment of the patient.

This bill would provide that a health care practitioner who fails to consult the CURES database is required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board. The bill would make the above-mentioned provisions operative 6 months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, user support, and education, as specified.

This bill would also exempt a health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, from civil or administrative liability arising from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

Existing law requires the operation of the CURES database to comply with all applicable federal and state privacy and security laws and regulations. Existing law authorizes the disclosure of data obtained from the CURES database to agencies and entities only for specified purposes and requires the Department of Justice to establish policies, procedures, and regulations regarding the use, access, disclosure, and security of the information within the CURES database.

This bill would authorize a health care practitioner to provide a patient with a copy of the patient's CURES patient activity report if no additional CURES data is provided. The bill would also prohibit a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances from obtaining data from the CURES database.

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

SECTION 1. Section 11165 of the Health and Safety Code is amended to read:

11165. (a) To assist health care practitioners in their efforts to ensure appropriate prescribing, ordering, administering, furnishing, and dispensing of controlled substances, law enforcement and regulatory agencies in their efforts to control the diversion and resultant abuse of Schedule II, Schedule III, and Schedule IV controlled substances, and for statistical analysis, education, and research, the Department of Justice shall, contingent upon the availability of adequate funds in the CURES Fund, maintain the Controlled Substance Utilization Review and Evaluation System (CURES) for the electronic monitoring of, and Internet access to information regarding, the prescribing and dispensing of Schedule II, Schedule III, and Schedule IV controlled substances by all practitioners authorized to prescribe, order, administer, furnish, or dispense these controlled substances.

(b) The Department of Justice may seek and use grant funds to pay the costs incurred by the operation and maintenance of CURES. The department

shall annually report to the Legislature and make available to the public the amount and source of funds it receives for support of CURES.

(c) (1) The operation of CURES shall comply with all applicable federal and state privacy and security laws and regulations.

(2) (A) CURES shall operate under existing provisions of law to safeguard the privacy and confidentiality of patients. Data obtained from CURES shall only be provided to appropriate state, local, and federal public agencies for disciplinary, civil, or criminal purposes and to other agencies or entities, as determined by the Department of Justice, for the purpose of educating practitioners and others in lieu of disciplinary, civil, or criminal actions. Data may be provided to public or private entities, as approved by the Department of Justice, for educational, peer review, statistical, or research purposes, provided that patient information, including any information that may identify the patient, is not compromised. Further, data disclosed to any individual or agency as described in this subdivision shall not be disclosed, sold, or transferred to any third party, unless authorized by, or pursuant to, state and federal privacy and security laws and regulations. The Department of Justice shall establish policies, procedures, and regulations regarding the use, access, evaluation, management, implementation, operation, storage, disclosure, and security of the information within CURES, consistent with this subdivision.

(B) Notwithstanding subparagraph (A), a regulatory board whose licensees do not prescribe, order, administer, furnish, or dispense controlled substances shall not be provided data obtained from CURES.

(3) In accordance with federal and state privacy laws and regulations, a health care practitioner may provide a patient with a copy of the patient's CURES patient activity report as long as no additional CURES data is provided and keep a copy of the report in the patient's medical record in compliance with subdivision (d) of Section 11165.1.

(d) For each prescription for a Schedule II, Schedule III, or Schedule IV controlled substance, as defined in the controlled substances schedules in federal law and regulations, specifically Sections 1308.12, 1308.13, and 1308.14, respectively, of Title 21 of the Code of Federal Regulations, the dispensing pharmacy, clinic, or other dispenser shall report the following information to the Department of Justice as soon as reasonably possible, but not more than seven days after the date a controlled substance is dispensed, in a format specified by the Department of Justice:

(1) Full name, address, and, if available, telephone number of the ultimate user or research subject, or contact information as determined by the Secretary of the United States Department of Health and Human Services, and the gender, and date of birth of the ultimate user.

(2) The prescriber's category of licensure, license number, national provider identifier (NPI) number, if applicable, the federal controlled substance registration number, and the state medical license number of any prescriber using the federal controlled substance registration number of a government-exempt facility.

(3) Pharmacy prescription number, license number, NPI number, and federal controlled substance registration number.

(4) National Drug Code (NDC) number of the controlled substance dispensed.

(5) Quantity of the controlled substance dispensed.

(6) International Statistical Classification of Diseases, 9th revision (ICD-9) or 10th revision (ICD-10) Code, if available.

(7) Number of refills ordered.

(8) Whether the drug was dispensed as a refill of a prescription or as a first-time request.

(9) Date of origin of the prescription.

(10) Date of dispensing of the prescription.

(e) The Department of Justice may invite stakeholders to assist, advise, and make recommendations on the establishment of rules and regulations necessary to ensure the proper administration and enforcement of the CURES database. All prescriber and dispenser invitees shall be licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, in active practice in California, and a regular user of CURES.

(f) The Department of Justice shall, prior to upgrading CURES, consult with prescribers licensed by one of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, one or more of the boards or committees identified in subdivision (d) of Section 208 of the Business and Professions Code, and any other stakeholder identified by the department, for the purpose of identifying desirable capabilities and upgrades to the CURES Prescription Drug Monitoring Program (PDMP).

(g) The Department of Justice may establish a process to educate authorized subscribers of the CURES PDMP on how to access and use the CURES PDMP.

SEC. 2. Section 11165.1 of the Health and Safety Code is amended to read:

11165.1. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 shall, before July 1, 2016, or upon receipt of a federal Drug Enforcement Administration (DEA) registration, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that practitioner the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES Prescription Drug Monitoring Program (PDMP).

(ii) A pharmacist shall, before July 1, 2016, or upon licensure, whichever occurs later, submit an application developed by the Department of Justice to obtain approval to access information online regarding the controlled

substance history of a patient that is stored on the Internet and maintained within the Department of Justice, and, upon approval, the department shall release to that pharmacist the electronic history of controlled substances dispensed to an individual under his or her care based on data contained in the CURES PDMP.

(B) An application may be denied, or a subscriber may be suspended, for reasons which include, but are not limited to, the following:

- (i) Materially falsifying an application for a subscriber.
- (ii) Failure to maintain effective controls for access to the patient activity report.
- (iii) Suspended or revoked federal DEA registration.
- (iv) Any subscriber who is arrested for a violation of law governing controlled substances or any other law for which the possession or use of a controlled substance is an element of the crime.
- (v) Any subscriber accessing information for any other reason than caring for his or her patients.

(C) Any authorized subscriber shall notify the Department of Justice within 30 days of any changes to the subscriber account.

(2) A health care practitioner authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances pursuant to Section 11150 or a pharmacist shall be deemed to have complied with paragraph (1) if the licensed health care practitioner or pharmacist has been approved to access the CURES database through the process developed pursuant to subdivision (a) of Section 209 of the Business and Professions Code.

(b) Any request for, or release of, a controlled substance history pursuant to this section shall be made in accordance with guidelines developed by the Department of Justice.

(c) In order to prevent the inappropriate, improper, or illegal use of Schedule II, Schedule III, or Schedule IV controlled substances, the Department of Justice may initiate the referral of the history of controlled substances dispensed to an individual based on data contained in CURES to licensed health care practitioners, pharmacists, or both, providing care or services to the individual.

(d) The history of controlled substances dispensed to an individual based on data contained in CURES that is received by a practitioner or pharmacist from the Department of Justice pursuant to this section is medical information subject to the provisions of the Confidentiality of Medical Information Act contained in Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code.

(e) Information concerning a patient's controlled substance history provided to a prescriber or pharmacist pursuant to this section shall include prescriptions for controlled substances listed in Sections 1308.12, 1308.13, and 1308.14 of Title 21 of the Code of Federal Regulations.

(f) A health care practitioner, pharmacist, and any person acting on behalf of a health care practitioner or pharmacist, when acting with reasonable care and in good faith, is not subject to civil or administrative liability arising

from any false, incomplete, inaccurate, or misattributed information submitted to, reported by, or relied upon in the CURES database or for any resulting failure of the CURES database to accurately or timely report that information.

SEC. 3. Section 11165.4 is added to the Health and Safety Code, to read:

11165.4. (a) (1) (A) (i) A health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance shall consult the CURES database to review a patient's controlled substance history before prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient for the first time and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(ii) If a health care practitioner authorized to prescribe, order, administer, or furnish a controlled substance is not required, pursuant to an exemption described in subdivision (c), to consult the CURES database the first time he or she prescribes, orders, administers, or furnishes a controlled substance to a patient, he or she shall consult the CURES database to review the patient's controlled substance history before subsequently prescribing a Schedule II, Schedule III, or Schedule IV controlled substance to the patient and at least once every four months thereafter if the substance remains part of the treatment of the patient.

(B) For purposes of this paragraph, "first time" means the initial occurrence in which a health care practitioner, in his or her role as a health care practitioner, intends to prescribe, order, administer, or furnish a Schedule II, Schedule III, or Schedule IV controlled substance to a patient and has not previously prescribed a controlled substance to the patient.

(2) A health care practitioner shall obtain a patient's controlled substance history from the CURES database no earlier than 24 hours, or the previous business day, before he or she prescribes, orders, administers, or furnishes a Schedule II, Schedule III, or Schedule IV controlled substance to the patient.

(b) The duty to consult the CURES database, as described in subdivision (a), does not apply to veterinarians or pharmacists.

(c) The duty to consult the CURES database, as described in subdivision (a), does not apply to a health care practitioner in any of the following circumstances:

(1) If a health care practitioner prescribes, orders, or furnishes a controlled substance to be administered to a patient while the patient is admitted to any of the following facilities or during an emergency transfer between any of the following facilities for use while on facility premises:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(2) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance in the emergency department of a general acute care hospital and the quantity of the controlled substance does not exceed a nonrefillable seven-day supply of the controlled substance to be used in accordance with the directions for use.

(3) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient as part of the patient's treatment for a surgical procedure and the quantity of the controlled substance does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use, in any of the following facilities:

(A) A licensed clinic, as described in Chapter 1 (commencing with Section 1200) of Division 2.

(B) An outpatient setting, as described in Chapter 1.3 (commencing with Section 1248) of Division 2.

(C) A health facility, as described in Chapter 2 (commencing with Section 1250) of Division 2.

(D) A county medical facility, as described in Chapter 2.5 (commencing with Section 1440) of Division 2.

(E) A place of practice, as defined in Section 1658 of the Business and Professions Code.

(4) If a health care practitioner prescribes, orders, administers, or furnishes a controlled substance to a patient currently receiving hospice care, as defined in Section 1339.40.

(5) (A) If all of the following circumstances are satisfied:

(i) It is not reasonably possible for a health care practitioner to access the information in the CURES database in a timely manner.

(ii) Another health care practitioner or designee authorized to access the CURES database is not reasonably available.

(iii) The quantity of controlled substance prescribed, ordered, administered, or furnished does not exceed a nonrefillable five-day supply of the controlled substance to be used in accordance with the directions for use and no refill of the controlled substance is allowed.

(B) A health care practitioner who does not consult the CURES database under subparagraph (A) shall document the reason he or she did not consult the database in the patient's medical record.

(6) If the CURES database is not operational, as determined by the department, or when it cannot be accessed by a health care practitioner because of a temporary technological or electrical failure. A health care practitioner shall, without undue delay, seek to correct any cause of the temporary technological or electrical failure that is reasonably within his or her control.

(7) If the CURES database cannot be accessed because of technological limitations that are not reasonably within the control of a health care practitioner.

(8) If consultation of the CURES database would, as determined by the health care practitioner, result in a patient's inability to obtain a prescription

in a timely manner and thereby adversely impact the patient's medical condition, provided that the quantity of the controlled substance does not exceed a nonrefillable five-day supply if the controlled substance were used in accordance with the directions for use.

(d) (1) A health care practitioner who fails to consult the CURES database, as described in subdivision (a), shall be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

(2) This section does not create a private cause of action against a health care practitioner. This section does not limit a health care practitioner's liability for the negligent failure to diagnose or treat a patient.

(e) This section is not operative until six months after the Department of Justice certifies that the CURES database is ready for statewide use and that the department has adequate staff, which, at a minimum, shall be consistent with the appropriation authorized in Schedule (6) of Item 0820-001-0001 of the Budget Act of 2016 (Chapter 23 of the Statutes of 2016), user support, and education. The department shall notify the Secretary of State and the office of the Legislative Counsel of the date of that certification.

(f) All applicable state and federal privacy laws govern the duties required by this section.

(g) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1160
Author: Mendoza
Chapter: 868
Bill Date: August 29, 2016, Amended
Subject: Workers' Compensation
Sponsor: California Professional Firefighters (Co-sponsor)
 California Labor Federation, AFL-CIO (Co-sponsor)
Position: Supported provisions contained in SB 563 (Pan)

DESCRIPTION OF CURRENT LEGISLATION:

The provisions contained in SB 563 (Pan), which the Medical Board of California (Board) supported, were amended into this bill. This bill makes a series of significant, wide-ranging changes to the Division of Workers' Compensation's (DWC) operation and utilization review (UR) processes, approval of UR processes, fraud prevention, and lien filing and collection. The provisions that were previously included in SB 563 and that impact the Board ensure that physicians involved in authorizing injured worker medical care on behalf of the employer and/or payor are not being inappropriately incentivized to modify, delay, or deny requests for medically necessary services. This bill includes many other provisions.

BACKGROUND

In California's workers' compensation system, an employer or insurer cannot deny treatment. When an employer or insurer receives a request for medical treatment, the employer or insurer can either approve the treatment or, if the employer or insurer believes that a physician's request for treatment is medically unnecessary or harmful, the employer or insurer must send the request to UR. UR is the process used by employers or claims administrators to review medical treatment requested for the injured worker, to determine if the proposed treatment is medically necessary. UR is used to decide whether or not to approve medical treatment recommended by a treating physician. In California, the Department of Industrial Relations, Division of Workers' Compensation, does not require physicians performing UR to be licensed in California.

In April 2013, the Board reaffirmed that engaging in UR is the practice of medicine and stated that the Board will not automatically deem UR complaints as non-jurisdictional. In addition, the Board stated it will review UR complaints against California-licensed physicians to determine if a quality of care issue is present, and if so, the complaint will follow the normal complaint review process.

ANALYSIS

This bill makes a series of significant, wide-ranging changes to the DWC's operation and utilization review (UR) processes, approval of UR processes, fraud prevention, and lien filing and collection. This bill prohibits an employer, or any entity conducting UR on behalf of an employer, from providing any financial incentive or consideration to a physician based on the number of modifications, delays, or denials made by the physician. This bill gives the DWC administrative director (AD) the authority to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting UR on behalf of the employer, and the UR physician. This bill prohibits an insurer or third-party administrator from referring a claim for review to a UR organization in which it has a financial interest, unless that interest is disclosed to the employer. This bill provides that any information obtained by the AD relating to these contracts is not subject to disclosure pursuant to the Public Records Act. This bill includes many other provisions that impact the DWC, but not the Board.

UR has increasingly become an area of concern from a variety of stakeholders. Both injured workers and medical providers report delays and denials of medical care due to the UR process. This bill seeks to address the reported challenges with UR and will ensure that UR decisions are based on the best available medical science. There is currently no explicit prohibition in law related to UR to ensure that a physician's judgment for medical necessity is not compromised by financial incentives. This bill will promote the Board's mission of consumer protection and the Board took a support position on the provisions in this bill that were previously included in SB 563 (Pan).

FISCAL: None to the Board

SUPPORT: California Professional Firefighters (Sponsor); California Labor Federation, AFL-CIO (Sponsor); Acclamation Insurance Management Services; California Alliance of Self-Insured Groups; California Medical Association; California Occupational Medicine Physicians; Communication Workers of America, District 9; Orange County Professional Firefighters Association, Local 3631; Risk Insurance Management Society; Small Business California; U.S. HealthWorks Medical Group; UPS; and Western Occupational and Environmental Association

OPPOSITION: California Neurology Society; California Society of Industrial Medicine and Surgery; California Society of Physical Medicine and Rehabilitation; California Workers' Compensation Interpreters Association; California Workers' Compensation Services Association; and Voters Injured at WORK

IMPLEMENTATION:

- Newsletter article(s) and stand-alone article
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section

Senate Bill No. 1160

CHAPTER 868

An act to amend Sections 138.4, 138.6, 4610.5, 4610.6, 4903.05, 4903.8, 5307.27, 5710, 5811, and 6409 of, to amend, repeal, and add Section 4610 of, and to add Section 4615 to, the Labor Code, relating to workers' compensation.

[Approved by Governor September 30, 2016. Filed with
Secretary of State September 30, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1160, Mendoza. Workers' compensation.

Existing law establishes a workers' compensation system, administered by the Administrative Director of the Division of Workers' Compensation, to compensate an employee for injuries sustained in the course of his or her employment.

Existing law requires the administrative director to develop and make available informational material written in plain language that describes the overall workers' compensation claims process, as specified.

This bill would require the administrative director to adopt regulations to provide employees with notice regarding access to medical treatment following the denial of a claim under the workers' compensation system.

Existing law requires the Administrative Director of the Division of Workers' Compensation of the Department of Industrial Relations to develop a workers' compensation information system in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, with certain data to be collected electronically and to be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. Existing law requires the administrative director to assess an administrative penalty of not more than \$5,000 in a single year against a claims administrator for a violation of those data reporting requirements.

This bill would increase that penalty assessment to not more than \$10,000. The bill would require the administrative director to post on the Division of Workers' Compensation Internet Web site a list of claims administrators who are in violation of the data reporting requirements.

Existing law requires every employer to establish a utilization review process, and defines "utilization review" as utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, prior to, retrospectively, or concurrent with providing medical treatment services. Existing law also provides for an independent medical

review process to resolve disputes over utilization review decisions, as defined.

This bill would revise and recast provisions relating to utilization review, as specified, with regard to injuries occurring on or after January 1, 2018. Among other things, the bill would set forth the medical treatment services that would be subject to prospective utilization review under these provisions, as provided. The bill would authorize retrospective utilization review for treatment provided under these provisions under limited circumstances, as specified. The bill would establish procedures for prospective and retrospective utilization reviews and set forth provisions for removal of a physician or provider under designated circumstances. On and after January 1, 2018, the bill would establish new procedures for reviewing determinations regarding the medical necessity of medication prescribed pursuant to the drug formulary adopted by the administrative director, as provided. The bill would make conforming changes to related provisions to implement these changes.

The bill would, commencing July 1, 2018, require each utilization review process to be accredited by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The bill would require the administrative director to adopt rules to implement the selection of an independent, nonprofit organization for accreditation purposes, as specified. The bill would authorize the administrative director to adopt rules to require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation and provide for certain exemptions. The bill would require the administrative director to develop a system for electronic reporting of documents related to utilization review performed by each employer, to be administered by the division. The bill would require the administrative director, on or after March 1, 2019, to contract with an outside independent research organization to evaluate and report on the impact of provision of medical treatment within the first 30 days after a claim is filed, for claims filed on or after January 1, 2017, to January 1, 2019. The bill would require the report to be completed before January 1, 2020, and to be distributed to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance.

Existing law requires every lien claimant to file its lien with the appeals board in writing upon a form approved by the appeals board. Existing law requires a lien to be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement, as specified.

This bill would require certain lien claimants that file a lien under these provisions to do so by filing a declaration, under penalty of perjury, that includes specified information. The bill would require current lien claimants to also file the declaration by a specified date. The bill would make a failure

to file a declaration under these provisions grounds for dismissal of a lien. Because the bill would expand the crime of perjury, the bill would impose a state-mandated local program.

The bill would also automatically stay any physician or provider lien upon the filing of criminal charges against that person or entity for specified offenses involving medical fraud, as provided. The bill would authorize the administrative director to adopt regulations to implement that provision. The bill would state findings and declarations of the Legislature in connection with these provisions.

Existing law prohibits the assignment of a lien under these provisions, except under limited circumstances, as specified.

This bill would, for liens filed after January 1, 2017, invalidate any assignment of a lien made in violation of these provisions, by operation of law.

Existing law requires the administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, to adopt, after public hearings, a medical treatment utilization schedule to incorporate evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission, as specified.

This bill would authorize the administrative director to make updates to the utilization schedule by order, which would not be subject to the Administrative Procedure Act, as specified. The bill would require any order adopted pursuant to these provisions to be published on the Internet Web site of the division.

