

*A report to Senate Business, Professions
and Economic Development Committee*

MEDICAL BOARD OF CALIFORNIA

SUNSET REVIEW REPORT 2012

VOLUME I

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MEDICAL BOARD OF CALIFORNIA

Executive Office



November 1, 2012

The Honorable Curren D. Price, Jr., Chair
Senate Business, Professions and Economic Development Committee
State Capitol, Room 2053
Sacramento, CA 95814

Dear Senator Price:

On behalf of the Medical Board of California (Board), it is my honor and privilege to present to you and the Committee the Medical Board of California's 2012 Sunset Review Report. This report has been prepared at the direction of the Senate Business, Professions, and Economic Development Committee in preparation for the Board's 2013 review by the California Legislature.

The Board is an active consumer protection agency that licenses and regulates physicians and surgeons and those allied health care professionals in California who fall under its statutory mandate. The Board has a dual responsibility: both to ensure consumer protection and to ensure that California remains a professionally attractive destination where excellent physicians want to practice. The Board has a duty to maintain the confidence of consumers, letting them know that their protection is paramount to its goals, and a responsibility to the profession to ensure that Californians are confident that the health care delivered in California is of high quality and that California continues to attract the best physicians.

The success of the Board's Enforcement Program is illustrated below.

From fiscal year 2006/2007 to fiscal year 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.

These improvements can be partially attributed to the Vertical Enforcement/Prosecution model, but more significantly to the staff who did more, with reduced resources, in less time. It is especially noteworthy to see the 203% increase in cases referred for criminal action due in large part to the re-establishment of the Operation Safe Medicine Unit.

The Board's Licensing Program is reviewing applications within approximately 30 days of their receipt, significantly lower than the 122 days in fiscal year 2008/2009. The Licensing Program enhanced its international medical school review by adding an additional position and recognizing 48 additional schools in fiscal year 2011/2012.

The Board is also in the process of converting to a new computer system that will make significant improvements in the licensing and enforcement processes, including integrating with the Attorney General's Office computer system. The Board, along with several other healing arts board within the Department of Consumer Affairs, will launch in Phase 1 of the project and it is anticipated the integration with the Attorney General's Office will take place in Phase 3. Phase 1 launch is expected to occur in early 2013.

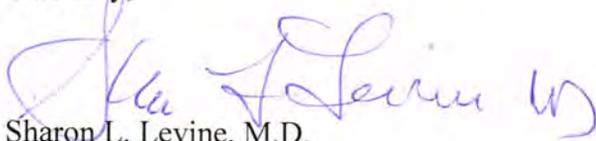
The Board's goals for the future are to continue to enhance efficiency of the operations of the Board and the staff; continue to reduce processing times for both licensing and enforcement, the core functions of the Board; and to look for additional ways to make the Board's work relevant and meaningful to consumers and to the profession. These goals are reflected in the 18 new issues identified in this report, and include the following:

- Licensing Enhancements – review and potentially allow for the evolving method of teaching medical students in year round classes with shortened number of academic years required; establish guidelines regarding re-entry after a period of non-practice, to ensure public protection; and undertake a careful review and study of Maintenance of Licensure currently being piloted by the Federation of State Medical Boards.
- Enforcement/Consumer Protection Enhancements – seek legislation to require coroners to report all deaths related to prescription drug abuse or excessive use to the Board; seek legislation to establish by regulation the knowledge, training, and ability a physician must possess to supervise other health care providers; and seek legislation to enhance peer review reporting.
- Overall Program Enhancements – seek legislation to address ongoing issues related to midwifery, including supervision, access to drugs and devices related to the practice of midwifery, and midwifery students/apprenticeship; consider moving oversight of the Registered Dispensing Opticians Program from the Medical Board to an appropriate agency, such as the Department of Consumer Affairs; and eliminate the requirement for the Board to determine equivalency of, and approve, specialty boards that are not approved by the American Board of Medical Specialties.

In addition to the proposed enhancements noted above, the Board will present its evaluation of the Vertical/Enforcement/Prosecution model in Spring 2013. This report may include recommendations for additions or revisions to the Board's statutory authority.

The Board believes Sunset Review is an opportunity for the Board to work with the Legislature to review the body of law which governs the practice of medicine. The Board wants to ensure the law is consistent with 21st century clinical practice and that it continues to evolve along with the changes in medical training and practice and as consumer access to advanced medical technology and new approaches to care delivery continue to change and evolve. The Board is very cognizant of coming changes as it moves towards full implementation of the Affordable Care Act in California in 2014, and the impact those changes will have on the public, the Board, and the profession. The Board looks forward to working with the Legislature, the Administration, and our stakeholders, as the Board moves through the Sunset Review process.

Sincerely,



Sharon L. Levine, M.D.
Board President

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. The appendices contain a sunset report for each of the Board's allied health professions.

The information in this report is organized within each of the 12 sections by headings that most often correspond to a specific question asked by the Committee, although some additional information and details may be included to provide greater clarity of the subject matter. 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. [Section 12, Attachment S](#) is a list of acronyms used throughout the document.

TABLE OF CONTENTS

Executive Summary	1
Section 1 – Background and Description of the Board and Regulated Professions	8
History and Functions of the Board	9
Board Composition	12
Board Committees and Their Functions.....	13
Board and Committee Meetings/Quorum Issues.....	16
Major Changes to the Board Since the Last Sunset Review	17
Legislation Sponsored by the Board and Affecting the Board Since the Last Sunset Review	22
Regulation Changes Approved by the Board Since the Last Sunset Review	32
Major Studies Conducted by the Board	37
Major Publications Prepared by the Board	41
National Association Memberships.....	41
Section 2 – Performance Measures and Customer Satisfaction Surveys.....	44
Performance Measure Reports Published by the Department of Consumer Affairs	45
Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs	47
Applicant Satisfaction Survey Conducted by the Board	50
Section 3 – Fiscal and Staff.....	55
Fiscal Issues	56
Board’s Current Reserve Level, Statutory Requirement, and Spending Issues.....	56
Deficit Projections and Anticipated Fee Changes.....	56
General Fund.....	57
Expenditures by Program Component	58
Budget Distribution.....	58
Renewal Cycle and History of Fee Changes	58
Revenues and Reimbursements	60
Budget Change Proposals	60
Board Approved Budget Augmentations.....	62

Staffing Issues	64
Staffing Challenges, Vacancy Rate, Recruitment/Retention, and Succession Planning	64
Staff Development	65
Section 4 – Licensing Program.....	66
Physicians	68
Performance Targets/Expectations	68
Timeframes for Application Review and Licensing – Performance Barriers/Improvements Made.....	68
Cycle Times	70
Verification of Applicant Information – Criminal History Information/ Prior Disciplinary Action	72
Applicant Fingerprints.....	73
Licensee Fingerprints	74
National Practitioner Databank and Physician Information	74
Primary Source Verification	74
Legal Requirements and Process for Out-of-State and Out-of-Country Applicants.....	74
No Longer Interested Notification to DOJ	76
Examination Process	76
Examination Data – Pass Rates	77
Existing Statute Changes.....	77
School Approval	77
Legal Requirements Regarding Approval of International Schools	78
Continuing Medical Education/Competency Requirements	81
Verification of CME	81
CME Audits.....	81
CME Course Approval	82
Auditing CME Providers	82
Licensees’ Continuing Competence	82
Fictitious Name Permits	83
Special Faculty Permits.....	85
Special Programs	87
Medical Assistants.....	89

Outpatient Surgery Setting Accreditation	90
Specialty Board Certification	92
Section 5 – Enforcement Program.....	93
Performance Targets/Expectations	94
Trends in Enforcement Data – Performance Barriers	95
Improvements.....	99
Future Improvements.....	99
Legislative Enhancements/Amendments	100
Enforcement Statistics.....	101
Increases or Decreases in Disciplinary Action	105
Case Prioritization	105
Mandatory Reporting	105
Statute of Limitations	108
Unlicensed Activity and the Underground Economy	108
Citation and Fine	110
Citations and Fines – Types of Violations.....	110
Informal Conferences or Administrative Procedure Act Appeals.....	111
Common Citation And Fine Violations	111
Citation and Fine Average Amounts – Pre and Post Appeal	111
Franchise Tax Board Intercept Program.....	111
Cost Recovery and Restitution	112
FTB Intercept Program for Cost Recovery	112
Section 6 – Public Information Policies	114
Board’s Web site and Posting Meeting Materials and Minutes	115
Webcasting.....	115
Meeting Calendars	115
Complaint Disclosure Policy and Posting Accusations/Disciplinary Actions	115
Information Available to the Public.....	116
Consumer Outreach and Education.....	117

Section 7 – Online Practice Issues 120

 Online Practice Regulation..... 121

Section 8 – Workforce Development and Job Creation 122

 Workforce Development..... 123

 Assessment of the Impact of Licensing Delays..... 126

 Board’s Efforts to Inform Potential Licensees of Licensing Requirements/Process 127

 Workforce Development Data 129

Section 9 – Current Issues 131

 Status of Uniform Standards for Substance Abusing Licensees 132

 Status of the Consumer Protection Enforcement Initiative Regulations 132

 BreEZe 134

Section 10 – Board Action and Response to Prior Sunset Issues 135

 Prior Sunset Issues 135

Section 11 – New Issues 145

 United States Medical Licensing Examination Step 3 Change 148

 Accelerated Track and Competency-Based Medical School Programs 150

 Maintenance of Licensure..... 152

 Physician Re-entry Program..... 155

 Mandatory Email Address for Licensees 156

 Public Disclosure of Postgraduate Training 157

 Physicians’ Accredited Residency Training Programs
 and the Prohibition Against the Corporate Practice of Medicine 158

 Coroner Reporting of Prescription Drug Overdose 161

 Controlled Substance Utilization Review and Evaluation System (CURES) and California
 Prescription Drug Monitoring Program Funding 162

 Medical Malpractice Cases -- No Upfront Review 164

 Physician Availability – Knowledge And Training..... 165

 Consistency in the Time to Provide Medical Records 166

 Peer Review Reporting Pursuant to B&P Code Section 805 167

 Public Disclosure – Ten Year Posting Requirement..... 169

Expert Reviewer Opinions	171
Specialty Board Advertising	173
Section 12 – Attachments	177
Attachment A – Board Member Administrative Procedure Manual	178
Attachment B – Current Organizational Chart Showing Relationship of Committees to the Board and Membership of Each Committee.....	194
Attachment C – Major Studies and Publications	196
Attachment D – Year-End Organizational Charts	199
Attachment E – Sunset Report Form with Questions	212
Attachment F – Board Member Attendance.....	227
Attachment G – Board Member Committee Roster	236
Attachment H – B&P Code Section and CCR Section for Applicant Review Committee.....	239
Attachment I – B&P Code Section for Special Faculty Permit Review Committee.....	241
Attachment J – B&P Code Sections for Special Programs Committee	243
Attachment K – B&P Code Section for Midwifery Advisory Council.....	249
Attachment L – B&P Code Section for Panel A and Panel B	251
Attachment M – Performance Measures	253
Attachment N – Revenue and Fee Schedule.....	274
Attachment O – National Practitioner Data Bank Study by the Board.....	279
Attachment P – United States Medical Licensing Examination Performance Data.....	289
Attachment Q – Strategic Plan Objective 5.2 - 2012.....	306
Attachment R – Attorney General’s Office Response to Medical Board of California’s Program Evaluation.....	308
Attachment S – List of Acronyms.....	333
Appendix I – Midwifery Program	1
Section 1 – Background and Description of Midwifery Program	1
Section 2 – Performance Measures and Customer Satisfaction Surveys.....	2
Section 3 – Fiscal and Staff Issues	2
Section 4 – Licensing Program.....	3
Section 5 – Enforcement Program	8

Section 6 – Public Information Policies	13
Section 7 – Online Practice Issues.....	13
Section 8 – Workforce Development and Job Creation.....	13
Section 9 – Current Issues.....	13
Section 10 – Board Action and Response to Prior Sunset Issues.....	13
Section 11 – New Issues	14
Section 12 – Attachments	16
Appendix II – Polysomnographic Program	1
Section 1 – Background and Description of Polysomnographic Program.....	2
Section 2 – Performance Measures and Customer Satisfaction Surveys.....	3
Section 3 – Fiscal and Staff.....	3
Section 4 – Licensing Program.....	4
Section 5 – Enforcement Program	8
Section 6 – Public Information Policies	11
Section 7 – Online Practice Issues.....	12
Section 8 – Workforce Development and Job Creation.....	12
Section 9 – Current Issues.....	12
Section 10 – Board Action and Response to Prior Sunset Issues.....	12
Section 11 – New Issues	12
Section 12 – Attachments	12
Appendix III – Registered Dispensing Optician Program.....	1
Section 1 – Background and Description of the Registered Dispensing Optician Program.....	2
Section 2 – Performance Measures and Customer Satisfaction Surveys.....	4
Section 3 – Fiscal and Staff.....	4
Section 4 – Licensing Program.....	6
Section 5 – Enforcement Program	11
Section 6 – Public Information Policies	17
Section 7 – Online Practice Issues.....	17
Section 8 – Workforce Development and Job Creation.....	17
Section 9 – Current Issues.....	18

Section 10 – Board Action and Response to Prior Sunset Issues.....	18
Section 11 – New Issues	18
Section 12 – Attachments	19
Appendix IV – Research Psychoanalyst	1
Section 1 – Background and Description of Research Psychoanalyst.....	2
Section 2 – Performance Measures and Customer Satisfaction Surveys.....	3
Section 3 – Fiscal and Staff.....	3
Section 4 – Licensing Program.....	3
Section 5 – Enforcement Program	6
Section 6 – Public Information Policies	10
Section 7 – Online Practice Issues.....	10
Section 8 – Workforce Development and Job Creation.....	10
Section 9 – Current Issues	11
Section 10 – Board Action and Response to Prior Sunset Issues.....	11
Section 11 – New Issues	11
Section 12 – Attachments	11

Executive Summary

Background and Description of the Board and Regulated Professions

- Executive Summary
 - Structural Changes in the Board Membership
 - Vertical Enforcement and Prosecution Model
 - Office of Administrative Hearing Administrative Law Judge Training
 - Expert Reviewer Training
 - Reduction of Length of Field Investigations
 - Reduction of Average Time to Process Initial Licensing Applications
 - Elimination of the Diversion Program to Monitor Substance Abusing and Mentally Impaired Physicians
 - Promotion of Medical Board Services to Physicians and Consumers
 - Unlicensed Practice of Medicine and the Re-establishment of Operation Safe Medicine (OSM)
 - Increasing Access to Care
- The Future



Executive Summary

It has been seven years since the Medical Board of California (Board) has appeared before the Legislature for a review of the authorizing legislation and body of law under which the Board operates. In that time there have been substantial changes to the Board's structure, the laws governing it, and California government in general.

Like all California agencies in this economic and political environment, the Board has experienced some major challenges. Similar to medical boards across the country, it continues to grapple with issues relating to healthcare and professional licensing, and establishing new ways to deliver services that protect the public while operating within a context and a system requiring due process --- all within the complex and rapidly evolving enterprise of healthcare delivery, over which medical boards have little jurisdiction.

The challenge of all medical boards is to meet consumers' expectations for a safe, qualified, and high performing physician workforce in the narrow authority of regulating physicians, while helping consumers understand what they can do to participate as fully informed and actively engaged participants in their own care as they seek medical care within a much larger system. This is likely to become even more challenging as the State moves forward in implementing The Affordable Care Act with its important consumer advantages and protections, but with additional levels of complexity, which consumers will have to navigate.

At the time of the Board's most recent Sunset Review, in 2005, the Enforcement Monitor, established by SB 1950 (Figueroa, Chapter 1085, Statutes of 2002), had just completed her work in reviewing all of the Board's Enforcement operations. The final report included numerous recommendations for improvements. Since then, most have been addressed, either through legislation, regulation, policy or procedural changes.

Despite challenges, the Board is pleased to report to the Committee a number of significant accomplishments.

Structural Changes in the Board Membership

In 2008, the Board was changed from 21 Members to 15, including seven public and eight physician Members. In addition, the two previously separate divisions of the Board - one to handle licensing and allied health and the other for physician discipline and enforcement - were made into one deliberative body. While it has been a challenge to maintain a quorum at times, the smaller, one-body structure has allowed all Members to become fully informed on all matters and able to take a more integrated approach to problems relating to licensing and disciplinary matters.

Vertical Enforcement/Prosecution Model

In 2005, as a result of the Enforcement Monitor's recommendation, legislation created a pilot program establishing a vertical enforcement/prosecution (VE/P) model to handle Board investigations and prosecutions (SB 231, Chapter 674, Statutes of 2005). VE/P requires Board investigators and Attorney General (AG) Health Quality Enforcement Section (HQES) prosecutors to work together from the beginning of an investigation to the conclusion of legal proceedings.

Since 2006, the Board has implemented this model. It was thoroughly studied in 2010, and a number of modifications have been and are continuing to be made to make the program more efficient. Although the investigation timelines have shortened, it is unknown if this is due to VE/P or if it is due to increased efficiencies in enforcement processes and procedures in general. In order to determine if VE/P is a successful program, the Board is in the process of obtaining comparable data from the AG HQES. This will be evaluated in more detail and reported to the Legislature in the Spring 2013 report.

What the Board does know 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.

Office of Administrative Hearing Administrative Law Judge Training

In coordination with the Office of Administrative Hearings (OAH), the Board has initiated training the judges that hear Board disciplinary cases. The law (Government Code section 11371) requires that Administrative Law Judges (ALJ) receive medical training as recommended by the Board.

OAH and the Board developed a training program that included pain management and appropriate medication standards, chronic pain issues, new developments in medicine, electronic health records, and other relevant subjects. While the first session was a day-long training course, future training will be conducted in a shorter but more frequent manner, and capture current topics of importance.

Expert Reviewer Training

Expert reviewers are extremely important in the investigation and prosecution process. The expert reviewer's report is a critical resource in establishing violations or eliminating cases that should not be prosecuted.

Historically, only minimal training has been provided to the experts, and the Board has often been at a disadvantage in prosecutions due to the low level of fees paid in comparison to those paid by defense attorneys. In addition, the defense may use the same experts many times and need not be constrained by regulatory and policy guidelines. For these reasons, the Board undertook the development of a new expert reviewer training program to improve the performance of its experts.

A training course was developed and an eight-hour training course was presented to the Northern California expert reviewers. The training incorporated presentations from an ALJ, a district medical consultant, an attorney who represents respondent physicians, and a Supervising Deputy Attorney General (SDAG). In addition, interactive computer equipment in the training allowed attendees to participate by responding to scenarios and engaging in discussion. A film was produced that showed

good expert testimony versus poor testimony. Over 100 experts have attended this new training in 2012 and more will be attending in 2013.

Reduction of Timeframe for Field Investigations

Perhaps one of the most significant accomplishments to report is the reduction of investigation times. The average time to complete an investigation in the field has been reduced from 324 days in 2008, to 264 in 2012 – an almost 20% reduction. This accomplishment can be attributed to a number of factors, including the commitment and dedication of staff to perform at the highest level, the ability to hire/replace staff, a reduction in furloughs, and the implementation of the Case Aged Council.

Reduction of Average Time to Process Initial Licensing Applications

In 2008, the Board began experiencing a serious backlog in application reviews. In 2009, the Board was reviewing applications in excess of 100 days from the receipt of the application. This unacceptable rate was largely due to staffing shortages and mandatory furlough days imposed by an Executive Order. In order to eliminate the backlogs and reduce the time for processing, the Board reviewed all procedures and policies to streamline where legally possible.

With the use of overtime and streamlined processes, the backlog was eliminated. Now that full staffing has been restored and revised policies put in place, the amount of time for initial review has been reduced by 70%. At present, Board staff is now averaging 36 days to provide applicants with an initial review of their application. In addition, applicants may now privately look-up the progress of their application on a web-based program, allowing for real-time status and information about any deficiencies that have been identified.

Elimination of the Diversion Program to Monitor Substance Abusing and Mentally Impaired Physicians

The Board's Diversion Program, in effect since 1980, was allowed to sunset and ceased to exist on June 30, 2008. That year, the Board unanimously voted to not seek reauthorization of the program and the Legislature concurred. The Board had been grappling with the program for years, attempting to fix the many problems discovered during independent program audits. After the fifth failed audit, the Board concluded that such a program was inappropriate for the Board's capabilities. While physicians suffering from substance abuse are free to seek private treatment, physicians identified with a problem will be subject to discipline, when appropriate, and will no longer be diverted into a confidential program, immune from disciplinary action.

The Board developed a transition plan for individuals enrolled in the program when it was eliminated. For those participants, biological fluid testing continued and they were encouraged to seek a program that would assist them with their recovery.

Promotion of Board Services to Physicians and Consumers

Notice to Consumers – The Board was concerned that many patients were not aware of the Board's existence or where they could seek information or file complaints. In 2010, the Board adopted a regulation that requires physicians to provide notice to patients that they are regulated by the Board and provides the Board's contact information (Title 16, California Code of Regulations (CCR) section 1355.4). The regulations require physicians to prominently post a sign in their office, give patients a notice which they must sign, or provide the information on discharge instructions.

Web site – The Board has made use of technology in reaching out to its licensees and consumers, by:

- Posting meeting materials and minutes;
- Providing webcasting of all Board meetings and most Committee meetings;
- Posting meeting calendars;
- Providing public documents and the complaint disclosure policy and disciplinary actions;
- Providing physician profiles, including educational information and voluntary information provided by physicians about their practice and languages spoken;
- Posting brochures, including those required to be distributed by physicians, and consumer-oriented publications and tip sheets relating to information about the Board and services available (many of which are available in multiple languages);
- Posting publications, such as annual reports, Newsletters, reports to the Legislature;
- Providing links to other sites for various services not under the Board's jurisdiction;
- Posting an Outpatient Surgery Setting database that provides owner information, accreditation information, and status; and
- Creating a physician licensing application database that allows applicants to privately view where their initial licensing application is in the review process, and any noted deficiencies.

Unlicensed Practice of Medicine and the Re-establishment of Operation Safe Medicine (OSM)

In 2009, the Board re-established the OSM Unit within the Enforcement Program to address the unlicensed practice of medicine. OSM had initially been established in 2000, and had been successful until 2003, when it had to disband due to budgetary constraints.

In 2008, legislation required the Board to work with the Board of Registered Nursing (SB 1423, Figueroa, Chapter 873, Statutes of 2006) on issues relating to medical spas, lasers and cosmetic procedures --- procedures often performed by non-physicians, and often non-nurses and those not licensed. The Board held three public forums and concluded that consumers were not being sufficiently protected from unlicensed practice. The testimony provided at those forums supplied the Board with the needed evidence to re-establish OSM and obtain approval for the establishment of positions.

OSM staff is exclusively assigned to the proactive identification, investigation, and prosecution of: unlicensed individuals who hold themselves out to the public as licensed qualified medical practitioners; corporate practice of medicine violations; and the enforcement of the law related to the use of lasers for cosmetic procedures. The staff assigned to OSM have the specialized training and expertise necessary to address the continued proliferation of unlicensed cases. In FY 2011/12, the Board referred 112 cases for criminal action; this is more than twice as many referred in the prior fiscal year, and OSM was largely responsible for this major increase.

Increasing Access to Care

While providing access to care is not under the direct jurisdiction of the Board, the Board Members have held a commitment to doing what the Board could within its authority to increase Californian's access to quality medical care. Over the years, the Board has initiated a number of policies and programs to increase access to medical care.

The Stephen M. Thompson Physician Corps Loan Repayment Program – In 2003, at the Board's suggestion, the Physician Corps Loan Repayment Program was established with seed money from the Board's contingency fund. The program provides loan repayment of up to \$105,000 to physicians in exchange for practicing in a designated underserved area for a minimum of three years.

Since then, there have been a number of private donations received, including donations from physicians on their licensing renewal form that added a voluntary \$50 fee. In 2009, a \$25 mandatory fee for the Loan Repayment Program was added to physicians' renewal fee by legislation supported by the Board (AB 2439, Del La Torre, Chapter 640, Statutes of 2008). While the program is now administrated by the Health Professions Education Foundation, the mandatory fee guarantees a future for the program – a program that has funded 223 awards for physician positions in underserved areas since 2003, which has facilitated care being provided to thousands of patients in California.

Sponsored Free Healthcare Events – In compliance with Business and Professions Code section 901, created by AB 2699 (Bass, Chapter 270, Statutes of 2010), the Board was the first board in the Department of Consumer Affairs to adopt and have regulations enacted to 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 healthcare events and the physicians who volunteer their services. Physicians must hold a license in good standing in another state to register.

Prescription Drug Abuse Epidemic

For years, the Board has been grappling with issues relating to substance abuse of physicians, as well as inappropriate prescribing of controlled substances to patients with no medical justification. While a problem for years, the scope has never been as large or broad, and has now reached epidemic proportions.

Additional complication comes from California's prescription drug monitoring program, CURES, which is outdated, under-funded, and underutilized. The current system is not user-friendly for physicians or pharmacists, and therefore is not currently an effective tool. CURES is also in danger of being de-funded if a new funding source is not identified in the near future.

Another issue that has been identified that contributes to the growing problem of inappropriate prescribing is underreporting by Coroner's offices. Existing law requires coroner's offices in California to report deaths that may be a result of gross negligence or incompetence by a physician to the Board. However, in FY 2011/12, the Board only received four reports from coroner's offices in California, even though the number of deaths related to overprescribing continues to increase.

For these reasons, the Medical and Pharmacy Boards are hosting a joint forum in 2013 to shed light on the problem, identify solutions, and establish better communication between all involved in combating the problem. The forum will include state, local, and federal agencies, and will invite state lawmakers to participate so that needed legislation and funding may be found for innovative solutions to this massive problem. It is the hope of the Board that this event will serve as a catalyst for needed change and create the preventative medicine needed to halt and reverse this serious problem that is creating misery, increasing medical costs, and is a threat to the public health of all Californians.

The Board has also included several new issues in this report regarding the prescription drug abuse epidemic. One new issue proposes to require all coroner's offices in California to report prescription drug overdose deaths to the Board. This requirement will ensure the Board is aware of these cases, and this reporting may help to identify physicians who are overprescribing or inappropriately prescribing prescription medications to patients in California. The Board is also open to proposals that would help fund CURES, so it can be enhanced and supported.

The Future

While the Board is proud of its accomplishments, it is always looking to the future. Since the last Sunset Review, the Board has initiated two strategic planning processes; the last plan is included within this report.

The Board continues its commitment to the goals of increasing public protection through its Licensing and Enforcement Programs, creating a more efficient organization, providing useful guidance to physicians, empowering patients through education, building better communication and relationships with relevant organizations, and providing assistance to increase access to quality medical care.

In addition, the Board continues to monitor emerging trends and issues that affect the quality of medical care, physician education and training, professional standards, advances in technology relating to medicine, and public health in general. As California moves forward with implementation of The Affordable Care Act, the Board stands ready to assist within its jurisdiction and to anticipate medical practice issues that may arise.

The Board looks forward to working with the Committee to improve its performance on matters of importance to Members and lawmakers. As is apparent in the report, the Board has been a proactive force and advocate in seeking legislation to solve problems experienced by the Board and to promote better medical care for Californians. It is the hope of the Board that the Legislature will use this report as a resource in its efforts to address the many challenges and opportunities related to providing medical care in the state in the near and distant future.

Section 1

Background and Description of the Board and Regulated Professions

- History and Functions of the Board
- Board Composition
- Board Committees and Their Functions
- Board and Committee Meetings/Quorum Issues
- Major Changes to the Board Since the Last Sunset Review
- Legislation Sponsored by the Board and Affecting the Board Since the Last Sunset Review
- Regulation Changes Approved by the Board Since the Last Sunset Review
- Major Studies Conducted by the Board
- Major Publications Prepared by the Board
- National Association Memberships

Related Attachments

- Attachment F – Board Member Attendance
- Attachment G – Board Member Committee Roster
- Attachment H – Code/Regulation Sections for Applicant Review Committee
- Attachment I – Code Section for Special Faculty Permit Review Committee
- Attachment J – Code Sections for Special Programs Committee
- Attachment K – Code Section for Midwifery Advisory Council
- Attachment L – Code Section for Panel A and Panel B



History and Functions of the Board

History

The Medical Board of California's (Board) rich 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 punitive 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 towards 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 have jurisdiction over licensed midwives. In 1996, outpatient surgery settings were required to be

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

accredited and the Board had to approve 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. More improvements to public disclosure occurred in 1998, including a requirement for information to be posted on the Board's Web site. This provided immediate access to a physician's profile, thus increasing consumer protection. The statute of limitations law passed in 1999 and limited 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, and it continues to fulfill its purpose (through the Health Professions Education Fund (HPEF)) 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. (See Major Changes to the Board Since the Last Sunset Review for more details regarding these changes.)

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 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."*

In order to meet the Board's mission, it is very important that the Board keep pace with the ever changing medical profession and practice. The Board's meeting agendas and 2012 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 the most 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.

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 transferred to the Board's Investigative Unit, which is comprised of sworn peace officers. These investigators are Board employees and are trained specifically for investigating medical cases. The investigators are located in 12 district offices throughout the state. The Board has an Office of Standards and Training that provides and oversees Peace Officer Standards and Training (POST) required training for the investigators. This ensures that the investigators maintain the required training, ensures that the training is still related to the Board's functions, and ensures the training is provided by individuals who are knowledgeable about the Board.