Existing law requires a deponent to receive certain expenses and reimbursements if an employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee. Existing law authorizes the deponent to receive a reasonable allowance for attorney's fees, if represented by an attorney licensed in this state.

This bill would authorize the administrative director to determine the range of reasonable fees to be paid to a deponent.

Existing law provides that it is the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter. Existing law sets forth the qualifications of a qualified interpreter for these purposes, and provides for the settings under which a qualified interpreter may render services.

This bill would require the administrative director to promulgate regulations establishing criteria to verify the identity and credentials of individuals that provide interpreter services under these provisions.

Existing law requires physicians, as defined, who attend to injured or ill employees to file reports with specific information prescribed by law.

This bill would revise those reporting requirements, as prescribed.

This bill would incorporate changes to Section 4610 of the Labor Code proposed by AB 2503, to be operative as specified if both bills are enacted.

Existing constitutional provisions require that a statute that limits the right of access to the meetings of public bodies or the writings of public

officials and agencies be adopted with findings demonstrating the interest protected by the limitation and the need for protecting that interest.

This bill would make legislative findings to that effect.

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

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

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

SECTION 1. Section 138.4 of the Labor Code is amended to read:

138.4. (a) For the purpose of this section, "claims administrator" means a self-administered workers' compensation insurer; or a self-administered self-insured employer; or a self-administered legally uninsured employer; or a self-administered joint powers authority; or a third-party claims administrator for an insurer, a self-insured employer, a legally uninsured employer, or a joint powers authority.

(b) With respect to injuries resulting in lost time beyond the employee's work shift at the time of injury or medical treatment beyond first aid:

(1) If the claims administrator obtains knowledge that the employer has not provided a claim form or a notice of potential eligibility for benefits to the employee, it shall provide the form and notice to the employee within three working days of its knowledge that the form or notice was not provided.

(2) If the claims administrator cannot determine if the employer has provided a claim form and notice of potential eligibility for benefits to the employee, the claims administrator shall provide the form and notice to the employee within 30 days of the administrator's date of knowledge of the claim.

(c) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall prescribe reasonable rules and regulations, including notice of the right to consult with an attorney, where appropriate, for serving on the employee (or employee's dependents, in the case of death), the following:

(1) Notices dealing with the payment, nonpayment, or delay in payment of temporary disability, permanent disability, supplemental job displacement, and death benefits.

(2) Notices of any change in the amount or type of benefits being provided, the termination of benefits, the rejection of any liability for compensation, and an accounting of benefits paid.

(3) Notices of rights to select the primary treating physician, written continuity of care policies, requests for a comprehensive medical evaluation, and offers of regular, modified, or alternative work.

(d) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall develop, make fully accessible on the department's Internet Web site, and make available at

district offices informational material written in plain language that describes the overall workers' compensation claims process, including the rights and obligations of employees and employers at every stage of a claim when a notice is required.

(e) Each notice prescribed by the administrative director shall be written in plain language, shall reference the informational material described in subdivision (d) to enable employees to understand the context of the notices, and shall clearly state the Internet Web site address and contact information that an employee may use to access the informational material.

(f) On or before January 1, 2018, the administrative director shall adopt regulations to provide employees with notice that they may access medical treatment outside of the workers' compensation system following the denial of their claim.

SEC. 2. Section 138.6 of the Labor Code is amended to read:

138.6. (a) The administrative director, in consultation with the Insurance Commissioner and the Workers' Compensation Insurance Rating Bureau, shall develop a cost-efficient workers' compensation information system, which shall be administered by the division. The administrative director shall adopt regulations specifying the data elements to be collected by electronic data interchange.

(b) The information system shall do the following:

(1) Assist the department to manage the workers' compensation system in an effective and efficient manner.

(2) Facilitate the evaluation of the efficiency and effectiveness of the delivery system.

(3) Assist in measuring how adequately the system indemnifies injured workers and their dependents.

(4) Provide statistical data for research into specific aspects of the workers' compensation program.

(c) The data collected electronically shall be compatible with the Electronic Data Interchange System of the International Association of Industrial Accident Boards and Commissions. The administrative director may adopt regulations authorizing the use of other nationally recognized data transmission formats in addition to those set forth in the Electronic Data Interchange System for the transmission of data required pursuant to this section. The administrative director shall accept data transmissions in any authorized format. If the administrative director determines that any authorized data transmission format is not in general use by claims administrators, conflicts with the requirements of state or federal law, or is obsolete, the administrative director may adopt regulations eliminating that data transmission format from those authorized pursuant to this subdivision.

(d) (1) The administrative director shall assess an administrative penalty against a claims administrator for a violation of data reporting requirements adopted pursuant to this section. The administrative director shall promulgate a schedule of penalties providing for an assessment of no more than ten thousand dollars (\$10,000) against a claims administrator in any single year, calculated as follows:

(A) No more than one hundred dollars (\$100) multiplied by the number of violations in that year that resulted in a required data report not being submitted or not being accepted.

(B) No more than fifty dollars (\$50) multiplied by the number of violations in that year that resulted in a required report being late or accepted with an error.

(C) Multiple errors in a single report shall be counted as a single violation.

(D) No penalty shall be assessed pursuant to Section 129.5 for any violation of data reporting requirements for which a penalty has been or may be assessed pursuant to this section.

(2) The schedule promulgated by the administrative director pursuant to paragraph (1) shall establish threshold rates of violations that shall be excluded from the calculation of the assessment, as follows:

(A) The threshold rate for reports that are not submitted or are submitted but not accepted shall not be less than 3 percent of the number of reports that are required to be filed by or on behalf of the claims administrator.

(B) The threshold rate for reports that are accepted with an error shall not be less than 3 percent of the number of reports that are accepted with an error.

(C) The administrative director shall set higher threshold rates as appropriate in recognition of the fact that the data necessary for timely and accurate reporting may not be always available to a claims administrator or the claims administrator's agents.

(D) The administrative director may establish higher thresholds for particular data elements that commonly are not reasonably available.

(3) The administrative director may estimate the number of required data reports that are not submitted by comparing a statistically valid sample of data available to the administrative director from other sources with the data reported pursuant to this section.

(4) All penalties assessed pursuant to this section shall be deposited in the Workers' Compensation Administration Revolving Fund.

(5) The administrative director shall publish an annual report disclosing the compliance rates of claims administrators and post the report and a list of claims administrators who are in violation of the data reporting requirements on the Internet Web site of the Division of Workers' Compensation.

SEC. 3. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

- (1) Developed with involvement from actively practicing physicians.
- (2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.
- (3) Evaluated at least annually, and updated if necessary.
- (4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
- (5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of

medical treatment services to employees all of the following requirements shall be met:

(1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between

the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and

the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Every employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

(j) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 3.5. Section 4610 of the Labor Code is amended to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) Each employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(c) Each utilization review process shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27. These policies and procedures, and a description of the utilization process, shall be filed with the administrative director and shall be disclosed by the employer to employees, physicians, and the public upon request.

(d) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination. The employer,

insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services, complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(e) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve.

(f) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

- (1) Developed with involvement from actively practicing physicians.
- (2) Consistent with the schedule for medical treatment utilization adopted pursuant to Section 5307.27.
- (3) Evaluated at least annually, and updated if necessary.
- (4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.
- (5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

(g) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees all of the following requirements shall be met:

- (1) Prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of the information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(2) If the employee's condition is one in which the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(3) (A) Decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision. Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated to physicians initially by telephone or facsimile, and to the physician and employee in writing within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is not approved in full, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(B) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

(4) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines

used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify the reason for the decision and specify the information that is needed.

(5) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1) or (2) because the employer or other entity is not in receipt of all of the information reasonably necessary and requested, because the employer requires consultation by an expert reviewer, or because the employer has asked that an additional examination or test be performed upon the employee that is reasonable and consistent with good medical practice, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information requested but not received, the expert reviewer to be consulted, or the additional examinations or tests required. The employer shall also notify the physician and employee of the anticipated date on which a decision may be rendered. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2).

(6) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(7) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(8) If utilization review is deferred pursuant to paragraph (7), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (1) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(h) Each employer, insurer, or other entity subject to this section shall maintain telephone access for physicians to request authorization for health care services.

(i) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for

the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

(j) This section shall remain in effect only until January 1, 2018, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2018, deletes or extends that date.

SEC. 4. Section 4610 is added to the Labor Code, to read:

4610. (a) For purposes of this section, "utilization review" means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee's initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

- (4) Home health care services.
 - (5) Imaging and radiology services, excluding X-rays.
 - (6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.
 - (7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.
 - (8) Any other service designated and defined through rules adopted by the administrative director.
- (d) Any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 30 days of the date the service was provided.
- (e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.
- (f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.
- (1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the pre-designated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.
- (2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.
- (g) Every employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.
- (1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment

utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2) The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or Section 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(3) (A) No person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, and where these services are within the scope of the physician's practice, requested by the physician may modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B) (i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrator's financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical

material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

(h) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. No charge shall be required for an employee whose physician's request for medical treatment services is under review.

(i) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of medical treatment services to employees, all of the following requirements shall be met:

(1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the request for authorization for medical treatment. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

(2) In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of receipt of information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(3) When the employee's condition is such that the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(4) (A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate for the medical needs of the employee. Medical care provided during a

concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. Any compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in such a way as to minimize reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. No fees shall be levied upon insurers or self-insured employers making reports required by this section.

(5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j) (1) If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, the employer shall request only the information reasonably necessary to make the determination.

(2) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify, or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to any further

recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(l) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(m) If utilization review is deferred pursuant to subdivision (l), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(n) Every employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers' Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(p) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate

Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

(r) This section shall become operative on January 1, 2018.

SEC. 4.5. Section 4610 is added to the Labor Code, to read:

4610. (a) For purposes of this section, “utilization review” means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, or deny, based in whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians, as defined in Section 3209.3, prior to, retrospectively, or concurrent with the provision of medical treatment services pursuant to Section 4600.

(b) For all dates of injury occurring on or after January 1, 2018, emergency treatment services and medical treatment rendered for a body part or condition that is accepted as compensable by the employer and is addressed by the medical treatment utilization schedule adopted pursuant to Section 5307.7, by a member of the medical provider network or health care organization, or by a physician predesignated pursuant to subdivision (d) of Section 4600, within the 30 days following the initial date of injury, shall be authorized without prospective utilization review, except as provided in subdivision (c). The services rendered under this subdivision shall be consistent with the medical treatment utilization schedule. In the event that the employee is not subject to treatment with a medical provider network, health care organization, or predesignated physician pursuant to subdivision (d) of Section 4600, the employee shall be eligible for treatment under this section within 30 days following the initial date of injury if the treatment is rendered by a physician or facility selected by the employer. For treatment rendered by a medical provider network physician, health care organization physician, a physician predesignated pursuant to subdivision (d) of Section 4600, or an employer-selected physician, the report required under Section 6409 and a complete request for authorization shall be submitted by the physician within five days following the employee’s initial visit and evaluation.

(c) Unless authorized by the employer or rendered as emergency medical treatment, the following medical treatment services, as defined in rules adopted by the administrative director, that are rendered through a member of the medical provider network or health care organization, a predesignated physician, an employer-selected physician, or an employer-selected facility, within the 30 days following the initial date of injury, shall be subject to prospective utilization review under this section:

(1) Pharmaceuticals, to the extent they are neither expressly exempted from prospective review nor authorized by the drug formulary adopted pursuant to Section 5307.27.

(2) Nonemergency inpatient and outpatient surgery, including all presurgical and postsurgical services.

(3) Psychological treatment services.

(4) Home health care services.

(5) Imaging and radiology services, excluding X-rays.

(6) All durable medical equipment, whose combined total value exceeds two hundred fifty dollars (\$250), as determined by the official medical fee schedule.

(7) Electrodiagnostic medicine, including, but not limited to, electromyography and nerve conduction studies.

(8) Any other service designated and defined through rules adopted by the administrative director.

(d) Any request for payment for treatment provided under subdivision (b) shall comply with Section 4603.2 and be submitted to the employer, or its insurer or claims administrator, within 30 days of the date the service was provided.

(e) If a physician fails to submit the report required under Section 6409 and a complete request for authorization, as described in subdivision (b), an employer may remove the physician's ability under this subdivision to provide further medical treatment to the employee that is exempt from prospective utilization review.

(f) An employer may perform retrospective utilization review for any treatment provided pursuant to subdivision (b) solely for the purpose of determining if the physician is prescribing treatment consistent with the schedule for medical treatment utilization, including, but not limited to, the drug formulary adopted pursuant to Section 5307.27.

(1) If it is found after retrospective utilization reviews that there is a pattern and practice of the physician or provider failing to render treatment consistent with the schedule for medical treatment utilization, including the drug formulary, the employer may remove the ability of the predesignated physician, employer-selected physician, or the member of the medical provider network or health care organization under this subdivision to provide further medical treatment to any employee that is exempt from prospective utilization review. The employer shall notify the physician or provider of the results of the retrospective utilization review and the requirement for prospective utilization review for all subsequent medical treatment.

(2) The results of retrospective utilization review may constitute a showing of good cause for an employer's petition requesting a change of physician or provider pursuant to Section 4603 and may serve as grounds for termination of the physician or provider from the medical provider network or health care organization.

(g) Each employer shall establish a utilization review process in compliance with this section, either directly or through its insurer or an entity with which an employer or insurer contracts for these services.

(1) Each utilization review process that modifies or denies requests for authorization of medical treatment shall be governed by written policies and procedures. These policies and procedures shall ensure that decisions based on the medical necessity to cure and relieve of proposed medical treatment services are consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(2) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. The employer, insurer, or other entity shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 or 2450 of the Business and Professions Code. The medical director shall ensure that the process by which the employer or other entity reviews and approves, modifies, or denies requests by physicians prior to, retrospectively, or concurrent with the provision of medical treatment services complies with the requirements of this section. Nothing in this section shall be construed as restricting the existing authority of the Medical Board of California.

(3) (A) A person other than a licensed physician who is competent to evaluate the specific clinical issues involved in the medical treatment services, if these services are within the scope of the physician's practice, requested by the physician, shall not modify or deny requests for authorization of medical treatment for reasons of medical necessity to cure and relieve or due to incomplete or insufficient information under subdivisions (i) and (j).

(B) (i) The employer, or any entity conducting utilization review on behalf of the employer, shall neither offer nor provide any financial incentive or consideration to a physician based on the number of modifications or denials made by the physician under this section.

(ii) An insurer or third-party administrator shall not refer utilization review services conducted on behalf of an employer under this section to an entity in which the insurer or third-party administrator has a financial interest as defined under Section 139.32. This prohibition does not apply if the insurer or third-party administrator provides the employer and the administrative director with prior written disclosure of both of the following:

(I) The entity conducting the utilization review services.

(II) The insurer or third-party administrator's financial interest in the entity.

(C) The administrative director has authority pursuant to this section to review any compensation agreement, payment schedule, or contract between the employer, or any entity conducting utilization review on behalf of the employer, and the utilization review physician. Any information disclosed to the administrative director pursuant to this paragraph shall be considered confidential information and not subject to disclosure pursuant to the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code). Disclosure of the information to the administrative director pursuant to this subdivision shall not waive the provisions of the Evidence Code relating to privilege.

(4) A utilization review process that modifies or denies requests for authorization of medical treatment shall be accredited on or before July 1, 2018, and shall retain active accreditation while providing utilization review

services, by an independent, nonprofit organization to certify that the utilization review process meets specified criteria, including, but not limited to, timeliness in issuing a utilization review decision, the scope of medical material used in issuing a utilization review decision, peer-to-peer consultation, internal appeal procedure, and requiring a policy preventing financial incentives to doctors and other providers based on the utilization review decision. The administrative director shall adopt rules to implement the selection of an independent, nonprofit organization for those accreditation purposes. Until those rules are adopted, the administrative director shall designate URAC as the accrediting organization. The administrative director may adopt rules to do any of the following:

(A) Require additional specific criteria for measuring the quality of a utilization review process for purposes of accreditation.

(B) Exempt nonprofit, public sector internal utilization review programs from the accreditation requirement pursuant to this section, if the administrative director has adopted minimum standards applicable to nonprofit, public sector internal utilization review programs that meet or exceed the accreditation standards developed pursuant to this section.

(5) On or before July 1, 2018, each employer, either directly or through its insurer or an entity with which an employer or insurer contracts for utilization review services, shall submit a description of the utilization review process that modifies or denies requests for authorization of medical treatment and the written policies and procedures to the administrative director for approval. Approved utilization review process descriptions and the accompanying written policies and procedures shall be disclosed by the employer to employees and physicians and made available to the public by posting on the employer's, claims administrator's, or utilization review organization's Internet Web site.

(h) The criteria or guidelines used in the utilization review process to determine whether to approve, modify, or deny medical treatment services shall be all of the following:

(1) Developed with involvement from actively practicing physicians.

(2) Consistent with the schedule for medical treatment utilization, including the drug formulary, adopted pursuant to Section 5307.27.

(3) Evaluated at least annually, and updated if necessary.

(4) Disclosed to the physician and the employee, if used as the basis of a decision to modify or deny services in a specified case under review.

(5) Available to the public upon request. An employer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An employer may charge members of the public reasonable copying and postage expenses related to disclosing criteria or guidelines pursuant to this paragraph. Criteria or guidelines may also be made available through electronic means. A charge shall not be required for an employee whose physician's request for medical treatment services is under review.

(i) In determining whether to approve, modify, or deny requests by physicians prior to, retrospectively, or concurrent with the provisions of

medical treatment services to employees, all of the following requirements shall be met:

(1) Except for treatment requests made pursuant to the formulary, prospective or concurrent decisions shall be made in a timely fashion that is appropriate for the nature of the employee's condition, not to exceed five working days from the receipt of a request for authorization for medical treatment and supporting information reasonably necessary to make the determination, but in no event more than 14 days from the date of the medical treatment recommendation by the physician. Prospective decisions regarding requests for treatment covered by the formulary shall be made no more than five working days from the date of receipt of the medical treatment request. The request for authorization and supporting documentation may be submitted electronically under rules adopted by the administrative director.

(2) In cases where the review is retrospective, a decision resulting in denial of all or part of the medical treatment service shall be communicated to the individual who received services, or to the individual's designee, within 30 days of the receipt of the information that is reasonably necessary to make this determination. If payment for a medical treatment service is made within the time prescribed by Section 4603.2, a retrospective decision to approve the service need not otherwise be communicated.

(3) If the employee's condition is one in which the employee faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the employee's life or health or could jeopardize the employee's ability to regain maximum function, decisions to approve, modify, or deny requests by physicians prior to, or concurrent with, the provision of medical treatment services to employees shall be made in a timely fashion that is appropriate for the nature of the employee's condition, but not to exceed 72 hours after the receipt of the information reasonably necessary to make the determination.

(4) (A) Final decisions to approve, modify, or deny requests by physicians for authorization prior to, or concurrent with, the provision of medical treatment services to employees shall be communicated to the requesting physician within 24 hours of the decision by telephone, facsimile, or, if agreed to by the parties, secure email.

(B) Decisions resulting in modification or denial of all or part of the requested health care service shall be communicated in writing to the employee, and to the physician if the initial communication under subparagraph (A) was by telephone, within 24 hours for concurrent review, or within two business days of the decision for prospective review, as prescribed by the administrative director. If the request is modified or denied, disputes shall be resolved in accordance with Section 4610.5, if applicable, or otherwise in accordance with Section 4062.

(C) In the case of concurrent review, medical care shall not be discontinued until the employee's physician has been notified of the decision and a care plan has been agreed upon by the physician that is appropriate

for the medical needs of the employee. Medical care provided during a concurrent review shall be care that is medically necessary to cure and relieve, and an insurer or self-insured employer shall only be liable for those services determined medically necessary to cure and relieve. If the insurer or self-insured employer disputes whether or not one or more services offered concurrently with a utilization review were medically necessary to cure and relieve, the dispute shall be resolved pursuant to Section 4610.5, if applicable, or otherwise pursuant to Section 4062. A compromise between the parties that an insurer or self-insured employer believes may result in payment for services that were not medically necessary to cure and relieve shall be reported by the insurer or the self-insured employer to the licensing board of the provider or providers who received the payments, in a manner set forth by the respective board and in a way that minimizes reporting costs both to the board and to the insurer or self-insured employer, for evaluation as to possible violations of the statutes governing appropriate professional practices. Fees shall not be levied upon insurers or self-insured employers making reports required by this section.