The investigators investigate the complaint (in coordination with Deputy Attorneys General (DAG)) 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 the probation. The Probation Unit is comprised of Inspectors who are located throughout the state, housed within the 12 field 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, and allows the Board to make changes to its Web site 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 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 education 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 Web site 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 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 contact lens dispensers, registered dispensing opticians, registered non-resident contact lens sellers, registered spectacle lens dispensers, 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 who 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 Board 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)
Michael Bishop, M.D.	12/21/11		06/01/13	Governor	Physician*
Silvia Diego, M.D.	07/30/10	08/08/11	06/01/14	Governor	Physician*
Dev Gnanadev, M.D.	12/21/11		06/01/14	Governor	Physician
Sharon Levine, M.D.	02/11/09	07/29/11	06/01/15	Governor	Physician
Reginald Low, M.D.	08/10/06	07/29/09	06/01/13	Governor	Physician*
Denise Pines	08/29/12		06/01/16	Governor	Public
Janet Salomonson, M.D.	08/10/06	07/29/09	06/01/13	Governor	Physician
Gerrie Schipske, R.N.P., J.D.	06/12/07	05/23/12	06/01/15	Senate Rules Committee	Public
David Serrano Sewell, J.D.	08/29/12		06/01/16	Governor	Public
Barbara Yaroslavsky	09/24/03	06/01/07 06/01/11	06/01/15	Speaker of the Assembly	Public
Vacant			06/01/14	Governor	Public
Vacant			06/01/14	Governor	Public
Vacant			06/01/16	Governor	Public
Vacant			06/01/14	Governor	Physician
Vacant			06/01/16	Governor	Physician

* faculty appointments

Board Committees and Their Functions

The Board has nine Committees, eight Subcommittees, two Panels, and one Council which assist with the work of the Board. Three 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 new Strategic Plan (2012), the Board must convene every other year to discuss the purpose of each Committee and re-evaluate the need for the Committees/Subcommittees created by the Board. The Board conducted this review at its February 2012 meeting; 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](#).

Although this list details the Board Committees, the activities of the Committees are dependent upon the number of Members appointed to the Board. If the membership of the Board is not complete (15), it is very difficult to make the Committee structure of the Board perform efficiently. With vacancies on the Board, there are not enough Members to assign to the all of the Committees. Therefore the Committees with the most pressing issues may be the only Committees that have Members and meet to perform the functions of the Committee.

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) 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, via a task force, the Board's VE/P Model. The Committee provides recommendations to the full Board.

Application Review Committee (Statutory Committee – B&P Code section 2099 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 California Code of Regulations Title 16 section 1321(d) and written licensing exam waiver requests per B&P Code section 2113). 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 a final approval or denial. See [Section 12, Attachment I](#) for specific sections of law.

Special Programs Committee (Statutory Committee – B&P Code sections 2072-2073, 2111-2113, and 2115)

This Committee's purpose is to provide 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 J](#) for specific sections of law.

Access to Care Committee/Cultural & Linguistic Competency Committee (non-statutory)

The purpose of this Committee is to identify opportunities for the Board to promote and assist physician involvement in access to care issues by providing policy development, program direction,

and recommendations to the Board; and encourage activities designed to promote the cultural and linguistic competency of physicians.

This Committee also has a Subcommittee of individuals addressing the cultural and linguistic competency of physicians.

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; monitor the Board's strategic communication plan; develop physician wellness information by identifying available activities and resources that renew and balance a physician's life, both personal and professional.

This Committee has a Subcommittee that assists with the development of physician wellness information and wellness resources.

Committee on Physician Supervisory Responsibilities (non-statutory)

The purpose of this Committee is to discuss the issue of physician availability in non-traditional settings, including those where cosmetic procedures take place; develop regulatory language related to physician availability in cosmetic surgery settings that use laser impulse light, and to discuss issues relating to physician supervision and its definition.

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 physician supervision, challenge mechanisms, and examinations, as specified by the Board. This Council makes recommendations to the full Board. See [Section 12, Attachment K](#) 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 L](#) 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 L](#) for specific sections of law.

The Board has six two-person Subcommittees that the President appoints as the need arises.

Budget Subcommittee

This Subcommittee meets with the Executive Director and Deputy Director to review budget documents, expenditures, and revenues.

Legislation Subcommittee

This Subcommittee reviews legislative amendments and pending legislation as necessary.

Strategic Plan Subcommittee

This Subcommittee assists staff in the drafting and revision of the Board's Strategic Plan every three to four years.

Full Board Evaluation/Sunset Subcommittees(3)

These Subcommittees meet with the Executive Director and Deputy Director to review sunset review questions and responses. The President has established a Subcommittee for Enforcement, Licensing, and Overall Review.

Board and Committee Meetings/Quorum Issues

Although the full Board has not had any meetings that had to be canceled due to a lack of a quorum, there have been items at these meetings that had to be tabled to a later time due to lack of a quorum at the time. In addition, the Board has held a Committee meeting (April 2012) where no action could be taken because a Member had to cancel attendance resulting in the lack of a quorum of the Committee. B&P Code section 2013 requires that four Members of the Panel constitutes a quorum for the transaction of business. At the May 2012 meeting, one of the Board Panels had to cancel an oral argument that was scheduled due to the lack of a quorum. This caused additional expense to the Board for an ALJ and a DAG. In addition, it caused undue expense and hardship to the Respondent, who was represented by legal counsel, and who traveled from Northern California to Southern California. This Respondent had to wait until the next meeting to present to the Panel.

The Board establishes its meetings for the following full year at its July 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. If an emergency meeting of the Board (or a Committee) is needed, calendars have to be cleared, and if not available, a teleconference meeting space secured.

The full Board holds quarterly meetings throughout the State. These meetings are usually during the months of January/February, April/May, July/August, and October/November. The Board Members have evaluated the issue of travel costs versus accessibility to consumers and determined they want the full Board meetings held Statewide. This would allow for public or physician participation in areas all over the State. Therefore, the Board holds its quarterly meetings in the Los Angeles, San Francisco, San Diego, and Sacramento areas. The Board has determined that the ability to have the public and physicians in these areas attend a meeting far outweighs the cost to hold these meetings Statewide.

In the past, the Board held most of the Committee meetings during the day prior to the full Board's quarterly meeting. Due to the lack of Board membership, Members sit on more than one Committee. Therefore, at these quarterly meetings, in most circumstances, the Committee meetings cannot overlap as Members may need to be at both. At the meeting in February 2012, where the Committees' composition and purpose were discussed, the Board also discussed when the Committees should meet. With the exception of the Licensing and Enforcement Committees and the Application Review and Special Programs Committees, it was decided that the Committees should meet on an as-needed basis and may meet off-cycle of the quarterly Board meetings. The Board determined that more in-depth discussions can be held at off-cycle meetings, as longer meetings can

be scheduled. 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 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 Board takes its mission very seriously as evidenced by the changes that have taken place since the last Sunset Review Report. Since 2005, the Board has undergone a significant number of changes. These changes will be discussed here, but some will be discussed more in depth later in this report. In January 2006, the Board implemented the VE/P. This model was the result of a recommendation from a legislatively mandated report performed by an outside entity who reviewed the Board's Enforcement Program. The "Enforcement Monitor's Report" recommended that in order to streamline the enforcement and prosecution process, the HQES of the AG's Office hire/employ the investigators and institute a vertical prosecution process. The Legislature revised the law to institute a VE/P model where DAGs would work in tandem with the Board to investigate and prosecute complaints received by the Board. Prior to the VE/P model, the Board's investigators would investigate a case and once a violation of the Medical Practice Act was established, the case would be forwarded to the HQES for a DAG to file an accusation and handle the prosecution portion of the case. With the VE/P model, an investigation is assigned to both a Board investigator and a DAG at the initiation of the investigation and they work collaboratively to investigate and prosecute the case. The Board has been using the VE/P model since 2006. (More information on the VE/P, including the success and challenges, is provided in Section 5, Enforcement Program.)

With the establishment of this new model, which includes having the HQES involved earlier in the enforcement process, the Board would not have had the revenue to pay for the costs incurred for the Enforcement Program. Therefore, in 2006, in order to meet the increase in costs, the Board's physician's license and renewal fees increased for the first time since 1994. In 2005, the fee was \$600.00. However, through legislation effective January 1, 2006, the license and renewal fees increased to \$790.00. Part of the legislative agreement for the fee increase was that the Board would no longer order cost recovery. Prior to this legislative change, the costs for the investigation and prosecution of a case were requested by the Board at the time of resolution of a disciplinary action. In most instances, the physician was required through the order of the disciplinary decision to pay all or a portion of these costs. Pursuant to this legislation, the Board can no longer order cost recovery for the investigation and prosecution of cases involving a physician (see B&P Code section 125.3(k)).

In 2008 the Board's membership changed drastically. Prior to 2008, the Board was made up of two Divisions, the Division of Licensing and the Division of Medical Quality. The Division of Licensing handled all policy decisions related to the Board's licensing functions. The Division of Medical Quality dealt with all enforcement policy decisions. When a Member was appointed to the Board, the Member was identified to fill one of the Division vacancies; a Member could not move from one Division to another (unless the Member was reappointed into another Division). All discussion on the related topics was performed within individual Division meetings. The Members became very proficient in the laws, regulations, and policy relating to their specific Division, i.e. licensing or enforcement issues, but the Members were not fully versed in issues that were not within their Division. However, the full Board made final decisions on regulations and took positions on

legislation, which crossed over both Divisions. The Board and Board staff realized that this was not the best arrangement in order to meet the Board's mission of consumer protection. Therefore, the Board held meetings and discussed how the Board should reorganize in order to have well rounded Members that understood all issues, whether it was a licensing issue or whether it was an enforcement issue. The Board determined that the elimination of the two Divisions would be in its best interest.

Additionally, while the Board was discussing the issue of the two Divisions, it also identified that the Board membership was too large for one consolidated Board. At the time, the Board was made up of 21 Members, 12 within the Division of Medical Quality and 7 within the Division of Licensing. There were 12 physicians and 9 public Members. Several of the positions were vacant and had not been filled for a significant amount of time. Additionally, the Board determined that there were issues with having a Board of that size, including the expense, the need for larger meeting space, the ability for some Members to be less involved, and the issue in accommodating all the Members' schedules for meetings. The Board determined that a smaller number of Members would make the Board more cohesive and increase the Board's effectiveness, as long as all Members actively participated and all positions were filled in a timely manner.

Legislation was sought and passed, which became effective on January 1, 2008, that changed the Board's structure by consolidating the two Divisions and making one Board. It also changed the size of the Board from 21 Members to 15 Members. This membership structure has remained the same since that time and the Board has found that the elimination of the Divisions has greatly increased the Board Member knowledge of issues that come before them for discussion and decision. The Board has not been able to fully determine whether the change in the number of Members has achieved the anticipated improvements as the Board has not had the full complement of Members and therefore cannot determine if 15 Members is the appropriate number.

The same bill that made the changes to the structure of the Board, Assembly Bill 253 (Eng, Chapter 678, Statutes of 2007), also provided the authority for the Executive Director of the Board to adopt default decisions and stipulated decisions for surrender. This was a significant change and it created an expedited process for these decisions, thus improving consumer protection.

One other significant change for the Board was the conclusion of the Board's Diversion Program on July 1, 2008 and the repeal of the authority for the Program effective January 1, 2009. The Board's Diversion Program was a monitoring program for substance abusing physicians (and some with mental impairment) that ensured physicians were complying with the requirements of their agreement with the 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 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 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 Program. Based upon the concerns over the safety of patients, the Legislature did not approve the continuation of this 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 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 Program without any record of disciplinary action. If the physician successfully completed the Board's 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. It contracted with a vendor to provide these services. Today, without the Program, when an individual is identified with a 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 Web site or Newsletter. This Committee has since been consolidated with the Education Committee.

Relocation

In March of 2008, the Board moved from its longstanding offices on Howe Avenue to its current location on Evergreen Street. Although the Board initially had some problems, specifically with its phone center, the Board is now fully acclimated. Part of the move and the new phone system allows the public to leave their number in a queue. When they are next in the queue, the phone system calls them back automatically. This has assisted the public not only financially (for those who call long distance), but also eliminates the frustration that occurs when on hold.

Change in Leadership

In April 2010, Linda Whitney was appointed as Executive Director of the Board, following her appointment as interim Executive Director in January 2010. Ms. Whitney was previously the Board's Chief of Legislation and brought with her a wealth of information about the Board and its functions. Through her leadership, significant improvements have been made to all areas of the Board, specifically within the Board's Licensing Program where the review time for an initial application went from approximately 120 days prior to her hiring to the current average of 30-40 days.

Strategic Planning

Since the last Sunset Review Report, the Board has written and approved two Strategic Plans, in 2008 and 2012. The Board recently went through the strategic planning process and adopted the

new 2012 Strategic Plan at its February 2012 meeting. The Board receives updates on the progress of the Strategic Plan at the full Board, Executive Committee, and the Education Committee meetings. (See Section 12, Attachment C for the 2012 Strategic Plan.)

Other Improvements

The Board has made significant changes to ensure transparency and expedite public notice regarding Board actions. The Board developed a subscriber's list that allows any individual to go to the Board's Web site and sign up to receive "news" from the Board via an email alert. Such information could be a disciplinary action taken against a physician, new proposed regulations, the release of the Board's Newsletter, or notification of an upcoming meeting. Anyone who is interested in receiving this information can "subscribe" to one (or all) of these notifications.

The Board's ISB also developed a system that allows any applicant to log into the Board's secure Web site and view the status of his/her application. The Board's staff was inundated with phone calls and emails from applicants asking for the status of their application. These calls and emails resulted in time being taken away from the actual review and processing of the licensing applications. In order to deal with this workload, the ISB developed a system where applicants could use their application number to view the status of the application to ensure it was received, and to verify receipt of documents or identify those that had not been received. This resulted in a significant increase in staff production.

The Board revamped and improved its Web site public disclosure screen (or license lookup). The public can now verify their physician's license is renewed and current, also 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 Board's action.

The Board began posting all Board agendas and meeting materials online, allowing the public to review the entire Board packet, including issue memos, prior to the Board meetings. The Board also began requesting that all of its meetings be Webcast (dependent upon the availability of the DCA's staff). The meetings that have been Webcast remain available on the Board's Web site.

The Board established a unit solely devoted to the unlicensed practice of medicine (Operation Safe Medicine) in Southern California. The investigators within this unit are specially trained in undercover operations and have taken a proactive role in finding unlicensed individuals performing the practice of medicine. This unit has conducted arrests, filed a number of cases with the district attorneys' offices, and has been a huge asset to public protection. This unit actively works with other law enforcement agencies at the local, state, and federal levels.

In accordance with Government Code section 11371, the Board has coordinated with the Office of Administrative Hearings (OAH) to initiate training for the ALJs assigned to hear Board cases. This section of law states the ALJs shall have medical training as recommended by the Board. The Board and the OAH developed a program that will provide this medical training. In the initial daylong session provided in June 2012, topics included pain management/appropriate medication standards, chronic pain issues, new developments in medicine, and other related subjects. The training was

cost effective as it was accomplished with video conferencing technology and presenters were located throughout the state with the ALJs in their respective offices. In order to provide the most time efficient method of training, it was determined that future training would be conducted in a “brown bag” manner during the lunch hour to allow judges to continue attending hearings. In September 2012, the first training of this type occurred. Training was provided again via video conference and the topic was the rehabilitation courses provided by the University of California – San Diego. The training provided a synopsis and description of the courses the ALJs order as conditions of probation, e.g. Physician Boundaries Course, Prescribing Practices Course, Ethics Course, Medical Record Keeping Course, etc. In October 2012 training will include a presentation on the Physician Assessment and Clinical Education Program, which is also a condition that can be ordered as part of probation. Additional training opportunities are being developed in order to meet this training mandate.

In 2005, the Board worked with the California Medical Association on legislation to authorize a \$50 voluntary fee for the Steven M. Thompson Loan Repayment Program. This program encourages recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of educational loans, up to \$105,000, in exchange for their service in a designated underserved area for a minimum of three years. In 2008, legislation supported by the Board was passed (AB 2439, De La Torre, Chapter 640, Statutes of 2007) that required an additional \$25 on all initial and renewal licenses to help with this program. The Board believes that this program is a means to assist with access to care issues that plague this State. The Board, which created the loan repayment program by funding it with the initial monies, has been very supportive of this program due to its benefits for the underserved of California. (See Section 8 for more information on the Loan Repayment Program.)

Major Challenges

In the last five years, the Board has had some major challenges, specifically tied to Budget Letters, Executive Orders, and other restrictions on hiring, travel, and purchasing. Although the Board understands the necessity to achieve savings in order to meet the current (and prior) budget deficit, these orders and restrictions have impacted the Board. (See specific information within each particular section.)

Beginning in 2008 and continuing until the present, the Board has been under either a hiring freeze where it could not fill its vacant positions, or had staff furloughed anywhere from eight to twenty four hours per month. Under the furloughs, the Board had a very difficult time ensuring that the applications and complaints were processed in a timely manner. Additionally, due to the furloughs in 2008 to 2010 only impacting certain State agencies, the Board also lost a number of staff who went to departments that were not impacted by the furloughs.

When the hiring freeze occurred, the Board had a significant vacancy rate. Additionally, as individuals retired, the Board could not hire to fill behind these vacancies. In October 2011, the Board hit an all-time high of a 25% vacancy rate. A large percentage of these vacancies were within the Board’s investigative unit whose main function was the investigation of physicians who had allegedly violated the Medical Practice Act and could have been a danger to the public. The hiring freeze was lifted in November 2011 and the Board’s top priority was filling all vacant positions. At the Board meeting in July 2012, it was reported that the Board’s current vacancy rate was 10%. However,

taking into consideration individuals who were pending hire or background investigations, the Board's potential vacancy rate was 3%. The Board has realized the importance to public protection by having a full complement of staff. Therefore the hiring of staff has been a very high priority.

Another challenge for the Board has been the reduction in the Board's fleet for its investigative and inspector staff. Currently, with the reduction of the Board's fleet, the Board does not have enough vehicles for the staff who are identified to perform investigative and probation monitoring duties. This results in the need to either rent a car or to limit staff's use of a vehicle to perform their duties. This leads to inefficiencies as well as increases the time it takes to investigate a physician alleged to have violated the law or to interview/monitor a physician who has been placed on probation. The Board is examining how it does business in monitoring physicians on probation to determine what alternative can be implemented for those inspectors without a daily use vehicle.

The travel restrictions that have been placed upon the Board has resulted in the Board not being able to perform the educational outreach activities to the public or physicians as set forth in the Strategic Plan. In addition, the Board has had to limit the travel of appropriate staff attending Board meetings. Such limitations can lead to inefficient meetings and, in some instances, moving an issue to a future Board meeting.

As stated above in the sections regarding Board Committees and quorums, the lack of full Board membership has been another challenge. Without the full complement of Board Members, the Board has not been able to determine whether the 15 Member Board is sufficient to perform the functions of the Board. The Board has been unable to adequately operate the Committee meetings that are necessary to develop the policy to be presented to the Board for decisions because there are not enough Members. Members have had to be on multiple Committees and the workload associated with the Committees can be overwhelming. Therefore, some Committees have not been able to meet and perform the necessary functions.

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

Board Sponsored Legislation

2005

- *AB 327 (de la Torre, Chapter 293) Steven M. Thompson Physician Corps Loan Repayment Program*

This bill authorized the Medical Board of California (Board) to accept a voluntary \$50 fee for the issuance and renewal of a physician's license, in order to fund the Steven M. Thompson Loan Repayment Program (STLRP). The STLRP is now funded by a mandatory \$25 fee.

- *AB 920 (Aghazarian, Chapter 317) California Physicians Corps Program*

This bill moved the Steven M. Thompson Physician Corps Loan Repayment Program and the Volunteer Physician Program from the Board to the Health Professions Education Foundation (HPEF) in the Office of Statewide Health Planning and Development (OSHPD). The bill also added two Members to the HPEF Board, appointed by the Medical Board.

2006➤ *AB 1796 (Bermudez, Chapter 843) Advisory Committees and Licensing Program Changes*

This bill authorized the Board to establish advisory committees consisting of physicians and public members who are not required to be Members of the Board. The bill required an applicant to obtain a passing score on the USMLE, Step 3, within four attempts. The bill also provided that applicants who are denied licensure could not reapply until three years after the date the application was denied, except under certain conditions. The bill also allowed the Board's Licensing Program (then named the Division of Licensing) to obtain probation monitoring costs and waived the fee for a physician's voluntary license for practitioners who reside in California.

➤ *AB 2198 (Houston, Chapter 350) Controlled Substances and Dangerous Drugs*

This bill incorporated the recommendations of the Board's Pain Management Task Force and made changes to the pain management laws to facilitate the treatment of pain. This bill changed the "good faith prior exam" requirement related to prescribing, dispensing or furnishing dangerous drugs, to an "appropriate prior examination."

➤ *AB 2260 (Negrete McLeod, Chapter 565) Special Programs and Special Faculty Permits*

This bill revised the special fellow and faculty programs by adding initial and renewal provisions and specified the action to be taken if a complaint is received. This bill expanded the current program. This bill also prohibited a physician from including, or permitting to be included, a "gag clause" provision within a civil settlement that prohibits another party to the dispute from contacting, cooperating, filing a complaint, or requiring the withdrawal of the complaint with the Board.

➤ *SB 1232 (Runner, Chapter 133) Out-of-state Physicians*

This bill added criteria for the evaluation of applicants for licensure under B&P Code section 2135.5. It required that an applicant be licensed by the state of origin for a period of at least four years and required the applicant to satisfy other criteria before the Board (then the Division of Licensing) could determine the applicant's compliance with the curriculum, clinical instruction, and examination requirements.

➤ *SB 1438 (Figueroa, Chapter 223) Reporting Requirements*

This bill required physicians to report all misdemeanor convictions, and required the Board to post on its Web site misdemeanor convictions for physicians that result in disciplinary actions or an accusation that is not subsequently withdrawn or dismissed. This bill stated the legislative intent to have the Bureau of State Audits review the Board's operations prior to sunset review. The bill also revised the due dates of various reports and amended the B&P Code section 800 reporting sections to clarify the reporting requirements for physicians.

➤ *SB 1638 (Figueroa, Chapter 536) Midwifery Advisory Council and Midwife Annual Report*

This bill required the Board to create and appoint a Midwifery Advisory Council. It required licensed midwives to make annual reports to OSHPD on specified information regarding birth outcomes, with the first report due in March 2008. This bill also required each licensed midwife who assists or supervises childbirth occurring in an out-of-hospital setting to annually report to OSHPD specified information regarding his or her practice for the previous year. This bill required the data to be consolidated by OSHPD and reported back to the Board for inclusion in the Board's annual report.

➤ *SB 1851 (Health Comm., Chapter 485) Informed Consent – Cancer*

This bill required a physician, upon diagnosis of breast cancer, to provide the summary of alternative efficacious methods of treatment for breast cancer to the patient, prior to obtaining consent for any breast cancer treatment (other than screening or biopsy). This bill also allowed the physician to choose to provide the summary to the patient prior to performance of a screening or biopsy.

2007

➤ *AB 253 (Eng, Chapter 678) Board Division Consolidation and Membership Change*

This bill combined the Division of Licensing and the Division of Medical Quality into one Board. This bill also allowed the Board to delegate to the Executive Director the authority to adopt default decisions and stipulations for surrender of a license. Lastly, this bill reduced the Board Membership from 21 Members (12 physician Members, and 9 public Members) to 15 Members (8 physician Members, and 7 public Members).

➤ *AB 329 (Nakanishi, Chapter 386) Telemedicine Pilot Program*

This bill allowed the Board to establish a telemedicine pilot program. It authorized the Board to implement the program by convening a working group of interested parties. The Board was required to make recommendations to the Legislature within one calendar year of the commencement date of the pilot program (this final report will be completed in Fall, 2012).

➤ *SB 761 (Ridley-Thomas) Diversion Program and VE/P - Did not pass out of the Legislature*

This bill would have extended the dates on which the provisions for the Diversion Program are repealed from January 1, 2009 to January 1, 2011. The bill would have required the Board to create and appoint a Diversion Advisory Council (DAC). It would have extended the sunset date of the VE/P model from January 1, 2009 to January 1, 2011. In addition, the bill would have authorized the Board to employ special agents and to transition investigators who are peace officers to a special agent classification. Lastly, the bill would have deleted the requirement that an investigator be under the direction of the DAG who is simultaneously assigned a complaint, and instead, required that investigator assist the DAG, who would be responsible for the legal direction of the case.

This bill was set to be amended to delete all the provisions related to Diversion once it passed out of the Assembly Appropriations Committee. This bill was held in the committee due to concerns related to the legislative reclassification of investigators. The provisions of this bill regarding the VE/P model were incorporated into SB 797.

2008

➤ *AB 2442 (Nakanishi, VETOED) Diversion Program Reporting*

This bill would have, in light of the sunset of the Medical Board's Diversion Program, repealed sections in law that referenced and required reporting to the Board's Diversion Program. This language was later included in an omnibus bill.

➤ *AB 2443 (Nakanishi, VETOED) Physician Well-being*

This bill would have required the Board to establish a program within existing resources to promote well-being of medical students, post-graduate trainees, and licensed physicians.

➤ *AB 2444 (Nakanishi, Chapter 242) Public Letters of Reprimand and Education*

This bill allowed public letters of reprimand to include educational or specified training requirements.

➤ *AB 2445 (Nakanishi, Chapter 247) Applicant Public Letters of Reprimand*

This bill allowed the Board to issue public letters of reprimand concurrently with a physician's license for minor violations and to disclose said public letter of reprimand on the Board's Web site. This bill required the public letter of reprimand be purged three years from the date of issuance.

2009

➤ *AB 501 (Emmerson, Chapter 400) Licensing Program changes*

This bill allowed graduates of approved medical schools to use the initials M.D. as long as they do not represent themselves as a physician who is entitled to practice medicine and do not engage in any of the acts prohibited by section 2060 of the B&P Code. It also allowed others who hold an unrestricted license to use the initials M.D. as long as they are not representing themselves as physicians who are allowed to practice in California. In addition, it allowed the Board to issue an initial limited license to an applicant for licensure who is otherwise eligible for a medical license in California, but is unable to practice all aspects of medicine safely due to a disability. This bill established a cap on the licensing fee imposed by the Board (the cap would be fixed by the Board at a fee equal to or less than seven hundred ninety dollars (\$790)) and increased the amount of reserve allowed in the Contingent Fund of the Board. It directed the Office of State Audits and Evaluations within the Department of Finance to perform a review of the Board's financial status instead of the Bureau of State Audits (results of the review had to be available by June 1, 2012) and required the funding for the review to come from the existing resources of the Office of State Audits and Evaluations within DOF.

➤ *AB 1070 (Hill, Chapter 505) Enforcement Program changes*

This bill required reporting under B&P Code section 801.01 and made various technical changes to the section to enhance the Board's ability to effectively protect consumers. It also allowed the Board President to sit on a disciplinary panel when the Board does not have a full complement of Members. The bill required all medical records requested by the Board to be certified and allowed an ALJ to recommend that a licensee be issued a public reprimand that includes additional requirements for education and training. The bill required all licensees to report to the Board information regarding any specialty board certifications held and the licensee's practice status and allowed licensees to report his or her cultural background and foreign language proficiencies. Lastly, the bill extended the sunset date of the VE/P model from July 1, 2010 to July 1, 2012 and required the Board to establish and implement a plan to assist in team building between the Board's staff and the HQES of the DOJ.

2010

➤ *AB 1767 (Hill, Chapter 451) Expert Representation and HPEF Membership*

This bill required the Board to provide representation (through the AG's Office) to a licensed physician who provides expertise to the Board in the evaluation of the conduct of a licensee when, as a direct result of providing the expertise, the physician is subject to a disciplinary proceeding undertaken by a specialty board of which the physician is a member. This bill also extended the sunset date of the two Members appointed by the Board to the HPEF from January 1, 2011, to January 1, 2016.

➤ *SB 1031 (Corbett, VETOED) Medical Malpractice Insurance for Volunteer Physicians*

This bill would have created the Volunteer Insured Physicians (VIP) Program for the purpose of providing a licensee who would like to provide uncompensated care to patients with insurance coverage. The services provided would have been required to be general medicine or family practice level care. This bill would have established a procedure that consisted of a voluntary service

agreement between the licensed physician and the Board, initiated by application to the VIP program. This bill would have provided a definition for qualified healthcare entities and would have created a voluntary services contract to be executed between the physician and the hospital, clinic, or health care agency. Licensees in the VIP program would have been required to hold a full and unrestricted license in California, be in good standing, and have no record of discipline.

2011

➤ *AB 1127 (Brownley, Chapter 115) Failing to Participate in a Board Interview*

This bill made it unprofessional conduct for a physician who is the subject of an investigation by the Board to repeatedly fail, absent good cause, to attend and participate in an interview scheduled by mutual agreement of the physician and the Board.

➤ *AB 1267 (Halderman, Chapter 169) Inactive License for Misdemeanor Incarceration*

This bill authorized the Board to automatically place a physician's license on inactive status for the period of incarceration when he/she is incarcerated after the conviction of a misdemeanor. This bill allowed the Board to disclose the reason for the inactive status on the Board's Web site. The bill also required the Board to change the physician's license status back to its prior or appropriate status within five business days of receiving notice that the physician is no longer incarcerated. Lastly, the bill required the Board to adopt regulations to specify the type of notice required to be submitted to the Board. (*Regulations on this subject have been adopted by the Board but are still being finalized.*)

➤ *SB 541 (Price, Chapter 339) Expert Consultants*

This bill, which was co-sponsored by the Board and the Contractors State License Board, enabled all boards and bureaus in the DCA to continue to utilize expert consultants, using a simplified contract and an expedited contracting process, without having to go through the formal contracting process.

2012

➤ *AB 1533 (Mitchell, Chapter 109) International Medical Graduates*

This bill, which was co-sponsored by the Board and the University of California (UC), authorized a pilot for the University of California at Los Angeles (UCLA) international medical graduate (IMG) program. The pilot will allow program participants to engage in supervised patient care activities for a typical assignment lasting 16 weeks (but not to exceed 24 weeks), as part of an approved and supervised clinical clerkship/rotation at UCLA health care facilities, or with other approved UCLA affiliates. All such training will occur with supervision provided by licensed physicians. This bill also requested the UC to prepare a report for the Board and the Legislature on or before January 1, 2018. The report should include the number of participants in the pilot program, the number of participants issued a license by the Board, the number of participants who practice in designated medically underserved areas, and the potential for retention or expansion of the pilot program. The bill sunsets the pilot program on January 1, 2019.

➤ *SB 1575 (B&P Comm., Chapter 799) Omnibus*

This bill clarified that the Board has enforcement jurisdiction over all licensees, including physicians with a non-practice license status. This bill also allowed the Board to send renewal notices via email if requested by the physician, and includes a process to ensure that the email address on record is current. This bill also established a retired license status for licensed midwives.

Legislation Impacting the Board**2005**➤ *AB 367 (Nakanishi, Chapter 144) Physician's Fee Waiver*

This bill waived the initial physician licensing fee if the applicant is requesting voluntary licensing status.

Board Position: Support

➤ *SB 279 (Cedillo, Chapter 596) Locum Tenens Services*

This bill provided that a temporary physician staffing agency, commonly referred to as a locum tenens agency, is not an employer of the physicians it places.

Board Position: Support

2006➤ *AB 2283 (Oropeza, Chapter 612) Posting of Annual Data collected by the Board*

This bill required the information regarding physician cultural background and foreign language proficiency collected by the Board to be posted annually on the Board's Web site by primary practice location (zip codes). The annual date for the posting of the information coincides with the Board's annual report date.

Board Position: Support

➤ *AB 2342 (Nakanishi, Chapter 276) Cultural Background and Foreign Language Proficiency*

This bill required the Board, in conjunction with the HPEF, to conduct a study on the issue of Board sponsored medical malpractice insurance for physicians who provide voluntary, unpaid services, as described, contingent on an appropriation of funds for that purpose.

Board Position: Support

➤ *AB 2986 (Mullin, Chapter 286) Controlled Substances – Prescription Requirements*

This bill harmonized California's current Controlled Substance Utilization Review and Evaluation System (CURES) program to the newly enacted "National All Schedules Prescription Electronic Reporting (NASPER) Act of 2005" in order for California to qualify for federal grant funding. This bill also provided that the CURES program will monitor and report on the prescribing and dispensing of Schedule IV controlled substances.

Board Position: Support

➤ *SB 1423 (Figueroa, Chapter 873) Laser Procedures*

This bill required the Board, in conjunction with the Board of Registered Nursing (BRN), to evaluate and study issues related to the use of laser or intense light pulse devices for elective cosmetic procedures. This bill also required to Board to adopt regulations relating to the findings on or before January 1, 2009 (the findings did not include adopting regulations, instead recommended enforcing existing laws).

Board Position: Oppose

2007➤ *SB 620 (Correa, Chapter 210) Dentistry – General Anesthesia*

This bill removed the January 1, 2008 sunset date on the permitting process for physicians who administer general anesthesia for dental patients.

Board Position: Support

2008➤ *AB 547 (Ma, VETOED) Licensure Fees*

This bill was a result of a fiscal audit by the Bureau of State Audits where it concluded that the Board had excess in its reserves and should pursue a reduction. This bill would have established a cap on the physician licensing fee.

Board Position: Support if Amended (to allow a fund reserve of between 2 and 6 months)

➤ *AB 2439 (De La Torre, Chapter 640) Steven M. Thompson Physician Corps Loan Repayment Program*

This bill required the Board to assess an additional \$25 fee at licensure or renewal of a physician's license for the purpose of helping to fund the Steven M. Thompson Physician Corps Loan Repayment Program, which provides loan repayment awards. This bill required the Program to dedicate a maximum of 15% of this revenue, from physicians fees, to loan assistance for physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 or adults with disabilities.

Board Position: Support

➤ *SB 797 (Ridley-Thomas, Chapter 33) VE/P extension and enhancements*

This bill extended the sunset date of the VE/P model to July 1, 2011 and specified that an investigator is not under the supervision of the DAG. It also required the Board to increase its computer capabilities and compatibilities with the HQES in the AG's Office and required the Board to implement a plan to locate its enforcement staff and the staff of HQES in the same offices. Lastly, this bill required the Board, in consultation with specified agencies, to make recommendations to the Governor and the Legislature on the VE/P model by July 1, 2009.

➤ *SB 1379 (Ducheny, Chapter 607) Physician Loan Repayment, Health Care Service Plans, and California Major Risk Medical Insurance Program*

This bill prohibited the Department of Managed Health Care (DMHC) from using fines and penalty revenues to reduce assessments levied on health care service plans and redirected these penalty revenues to the Steven M. Thompson Physician Corps Loan Repayment Program. This bill redirected the first \$1 million of fine revenue from the DMHC's budget to the Program within the HPEF. Additionally, this bill required DMHC to immediately make a one-time transfer of \$1 million to the Medically Underserved Account for Physicians within the HPEF to be used by the Program.

Board Position: Support

➤ *SB 1441 (Ridley-Thomas, Chapter 548) Healing Arts Practitioners – Substance Abuse*

This bill established the Substance Abuse Coordination Committee (SACC) within the DCA, comprised of the executive officers of the department's healing arts licensing boards. The bill required the SACC to formulate, no later than January 1, 2010, uniform and specific standards in specified

areas that each healing arts board would be required to use in dealing with substance-abusing licensees, whether or not the Board had a formal diversion program.

Board Position: Support

2009

➤ *AB 1116 (Carter, Chapter 509) Cosmetic Surgery*

This bill enacted the Donda West Law, and required physicians or dentists to conduct a physical examination and give a written clearance prior to performing elective cosmetic surgery on patients, including liposuction. This bill required the physical examination and written clearance to be conducted by one of the following: a licensed physician, a nurse practitioner, a physician assistant, or a dentist licensed to perform surgery. The examination must include the taking of a complete medical history.

Board Position: Support

➤ *SB 132 (Denham, Chapter 635) Polysomnographic Program – Sleep and Wake Disorders*

This bill required the Board to adopt regulations to establish qualifications for certified polysomnographic technologists, polysomnographic technicians, and polysomnographic trainees. This bill authorized persons who meet specified education, examination, and certification requirements to use the title "certified polysomnographic technologist" and engage in the practice of polysomnography under the supervision and direction of a licensed physician.

Board Position: Support

➤ *SB 820 (Negrete McLeod, VETOED) Peer Review*

This bill included provisions related to peer review, regarding the following: what is contained in the central file, what information can be disclosed and posted on the Board's Web site; defining peer review; clarifying reporting requirements, and requiring new peer review reports.

Board Position: Support

2010

➤ *AB 583 (Hayashi, Chapter 436) Disclosure of Education*

This bill required health care practitioners to provide their name, license type, highest level of academic degree, and board certification in a written disclosure or in their offices, as specified.

Board Position: Support

➤ *AB 2699 (Bass, Chapter 270) Licensure Exemption*

This bill exempted specified health care practitioners (including physicians), who are licensed and certified in other states, from California state licensure, for the purposes of providing voluntary health care services to uninsured and underinsured Californians on a short-term basis.

Board Position: Oppose - *The Board was the first entity to develop regulations in order to implement this bill. The regulations were approved and were effective 8/20/12.*

➤ *SB 700 (Negrete McLeod, Chapter 505) Peer Review*

This bill focused on enhancements to the peer review system related to the Board and oversight by the California Department of Public Health. This bill added a definition of peer review and allowed the Board to obtain peer review minutes or reports.

Board Position: Support

➤ *SB 1172 (Negrete McLeod, Chapter 517) Cease Practice*

This bill required all healing arts boards under the DCA to order a licensee to cease practice if the licensee tests positive for any substance that is prohibited under the terms of the licensee's probation or Diversion Program. This bill allowed a healing arts board to adopt regulations authorizing the board to order a licensee to cease practice for major violations or when ordered to undergo a clinical diagnostic evaluation.

Board Position: Support

➤ *SB 1410 (Cedillo, VETOED) Licensure Examinations*

This bill would have deleted the limitation in existing law that an applicant for licensure may only make four attempts to obtain a passing score on Step III of the United States Medical Licensing Examination (USMLE). This bill would have required the Board to adopt a resolution at a public meeting every time it adopts a USMLE passing score, prohibited the Board from delegating the responsibility to adopt the passing score to any other entity, and required the passing score to be a numerical score and not a percentage.

Board Position: Oppose

2011

➤ *AB 415 (Logue, Chapter 547) Telehealth*

This bill repealed existing law related to telemedicine and replaced this law with the Telehealth Advancement Act of 2011, which revised and updated existing law to facilitate the advancement of telehealth as a service delivery mode in managed care and the Medi-Cal Program.

Board Position: Support

➤ *AB 536 (Ma, Chapter 379) Web site Posting*

This bill required the Board to post notification of expungement orders and the date of expungement on its Web site within six months of receipt of the certified expungement order.

Board Position: Support

➤ *SB 100 (Price, Chapter 645) Outpatient Surgery Settings*

This bill required the Board to obtain and maintain a listing of information on outpatient settings on its Web site, including name and address of owners, and the facility name and effective dates of accreditation (*this database is up and running as of July 2012*). The Board must update its Web site if the outpatient setting's accreditation is revoked, suspended, placed on probation, or if a reprimand is received. This bill required the Board 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 proposed language is set for regulatory hearing at the October 2012 Board Meeting*). This bill also made a number of changes regarding the approval, oversight, and inspection of outpatient settings by the Board and accreditation agencies approved by the Board. It required all outpatient settings with multiple service locations to have all sites inspected. This bill provided that all final inspection reports, which include the lists of deficiencies, plans of correction or requirements for improvements and correction, and corrective action completed, be public records open to public inspection. In addition, this bill required that when an accrediting agency denies an outpatient setting's accreditation and the outpatient setting applies to

a different accrediting agency, the new accrediting agency must ensure that all previous deficiencies have been corrected and a new onsite inspection must be conducted.

Board Position: Support

➤ *SB 380 (Wright, Chapter 236) Continuing Medical Education*

This bill authorized the Board to set content standards for any educational activity concerning a chronic disease that includes appropriate information on the impact, prevention, and cure of the chronic disease by the application of changes in nutrition and lifestyle behavior. This bill required the Board to periodically disseminate information and educational material regarding the prevention and treatment of chronic disease by the application of changes in nutrition and lifestyle behavior to each licensed physician and to each general acute care hospital in California. This bill also required the Board to convene a working group of interested parties to discuss nutrition and lifestyle behavior for the prevention and treatment of chronic disease at a quarterly board meeting within three years of the effective date of the bill.

Board Position: Neutral

2012

➤ *AB 589 (Perea, Chapter 339) Medical School Scholarships*

This bill created the Steven M. Thompson Medical School Scholarship Program (STMSSP) within the HPEF. The STMSSP is to be funded by private funds and will only be implemented if sufficient funds are available.

Board Position: Support

➤ *AB 1548 (Carter, Chapter 140) Cosmetic Surgery – Employment of Physicians*

This bill prohibited outpatient cosmetic surgery centers from violating the prohibition of the corporate practice of medicine. This bill defined “outpatient elective cosmetic medical procedures or treatments”. This bill enhanced the penalty for corporations violating the prohibition of the corporate practice of medicine to a public offense punishable by imprisonment for up to five years and/or by a fine not exceeding \$50,000.

Board Position: Support

➤ *AB 1621 (Halderman, Chapter 76) Prostate Cancer*

This bill exempted physicians working on trauma cases from current law that requires physicians to provide specified information on prostate diagnostic procedures to patients who undergo an examination of the prostate gland.

Board Position: Support

➤ *SB 122 (Price, Chapter 789) International Medical Graduates*

This bill allowed individuals 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). In addition, this bill also required these individuals to be certified by a specialty board approved by the ABMS and to have successfully completed the licensing examination required in existing law. The applicant must also have successfully completed three years of postgraduate

training and not have any discipline on their license in another state or any adverse judgments or settlements relating to the practice of medicine.

Board Position: Support

➤ *SB 1095 (Rubio, Chapter 454) Clinics – Limited License by the Board of Pharmacy*

This bill expanded the type of clinics that may be issued a limited license by the Board of Pharmacy to include specified outpatient settings and Medicare certified ambulatory surgical centers. The license issued by the Board of Pharmacy allows these clinics to purchase drugs at wholesale for administration or dispensing to clinic patients for pain and nausea under the direction of a physician.

Board Position: Support

➤ *SB 1236 (Price, Chapter 332) Physician Assistants/VE/P*

This bill renamed the Physician Assistant Committee to the Physician Assistant Board (PAB), and made it its own Board, not a committee of the Medical Board. This bill extended the sunset date of the PAB to January 1, 2017 and revised the makeup of the Members of the PAB. Upon expiration of the current Medical Board Member, this bill required a Member to be appointed to the PAB that is also a Member of the Board, but that Member shall serve as an ex officio, nonvoting Member whose functions will include reporting to the Board on the actions or discussion of the PAB. This bill extends the sunset date of the VE/P model, from January 1, 2013 to January 1, 2014.

Board Position: Support

➤ *SB 1274 (Wolk, Chapter 793) Corporate Practice of Medicine*

This bill narrowly expanded the corporate practice of medicine exemption to allow Shriners Hospital for Children to continue to employ physicians, and also allowed the hospital to bill insurers for the services rendered to patients with insurance coverage.

Board Position: Support

Regulation Changes Approved by the Board Since the Last Sunset Review

The following regulation changes have been completed since the last Sunset Report in 2005.

2005

➤ *Amend CCR sections 1319.4, 1321, 1322, 1328 and repeal 1319, 1326, 1329.1, and 1351*

This section 100 regulatory change included minor amendments regarding applications for medical licensure. This package also amended the time allowed for the Board to review an application and provide notification to an applicant as to the status of the application (60 working days) and the time to notify an applicant regarding the Board's decision on the application (100 days). Changes also included approving the Royal College of Physicians and Surgeons of Canada as meeting the requirements for postgraduate training and amended requirements for foreign medical school graduates to complete the required clinical training in an approved "program" rather than an approved "hospital." Lastly, the regulation changes included specifying the written examinations recognized by the Board in order to meet the requirements for licensure and repealed sections that were obsolete.

➤ *Adopt CCR section 1335.35*

This regulatory change included standardizing and formalizing the language used by the Board to display a physician's license information on the Web site. The Board established disclaimers and

definitions to assist the public in understanding how to use the information posted on the Board's Web site.

➤ *Amend CCR section 1379.20*

This regulatory change required a midwife, who does not carry liability insurance, to disclose this fact to the client in either written or oral form and note this disclosure in the patient's file.

➤ *Adopt CCR section 1358.1*

This new section specified the provider requirement and the criteria for an ethics course, ordered as a condition of probation. The requirements were established to ensure the course is designed to effectuate behavioral change.

➤ *Amend CCR section 1364.11*

This regulatory change added minor violations of probation to the list of citable offenses and increased the maximum fine amount to \$5,000.

2006

➤ *Amend CCR section 1313.01*

This section 100 regulatory change renamed the California Physician Corps Loan Repayment Program to the Steven M. Thompson Physician Corps Loan Repayment Program.

➤ *Adopt CCR section 1304.5*

This new section allowed the Board to deem a decision, or part of a decision, as a precedential decision, which assists in uniformity and provides the Board with an additional resource when prosecuting a case.

➤ *Amend CCR sections 1351.5 and 1352*

This regulatory change increased the physician's initial license and renewal fees by \$15.00 in order to make neutral the loss of income due to the elimination of cost recovery.

➤ *Adopt CCR section 1379.19*

This new section defined the appropriate standard of care for licensed midwives and the level of supervision required for the practice of midwifery. The adoption of midwifery standards of care was necessary because midwifery is a distinct profession.

2007

➤ *Adopt CCR section 1315.03, 1326 and amend 1325.4*

This new section specified application requirements for foreign trained physicians for faculty positions in approved medical schools. It also established the qualifications and criteria for the Special Faculty Permit Review Committee responsible for advising the Board on the approval of B&P Code section 2168.1 applicants. It also reworded the statement that the "applicant will be under a designated supervisor who is a licensed physician" to more clearly state the applicant will be "supervised by a licensed physician who is a faculty member and is on the staff of the medical school's medical center where the applicant will be participating."

➤ *Adopt CCR section 1351.1*

This new section set the initial and renewal applicant fees for Special Program applicants under B&P Code section 2111 and 2113. These applications are for foreign fellowships and guest medical school faculty members.

2008

➤ *Adopt CCR section 1364.32 and amend 1364.30*

This new section required written arguments submitted in response to an order of non-adoption or reconsideration to include the citation for the record and authority for each point addressed, if applicable. This regulatory change authorized the ALJ or any panel member to request a party to support the party's oral argument on the matter with a specific citation to the record and required the respondent to be placed under oath if they address the panel.

➤ *Amend CCR section 1399.540*

This regulatory change named the document that delegates services from a physician to a physician assistant, the "Delegation of Services Agreement" and required it to be signed and dated by both the supervising physician and the physician assistant, making it more likely both parties understand and agree with the contents of the document. Changes also included allowing the Delegation of Services Agreement to be signed by more than one supervising physician, only if the same medical services are delegated by each supervising physician, and allowing a physician assistant to provide medical services pursuant to more than one Delegation of Services Agreement.

➤ *Amend CCR section 1361*

This regulatory change made revisions to the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* by deleting reference to the Division of Medical Quality and the Diversion Program, which no longer exist.

➤ *Amend CCR section 1336*

This regulatory change required licensees to complete 50 hours of continuing medical education (CME) each two-year renewal period, instead of completing 100 hours of CME during a four-year period.

2009

➤ *Amend CCR sections 1351.5 and 1352*

These regulatory changes reduced the initial license fee and renewal fee for physicians, to offset the elimination of the Diversion Program.

➤ *Amend CCR section 1338*

This regulatory change modified the wording for CME audits from "once" each year to "during" each year, which provides for a more manageable, predictable, and consistent workload.

➤ *Amend CCR section 1314.1*

This regulatory change updated and added specificity to the existing standards and methodology that the Board uses to review International Medical Schools, which provided more clarity to the Board's requirements for schools seeking recognition and, in turn, led to more efficiency in the Board's review process.

2010➤ *Adopt CCR section 1355.4*

This new section known as “notice to consumers” requires physicians to notify their patients that they are licensed and regulated by the Medical Board of California by prominently posting a sign or providing a written notice signed by the patient, that includes the Medical Board’s contact information. This regulation provides awareness for the consumer of the existence of the Medical Board and informs consumers that they can contact the Medical Board if they have a complaint about a physician.

2011➤ *Amend CCR section 1328*

This regulatory change recognized the examination combination of USMLE Steps 1 & 2 and NBME Step 3 to meet the examination requirement for a physician’s license. This expanded the combination of acceptable examinations to accommodate an applicant who otherwise might not qualify for licensure.

➤ *Amend CCR section 1306*

This regulatory change more clearly described the circumstances under which the Board will treat an applicant as abandoned, by more clearly notifying applicants of their responsibilities of meeting a 365 day timeframe. This allows the Board to focus its resources on current applicants who are diligently pursuing licensure.

➤ *Amend CCR sections 1327 (a) and 1327 (a)(3)*

These regulatory changes clarified that foreign medical students who practice medicine in a clinical training program approved by the Board must be enrolled in a foreign medical school recognized by the Board. The changes also added another continuing education accreditation agency, the Accreditation Council for Continuing Medical Education (ACCME), which accredits clinical training programs for health facilities. This provided more training opportunities for foreign medical students.

➤ *Adopt CCR sections 1315.50, 1315.53, and 1315.55*

These new sections established the requirements for an applicant seeking a limited practice license. These new sections defined and established the criteria needed for an independent clinical evaluation, and prescribe the information the evaluation must include, in order for the Board to make a determination of the applicant’s ability to practice medicine safely and issue a limited practice license.

➤ *Amend CCR section 1361*

This regulatory change revised the Manual of Disciplinary Orders and Disciplinary Guidelines to make it consistent with current law, to reflect recent changes in law, to make technical changes to address unnecessary and duplicative elements, and to make changes to reflect the current probationary environment, including adding many elements of the DCA uniform standards regarding substance abuse related terms and conditions.

➤ *Adopt CCR sections 1379.40 – 1397.78*

These new sections established the Polysomnography Program, including the qualifications for certified polysomnographic technologists, technicians, and trainees, application and registration requirements, required education and examinations, and associated disciplinary actions. Adopting this regulatory package was necessary for the Board to be able to establish this program that was mandated in statute.

2012

➤ *Adopt CCR sections 1333 – 1333.3*

These new sections are regarding sponsored free healthcare events. Regulations were needed in order to implement statute that allowed for these events and out-of-state practitioners to participate in these events. The Board was the first agency to have regulations approved for sponsored free healthcare events. These sections provided the rules and documents for registration of sponsored free healthcare events and the physicians who volunteer their services. These sections require sponsors of such events in California to register a minimum of 90 days in advance and require physicians from out-of-state to register with the Board to practice at the events. These sections require fingerprints and background checks of all physicians registering to provide their services, prior to registration, and the registration is only good for up to 10 days at such events. In order to be eligible to register, physicians must hold a license in good standing in another state. Lastly, these sections provide the grounds in which the Board can terminate a registration.

➤ *Adopt CCR section 1355.45*

This proposed regulation is in the review process, and is regarding an inactive license for physicians who have been incarcerated for a misdemeanor. These regulations are required in order to fully implement existing statute sponsored by the Board. This proposed section will define the notice that the Board will accept to restore a physician's license after they are released from incarceration, and will also specify how the Board can disclose the inactive status and the misdemeanor incarceration on its Web site. The final statement of reasons for this regulatory package is currently in the process of being finalized.

➤ *Adopt CCR section 1364.50*

This proposed regulation is in the review process, and is regarding physician availability. The Board is required to adopt this regulation by statute. This section will clarify for physicians and mid-level practitioners how available the supervising physician must be when the mid-level practitioner is performing elective cosmetic procedures using a laser or intense pulse light device. This will help to ensure physicians meet these standards and are appropriately available to decrease the chances of patient harm. The Board will hold a regulatory hearing on this proposed regulation on October 26, 2012 at its Board Meeting in San Diego.

➤ *Amend CCR section 1379.50*

This proposed amendment is in the review process, and is regarding the Polysomnography Program. The proposed amendment would remove the requirement that Basic Life Support certification can only be provided by the American Heart Association and would allow the requirement to also be met by certification issued by the American Health and Safety Institute. This revision will allow applicants for a Polysomnography Registration to have more options to choose from when obtaining the

required Basic Life Support Certification. The Board will hold a regulatory hearing on this proposed amendment on October 26, 2012 at its Board Meeting in San Diego.

Major Studies Conducted by the Board

The Board has completed several studies in the last six years, some mandated by law, and some as requested by the Board. The Board contracted with another entity to perform some of the studies; however, certain studies were completed by Board staff. The links to the reports have been listed below and are listed in [Section 12, Attachment C](#) (hard copies are available in Volumes II, III, and IV). Below is a synopsis of each of the studies, including the reason the study was performed.

Report on Malpractice Insurance for Volunteer Physicians

Assembly Bill (AB) 2342 (Nakanishi, Chapter 276, Statutes of 2006) added B&P Code section 2023 to the Medical Practice Act. This section mandated the Board, in conjunction with the HPEF, to study the cost of providing medical malpractice coverage to physicians who volunteer their time to provide uncompensated medical coverage to patients. The study also needed to look at options for providing insurance to these physicians and funding for the malpractice coverage. The Board contracted with the University of California – Davis Health System to conduct the study. The study concluded that, “In order to provide the most cost-effective liability protection model for physicians, some form of charitable immunity statute must be passed in this state, eliminating or reducing the likelihood that physicians providing voluntary, unpaid medical care would be susceptible to personal liability in a malpractice action.” To date, no legislation has been signed based upon this study.

Report: http://www.mbc.ca.gov/publications/malpractice_insurance.pdf

Appendix: http://www.mbc.ca.gov/publications/malpractice_insurance_appendix.pdf

Comprehensive Study of Peer Review in California: Final Report

On July 31, 2008 a study was completed pursuant to B&P Code section 805.2, which required a comprehensive study of the peer review process. The study also had to include an evaluation of the continuing validity of B&P Code sections 805 and 809 to 809.8 and their relevance to the conduct of peer review in California. The Board contracted with a healthcare consulting organization outside entity to conduct this study and write the report. 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 B&P Code section 805 reporting and B&P Code section 809 hearings. Senate Bill 820 (Negrete McLeod) was introduced in 2009 to define some of the requirements and clarify the peer review process based on the results of the study; this bill was vetoed. However, Senate Bill 700 (Negrete McLeod, Chapter 505, Statutes of 2010) passed, which focused on enhancements to the peer review system and made other improvements to peer review.

Report: http://www.mbc.ca.gov/publications/peer_review.pdf

Appendix: http://www.mbc.ca.gov/publications/peer_review_appendix.pdf

Physician Misconduct and Public Disclosure Practices at the Medical Board of California

Senate Bill 1438 (Figueroa, Chapter 223, Statutes of 2006) required the Board pursuant to B&P Code section 2026 to study the role of public disclosure in the public protection mandated of the Board. The study was to focus on considering whether the public is adequately informed about physician

misconduct by the Board's laws and regulations for disclosure. The California Research Bureau (CRB) of the California State Library was mandated to perform the study. The report contained policy options or recommendations, most of which required legislative changes. To date, no legislation has been signed based upon this study.

<http://www.library.ca.gov/crb/08/08-015.pdf>

Vertical Enforcement – Report to the Legislature – November 2007

Vertical Enforcement Model Report to the Legislature – June 2009

Vertical Enforcement and Prosecution Model Report to the Legislature – March 2012

The Board was mandated to provide reports to the Legislature regarding the implementation of the VE/P model. Each of these reports provided information on the successes and challenges of this type of model, and included a significant amount of statistical data. The first two reports contained recommendations on improvements that could be implemented to the model in order to enhance its effectiveness. The Board and the HQES of the AG's Office have made several changes based upon the recommendations in these studies. The third report provided the details on these changes and what the Board has done to implement the recommendations.

November 2007: http://www.mbc.ca.gov/publications/legislature_report.pdf

June 2009: http://www.mbc.ca.gov/publications/vertical_enforcement_model_report_2009_06.pdf

March 2012: http://www.mbc.ca.gov/publications/vert_enf_model_report_2012_03.pdf

Medical Board of California - Program Evaluation

The Board requested that an evaluation be completed of the Board's Programs to determine the sufficiency of fees to meet legislative goals and mandates; identify laws, regulations, policies, and procedures that may hinder effectiveness; identify the value of services provided by external agencies; identify the value of services provided by contractors; identify the uses and effectiveness of major equipment purchases; and determine the effectiveness of IT applications used for enforcement and licensing. The Board contracted with an outside vendor to perform this review. The vendor, upon review of the Board's expenditures, determined that based upon the amount of money expended for the AG's Office in comparison to the performance trends, further in-depth review of the VE/P model was required. Therefore, in consultation with the Board management it was determined that the scope of the project would be changed to a full review of the VE/P model. The study would look at identifying and assessing the impacts of the VE Pilot Project on the Enforcement Program; identifying and assessing the benefits provided from increased expenditures for VE-related legal services; identifying and assessing other factors contributing to Enforcement Program performance; and developing an Enforcement Program Performance Improvement Plan. The report, released August 31, 2010, identified several recommendations. The Board's VE/P update report presented in March 2012 identified how the Board is implementing the recommendations. More information will be provided in this report, as well as in a future update on the VE/P model. Some of the recommendations would require legislative changes.

Volume I: http://www.mbc.ca.gov/publications/program_evaluation_vol-i.pdf

Volume II: http://www.mbc.ca.gov/publications/program_evaluation_vol-ii.pdf

Bureau of State Audits Report 2007-038

On October 16, 2007, the Bureau of State Audits (BSA) released a report pursuant to B&P Code section 2435, which required the BSA to review the Board's financial status and its projections related to expenses, revenues, reserves, and the amount of refunds or licensure fee adjustments needed to maintain the reserve level legally mandated for the medical board's contingent fund. The audit had two findings: 1) seek amendments to the code to allow it to adjust fees when necessary to maintain proper reserves; and 2) refund or decrease fees for physicians to reduce the reserve balances to the level legally mandated. In response to the BSA Report, the Board sponsored Assembly Bill 501 (Emmerson, Chapter 400, Statutes of 2009), which proposed to change the Board's statutory renewal fee to a cap of "up to" \$790, allowing the Board to adjust its fees when necessary. It also proposed to change the Board's fund reserve mandated level from "two months" to "not less than two nor more than four months". This bill passed. The Board staff reports at each of its meetings on the Board's budget and fund condition. As reported at the meetings, the Board does not feel it is prudent to decrease its fees at this time because the Board has had a number of items that have impacted the budget's expenditures resulting in higher than normal reversions. The Board has had furloughs, hiring freezes resulting in a large number of vacancies, and other restrictions limiting the Board's spending. However, the Board is projecting to be close to its statutory mandate at the end of this year and within its mandate in FY 2013/2014.