(5) Communications regarding decisions to approve requests by physicians shall specify the specific medical treatment service approved. Responses regarding decisions to modify or deny medical treatment services requested by physicians shall include a clear and concise explanation of the reasons for the employer's decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. If a utilization review decision to deny a medical service is due to incomplete or insufficient information, the decision shall specify all of the following:

(A) The reason for the decision.

(B) A specific description of the information that is needed.

(C) The date(s) and time(s) of attempts made to contact the physician to obtain the necessary information.

(D) A description of the manner in which the request was communicated.

(j) (1) Unless otherwise indicated in this section, a physician providing treatment under Section 4600 shall send any request for authorization for medical treatment, with supporting documentation, to the claims administrator for the employer, insurer, or other entity according to rules adopted by the administrative director. If an employer, insurer, or other entity subject to this section requests medical information from a physician in order to determine whether to approve, modify, or deny requests for authorization, that employer, insurer, or other entity shall request only the information reasonably necessary to make the determination.

(2) If the employer, insurer, or other entity cannot make a decision within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i) because the employer or other entity is not in receipt of, or in possession of, all of the information reasonably necessary to make a determination, the employer shall immediately notify the physician and the employee, in writing, that the employer cannot make a decision within the required timeframe, and specify the information that must be provided by the physician for a determination to be made. Upon receipt of all information

reasonably necessary and requested by the employer, the employer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1), (2), or (3) of subdivision (i).

(k) A utilization review decision to modify or deny a treatment recommendation shall remain effective for 12 months from the date of the decision without further action by the employer with regard to a further recommendation by the same physician, or another physician within the requesting physician's practice group, for the same treatment unless the further recommendation is supported by a documented change in the facts material to the basis of the utilization review decision.

(l) Utilization review of a treatment recommendation shall not be required while the employer is disputing liability for injury or treatment of the condition for which treatment is recommended pursuant to Section 4062.

(m) If utilization review is deferred pursuant to subdivision (l), and it is finally determined that the employer is liable for treatment of the condition for which treatment is recommended, the time for the employer to conduct retrospective utilization review in accordance with paragraph (2) of subdivision (i) shall begin on the date the determination of the employer's liability becomes final, and the time for the employer to conduct prospective utilization review shall commence from the date of the employer's receipt of a treatment recommendation after the determination of the employer's liability.

(n) Each employer, insurer, or other entity subject to this section shall maintain telephone access during California business hours for physicians to request authorization for health care services and to conduct peer-to-peer discussions regarding issues, including the appropriateness of a requested treatment, modification of a treatment request, or obtaining additional information needed to make a medical necessity decision.

(o) The administrative director shall develop a system for the mandatory electronic reporting of documents related to every utilization review performed by each employer, which shall be administered by the Division of Workers' Compensation. The administrative director shall adopt regulations specifying the documents to be submitted by the employer and the authorized transmission format and timeframe for their submission. For purposes of this subdivision, "employer" means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(p) If the administrative director determines that the employer, insurer, or other entity subject to this section has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the administrative director may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed to be an exclusive remedy for the administrative director. These penalties shall be deposited in the Workers' Compensation Administration Revolving Fund.

(q) The administrative director shall contract with an outside, independent research organization on or after March 1, 2019, to evaluate the impact of the provision of medical treatment within the first 30 days after a claim is filed, for a claim filed on or after January 1, 2017, and before January 1, 2019. The report shall be provided to the administrative director, the Senate Committee on Labor and Industrial Relations, and the Assembly Committee on Insurance before January 1, 2020.

(r) This section shall become operative on January 1, 2018.

SEC. 5. Section 4610.5 of the Labor Code is amended to read:

4610.5. (a) This section applies to the following disputes:

(1) Any dispute over a utilization review decision regarding treatment for an injury occurring on or after January 1, 2013.

(2) Any dispute over a utilization review decision if the decision is communicated to the requesting physician on or after July 1, 2013, regardless of the date of injury.

(3) Any dispute occurring on or after January 1, 2018, over medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(b) A dispute described in subdivision (a) shall be resolved only in accordance with this section.

(c) For purposes of this section and Section 4610.6, the following definitions apply:

(1) “Disputed medical treatment” means medical treatment that has been modified or denied by a utilization review decision on the basis of medical necessity.

(2) “Medically necessary” and “medical necessity” mean medical treatment that is reasonably required to cure or relieve the injured employee of the effects of his or her injury and based on the following standards, which shall be applied as set forth in the medical treatment utilization schedule, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27:

(A) The guidelines, including the drug formulary, adopted by the administrative director pursuant to Section 5307.27.

(B) Peer-reviewed scientific and medical evidence regarding the effectiveness of the disputed service.

(C) Nationally recognized professional standards.

(D) Expert opinion.

(E) Generally accepted standards of medical practice.

(F) Treatments that are likely to provide a benefit to a patient for conditions for which other treatments are not clinically efficacious.

(3) “Utilization review decision” means a decision pursuant to Section 4610 to modify or deny, based in whole or in part on medical necessity to cure or relieve, a treatment recommendation or recommendations by a physician prior to, retrospectively, or concurrent with, the provision of medical treatment services pursuant to Section 4600 or subdivision (c) of Section 5402. “Utilization review decision” may also mean a determination, occurring on or after January 1, 2018, by a physician regarding the medical

necessity of medication prescribed pursuant to the drug formulary adopted pursuant to Section 5307.27.

(4) Unless otherwise indicated by context, “employer” means the employer, the insurer of an insured employer, a claims administrator, or a utilization review organization, or other entity acting on behalf of any of them.

(d) If a utilization review decision denies or modifies a treatment recommendation based on medical necessity, the employee may request an independent medical review as provided by this section.

(e) A utilization review decision may be reviewed or appealed only by independent medical review pursuant to this section. Neither the employee nor the employer shall have any liability for medical treatment furnished without the authorization of the employer if the treatment is modified or denied by a utilization review decision, unless the utilization review decision is overturned by independent medical review in accordance with this section.

(f) As part of its notification to the employee regarding an initial utilization review decision based on medical necessity that denies or modifies a treatment recommendation, the employer shall provide the employee with a one-page form prescribed by the administrative director, and an addressed envelope, which the employee may return to the administrative director or the administrative director’s designee to initiate an independent medical review. The employee may also request independent medical review electronically under rules adopted by the administrative director. The employer shall include on the form any information required by the administrative director to facilitate the completion of the independent medical review. The form shall also include all of the following:

(1) Notice that the utilization review decision is final unless the employee requests independent medical review.

(2) A statement indicating the employee’s consent to obtain any necessary medical records from the employer or insurer and from any medical provider the employee may have consulted on the matter, to be signed by the employee.

(3) Notice of the employee’s right to provide information or documentation, either directly or through the employee’s physician, regarding the following:

(A) The treating physician’s recommendation indicating that the disputed medical treatment is medically necessary for the employee’s medical condition.

(B) Medical information or justification that a disputed medical treatment, on an urgent care or emergency basis, was medically necessary for the employee’s medical condition.

(C) Reasonable information supporting the employee’s position that the disputed medical treatment is or was medically necessary for the employee’s medical condition, including all information provided to the employee by the employer or by the treating physician, still in the employee’s possession, concerning the employer’s or the physician’s decision regarding the disputed

medical treatment, as well as any additional material that the employee believes is relevant.

(g) The independent medical review process may be terminated at any time upon the employer's written authorization of the disputed medical treatment. Notice of the authorization, any settlement or award that may resolve the medical treatment dispute, or the requesting physician withdrawing the request for treatment, shall be communicated to the independent medical review organization by the employer within five days.

(h) (1) The employee may submit a request for independent medical review to the division. The request may be made electronically under rules adopted by the administrative director. The request shall be made no later than as follows:

(A) For formulary disputes, 10 days after the service of the utilization review decision to the employee.

(B) For all other medical treatment disputes, 30 days after the service of the utilization review decision to the employee.

(2) If at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity, the time for the employee to submit a request for independent medical review to the administrative director or administrative director's designee is extended to 30 days after service of a notice to the employee showing that the other dispute of liability has been resolved.

(3) If the employer fails to comply with subdivision (f) at the time of notification of its utilization review decision, the time limitations for the employee to submit a request for independent medical review shall not begin to run until the employer provides the required notice to the employee.

(4) A provider of emergency medical treatment when the employee faced an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, may submit a request for independent medical review on its own behalf. A request submitted by a provider pursuant to this paragraph shall be submitted to the administrative director or administrative director's designee within the time limitations applicable for an employee to submit a request for independent medical review.

(i) An employer shall not engage in any conduct that has the effect of delaying the independent review process. Engaging in that conduct or failure of the employer to promptly comply with this section is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day that proper notification to the employee is delayed. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(j) For purposes of this section, an employee may designate a parent, guardian, conservator, relative, or other designee of the employee as an agent to act on his or her behalf. A designation of an agent executed prior

to the utilization review decision shall not be valid. The requesting physician may join with or otherwise assist the employee in seeking an independent medical review, and may advocate on behalf of the employee.

(k) The administrative director or his or her designee shall expeditiously review requests and immediately notify the employee and the employer in writing as to whether the request for an independent medical review has been approved, in whole or in part, and, if not approved, the reasons therefor. If there appears to be any medical necessity issue, the dispute shall be resolved pursuant to an independent medical review, except that, unless the employer agrees that the case is eligible for independent medical review, a request for independent medical review shall be deferred if at the time of a utilization review decision the employer is also disputing liability for the treatment for any reason besides medical necessity.

(l) Upon notice from the administrative director that an independent review organization has been assigned, the employer shall electronically provide to the independent medical review organization under rules adopted by the administrative director a copy and list of all of the following documents within 10 days of notice of assignment:

(1) A copy of all of the employee's medical records in the possession of the employer or under the control of the employer relevant to each of the following:

- (A) The employee's current medical condition.
- (B) The medical treatment being provided by the employer.
- (C) The request for authorization and utilization review decision.

(2) A copy of all information provided to the employee by the employer concerning employer and provider decisions regarding the disputed treatment.

(3) A copy of any materials the employee or the employee's provider submitted to the employer in support of the employee's request for the disputed treatment.

(4) A copy of any other relevant documents or information used by the employer or its utilization review organization in determining whether the disputed treatment should have been provided, and any statements by the employer or its utilization review organization explaining the reasons for the decision to deny or modify the recommended treatment on the basis of medical necessity. The employer shall concurrently provide a copy of the documents required by this paragraph to the employee and the requesting physician, except that documents previously provided to the employee or physician need not be provided again if a list of those documents is provided.

(m) Any newly developed or discovered relevant medical records in the possession of the employer after the initial documents are provided to the independent medical review organization shall be forwarded immediately to the independent medical review organization. The employer shall concurrently provide a copy of medical records required by this subdivision to the employee or the employee's treating physician, unless the offer of medical records is declined or otherwise prohibited by law. The

confidentiality of medical records shall be maintained pursuant to applicable state and federal laws.

(n) If there is an imminent and serious threat to the health of the employee, as specified in subdivision (c) of Section 1374.33 of the Health and Safety Code, all necessary information and documents required by subdivision (l) shall be delivered to the independent medical review organization within 24 hours of approval of the request for review.

(o) The employer shall promptly issue a notification to the employee, after submitting all of the required material to the independent medical review organization, that lists documents submitted and includes copies of material not previously provided to the employee or the employee's designee.

(p) The claims administrator who issued the utilization review decision in dispute shall notify the independent medical review organization if there is a change in the claims administrator responsible for the claim. Notice shall be given to the independent medical review organization within five working days of the change in administrator taking effect.

SEC. 6. Section 4610.6 of the Labor Code is amended to read:

4610.6. (a) Upon receipt of a case pursuant to Section 4610.5, an independent medical review organization shall conduct the review in accordance with this article and any regulations or orders of the administrative director. The organization's review shall be limited to an examination of the medical necessity of the disputed medical treatment.

(b) Upon receipt of information and documents related to a case, the medical reviewer or reviewers selected to conduct the review by the independent medical review organization shall promptly review all pertinent medical records of the employee, provider reports, and any other information submitted to the organization or requested from any of the parties to the dispute by the reviewers. If the reviewers request information from any of the parties, a copy of the request and the response shall be provided to all of the parties. The reviewer or reviewers shall also review relevant information related to the criteria set forth in subdivision (c).

(c) Following its review, the reviewer or reviewers shall determine whether the disputed health care service was medically necessary based on the specific medical needs of the employee and the standards of medical necessity as defined in subdivision (c) of Section 4610.5.

(d) (1) The organization shall complete its review and make its determination in writing, and in layperson's terms to the maximum extent practicable, and the determination shall be issued, as follows:

(A) For a dispute over medication prescribed pursuant to the drug formulary submitted under subdivision (h) of Section 4610.5, within five working days from the date of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(B) For all other medical treatment disputes submitted for review under subdivision (h) of Section 4610.5, within 30 days of receipt of the request for review and supporting documentation, or within less time as prescribed by the administrative director.

(C) If the disputed medical treatment has not been provided and the employee's provider or the administrative director certifies in writing that an imminent and serious threat to the health of the employee may exist, including, but not limited to, serious pain, the potential loss of life, limb, or major bodily function, or the immediate and serious deterioration of the health of the employee, the analyses and determinations of the reviewers shall be expedited and rendered within three days of the receipt of the information.

(2) Subject to the approval of the administrative director, the deadlines for analyses and determinations involving both regular and expedited reviews may be extended for up to three days in extraordinary circumstances or for good cause.

(e) The medical professionals' analyses and determinations shall state whether the disputed health care service is medically necessary. Each analysis shall cite the employee's medical condition, the relevant documents in the record, and the relevant findings associated with the provisions of subdivision (c) to support the determination. If more than one medical professional reviews the case, the recommendation of the majority shall prevail. If the medical professionals reviewing the case are evenly split as to whether the disputed health care service should be provided, the decision shall be in favor of providing the service.

(f) The independent medical review organization shall provide the administrative director, the employer, the employee, and the employee's provider with the analyses and determinations of the medical professionals reviewing the case, and a description of the qualifications of the medical professionals. The independent medical review organization shall keep the names of the reviewers confidential in all communications with entities or individuals outside the independent medical review organization. If more than one medical professional reviewed the case and the result was differing determinations, the independent medical review organization shall provide each of the separate reviewer's analyses and determinations.

(g) The determination of the independent medical review organization shall be deemed to be the determination of the administrative director and shall be binding on all parties.

(h) A determination of the administrative director pursuant to this section may be reviewed only by a verified appeal from the medical review determination of the administrative director, filed with the appeals board for hearing pursuant to Chapter 3 (commencing with Section 5500) of Part 4 and served on all interested parties within 30 days of the date of mailing of the determination to the aggrieved employee or the aggrieved employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the following grounds for appeal:

(1) The administrative director acted without or in excess of the administrative director's powers.

(2) The determination of the administrative director was procured by fraud.

(3) The independent medical reviewer was subject to a material conflict of interest that is in violation of Section 139.5.

(4) The determination was the result of bias on the basis of race, national origin, ethnic group identification, religion, age, sex, sexual orientation, color, or disability.

(5) The determination was the result of a plainly erroneous express or implied finding of fact, provided that the mistake of fact is a matter of ordinary knowledge based on the information submitted for review pursuant to Section 4610.5 and not a matter that is subject to expert opinion.

(i) If the determination of the administrative director is reversed, the dispute shall be remanded to the administrative director to submit the dispute to independent medical review by a different independent review organization. In the event that a different independent medical review organization is not available after remand, the administrative director shall submit the dispute to the original medical review organization for review by a different reviewer in the organization. In no event shall a workers' compensation administrative law judge, the appeals board, or any higher court make a determination of medical necessity contrary to the determination of the independent medical review organization.

(j) Upon receiving the determination of the administrative director that a disputed health care service is medically necessary, the employer shall promptly implement the decision as provided by this section unless the employer has also disputed liability for any reason besides medical necessity. In the case of reimbursement for services already rendered, the employer shall reimburse the provider or employee, whichever applies, within 20 days, subject to resolution of any remaining issue of the amount of payment pursuant to Sections 4603.2 to 4603.6, inclusive. In the case of services not yet rendered, the employer shall authorize the services within five working days of receipt of the written determination from the independent medical review organization, or sooner if appropriate for the nature of the employee's medical condition, and shall inform the employee and provider of the authorization.

(k) Failure to pay for services already provided or to authorize services not yet rendered within the time prescribed by subdivision (l) is a violation of this section and, in addition to any other fines, penalties, and other remedies available to the administrative director, the employer shall be subject to an administrative penalty in an amount determined pursuant to regulations to be adopted by the administrative director, not to exceed five thousand dollars (\$5,000) for each day the decision is not implemented. The administrative penalties shall be paid to the Workers' Compensation Administration Revolving Fund.

(l) The costs of independent medical review and the administration of the independent medical review system shall be borne by employers through a fee system established by the administrative director. After considering any relevant information on program costs, the administrative director shall establish a reasonable, per-case reimbursement schedule to pay the costs of independent medical review organization reviews and the cost of

administering the independent medical review system, which may vary depending on the type of medical condition under review and on other relevant factors.

(m) The administrative director may publish the results of independent medical review determinations after removing individually identifiable information.

(n) If any provision of this section, or the application thereof to any person or circumstances, is held invalid, the remainder of the section, and the application of its provisions to other persons or circumstances, shall not be affected thereby.

SEC. 7. Section 4615 is added to the Labor Code, to read:

4615. (a) Any lien filed by or on behalf of a physician or provider of medical treatment services under Section 4600 or medical-legal services under Section 4621, and any accrual of interest related to the lien, shall be automatically stayed upon the filing of criminal charges against that physician or provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the Medicare or Medi-Cal programs. The stay shall be in effect from the time of the filing of the charges until the disposition of the criminal proceedings. The administrative director may promulgate rules for the implementation of this section.

(b) The administrative director shall promptly post on the division's Internet Web site the names of any physician or provider of medical treatment services whose liens were stayed pursuant to this section.

SEC. 8. Section 4903.05 of the Labor Code is amended to read:

4903.05. (a) Every lien claimant shall file its lien with the appeals board in writing upon a form approved by the appeals board. The lien shall be accompanied by a full statement or itemized voucher supporting the lien and justifying the right to reimbursement and proof of service upon the injured worker or, if deceased, upon the worker's dependents, the employer, the insurer, and the respective attorneys or other agents of record. For liens filed on or after January 1, 2017, the lien shall also be accompanied by an original bill in addition to either the full statement or itemized voucher supporting the lien. Medical records shall be filed only if they are relevant to the issues being raised by the lien.

(b) Any lien claim for expenses under subdivision (b) of Section 4903 or for claims of costs shall be filed with the appeals board electronically using the form approved by the appeals board. The lien shall be accompanied by a proof of service and any other documents that may be required by the appeals board. The service requirements for Section 4603.2 are not modified by this section.

(c) (1) For liens filed on or after January 1, 2017, any lien claim for expenses under subdivision (b) of Section 4903 that is subject to a filing fee under this section shall be accompanied at the time of filing by a declaration stating, under penalty of perjury, that the dispute is not subject to an independent bill review and independent medical review under Sections

4603.6 and 4610.5, respectively, that the lien claimant satisfies one of the following:

(A) Is the employee's treating physician providing care through a medical provider network.

(B) Is the agreed medical evaluator or qualified medical evaluator.

(C) Has provided treatment authorized by the employer or claims administrator under Section 4610.

(D) Has made a diligent search and determined that the employer does not have a medical provider network in place.

(E) Has documentation that medical treatment has been neglected or unreasonably refused to the employee as provided by Section 4600.

(F) Can show that the expense was incurred for an emergency medical condition, as defined by subdivision (b) of Section 1317.1 of the Health and Safety Code.

(G) Is a certified interpreter rendering services during a medical-legal examination, a copy service providing medical-legal services, or has an expense allowed as a lien under rules adopted by the administrative director.

(2) Lien claimants shall have until July 1, 2017, to file a declaration pursuant to paragraph (1) for any lien claim filed before January 1, 2017, for expenses pursuant to subdivision (b) of Section 4903 that is subject to a filing fee under this section.

(3) The failure to file a signed declaration under this subdivision shall result in the dismissal of the lien with prejudice by operation of law. Filing of a false declaration shall be grounds for dismissal with prejudice after notice.