<http://www.bsa.ca.gov/pdfs/reports/2007-038.pdf>

Medical Board of California Financial Status

The legislation which changed the Board's reserve mandate from two months to between two and four months (Assembly Bill 501 (Emmerson, Chapter 400, Statutes of 2009)) also included a requirement that the Department of Finance Office of State Audits and Evaluations perform a preliminary review of the Board's financial status. The review needed to include, but not be limited to, the Board's projections related to expenses, revenues, and reserves, and the impact of the loan from the Contingent Fund of the Medical Board of California to the General Fund made pursuant to the Budget Act of 2008. This audit was completed and submitted to the Board in its final form on May 31, 2012. The audit found that although the loans to the General Fund have not impacted the Board's ability to operate at this time, should the Board have the anticipated increase in expenditures and the loans not be repaid; the months in reserve will drop below the mandated level of two to four months. The Board found that the report accurately captured the information provided and met the mandate of the legislature. No action was necessary.

http://www.dof.ca.gov/osae/audit_reports/documents/FinalReportMedicalBoardofCaliforniaFinancialStatusWEB.pdf

Creating a Sustainable Licensing Program – Business Process Reengineering Study

In 2009, the Board's Licensing Program was taking a significant amount of time to process licensing applications. At the Board's request, a vendor was hired to identify improvements in the Licensing Program to increase process efficiency, facilitate consistent and continued statutory and regulatory compliance, and improve focus on customer service. The completed study made recommendations, including the need for additional staff in the Licensing Program. The Board has implemented most of the recommendations and continues to move forward with these improvements. The Board, based

upon this study, also sought additional staff in the Licensing Program. This request was granted and the Board received 7.8 additional positions for the Licensing Unit.

<http://www.mbc.ca.gov/publications/creating-sustainable-lic-prgm.pdf>

Department of Consumer Affairs Risk Analysis

In 2011, the DCA Internal Audits Office performed a risk analysis of the Board's CCU. The assessment looked at whether the Board was prioritizing and processing complaints in an efficient and effective manner and, given existing resources, where the Board can improve its processes and procedures to better protect the public. The assessment found four areas of concern, including: complaint cases may not be adequately prioritized; complaint cases may not be assigned in a timely fashion to a medical specialist; medical specialists may have the cases too long; and, CCU tracking reports are missing prioritization information. A majority of the issues surrounded the Board's upfront medical specialty review. (More information regarding this issue is included in Section 5, Enforcement Program and Section 11, New Issues.) The Board's Enforcement Committee received the presentation with this information at the July 2012 Board meeting and will be determining further action. Although the assessment was completed in 2011, some of the data used was for prior years, and since that time, the CCU has addressed the issue of getting cases to a medical specialist in a timely manner and also the length of time the specialist is allowed to review the case. The issue with prioritization on the reports should be remedied with the BreEZe system when it is released.

<http://www.mbc.ca.gov/publications/risk-analysis-presentation.pdf>

Senate Bill 376: Direct Employment of Physicians

SB 376 (Chesbro, Chapter 411, Statutes of 2003) required the Board to report to the Legislature by October 1, 2008, on the pilot program that allowed for the direct employment of physicians by qualified hospital districts. The purpose of the pilot was to improve access to health care in rural and medically underserved areas. The study found that participation in the pilot program was limited and, therefore, the Board was limited in its ability to make a full evaluation. The report concluded that there may be justification to extend the pilot so that a better evaluation of the direct employment of physicians could be made. Legislation did not pass to continue this pilot program.

http://www.mbc.ca.gov/publications/sb376_report_legislature.pdf

California Physician Corps Loan Repayment Program – 2004 Report to the Legislature

Pursuant to B&P Code section 2154.7, the Board had to report to the Legislature on the loan repayment program. This was a program that encouraged recently licensed physicians to practice in underserved locations in California by authorizing a plan for repayment of educational loans, up to \$105,000, in exchange for their service in a designated underserved area for a minimum of three years. The report, provided a synopsis of the program, including the awardees for 2003 and 2004 and where they were practicing in the State.

http://www.mbc.ca.gov/licensees/loan_repay_2004_legislature_rept.pdf

Steven M. Thompson Physician Corps Loan Repayment Program – Supplement to the 2004 Report to the Legislature

The report, prepared in October 2005, provided information about the 2005 awardees and updated statistics on the loan repayment program.

http://www.mbc.ca.gov/licensees/loan_repay_2004_legislature_rept_sup.pdf

Major Publications Prepared by the Board

Board Newsletter – The Board publishes its Newsletter every quarter. The Newsletter contains useful information for both physicians and the public. The Board no longer sends 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.

Newsletters: <http://www.mbc.ca.gov/publications/newsletters/Index.html>

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.

http://www.mbc.ca.gov/about_us/laws/laws_guide.pdf

Strategic Plan – The Board has published two Strategic Plans since the last sunset review, one in 2008 and one in 2012.

2008: http://www.mbc.ca.gov/publications/strategic_plan/strategic_plan_2008.pdf

2012: http://www.mbc.ca.gov/publications/strategic_plan/strategic_plan_2012.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.

Annual Reports: http://www.mbc.ca.gov/publications/annual_reports.html

Disciplinary Guidelines – The Board recently amended its Guidelines, which are used by the Board and the ALJs in identifying the penalty for a violation of the law.

http://www.mbc.ca.gov/enforcement/disciplinary_guide.pdf

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 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. telehealth and the ability to practice medicine across state lines without a license in each state (license portability), maintenance of licensure, minimum data sets for workforce evaluation, centralized credential verification and housing, 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 a negative 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 participates on the Special Committee on Ethics and Professionalism, the Post-Licensure Assessment System Program Committee, the USMLE Step 3 Committee, the By-Laws Committee, and various non-ongoing, single issue committees. A former Member is on the FSMB Board and the FSMB Foundation.

Meetings of the FSMB attended:

April 2012 – Fort Worth, TX

April 2011 – Seattle, WA

April 2010 – Chicago, IL

May 2009 – Washington, D.C.

May 2008 – San Antonio, TX

May 2007 – San Francisco, CA

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. Due to travel restrictions, many of those committees are held via teleconferencing to encourage participation by all.

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 practice 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.

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.

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 USMLE is given in three steps and each step has an Advisory Committee. Recently one of the Board Members was appointed by the FSMB Board of Directors to a three-year term on the Step 3 Committee. In addition, this Board Member attends interim work groups and participated in the Step 2 Clinical Skills Standard Setting Panel. Most participants in these Committees are full time medical school faculty members and the Board Member brings an additional perspective as a Member of a state medical board.

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
- Applicant Satisfaction Survey Conducted by the Board

Related Attachments

- Attachment M – Department Quarterly Performance Measure Reports



Performance Measure Reports Published by the Department of Consumer Affairs

All quarterly and annual performance measure reports for FY 2010/2011 and FY 2011/2012 as published on the Department of Consumer Affairs Web site are in [Section 12, Attachment M](#). Below is the annual report for FY 2011/2012. The performance measure reports are part of the DCA’s Consumer Protection Enforcement Initiative (CPEI). They are generic for the entire DCA. Thus, the second graph “Intakes” refers to cycle time from complaint receipt to assignment to an analyst in the CCU (not to an investigator). The graph for “Intake and Investigation” averages the time for cases closed by the CCU and the time for the cases closed by the investigators in the field office (there is no delineation of CCU versus field offices).

Department of Consumer Affairs
 Medical Board of California

Performance Measures
Annual Report (2011 – 2012 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.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

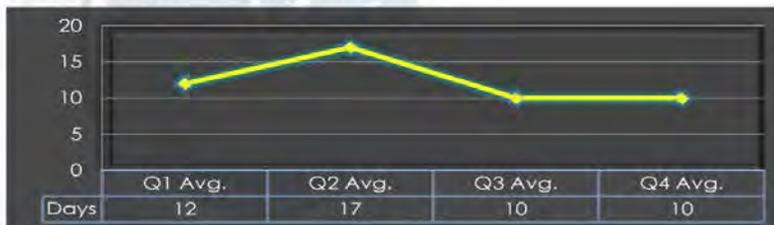
The Board had an annual total of 7,004 this fiscal year.



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.

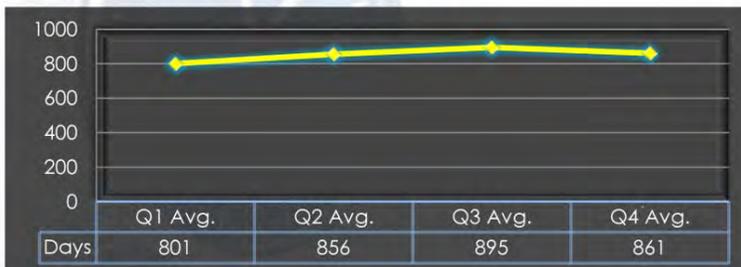
The Board has set a target of 125 days for this measure.



Discipline

Average number of days to complete the enforcement process (intake, investigation, and formal discipline) for those cases closed at the discipline stage. Does not include withdrawals or dismissals.

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.



Consumer Satisfaction Survey Conducted by the Department of Consumer Affairs

Beginning in January 2010, the DCA launched an online consumer satisfaction survey. The survey was implemented as part of DCA's new CPEI to overhaul the enforcement and disciplinary processes of healing arts boards. The Board began including the link to the online survey 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 was also included in the closure letter mailed. The prepaid postcard could be completed and mailed to DCA instead of completing the survey online.

For FY 2010/2011, DCA only received 67 responses on behalf of the Board either by the online survey or the prepaid postcard; there were 90 responses in FY 2011/2012. This is an increase of 23 responses compared to the prior fiscal year. Approximately one percent of the individuals who file complaints respond and complete the survey. 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 do not complete the surveys at all because of their disappointment with the Board's decision to close their complaints without taking disciplinary action against the licensee. 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 disciplinary action and may result in a cease and desist letter or a citation/fine. Compared to the number of complaints received only a small amount of cases go on to receive formal disciplinary action. For example, in FY 2011/2012 the Board received 6,923 physicians complaints. During the same FY, 5,662 were closed by the complaint unit with no referral for further investigations and 1,577 investigations were referred to an area field office for further investigation and possible prosecution. In FY 2011/2012 the Board took 393 administrative or disciplinary actions.

The data below shows the responses for FYs 2010/2011 and 2011/2012 to the seven questions that make-up the survey. The data indicates that most survey participants contact the Board by regular mail. About 40% indicated they were very dissatisfied with the time it took the Board to resolve their complaint. In FY 2011/2012, 26% indicated they were very satisfied with the time it took the Board to respond to their initial correspondence. When asked how satisfied they were with the explanation the Board provided regarding the outcome of their complaint, 83% in FY 2010/2011 and 72% in 2011/2012 stated they were very dissatisfied. In rating the overall satisfaction with the way the Board handled their complaint, 70-75% responded they were very dissatisfied. An average of 33% indicated they would absolutely not contact the Board for a similar situation. 36-41% stated they would absolutely not recommend their friends or family contact the Board if they are experiencing a similar situation.

The Board continues to look for ways to improve its communication with complainants. Letters are sent at various stages throughout the complaint process, including at time of receipt, review by a medical consultant, transmittal of the complaint to the district office for full investigation, referral of the matter to the AG's Office, and at the filing of an accusation and disciplinary action (if warranted). The Board also looks for ways to enhance its explanation of why a complaint is closed and what is required in order to pursue disciplinary action. An explanation of the burden of proof also needs to be provided so complainants understand the difference between the malpractice burden of proof (preponderance of the evidence) and the much more difficult burden of proof for administrative action (clear and convincing evidence).

Section 2

Performance Measures and Customer Satisfaction Surveys

Below are the results for FY 2010/2011 and FY 2011/2012 CPEI Consumer Satisfaction Survey:

How did you contact our Board/Bureau?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
In-person	0%	0	2%	2
Phone	6%	4	14%	13
Email	3%	2	2%	2
Regular mail	80%	54	77%	68
Web Site	11%	7	5%	5
Totals	100%	67	100%	90

How satisfied were you with the time it took for us to resolve your complaint?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Very dissatisfied	41%	27	44%	40
Somewhat dissatisfied	16%	11	12%	11
Neither satisfied nor dissatisfied	22%	15	19%	16
Somewhat satisfied	15%	10	12%	11
Very satisfied	6%	4	13%	12
Totals	100%	67	100%	90

How satisfied were you with the time it took to respond to your initial correspondence?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Very dissatisfied	37%	25	17%	15
Somewhat dissatisfied	10%	7	17%	15
Neither satisfied nor dissatisfied	20%	13	23%	22
Somewhat satisfied	12%	8	17%	15
Very satisfied	21%	14	26%	23
Totals	100%	67	100%	90

Section 2

Performance Measures and Customer Satisfaction Surveys

How satisfied were you with the explanation you were provided regarding the outcome of your complaint?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Very dissatisfied	83%	55	72%	65
Somewhat dissatisfied	7%	5	6%	5
Neither satisfied nor dissatisfied	0%	0	1%	1
Somewhat satisfied	6%	4	9%	8
Very satisfied	4%	3	12%	11
Totals	100%	67	100%	90

Overall, how satisfied were you with the way in which we handled your complaint?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Very dissatisfied	75%	50	70%	63
Somewhat dissatisfied	9%	6	9%	8
Neither satisfied nor dissatisfied	5%	3	3%	3
Somewhat satisfied	4%	3	7%	6
Very satisfied	7%	5	11%	10
Totals	100%	67	100%	90

Would you contact us again for a similar situation?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Absolutely not	34%	23	32%	28
Probably not	25%	17	19%	17
Maybe	14%	9	9%	8
Probably	4%	3	15%	14
Definitely	23%	15	25%	23
Totals	100%	67	100%	90

Would you recommend us to a friend or family member experiencing a similar situation?	FY 2010/2011		FY 2011/2012	
	Response Percent	Response Count	Response Percent	Response Count
Absolutely not	36%	24	41%	37
Probably not	35%	23	15%	14
Maybe	11%	8	7%	6
Probably	0%	0	6%	5
Definitely	18%	12	31%	28
Totals	100%	67	100%	90

Applicant Satisfaction Survey Conducted by the Board

The Board developed an applicant satisfaction survey using SurveyMonkey, an online survey tool, to gather information from applicants in an effort to improve the Board's application process. When an applicant has been issued a physician's license, Board staff sends the applicant a congratulatory letter. Beginning August 22, 2012 this letter, sent by email or via regular postal service, also included a Web link inviting the newly licensed physician to participate in the survey. Board staff collected responses, analyzed the information provided, and reported findings to the Chief of Licensing for review and follow-up on applicable changes to the application review process as necessary.

Of the 77 responses received, 91% indicated that the physician's application instructions were clearly stated and 84% said the Web site was comprehensive and informative. 81% stated they were either very satisfied or somewhat satisfied with the way the Board processed their application and 70% stated they were either very satisfied or somewhat satisfied with the time it took the Board to process their application.

Below are the results of the Board's Applicant Satisfaction Survey for August 22, 2012 through October 4, 2012:

	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
For which license or registration did you apply?		
Physician's License – US/Canadian Graduate	69%	54
Physician's License – International Graduate	30%	23
Postgraduate Training Authorization Letter – International Graduate	1%	1
Other	0%	0
Totals	100%	77

	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Did you attend a licensing fair, sponsored by your Graduate Medical Education Office, at which a Medical Board staff member participated?		
Yes	14%	11
No	86%	66
Totals	100%	77

	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
If you attended a licensing fair at which a Board staff member participated, how satisfied were you with the services provided?		
Very satisfied	16%	12
Somewhat satisfied	1%	1
Somewhat dissatisfied	0%	0
Very dissatisfied	0%	0
Not applicable; I did not attend a licensing fair	83%	64
Totals	100%	77

Section 2

Performance Measures and Customer Satisfaction Surveys

		Aug. 22–Oct. 4, 2012	
Did the application instructions clearly state how to complete the application?		Response Percent	Response Count
Yes		91%	70
No		9%	7
Totals		100%	77

		Aug. 22–Oct. 4, 2012	
Did you visit the Medical Board's Web site for help and/or additional information?		Response Percent	Response Count
Yes		88%	68
No		12%	9
Totals		100%	77

		Aug. 22–Oct. 4, 2012	
Did the information on the Medical Board's Web site clearly indicate the requirements and how to apply for licensure?		Response Percent	Response Count
Yes, the Web site was comprehensive and informative		84%	65
No, Web site did not adequately inform me of licensure requirements		9%	7
Not applicable, I did not view the Board's Web site		7%	5
Totals		100%	77

		Aug. 22–Oct. 4, 2012	
Did the instructions on the Medical Board's Web site adequately address your questions concerning the application process?		Response Percent	Response Count
Yes, the Web site was comprehensive and informative		73%	56
No, the Web site did not address all of my questions		21%	16
Not applicable, I did not view the Board's Web site		6%	5
Totals		100%	77

		Aug. 22–Oct. 4, 2012	
Did you use the Medical Board's Web Applicant Access System to track the progress of your application?		Response Percent	Response Count
Yes		84%	65
No		16%	12
Totals		100%	77

Section 2

Performance Measures and Customer Satisfaction Surveys

If you used the Web Applicant Access System, how satisfied were you with the information it provided?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Very satisfied	32%	25
Somewhat satisfied	38%	29
Somewhat dissatisfied	13%	10
Very dissatisfied	4%	3
Not Applicable, I did not use the Web Applicant Access System	13%	10
Totals	100%	77

How satisfied were you with the timeliness in notifying you of any deficiencies in your application?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Very satisfied	53%	41
Somewhat satisfied	20%	15
Somewhat dissatisfied	14%	11
Very dissatisfied	13%	10
Totals	100%	77

If you contacted Board staff by telephone or email regarding your pending application, did staff respond within two business days?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Yes	56%	43
No	25%	19
Not applicable; I did not need to contact the Board	19%	15
Totals	100%	77

How satisfied were you with the courteousness, helpfulness, and responsiveness of the staff person who processed your application?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Very satisfied	56%	43
Somewhat satisfied	14%	11
Somewhat dissatisfied	10%	8
Very dissatisfied	8%	6
Not applicable; I did not communication with staff person	12%	9
Totals	100%	77

How satisfied were you with the way the Medical Board processed your application?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Very satisfied	56%	43
Somewhat satisfied	25%	19
Somewhat dissatisfied	5%	4
Very dissatisfied	14%	11
Totals	100%	77

Have you ever held a physician's license in another state?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Yes	58%	45
No	42%	32
Totals	100%	77

If you held a physician's license in another state, how did that state's application process compare to our Board's process?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Somewhat worse	4%	3
Much worse	7%	5
About the same	18%	14
Much better	24%	19
Somewhat better	7%	5
Not applicable; I have never held a license in another state	40%	31
Totals	100%	77

How satisfied were you with the time it took the Medical Board to process your application?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Very satisfied	47%	36
Somewhat satisfied	23%	18
Somewhat dissatisfied	14%	11
Very dissatisfied	16%	12
Totals	100%	77

Was your experience with the Medical Board's licensing process better than you expected it to be, worse than you expected it to be, or about what you expected it to be?	Aug. 22–Oct. 4, 2012	
	Response Percent	Response Count
Much better	31%	24
Somewhat better	18%	14
About what was expected	26%	20
Somewhat worse	16%	12
Much worse	9%	7
Totals	100%	77

Section 3

Fiscal and Staff

- Fiscal Issues
 - Board's Current Reserve Level, Statutory Requirement, and Spending Issues
 - Deficit Projections and Anticipated Fee Changes
 - General Fund
 - Expenditures by Program Component
 - Budget Distribution
 - Renewal Cycle and History of Fee Changes
 - Revenues and Reimbursements
 - Budget Change Proposals
 - Board Approved Budget Augmentations
- Staffing Issues
 - Staffing Challenges, Vacancy Rate, Recruitment/Retention, and Succession Planning
 - Staff Development

Related Attachments

- Attachment N – Fee Schedule



Fiscal Issues

Board's Current Reserve Level, Statutory Requirement, and Spending Issues

At the end of FY 2011/2012, the Board had a fund reserve of \$24,612,849 which equates to a 5.2 month reserve. The Board's statutory reserve, pursuant to B&P Code section 2435, should be between two to four months. The Board understands that the current reserve is over the statutory limit, however, there are several factors that have contributed to this overage. As stated previously, the Board has had various hiring limitations that have impacted the Board's expenditures. The furloughs that occurred from 2008 to 2010 and the hiring freeze in 2010 through 2011 both reduced the Board's expenditures significantly. Additionally, with the hiring freeze, the Board had a 25% vacancy rate. The lack of spending due to these vacancies impacted the Board's reserve level. When the Board has reductions, so do other State agencies; thus Office of Administrative Hearing expenditures were down, as it too could not fill vacancies and had furloughs. Lastly, restrictions on spending, including a 15% reduction to spending in 2008/2009, the restriction on purchasing vehicles (the Board has not purchased vehicles since 2008), and the restrictions on travel, have drastically impacted the Board's reserve level. There was an increase in expenditures in FY 2011/2012 because the Board was allowed to begin hiring at the end of November 2011. However, there was still almost half a year with a significant vacancy rate. In FY 2012/2013 the Board will be able to purchase vehicles; however, the Board is again under a Personal Leave Program (similar to the furloughs) which will decrease salaries and wages by almost five percent. Also in FY 2012/2013, the Board has had to terminate all student assistant positions and about half of its retired annuitants. At this time, it is uncertain of the fiscal impact of the elimination of these positions as the Board will be trying to hire seasonal and permanent intermittent employees to replace these positions. The fiscal impact of these changes is unknown at this time. The Board is projected to be close to its statutory mandate at the end of FY 2012/2013 and within it at the end of FY 2013/2014.

The Outpatient Settings fund is also under the purview of the Board. Table 2a shows the revenue and expenditures for the Outpatient Setting Program. When the law passed to create this Program, the Board loaned \$150,000 to the implementation of this Program. Due to the low revenue of this Program, 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 2012/2013, 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 at a deficit and in need of a fee increase in FY 2014/2015 or FY 2015/2016. However, with the uncertainty of the State's fiscal condition, it is unknown whether the projections for future fiscal years will remain as projected. 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's reserve were to be at the projected level in FY 2014/2015, then the Board would request reimbursement of its general fund loans and a fee increase would not 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 had two loans made to the general fund. The first loan was for \$6 million and occurred in FY 2008/2009. The second loan was for \$9 million and occurred in FY 2011/2012. The Board has not required any payments from the general fund on these loans. If the Board should fall below its statutory mandate of two to four months reserve, then the Board will request payment for these loans. However, the Board is not at that level and is not projected to be there until at least FY 2014/2015.

Table 2. Fund Condition					Proposed**	Proposed **
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	23,866	24,378	27,903	30,246	24,612	20,551
Revenues and Transfers*	53,470	52,136	51,778	56,136	52,513	52,499
Total Revenue	\$77,336	\$76,515	\$79,681	\$86,383	\$77,125	\$73,050
Budget Authority	50,747	49,498	51,826	54,399	56,477	56,382
Expenditures	46,957	48,612	49,435	52,770	56,574	56,382
Loans to General Fund	6,000	--	--	9,000	--	--
Accrued Interest, Loans to General Fund	--	--	--	--	--	--
Loans Repaid From General Fund	--	--	--	--	--	--
Fund Balance	\$24,378	\$27,903	\$30,246	\$24,612	\$20,551	\$16,668
Months in Reserve	5.5	6.1	6.6	5.2	4.4	3.6

*includes prior year adjustments, revenue, and reimbursements.

** as of October 1, 2012

Table 2a. Fund Condition Outpatient Settings					Proposed	Proposed
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	195	197	260	261	258	291
Revenues and Transfers*	4	69	1	1	60	1
Total Revenue	199	266	261	262	318	292
Budget Authority	26	26	26	28	27	27
Expenditures	2	6	0	4	27	27
Loans to General Fund	--	--	--	--	--	--
Accrued Interest, Loans to General Fund	--	--	--	--	--	--
Loans Repaid From General Fund	--	--	--	--	--	--
Fund Balance	197	260	261	258	291	265

*includes prior year adjustments, revenue, and reimbursements.

Expenditures by Program Component

Table 3 below indicates the amount of expenditures in each of the Board's Programs. In addition, the chart, which is in the Board's Annual Report every year, shows the budgeted (not actual) expenditures and percentages in each of the Board's Programs (including pro rata) for FY 2011/2012. The Enforcement Program (including the AG's Office and the Office of Administrative Hearings, and Probation Monitoring) makes up approximately 78% of the Board's overall expenditures. The Licensing Program accounts for about 10% of the Board's expenditures, while the ISB accounts for approximately 6%. The Executive and Administrative Programs make up about 6% 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.

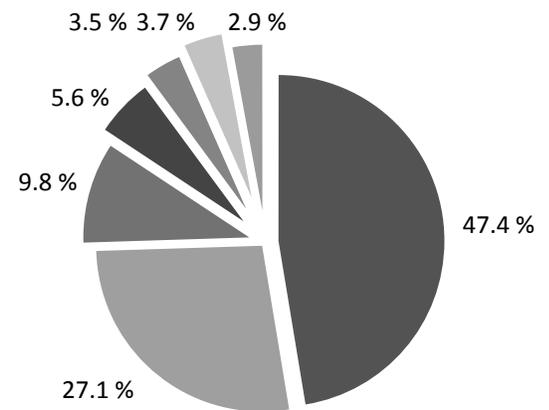
Table 3. Expenditures by Program Component

(Dollars in Thousands)	FY 2008/09		FY 2009/10		FY 2010/11		FY 2011/12	
	Personnel Services	OE&E						
Enforcement	11,992	18,172	12,643	19,405	14,305	18,968	14,525	20,051
Examination	--	--	--	--	--	--	--	--
Licensing	2,936	1,458	3,111	1,564	3,237	1,648	3,210	1,832
Administration *	3,538	2,865	3,403	3,086	3,502	2,092	3,648	3,092
DCA Pro Rata and Statewide	--	5,994	--	5,360	--	5,571	--	6,227
Diversion (if applicable)	--	--	--	--	--	--	--	--
TOTALS	\$18,466	\$28,489	\$19,157	\$29,415	\$21,044	\$28,279	\$21,383	\$31,202

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

Budget Distribution (budgeted not actual)

Enforcement Operations	\$25,758,000	47.4%
Legal & Hearing Services	14,752,000	27.1%
Licensing	5,336,000	9.8%
Information Systems	3,069,000	5.6%
Probation Monitoring	1,885,000	3.7%
Executive	2,013,000	3.5%
Administrative Services	1,586,000	2.9%
Total	\$54,399,000	100%



Renewal Cycle and History of Fee Changes

Although the Board licenses other allied health programs, the Board's main revenue source is from the physician's renewal fees (see the pie chart below which is included in the Board's Annual Report every year). The fees for the allied health programs have remained the same over the last six years; however, the physician's renewal fee has changed several times within this timeframe. As previously stated, in order to financially support the VE/P model, the Board's physician's initial licensure and renewal fees were increased from \$600 to \$790 effective January 1, 2006 (first fee increase since

1994). Included in the statutory language to increase the fee to \$790, was language that stated the Board may, by regulation, increase the renewal fee by an amount required to offset the elimination of reimbursement of investigation and prosecution costs (see discussion in Section 1 regarding the elimination of these costs). Therefore, the Board began the regulatory process and effective January 1, 2007, the physician's initial licensure and renewal fees were increased by \$15 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 (fee increased from \$790 to \$805).

With the elimination of the Board's Diversion Program on July 1, 2008, the Board was mandated to reduce the physician's initial licensure and renewal fees based upon the reduction in expenditures from the loss of this Program. The Board again went through the regulatory process, and effective July 1, 2009, the physician's initial licensure and renewal fees were decreased by \$22 to \$783. This is the current physician's initial licensure and renewal fee. As stated above, the Board has no intentions of increasing or decreasing this fee at this time.

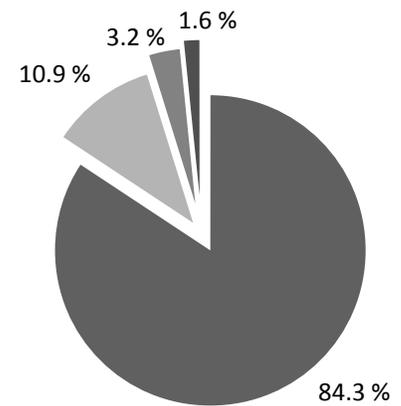
(NOTE: The Board also determined that for those physicians who paid their renewal/licensure fee from July 1, 2008 to July 1, 2009, prior to the passage of the regulations for this reduction, the Board would reduce the amount they owed for their renewal in FY 2010/11. This was a one-time reduction and was done through a reduced fee rather than a refund due to the cost of issuing refund checks. This ensured that the Board did not receive any fees for the eliminated Diversion Program.)

The full schedule can be found in [Section 12, Attachment N](#), below is a list of the significant funding sources.