(d) All liens filed on or after January 1, 2013, for expenses under subdivision (b) of Section 4903 or for claims of costs shall be subject to a filing fee as provided by this subdivision.

(1) The lien claimant shall pay a filing fee of one hundred fifty dollars (\$150) to the Division of Workers' Compensation prior to filing a lien and shall include proof that the filing fee has been paid. The fee shall be collected through an electronic payment system that accepts major credit cards and any additional forms of electronic payment selected by the administrative director. If the administrative director contracts with a service provider for the processing of electronic payments, any processing fee shall be absorbed by the division and not added to the fee charged to the lien filer.

(2) On or after January 1, 2013, a lien submitted for filing that does not comply with paragraph (1) shall be invalid, even if lodged with the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(3) The claims of two or more providers of goods or services shall not be merged into a single lien.

(4) The filing fee shall be collected by the administrative director. All fees shall be deposited in the Workers' Compensation Administration Revolving Fund and applied for the purposes of that fund.

(5) The administrative director shall adopt reasonable rules and regulations governing the procedure for the collection of the filing fee, including emergency regulations as necessary to implement this section.

(6) Any lien filed for goods or services that are not the proper subject of a lien may be dismissed upon request of a party by verified petition or on the appeals board's own motion. If the lien is dismissed, the lien claimant will not be entitled to reimbursement of the filing fee.

(7) No filing fee shall be required for a lien filed by a health care service plan licensed pursuant to Section 1349 of the Health and Safety Code, a group disability insurer under a policy issued in this state pursuant to the provisions of Section 10270.5 of the Insurance Code, a self-insured employee welfare benefit plan, as defined in Section 10121 of the Insurance Code, that is issued in this state, a Taft-Hartley health and welfare fund, or a publicly funded program providing medical benefits on a nonindustrial basis.

SEC. 9. Section 4903.8 of the Labor Code is amended to read:

4903.8. (a) (1) Any order or award for payment of a lien filed pursuant to subdivision (b) of Section 4903 shall be made for payment only to the person who was entitled to payment for the expenses as provided in subdivision (b) of Section 4903 at the time the expenses were incurred, who is the lien owner, and not to an assignee unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee.

(2) All liens filed pursuant to subdivision (b) of Section 4903 shall be filed in the name of the lien owner only, and no payment shall be made to any lien claimant without evidence that he or she is the owner of that lien.

(3) Paragraph (1) does not apply to an assignment that was completed prior to January 1, 2013, or that was required by a contract that became enforceable and irrevocable prior to January 1, 2013. This paragraph is declarative of existing law.

(4) For liens filed after January 1, 2017, the lien shall not be assigned unless the person has ceased doing business in the capacity held at the time the expenses were incurred and has assigned all right, title, and interest in the remaining accounts receivable to the assignee. The assignment of a lien, in violation of this paragraph is invalid by operation of law.

(b) If there has been an assignment of a lien, either as an assignment of all right, title, and interest in the accounts receivable or as an assignment for collection, a true and correct copy of the assignment shall be filed and served.

(1) If the lien is filed on or after January 1, 2013, and the assignment occurs before the filing of the lien, the copy of the assignment shall be served at the time the lien is filed.

(2) If the lien is filed on or after January 1, 2013, and the assignment occurs after the filing of the lien, the copy of the assignment shall be served within 20 days of the date of the assignment.

(3) If the lien is filed before January 1, 2013, the copy of the assignment shall be served by January 1, 2014, or with the filing of a declaration of readiness or at the time of a lien hearing, whichever is earliest.

(c) If there has been more than one assignment of the same receivable or bill, the appeals board may set the matter for hearing on whether the multiple assignments constitute bad-faith actions or tactics that are frivolous, harassing, or intended to cause unnecessary delay or expense. If so found by the appeals board, appropriate sanctions, including costs and attorney's fees, may be awarded against the assignor, assignee, and their respective attorneys.

(d) At the time of filing of a lien on or after January 1, 2013, or in the case of a lien filed before January 1, 2013, at the earliest of the filing of a declaration of readiness, a lien hearing, or January 1, 2014, supporting documentation shall be filed including one or more declarations under penalty of perjury by a natural person or persons competent to testify to the facts stated, declaring both of the following:

(1) The services or products described in the bill for services or products were actually provided to the injured employee.

(2) The billing statement attached to the lien truly and accurately describes the services or products that were provided to the injured employee.

(e) A lien submitted for filing on or after January 1, 2013, for expenses provided in subdivision (b) of Section 4903, that does not comply with the requirements of this section shall be deemed to be invalid, whether or not accepted for filing by the appeals board, and shall not operate to preserve or extend any time limit for filing of the lien.

(f) This section shall take effect without regulatory action. The appeals board and the administrative director may promulgate regulations and forms for the implementation of this section.

SEC. 10. Section 5307.27 of the Labor Code is amended to read:

5307.27. (a) The administrative director, in consultation with the Commission on Health and Safety and Workers' Compensation, shall adopt, after public hearings, a medical treatment utilization schedule, that shall incorporate the evidence-based, peer-reviewed, nationally recognized standards of care recommended by the commission pursuant to Section 77.5, and that shall address, at a minimum, the frequency, duration, intensity, and appropriateness of all treatment procedures and modalities commonly performed in workers' compensation cases. Evidence-based updates to the utilization schedule shall be made through an order exempt from Sections 5307.3 and 5307.4, and the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), but the administrative director shall allow at least a 30-day period for public comment and a public hearing. The administrative director shall provide responses to submitted comments prior to the effective date of the updates. All orders issued pursuant to this subdivision shall be published on the Internet Web site of the Division of Workers' Compensation.

(b) On or before July 1, 2017, the medical treatment utilization schedule adopted by the administrative director shall include a drug formulary using evidence-based medicine. Nothing in this section shall prohibit the authorization of medications that are not in the formulary when the variance is demonstrated, consistent with subdivision (a) of Section 4604.5.

(c) The drug formulary shall include a phased implementation for workers injured prior to July 1, 2017, in order to ensure injured workers safely transition to medications pursuant to the formulary.

(d) This section shall apply to all prescribers and dispensers of medications serving injured workers under the workers' compensation system.

SEC. 11. Section 5710 of the Labor Code is amended to read:

5710. (a) The appeals board, a workers' compensation judge, or any party to the action or proceeding, may, in any investigation or hearing before the appeals board, cause the deposition of witnesses residing within or without the state to be taken in the manner prescribed by law for like depositions in civil actions in the superior courts of this state under Title 4 (commencing with Section 2016.010) of Part 4 of the Code of Civil Procedure. To that end the attendance of witnesses and the production of records may be required. Depositions may be taken outside the state before any officer authorized to administer oaths. The appeals board or a workers' compensation judge in any proceeding before the appeals board may cause evidence to be taken in other jurisdictions before the agency authorized to hear workers' compensation matters in those other jurisdictions.

(b) If the employer or insurance carrier requests a deposition to be taken of an injured employee, or any person claiming benefits as a dependent of an injured employee, the deponent is entitled to receive in addition to all other benefits:

(1) All reasonable expenses of transportation, meals, and lodging incident to the deposition.

(2) Reimbursement for any loss of wages incurred during attendance at the deposition.

(3) One copy of the transcript of the deposition, without cost.

(4) A reasonable allowance for attorney's fees for the deponent, if represented by an attorney licensed by the State Bar of this state. The fee shall be discretionary with, and, if allowed, shall be set by, the appeals board, but shall be paid by the employer or his or her insurer. The administrative director shall, on or before July 1, 2018, determine the range of reasonable fees to be paid.

(5) If interpretation services are required because the injured employee or deponent does not proficiently speak or understand the English language, upon a request from either, the employer shall pay for the services of a language interpreter certified or deemed certified pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code. The fee to be paid by the employer shall be in accordance with the fee schedule adopted

by the administrative director and shall include any other deposition-related events as permitted by the administrative director.

SEC. 12. Section 5811 of the Labor Code is amended to read:

5811. (a) No fees shall be charged by the clerk of any court for the performance of any official service required by this division, except for the docketing of awards as judgments and for certified copies of transcripts thereof. In all proceedings under this division before the appeals board, costs as between the parties may be allowed by the appeals board.

(b) (1) It shall be the responsibility of any party producing a witness requiring an interpreter to arrange for the presence of a qualified interpreter.

(2) A qualified interpreter is a language interpreter who is certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code. The duty of an interpreter is to accurately and impartially translate oral communications and transliterate written materials, and not to act as an agent or advocate. An interpreter shall not disclose to any person who is not an immediate participant in the communications the content of the conversations or documents that the interpreter has interpreted or transliterated unless the disclosure is compelled by court order. An attempt by any party or attorney to obtain disclosure is a bad faith tactic that is subject to Section 5813.

Interpreter fees that are reasonably, actually, and necessarily incurred shall be paid by the employer under this section, provided they are in accordance with the fee schedule adopted by the administrative director.

A qualified interpreter may render services during the following:

- (A) A deposition.
- (B) An appeals board hearing.
- (C) A medical treatment appointment or medical-legal examination.
- (D) During those settings which the administrative director determines are reasonably necessary to ascertain the validity or extent of injury to an employee who does not proficiently speak or understand the English language.

(c) The administrative director shall promulgate regulations establishing criteria to verify the identity and credentials of individuals who provide interpreter services in all necessary settings and proceedings within the workers' compensation system. Those regulations shall be adopted no later than January 1, 2018.

SEC. 13. Section 6409 of the Labor Code is amended to read:

6409. (a) Every physician as defined in Section 3209.3 who attends any injured employee shall file a complete report of that occupational injury or occupational illness in a manner prescribed by the administrative director of the Division of Workers' Compensation. The report shall include a diagnosis, the injured employee's description of how the injury or illness occurred, any treatment rendered at the time of the examination, any work restrictions resulting from the injury or illness, a treatment plan, and other content as prescribed by the administrative director. The form shall be filed electronically with the Division of Workers' Compensation and the

employer, or if insured, with the employer's insurer, within five days of the initial examination. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall also, within 24 hours of the initial examination, file a complete report with the local health officer by facsimile transmission or other means. If the treatment is for pesticide poisoning or a condition suspected to be pesticide poisoning, the physician shall not be compensated for the initial diagnosis and treatment unless the report is filed with the Division of Workers' Compensation, the employer, or if insured, with the employer's insurer, and includes or is accompanied by a signed affidavit which certifies that a copy of the report was filed with the local health officer pursuant to this section.

(b) As used in this section, "occupational illness" means any abnormal condition or disorder caused by exposure to environmental factors associated with employment, including acute and chronic illnesses or diseases which may be caused by inhalation, absorption, ingestion, or direct contact.

SEC. 14. The Legislature finds and declares that Sections 4 and 4.5 of this act, which add Section 4610 to the Labor Code, impose a limitation on the public's right of access to the meetings of public bodies or the writings of public officials and agencies within the meaning of Section 3 of Article I of the California Constitution. Pursuant to that constitutional provision, the Legislature makes the following findings to demonstrate the interest protected by this limitation and the need for protecting that interest:

The limitations on the people's rights of access set forth in this act are necessary to protect the privacy and integrity of information submitted to the Administrative Director of the Division of Workers' Compensation pursuant to Section 4610 of the Labor Code.

SEC. 15. The amendment of paragraphs (1) and (2) of subdivision (a) of Section 4903.8 of the Labor Code made by this act does not constitute a change in, but is declaratory of, existing law.

SEC. 16. The Legislature finds and declares the following:

(a) Section 4 of Article XIV of the California Constitution vests the Legislature with plenary power to create and to enforce a complete system of workers' compensation by appropriate legislation, and that plenary power includes, without limitation, the power and authority to make full provision for the manner and means by which any lien for compensation for those services may be filed or enforced within the workers' compensation system.

(b) Despite prior legislative action to reform the lien filing and recovery process within the workers' compensation system, including Senate Bill 863 in 2012, there continues to be abuse of the lien process within the workers' compensation system by some providers of medical treatment and other medical-legal services who have engaged in fraud or other criminal conduct within the workers' compensation system, or who have engaged in medical billing fraud, insurance fraud, or fraud against the federal Medicare or Medi-Cal systems.

(c) Notwithstanding fraudulent and criminal conduct by some providers of medical treatment or other medical-legal services, those providers have continued to file and to collect on liens within the workers' compensation

system while criminal charges alleging fraud within the workers' compensation system, or medical billing or insurance fraud, or fraud within the federal Medicare or Medi-Cal systems, are pending against those providers.

(d) The ability of providers of medical treatment or other medical-legal services to continue to file and to collect on liens, while criminal charges are pending against the provider, including through the use of lien or collection assignments, has created excessive and unnecessary administrative burdens for the workers' compensation system, has resulted in pressure on employers and insurers to settle liens that may in fact have arisen from prior or ongoing criminal conduct, has threatened the health and safety of workers who may be referred for or receive medical treatment or other medical-legal services that not reasonable and necessary, has allowed continued funding of fraudulent practices through ongoing lien collections during the pendency of criminal proceedings, and has undermined public confidence in the workers' compensation system.

(e) Therefore, in order to ensure the efficient, just, and orderly administration of the workers' compensation system, and to accomplish substantial justice in all cases, the Legislature declares that it is necessary to enact legislation to provide that any lien filed by, or for recovery of compensation for services rendered by, any provider of medical treatment or other medical-legal services shall be automatically stayed upon the filing of criminal charges against that provider for an offense involving fraud against the workers' compensation system, medical billing fraud, insurance fraud, or fraud against the federal Medicare or Medi-Cal programs, and that the stay shall remain in effect until the resolution of the criminal proceedings.

SEC. 17. (a) Section 3.5 of this bill incorporates amendments to Section 4610 of the Labor Code proposed by both this bill and Assembly Bill 2503. It shall only become operative if (1) both bills are enacted and become effective on or before January 1, 2017, (2) each bill amends Section 4610 of the Labor Code, and (3) this bill is enacted after Assembly Bill 2503, in which case Section 3 of this bill shall not become operative.

(b) Section 4.5 of this bill incorporates, in Section 4610 of the Labor Code as proposed to be added by this bill, amendments to Section 4610 of the Labor Code that are proposed by Assembly Bill 2503. It shall only become operative if (1) both bills are enacted on or before January 1, 2017, (2) Assembly Bill 2503 amends Section 4610 of the Labor Code, and (3) this bill adds Section 4610 to the Labor Code, in which case, regardless of the order in which this bill and Assembly Bill 2503 are enacted, Section 4 of this bill shall not become operative.

SEC. 18. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime

within the meaning of Section 6 of Article XIII B of the California Constitution.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1174
Author: McGuire
 Chapter: 840
Bill Date: August 19, 2016, Amended
Subject: Medi-Cal: Children: Prescribing Patterns: Psychotropic Medications
Sponsor: National Center for Youth Law
Current Position: Support if Amended

DESCRIPTION OF CURRENT LEGISLATION:

This bill adds to the Medical Board of California's (Board) priorities, repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to children without a good faith prior exam and medical reason. This bill requires 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.

BACKGROUND

In August 2014, the Board received a letter from Senator Lieu, who was at the time the Chair of the Senate Business, Professions and Economic Development Committee. The letter asked the Board to look into the issue of inappropriate prescribing of psychotropic medication to foster children. The Board receives very few complaints regarding foster children being prescribed psychotropic medications, so the Board researched other avenues to identify physicians who may be inappropriately prescribing. The Board met with DHCS and DSS regarding what data was available, what could be provided to the Board, and what data would assist in the identification of inappropriately prescribing physicians. After many meetings, a Data Use Agreement (DUA) was finalized in April 2015 requesting a listing of all physicians who had prescribed three or more psychotropic medications for 90 days or more. For each child that fit into this category, the Board requested a list of the medications prescribed, the start and stop date for each medication, the prescriber's name and contact information, the child's birth date, and any other information that DHCS and DSS thought might be relevant to assist in this process.

Upon receipt of the information requested in the DUA in 2015, the Board secured an expert pediatric psychiatrist to review the information and determine any physician who may be potentially prescribing inappropriately. It is important to note that once a physician is identified, the Board's normal complaint process will be followed, including obtaining medical records, conducting a physician interview and having an expert physician review the case. The complaint and investigation process is confidential, and nothing is public until an accusation is filed. Upon review by the Board's expert, it was determined that additional information was

needed to identify physicians that may warrant additional investigation. The new information includes diagnosis associated with the medication, dosage of medication prescribed, schedule of dosage, and weight of the child/adolescent. The Board obtained this information in June and it was reviewed by the Board's expert. The Board's expert has confirmed that the additional information is sufficient to identify potential inappropriate prescribers for further review by the Board.

ANALYSIS

This bill adds to the Board's priorities acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor. Although the Board already has excessive prescribing of controlled substances in its priorities, many psychotropic medications are not controlled substances, so they would not be covered in the Board's existing priorities.

This bill requires DHCS and DSS to provide data to the Board on an annual basis, pursuant to a data-sharing agreement, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. The data shall be drawn from existing data sources maintained by the departments. Prior to the release of the data, personal identifiers must be removed and a unique identifier shall be submitted. For each foster child who falls into this category, the following information shall be submitted to the Board:

- A list of the psychotropic medications prescribed.
- The start and stop dates, if any, for each psychotropic medication prescribed.
- The prescriber's name and contact information.
- The child or adolescent's year of birth.
- Any other information that is de-identified and necessary to the Board to allow the Board to exercise its statutory authority as an oversight entity.
- The unit and quantity of the medication and the number of days' supply of the medication.

This bill requires the Board to review this data on a quarterly basis to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, conduct an investigation. This bill specifies that the Board shall contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the Board. This bill requires the consultant to consider the treatment guidelines published by DHCS and DSS when assessing prescribing patterns.

If the Board investigates a physician for inappropriate prescribing and concludes that there is a violation of law, the Board must take appropriate disciplinary action. This bill requires the Board to report this data annually to the Legislature in its annual report.

This bill requires DHCS to disseminate its treatment guidelines on an annual basis through its existing communications with Medi-Cal providers.

On or before January 1, 2022, this bill requires the Board, in conjunction with DHCS and DSS, to conduct an internal review of its data, investigative, and disciplinary activities undertaken for the purpose of determining the efficacy of these activities and the Board must revise its procedures, if determined to be necessary. This bill would sunset in 10 years, as it will only remain in effect until January 1, 2027, unless a later enacted statute deletes or extends that date.

According to the author, over the past fifteen years the rate of foster youth prescribed psychotropic medication has increased 1,400 percent. Nearly 1 in 4 California foster teens are prescribed psychotropic drugs, and of those nearly 60 percent were prescribed an anti-psychotic, the drug class most susceptible to debilitating side effects. There have been several Senate hearings on this issue, and according to the hearing background information, concerns over the use of psychotropic medications among children have been well documented in research journals and the mainstream media for more than a decade.

Anecdotally, the Board does not receive complaints regarding inappropriate prescribing of psychotropic medications to foster children. The data that will be required to be submitted to the Board pursuant to this bill will ensure that the Board can review prescribing data on an on-going basis to help identify physicians who may be inappropriately prescribing. The data the Board has received under the DUA is only a snapshot in time, for a 6 month time period in 2014. Any information that can help the Board identify inappropriate prescribing can be utilized as a tool for the Board to use in its complaint and investigation process. However, once a possible inappropriate prescriber is identified, the Board will still have to go through its normal complaint and investigation process.

This bill will further the Board's mission of consumer protection for a very vulnerable population. The Board did request a three- to five-year sunset date be included in this bill to allow the Board to determine if the data provided is useful to the Board in assisting with identifying physicians who may be inappropriately prescribing and pursuing investigations. The author instead included a 10-year sunset date, but also included language to require the Board to do an internal review in five years. This review would consider the efficacy of the data in relation to the Board's investigative and disciplinary actions and would allow the Board to revise its data review procedures, if necessary.

FISCAL: This bill will result in minor and absorbable fiscal impact to have an expert pediatric psychiatrist review the data and report the results to the Legislature, DHCS and DSS on an on-going basis. This is currently being done now, but not on an on-going basis.