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA							
Physician Application Fee (B&P 2435)	442.00	442.00	2,719,137	2,625,899	2,697,296	2,958,876	5.62%
Physician Initial License Fee (B&P 2435) (Title 16, CCR 1351.5)	783.00	790.00	1,512,442	1,285,555	1,408,668	1,492,531	2.84%
Physician Initial License Fee (Reduced – 1/2) (B&P 2435)	391.50	395.00	1,319,034	1,428,937	1,374,825	1,467,768	2.79%
Physician Biennial Renewal Fee (B&P 2435) (Title 16, CCR 1352)	783.00	790.00	44,478,782	44,455,854	43,570,578	46,047,490	87.51%

Revenues and Reimbursements

Physician & Surgeon Renewals	\$46,048,000	84.3%
Application & Initial License Fees	5,919,000	10.9%
Reimbursements	1,749,000	3.2%
Other Regulatory Fees, Delinquency/Penalty/Reinstatement Fees, Interest on Fund, Miscellaneous	890,000	1.6%
Total	\$54,606,000	100%

**Budget Change Proposals (BCP)**

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.

Reduce distributed costs – Since the time the Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board (SLPAB) was a Committee under the Division of Allied Health the Board had been performing certain functions for SLPAB. As the years passed, certain functions were returned to the SLPAB. In FY 2008/09, the SLPAB took over its own cashing functions. With the work being transitioned from the Board to SLPAB, there was a need to decrease the Board's expenditures through a negative BCP.

Operation Safe Medicine – The Board was receiving a significant number of complaints regarding unlicensed activity. Additionally, it was brought to the Board's attention that consumers were being injured by unlicensed individuals working out of garages, back office clinics, etc. The Board's investigative workload did not allow for the Board to take a proactive approach to this new issue, nor did it allow for the investigators to timely investigate these cases of unlicensed activity. Therefore, the Board determined that a specialized unit, made up of investigators specifically trained in these types of undercover surveillance cases, would improve consumer protection and would allow the Board to be more proactive, rather than reactive. These individuals would work closely with the local law enforcement and District Attorney's Office to file criminal cases against these unlicensed individuals. The Board received six positions for a Southern California Unit; however, they were only approved on a two-year limited term basis. Although the Board received the position authority, the Board had to absorb the funding for these positions.

Because the position authority for these positions was only approved on a two-year limited term basis, the Board had to again request authority for these positions. The Board did not receive approval for these positions in FY 2011/2012, however, these positions were approved for FY 2012/2013. The Board received authority for the ongoing six positions; however, the Board did not receive funding and had to again absorb it through internal redirection.

Probation Unit – Due to an increase in probation monitoring workload, and due to a need to remove probation monitoring from the investigators in the field, the Board requested five more staff for its Probation Unit. The Board reorganized its probation monitoring program by reclassifying investigator assistant positions into inspectors to perform the monitoring. Prior to this change, the monitoring was being conducted by the field investigators who already had a full workload of cases based upon complaints. The investigators' first priority was investigating physicians who were a danger to the public. The Board saw a need to have a unit solely dedicated to probation monitoring in order to ensure compliance of probation terms, thus assisting with consumer protection. The Board received five additional positions, but did not receive the funding and therefore had to absorb it through internal redirection.

Licensing Program – Due to the length of time it was taking to review applications for licensure and issue licenses, the Board hired a vendor to study the Board's Licensing Program to find efficiencies (see Major Studies section). Based upon this study and upon the additional workload within the unit, the Board determined that the Licensing Program was understaffed. The Board requested and received an additional 7.8 positions within its Licensing Program; however, the Board did not receive funding for the positions and had to absorb the funding through internal redirection.

Polysomnography Program – Pursuant to SB 132 (Denham, Chapter 635, Statutes of 2009), three new licensing categories were initiated within the authority of the Medical Board of California: polysomnography trainee, polysomnography technician, and polysomnography technologist. In order to perform the additional workload, the Board requested one position at the Associate Analyst level to implement the program and write regulations. The Board requested this staffing level for one year only, and requested the level be changed to the Office Technician level on an ongoing basis. The position and funding were approved as requested.

Consumer Protection Enforcement Initiative (CPEI) – The DCA developed a department-wide BCP as part of its CPEI. These 22.5 positions were to assist with the review and processing of complaints in order to improve the enforcement process timelines. Because the Board investigated cases for other allied health boards, the Board received 2.5 special investigators within the 22.5 positions to perform the workload associated with those entities. In FY 2011/2012 the authority for the 2.5 positions was transferred from the Board to the other boards. Therefore, the Board ultimately received 20 positions.

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
1110-18	08/09	Reduction for decrease in SPLAB services	N/A	N/A	N/A	N/A	(\$14,000)	(\$14,000)

Table 5. Budget Change Proposals (BCPs) (cont.)								
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
1110-17	09/10	Operation Safe Medicine Unit to conduct unlicensed activity investigations	Two Units – Northern/Southern California 8 Senior Investigators 2 Supervising Investigators 2 OTs	One Unit – Southern CA 4 Senior Investigators 1 Supervising Investigator 1 OT (2 year - limited term)	\$1,072,000	\$0	\$418,000	\$0
1110-19	09/10	Additional Probation Monitoring Positions	3 Inspectors 1 MST 1 OT	3 Inspectors 1 MST 1 OT	\$287,000	\$0	\$124,000	\$0
1110-15	10/11	Additional Licensing Program Positions	3 MST 2 SSA .80 OT 2 AGPA 1 SSM I	2 MST 2 SSA .80 OT 2 AGPA 1 SSM I	\$536,000	\$0	\$109	\$0
1110-10L	10/11	Polysomnography Program	1 AGPA for 1 year; 1 OT ongoing	1 AGPA for 1 year; 1 OT ongoing	\$80,000	\$80,000	\$8,000	\$8,000
1110-1A	10/11	CPEI Enforcement Reform	15.4 Special Investigators 2 SSIMs Ongoing 20.5 Special Investigators 2 SSIMs	15.4 Special Investigators 2 SSIMs Ongoing 20.5 Special Investigators 2 SSIMs	\$1,381,000	\$1,381,000	\$460,000	\$460,000
	12/13	Operation Safe Medicine	1 Supervising Investigator 4 Investigators 1 OT	1 Supervising Investigator 4 Investigators 1 OT	\$534,000	\$0	\$49,000	\$0

Board Approved Budget Augmentations

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 BreZE project was initiated. Since the scope of the BreZE 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. When the CRIMS project first began, the Board Members approved moving forward with a request to augment the Board's ISB staff due to the need for staffing to write the requirements and monitor the project. The Board requested one Associate Programmer for FY 2009/10 and two Staff Programmers for 10/11 (FY 2009/10 - \$79,000 and FY 2010/11 - \$415,000); however, those requests were denied.

In response to the Board's receipt of a significant number of complaints regarding unlicensed activity, the Board determined that it needed a unit specifically assigned to the investigation of unlicensed activity, including individuals working out of garages, back office clinics, etc. The Board wanted offices of specialized investigators to investigate unlicensed activity in Northern and Southern California. Therefore, the Board Members approved an augmentation in FY 2009/10 for 12 staff to operate two Operation Safe Medicine Units – six to perform the investigations in Northern California and six to investigate cases in Southern California. However, the request was denied for a Northern California Unit until a need could be shown because most of the issues identified were in Southern California. The Board only received authority for six positions in Southern California. Additionally, the positions were only approved on a two-year limited term basis. The Board would not be able to receive permanent authority for these positions until it had demonstrated a need for the positions to be permanent. Additionally, although the Board requested funding for the positions, the Board had to absorb the funding for the positions within its existing resources. Because the position authority for these positions was only approved on a two-year limited term basis, the Board had to again request authority for these positions. The Board did not receive approval for these positions in FY 2011/12, however, these positions were approved for FY 2012/13. The Board received authority for the ongoing six positions; however, the Board did not receive funding and had to again absorb it through internal redirection.

Due to the increase in call volume and staffing workload, the Board Members approved an augmentation for four Office Technicians to perform duties in the Board's Consumer Information Unit. This Unit is the first contact consumers have with the Board, and the Members thought it was important to have a low call wait time. However, the request was denied (\$267,000).

AB 2699 (Bass, Chapter 270, Statutes of 2010) authorized the Board to temporarily approve individuals licensed and in good standing in another state, district, or territory of the United States to provide health care services at free health care events in California sponsored by certain entities. The Board Members approved an augmentation for .5 position to implement and manage this new program. However, the request was denied (\$43,000).

The Board knew there would be a significant amount of work with the preparation and implementation of the BreEZe project. The Board Members did not want this project to impact the existing Board staff's workload, which could result in the Board not meeting its mandatory functions. Therefore, the Board Members approved an augmentation for two Staff Programmers on a limited term basis. This request was denied (\$138,000).

The Board's Medical Consultants are permanent intermittent employees who are paid from the temp help line of the Board's budget. Due to the current and anticipated workload for these staff members, the Board approved moving forward with a request to increase this spending authority by \$196,000. However, this request was denied.

The Board's ISB staff developed a method for applicants to be able to go online and view the status of their application. However, in order to ensure the system was updated with current information, more staff was needed to provide data input. The staff would be recording all documents received by the Board into the system, so an applicant could see what was missing from his/her application file. Several documents for the physician application have to be sent directly from an outside entity (e.g. medical school, post graduate training program, etc.) to the Board and the applicants want to know if the entity sent in their documents. Having the information available online is easier for the applicant and the Board. To meet this workload, the Board Members approved an augmentation of two Office Technicians (\$124,000); however, the request was denied.

Staffing Issues

Staffing Challenges, Vacancy Rate, Recruitment/Retention, and Succession Planning

As identified in other areas of this report, the Board had some staffing issues in the past five years. Even prior to the budget crisis, which resulted in furloughs, hiring freeze, etc., the Board had difficulty in filling some of its positions. The Board employs its own sworn investigative staff. These positions have been difficult to fill due to issues, including salary inequities, substantial workload, lack of geographical pay, etc. Beginning with the three-day furloughs, resulting in an almost 15% reduction in pay, several of these individuals either retired or went to other agencies that did not impose the pay reduction. When the hiring freeze was imposed, these positions were vacant. This resulted in a significant vacancy rate in the enforcement field staff. In addition, these positions require an extensive background investigation be performed prior to hiring the individual, which must be conducted in accordance with POST standards, and can take four to six months to complete. The investigator may also have to attend a 16-week academy. These positions are difficult to recruit for and it is also difficult to retain the individuals who have been hired. The Board commissioned a study to examine the need to reclassify these positions. The outcome was that the positions need not be reclassified, but they should have "deeper classes" for those with advanced training, experience, and skills. The study also said that there should be geographical and field training officer pay differentials. Lastly, the study stated the minimum qualifications for the investigator classification should be expanded from the limited types of degrees that can be used to meet the qualifications (e.g. criminal justice, administration of justice, police science, etc.)

In December 2010, the DCA eliminated the "Senior Investigator" and prior "Investigator" classifications and moved all individuals into a general "Investigator" classification, which increased the starting salary and eliminated the need to test into the senior investigator classification. This has made transfers from other agencies easier, thus facilitating better recruitment efforts. Although this partially addresses the results of the study, it does not address all of the issues.

Despite the prior hiring challenges, when the hiring freeze lifted at the end of 2011 the Board was able to identify individuals to fill almost every investigator vacancy. This was due, in large part, to layoffs by other agencies, especially the DOJ and the Department of Corrections and Rehabilitation. Some of these individuals who were hired or are currently in background are not going to need the 16 week POST academy. This is a savings to the Board in both money and time between when the individual is hired and when they can be productive.

Since the hiring freeze lifted, the Board has been very successful in all Programs in both recruiting employees and retaining them. This is evidenced by the Board's vacancy rate, which dropped from 25% to 9%, not including those in background, which would take the vacancy rate to 6% if all reported to the Board.

The Board is very diligent about training its staff and providing opportunities for upward mobility. The Board interviews every internal (Board) candidate that meets the requirements for a vacant position. If the internal candidate meets the qualifications and can perform the duties of the vacant position, the Board will promote from within. Following interviews where internal candidates are not successful, the Board Managers provide feedback to the employee for future growth and development. Currently the Board is working on its own upward mobility program assisting staff in resume writing and interview skills.

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. Part of the duties of the Board's Office of Standards and Training Unit is ensuring that the investigators have the required training. This unit also provides POST certified classes for its investigators. This guarantees statewide consistency and enables the new investigators to get the training they need to perform the duties. The Board also has Field Training Officers who work with new investigators to ensure an easy transition and assists in the learning process. The Board does everything it can (with the resources it has) to ensure that new staff receive the training they need to be successful.

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 those in the investigator classification, some training is mandatory. As stated above, the Board has its own training unit that monitors and provides some of this required training. For all other staff, the Board Managers are held responsible for meeting with staff and discussing with them any needed or recommended training. The 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 understands the importance of staff and is very supportive of every effort to keep staff knowledgeable and performing at their best.

Unfortunately, with travel restrictions and the budget restrictions in the last fiscal year, the Board has not been able to send staff to as many training classes as it would like. However, when training is local or is provided by the DCA, which is free, the Board encourages staff to attend. Over the past five fiscal years the Board has spent the following on training:

FY 2007/2008 - \$73,829
FY 2008/2009 - \$89,095
FY 2009/2010 - \$63,043
FY 2010/2011 - \$87,096
FY 2011/2012 - \$36,135

Section 4

Licensing Program

- 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
 - No Longer Interested Notification to DOJ
 - Examination Process
 - Examination Data – Pass Rates
 - Existing Statute Changes
 - School Approval
 - Legal Requirements Regarding Approval of International Schools
 - Continuing Medical 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

Related Attachments

- Attachment O – National Practitioner Data Bank Study by the Board
- Attachment P – United States Medical Licensing Examination (USMLE) Performance Data



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:

- 2168 Special Faculty Permits
- Special Programs – B&P Code sections 2072, 2073, 2111, 2112, 2113, and 2115 and CCR section 1327
- Licensed Midwives
- Registered Dispensing Opticians (businesses)
- Spectacle Lens Dispensers
- Contact Lens Dispensers
- Out-of-State Contact Lens Sellers
- Research Psychoanalysts/Student Research Psychoanalysts
- Polysomnographic Trainees, Technicians, and Technologists
- Sponsored Free Health Care Event Out-of-State Physician Registration (regulations were finalized in August 2012 and no applications have been received to date)

The Board also has a recognition 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 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 AMBS but believe they have equivalent requirements.

On a larger scale, 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, Registered Dispensing Opticians, Spectacle Lens Dispensers, Contact Lens Dispensers, Out-of-State Contact

Lens Sellers, Research Psychoanalysts, Student Research Psychoanalysts or the Polysomnographic Program. These licensing/registration types will be addressed in the Appendix section under their specific program listing.

Physicians

Performance Targets/Expectations

CCR section 1319.4 requires that within 60 working days of receipt of an application pursuant to B&P Code 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 that it is deficient and what specific information or documentation is required to complete the application.

Although timeframes are defined in regulations (60 working days, approximately 90 calendar days), the Licensing Program has set expectations and a Strategic Plan objective that U.S., International, and Postgraduate Training Authorization Letter (PTAL) applications be reviewed within 45 calendar days. The Program has met these goals for the last one and a half years and is currently reviewing all application types 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. This goal is currently being met.

The Licensing Program provides weekly updates to the Board Members on meeting these goals, as well as provides an update to the Licensing Committee at its quarterly meetings on how it is meeting its strategic plan objective. The Board is currently in compliance with the mandated timeframes and is also reaching the internal goals that have been set by the program.

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

The Board has seen a significant decrease in the average time to process applications and issue licenses within the last two years. In 2009 the Board was reviewing applications in excess of 100 days from receipt of the application. The increased timeframe to review applications was due in part to staffing shortages and mandatory furlough days imposed by the Governor's Executive Orders. During this time, processes and procedures were reviewed and streamlined where possible; however, the Board was unable to significantly decrease the average time until staffing was returned to full capacity.

The Board has seen an increase in applications each year and anticipates that these numbers will continue to grow. Pending applications continue to increase due to the additional applications received each year. However, many of the applications that are pending are outside of the Board's control. The strengthening of CCR section 1306, which allows the Board to close an application if it has not been completed within 365 days from the date of written notification of the documents needed to complete the application, has allowed the Board to decrease the number of pending applications. The Board is constantly striving to review and approve applications within the set timeframes to ensure compliance with the law. It has ensured that this occurs by reviewing policies and procedures within the Program for best practices and efficiencies. The Board also performs outreach to applicants and postgraduate training programs to encourage them to submit their applications six months or more before the license is needed and to assist them with questions on the applications.

Table 6. Licensee Population

		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Physician & Surgeon	Active	127,436	128,866	130,670	132,842
	Out-of-State	26,682	26,774	27,279	27,732
	Out-of-Country	854	837	830	830
	Delinquent*	11,355	12,051	12,383	12,163

*Licensees may remain in delinquent status up to five years before the license is canceled, thus this number does not accurately reflect those who intend to pay fees and practice in California.

Table 7a. Licensing Data by Type

Physicians		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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	5,964	5,110	282	5,110	5,772	-	-	-	-	**
	(Renewal)	60,814	n/a	n/a	60,814	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6,047	5,272	452	5,272	3,992	-	-	-	-	**
	(Renewal)	62,656	n/a	n/a	62,656	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	6,623	5,351	72	5,351	3,823	-	-	-	-	**
	(Renewal)	64,351	n/a	n/a	64,351	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

** See below section on Cycle Times

Table 7b. Total Licensing Data

	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	5,964	6,047	6,623
Initial License/Initial Exam Applications Approved	5,110	5,272	5,351
Initial License/Initial Exam Applications Closed	282	452	72
License Issued	5,110	5,272	5,351
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	5,772	3,992	3,823
Pending Applications (outside of board control)*	-	-	-
Pending Applications (within the board control)*	-	-	-

Table 7b. Total Licensing Data (cont.)			
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	60,814	62,656	64,351
* Optional. List if tracked by the board.			
** See below section on Cycle Times			

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. The Board immediately sends deficiency notices to the applicants notifying them 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 remediate. 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 the longer cycle times 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 pending in the application 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 30-90 days in the licensure process.

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 approved 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, however, they 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 began in FY 2008/2009 to identify 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 school, and then went on to licensure. In FY 2008/2009, 2009/2010 and somewhat in 2010/2011, the Board still captured data in the international graduate category for individuals who had previously received a PTAL. However, the Board believes that this issue was resolved and the statistics in FY 2011/2012 accurately reflect the processing times for these three groups. The following chart identifies the licensure cycle times for each type of applicant as identified above. The average days is from the time of receipt of the application until licensure.

FY	2008/2009		2009/2010		2010/2011		2011/2012	
	Record Count	Average Days						
US	3452	169	3849	188	3927	152	4013	142
International	1179	696	999	523	937	391	901	297
PTAL	56	800	262	1148	408	1271	437	1313*
Total	4687	--	5110	--	5272	--	5351	--

*If the two year required postgraduate training time of 730 days is subtracted, then the cycle time is 583 days, which includes time from issuance of a PTAL until postgraduate training begins.

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 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. This is an area where the Board has seen marked improvement over the last two years. The Licensing Program found efficiencies in the process and received additional staff. The improvements can be seen in the following chart. The average days is from the time of receipt of the application until the initial review (which results in licensure or a deficiency letter being sent to the applicant).

FY	2008/2009		2009/2010		2010/2011		2011/2012	
	Record Count	Average Days						
US	3944	122	3865	70	3903	36	4272	39
International	1012	108	895	65	963	37	1094	32
PTAL	1108	110	1171	66	1183	39	1255	32
Total	6064	--	5931	--	6049	--	6621	--

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 with the intent to benefit one's self 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 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 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. 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 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 Letter of Good Standing (LGS) 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 LGS 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 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 court must provide a letter to that effect.

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.

Questions 26-38 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. 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 directly to the Board directly by the appropriate authority.

Form L2 of the application, Certificate of Medical Education, must be completed for 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.

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 physicians 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. 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 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. 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 who determines the appropriate action to take.

Queries are not submitted to the NPDB during the renewal process. The Board recently performed a study of the information provided to the NPDB compared to information received by the Board. See [Section 12, Attachment O](#) for a copy of the staff memo provided to 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 and training, 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/RCPSG Postgraduate Training; L5 – Certificate of Clinical Clerkships; L6 – Certificate of Clinical Training; 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 the most strict 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-L1E); 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 request a report from the American Medical Association for each applicant.

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, 2141, 2146, 2151, 2170, 2171, 2176, 2177, 2183, 2184 and 2186 provide the basis for specified requirements, documentation, and pathway to licensure. CCR sections 1307, 1314, 1315, 1315.50, 1315.53, 1315.55, 1319.4, 1320, 1321, 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, regulation, and policy. These documents include the application forms completed and signed by the applicant (Form L1A-L1E); 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.

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, 2141, 2143, 2171, 2176, 2177, 2183 and 2184 provide the basis for specified requirements, documentation and pathway to licensure. 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, that 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. From time of completion to licensure (if not held for birth month issuance) is less than seven days, and could be next day depending upon the licensure batch cycle.

No Longer Interested Notification to DOJ

The Board has identified a process for No Longer Interested (NLI) notifications and will begin 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 a NLI notification will be sent to DOJ. A 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. Additionally, a NLI notification will be sent to DOJ on a monthly basis for all other former licensees when their license has been canceled for non-renewal, canceled upon notification of demise, or voluntarily surrendered. The Board will send these NLI notifications to the California DOJ for former applicants and licensees on a regular and ongoing basis once BreEZe has been launched.

The DCA attempted an electronic transmission of the NLI notifications to DOJ for boards and bureaus excluding notifications for applicants that have closed their file. However, this practice was suspended due to poor match rates between the DCA and DOJ computer systems and other ongoing issues. Thus, NLI notifications will be manually submitted to DOJ by fax. It may take weeks for DOJ to process these manual requests. In the event a reapplication is processed for a former applicant or licensee, it is possible that DOJ may not process the NLI request prior to the resubmission of new fingerprints. If the NLI request is processed after the resubmission of new fingerprints, the Board would not get subsequent arrest reports that it should receive for a current applicant/licensee. To make sure this does not happen, staff will verify the date the NLI request was sent to DOJ and subsequent application was received. Staff may also contact DOJ, if necessary, to ensure the NLI request is not processed after the reapplication fingerprints are submitted.

It is anticipated that the new BreEZe computer system will have an interface component that will electronically send DOJ NLI notification for all previous applicants/licensees. The Board is expected to roll out the BreEZe system by early 2013, but this interface is not anticipated to be complete until sometime after launch.

Examination Process

The Board requires applicants to pass a nationally recognized examination. The current required examination is the United States Medical Licensing Examination (USMLE) Steps 1, 2 Clinical Skills, 2 Clinical Knowledge and 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 NBME and the 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 CCR section 1328. The validity of the examination is established by CCR section 1329.2.

The Board's minimum passing score, established by board resolution, is and always has been 75 (scaled score). The Board relinquished the establishment of the scoring process to the FSMB and NBME, respectively. The Board does not require any California specific examination. The USMLE is the only examination required for licensure.

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. This information, obtained from the USMLE is provided in [Section 12, Attachment P](#).

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 2090 – The Board does not dictate curriculum content*
- Section 2091 – The Board does not dictate curriculum content*
- Section 2091.1 – The Board does not dictate curriculum content*
- Section 2091.2 – The Board does not dictate curriculum content*
- Section 2115 – There appears to be no interest in this exemption as it has never been used

**These topics have been incorporated into curriculum in various formats, were added to California law in the 1980s and early 1990s, and specification is no longer necessary.*

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 regulations.

U.S./Canadian Medical Schools – 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 medical education programs leading to the issuance of Medical Doctor (M.D.) degrees in the U.S. and Canada. B&P Code sections 2084, 2085, 2089, 2089.5 and 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 schools credentials based upon CCR 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 CCR 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 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 174 medical schools in the U.S. and Canada that are accredited by the LCME. 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 1,540 international medical schools. Some of these schools require a re-assessment every seven years as mandated in CCR section 1314.1. None of these schools have been re-assessed as required due to lack of sufficient staffing. The Board plans to begin this process in FY 2013/2014.

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 the members' timely decision at a quarterly Board meeting.

All non-U.S. and 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.

Prior to 1985, Board staff conducted no reviews of international medical schools. If an applicant graduated from a new medical school that was listed in the World Health Organization's "Directory of Medical Schools," staff issued the school a "school code" and processed the application routinely. WHO listing is not required in statute or regulation. It is merely a listing of the names and addresses of medical schools. No one organization conducts any quality review of the schools. In addition, for political reasons, the Directory excluded all Taiwanese medical schools. Therefore, this Directory is not a practical tool for evaluating international medical schools. The [Foundation for the Advancement of International Medical Education and Research \(FAIMER\)](#), established in 2000 by the [Educational Commission for Foreign Medical Graduates \(ECFMG\)](#), also publishes an International Medical Education Directory (IMED) that provides updated information about international medical schools that are recognized by the appropriate government agency in the country where the school is located.

However, FAIMER is not an accreditation agency and does not recognize, endorse, or accredit any of the schools listed in the IMED. In fact, there are many schools on the IMED list that have been disapproved by the Board. Thus, this tool is also impractical for the evaluation of international medical schools. No other international organization exists that evaluates or accredits the world's 2000+ international medical schools for compliance with some educational standard.

Almost all international medical schools are founded to train physicians to address the medical needs of their country's population. In the late 1970s, however, entrepreneurs began to develop for-profit, English-language medical schools in the Caribbean aimed at attracting Americans who were unable to enter U.S. medical schools. Staff issued school codes to these schools as their graduates began to apply to the Board in the early 1980s.

In the spring of 1983, the U.S. Postal Service uncovered a scandal involving the widespread production of fraudulent medical diplomas and other unethical practices on the part of officials at CETEC and CIFAS Universities in the Dominican Republic and their U.S. agents. During the course of the Postal Service's investigation, other medical schools in the Dominican Republic and in other Caribbean nations were implicated. Thousands of individuals - many of them nurses, physician assistants, pharmacists, chiropractors, and podiatrists - bought fraudulent transcripts and diplomas for prices ranging from \$8,000 to \$50,000. These individuals spent little or no time attending the school listed on their diploma. As a result of the Postal Service's findings, licensing boards across the U.S. were forced to investigate the backgrounds of thousands of applicants and licensees who had attended the implicated schools. Individuals who were found to have submitted false documentation had their licenses revoked or were dismissed from training programs. Dominican authorities closed two schools, CETEC and CIFAS, and jailed administrators who were involved in document forgery schemes.

The Board realized the need to take proactive steps to protect California's patients from being treated by students and graduates of medical schools that do not meet the minimum requirements of law. The Board's first act was to disapprove the six proprietary schools that were either implicated in the scandal or were violating California law. Subsequently, the Board conducted onsite inspections to those medical schools and developed an orderly process for evaluating new proprietary international schools that attract U.S. citizens. Of the 12 schools that the Board reviewed in the Caribbean, four were recognized and three were disapproved following a site inspection. The Board disapproved five schools after they either failed to cooperate in the Board's information-gathering process or were closed by their governments for malfeasance. In each instance where a school challenged its disapproval, the courts affirmed the Board's authority.

On the recommendations of the task force, the Board adopted a set of guidelines for the licensing program staff to follow in evaluating the medical education of individual applicants who were trained outside the U.S. or Canada. The guidelines recognized that some students from the Caribbean schools in question could have at least some acceptable credentials and also sought to avoid charges of selective enforcement between countries and their schools. The policy adopted by the Board in 1983 also included the concept of remediation, allowing students who were short in training in certain areas the option of taking additional work and correcting their deficiencies. This permitted eventual licensure of numerous applicants who attended the Caribbean schools. After the guidelines were implemented on an interim basis, the taskforce conducted a survey of the curricula of all 128

U.S. medical schools. Using the data gathered, the Board and staff developed regulations formalizing the guidelines with some modifications.

While the late 1980s saw dwindling enrollments and school closures in the offshore medical school industry, the 1990s saw an expansion in the development of new proprietary medical schools.

In addition, many existing Eastern European medical schools have opened “English-language programs” that promise to prepare students to pass the USMLE and practice medicine in the U.S. The primary countries involved are Hungary, Poland, Czechoslovakia, Slovakia, Russia, Armenia, and, more recently, China. Their approach is that students will receive their basic sciences education in English while simultaneously learning the native language to prepare them to interact with patients during their clinical clerkships. The English-language programs use the existing school’s building and other resources, such as bilingual faculty who have the time available to teach additional classes in English. Some of the English-language programs allow students to return to the U.S. for some or all of their clinical rotations. Minimal oversight of the clinical training received abroad is not uncommon.

As world population expands, many countries have built new medical schools to meet their citizens’ expanding health care needs. According to FAIMER, as of March 2012, there are currently 2,246 operating medical schools in 177 countries or territories. Section 1314.1 of the CCR, 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”].

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.

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 future 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.

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. 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 Medical 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 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.

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. 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

In the past, the Board performed the CME audit once annually. This was a major endeavor for Board staff as multiple processes went into administering the audit, many of which were completed manually

due to limited ISB resources at the time. This resulted in the audit taking an average of six to nine months to complete with multiple staff members' involvement. With the advancements in technology and experienced ISB staff, the process to complete the audit was revamped in January 2011. Currently, the CME audit is performed on a monthly basis and is designed to randomly audit approximately 10% of the total number of renewing physicians per year. The process to select physicians to undergo the audit is now an automatic computer driven procedure based on requirements programmed into the reporting system. 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 CCR section 1338(c).

The Board last conducted a yearly audit of CME in 2006. Due to limited resources the audit was not performed again until January 2011 when the monthly auditing system was created. Since January 2011, the Board has conducted 20 random CME audits and will continue to randomly audit on a monthly basis. Approximately 10% of the randomly selected physicians failed the audit in 2011.

CME Course Approval

Approved CME consists of courses or programs designated by the American Medical Association (AMA) or the California Medical Association (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.

Approved CME is defined as programs which qualify for Category 1 credit from the CMA or the AMA. The CMA and AMA are responsible for approving CME providers as well as courses being designated as Category 1. The Board does not approve CME providers or courses.

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

The Board has continuously reviewed the policies related to CME over the years and continues to do so. Committees have been formed to discuss issues related to the CME requirements as well as the procedures for performing audits. The process was revamped in 2011 after careful review of the processes that were in place. Future enhancements will continue to be discussed and researched for

best practices. The Board is also looking at the Maintenance of Licensure/Certification issue as proposed by the FSMB. This would require more in-depth and specific continuing education. These pilot programs are in their infancy at this time, however, part of the Board's Strategic Plan is to review these new programs and determine if the Board should seek legislative changes for continuing competency. (For more information on physician re-entry, see Section 11, New Issues.)

Fictitious Name Permits

Performance Targets/Expectations

California Code of Regulations section 1350.2 requires that the Board shall, within a reasonable time after an application has been filed, issue a 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.

Improvements and efficiencies have been achieved by providing more detailed application instructions, along with a newly added checklist as part of the FNP application on the Board's Web site. During FY 2011/2012, the FNP application and all other forms used to update FNPs, were launched as PDF documents. The PDF application and all other forms now provide the FNP applicants with the convenience of being able to type on the form using fill-in boxes and then printing the form. The PDF format has eliminated many errors that resulted from Board staff trying to interpret hand writing. Minimizing such errors has reduced the number of applications "pending with deficiencies" as well as FNPs incorrectly issued with typos. This has expedited the processing while saving staff time and resources.

The Board believes that the BreEZe project will increase efficiencies in FNP processing procedures. BreEZe will allow for the applicant to pay fees and submit the application online, which should increase efficiencies and speed processing times.

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 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Fictitious Name Permit	Active	12,322	12,558	13,105	13,738
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	2,360	2,595	2,673	2,717

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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,301	1,100	0	1,100	86	-	-	-	-	36
	(Renewal)	4,968	n/a	n/a	4,968	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,390	1,266	0	1,266	89	-	-	-	-	38
	(Renewal)	4,943	n/a	n/a	4,943	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1,424	1,410	0	1,410	94	-	-	-	-	36
	(Renewal)	5,294	n/a	n/a	5,294	n/a	n/a	n/a	n/a	n/a	n/a
* Optional. List if tracked by the board.											
Table 7b. Total Licensing Data											
						FY 2009/10	FY 2010/11	FY 2011/12			
Initial Licensing Data:											
Initial License/Initial Exam Applications Received						1,301	1,390	1,424			
Initial License/Initial Exam Applications Approved						1,100	1,266	1,410			
Initial License/Initial Exam Applications Closed						0	0	0			
License Issued						1,100	1,266	1,410			
Initial License/Initial Exam Pending Application Data:											
Pending Applications (total at close of FY)						86	89	94			
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)						36	38	36			
Average Days to Application Approval (incomplete applications)*						-	-	-			
Average Days to Application Approval (complete applications)*						-	-	-			
License Renewal Data:											
License Renewed						4,968	4,943	5,294			
* Optional. List if tracked by the board.											

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 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 Web site 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 a 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 eight medical schools in California and two Board Members (one physician Member and one public Member) for a total of ten Members.

California currently has eight 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

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 CCR section 1315.02, the Dean is required to report to the Board (within 30 days) that a SFP holder no longer meets the requirements to hold a SFP. Upon receipt of notification that a SFP holder no longer meets the requirements for a SFP, the Board will cancel the SFP.

SFP holders are listed on the Board's Web site with licensed physicians. The public can search the Board's Web site to verify a SFP holder's current status and public record. The complaint process is the same for a 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 a SFP holder. A 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.

On September 6, 2012, a Special Faculty Permit Review Committee meeting was held to evaluate the current statutes and regulations to determine if any changes were needed to the statutes and/or regulations. The Committee determined that the SFP program was working well by providing public protection and still meeting the needs of the sponsoring California medical schools, thus changes to the current statutes and regulations were unwarranted at this time.

Table 7a. Licensing Data by Type								
Special Faculty Permit		Received	Approved	Closed	Issued	Pending Applications		
						Total (Close of FY)	Outside Board control*	Within Board control*
FY 2009/10	(License)	1	2	0	2	0	-	-
	(Renewal)	5	n/a	n/a	5	n/a	n/a	n/a
FY 2010/11	(License)	0	0	0	0	1	-	-
	(Renewal)	11	n/a	n/a	11	n/a	n/a	n/a
FY 2011/12	(License)	5	2	0	2	3	-	-
	(Renewal)	4	n/a	n/a	4	n/a	n/a	n/a

* Optional. List if tracked by the board.

As of October 1, 2012 the Board has approved 22 SFPs; 17 SFPs are current, one SFP is pending fees, and four SFPs have been canceled (not discipline).

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 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 (previously the Division of Licensing), 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 (previously the Division of Licensing), 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 (previously the Division of Licensing) 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, supervised by the staff of the medical school's medical center. The appointment is for one year and may be renewed annually two times for a maximum time 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 program to periodically review these programs.

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 which is approved by the Joint Commission. The Board (previously the Division of Licensing) must approve the visiting physician and the sponsoring hospital prior to the visiting physician starting. The visiting physician shall be under the direct supervision at all times by 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. 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 program to periodically review these programs.

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 (previously the Division of Licensing). 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 program to periodically review these programs.

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 (previously the Division of Licensing) 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. The visiting physician shall be under direct supervision at all times 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 this section of law as no hospital has shown interest in this specific 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. 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.

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

SPECIAL PROGRAMS FY 2011/12

Permit	Applications Received	Applications Reviewed	Permits Issued	Permits Renewed	Total Pending	Applications Withdrawn or Denied
2111	24	26	17	13	16	1
2112	1	1	2	0	1	0
2113	26	28	29	38	13	1
2072	0	0	0	0	0	0
1327	0	0	0	2	0	0

SPECIAL PROGRAMS FY 2010/11

Permit	Applications Received	Applications Reviewed	Permits Issued	Permits Renewed	Total Pending	*Applications Withdrawn or Denied
2111	33	27	24	36	2	
2112	2	1	1	0	1	
2113	24	21	14	57	13	
2072	0	0	0	0	0	
1327	2	2	1	1	0	

* Information not available FY 2010/2011

Medical Assistants

The Board does not license or register medical assistants. However, the Board does approve certifying organizations that provide certification to medical assistants. CCR section 1366.33 requires that within 60 working days of receipt of an application for approval as certifying organization, the Board shall inform the applicant in writing whether it is complete and accepted for filing or that it is deficient and what specific information or documentation is required to complete the application. There are currently three approved certifying organizations. The Board has not received an initial application for a certifying organization since September 15, 1995 and there are no pending applications at this time. However, should one be received, the Board has set an internal goal that new applications will be reviewed within 60 calendar days, and the Board fully anticipates that this goal will be met.

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.

The Board would not require primary source documentation for this application type as the certifying organization would be providing documentation to support that it meets the requirements set forth in CCR section 1366.31. It would self-report and document its compliance.

Outpatient Surgery Setting Accreditation

Currently, California law prohibits physicians from performing some outpatient surgeries, unless it is performed in an accredited or licensed 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 setting's operations.

The Board has approved the following four 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

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.

Pursuant to the enactment of SB 100 (Price, Chapter 645), effective January 1, 2012, the Board maintains a list of accredited outpatient settings based upon the information provided by the accreditation agencies approved by the Board. The Board posts the information on its Web site. The information on the Web site 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 Web site 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.

This site may be found at the following link: <http://www2.mbc.ca.gov/OSSDPublic/>

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.

SB 100 also called for the accrediting agency to inspect the setting no less often than once every three years. The inspection reports are required to be provided to the Board and posted on the Web site 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.

The outpatient settings are also subject to the same adverse event report requirements that are currently in place for hospitals and other licensed health care facilities. These reports are required to be provided to the California Department of Public Health (CDPH). Should the CDPH identify areas that are under the Board's jurisdiction, it will refer the matter to the Board for investigation.

The accrediting agency is also required to determine if any outpatient setting that applies for accreditation has had any prior denial of accreditation by any of the other agencies. If so, the accrediting agency must ensure that all previous deficiencies have been corrected and a new onsite inspection must be conducted.

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 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 is 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 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.

Section 5

Enforcement Program

- Performance Targets/Expectations
- Trends in Enforcement Data – Performance Barriers
- Improvements
- Future Improvements
- Legislative Enhancements/Amendments
- Enforcement Statistics
- Increases or Decreases in Disciplinary Action
- Case Prioritization
- Mandatory Reporting
- 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
- FTB Intercept Program for Cost Recovery

Related Attachments

- Attachment Q – Enforcement Processing Timeframes
- Attachment R – Attorney General’s Response to Medical Board of California’s Program Evaluation



Enforcement Program

Performance Targets/Expectations

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 goes on to say that if the Board believes that the case involved complex medical or fraud issues or complex business or financial arrangements then this goal should be no more than one year to investigate.

Approximately 80% of the complaints received are closed in the CCU. In FY 2011/2012 the average time in the CCU to either close a complaint or refer it to the district office for investigation was 83 days. Therefore, approximately 80% of the complaints are closed within the 180 days. The other 20% of the Board's complaints are referred to the field for investigation by a sworn peace officer. In FY 2011/2012, the average time to complete an investigation was 264 days. Adding the average time in the CCU to the average time in the field for investigation results in 347 days, which is less than one year. Although the Board has no system to identify a case as complex or non-complex, the Board believes that the majority of the cases that are transmitted to the district offices for investigation are complex cases.

In FY 2007/2008, the Board developed some internal performance targets. One of these targets is to reduce case aging by 10-20% for investigations in the Board's district offices. This has been accomplished. Since FY 2007/2008, the Board has reduced the average time to investigate a complaint from 324 days to 264 days, or an average of 18.5%.

In the Board's 2012 strategic plan, it identified an objective to reduce the complaint processing average to less than 70 days, with 50-60% less than 50 days. The Board has not yet reached this goal, but is continuing to identify ways to meet this goal. At the Enforcement Committee in July 2012, the CCU identified areas where staff will work on improving the timeframes, including improving the time it takes to initially review a complaint and enter it into the Board's computer database and the time it takes to submit the complaint to an expert for review.

Pursuant to B&P Code section 2220.08, the Board is required to have an upfront review by a medical expert on almost all cases involving quality of care. The CCU is also monitoring the time it takes to obtain an up-front review from a medical expert. To reduce timeframes, the CCU staff will follow-up with the experts to ensure they are reviewing the complaint in a timely manner. Additionally, the Board is looking at adding malpractice complaints to those that are excluded from the up-front medical expert review. (For more information on upfront review of malpractice cases, see Section 11, New Issues.)

Another improvement to reduce timeframes and ensure quality review is the development of a new expert reviewer training program. Expert Reviewers are extremely important in the investigation and prosecution process. The expert report is a critical resource in establishing violations or eliminating cases that should not be prosecuted. Historically, only minimal training has been provided to the experts. In the mid-1990s training sessions were established and conducted in each area. Sessions were attended by physicians who wished to conduct expert reviews and included a DAG, a Supervising Investigator, and a Medical Consultant. These sessions were held after normal working

hours, were time consuming, and expensive. The face-to-face training sessions evolved into a video and syllabus. However, the Board's experts remained a focus of criticism because their performance was not equal to many of the defense experts secured by respondents. In an effort to improve the quality of expert reviewer work product and promote timely reviews, an eight (8) hour training course was developed and presented to the Northern California expert reviewers in 2012. The training incorporated presentations from an ALJ, a district medical consultant, an attorney who represents physicians, and a Supervising DAG.

An interactive computer program allowed the attendees to participate by responding to scenarios and engaging in discussion. A video showing good expert testimony versus poor testimony was incorporated into this training. Approximately 100 expert reviewers attended the training and the Board was able to provide continuing medical education credit as inducement to attend. The Expert Reviewer Training will be presented throughout the state. The next training is scheduled for February 2013 in Irvine. This training will also be provided on an ongoing basis to assist in training new experts as they sign contracts.

All of the changes discussed will assist the Board in meeting its goals, targets, and objectives. A copy of the chart provided to the Board at each quarterly meeting in response to Objective 5.2 of the Board's strategic plan pertaining to enforcement timeframes is included as [Section 12, Attachment Q](#).

Trends in Enforcement Data – Performance Barriers

The Board's statistics reflect an increase of about 600 complaints in FY 2010/2011. Although the Board cannot verify the reason for the increase, it could be related to the Board's increased outreach efforts to inform the consumers of the Board through the "notice to consumers" requirement. A regulatory change became effective in 2010 that required physicians to notify their patients that they are licensed and regulated by the Board. A physician can meet this requirement by prominently posting a sign or by providing a written notice, signed by the patient, that includes the Board's contact information. The intent of this regulation is to make consumers aware of the existence of the Board and to inform consumers that they may contact the Board if they have a concern about a physician. The Board's increase in complaints is in the "Public" source category, so this increase could well have resulted from the notification requirement.

The Board has also seen a continued growth in the number of cases referred to formal investigation at the Board's district offices. The chart below shows this increase.

Fiscal Year	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Investigations Opened	1133	1123	1312	1338	1577

At the same time the investigations were increasing, the Board's staff vacancy rate in the district offices was also increasing, especially in FY 2011/2012.

Fiscal Year	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Vacancy rate (as of June 30)	9%	13%	15%	9%	18%

The Board's Enforcement Program has faced significant challenges in the last four years that have impacted the Program's performance.

Furloughs/Hiring Freeze – Staff were furloughed two days per month beginning in February 2009 until June 30, 2009. On July 1, 2009, staff were furloughed three days per month until June 30, 2010. From April 1, 2011 until April 1, 2012, the Board's investigators were furloughed one day per month. This was a devastating loss of work force hours. The loss of pay caused some staff who otherwise would not have retired to leave the Board prematurely, thus creating additional vacancies. This was exacerbated by the hiring freeze (effective August 31, 2010), which severely hindered the Board's ability to replace departing staff. When hiring resumed without restrictions on November 23, 2011, Board staff quickly scheduled interviews with DOJ agents being laid off, and identified approximately 15 of those individuals to fill vacancies. Despite expending significant staffing resources to conduct expeditious background investigations, only four of those individuals accepted positions and were hired; the other nine individual's jobs were saved and they remained with DOJ due to the higher agent salary.

Retention – The Board contracted with Cooperative Personnel Services (CPS) to conduct an investigator classification review in order to determine if there was justification for an increase in Board investigator pay to assist with retention. Investigator exit interviews cite the difficulty of the job, working in the VE/P model, and pay as reasons for leaving the Board for other agencies. The CPS report concluded that a new classification would not be appropriate. CPS recommended seeking pay differentials based on the substantial training that is provided to Board investigators. However, that recommendation was fraught with problems because the investigator classification is used in other sections of the DCA.

VE/P Model – Government Code section 12529.6 implemented the concept of a VE/P model which became operative January 1, 2006. This law pairs a DAG with an investigator at the outset of an investigation. Modifications to this model were made due to staffing limitations where a "lead" DAG is assigned to a district office and provides legal support and direction to investigators until a "primary" DAG is assigned to the case. Sexual misconduct cases, or cases where there is a potential imminent threat to the consumer, are immediately assigned to a "primary" DAG.

VE/P was studied in a report prepared by Benjamin Frank, LLC (See Section 12, Attachment C, *Medical Board of California – Program Evaluation*, Volumes I and II). Mr. Frank concluded that the insertion of DAGs into the investigative process did not translate into more positive disciplinary outcomes or a decrease in investigation completion times. Mr. Frank recommended scaling back and optimizing DAG involvement in investigations. His report identified the best practices (and most fiscally sound use of DAG hours), were found to occur in Northern California, where DAGs do not typically attend complainant/witness and subject interviews unless the case facts support their attendance. Northern California's disciplinary timeline statistics are superior to that of the Los Angeles area, where DAGs are significantly involved in every aspect of the investigation. According to Mr. Frank's assessment, this translates to tremendous costs that are unnecessary, but more importantly, translates to significant investigator frustration that is a causative factor in attrition.

The AG's Office took great exception to certain portions of Mr. Frank's report, namely the cost of VE/P in the investigation phase of the case and that greater DAG involvement under the VE/P model has not translated into greater public protection. The AG Office's October 4, 2010 response to the Board states, "Significantly, during the past two years, imposition of the most serious disciplinary action in cases handled by HQES --- Los Angeles, where DAGs presently have greater involvement during the investigation stage, has increased 14.3%. This statistic, standing alone, undermines a central premise of the Frank Report, namely, that greater DAG involvement under the VE/P model has not translated into greater public protection. As this final statistical measure clearly demonstrates, since implementation of the VE/P model, imposition of the most severe disciplinary outcomes has increased 10.8% statewide from the pre-VE/P time period, with the resulting increase in public protection." (See [Section 12, Attachment R](#))

Also in the response to the report, the AG's Office raised the issue of accusations resulting in "serious discipline" to explain the extensive DAG involvement in the Los Angeles office of HQES. Serious discipline was defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. HQES prepared a chart illustrating, by each area HQES office, the percentage of accusations resulting in serious discipline. The statistics are in the chart below. The chart was modified to change the sequence of offices to reflect the level of DAG involvement in each case, and calendar years 2010, 2011 and 2012 (up to 8-1-12) were included. As the chart illustrates, as VE/P has evolved, there is little difference in disciplinary outcome in terms of "seriousness" among the offices where there is substantial DAG involvement and minimal DAG involvement. What is important to note about this, is that Board investigators who work with the San Francisco and Sacramento offices of HQES report greater job-satisfaction because they do not have the difficulty in coordinating with the DAGs to attend interviews where the DAG attendance is deemed unnecessary.

Percentage of Results in Serious Discipline							
Calendar Year	2006	2007	2008	2009	2010	2011	2012 (as of 8-1-12)
Los Angeles	65.6	68.1	72.7	82.4	85.7	77.7	85.7
San Diego	59.3	50.9	72.3	64.3	71.4	77.4	84.4
Sacramento	61	72.7	64	75	63.6	79.1	83.3
San Francisco	65.4	61.3	54.5	80	67.3	83.7	68.4
Overall Average for all HQES offices	62.7%	61.1%	67.1%	73.5%	74%	79%	81.8%

If one changes the definition of "serious discipline" to the penultimate discipline (revocation or surrender), the following chart depicts the percentage of overall disciplinary outcomes that resulted in a surrender or revocation (including default revocations) by HQES office. The chart comports with the theory that DAG involvement does not necessarily correlate to serious disciplinary outcomes.

Percentage of Revocations/Surrenders			
Calendar year	2010	2011	2012 (as of 8-1-12)
Los Angeles	33.3	29.6	20
San Diego	28.5	37	21.2
Sacramento	17.3	29.1	25
San Francisco	19.5	44.1	26.3
Overall Average for all HQES offices	26.5	34.7	22.2

What is difficult to discern is whether the improvements in decreasing case age and improving disciplinary outcomes is directly attributable to VE/P or to other causes. (This will be examined more fully in the Spring 2013 report.) For example, the Board implemented a variety of policies and procedures to address case aging, including modifying the template, policy, and procedures for subpoenas duces tecum; eliminating medical consultant memoranda; allowing the transcribing of interviews; and paying strict attention to cases that were aging. A policy was instituted and training was provided on record acquisition and seeking sanctions immediately when records were not received. The Board has also provided more substantial and consistent training to its investigators which undoubtedly has contributed to some of this success.

Board staff, in revising the Joint Vertical Enforcement Guidelines in July 2011, were unsuccessful in lessening DAG involvement, however DAGs (as well as investigators) were provided strict timelines by which certain tasks had to be completed, otherwise they were deemed “approved” for the purposes of moving forward with an investigation. This is a means to keep cases moving when DAGs are unable to participate in the parts of investigation due to conflicting workload issues.

VE/P remains inconsistently applied statewide. In Northern California (Sacramento, San Francisco and Oakland), VE/P is considerably more “hands off.” DAGs rarely attend complainant interviews (unless it is a sexual misconduct case) and do not attend every physician interview. In Los Angeles, DAGs attend almost every complainant interview, every subject interview, and some witness interviews. In San Diego, DAGs attend some complainant interviews (including all sexual misconduct complainant interviews), all subject interviews, and some witness interviews.

The primary frustration with DAG involvement rests with scheduling. There is an inherent potential for delay for each schedule that needs accommodation for an appointment. This has become burdensome for Board staff. The DAGs’ schedules often preclude timely attendance at an interview due to trials and obligations on other cases. Coupling this with an investigator trying to include the subject, the medical consultant, and the subject’s attorney, creates unnecessary delays in time.

The statistics do not bear out the need for DAGs to attend most interviews. There is no correlation to an improvement in the time to file an accusation, procure an Interim Suspension Order, or improve disciplinary outcomes to the amount of DAG time spent in interviews in a case.

The Board is conducting a thorough review of the statistics related to the VE/P and plans to have a complete report prepared in the Spring of 2013. This report will be provided to the Senate Business,

Professions, and Economic Development Committee. This report will include a review of factors that will help assess the efficacy of the VE/P and any recommendations from the Board regarding its continuation. This report will include statistics on the investigation time, the time to file an accusation, the time to obtain an Interim Suspension Order, investigator turnover, cost of the VE/P, and an update on the statistics obtained in Mr. Frank's review to determine if any improvements have been made since 2010. This report will also look at the number of dismissals and withdrawals of accusations, the elapsed time from referral for investigation to stipulation received, include a comparative analysis on case outcomes versus cost, and identify the types/category of cases which are improved by VE/P. All of this information will be analyzed by the area of the state in which the work is being performed. The Board will also examine the serious discipline percentages to determine how they compare or contrast with previous data.

Improvements

Despite the challenges, the time to complete an investigation in field operations has improved significantly. The following chart depicts the decrease in the time it takes to complete an investigation. The average days is from when the investigation is assigned to an investigator in a field office until the case is either closed or referred to the DAG for the filing of an accusation.

Fiscal Year	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Average days to complete investigation in field operations	324	349	328	312	264

There are several improvements that have been made in order to accomplish this reduction in investigation time. Improvements include:

- Providing managers with a variety of statistical information to measure investigator's performance
- Mandating zero tolerance for delayed medical record acquisition (policy enhancement and legislation tightening);
- Providing consistent Field Training Officer (FTO) training program for investigators,
- Providing statewide training on time management;
- Establishing Aged Case Council – cases that meet a chronologic milestone get the attention of the Chief and Deputy Chief of Enforcement for a case conference with the investigator to strategize on case resolution;
- Adhering to strict deadlines for milestone tasks for both the DAGs and the investigators to eliminate unnecessary delays;
- Developing statewide training for the investigators and the DAGs on medical record procurement and subpoena enforcement actions;
- Eliminating unnecessary tasks (memoranda from medical consultants; sending interviews out for transcribing); and
- Streamlining the subpoena policy by modifying the declaration to make the process easier.

Future Improvements

The Board recommends further improvements in order to continue to decrease the investigation time. Some of these improvements can be made internally, and the Board is seeking these changes,

however, some of the changes will require either an augmentation of staff/resources or enabling legislation.

The Board needs to increase the number of medical consultant hours it currently uses in the Enforcement Program, which may require an augmentation. This suggestion was made by both Mr. Frank in his report as well as the AG's Office.

The Board is improving its expert reviewer program. The Board has vastly improved its medical expert training program and needs to expand it in order to ensure consistency statewide. This will improve the quality of opinions, which reduces timelines by negating the need for addenda from experts. However, the Board does not currently have the necessary staff in place to provide the support for this training. The Board needs to consider increasing the number of analysts available to support the expert reviewer program so that recruitment, procurement, and training of experts can happen consistently. The Board is examining the use of existing CPEI positions to hire analysts for the expert reviewer program.

There may be a need to modify VE/P to comport with the statistical evaluation that will be available in Spring 2013. This could include using the VE/P resources only for sexual misconduct cases, cases that may result in an Interim Suspension Order, highly complex cases, and highly specialized cases (e.g. 805 investigations; corporate unlicensed practice of medicine cases). This would reduce the need for DAGs to attend every complainant interview, every subject interview and other witness interviews.

Legislative Enhancements/Amendments

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. Some of the changes are listed below; however, several changes have been identified in more detail in Section 11, New Issues.

B&P Code section 802.01 – Currently, investigators regularly make multiple requests and even issue subpoenas duces tecum in order to obtain certified arrest reports from other law enforcement agencies. A requirement that law enforcement agencies release certified copies of reports relating to physicians pursuant to a sworn peace officer's request would lessen the time it takes requesting, and ultimately subpoenaing these important reports. This change could lead to a savings of at least 30 days per investigation of these cases.

B&P Code section 805.1 – Currently, investigators issue three subpoenas duces tecum to obtain the documents that caused an 805 report to be filed: a subpoena requesting the information for which the 805 report was filed; a subpoena requesting the identities of the redacted patient information received pursuant to the first subpoena; and lastly, a subpoena requesting the certified medical records should the patient not authorize or not respond to a request for authorization to release records. The health facility is legally entitled to 30 days for each subpoena that is issued. This adds 60-90 days to an investigation (assuming the subpoena does not have to be enforced). A suggested change would be to remove the language "in the record of any disciplinary proceeding". This will eliminate the need to serve multiple subpoenas duces tecum during the course of an 805 report

investigation and reduce the time it takes to complete an 805 report investigation by 60 days (assuming the Board does not have to go to subpoena enforcement).

B&P Code section 2220.05 – The priority system set in law should be re-examined as the law does not include all of the most serious types of cases. The Board recommends that this section be studied for the addition and deletion of types of cases that are warranted.

B&P Code section 2234(h) – Currently, the law includes as unprofessional conduct the “repeated failure” in the absence of “good cause,” to attend and participate in an interview scheduled by “mutual agreement”. This statute, although well intended, has been ineffective in reducing the time it takes to complete an interview with a licensee. The Board recommends the law be amended for only extraordinary circumstances (illness and planned absence). The concept is that no more than thirty days should elapse between the time the interview is requested and completed.

B&P Code section 2280 – The Board has seen a substantial increase in physician impairment cases. Currently, there is no mechanism in place that requires a physician to submit to a chemical test when there is cause to believe the physician is practicing medicine under the influence of alcohol or a controlled substance. The Board recommends adding or amending law to require a physician, who is believed to be under the influence of alcohol or controlled substances while seeing patients, to submit to a urine or chemical test if requested to do so by a peace officer. Refusal could result in the temporary suspension of the license.

Enforcement Statistics

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	6,186	6,771	6,473
Closed	0	0	0
Referred to INV	6,226	6,782	6,471
Average Time to Close	11	9	12
Pending (close of FY)	148	140	151
Source of Complaint (Use CAS Report 091)			
Public	4,159	4,818	4,352
Licensee/Professional Groups	1,330	1,204	1,220
Governmental Agencies	902	927	1,179
Other	148	173	172

Table 9a. Enforcement Statistics (cont.)			
	FY 2009/10	FY 2010/11	FY 2011/12
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	353	351	450
CONV Closed	353	346	463
Average Time to Close	11	11	11
CONV Pending (close of FY)	12	17	4
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied	3	3	0
SOIs Filed	2	6	11
SOIs Withdrawn	2	1	4
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	596	249	249
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	276	265	312
Accusation Filed--Average Days from Case Referred to AG's Office to Accusation Filed	106	107	104
Accusations Withdrawn	10	14	10
Accusations Dismissed	8	7	7
Accusations Declined	8	27	14
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	1,041	904	858
Pending-No Accusation Filed (close of FY)	156	173	155
Pending-Accusation Filed (close of FY)	307	376	402
Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	48	61	71
Stipulations	176	145	200
Average Days to Complete	889	870	930
AG Cases Initiated	457	471	485
AG Cases Pending (close of FY)	463	549	557
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	27	31	35
Surrender	64	42	61
Suspension	0	0	0
Probation with Suspension	11	14	12
Probation	84	79	107
Probationary License Issued	19	23	24
Public Reprimand	116	107	121
Other	4	4	1

Table 9b. Enforcement Statistics (cont.)			
	FY 2009/10	FY 2010/11	FY 2011/12
PROBATION			
New Probationers	114	116	142
Probations Successfully Completed	55	44	54
Probationers (close of FY)	555	505	513
Petitions to Revoke Probation Filed	24	35	34
Probations Revoked	7	7	11
Surrender of License while on Probation	7	4	10
Probations Modified	1	1	1
Probations Extended (includes those with suspension & probation)	13	5	10
Probationers Subject to Drug Testing	112	104	125
Drug Tests Ordered	1,172	1,804	2,994
Positive Drug Tests*	122	164	306
Public Reprimand	0	1	0
Other Decision	1	1	0
Petition Withdrawn or Dismissed	1	1	3
Petition for Reinstatement Granted	5	5	6
<i>*No. of positive tests include those where the licensee had a prescription for the substance</i>			

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	6,579	7,128	6,923
Closed	6,544	7,081	7,206
Average days to close	142	137	141
Pending (close of FY)	2,317	2,470	2,295
Desk Investigations (Use CAS Report EM 10)			
Closed	5,186	5,632	5,663
Average days to close	80	76	89
Pending (close of FY)	1,291	1,448	1,179
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	1,273	1,399	1,543
Average days to close	396	383	333
Pending (close of FY)	1,146	1,084	1,116

Table 9c. Enforcement Statistics (cont.)			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	19	22	28
PC 23 Orders Requested	12	9	14
Other Suspension Orders	31	38	36
Public Letter of Reprimand	57	56	59
Cease & Desist/Warning	9	20	7
Referred for Diversion	n/a	n/a	n/a
Compel Examination Granted	20	11	18
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	111	65	139
Average Days to Complete	189	194	232
Amount of Fines Assessed	\$216,550	\$48,880	\$146,800
Reduced, Withdrawn, Dismissed	\$12,675	\$20,225	\$45,000
Amount Collected	\$44,149	\$52,921	\$58,852
CRIMINAL ACTION			
Referred for Criminal Prosecution	35	41	112

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	213	60	58	60	391	34%
2 Years	118	62	60	59	299	25%
3 Years	39	52	48	76	215	18%
4 Years	17	50	42	72	181	15%
Over 4 Years	12	29	24	31	96	8%
Total Cases Closed	399	253	232	298	1,182	100%
Investigations (Average %)						
Closed Within:						
90 Days	3,456	3,447	3,987	3,621	14,511	53%
180 Days	1,759	1,789	1,715	1,905	7,168	26%
1 Year	620	640	632	996	2,888	11%
2 Years	408	510	584	595	2,097	8%
3 Years	153	154	163	89	559	2%
Over 3 Years	3	4	0	0	7	0%
Total Cases Closed	6,399	6,544	7,081	7,206	27,230	100%

Increases or Decreases in Disciplinary Action

As reflected in the chart below, the overall statistics show an increase in disciplinary actions.