SUPPORT: National Center for Youth Law (Sponsor); Bay Area Youth Center; California Youth Connection; California Youth Empowerment Network;

Children Now; Consumer Attorneys of California; Consumer Watchdog; Contra Costa County; Family Voices of California; First Focus Campaign for Children; John Burton Foundation; Kids in Common; Madera County Department of Social Services; Medical Board of California (if amended); Peers Envisioning and Engaging in Recovery Services; San Luis Obispo County Department of Social Services; Sunny Hills Services; Therapists for Peace and Justice; Woodland Community College and Foster and Kinship Care Education; Youth Law Center; and two individuals

OPPOSITION: California Academy of Child and Adolescent Psychiatry

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Meet with DHCS and DSS to work out the details of the DUA to ensure the Board receives the required data and can review it on a quarterly basis beginning January 1, 2017
- Identify additional pediatric psychiatrist consultants that can perform the initial data review and identify possible inappropriate prescribing for further review
- Formalize the process with DSS for requesting authorizations for medical records for de-identified foster youth so these investigations are not delayed
- Amend the Board's Annual Report to include complaints, investigations, and disciplinary actions taken as a result of the data review and subsequent investigation

Senate Bill No. 1174

CHAPTER 840

An act to amend Section 2220.05 of, and to add and repeal Section 2245 of, the Business and Professions Code, and to add and repeal Section 14028 of the Welfare and Institutions Code, relating to Medi-Cal.

[Approved by Governor September 29, 2016. Filed with
Secretary of State September 29, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1174, McGuire. Medi-Cal: children: prescribing patterns: psychotropic medications.

Existing law, the Medical Practice Act, among other things provides for the licensure and regulation of physicians and surgeons by the Medical Board of California. Under existing law, the board's responsibilities include enforcement of the disciplinary and criminal provisions of the act.

Existing law provides for the Medi-Cal program, which is administered by the State Department of Health Care Services, under which qualified low-income individuals receive health care services, including early and periodic screening, diagnosis, and treatment for any individual under 21 years of age. The Medi-Cal program is, in part, governed and funded by federal Medicaid program provisions. Existing law establishes a statewide system of child welfare services, administered by the State Department of Social Services, with the intent that all children are entitled to be safe and free from abuse and neglect.

This bill would, until January 1, 2027, require the State Department of Health Care Services and the State Department of Social Services, pursuant to a specified data-sharing agreement, to provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for specified children and minors placed in foster care using data provided by the State Department of Health Care Services and the State Department of Social Services, as prescribed. The bill would require that the data concerning psychotropic medications and related services be drawn from existing data sources maintained by the departments and shared pursuant to a data-sharing agreement and would require that, every 5 years, the board, the State Department of Health Care Services, and the State Department of Social Services consult and revise the methodology, if determined to be necessary. The bill would require the board to contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the board. Commencing July 1, 2017, the bill would require the board to report annually to the Legislature, the State Department of Health Care Services, and the

State Department of Social Services the results of the analysis of the data. The bill would, until January 1, 2027, require the board to review the data in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and conduct an investigation, if warranted, and would require the board to take disciplinary action, as specified. The bill would require the board, on or before January 1, 2022, to conduct an internal review of those activities and to revise procedures relating to those activities, if determined to be necessary. The bill would require the State Department of Health Care Services to disseminate treatment guidelines on an annual basis through its existing communications with Medi-Cal providers, as specified. The bill would require the board to handle on a priority basis investigations of repeated acts of excessive prescribing, furnishing, or administering psychotropic medications to a minor, as specified.

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

SECTION 1. Section 2220.05 of the Business and Professions Code is amended to read:

2220.05. (a) In order to ensure that its resources are maximized for the protection of the public, the Medical Board of California shall prioritize its investigative and prosecutorial resources to ensure that physicians and surgeons representing the greatest threat of harm are identified and disciplined expeditiously. Cases involving any of the following allegations shall be handled on a priority basis, as follows, with the highest priority being given to cases in the first paragraph:

(1) Gross negligence, incompetence, or repeated negligent acts that involve death or serious bodily injury to one or more patients, such that the physician and surgeon represents a danger to the public.

(2) Drug or alcohol abuse by a physician and surgeon involving death or serious bodily injury to a patient.

(3) Repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances, or repeated acts of prescribing, dispensing, or furnishing of controlled substances without a good faith prior examination of the patient and medical reason therefor. However, in no event shall a physician and surgeon prescribing, furnishing, or administering controlled substances for intractable pain consistent with lawful prescribing, including, but not limited to, Sections 725, 2241.5, and 2241.6 of this code and Sections 11159.2 and 124961 of the Health and Safety Code, be prosecuted for excessive prescribing and prompt review of the applicability of these provisions shall be made in any complaint that may implicate these provisions.

(4) Repeated acts of clearly excessive recommending of cannabis to patients for medical purposes, or repeated acts of recommending cannabis to patients for medical purposes without a good faith prior examination of the patient and a medical reason for the recommendation.

(5) Sexual misconduct with one or more patients during a course of treatment or an examination.

(6) Practicing medicine while under the influence of drugs or alcohol.

(7) Repeated acts of clearly excessive prescribing, furnishing, or administering psychotropic medications to a minor without a good faith prior examination of the patient and medical reason therefor.

(b) The board may by regulation prioritize cases involving an allegation of conduct that is not described in subdivision (a). Those cases prioritized by regulation shall not be assigned a priority equal to or higher than the priorities established in subdivision (a).

(c) The Medical Board of California shall indicate in its annual report mandated by Section 2312 the number of temporary restraining orders, interim suspension orders, and disciplinary actions that are taken in each priority category specified in subdivisions (a) and (b).

SEC. 2. Section 2245 is added to the Business and Professions Code, to read:

2245. (a) The Medical Board of California on a quarterly basis shall review the data provided pursuant to Section 14028 of the Welfare and Institutions Code by the State Department of Health Care Services and the State Department of Social Services in order to determine if any potential violations of law or excessive prescribing of psychotropic medications inconsistent with the standard of care exist and, if warranted, shall conduct an investigation.

(b) The State Department of Health Care Services shall disseminate the treatment guidelines on an annual basis through its existing communications with Medi-Cal providers, such as the department's Internet Web site or provider bulletins.

(c) If, after an investigation, the Medical Board of California concludes that there was a violation of law, the board shall take disciplinary action, as appropriate, as authorized by Section 2227.

(d) If, after an investigation, the Medical Board of California concludes that there was excessive prescribing of psychotropic medications inconsistent with the standard of care, the board shall take action, as appropriate, as authorized by Section 2227.

(e) (1) Notwithstanding Section 10231.5 of the Government Code, commencing July 1, 2017, the Medical Board of California shall report annually to the Legislature, the State Department of Health Care Services, and the State Department of Social Services the results of the analysis of data described in Section 14028 of the Welfare and Institutions Code.

(2) A report to be submitted pursuant to this subdivision shall be submitted in compliance with Section 9795 of the Government Code.

(f) On or before January 1, 2022, and in conjunction with the consultation with the State Department of Social Services and the State Department of Health Care Services required by subdivision (a) of Section 14028 of the Welfare and Institutions Code, the Medical Board of California shall conduct an internal review of its data review, investigative, and disciplinary activities undertaken pursuant to this section for the purpose of determining the

efficacy of those activities and shall revise its procedures relating to those activities, if determined to be necessary.

(g) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

SEC. 3. Section 14028 is added to the Welfare and Institutions Code, to read:

14028. (a) (1) In order to ensure appropriate oversight of psychotropic medications prescribed for children, pursuant to Section 2245 of the Business and Professions Code, the department and the State Department of Social Services, pursuant to a data-sharing agreement that shall meet the requirements of all applicable state and federal laws and regulations, shall provide the Medical Board of California with information regarding Medi-Cal physicians and their prescribing patterns of psychotropic medications and related services for individuals described in subparagraphs (B) and (C) of paragraph (1) of subdivision (c). The data concerning psychotropic medications and related services shall be drawn from existing data sources maintained by the departments. Every five years, the Medical Board of California, the department, and the State Department of Social Services shall consult and revise the methodology, if determined to be necessary.

(2) At minimum, the department, on an annual basis, shall share with the Medical Board of California data, including, but not limited to, pharmacy claims data for all foster children who are or have been on three or more psychotropic medications for 90 days or more. Prior to the release of this data, personal identifiers such as name, date of birth, address, and social security number shall be removed and a unique identifier shall be submitted. For each foster child who falls into these categories, the department shall submit the following information to the board:

(A) A list of the psychotropic medications prescribed.

(B) The start and stop dates, if any, for each psychotropic medication prescribed.

(C) The prescriber's name and contact information.

(D) The child's or adolescent's year of birth.

(E) Any other information that is deidentified and necessary to the Medical Board of California to allow the board to exercise its statutory authority as an oversight entity.

(F) The unit and quantity of the medication and the number of days' supply of the medication.

(b) The Medical Board of California shall contract for consulting services from, if available, a psychiatrist who has expertise and specializes in pediatric care for the purpose of reviewing the data provided to the board pursuant to subdivision (a). The consultant shall consider the treatment guidelines published by the department and the State Department of Social Services when assessing prescribing patterns.

(c) The Medical Board of California, pursuant to subdivision (a), shall analyze prescribing patterns by population for both of the following:

(1) Children adjudged as dependent children under Section 300 and placed in foster care.

(2) A minor adjudged a ward of the court under Section 601 or 602 who has been removed from the physical custody of the parent and placed into foster care.

(d) This section shall remain in effect only until January 1, 2027, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2027, deletes or extends that date.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1177
Author: Galgiani
Chapter: 591
Bill Date: August 18, 2016, Amended
Subject: Physician and Surgeon Health and Wellness Program
Sponsor: California Medical Association (CMA)
Position: Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill authorizes the establishment of a Physician and Surgeon Health and Wellness Program (PHWP) within the Medical Board of California (Board). The PHWP will provide for 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 authorizes the Board to contract with a private third-party independent administering entity to administer the program.

BACKGROUND

The Board’s Diversion Program was a monitoring program for substance abusing physicians (and some physicians with mental impairment) that ensured physicians were complying with the requirements of their agreement with the Diversion Program. The terms included abstaining from drugs and/or alcohol, biological fluid testing, attending group therapy, etc. Senate Bill 761 (Ridley-Thomas), which was the vehicle to extend the dates of the Board’s Diversion Program from January 1, 2009 through January 1, 2011, did not pass out of the Legislature. During the hearings for this bill, the discussion and debate surrounding the Board’s Diversion Program centered on the multiple audits indicating concerns with the Diversion Program and its protection of the consumers of California. The Board’s Diversion Program was very different than any other board’s Diversion Programs within the Department of Consumer Affairs (DCA). The Board’s Diversion Program was run by the Board itself, not by an outside vendor, was staffed by civil service employees hired by the Board, and was subject to the budget/legislative process for any changes in the number of staff needed to run the Diversion Program. Based upon the concerns over the safety of patients, the Legislature did not approve the continuation of this Diversion Program and it became inoperative on July 1, 2008.

The Board and its staff developed a transition plan for the individuals that were in the Diversion Program on July 1, 2008. The plan not only transitioned the individuals in the Program to other monitoring programs, but also identified how the Board would perform its mission of consumer protection with individuals who were found to have a substance abuse

problem without the existence of a Diversion Program for physicians.

Under the Diversion Program, physicians who were found to only have a substance abuse problem or mental impairment were allowed to enter the Diversion Program without any record of disciplinary action. If the physician successfully completed the Board's Diversion Program the public never became aware of the issue. The Board determined that the best way to ensure physicians with a substance abuse problem were not endangering the public would be to continue the biological fluid testing requirements. The Board contracted with a vendor to provide these services. Today, without the Diversion Program, when an individual is identified to have an abuse problem, the Board pursues disciplinary action and, if action is taken, the physician is normally placed on probation with terms and conditions including submitting to biological fluid testing. It is up to the physicians to seek a program that will assist them in maintaining abstinence.

With the elimination of the Board's Diversion Program, the Board also knew there would be a need for information regarding physician wellness and resources to assist physicians seeking wellness. Therefore, the Board established a Wellness Committee whose main function was to provide articles for the Board's Newsletter regarding physician wellness, locate resources for physicians who are struggling with impairment issues, and entertain presentations on physician wellness. The information gathered by the Wellness Committee was then provided to physicians via the Board's website or Newsletter. This Committee has since been consolidated with the Education Committee.

At the Board's October 2015 Board Meeting, after meetings with consumer groups, provider groups, and physician health programs, the Board adopted elements that a physician health program should include, in order to be supported by the Board.

ANALYSIS

This bill authorizes the establishment of a PHWP within the Board. The PHWP would provide early identification of, and appropriate interventions to support a physician in the rehabilitation from substance abuse to ensure that the licensee remains able to practice medicine in a manner that will not endanger the public health and safety and maintain the integrity of the medical profession. The PHWP shall aid a physician with substance abuse issues impacting his or her ability to practice medicine.

If the Board establishes a program, it shall do all the following:

- Provide for the education of all licensed physician and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.
- Offer assistance to a physician in identifying substance abuse problems.
- Evaluate the extent of substance abuse problems and refer the physician to the appropriate treatment by executing a written agreement with the physician participant.

- Provide for the confidential participation by a physician with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. If an investigation occurs after the physician has enrolled in the PHWP, the Board may inquire whether the physician is enrolled in the PHWP and the program shall respond accordingly.
- Comply with the Uniform Standards for Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the Department of Consumer Affairs pursuant to Business and Professions Code Section 315.

If the Board establishes a PHWP, it would be required to contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the PHWP shall be administered by the Board. The administering entity is required to have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals. The administering entity is required to identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and is required to establish a process for evaluating the effectiveness of such programs. The administering entity is required to provide counseling and support for the physician participant and for the family of any physician referred for treatment. The administering entity will have to make their services available to all licensed California physicians, including those who self-refer to the PHWP. The administering entity is required to have a system for immediately reporting a physician from the program to the Board, including but not limited to, a physician who withdraws or is terminated. The system needs to ensure absolute confidentiality in the communication to the Board. The administering entity cannot provide this information to any other individual or entity unless authorized by the physician participant. The contract entered into with the Board needs to require the administering entity to do the following:

- Provide regular communication to the Board, including annual reports to the Board with program statistics, including, but not limited to, the number of participants, the number of participants referred by the Board as a condition of probation, the number of participants who successfully completed their agreement period, and the number of participants terminated from the program. The reports would not be allowed to disclose any personally identifiable information.
- Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements and its implementing rules and regulations. Any audit conducted must maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and must not disclose any information identifying a program participant.

If the Board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the Board, the Board can terminate the contract.

This bill requires a physician, as a condition of participation in the PHWP, to enter into an individual agreement with the PHWP and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the written agreement. The agreement shall include the following:

- A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program.
- Compliance with terms and conditions of treatment and monitoring.
- Criteria for program completion.
- Criteria for termination of a physician participant from the program.
- Acknowledgement that withdrawal or termination of a physician participant from the program shall be reported to the Board.
- Acknowledgement that expenses related to treatment, monitoring, laboratory tests, and other specified activities shall be paid by the physician participant.

This bill specifies that any agreement entered into would not be considered a disciplinary action or order by the Board and shall not be disclosed to the Board if both of the following apply:

- The physician did not enroll in the PHWP as a condition of probation or as a result of an action by the Board.
- The physician is in compliance with the conditions and procedures in the agreement.

This bill specifies that any oral or written information reported to the Board is confidential and shall not constitute a waiver of any existing evidentiary privileges. However, confidentiality regarding the physician's participation in the program and related records shall not apply if the Board has referred a participant as a condition of probation or as otherwise authorized by this article. This bill specifies that it does not prohibit, require, or otherwise affect the discovery or admissibility of evidence in an action by the Board against a physician based on acts or omissions that are alleged to be grounds for discipline. This bill specifies that participation in the program shall not be a defense to any disciplinary action that may be taken by the Board. The requirements in this bill would not preclude the Board from taking disciplinary action against a physician who is terminated unsuccessfully from the program but the disciplinary action may not include any confidential information unless authorized (the information is only confidential if the participant is not on probation and is complying with his or her individual agreement with the PHWP and if the participant does not withdraw from the program).

This bill establishes the Physician and Surgeon Health and Wellness Program Account in the contingent fund of the Board. Any fees collected from participants shall be deposited into this account and upon appropriation by the Legislature, shall be available for support of the program. This bill requires the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP shall pay. The fee is required to be set at a level

sufficient to cover all costs of participating in the PHWP, including any administrative costs incurred by the Board to administer the PHWP. This bill allows the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP. These moneys could not be used to cover costs for individual physicians to participate in the program.

According to the sponsor, this bill will bring California in line with the majority of other states who recognize that wellness and treatment programs serve to enhance public health and provide resources for those in need of help.

The PHWP proposed by this bill is not a diversion program, it will not divert physicians from discipline; this is of utmost importance for consumer protection. The Board will not be running this program, it will be run by a private third-party independent administering entity that will be selected pursuant to the request for proposals process. This bill requires the PHWP to comply with the Uniform Standards and requires any physician participants who terminate or withdraw from the PHWP to be reported to the Board. These are both very important elements for consumer protection. This bill also allows for communication to the Board for those physicians ordered to the PHWP as a condition of probation, which is also important for consumer protection. Clarifying amendments were taken in Business and Professions Code Section 2340.6(c) to make it clear that confidentiality shall not apply if a physician is not in compliance with the conditions and procedures in the agreement. With this amendments, Board staff believes that this bill is in compliance with the Uniform Standards. Board staff also believes that the PHWP proposed by this bill aligns with the Board-approved elements and the Board has taken a support position on this bill.

FISCAL: This bill requires the Board to adopt regulations to determine the appropriate fee that a physician participating in the PHWP must pay. The fee is required to be set at a level sufficient to cover all costs of participating in the PHWP. Any fees collected by the Board from participants shall be deposited into the newly established Physician and Surgeon Health and Wellness Program Account in the Contingent Fund of the Board and, upon appropriation by the Legislature, shall be available for support of the program. This bill allows the Board, subject to appropriation by the Legislature, to use moneys from the Board's existing contingent fund to support the initial costs for the Board to establish the PHWP.

The Board will need one staff position at the Associate Governmental Program Analyst level to set up the PHWP and then coordinate with the third-party vendor to implement the PHWP.

SUPPORT: CMA (Sponsor); California Chapter of the American College of Emergency Physicians; California Health Advocates; California Hospital Association; California Primary Care Association; Medical

OPPOSITION:

Board of California; and Union of American Physicians and Dentists
Center for Public Interest Law
Consumers Union's Safe Patient Project

IMPLEMENTATION:

- Newsletter article(s) (including several stand-alone articles)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Hire the Associate Governmental Program Analyst position – the first task for this position will be to develop regulations (est. date of completion to hire – January 2017)
- Submit change request for BreEZe to add public secondary status code modifier
- Develop regulations to specify the requirements for the administering entity, including communication from the administering entity to the Board, and shared services for the administering entity to pay the Board for administration costs from participant fees
- Update regulations for the Board's Disciplinary Guidelines and Uniform Standards (this will be one regulatory package with administering entity regulations – estimated regulatory hearing at the October 2017 Board Meeting – the other deadlines will depend on when these regulations are adopted)
- Once regulations are adopted, the Board will issue a request for proposals (RFP) to select an administering entity and will include the requirements in the regulations in the RFP process
- Once the administering entity is selected, the Board will have to adopt regulations to set the fee for participants, which must cover all of the administering entities' fees and any costs to the Board for administering the program
- The Board will work with the administering entity to establish a process for filing complaints when the program notifies the Board of any participants that withdraw or who do not comply with the program requirements (including the Uniform Standards)
- Update the Board's website with information about the new program

Senate Bill No. 1177

CHAPTER 591

An act to add Article 14 (commencing with Section 2340) to Chapter 5 of Division 2 of the Business and Professions Code, relating to healing arts.

[Approved by Governor September 24, 2016. Filed with
Secretary of State September 24, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1177, Galgiani. Physician and Surgeon Health and Wellness Program.

Existing law establishes in the Department of Consumer Affairs the Substance Abuse Coordination Committee, comprised of the executive officers of the department's healing arts boards and a designee of the State Department of Health Care Services. Existing law requires the committee to formulate, by January 1, 2010, uniform and specific standards in specified areas that each healing arts board is required to use in dealing with substance-abusing licensees, whether or not a healing arts board has a formal diversion program.

Existing law, the Medical Practice Act, provides for the licensure and regulation of physicians and surgeons by the Medical Board of California within the Department of Consumer Affairs. Existing law requires all moneys paid to and received by the Medical Board of California to be paid into the State Treasury and credited to the Contingent Fund of the Medical Board of California, which, except for fine and penalty money, is a continuously appropriated fund.

This bill would authorize the board to establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse, as specified. If the board establishes a program, the bill would require the board to contract for the program's administration with a private 3rd-party independent administering entity meeting certain requirements. The bill would require program participants to enter into an individual agreement with the program that includes, among other things, a requirement to pay expenses related to treatment, monitoring, and laboratory tests, as provided.

This bill would create the Physician and Surgeon Health and Wellness Program Account within the Contingent Fund of the Medical Board of California. The bill would require the board to adopt regulations to determine the appropriate fee for a physician and surgeon to participate in the program, as specified. The bill would require these fees to be deposited in the Physician and Surgeon Health and Wellness Program Account and to be available, upon appropriation by the Legislature, for the support of the program. Subject to appropriation by the Legislature, the bill would authorize

the board to use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program, except the bill would prohibit these moneys from being used to cover any costs for individual physician and surgeon participation in the program.

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

SECTION 1. Article 14 (commencing with Section 2340) is added to Chapter 5 of Division 2 of the Business and Professions Code, to read:

Article 14. Physician and Surgeon Health and Wellness Program

2340. (a) The board may establish a Physician and Surgeon Health and Wellness Program for the early identification of, and appropriate interventions to support a physician and surgeon in his or her rehabilitation from, substance abuse to ensure that the physician and surgeon remains able to practice medicine in a manner that will not endanger the public health and safety and that will maintain the integrity of the medical profession. The program, if established, shall aid a physician and surgeon with substance abuse issues impacting his or her ability to practice medicine.

(b) For the purposes of this article, “program” shall mean the Physician and Surgeon Health and Wellness Program.

(c) If the board establishes a program, the program shall meet the requirements of this article.

2340.2. If the board establishes a program, the program shall do all of the following:

(a) Provide for the education of all licensed physicians and surgeons with respect to the recognition and prevention of physical, emotional, and psychological problems.

(b) Offer assistance to a physician and surgeon in identifying substance abuse problems.

(c) Evaluate the extent of substance abuse problems and refer the physician and surgeon to the appropriate treatment by executing a written agreement with a physician and surgeon participant.

(d) Provide for the confidential participation by a physician and surgeon with substance abuse issues who does not have a restriction on his or her practice related to those substance abuse issues. If an investigation of a physician and surgeon occurs after the physician and surgeon has enrolled in the program, the board may inquire of the program whether the physician and surgeon is enrolled in the program and the program shall respond accordingly.

(e) Comply with the Uniform Standards Regarding Substance-Abusing Healing Arts Licensees as adopted by the Substance Abuse Coordination Committee of the department pursuant to Section 315.

2340.4. (a) If the board establishes a program, the board shall contract for the program's administration with a private third-party independent administering entity pursuant to a request for proposals. The process for procuring the services for the program shall be administered by the board pursuant to Article 4 (commencing with Section 10335) of Chapter 2 of Part 2 of Division 2 of the Public Contract Code. However, Section 10425 of the Public Contract Code shall not apply to this subdivision.

(b) The administering entity shall have expertise and experience in the areas of substance or alcohol abuse in healing arts professionals.

(c) The administering entity shall identify and use a statewide treatment resource network that includes treatment and screening programs and support groups and shall establish a process for evaluating the effectiveness of those programs.

(d) The administering entity shall provide counseling and support for the physician and surgeon and for the family of any physician and surgeon referred for treatment.

(e) The administering entity shall make their services available to all licensed California physicians and surgeons, including those who self-refer to the program.

(f) The administering entity shall have a system for immediately reporting a physician and surgeon, including, but not limited to, a physician and surgeon who withdraws or is terminated from the program, to the board. This system shall ensure absolute confidentiality in the communication to the board. The administering entity shall not provide this information to any other individual or entity unless authorized by the participating physician and surgeon or this article.

(g) The contract entered into pursuant to this section shall also require the administering entity to do the following:

(1) Provide regular communication to the board, including annual reports to the board with program statistics, including, but not limited to, the number of participants currently in the program, the number of participants referred by the board as a condition of probation, the number of participants who have successfully completed their agreement period, and the number of participants terminated from the program. In making reports, the administering entity shall not disclose any personally identifiable information relating to any participant.

(2) Submit to periodic audits and inspections of all operations, records, and management related to the program to ensure compliance with the requirements of this article and its implementing rules and regulations. Any audit conducted pursuant to this section shall maintain the confidentiality of all records reviewed and information obtained in the course of conducting the audit and shall not disclose any information identifying a program participant.

(h) If the board determines the administering entity is not in compliance with the requirements of the program or contract entered into with the board, the board may terminate the contract.

2340.6. (a) A physician and surgeon shall, as a condition of participation in the program, enter into an individual agreement with the program and agree to pay expenses related to treatment, monitoring, laboratory tests, and other activities specified in the participant's written agreement. The agreement shall include all of the following:

- (1) A jointly agreed-upon plan and mandatory conditions and procedures to monitor compliance with the program.
- (2) Compliance with terms and conditions of treatment and monitoring.
- (3) Criteria for program completion.
- (4) Criteria for termination of a physician and surgeon participant from the program.
- (5) Acknowledgment that withdrawal or termination of a physician and surgeon participant from the program shall be reported to the board.
- (6) Acknowledgment that expenses related to treatment, monitoring, laboratory tests, and other activities specified by the program shall be paid by the physician and surgeon participant.

(b) Any agreement entered into pursuant to this section shall not be considered a disciplinary action or order by the board and shall not be disclosed to the board if both of the following apply:

- (1) The physician and surgeon did not enroll in the program as a condition of probation or as a result of an action by the board.
- (2) The physician and surgeon is in compliance with the conditions and procedures in the agreement.

(c) Any oral or written information reported to the board shall remain confidential and shall not constitute a waiver of any existing evidentiary privileges. However, confidentiality regarding the physician and surgeon's participation in the program and related records shall not apply if the board has referred a participant as a condition of probation or as otherwise authorized by this article.

(d) Nothing in this section prohibits, requires, or otherwise affects the discovery or admissibility of evidence in an action by the board against a physician and surgeon based on acts or omissions that are alleged to be grounds for discipline.

(e) Participation in the program shall not be a defense to any disciplinary action that may be taken by the board. This section does not preclude the board from commencing disciplinary action against a physician and surgeon who is terminated unsuccessfully from the program. However, that disciplinary action shall not include as evidence any confidential information unless authorized by this article.

2340.8. (a) The Physician and Surgeon Health and Wellness Program Account is hereby established within the Contingent Fund of the Medical Board of California. Any fees collected by the board pursuant to subdivision (b) shall be deposited in the Physician and Surgeon Health and Wellness Program Account and shall be available, upon appropriation by the Legislature, for the support of the program.

(b) The board shall adopt regulations to determine the appropriate fee that a physician and surgeon participating in the program shall provide to

the board. The fee amount adopted by the board shall be set at a level sufficient to cover all costs for participating in the program, including any administrative costs incurred by the board to administer the program.

(c) Subject to appropriation by the Legislature, the board may use moneys from the Contingent Fund of the Medical Board of California to support the initial costs for the board to establish the program under this article, except these moneys shall not be used to cover any costs for individual physician and surgeon participation in the program.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

<u>Bill Number:</u>	SB 1189
<u>Author:</u>	Pan and Jackson
<u>Chapter:</u>	787
<u>Bill Date:</u>	August 19, 2016, Amended
<u>Subject:</u>	Autopsies: Licensed Physicians and Surgeons
<u>Sponsor:</u>	Union of American Physicians and Dentists (UAPD)
<u>Position:</u>	Support

DESCRIPTION OF CURRENT LEGISLATION:

This bill requires that a forensic autopsy be conducted by a licensed physician and surgeon and requires that the results of a forensic autopsy can only be determined by a licensed physician and surgeon.

BACKGROUND

California law does not define the term “autopsy,” but a 1970 opinion of the California Attorney General states that an autopsy is a “form of postmortem examination in which a dead body is examined and at least partially dissected for the purpose of ascertaining the cause of death, the nature and extent of lesions of disease, or any other abnormalities present.”

The Ventura County District Attorney’s (DA) Office published a report in February 2016 entitled “A Report on the Ventura County Medical Examiner Investigation.” In this report, the Ventura County DA reviews the investigation it conducted on Ventura County’s former Medical Examiner, and discusses the obstacles faced by the DA’s office in pursuing criminal action. In the report, it brings up several grey areas of law related to autopsies and who can perform them. The report states that there is no California law that defines an autopsy and there is no statute that clearly defines that performance of an autopsy is the practice of medicine. The report also states there is a need for legislation to clarify whether the performance of an autopsy is included in the practice of medicine.

Fifty of California’s 58 counties have sheriff-coroner offices, which means that the two offices are consolidated and the sheriff also serves as the coroner. There are sections in the Government Code that authorize the coroner to perform autopsies. There is also a section in the Health and Safety Code that allows an autopsy to be performed by a coroner or other officer authorized by law to perform autopsies. The definition of the practice of medicine in the Medical Practice Act does not specifically address that conducting an autopsy on a dead body constitutes the practice of medicine. The Ventura County DA’s office makes recommendations in the conclusion of its report that the Legislature should consider amending existing law to clarify whether an autopsy is the practice of medicine and to define the term autopsy.

ANALYSIS

This bill expressly states that forensic autopsies can only be conducted by a licensed physician and surgeon. This bill requires that the results of an autopsy may only be determined by a licensed physician and surgeon. This bill defines a forensic autopsy as an examination of a body of a decedent to generate medical evidence for which the cause and manner of death is determined. This bill specifies at the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon, trained county personnel who are necessary to the performance of an autopsy may take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent. This bill defines a postmortem examination to mean the external examination of the body where no manner or cause of death is determined. This bill requires the manner of death to be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner shall consult with the licensed physician and surgeon in the determination of the manner of death.

This bill provides, for health and safety purposes, all persons in the autopsy suite to be informed of the risks presented by blood borne pathogens and they should wear personal protective equipment, as specified. This bill only allows individuals who are directly involved in the investigation of the death of the decedent in the autopsy suite. If an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved in the death of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of an autopsy. This bill allows individuals in the autopsy suite for educational and research purposes at the discretion of the coroner, and in consultation with any licensed physician and surgeon conducting an autopsy. This bill requires police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to the death that is incident to law enforcement activity to be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death. This bill makes conforming changes to other portions of the Government Code that reference autopsies.

According to the authors, a medically-trained physician and surgeon is best equipped to determine the results of an autopsy. Clarifying that a medically trained professional should be the one who conducts the autopsy also clarifies ambiguities in existing law. The sponsors of this bill believe that elected officials lack the medical expertise necessary to perform an autopsy to the same degree as a licensed physician and surgeon and this bill seeks to add further legitimacy and authority to death investigations in coroner cases.

The Board believes there are grey areas in the law related to autopsies being the practice of medicine and who can perform autopsies. This bill makes it clear in the law that autopsies can only be performed by licensed physicians and surgeons, which is appropriate. This clarification will assist the Board in its enforcement actions and further the Board's

mission of consumer protection. For these reasons, the Board has taken a support position on this bill.

FISCAL: None

SUPPORT: UAPD (Sponsor)
Consumer Attorneys of California
Medical Board of California
National Association of Medical Examiners
Ventura County District Attorney's Office
Three individuals

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Update the Board's website to include information on the requirements of this bill

Senate Bill No. 1189

CHAPTER 787

An act to amend Sections 27491.4, 27491.41, 27491.43, 27491.46, 27491.47, and 27520 of, and to add Section 27522 to, the Government Code, relating to autopsies.

[Approved by Governor September 28, 2016. Filed with Secretary of State September 28, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1189, Pan. Postmortem examinations or autopsies: forensic pathologists.

Existing law requires a county coroner to inquire into and determine the circumstances, manner, and cause of certain deaths. Existing law either requires or authorizes a county coroner, under certain circumstances, to perform, or cause to be performed, an autopsy on a decedent. Existing law imposes certain requirements on a postmortem examination or autopsy conducted at the discretion of a coroner, medical examiner, or other agency upon an unidentified body or human remains. Existing law requires the coroner to perform an autopsy pursuant to a standardized protocol developed by the State Department of Public Health in any case where an infant has died suddenly and unexpectedly.

Existing law authorizes the board of supervisors of a county to consolidate the duties of certain county offices in one or more of specified combinations, including, but not limited to, sheriff and coroner, district attorney and coroner, and public administrator and coroner. Existing law authorizes the board of supervisors of a county to abolish the office of coroner and provide instead for the office of medical examiner, as specified, and requires the medical examiner to be a licensed physician and surgeon duly qualified as a specialist in pathology.

This bill would require that a forensic autopsy, as defined, be conducted by a licensed physician and surgeon. The bill would require that the results of a forensic autopsy be determined by a licensed physician and surgeon. The bill would require the manner of death to be determined by the coroner or medical examiner of a county. The bill would authorize trained county personnel who are necessary to the performance of an autopsy to take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent at the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon. The bill would require, if a licensed physician and surgeon conducts a forensic autopsy, the coroner or medical examiner to consult with the licensed physician and surgeon in the determination of the manner of death. The bill would require the coroner to conduct an evaluation pursuant to a standardized protocol developed by

the State Department of Public Health in any case where an infant has died suddenly and unexpectedly.

The bill would require, for health and safety purposes, that all persons in the autopsy suite be informed of the risks presented by bloodborne pathogens and be informed that they should wear personal protective equipment, as specified. The bill would require that only individuals who are directly involved in the investigation of the death of the decedent be allowed into the autopsy suite but would permit individuals to be in the autopsy suite for educational and research purposes at the discretion of the coroner, in consultation with any licensed physician and surgeon conducting an autopsy. The bill would prohibit law enforcement personnel directly involved in the death of an individual who died due to involvement of law enforcement activity from being involved with any portion of the postmortem examination or being inside the autopsy suite during the performance of the autopsy. The bill would define a postmortem examination for this purpose to be the external examination of the body where no manner or cause of death is determined.

The bill would require specified materials that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity to be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death.

The bill would specify that these provisions shall not be construed to limit the practice of an autopsy for educational or research purposes.

By imposing additional duties upon local officials and law enforcement agencies, this bill would create a state-mandated local program.

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

The bill would provide that, if the Commission on State Mandates determines that the bill contains costs mandated by the state, reimbursement for those costs shall be made pursuant to these statutory provisions.

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

SECTION 1. Section 27491.4 of the Government Code is amended to read:

27491.4. (a) For purposes of inquiry the coroner shall, within 24 hours or as soon as feasible thereafter, where the suspected cause of death is sudden infant death syndrome and, in all other cases, the coroner may, in his or her discretion, take possession of the body, which shall include the authority to exhume the body, order it removed to a convenient place, and make or cause to be made a postmortem examination, or cause to be made an autopsy thereon, and make or cause to be made an analysis of the stomach, stomach contents, blood, organs, fluids, or tissues of the body. The detailed medical findings resulting from an inspection of the body or autopsy by an examining licensed physician and surgeon shall be either reduced to writing or

permanently preserved on recording discs or other similar recording media, shall include all positive and negative findings pertinent to establishing the cause of death in accordance with medicolegal practice and this, along with the written opinions and conclusions of the examining licensed physician and surgeon, shall be included in the coroner's record of the death. The coroner shall have the right to retain only those tissues of the body removed at the time of the autopsy as may, in his or her opinion, be necessary or advisable to the inquiry into the case, or for the verification of his or her findings. Only individuals who are directly involved in the investigation of the death of the decedent may be present during the performance of the autopsy.

(b) In any case in which the coroner knows, or has reason to believe, that the deceased has made valid provision for the disposition of his or her body or a part or parts thereof for medical or scientific purposes in accordance with Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code, the coroner shall neither perform nor authorize any other person to perform an autopsy on the body unless the coroner has contacted or attempted to contact the physician last in attendance to the deceased. If the physician cannot be contacted, the coroner shall then notify or attempt to notify one of the following of the need for an autopsy to determine the cause of death: (1) the surviving spouse; (2) a surviving child or parent; (3) a surviving brother or sister; (4) any other kin or person who has acquired the right to control the disposition of the remains. Following a period of 24 hours after attempting to contact the physician last in attendance and notifying or attempting to notify one of the responsible parties listed above, the coroner may authorize the performance of an autopsy, as otherwise authorized or required by law.

(c) Nothing in this section shall be deemed to prohibit the discretion of the coroner to cause to be conducted an autopsy upon any victim of sudden, unexpected, or unexplained death or any death known or suspected of resulting from an accident, suicide, or apparent criminal means, or other death, as described in Section 27491.

SEC. 2. Section 27491.41 of the Government Code is amended to read:

27491.41. (a) For purposes of this section, "sudden infant death syndrome" means the sudden death of any infant that is unexpected by the history of the infant and where a thorough postmortem examination fails to demonstrate an adequate cause of death.

(b) The Legislature finds and declares that sudden infant death syndrome, also referred to as SIDS, is the leading cause of death for children under age one, striking one out of every 500 children. The Legislature finds and declares that sudden infant death syndrome is a serious problem within the State of California, and that the public interest is served by research and study of sudden infant death syndrome and its potential causes and indications.

(c) (1) To facilitate these purposes, the coroner shall, within 24 hours or as soon thereafter as feasible, cause an autopsy to be performed in any case where an infant has died suddenly and unexpectedly.

(2) However, if the attending licensed physician and surgeon desires to certify that the cause of death is sudden infant death syndrome, an autopsy may be performed at the discretion of the coroner. If the coroner causes an autopsy to be performed pursuant to this section, he or she shall also certify the cause of death.

(d) The autopsy shall be conducted pursuant to a standardized protocol developed by the State Department of Public Health. The protocol is exempt from the procedural requirements pertaining to the adoption of administrative rules and regulations pursuant to Article 5 (commencing with Section 11346) of Chapter 3.5 of Part 1 of Division 3 of Title 2 of the Government Code.

(e) The protocol shall be followed by all coroners throughout the state when conducting an evaluation as part of an autopsy required by this section. The coroner shall state on the certificate of death that sudden infant death syndrome was the cause of death when the coroner's findings are consistent with the definition of sudden infant death syndrome specified in the standardized autopsy protocol. The protocol may include requirements and standards for scene investigations, requirements for specific data, criteria for ascertaining cause of death based on the autopsy, and criteria for any specific tissue sampling, and any other requirements. The protocol may also require that specific tissue samples shall be provided to a central tissue repository designated by the State Department of Public Health.

(f) The State Department of Public Health shall establish procedures and protocols for access by researchers to any tissues, or other materials or data authorized by this section. Research may be conducted by any individual with a valid scientific interest and prior approval from the State Committee for the Protection of Human Subjects. The tissue samples, the materials, and all data shall be subject to the confidentiality requirements of Section 103850 of the Health and Safety Code.

(g) The coroner may take tissue samples for research purposes from infants who have died suddenly and unexpectedly without consent of the responsible adult if the tissue removal is not likely to result in any visible disfigurement.

(h) A coroner or licensed physician and surgeon shall not be liable for damages in a civil action for any act or omission done in compliance with this section.

(i) Consent of any person is not required before undertaking the autopsy required by this section.

SEC. 3. Section 27491.43 of the Government Code is amended to read:

27491.43. (a) (1) Notwithstanding any other law, except as otherwise provided in this section, in any case in which the coroner, before the beginning of an autopsy, dissection, or removal of corneal tissue, pituitary glands, or any other organ, tissue, or fluid, has received a certificate of religious belief, executed by the decedent as provided in subdivision (b), that the procedure would be contrary to his or her religious belief, the coroner shall neither perform, nor order the performance of, that procedure on the body of the decedent.

(2) If, before beginning the procedure, the coroner is informed by a relative or a friend of the decedent that the decedent had executed a certificate of religious belief, the coroner shall not order an autopsy to be performed, except as otherwise provided in this section, for 48 hours. If the certificate is produced within 48 hours, the case shall be governed by this section. If the certificate is not produced within that time, the case shall be governed by the other provisions of this article.

(b) Any person, 18 years of age or older, may execute a certificate of religious belief which shall state in clear and unambiguous language that any postmortem anatomical dissection or that specified procedures would violate the religious convictions of the person. The certificate shall be signed and dated by the person in the presence of at least two witnesses. Each witness shall also sign the certificate and shall print on the certificate his or her name and residence address.

(c) Notwithstanding the existence of a certificate, the coroner may at any time cause an autopsy to be performed or any other procedure if he or she has a reasonable suspicion that the death was caused by the criminal act of another or by a contagious disease constituting a public health hazard.