Fiscal Year	FY 06/07	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Cases to AG's Office	415	443	450	569	594	610
Probation Violation Reports Referred to AG's Office	19	17	27	32	35	33
Cases Referred for Criminal Action	37	29	27	35	41	112
License Restrictions/ Suspensions Imposed While Administrative Action Pending	43	33	54	50	60	64
Revocation	34	32	45	34	38	46
Surrender	67	70	35	71	46	71
Total Disciplinary Outcomes	310	314	272	349	317	390

Based on the information reflected in the statistical chart shown above, the percentage of increase from FY 2006/07 to FY 2011/12 are as follows:

- 47% more cases referred to the AG's Office
- 74% more probation violation cases referred to the AG's Office
- 49% more license restrictions/suspension imposed while administrative action pending
- 203% more cases referred for criminal action
- 35% more revocations
- 25% more cases resulting in probation
- 26% more disciplinary outcomes

Case Prioritization

B&P Code section 2220.05 established complaint priorities for the Board in 2003. The statute identified cases involving gross negligence, incompetence and repeated negligent acts that involve death or serious bodily injury to be the Board's highest priority. In addition, complaints involving drug and alcohol use by a physician, sexual misconduct during the course of an examination or treatment and repeated acts of clearly excessive prescribing, furnishing or administering controlled substances or excessive prescribing without a good faith prior examination, were defined as priorities for investigative and prosecutorial resources. The Board's complaint protocols beyond those statutorily mandated were incorporated into the Guidelines for Health Care Agencies by the DCA in 2009.

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 Web site regarding the reporting. The Board is continually looking for opportunities to educate those who are mandated to report of their need to notify the Board. These reports provide the Board with the information necessary to begin an investigation of a physician who might be a danger to the public.

B&P Code section 801.01 requires the reporting of settlements over \$30,000 and 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. There is no way to verify if the Board receives 100% of the reports, but those that are provided are submitted within the statutory timeframe. The Board has reminded insurers of the reporting requirements.

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

These reports appear to be reported as required. The Board is able to confirm that the reporting requirement is being met because reports of arrests and convictions are independently reported to the Board by the DOJ through the 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 for failing to report the criminal conviction as required by this statute. In FY 2010/2011 the Board issued 28 citations for failing to report pursuant to B&P Code section 802.1 and issued 24 citations in FY 2011/2012.

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 the reports as is required because the number of reports filed pursuant to 802.5 continues to decline. In FY 2006/2007 the Board received 22 reports compared to four in FY 2011/2012. The Board meets with the Coroners Association (including presenting at the September 2012 Association meeting) and provides information to the Association for its newsletter to remind the coroners of their reporting obligations. The Board resumed its efforts to educate the coroners' offices after an absence of several years in the hopes of achieving better compliance with the reporting requirements.

This is especially important because two of the Board's highest priorities involve cases of excessive prescribing and death. It appears the Board is not being notified of prescription drug overdose death cases because only one report was received in FY 2011/2012. (See more information on increased reporting in Section 11, New Issues.)

B&P Code section 803 and 803.5 requires 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.

The Board does not believe that it is receiving the reports from the court clerks as is required by statute because the number of reports filed pursuant to 803 continues to decline. In FY 2006/2007 the Board received 10 reports compared to four in FY 2011/2012. The Board routinely contacted the Clerk of the Court in each county and annually reminded them of their reporting obligations. In an attempt to streamline the reporting obligations, the Board modified the Court Clerk's reporting form to consolidate the form to include both types of information required to be reported and made the form available on the Board's Web site. The Board resumed its efforts to educate the court clerks after an absence of several years in the hopes of achieving better compliance with the reporting requirements.

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.

Peer review reporting continues to remain the same – low. In FY 2002/2003, the Board received 162 reports. In FY 2010/2011, the Board received 93 reports and in FY 2011/2012, 114 reports were received. There was a study performed in 2008 that attempted to evaluate the physician peer review process and reporting requirements. The report identified a number of concerns including inconsistencies in the way reporting entities conducted peer review and interpreted the law regarding their reporting obligations. The issue of increased reporting really rests with the mandated reporters and whether or not they are doing an adequate job of conducting peer review. The Legislature may want to consider whether the Licensing and Certification Unit within the California Department of Public Health (CDPH), which has oversight over health care facilities, and accreditation agencies should provide the Board with information on reportable peer review incidents found during an inspection of the facility. (For more information on this recommendation, see Section 11, New Issues.)

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 was intended to provide the Board with earlier notification of disciplinary action being taken against a physician by a peer review body. While the reporting requirement is still relatively new, it appears that the reports are being submitted as required. The Board anticipates the same concerns identified in the 2008 peer review study to affect the reporting required by this statute. The Legislature may want to consider whether the Licensing and Certification Unit within the CDPH, which has oversight over health care facilities, could do more comprehensive reviews for a set period of time to evaluate compliance with the peer review requirement. (For more information on this recommendation, see Section 11, New Issues.)

B&P Code section 2240 requires a physician who performs a medical procedure in an outpatient surgery setting that results in the death of a patient to report the incident to the Board within 15 days after the occurrence.

The Board 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. There is no way to currently verify if the Board receives 100% of the reports but those that are provided are submitted within the statutory timeframe. The Board does have 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 Board reminds physicians of their mandated reporting obligations in the quarterly Newsletter.

Statute of Limitations

B&P Code section 2230.5 sets forth that any 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 fraud or misrepresentation, in which case there is no 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 elapsed. Seven of those cases identified below (two in FY 2008/2009, 3 in FY 2009/2010, and 2 in FY 2010/2011) were lost after the investigation had been completed and the matter had been referred to the AG's Office with a request to file administrative charges. Unfortunately, the accusation was not filed before the statute of limitations expired.

Fiscal Year	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Complaints closed due to statute of limitations	56	84	64	99

Unlicensed Activity and the Underground Economy

The Board has made substantial, successful efforts to address unlicensed activity. On July 1, 2000, the Board was given the authority for four investigator positions that established the original Operation Safe Medicine (OSM) unit whose sole purpose was to investigate complaints of unlicensed

activity. This unit also worked with other regulatory and law enforcement agencies to find unlicensed facilities. Due to the vacancy reductions and vacancy sweeps in FY 2002/2003, the OSM positions were transferred to the Board's enforcement units in order to maintain minimum staffing levels in these other units. The OSM cases were transferred to the other field investigative staff that already had existing caseloads which included all types of complaints received by the Board. On July 1, 2009 OSM was re-established. In that BCP, the Board requested 12 positions in order to establish an OSM North and OSM South. Unfortunately, only six of the 12 requested positions were granted and only for a two-year limited-term basis. The chart below illustrates what OSM was able to accomplish in that two-year period of time and in the following year (the Board continued the positions within the Board's temporary help blanket in FY 2011/2012 and received permanent position authority in FY 2012/2013).

Fiscal Year	FY 09/10	FY 10/11	FY 11/12
OSM Cases referred for Administrative Prosecution	18	17	21
OSM cases referred for Criminal Prosecution	14	31	61
Number of felony convictions	3	0	3
Number of misdemeanor convictions	0	7	11
Number of infraction convictions	0	2	0

The volume and seriousness of the cases thus far investigated by OSM underscores the importance of this unit. Cases that staff investigated include the unlicensed practice of midwifery (result: conviction); a subject stealing the identity of a physician assistant and forging documents (felony charges filed); the unlicensed practice of medicine resulting in burns to a patient from a cosmetic procedure (felony charges filed); and a myriad of other violations of law. OSM has developed such an excellent reputation as a group of highly skilled, specialized and effective investigators of unlicensed practice. It is now receiving referrals from other law enforcement agencies, including the Orange County and Los Angeles County District Attorney's offices.

Northern California offices of the board have also investigated numerous unlicensed cases during the past two fiscal years. The San Jose office investigated an unlicensed individual who was performing hemorrhoid surgery and almost killed a man when his colon was perforated with a prong.

In the San Francisco area, an unlicensed individual performed liposuction in an unsanitary office while smoking a cigar and not wearing gloves. The victim held her own IV bag because there was no assistant. Board investigators executed a search and arrest warrant. The subject was charged with over 35 felonies.

In the San Jose area, a disbarred attorney was practicing medicine without a license by using a laser to cure toenail fungus. One child's toenails fell off because of the treatment. Search and arrest warrants were served. The subject was convicted of 19 felonies.

In the Pleasant Hill office, an unlicensed individual was convicted after injecting an unknown substance into the faces of female victims, causing permanent disfigurement.

In the San Jose area, an unlicensed individual was convicted and is serving seven years in prison for performing face lifts with Exacto knives.

The unlicensed practice of medicine is currently not designated as a priority by B&P Code section 2220.05. Consequently, without a unit dedicated solely to unlicensed practice, when caseloads increase (as they have done in the Northern California offices), there is less time and opportunity to investigate cases alleging unlicensed practice. Additional positions dedicated to the investigation of unlicensed cases would not only improve public protection, it would alleviate the disproportionate workload and improve case aging averages. The Board is considering the establishment of an OSM unit in Northern California.

Citation and Fine

In 2005, the Board amended CCR 1364.11 to increase the maximum fine amount to the \$5,000 statutory limit. At the same time, the Board expanded its authority to issue citations to address violations of a term or condition of probation. This has been an effective tool to address minor probation compliance issues such as failing to enroll or complete an ordered educational course or failing to pay ordered probation monitoring costs. For example, in 2009 there were 72 physicians on probation who were out of compliance with the requirement that they reimburse the Board each year for the costs associated with probation monitoring. The total outstanding costs due to the Board were \$349,000 as some had as many as six years of costs still due. The Board opted to issue citations to physicians who owed probation monitoring costs, and 48 citations were issued. Fourteen physicians were referred to the AG's Office for the filing of an administrative action. By utilizing the Board's citation authority to pursue these minor violations of probation, the Board was able to achieve compliance and recoup the ordered probation monitoring costs. By comparison, only 5 citations were issued this fiscal year to physicians for failing to pay the ordered probation monitoring costs.

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 failing to report address changes. The Board also has the authority to issue citations for the unlicensed practice of medicine and this administrative remedy is used when the local district attorney chooses not to pursue criminal charges against the individual. 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.

In addition, the Board has increased the number of citations issued for violations identified during the course of an investigation which 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 will require that 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

This chart depicts the number of requests received for an information conference and the number of requests for hearings.

Fiscal Year	Requests for Informal Office Conferences	Requests for Hearings (Appeals)	Total
2008/2009	47	6	55
2009/2010	45	0	45
2010/2011	27	4	31
2011/2012	59	6	65

Common Citation And Fine Violations

This chart identifies the Board's top five most common violations for which citations are issued.

Number of Citations Issued	Violation Charged
51	2266 – Failure to Maintain Adequate and Accurate Medical Records
49	802.1 – Failure to Report Criminal Convictions
21	2052 – Unlicensed Practice of Medicine
19	2021 – Failure to Report Change of Address
16	2264 – Aiding and Abetting Unlicensed Practice

Citation and Fine Average Amounts – Pre and Post Appeal

The Board is utilizing its citation authority to gain compliance with existing statutes or to enhance the physician's skills by requiring the completion of educational courses in order to satisfy the citation. The data from FY 2011/2012 indicates that 31% of the citations issued were withdrawn once an educational course was completed by the physician. The Board modified the fine amount by approximately 50% in 26% of the cases following an informal conference when the physician was able to substantiate he/she subsequently complied with the law charged in the citation. During this same time period, approximately 13 citations were withdrawn following the informal conference due to concerns about the evidence available to support the violation as charged in the citation. There were only a small number of citations (17%) where the fine amount was reduced following the informal conference 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, the average fine as originally issued was \$1,110 and was reduced to \$610 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 the 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 routinely pursue outstanding fines through FTB's 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.

Cost Recovery and Restitution

As previously mentioned, legislation effective, January 1, 2006, eliminated the Board's ability to recover costs for administrative prosecutions. However, some ALJs continue to order cost recovery that was outstanding prior to January 1, 2006 if a Petition for Reinstatement is granted (i.e. the physician was ordered to pay cost recovery at the time his/her license was revoked/surrendered and the physician never paid the outstanding amount).

The Board does have the ability to seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered and received for criminal investigations.

Fiscal Year	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Criminal Cost Recovery ordered	\$32,846	\$75,000	\$35,000	\$42,748
Criminal Cost Recovery received	\$8,094	\$0	\$0	\$16,887

The Board also orders probationers to pay a per annum fee for monitoring costs. A probationer cannot be released from probation without these costs being paid, therefore there is very little money due that remains uncollected. Probationers whose licenses are revoked or surrendered will be required to pay any outstanding costs upon reinstatement of their license if that occurs.

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice can be referred by the Board to the local district attorney for prosecution. Restitution has been ordered by a judge as a part of the criminal case prosecuted by the district attorney. The restitution identified in Table 12 was ordered due to these unlicensed cases. The Board is unable to identify how much is collected for the victim/patient because the court receives the funds and provides it to the victim/patient and the Board is not notified.

Calendar Year	2008	2009	2010	2011	2012
Probation Cost (per annum)	\$3173	\$3173	\$3673	\$3999	\$4098
Approximate uncollected costs (as of 8-20-12)	\$11,982	\$33,540	\$73,523	\$133,434	Not due

FTB Intercept Program for Cost Recovery

The Board does not use the Franchise Tax Board to collect probation monitoring costs as failure to pay these costs is a violation of probation for which additional disciplinary action is sought. However, any outstanding cost recovery (prior to January 1, 2006) was referred to the FTB Intercept Program. The Board rarely collects monies for this outstanding cost recovery through the FTB.

Table 11. Cost Recovery				
	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13****
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	3	1	1
Amount of Cost Recovery Ordered**	\$0	\$53,447	\$10,000	\$45,000
Amount Collected***	\$33,176	\$18,326	\$56,360	\$900
<p>* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act.</p> <p>**The cost recovery ordered in FY 2010/11, 2011/12, and 2012/13 were due to individuals who were reinstated and were ordered to pay the outstanding balances ordered at the time of the revocation or surrender.</p> <p>*** The Board still receives cost recovery from cases that were completed prior to January 1, 2006 as well as from those identified above.</p> <p>**** As of September 26, 2012.</p>				

Table 12. Restitution				
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered	\$316	\$0	\$10,100	\$3,980
Amount Collected*	\$0	\$0	\$0	\$0

*See the explanation in the paragraph entitled **Cost Recovery and Restitution**.

Section 6

Public Information Policies

- Board's Web site 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 Web site and Posting Meeting Materials and Minutes

The Board continually updates its Web site to reflect upcoming Board activities, changes in laws or regulations, licensing and registration application processing times, and other relevant information of interest to its stakeholders. Prior to all Board and Committee meetings, the agenda is posted on the Board's Web site, 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 are added as they become available. This information remains available on the Web site indefinitely. Minutes from each Board meeting are posted on the Board's Web site as an agenda item for the next Board meeting, and remain posted once they have been formally approved and adopted by the Board at the subsequent meeting. Once posted, they are also kept on the Web site indefinitely.

In order to facilitate information getting to the public in a timely manner, the Board has developed a subscription service on its Web site. The public can go to the Board's Web site and choose from a list of items (e.g. board meeting information, proposed regulations, Board enforcement actions, Board press releases, Newsletter, etc.) 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. The Board wants to ensure the public has every opportunity to receive up-to-date information about the Board.

Webcasting

The Board webcasts all of its Board meetings and most of its Committee meetings. The Board does plan to continue to webcast all Board meetings and expand webcasting of its Committee meetings. However, this is dependent upon resources from the DCA. When DCA staff is not available to webcast a meeting, the meeting is filmed and subsequently posted on the Web site. This filming, when webcasting resources are not available, began in July 2012.

Meeting Calendars

Board meeting calendars are reviewed and approved by the Board during the summer, usually at the July Board meeting, for the following calendar year, and are posted on the Web site as soon as the dates are approved by the Board. Many Committee calendars are not set for the entire year but are posted as soon as a date is selected, usually a month or more prior to the meeting. The Midwifery Advisory Council and the Special Faculty Permit Review Committee are set and posted for the entire year.

Complaint Disclosure Policy and Posting Accusations/Disciplinary Actions

The Board is committed to ensuring consumers are provided information regarding license status and disciplinary or enforcement actions against its licensees. The Board exceeds the DCA recommended minimum standards and is consistent with DCA Web site posting of accusations and disciplinary actions. In the event that the portion of the Board's Web site 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 Web site provides the following information:

- If a physician has been disciplined or formally accused of wrongdoing by the Board.

- 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 for a minor violation of the law by the Board within the last five years.
- If a physician has been issued a public letter of reprimand at time of licensure.
- 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 10-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 10-year period (beginning 1/1/03) if the physician practices in a low-risk specialty (all other specialties).

Note: Due to B&P Code section 2027, with the exception of felonies and hospital discipline resulting in the termination or revocation of a physician's privileges, all actions listed above must be removed from the Board's Web site 10 years from the effective date (or from the date the Board receives the information on the action in some instances). (For more information and further discussion on the 10 year posting requirement, see Section 11, New Issues.)

Information Available to the Public

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;
- Public record actions;
- 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 practice location zip code;
- 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 Web site 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 also provides an “Important User Notice” which informs the user of the exact parameters that are used in determining what is and is not public information, and what would appear on a record under public disclosure.

Consumer Outreach and Education

The Board has a multi-level approach to consumer outreach and education. The Board employs a public information officer to direct those activities. In addition, the Board had an 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) Web site.

Personal/speaking appearances have long been a mainstay of the Board’s outreach and education efforts. Until recently, Board staff had attended community events to distribute materials, provide presentations, and raise awareness about the Board. Since budget restrictions were imposed, the Board’s presence at such events has been somewhat curtailed. Outreach through community events now exists only where travel is allowable under the current guidelines. Outreach continues to be done locally and in areas of Board meetings when possible. When requests are made that are beyond such reasonable travel distances, the invitation is politely declined; however, the Board does send written materials to community events when requested. On occasion, local enforcement staff members may attend an outreach event or speaking engagement, but this is a rare occurrence due to enforcement priorities and staffing shortages.

Brochures and publications are available on the Board’s Web site and are provided at all 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
- Gynecological Cancers . . . What Women Need to Know – English
- 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
- 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

*Tip sheets include:

- How Complaints are Handled
- How to File a Complaint
- Medical Spas - What You Need to Know
- Be informed. Be healthy.
- Selecting a Physician

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 check over 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. In addition, Board staff will attend new medical student orientation sessions and postgraduate trainee orientation sessions.

Web site usage to obtain information about the Board has grown at a steady pace. The Board's Web site provides electronic editions of all the Board publications, Newsletters, meeting agendas, laws, regulations and meeting materials. On the Web site under the “About Us” tab is information about the Board, including its history, Board Members, and Board staff.

The Web site also includes links to helpful documents or other entities Web sites. Some of these useful links are:

- [Advance Health Care Directive Registry](#)
- [Collagen - Information to Patients Regarding Collagen Injections](#)
- [Consumer's Guide to Healthcare Providers](#)
- [Health Care Reform](#)
- [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](#)
- [Is Your Doctor Board Certified?](#)
- [Victim Compensation Program - Help With Medical Bills and Other Expenses for Victims of Violent Crime](#)
- [Information and Services for Consumers](#)
- [Enforcement Process](#)
- [Conviction - How it Might Affect a Medical License](#)

Frequently Asked Questions on:

- [Complaint Process](#)
- [General Office Practices/Protocols](#)
- [Internet Prescribing and Practicing](#)
- [Medical Records](#)
- [Physician Credentials/Practice Specialties](#)
- [Public Information/Disclosure](#)

In addition to consumer information, the Board's Web site has information for applicants, instructing them on the process for licensure and a quick link to check the status of the a license application. This online system provides applicants the ability to check the status of their application for a physician license or postgraduate training authorization letter. The system will display information regarding each required application document. Specifically, the system will display when a document is received, approved, or if an item is deficient.

The Board's Web site is also a tool for updating information, as well as research. Licensees may renew their license to practice medicine, update an email address, update the physician survey, and update an address of record.

The Web site also is a one stop location for laws and regulations, including proposed regulations, that govern the practice of medicine in California. It also provides statistics concerning the Board's Enforcement and Licensing Programs.

The Web site serves as an excellent tool in the Medical Board's outreach efforts to communicate with the public, licensees and applicants.

Section 7

Online Practice Issues

- Online Practice Regulation



Online Practice Regulation

The Board actively investigates and prosecutes violations of B&P Code sections 4067 and 2242.1, which forbid any person or entity from dispensing or furnishing any dangerous drug or device on the Internet for delivery to any person in this state without a prescription issued pursuant to an appropriate prior examination and medical indication. If an individual is not licensed in the State of California, the additional charge of B&P Code section 2052 (practicing medicine without a license) may also be sought. The Board has an investigator dedicated to cases alleging inappropriate/illegal internet prescribing.

Fiscal Year	FY 07/08	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Total cases received	17	9	8	11	13
Cases referred to field	15	9	8	10	8
Cases referred to DA or AG	4	11	3	4	3
Cases referred for cite/fine or PLR	0	0	3	5	5

Unfortunately, due to staffing limitations, the Board responds solely to complaints that have been made to the Board versus being able to proactively seek out offenders.

With the growth and use of telehealth the Board is actively working with the FSMB on national issues related to legally practicing across state borders/lines. (This will be an issue the Board will continue to discuss throughout 2013 and ongoing, especially in light of health care reform.)

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
- 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 qualification, allows these new licensees the ability to apply for and/or continue working in the 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 can process applications and issue licenses timely only with full staffing. The Board received 6,623 physician's applications in FY 2011/12. This was an increase of 576 physician's applications compared to the previous fiscal year.

In 2002, the Board led the charge in creating a loan repayment program for newly licensed physicians. This program was to be a significant step toward increased access to health care and, hopefully, creation of a replicable program to be followed by other states. While the immediate goal of the loan repayment program is to provide improved access to health care in underserved communities during each physician's three-year obligation, the Board also hopes that this three-year period will allow salaried physicians to grow roots in each respective community, remaining where they are working, even after the program's last payment has been made.

At the time, the population of California's medically underserved had reached, by most estimates, over six million. Various factors can limit access to critical medical services. Yet it was obvious beneficial alliances and partnerships could be formed with those who have similar objectives to assist the underserved. The Board recognized its ability, especially when working in concert with others, to influence the process through incentives and licensing initiatives, and thus co-sponsored the legislation and provided the initial funding.

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, along with the California Medical Association, the California Primary Care Association, and the Latino Coalition for a Healthy California, 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. There was 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.

Under the Board's loan repayment program, awardees must work in practice settings according to the following criteria:

- (1) The facility is located in a Health Professional Shortage Area (HPSA), or,
- (2) The facility holds a federal designation as one of the following:
 - (A) Community Health Center (CHC)
 - (B) Federally Qualified Health Center (FQHC)

- (C) Federally Qualified Health Center Look-Alike (FQHC-LA)
 - (D) Rural Health Center (RHC)
 - (E) Migrant Health Center (MHC)
 - (F) Public Housing Health Center (PHHC)
- (3) The facility is an outpatient health program/facility operated by tribal organizations (under the Indian Self-Determination Act) or urban Indian organizations (under the Indian Health Care Improvement Act)

The Medi-Cal threshold languages eligible under the Program include Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Mandarin, Other Chinese, Russian, Spanish, Tagalog, and Vietnamese. Program applicants were asked to self-identify the languages which they spoke.

While there were many co-sponsors of AB 982, only the Board was able to offer the funds required to make the program operational. Over \$3 million was placed into an account specifically for the loan repayment program. It was the goal of the Board to enter into loan repayment agreements as a demonstration that other viable programs can bring culturally and linguistically competent physicians, who are properly licensed, to offer their healthcare skills to the underserved. This was also to allow other assumptions to be measured, including whether the assistance with medical school debt results in the improved retention of physicians in underserved areas beyond the period of their commitment to the Program.

The Board sought to secure sufficient funding to provide, within the first five years of the Program, at least 100 culturally and linguistically competent physicians in areas of need to significantly address the health care disparities while the participating physicians are integrated within the system of health care delivery to the underserved.

Taking into account all money which has been committed to the loan repayment program and interest earned, over \$8 million was raised during the first three years. The sources of these funds include a significant contribution made by a private, family-run foundation; a matching grant was awarded by The California Endowment; a one-time transfer from the Cigarette and Tobacco Products Surtax Fund; and volunteer donations. Further, the Board converted \$450,000 that had been designated for Program workload and staffing into award money and implemented the Program with existing resources.

Despite these successes, the Board regrettably recognized the Program could better grow under the administration of a foundation. Under the Board's administration, loan repayments made to awardees were considered taxable income. Further, Board staff did not have the technical expertise to write grant proposals and raise funds.

With that in mind, the Board sponsored two bills in 2005:

AB 327 (De La Torre, Chapter 293, Statutes 2005) authorized the Board to allow licensees to pay a voluntary \$50 fee, at the time of issuance or renewal of a physician's license, to provide support for the loan repayment program. Monies collected would complement matching grants to sustain the Program. This voluntary fee was established to help provide a continuous source of funding for the Program and allow loan repayments into the future.

AB 920 (Aghazarian, Chapter 317, Statutes 2005) moved the program from the Board to the 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.

Despite the fact the Program is no longer administered by the Board, the Board continues to support the Program. Therefore, the Board supported AB 2439 (De La Torre, Chapter 640, Statutes 2008) to assess a mandatory fee of \$25 at the time of issuance or renewal of a physician's license. This bill also required the Program to dedicate a maximum of 15% of this revenue to physicians who agree to practice in geriatric care settings or settings that primarily serve adults over the age of 65 or adults with disabilities.

The following chart has been provided by HPEF to document the statistical history of the program and awards made:

Award Cycle	M.D./D.O. Applicants	M.D./D.O. Awards	Total Amount Requested	Amount M.D. Awards
2011	185	65/11	\$17,583,785	\$3,439,540
2010	63	22/7	\$5,036,259	\$2,125,578
2009	66	16	\$4,767,727	\$1,510,027
2008	40	5	\$3,484,255	\$250,000
2007	52	12	\$4,303,516	\$989,000
2006	63	21	\$5,640,000	\$1,686,810
2005	57	19	\$4,069,000	\$1,700,493
2004	77	16	\$6,154,000	\$1,310,178
2003	96	29	\$8,157,000	\$2,691,764
Total	699	223	\$59,195,542	\$17,069,781

NOTE: Beginning in 2010, doctors of osteopathic medicine (D.O.) were allowed to participate in the Program and D.O. licensees were assessed the same \$25 assessment. Thus, in the above chart, the figures for some years have identified D.O. awards. Further, during the March 2011 cycle, the program partnered with the California State Loan Repayment Program (SLRP). The Foundation was able to award an additional \$969,571 by leveraging federal funds from the American Reinvestment and Recovery Act. Twenty individuals received funding from the combined funding sources.

Staff reported at the May 2012 Board meeting on the retention rate of the first three years of awardees. During those three years awards were granted to 69 recipients. Based upon research of current work locations of those individuals, it is believed that about 39% of the awardees, or 27, are still working at the same practice site where they were working when they received the award and 24

of them, 35%, are working at other practices sites that are believed to be eligible under the program, for a total of 74% working in underserved areas. Eighteen of the awardees, or 26%, have moved on to other sites, some to faculty positions at various medical schools around the country, and others to hospital sites in California.

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). Per B&P Code sections 2065 and 2066, these unlicensed trainees must be licensed once they have reached a certain point in their post-graduate career. For most unlicensed trainees, that date is June 30, the traditional end-date of the 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 for the patients. Although the Board has not conducted an assessment on the impact of licensing delays, staff's frequent contact with representatives of hospitals, teaching programs, professional groups, etc., regularly make the Board aware of the implications of licensing delays.

During the past decade, the Board has maintained informal communications with the Graduate Medical Education (GME) staff and with physician recruiters at the major teaching hospitals about the application status of their trainees. While Board staff could not share any confidential information about the status of an application, they would work with hospital staff so they could encourage their applicants to respond to the Board once deficiencies in the file were identified.