(d) (1) If a certificate is produced, and if subdivision (c) does not apply, the coroner may petition the superior court, without fee, for an order authorizing an autopsy or other procedure or for an order setting aside the certificate as invalid. Notice of the proceeding shall be given to the person who produced the certificate. The proceeding shall have preference over all other cases.

(2) The court shall set aside the certificate if it finds that the certificate was not properly executed or that it does not clearly state the decedent's religious objection to the proposed procedure.

(3) The court may order an autopsy or other procedure despite a valid certificate if it finds that the cause of death is not evident, and that the interest of the public in determining the cause of death outweighs its interest in permitting the decedent and like persons fully to exercise their religious convictions.

(4) Any procedure performed pursuant to paragraph (3) shall be the least intrusive procedure consistent with the order of the court.

(5) If the petition is denied, and no stay is granted, the body of the deceased shall immediately be released to the person authorized to control its disposition.

(e) In any case in which the circumstances, manner, or cause of death is not determined because of the provisions of this section, the coroner may state on the certificate of death that an autopsy was not conducted because of the provisions of this section.

(f) A coroner shall not be liable for damages in a civil action for any act or omission taken in compliance with the provisions of this section.

SEC. 4. Section 27491.46 of the Government Code is amended to read:

27491.46. (a) The coroner shall have the right to retain pituitary glands solely for transmission to a university, for use in research or the advancement of medical science, in those cases in which the coroner has required an

autopsy to be performed pursuant to this chapter, and during a 48-hour period following such autopsy the body has not been claimed and the coroner has not been informed of any relatives of the decedent.

(b) In the course of any autopsy, the coroner may cause to be removed the pituitary gland from the body for transmittal to any public agency for use in manufacturing a hormone necessary for the physical growth of persons who are, or may become, hypopituitary dwarfs, if the coroner has no knowledge of objection to the removal and release of the pituitary gland having been made by the decedent or any other person specified in Section 7151.5 of the Health and Safety Code. Neither the coroner nor the medical examiner authorizing the removal of the pituitary gland, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of the pituitary gland pursuant to this section, shall incur civil liability for the removal of the pituitary gland in an action brought by any person who did not object prior to the removal of the pituitary gland, nor be subject to criminal prosecution for removal of the pituitary gland pursuant to the authority of this section.

Nothing in this subdivision shall supersede the terms of any gift made pursuant to Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code.

SEC. 5. Section 27491.47 of the Government Code is amended to read:

27491.47. (a) Notwithstanding any other law, the coroner may, in the course of an autopsy, authorize the removal and release of corneal eye tissue from a body within the coroner's custody, if all of the following conditions are met:

(1) The autopsy has otherwise been authorized.

(2) The coroner has no knowledge of objection to the removal and release of corneal tissue having been made by the decedent or any other person specified in Section 7151 of the Health and Safety Code and has obtained any one of the following:

(A) A dated and signed written consent by the donor or any other person specified in Section 7151 of the Health and Safety Code on a form that clearly indicates the general intended use of the tissue and contains the signature of at least one witness.

(B) Proof of the existence of a recorded telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code in the form of an audio recording of the conversation or a transcript of the recorded conversation, which indicates the general intended use of the tissue.

(C) A document recording a verbal telephonic consent by the donor or any other person specified in Section 7151 of the Health and Safety Code, witnessed and signed by no fewer than two members of the requesting entity, hospital, eye bank, or procurement organization, memorializing the consenting person's knowledge of and consent to the general intended use of the gift.

The form of consent obtained under subparagraph (A), (B), or (C) shall be kept on file by the requesting entity and the official agency for a minimum of three years.

(3) The removal of the tissue will not unnecessarily mutilate the body, be accomplished by enucleation, nor interfere with the autopsy.

(4) The tissue will be removed by a licensed physician and surgeon or a trained transplant technician.

(5) The tissue will be released to a public or nonprofit facility for transplant, therapeutic, or scientific purposes.

(b) Neither the coroner nor medical examiner authorizing the removal of the corneal tissue, nor any hospital, medical center, tissue bank, storage facility, or person acting upon the request, order, or direction of the coroner or medical examiner in the removal of corneal tissue pursuant to this section, shall incur civil liability for the removal in an action brought by any person who did not object prior to the removal of the corneal tissue, nor be subject to criminal prosecution for the removal of the corneal tissue pursuant to this section.

(c) This section shall not be construed to interfere with the ability of a person to make an anatomical gift pursuant to the Uniform Anatomical Gift Act (Chapter 3.5 (commencing with Section 7150) of Part 1 of Division 7 of the Health and Safety Code).

SEC. 6. Section 27520 of the Government Code is amended to read:

27520. (a) The coroner shall cause to be performed an autopsy on a decedent, for which an autopsy has not already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner shall cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(b) The coroner may cause to be performed an autopsy on a decedent, for which an autopsy has already been performed, if the surviving spouse requests him or her to do so in writing. If there is no surviving spouse, the coroner may cause an autopsy to be performed if requested to do so in writing by a surviving child or parent, or if there is no surviving child or parent, by the next of kin of the deceased.

(c) The cost of an autopsy requested pursuant to either subdivision (a) or (b) shall be borne by the person requesting that it be performed.

SEC. 7. Section 27522 is added to the Government Code, to read:

27522. (a) A forensic autopsy shall only be conducted by a licensed physician and surgeon. The results of a forensic autopsy shall only be determined by a licensed physician and surgeon.

(b) A forensic autopsy shall be defined as an examination of a body of a decedent to generate medical evidence for which the cause of death is determined. At the direction and supervision of a coroner, a medical examiner, or a licensed physician and surgeon, trained county personnel who are necessary to the performance of an autopsy may take body measurements or retrieve blood, urine, or vitreous samples from the body of a decedent.

(c) For purposes of this section, a postmortem examination shall be defined as the external examination of the body where no manner or cause of death is determined.

(d) For purposes of this section, the manner of death shall be determined by the coroner or medical examiner of a county. If a forensic autopsy is conducted by a licensed physician and surgeon, the coroner or medical examiner shall consult with the licensed physician and surgeon in the determination of the manner of death.

(e) For health and safety purposes, all persons in the autopsy suite shall be informed of the risks presented by bloodborne pathogens and that they should wear personal protective equipment in accordance with the requirements described in Section 5193 of Title 8 of the California Code of Regulations or its successor.

(f) (1) Only individuals who are directly involved in the investigation of the death of the decedent shall be allowed into the autopsy suite.

(2) If an individual dies due to the involvement of law enforcement activity, law enforcement personnel directly involved in the death of that individual shall not be involved with any portion of the postmortem examination, nor allowed inside the autopsy suite during the performance of the autopsy.

(3) Notwithstanding paragraph (1), individuals may be permitted in the autopsy suite for educational and research purposes at the discretion of the coroner and in consultation with any licensed physician and surgeon conducting an autopsy.

(g) Any police reports, crime scene or other information, videos, or laboratory tests that are in the possession of law enforcement and are related to a death that is incident to law enforcement activity shall be made available to the physician and surgeon who conducts the autopsy prior to the completion of the investigation of the death.

(h) This section shall not be construed to limit the practice of an autopsy for educational or research purposes.

SEC. 8. If the Commission on State Mandates determines that this act contains costs mandated by the state, reimbursement to local agencies and school districts for those costs shall be made pursuant to Part 7 (commencing with Section 17500) of Division 4 of Title 2 of the Government Code.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

Bill Number: SB 1261
Author: Stone
Chapter: 239
Bill Date: May 3, 2016, Amended
Subject: Physicians and Surgeons: Fee Exemption: Residency
Sponsor: California Primary Care Association (CPCA)
Position: Neutral

DESCRIPTION OF CURRENT LEGISLATION:

This bill deletes the requirement in existing law that a physician and surgeon must reside in California in order to get the license and renewal fees waived for providing volunteer services.

BACKGROUND

Currently, the initial or renewal license fee is waived for a physician and surgeon who resides in California, has a California address of record, and certifies to the Medical Board of California (Board) that the initial or renewal license is for the sole purpose of providing voluntary, unpaid service. A voluntary service physician licensee whose initial and/or renewal license fee has been waived pursuant to Business and Professions Code sections 2083 and 2442 must comply with the continuing medical education requirements.

ANALYSIS

SB 1261 deletes the California residency requirement for voluntary status licenses. This bill allows an out-of-state individual 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 that his or her license be placed in voluntary status. These options result in the initial license fee and/or subsequent renewal fees being waived. In order to be issued a voluntary status license, a licensee must certify to the Board that the sole purpose of his or her license is to provide voluntary, unpaid service. This bill may encourage more licensed physicians to provide volunteer services in California. The Board has taken a neutral position on this bill.

FISCAL: Minor and absorbable

SUPPORT: None on file

OPPOSITION: None on file

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff
- Update the Board's website regarding voluntary status licenses
- Update the Board's voluntary status license application and initial license application

Senate Bill No. 1261

CHAPTER 239

An act to amend Sections 2083 and 2442 of the Business and Professions Code, relating to healing arts.

[Approved by Governor August 29, 2016. Filed with Secretary of State August 29, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1261, Stone. Physicians and surgeons: fee exemption: residency.

The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California and establishes specific requirements for licensure and renewal. That act generally requires that an application for a certificate be accompanied by the fee required by the act, but requires the waiver of the fee for a physician and surgeon residing in California who certifies to the board that the license is for the sole purpose of providing voluntary, unpaid service. The act establishes a parallel fee waiver requirement for the renewal of a physician and surgeon's certificate.

This bill would remove from those application and renewal fee waiver provisions the requirement that a physician and surgeon reside in California.

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

SECTION 1. Section 2083 of the Business and Professions Code is amended to read:

2083. (a) Except as provided in subdivision (b), each application for a certificate shall be accompanied by the fee required by this chapter and shall be filed with the Division of Licensing.

(b) The license fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that the issuance of the license is for the sole purpose of providing voluntary, unpaid service.

SEC. 2. Section 2442 of the Business and Professions Code is amended to read:

2442. The renewal fee shall be waived for a physician and surgeon who certifies to the Medical Board of California that license renewal is for the sole purpose of providing voluntary, unpaid service.

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MEDICAL BOARD OF CALIFORNIA
LEGISLATIVE ANALYSIS

<u>Bill Number:</u>	SB 1478
<u>Author:</u>	Senate Business, Professions and Economic Development Committee
<u>Chapter:</u>	489
<u>Bill Date:</u>	August 18, 2016, Amended
<u>Subject:</u>	Healing Arts
<u>Sponsor:</u>	Author and affected healing arts boards
<u>Position:</u>	Support provisions related to the Medical Board of California

DESCRIPTION OF CURRENT LEGISLATION:

This bill was the vehicle by which omnibus legislation was carried by the Senate Business, Professions and Economic Development Committee. This analysis only includes the relevant sections of the bill in the Business and Professions Code (BPC) that are sponsored by and impact the Medical Board of California (Board). This bill deletes outdated sections of the BPC that are related to the Board. This bill also clarifies that the annual fee for the Controlled Substance Utilization Review and Evaluation System (CURES) shall not be applied to licensees in retired or inactive status, while this portion was not sponsored by the Board, it will impact the Board's licensees.

ANALYSIS

- This bill deletes BPC Section 2029 that requires the Board to keep copies of complaints for 10 years. The Board already has its own record retention schedule and BPC Section 2227.5 only requires the Board to keep complaints for seven years or until the statute of limitations has expired, whichever is shorter. BPC Section 2230.5 sets forth the statute of limitations for filing an accusation, which is three years from the date the Board finds out about the event or seven years from the date of the event, whichever occurs first. Both of these section of law make BPC 2029 inapplicable.
- This bill deletes the task force created in BPC Section 852, as it no longer exists.
- This bill also deletes Sections 2380-2392 of the BPC, which created the Bureau of Medical Statistics in the Board. The Bureau of Medical Statistics does not exist, so this change is code clean up only.

These changes will remove outdated and inapplicable sections from the BPC and the Board was pleased to sponsor/support these provisions in SB 1478.

This bill was amended and now clarifies that the annual fee for CURES shall not be applied to licensees in retired or inactive status. This provision was not sponsored by the Board, but it will impact the Board's licensees with a license in retired or inactive status.

FISCAL: None

SUPPORT: Medical Board of California

OPPOSITION: None on File

IMPLEMENTATION:

- Newsletter article(s)
- Notify/train Board staff; Department of Consumer Affairs, Division of Investigation staff; and the Attorney General's Office, Health Quality Enforcement Section
- Submit a request for changes to BreEZE to exclude the CURES fee from physician renewal transactions when the retired fee exempt modifier or inactive secondary status code modifiers are present, effective 7/1/2017
- Update the Board's website to specify that CURES fees do not need to be paid by licensees with a license in retired or inactive status

Senate Bill No. 1478

CHAPTER 489

An act to amend Sections 27, 208, 1632, 1634.1, 2467, 2541.3, 2541.6, 2545, 2550, 2550.1, 2552, 2553, 2554, 2555, 2555.1, 2558, 2559, 2559.2, 2559.3, 2559.5, 2561, 2563, 3027, 4980.36, 4980.37, 4980.43, 4980.78, 4980.79, 4980.81, 4992.05, 4996.3, 4996.18, 4996.23, 4999.12, 4999.40, 4999.47, 4999.52, 4999.60, 4999.61, and 4999.120 of, to add Sections 4980.09 and 4999.12.5 to, to repeal Sections 852, 2029, 2540.1, 4980.40.5, and 4999.54 of, and to repeal Article 16 (commencing with Section 2380) of Chapter 5 of Division 2 of, the Business and Professions Code, relating to healing arts.

[Approved by Governor September 22, 2016. Filed with
Secretary of State September 22, 2016.]

LEGISLATIVE COUNSEL'S DIGEST

SB 1478, Committee on Business, Professions and Economic Development. Healing arts.

Existing law provides for the licensure and regulation of healing arts professions and vocations by boards within the Department of Consumer Affairs.

(1) Existing law requires a Controlled Substance Utilization Review and Evaluation System (CURES) fee of \$6 to be assessed annually, at the time of license renewal, on specified licensees to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees.

The bill would, beginning July 1, 2017, except as specified, exempt licensees issued a license placed in a retired or inactive status from the CURES fee requirement.

(2) Existing law establishes the Task Force on Culturally and Linguistically Competent Physicians and Dentists. Existing law requires the task force to develop recommendations for a continuing education program that includes language proficiency standards of foreign language to be acquired to meet linguistic competency, identify the key cultural elements necessary to meet cultural competency by physicians, dentists, and their offices and assess the need for voluntary certification standards and examinations for cultural and linguistic competency.

This bill would delete those provisions.

(3) The Dental Practice Act provides for the licensure and regulation of dentists by the Dental Board of California. Existing law requires each applicant to, among other things, successfully complete the Part I and Part II written examinations of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

This bill would instead require the applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(4) The Medical Practice Act provides for the licensure and regulation of physicians and surgeons by the Medical Board of California.

Existing law requires the board to keep a copy of a complaint it receives regarding the poor quality of care rendered by a licensee for 10 years from the date the board receives the complaint, as provided.

This bill would delete that requirement.

Existing law creates the Bureau of Medical Statistics within the board. Under existing law, the purpose of the bureau is to provide the board with statistical information necessary to carry out their functions of licensing, medical education, medical quality, and enforcement.

This bill would abolish that bureau.

(5) Under existing law, the California Board of Podiatric Medicine is responsible for the certification and regulation of the practice of podiatric medicine. Existing law requires the board to annually elect one of its members to act as president and vice president.

This bill would instead require the board to elect from its members a president, a vice president, and a secretary.

(6) Under existing law, any person who violates any of the provisions governing prescription lenses is subject to a specified fine per violation. Existing law requires the fines from licensed physicians and surgeons and registered dispensing opticians to be available upon appropriation to the Medical Board of California for the purposes of administration and enforcement. Existing law requires the fines from licensed optometrists to be deposited into the Optometry Fund and to be available upon appropriation to the State Board of Optometry for the purposes of administration and enforcement. Beginning January 1, 2016, existing law makes the State Board of Optometry responsible for the registration and regulation of registered dispensing opticians.

This bill would instead require fines from registered dispensing opticians to be deposited in the Dispensing Opticians Fund and to be available upon appropriation to the State Board of Optometry.

(7) The Board of Behavioral Sciences is responsible for administering, among others, the Licensed Marriage and Family Therapist Act, the Clinical Social Worker Practice Act, and the Licensed Professional Clinical Counselor Act.

(A) Existing law, the Licensed Marriage and Family Therapist Act, provides for the regulation of the practice of marriage and family therapy by the Board of Behavioral Sciences. A violation of the act is a crime. Existing law requires the licensure of marriage and family therapists and the registration of marriage and family therapist interns. Under existing law, an “intern” is defined as an unlicensed person who has earned his or her master’s or doctoral degree qualifying him or her for licensure and is registered with the board. Existing law prohibits the abbreviation “MFTI”

from being used in an advertisement unless the title “marriage and family therapist registered intern” appears in the advertisement.

Existing law, the Licensed Professional Clinical Counselor Act, provides for the regulation of the practice of professional clinical counseling by the Board of Behavioral Sciences. Existing law requires the licensure of professional clinical counselors and the registration of professional clinical counselor interns. Under existing law, an “intern” is defined as an unlicensed person who meets specified requirements for registration and is registered with the board.

This bill, commencing January 1, 2018, would provide that certain specified titles using the term “intern” or any reference to the term “intern” in those acts shall be deemed to be a reference to an “associate,” as specified. Because this bill would change the definition of a crime in the Licensed Marriage and Family Therapist Act, it would impose a state-mandated local program.

(B) The Licensed Marriage and Family Therapist Act generally requires specified applicants for licensure and registration to meet certain educational degree requirements, including having obtained that degree from a school, college, or university that, among other things, is accredited by a regional accrediting agency recognized by the United States Department of Education.

This bill would authorize that accreditation to be by a regional or national institutional accrediting agency recognized by the United States Department of Education.

Existing law requires these applicants to meet specified educational requirements, including a minimum of two semester units of instruction in the diagnosis, assessment, prognosis, and treatment of mental disorders, including severe mental disorders, evidence-based practices, psychological testing, psychopharmacology, and promising mental health practices that are evaluated in peer-reviewed literature. Existing law requires these specified educational requirements to include at least one semester unit or 15 hours of instruction in psychological testing and at least one semester unit or 15 hours of instruction in psychopharmacology.

This bill would recast that instruction in psychological testing and psychopharmacology as a separate educational requirement.

Under the Licensed Marriage and Family Therapist Act, a specified doctoral or master’s degree approved by the Bureau for Private Postsecondary and Vocational Education as of June 30, 2007, is considered by the Board of Behavioral Sciences to meet the specified licensure and registration requirements if the degree is conferred on or before July 1, 2010. As an alternative, existing law requires the Board of Behavioral Sciences to accept those doctoral or master’s degrees as equivalent degrees if those degrees are conferred by educational institutions accredited by specified associations.

This bill would delete those provisions.

(C) Under the Licensed Marriage and Family Therapist Act, an applicant for licensure is required to complete experience related to the practice of marriage and family therapy under the supervision of a supervisor. Existing

law requires an applicant seeking licensure as a professional clinical counselor or a marriage and family therapist to possess a degree that contains a practicum coursework requirement that may be satisfied by conducting face-to-face counseling. Existing law requires applicants, trainees who are unlicensed persons enrolled in an educational program to qualify for licensure, and interns who are unlicensed persons who have completed an educational program and is registered with the board to be at all times under the supervision of a supervisor. Existing law requires interns and trainees to only gain supervised experience as an employee or volunteer and prohibits experience from being gained as an independent contractor. Similarly, the Licensed Professional Clinical Counselor Act requires clinical counselor trainees, interns, and applicants to perform services only as an employee or as a volunteer. The Licensed Professional Clinical Counselor Act prohibits gaining mental health experience by interns or trainees as an independent contractor.

The Clinical Social Worker Practice Act requires applicants to complete supervised experience related to the practice of clinical social work.

This bill would prohibit these persons from being employed as independent contractors and from gaining experience for work performed as an independent contractor reported on a specified tax form. The bill would specify that the face-to-face counseling requirement of the practicum coursework be face-to-face counseling of individuals, couples, families, or groups.

(D) Existing law, the Clinical Social Worker Practice Act, requires applicants for licensure as a clinical social worker to pass a clinical examination. Existing regulatory law requires the clinical examination to be the Association of Social Work Boards Clinical Examination. Existing law authorizes a fee for the clinical examination in the amount of \$100.

This bill would specify that the fee only applies to a board-administered clinical examination.

(E) The Licensed Professional Clinical Counselor Act defines the term “accredited” for the purposes of the act to mean a school, college, or university accredited by the Western Association of Schools and Colleges, or its equivalent regional accrediting association. The act requires each educational institution preparing applicants to qualify for licensure to notify each of its students in writing that its degree program is designed to meet specified examination eligibility or registration requirements and to certify to the Board of Behavioral Sciences that it has provided that notice. The act requires the Board of Behavioral Sciences to accept education gained while residing outside of California if the education is substantially equivalent, as specified.

This bill would re-define “accredited” to mean a school, college, or university accredited by a regional or national institutional accrediting agency that is recognized by the United States Department of Education. The bill would additionally require an applicant for registration or licensure to submit to the Board of Behavioral Sciences a certification from the applicant’s educational institution specifying that the curriculum and

coursework complies with those examination eligibility or registration requirements. The bill would instead require the board to accept education gained from an out-of-state school if the education is substantially similar.

(8) This bill would additionally delete various obsolete provisions, make conforming changes, and make other nonsubstantive changes.

(9) This bill would incorporate additional changes to Section 1632 of the Business and Professions Code proposed by AB 2331, that would become operative only if AB 2331 and this bill are both chaptered and become effective on or before January 1, 2017, and this bill is chaptered last.

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

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

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

SECTION 1. Section 27 of the Business and Professions Code, as amended by Section 1 of Chapter 32 of the Statutes of 2016, is amended to read:

27. (a) Each entity specified in subdivisions (c), (d), and (e) shall provide on the Internet information regarding the status of every license issued by that entity in accordance with the California Public Records Act (Chapter 3.5 (commencing with Section 6250) of Division 7 of Title 1 of the Government Code) and the Information Practices Act of 1977 (Chapter 1 (commencing with Section 1798) of Title 1.8 of Part 4 of Division 3 of the Civil Code). The public information to be provided on the Internet shall include information on suspensions and revocations of licenses issued by the entity and other related enforcement action, including accusations filed pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) taken by the entity relative to persons, businesses, or facilities subject to licensure or regulation by the entity. The information may not include personal information, including home telephone number, date of birth, or social security number. Each entity shall disclose a licensee's address of record. However, each entity shall allow a licensee to provide a post office box number or other alternate address, instead of his or her home address, as the address of record. This section shall not preclude an entity from also requiring a licensee, who has provided a post office box number or other alternative mailing address as his or her address of record, to provide a physical business address or residence address only for the entity's internal administrative use and not for disclosure as the licensee's address of record or disclosure on the Internet.

(b) In providing information on the Internet, each entity specified in subdivisions (c) and (d) shall comply with the Department of Consumer Affairs' guidelines for access to public records.

(c) Each of the following entities within the Department of Consumer Affairs shall comply with the requirements of this section:

(1) The Board for Professional Engineers, Land Surveyors, and Geologists shall disclose information on its registrants and licensees.

(2) The Bureau of Automotive Repair shall disclose information on its licensees, including auto repair dealers, smog stations, lamp and brake stations, smog check technicians, and smog inspection certification stations.

(3) The Bureau of Electronic and Appliance Repair, Home Furnishings, and Thermal Insulation shall disclose information on its licensees and registrants, including major appliance repair dealers, combination dealers (electronic and appliance), electronic repair dealers, service contract sellers, and service contract administrators.

(4) The Cemetery and Funeral Bureau shall disclose information on its licensees, including cemetery brokers, cemetery salespersons, cemetery managers, crematory managers, cemetery authorities, crematories, cremated remains disposers, embalmers, funeral establishments, and funeral directors.

(5) The Professional Fiduciaries Bureau shall disclose information on its licensees.

(6) The Contractors' State License Board shall disclose information on its licensees and registrants in accordance with Chapter 9 (commencing with Section 7000) of Division 3. In addition to information related to licenses as specified in subdivision (a), the board shall also disclose information provided to the board by the Labor Commissioner pursuant to Section 98.9 of the Labor Code.

(7) The Bureau for Private Postsecondary Education shall disclose information on private postsecondary institutions under its jurisdiction, including disclosure of notices to comply issued pursuant to Section 94935 of the Education Code.

(8) The California Board of Accountancy shall disclose information on its licensees and registrants.

(9) The California Architects Board shall disclose information on its licensees, including architects and landscape architects.

(10) The State Athletic Commission shall disclose information on its licensees and registrants.

(11) The State Board of Barbering and Cosmetology shall disclose information on its licensees.

(12) The State Board of Guide Dogs for the Blind shall disclose information on its licensees and registrants.

(13) The Acupuncture Board shall disclose information on its licensees.

(14) The Board of Behavioral Sciences shall disclose information on its licensees, including licensed marriage and family therapists, licensed clinical social workers, licensed educational psychologists, and licensed professional clinical counselors.

(15) The Dental Board of California shall disclose information on its licensees.

(16) The State Board of Optometry shall disclose information on its licensees and registrants.

(17) The Board of Psychology shall disclose information on its licensees, including psychologists, psychological assistants, and registered psychologists.

(d) The State Board of Chiropractic Examiners shall disclose information on its licensees.

(e) The Structural Pest Control Board shall disclose information on its licensees, including applicators, field representatives, and operators in the areas of fumigation, general pest and wood destroying pests and organisms, and wood roof cleaning and treatment.

(f) The Bureau of Medical Cannabis Regulation shall disclose information on its licensees.

(g) “Internet” for the purposes of this section has the meaning set forth in paragraph (6) of subdivision (f) of Section 17538.

SEC. 2. Section 208 of the Business and Professions Code is amended to read:

208. (a) Beginning April 1, 2014, a Controlled Substance Utilization Review and Evaluation System (CURES) fee of six dollars (\$6) shall be assessed annually on each of the licensees specified in subdivision (b) to pay the reasonable costs associated with operating and maintaining CURES for the purpose of regulating those licensees. The fee assessed pursuant to this subdivision shall be billed and collected by the regulating agency of each licensee at the time of the licensee’s license renewal. If the reasonable regulatory cost of operating and maintaining CURES is less than six dollars (\$6) per licensee, the Department of Consumer Affairs may, by regulation, reduce the fee established by this section to the reasonable regulatory cost.

(b) (1) Licensees authorized pursuant to Section 11150 of the Health and Safety Code to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances or pharmacists licensed pursuant to Chapter 9 (commencing with Section 4000) of Division 2.

(2) Beginning July 1, 2017, licensees issued a license that has been placed in a retired or inactive status pursuant to a statute or regulation are exempt from the CURES fee requirement in subdivision (a). This exemption shall not apply to licensees whose license has been placed in a retired or inactive status if the licensee is at any time authorized to prescribe, order, administer, furnish, or dispense Schedule II, Schedule III, or Schedule IV controlled substances.

(3) Wholesalers, third-party logistics providers, nonresident wholesalers, and nonresident third-party logistics providers of dangerous drugs licensed pursuant to Article 11 (commencing with Section 4160) of Chapter 9 of Division 2.

(4) Nongovernmental clinics licensed pursuant to Article 13 (commencing with Section 4180) and Article 14 (commencing with Section 4190) of Chapter 9 of Division 2.

(5) Nongovernmental pharmacies licensed pursuant to Article 7 (commencing with Section 4110) of Chapter 9 of Division 2.

(c) The funds collected pursuant to subdivision (a) shall be deposited in the CURES Fund, which is hereby created within the State Treasury. Moneys

in the CURES Fund shall, upon appropriation by the Legislature, be available to the Department of Consumer Affairs to reimburse the Department of Justice for costs to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

(d) The Department of Consumer Affairs shall contract with the Department of Justice on behalf of the Medical Board of California, the Dental Board of California, the California State Board of Pharmacy, the Veterinary Medical Board, the Board of Registered Nursing, the Physician Assistant Board of the Medical Board of California, the Osteopathic Medical Board of California, the Naturopathic Medicine Committee of the Osteopathic Medical Board, the State Board of Optometry, and the California Board of Podiatric Medicine to operate and maintain CURES for the purposes of regulating the licensees specified in subdivision (b).

SEC. 3. Section 852 of the Business and Professions Code is repealed.

SEC. 4. Section 1632 of the Business and Professions Code is amended to read:

1632. (a) The board shall require each applicant to successfully complete the written examination of the National Board Dental Examination of the Joint Commission on National Dental Examinations.

(b) The board shall require each applicant to successfully complete an examination in California law and ethics developed and administered by the board. The board shall provide a separate application for this examination. The board shall ensure that the law and ethics examination reflects current law and regulations, and ensure that the examinations are randomized. Applicants shall submit this application and required fee to the board in order to take this examination. In addition to the aforementioned application, the only other requirement for taking this examination shall be certification from the dean of the qualifying dental school attended by the applicant that the applicant has graduated, or will graduate, or is expected to graduate. Applicants who submit completed applications and certification from the dean at least 15 days prior to a scheduled examination shall be scheduled to take the examination. Successful results of the examination shall, as established by board regulation, remain valid for two years from the date that the applicant is notified of having passed the examination.

(c) Except as otherwise provided in Section 1632.5, the board shall require each applicant to have taken and received a passing score on one of the following:

(1) A portfolio examination of the applicant's competence to enter the practice of dentistry. This examination shall be conducted while the applicant is enrolled in a dental school program at a board-approved school located in California. This examination shall utilize uniform standards of clinical experiences and competencies, as approved by the board pursuant to Section 1632.1. The applicant shall pass a final assessment of the submitted portfolio at the end of his or her dental school program. Before any portfolio assessment may be submitted to the board, the applicant shall remit the required fee to the board to be deposited into the State Dentistry Fund, and a letter of good standing signed by the dean of his or her dental school or

**MEDICAL BOARD OF CALIFORNIA
TRACKER II BILLS
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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 59	Waldron	Mental Health Services: Assisted Outpatient Treatment	Chaptered, #251	03/28/16
AB 72	Bonta	Health Care Coverage: Out-of-Network Coverage	Chaptered, #492	08/25/16
AB 635	Atkins	Medical Interpretation Services	Chaptered, #600	08/18/16
AB 741	Williams	Mental Health: Community Care Facilities	Vetoed	08/19/16
AB 769	Jones-Sawyer	State Employees: Disciplinary Action	Vetoed	04/12/16
AB 796	Nazarian	Health Care Coverage: Autism and Pervasive Dev. Disorders	Chaptered, #493	08/16/16
AB 840	Ridley-Thomas	Nurses and Certified Nurse Assistants	Vetoed	08/18/16
AB 923	Steinorth	Respiratory Care Practitioners	Chaptered, #253	08/01/16
AB 1001	Maienschein	Child Abuse: Reporting: Foster Family Agencies	Chaptered, #850	08/18/16
AB 1033	Garcia, E.	Economic Impact Analysis: Small Business Definition	Chaptered, #346	05/02/16
AB 1067	Gipson	Foster Children: Rights	Chaptered, #851	08/17/16
AB 1069	Gordon	Prescription Drugs: Collection and Distribution Program	Chaptered, #316	08/15/16
AB 1299	Ridley-Thomas	Medi-Cal: Specialty Mental Health Services: Foster Children	Chaptered, #603	08/18/16
AB 1386	Low	Emergency Medical Care: Epinephrine Auto-Injectors	Chaptered, #374	06/28/16
AB 1639	Maienschein	Pupil Health: The Eric Paredes Sudden Cardiac Arrest Prevention Act	Chaptered, #792	08/15/16
AB 1668	Calderon	Investigational Drugs, Biological Products, and Devices	Chaptered, #684	08/15/16
AB 1696	Holden	Medi-Cal: Tobacco Cessation Services	Chaptered, #606	08/15/16
AB 1703	Santiago	Inmates: Medical Treatment	Chaptered, #65	
AB 1748	Mayes	Pupils: Pupil Health: Opioid Antagonist	Chaptered, #557	08/01/16
AB 1763	Gipson	Health Care Coverage: Colorectal Cancer: Screening and Testing	Vetoed	06/27/16
AB 1795	Atkins	Health Care Programs: Cancer	Chaptered, #608	08/24/16
AB 1823	Bonilla	California Cancer Clinical Trials Program	Chaptered, #661	08/19/16
AB 1831	Low	Health Care Coverage: Prescription Drugs: Refills	Vetoed	08/15/16
AB 1836	Maienschein	Mental Health: Referral of Conservatees	Chaptered, #819	08/02/16
AB 1864	Cooley	Inquests: Sudden Unexplained Death in Childhood	Vetoed	08/15/16

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BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 1887	Low	State Government: Discrimination: Travel	Chaptered, #687	08/15/16
AB 1954	Burke	Health Care Coverage: Reproductive Health Care Services	Chaptered, #495	08/17/16
AB 2048	Gray	National Health Service Corps State Loan Repayment Program	Chaptered, #454	08/15/16
AB 2083	Chu	Interagency Child Death Review	Chaptered, #297	06/14/16
AB 2086	Cooley	Workers' Compensation: Neuropsychologists	Vetoed	08/01/16
AB 2105	Rodriguez	Workforce Development: Allied Health Professionals	Chaptered, #410	08/10/16
AB 2115	Wood	Health Care Coverage: Disclosures	Vetoed	08/17/16
AB 2119	Chu	Medical Information: Disclosure: Medical Examiners and Forensic Pathologists	Chaptered, #690	08/15/16
AB 2179	Gipson	Hepatitis C Testing	Vetoed	08/16/16
AB 2193	Salas	California Board of Podiatric Medicine: Physician Assistant Board: Extension	Chaptered, #459	08/16/16
AB 2235	Thurmond	Board of Dentistry: Pediatric Anesthesia: Committee	Chaptered, #519	08/16/16
AB 2311	Brown	Emergency Services	Chaptered, #520	08/15/16
AB 2317	Mullin	California State University: Doctor of Audiology Degrees	Chaptered, #267	06/29/16
AB 2325	Bonilla	Ken Maddy California Cancer Registry	Chaptered, #354	08/10/16
AB 2394	Garcia, E.	Medi-Cal: Non-Medical Transportation	Chaptered, #615	08/16/16
AB 2404	Cooley	Public Employees' Retirement System: Optional Settlements	Chaptered, #199	08/02/16
AB 2503	Obernalte	Workers' Compensation: Utilization Review	Chaptered, #885	08/29/16
AB 2640	Gipson	Public Health: HIV	Chaptered, #670	08/15/16
AB 2696	Gaines, B.	Diabetes Prevention and Management	Chaptered, #108	04/18/16
AB 2737	Bonta	Nonprovider Health Care Districts	Chaptered, #421	06/20/16
AB 2828	Chau	Personal Information: Privacy Breach	Chaptered, #337	05/27/16
AB 2843	Chau	Public Records: Employee Contact Information	Chaptered, #830	08/18/16
AB 2844	Bloom	Public Contracts: Discrimination	Chaptered, #581	08/19/16

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Agenda Item 25A

BILL	AUTHOR	TITLE	STATUS	AMENDED
AB 2853	Gatto	Public Records	Chaptered, #275	06/16/16
AB 2859	Low	Professions and Vocations: Retired Category: Licenses	Chaptered, #473	08/03/16
AB 2883	Ins. Comm.	Workers' Compensation: Employees	Chaptered, #205	08/02/16
ACR 119	Chiu	Physician Anesthesiologist Week	Chaptered, #15	02/01/16
SB 3	Leno	Minimum Wage: Adjustment	Chaptered, #4	03/28/16
SB 10	Lara	Health Care Coverage: Immigration Status	Chaptered, #22	05/27/16
SB 24	Hill	California Public Employees' Pension Reform Act	Chaptered, #531	08/18/16
SB 66	Leyva	Career Technical Education	Chaptered, #770	08/18/16
SB 139	Galgiani	Controlled Substances	Chaptered, #624	08/18/16
SB 253	Monning	Juveniles: Psychotropic Medication	Vetoed	08/04/16
SB 441	Wolk	California Public Records Act: Exemptions	Chaptered, #477	06/22/16
SB 547	Liu	Aging and Long-Term Care Services, Supports and Program. Coord.	Vetoed	08/01/16
SB 826	Leno	Budget Act of 2016	Chaptered, #23	05/25/16
SB 914	Mendoza	Workers' Compensation: Medical Provider Networks	Chaptered, #84	01/26/16
SB 923	Hernandez	Health Care Coverage: Cost Sharing Changes	Chaptered, #192	05/31/16
SB 950	Nielsen	Excluded Employees: Arbitration	Vetoed	06/29/16
SB 999	Pavley	Health Insurance: Contraceptives: Annual Supply	Chaptered, #499	08/19/16
SB 1039	Hill	Professions and Vocations	Chaptered, #799	08/25/16
SB 1076	Hernandez	General Acute Care Hospitals: Observation Services	Chaptered, #723	08/18/16
SB 1090	Mitchell	Sexually Transmitted Diseases: Outreach and Screening Services	Vetoed	08/15/16
SB 1091	Liu	Long-Term Care Insurance	Chaptered, #589	08/18/16
SB 1095	Pan	Newborn Screening Program	Chaptered, #393	08/15/16
SB 1135	Monning	Health Care Coverage: Notice of Timely Access to Care	Chaptered, #500	08/15/16
SB 1139	Lara	Health Professionals: Medical Residency Programs: Undocumented Immigrants	Chaptered, #786	08/15/16

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Agenda Item 25A

BILL	AUTHOR	TITLE	STATUS	AMENDED
SB 1159	Hernandez	California Health Care Cost and Quality Database	Chaptered, #727	08/19/16
SB 1193	Hill	Healing Arts	Chaptered, #484	08/18/16
SB 1229	Jackson	Home-Generated Pharmaceutical Waste: Secure Drug Take-Back Bins	Chaptered, #238	06/27/16
SB 1234	De Leon	Retirement Savings Plans	Chaptered, #804	08/18/16
SB 1348	Cannella	Licensure Applications: Military Experience	Chaptered, #174	05/31/16
SB 1466	Mitchell	Early and Periodic Screening, Diagnosis, and Treatment Program	Vetoed	08/15/16
SCR 117	Pan	Palliative Care	Chaptered, #96	
SR 55	Bates	Relative to Drug Facts Week	Sen. Adopted	
SR 71	Berryhill	Relative to Organ Donation	Sen. Adopted	

**MEDICAL BOARD OF CALIFORNIA
Status of Pending Regulations**

Subject	Current Status	Date Approved by Board	Date Notice Published by OAL	Date of Public Hearing	Date of Final Adoption by Board	Date to DCA (and other control agencies) for Final Review *	Date to OAL for Review **	Date to Sec. of State***
Physician and Surgeon Licensing Examinations Minimum Passing Scores	Approved by OAL and filed with Secretary of State; Effective 1/1/17	5/8/15	6/5/15	7/31/15	7/31/15	5/20/16 to DCA 7/1/16 to Agency	8/18/16	9/7/16
Outpatient Surgery Setting Accreditation Agency Standards	Approved by OAL and filed with Secretary of State; Effective 1/1/17	5/8/15	6/5/15	7/31/15	7/31/15	5/20/16 to DCA 7/1/16 to Agency	8/18/16	9/27/16
Disclaimers and Explanatory Information Applicable to Internet Postings	Approved by OAL 7/19/16 and filed with Secretary of State; Effective 10/1/16	5/8/15	6/5/15	7/31/15	10/30/15	4/12/16 to DCA 5/4/16 to Agency	6/6/16	7/19/16
Disciplinary Guidelines	Following first and second modified text, file to DCA for review 8/25/16	7/25/14 7/31/15	9/4/15	10/30/15	7/29/16	8/25/16 to DCA		
Midwife Assistants	Hearing held 7/29/16; staff working to finalize file	5/6/16	6/3/16	7/29/16	7/29/16			
Physicians on Probations	Hearing to be held 10/28/16	7/29/16	9/9/16	10/28/16				
Citation and Fine	Hearing to be held 10/28/16	7/29/16	9/9/16	10/28/16				

Updated on Oct 4, 2016

* DCA is allowed 30 calendar days for review.
 ** OAL is allowed 30 working days for review.
 *** Rulemakings become effective on a quarterly basis, unless otherwise specified.