About five 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. It also forced the hospitals to become aware of their own staff's licensing requirements. This new collaboration has become a landmark-opportunity that benefits applicants, their employers, and the Board. The Board has identified one executive-level manager whose primary function is to act as liaison between the Board and hospital GME staff to build and facilitate improved communications and customer service.

Despite this improved customer service, the Board has experienced a cyclical backlog of applications for physician's licenses. The most severe backlog was experienced during late 2008 through 2009. This backlog was unacceptable to the Board as it delayed physicians' ability to practice medicine and it limited access to care for patients. While some of the causes were beyond the Board's control – across-the-board budget cuts, the on-going furlough program which caused a 12% loss in productivity, a steadily-increasing number of license applications—the Board recognized more improvements needed to be identified and implemented.

In 2009, the Board hired a consultant to identify improvements in the Licensing Program to increase process efficiencies, facilitate consistent and continued statutory and regulatory compliance, and improve focus on customer service. The scope of the study included not only the licensing and

renewal process, but also the ancillary units that support the licensing process. Business process maps were developed, current processes and workloads were observed, and recommendations were developed to meet the objectives of the study. At the end of the study, an implementation plan was developed and presented to the Board. See the Hubbert Systems Consulting Report: [Creating a Sustainable Licensing Program, Medical Board of California, Physician and Surgeon Licensing and Information Center, Business Process Reengineering Study.](#)

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). Management has set a goal of keeping the review time to 45 calendar days or less, half the regulatory timeframe. Since January 2011, the Board has met this goal approximately 80% 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 52 calendar days. Some of these improvements come from the implementation of recommendations from the aforementioned study.

Board's Efforts to Inform Potential Licensees of Licensing Requirements/Process

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.

In 2010, with the encouragement of the Board Members, the Board's Executive Director elevated the licensing education and outreach program to an executive-level function of the Board. 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 near-by entities that could benefit, 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 near-by 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.

In previous years, there has been a significant increase of applicants for whom the review process was problematic. As with society in general, applicants are showing an increasing evidence of 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.

The Board had this travel approved as mission critical. Annually, it is estimated that over 2,200 applicants have had a face-to-face meeting with the outreach manager, 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.

Although the Board believes this function, thus the travel, is mission critical, it has not been so deemed and therefore, pursuant to the Governor's Executive Order regarding travel restrictions, the Board cannot travel to these orientation sessions.

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, and Loma Linda.

This outreach (primarily the review of applications before they are submitted, providing an explanation of what other criminal-history, training, educational, related 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. In the last two years, due to the extensive outreach in 2010 and 2011, **the Board did not have to perform any overtime hours to ensure that those needing licensure were licensed by June 30.** Again, the Board equates this to 1) the significant education of staff and applicants at health care facilities and 2) the availability of the Board's education and outreach program manager to attend licensing events at which applications are reviewed, questions were answered, and applicants were informed of the need for timely submittal of applications.

Simply stated, the costs of supporting this education and outreach program are significantly less than the costs of the overtime hours spent in past years by the Board's Licensing Program.

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 Health 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's most comprehensive survey was statutorily mandated, effective January 1, 2002. The Board was required to collect and publish characteristics for each licensee. The required information included data on years of postgraduate training; time spent in clinical work, teaching, research, and administration; practice areas; and board certification. The race/ethnicity and foreign language questions were optional but equally important in efforts to examine physician demographics.

The survey is part of the physician renewal process. It 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 HealthCare 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.

In Fall 2008, CHCF sponsored a briefing at which the preliminary findings were presented, assessing the supply and geographic distribution of primary care and specialists in California. There was also a comparison of findings from previous studies. More than 90% of physicians had fully completed the survey. The data collected by the Board shows that previous studies have significantly overestimated California's reality: the overall supply of MD physicians in the state is 17% lower than that estimated by the American Medical Association (AMA). Further, of active patient care physicians in California, 34% were in primary care, which is 20% fewer than the estimate from AMA data. The study also identified significant variation in the per capita distribution of physicians across the counties. For the full report, see: <http://www.chcf.org/publications/2009/06/fewer-and-more-specialized--a-new-assessment-of-physician-supply-in-california>

Other reports of interest might be: http://www.futurehealth.ucsf.edu/Content/29/2008-05_Diversity_in_Californias_Health_Professions_Physicians.pdf and http://futurehealth.ucsf.edu/Content/29/2008-03_MD_Diversity_in_CA_New_Findings_from_the_CA_Med_Board_Survey.pdf

Most recently, CHCF published a report on California physicians' experience with electronic health records (EHRs) in 2011. The report summarizes findings from a survey that a team of researchers at the University of California, San Francisco conducted in partnership with the Board. The survey found that EHRs are used widely by California physicians, but many of their systems are not designed to meet new federal standards aimed at improving the quality of health care. Seventeen percent of California physicians are likely to be eligible for Medi-Cal incentive payments for meaningful use of EHRs. To download a copy of the report, go to <http://www.chcf.org/publications/2012/06/meaningful-use-ehrs-physicians>

Section 9

Current Issues

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



Status of Uniform Standards for Substance Abusing Licensees

The Executive Director of the Board served as a member of the Substance Abuse Coordination Committee which participated in the development of the Uniform Standards for Substance Abuse Healing Arts Licensees. The Board's implementation strategy consisted of analyzing the standards to determine which could be implemented through Board policy changes, which required modification to the Board's Manual of Model Disciplinary Orders and Disciplinary Guidelines, or which ones required legislation.

The Board's Diversion Program was eliminated in June 2008. Therefore, 8 of the 16 uniform standards relating to monitoring licensees in a recovery or diversion program were not applicable. In 2011, the Board updated the Manual of Model Disciplinary Orders and Disciplinary Guidelines through the regulatory process to conform to the applicable uniform standards. The main changes that were required focused on the biological fluid testing requirements. After passage of legislation, modifications were needed to provide the Board with the authority to remove a physician from practice or issue a "cease practice" order when a "positive" biological fluid test was identified in order to conform to Uniform Standard 2, 8, and 9. The Board's existing guidelines authorized the Board to obtain a medical or psychiatric evaluation whenever the Board deemed it necessary. Policy changes were made to include an evaluation by an addiction medicine specialist at any point during the probationary period in order to conform with Uniform Standard 1 and 2.

The Board's Disciplinary Guidelines were approved by the Office of Administrative Law in December 2011 and became effective in January 2012.

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 suggestions with 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 pursuant to B&P Code section 2224. The Board's Executive Director also has the authority to adopt a default decision. 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 statute if it tried to mandate revocation 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 section 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 could 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)).
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 Codes section 802.1.

BreEZe

The Board has spent a significant amount of hours participating in the development of BreEZe. The Board's Deputy Director is the Board and Bureau sponsor of the BreEZe Project. She has spent countless hours managing, monitoring and making decisions on critical issues for the project including serving on the Change Control Board and the Executive Steering Committee. The Board's ISB staff has contributed huge amounts of time on the project and has worked alongside the vendors since the early stages of the project. The Board's licensing and enforcement staff has assisted in the project by serving on various committees, work groups, and data verification and testing groups.

In 2010, the Board spent 1,751 hours on the BreEZe project. Two Board staff members were participating in a data conversation workgroup while five ISB staff members performed 1,720 hours of service to the project serving as subject matter experts assigned to assist with system requirements. Twenty-seven Board staff contributed to the project in 2011. The ISB provided 2,852 hours of the 3,255 total hours spent on the project during 2011. Two Board staff members began serving on the forms committee that is charged with standardizing the forms that will be part of the new system. Board staff continued on the project in 2012 and as of October 1, 2012 the Board has spent 5,125 hours on the project. So far, the Board has spent a total of 10,131 hours on the Breeze project. The Board has eight staff who will be providing training on the BreEZe system during the last two months of 2012 and into 2013.

Section 10

Board Action and Response to Prior Sunset Issues

- Prior Sunset Issues (12)



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 2005 Sunset Review. The recommendation is the response from the Sunset Review Committee itself. The comments section is the background on why the issue arose, or in many cases, the issues raised in the Enforcement Monitor's Reports. The Board Action and Response (2012) includes the actions taken since the 2005 Sunset Review to address the issue raised, or what has not been addressed.

ISSUE #1 (2005):

Should the licensing and regulation of physicians be continued by an independent board rather than by a bureau under the Department?

Recommendation (2005): The Joint Committee recommends that the Medical Board of California should be continued for another four years, and that some key changes must be implemented to assure the Board is able to continue with its consumer protection role.

Comments (2005): An exhaustive sunset review in 2002 revealed numerous and significant problems with the Board's enforcement and public disclosure practices. The Legislature responded by enacting SB 1950 (Figueora). The Department selected Julie D'Angelo Fellmeth of the Center for Public Interest Law as the Enforcement Monitor (Monitor), and chose Tom Papageorge of the Los Angeles District Attorney's Office as the Principal Consultant. SB 1950 also required the Board to undergo sunset review again in 2005.

In November of 2004, the Monitor issued its 294 page "*Initial Report: Medical Board of California Enforcement Program Monitor*". The Report identified serious and ongoing deficiencies in the Board's enforcement program and serious and ongoing deficiencies in the Board's related "diversion" program, which was designed to rehabilitate physicians with drug or alcohol problems. The Report suggested that the Board should be continued. However, it made 65 specific recommendations, a number of which were appropriate for Legislative consideration in 2005.

Board Action and Response (2012): The Board has implemented key changes to ensure its ability to continue with its consumer protection role. Senate Bill 231 (Figueroa, Chapter 674, Statutes of 2005) enacted changes to the Board as recommended by the Enforcement Monitor. Some of these changes are discussed in the items below. The Board was reauthorized for four years, then that was extended due to legislative workload until this sunset period.

ISSUE #2 (2005): Should the Medical Board be given authority to raise its licensing fees?

Recommendation (2005): The Board should be authorized to raise its fees to a level that will address its ongoing budget problems, and bring its staffing at least to the level it had in 2000 to allow the Board's enforcement unit to fulfill the public protection function that is its chief mission.

Comments (2005): Physicians pay only \$300 per year in licensing fees (\$600 biennial fee), and have since 1994. The Board is funded from physician license fees, and a few other funding from the licensees (such as fines). It receives no money from California's General Fund. Since 1994, the

Consumer Price Index has increased by 27.9%, which alone would justify fees at about \$382 a year (or a \$764 biennial fee), just so the Board could keep up with the ordinary cost of living -- not to mention higher wages for its employees. (*Report*, pp. 64-65)

Not only is the Board hobbled by fees that are lower in real terms than they were ten years ago, the Board's enforcement program is further affected because of the lasting effects of the statewide hiring freeze. The hiring freeze was imposed on the Board and all of state government by the Governor from 2001-03, and forced the Board in particular to lose almost 45 positions, *including 29 in its enforcement program alone*. This was supposedly justified because the state's General Fund faced serious and continuing deficits. This was applied to the Board even though the Board obtains no funds from the General Fund.

The freeze did give the Board an unintended – and fleeting – financial reprieve. With its dramatically declining budget reserves caused by static fees but rising inflation and workloads, the Board's inability to fill vacancies was akin to obtaining an unexpected source of revenue. This, in turn, allowed the Board to pay increases in the hourly rates charged by the AG's office, which have increased from \$112 per hour to \$139 per hour as of July, 2004, and will increase to \$146 per hour in July of 2005. This means the Board's expenses for case prosecution will increase from \$6.9 million in 2003-04 to approximately \$8.2 million in 2004-05, to \$8.7 million in 2005-06.

The Board's declining revenues now need to be addressed. The Department has officially informed the Board that it is headed for severe and increasing deficits, and must address the situation as soon as possible.

Board Action and Response (2012): SB 231 authorized the Board to increase physician licensing fees. Effective January 2006, physicians' initial license and biennial renewal fees were increased from \$600 to \$790. The fee increase was a key recommendation from the Enforcement Monitor's initial report. This fee increase has addressed the Board's budget problems and enhanced its ability to add staff to the enforcement unit thereby strengthening its public protection mission.

The fee was decreased to \$783 in 2009 when the Diversion Program was eliminated from the Board. The current total fee received is \$808, however, this includes a \$25 mandatory fee for the Physician Loan Repayment Program.

There is no current need to raise fees because when the fund condition is at a level lower than the minimum required, the Board will request that the loans to the General Fund be repaid.

ISSUE #3 (2005): Should the Medical Board be given authority to work with the Health Quality Enforcement Unit in the AG's office to coordinate investigation and prosecution functions?

Recommendation (2005): The Board should be authorized to work with the AG's office and the DCA, and to implement Vertical Prosecution. Any program that is developed should be monitored closely by the board and by this Committee to make sure it is achieving the results that are anticipated.

Comments (2005): Many state agencies and most federal agencies, with great success, require lawyers to work as a team with investigators. This is called “Vertical Prosecution.” In contrast, the Board has investigators work up cases by themselves, with occasional review by lawyers. When the investigator believes the case is ready, it is “handed off” to the prosecuting lawyers (DAGs), who then must address any legal issues the investigator might have left undone.

Vertical prosecution teams, in contrast, allow lawyers and investigators to view each case as a *whole*, rather than as two separate and independent sequential steps: the investigation and then the prosecution. The problem is an obvious one to anyone who practices this kind of law – investigating a case and litigating a case are not independent at all. The two are entirely interrelated and interdependent.

The Report clearly and repeatedly recommends implementation of a Vertical Prosecution Model. However, since this concept will be a significant departure from existing practice, it is important to assure that the advantages of the new system be monitored closely.

Board Action and Response (2012): In 2006, the Board began using a Vertical Enforcement and Prosecution (VE/P) model enacted by SB 231. Under this model, each complaint that is referred to a Board’s district office for investigation is simultaneously and jointly assigned to a Board investigator and a DAG from the AG’s Office. This team approach encourages early coordination and faster decisions, filings, and results. In the prior enforcement model, Board investigators would collect evidence and turn the case over to the AG’s Office for review and consideration of the filing of an accusation. The goal of this new model is to increase public protection by improving coordination and teamwork, increasing efficiency, and reducing investigative completion delays.

A version of SB 231 had included a provision to transfer Board investigators to the DOJ to streamline and centralize the enforcement system. The bill was amended to delete this provision. SB 231 instead created a pilot model under which investigators continued to be employed and supervised by Board staff but were also responsible for conducting investigations under the direction of the DAGs. This pilot model has been extended by the Legislature several times and there have been a number of reports on the VE/P model since its inception. There was a report to the legislature in 2007, 2009 and 2012 on the effectiveness of the model. The March 2012 report gives a status on the progress of implementing various recommendations to strengthen the program; although it is not a detailed analysis, one is due to the Legislature in Spring 2013.

ISSUE #4 (2005): Should the Medical Board crack down on physicians who improperly withhold records from the Medical Board?

Recommendation (2005): Physicians cannot be allowed any longer to flout the law; the Board must enforce existing law, and should be given additional tools to assure that investigations can commence in a timely manner.

Comments (2005): By statute (B&P Code section 2225), physicians have 15 days from the time they receive a patient’s signed release to turn those medical records over to the Board for its investigation of complaints. Physicians routinely flout this legal mandate, and suffer almost no consequences at all for such law-breaking.

The average time it takes to get medical records is astonishing, given what the law requires. The Board's CCU takes 66 days, on average – *over four times the legal limit* – to obtain the records it needs to adequately assess the complaints the Board receives. If a complaint then goes to a full investigation, it takes – again, on average – *74 additional days* – to get the certified records necessary for a full and proper investigation. Thus, it takes an average of 140 days for the Board *just to get appropriate medical records* – when the goal set in statute for the *complete investigation* is 180 days.

A core part of the problem is that the Board routinely elects not to enforce the 15 day limit, instead resorting to repeated cajoling. This problem can and should be fixed immediately. Because neither investigations nor disciplinary proceedings can (or should) begin without the full medical record having been reviewed, the 15 day legal limit is the foundation of the Board's entire enforcement program. The Report recommends that the Board enforce existing law requiring doctors to turn over medical records a patient has authorized the Board to review.

Board Action and Response (2012): AB 1070 Hill (Chapter 505, Statutes of 2009) required all medical records requested by the Board be certified. This has eliminated the need for the Board to request records a second time when the initial records received were not certified. The Board continues to work on shortening the time frame to obtain records and analyze the success of this legislation.

A joint statewide training for all DAGs and Board investigators was held in April 2011. The training included techniques for promptly acquiring medical records. "Medical Records Acquisition for the Investigator and Prosecutor" was presented by the Board's Deputy Chief of Enforcement and several DAGs. This presentation emphasized successful techniques and the importance of obtaining medical records in a timely manner. Also, the revision to the VE/P manual in July 2011 included enhancements to further spell out the expectations of the VE/P process. Specifically, a section was added to specify the expected time frame by which an investigatory task should be completed. With regard to obtaining medical records, an investigator is expected to request medical records within seven (7) business days of receiving a patient's authorization to obtain records. If the patient release is not received, the Board will seek a subpoena for those records within seven (7) business days.

ISSUE #5 (2005): Should the Notice of Intent requirement be replaced with something more helpful to the Board?

Recommendation (2005): Code of Civil Procedure section 364.1 should be eliminated and replaced with a more effective provision.

Comments (2005): B&P Code section 364.1 requires attorneys who wish to file a malpractice action against a physician to file a notice with the Board of their intent. The notices filed, however, have proved unhelpful to the Board. Often, they are so vague, broad, or lacking in specifics they fail to assist the Board in knowing whether a particular case might have some allegations worth pursuing. It would be more helpful to the Board to require its own licensees to notify the Board whenever they are the subject of a malpractice case. The Board would, itself, have jurisdiction to discipline noncompliance with this provision, unlike the current provision.

Board Action and Response (2012): SB 231 repealed section 364.1 of the Code of Civil Procedure because this provision did not provide useful information to the Board. The legislation did not address physicians supplying this information instead of legal counsel.

ISSUE #6 (2005): Should physicians be required to report to the Board malpractice judgments against them?

Recommendation (2005): B&P Code section 802 should be amended to include judgments.

Comments (2005): B&P Code section 802 requires physicians to report settlements and arbitration awards against them, but not actual judgments. There appears to be no sound reason for this distinction.

Board Action and Response (2012): SB 231 amended B&P Code section 802 to include the requirement that physicians report judgments against them not just settlements and arbitrations awards. The Board posts this information in its Web site.

ISSUE #7 (2005): Should physicians be required to report to the Board misdemeanor convictions against them if the misdemeanor is substantially related to the qualifications, functions, or duties of a physician?

Recommendation (2005): B&P Code section 802.1 should be amended to require physicians to report misdemeanor convictions against them that are substantially related to the qualifications, functions or duties of a physician. The Board should then promulgate appropriate regulations to implement this provision.

Comments (2005): B&P Code section 802.1 requires physicians to report certain criminal actions against them, but does not include misdemeanors. While a number of potential misdemeanors may have no connection to a physician's ability to practice medicine, some do – including misdemeanors related to concealing information from patients. The threshold of such reporting should be fairly high, and the Monitor suggested reporting misdemeanors that are “substantially related to the qualifications, functions, or duties of a physician.”

Board Action and Response (2012): SB 231 amended section 802.1 to require a physician to report misdemeanors that are substantially related to the qualifications, functions, or duties of a physician. SB 1438 Figueroa (Chapter 223, Statutes of 2006) was a clean-up bill to SB 231 and further amended section 802.1. The rationale was that it would be easier to have the licensees report all misdemeanor convictions and the Board would conduct a review to determine if the convictions are substantially related to the qualifications, functions, or duties of a physician.

SB 1438 specified a physician shall report certain actions, including the bringing of an indictment or information charging a felony against the licensee, the conviction of any felony, and the conviction of any misdemeanor.

ISSUE #8 (2005): Should the Board's venue statutes be amended to reduce the amount of "forum shopping" that defense attorneys engage in?

Recommendation (2005): B&P Code section 2019 and Government Code section 11508 should be amended to minimize the problem of forum shopping.

Comments (2005): B&P Code section 2019 and Government Code section 11508 provide for venue of administrative and court matters relating to the Board. However, both statutes permit defense attorneys to "forum shop" which is the ability to look around the state for judges the defense feels will be favorable to their side. Thus, cases that originated in Sacramento may wind up being heard in San Diego (or vice versa) because an attorney believes the courts or a particular judge will be more likely to rule for the licensee. This is both unfair and highly inconvenient.

Board Action and Response (2012): SB 231 amended Government Code section 11508 to minimize the problem of forum shopping. Government Code section 11508 now requires hearings on Board matters be conducted in Sacramento, Oakland, Los Angeles, or San Diego, depending on which facility is closest to the location where the transaction occurred or the respondent resides. This can only be changed upon agreement with both parties.

ISSUE #9 (2005): Should the typographical error in B&P Code section 2027 be fixed?

Recommendation: B&P Code section 2027 (a)(2) should be amended to fix the typographical error.

Comments (2005): In a recent case from the Court of Appeals, a typographical error in B&P Code section 2027 (a)(2) nearly caused the Board to lose a case. The language in a bill accidentally changed an "or" to "of", a seemingly innocuous change that could be read to suggest the Board does not have authority to post information about its own licensees when the Board, itself, has disciplined them. The court ultimately ruled in favor of the Board, but this should be rectified in the statute itself.

Board Action and Response (2012): SB 231 amended B&P Code section 2027(a)(2) to make it clear that the Board does have this authority.

ISSUE #10 (2005): Should the Little Hoover Commission be requested to conduct a study on the public policy of disclosure of malpractice lawsuits and settlements against physicians?

Recommendation (2005): The Little Hoover Commission (Commission) should be asked to study the public policy implications of the laws requiring public disclosure of malpractice lawsuits and settlements against the Board's licensees.

Comments (2005): There has been discussion and controversy about the importance of the public being aware of malpractice cases against physicians. SB 1950 required greater disclosure, but there are some questions about the effectiveness of this new law. The well respected Commission could conduct an objective study of this issue, to determine how effective the state's current disclosure policy is, and whether it should be amended.

Board Action and Response (2012): SB 231 added B&P Code section 2026 that specified the Commission conduct a study and make recommendations on the role of public disclosure in the public protection mandate of the Board. The study was to be conducted provided that funds were available to reimburse the Commission for its work and should have been completed no later than July 1, 2008. SB 1438 then repealed and amended B&P Code section 2026. This new section specified that the California Research Bureau (CRB) of the California State Library conduct the study and consider whether the public is adequately informed about physician misconduct by the current laws and regulations providing for disclosure.

The study was completed November 2008 and is available on the Board's Web site under the title, [Physician Misconduct and Public Disclosure Practices at the Medical Board of California](#). It offered 11 policy options for improving public access to information about physician misconduct. Although some of the options required legislation to implement, a couple of them were implemented without legislation. For example, the Board expanded the physician profile to include items from the physician survey including board certification. A regulation was adopted in 2010 that requires a physician inform consumers where to go for information or where to file a complaint about California physicians.

ISSUE #11 (2005): Should the Legislature's command that the Board conduct a study of hospital peer review be carried out?

Recommendation (2005): Section 805.2 of the B&P Code should be amended to require completion of this peer review study that was authorized in 2002, and place it among the Board's highest priorities.

Comments (2005): In B&P Code section 805.2, the Legislature required the Board to conduct a study of peer review reporting. That study was to be completed by November 1, 2003. It has not yet been conducted, because of the severe budgetary condition of the Board. Part of the fee increase included in SB 231 should be earmarked specifically to conduct this study, which has a core importance for the Board and the Legislature.

Board Action and Response (2012): SB 231 amended B&P Code section 805.2 to require a comprehensive study of the peer review process as it is conducted by peer review bodies defined in paragraph (1) of subdivision (a) of section 805, in order to evaluate the continuing validity of section 805 and sections 809 to 809.8, inclusive, and their relevance to the conduct of peer review in California. The Board contracted with Lumetra, a healthcare solutions company, to conduct the study. The July 2008 final report of the study is posted at the Board's Web site under, [Peer Review in California Final Report, Comprehensive Study](#). The report offered many recommendations of which most, if not all, would require legislation to implement. The report suggested redesigning the peer review process and creating an independent review organization; Board posting of any action recommended by the independent organization on its Web site; and revising the role of the Board in the review process, including giving the responsibility of the 809 hearing to the Board.

SB 700 (Negrete McLeod, Chapter 505, Statutes 2010) made enhancements to the peer review system related to the Board and oversight by the California Department of Public Health. This bill added a definition of peer review and allows the Board to obtain peer review minutes or reports.

Further, it requires the Board to post a fact sheet that explains and provides information on 805 reporting. This fact sheet can be found on the Board's Web site in the forms section under the heading "mandatory reporting": http://www.mbc.ca.gov/forms/805_factsheet.pdf.

ISSUE #12 (2005): Should the Board's Diversion Program for physicians with substance abuse problems be reviewed by the Bureau of State Audits?

Recommendation (2005): Request the Bureau of State Audits be charged with a full review of the Board's Diversion Program.

Comments (2005): Rather than discipline physicians with substance abuse problems, the Board allows them to enter a Diversion Program to try and address their problem. The Board's position is one of compassion to the affected physicians, since it attempts to allow them to work on curing the problem they have without being disciplined by the Board. Because of chronic understaffing and a budget that barely qualifies as adequate, the Board's Diversion Program presents serious questions of public safety. The Enforcement Monitor devoted an entire chapter to this single aspect of the Board, and found numerous problems: the program's most important monitoring functions are failing; urine testing is easy to evade, recordkeeping is spotty at best, and contractors who perform these tasks are far from consistent; the program is understaffed and dramatically underfunded, demonstrated by a 22% increase in participants, and no increase in staff; caseworkers who are supposed to be monitoring physicians are overloaded, and frequently do not keep up; and the program lacks clear and enforceable rules. The Monitor specifically recommended that the Bureau of State Audits be charged with a full review of the Diversion Program.

Board Action and Response (2012): SB 231 specified that the Legislature would request the Bureau of State Audits (BSA) conduct a thorough performance audit of the Board's Diversion Program. BSA conducted the audit in 2007 and evaluated the effectiveness of the Program and made recommendations regarding its continuation. The report is available on the Board's Web site under the title [Diversion Audit Report](#) — June 2007. The report concluded that although the Diversion Program made a number of improvements since the enforcement monitor's final report, it must continue to improve its performance and procedures in some specific areas to adequately protect the public. The following are recommendations from the report:

- To better monitor Diversion Program participants, Program management should create mechanisms to ensure that group facilitators, therapists, and work-site monitors submit required reports, and that the participants submit required meeting verifications.
- To ensure a timely and adequate response to positive drug tests or other indications of a relapse, the Diversion Program should do the following:
 - Immediately remove practicing physicians from work when notified of a positive drug test;
 - Require evaluation committees to provide justification when they determine that a positive drug test does not constitute a relapse; and
 - Have a qualified medical review officer evaluate all disputed drug test results if its new advisory committee determines that this action is needed.

- To provide adequate oversight of participants' random drug tests, the Diversion Program should ensure that both the case manager and group facilitator approve all vacation requests and should establish a more timely and effective reconciliation of scheduled drug tests to actual drug tests performed by comparing the calendar of randomly generated assigned dates to the lab results.
- To ensure that it adequately oversees its collectors, group facilitators, and Diversion Evaluation Committee Members, the Diversion Program should formally evaluate the performance of these individuals annually.
- To effectively oversee the Diversion Program, the Board should require it to create a reporting process that allows the Board to view each critical component of the program.
- To ensure that it adequately oversees the Diversion Program, the Board should have its Diversion Committee review and approve the Program's policy manual. Thereafter, the Diversion Committee should ensure that any policy change it approves is added to the manual.
- The Board should ensure that areas of program improvement recommended by the enforcement monitor are completed within the next six months.

SB 761 (Ridley-Thomas) was the vehicle to extend the dates of the Board's Diversion Program from January 1, 2009 through January 1, 2011. The Board took a position not to sponsor extension of the Program. This bill did not pass out of the Legislature. With no legislation to extend the Diversion Program, a transition plan was established. The plan identified the different groups of program participants and determined a course of action for each group following sunset of the Diversion Program. On July 1, 2008, the laws for the Diversion Program became inoperative and later repealed. The Board no longer has a Diversion Program.

Section 11

New Issues

- Licensing Program Enhancements (7)
- Enforcement Program/Consumer Protection Enhancements (8)
- Overall Program Enhancements (3)



The Board has developed 18 issues that it believes the Legislature should consider in its examination of the continuing authorization of the Board.

These issues are discussed in detail on the following pages, but are grouped below for easy reference.

Licensing Program Enhancements

Ensure the laws are written to accommodate the continuing evolution of medical training and testing in the United States and Worldwide.

1. Revise laws to allow for the changes that will take place in the USMLE Step examination process, specifically to address the Step 3 migration into two parts with two separate examination scores.
2. Revise laws to allow for the evolving method of teaching medical students in year round classes with shortened academic year requirements, in competency-based training methods, and in allowing for training in various settings other than hospital-based training.
3. Direct the Board to continue its study of Maintenance of Licensure and propose an approach at the next Sunset Review.
4. Revise the laws regarding re-entry into medical practice and licensure after a period of non-practice to ensure public protection.
5. Require that licensees provide and keep current, an email address for notifications.
6. Eliminate the requirement for the Board to post on its Web site postgraduate training information.
7. Revise laws to clarify that residents in accredited resident/fellowship programs in California are exempt from corporate practice laws.

Enforcement/Consumer Protection Enhancements

Ensure laws are written to provide enhanced consumer protection related to prescription drug use.

1. Require coroners to report all deaths related to prescription drug use to allow the Board to evaluate the incident and determine if there is a prescribing issue that needs to be investigated.
2. Identify an appropriate funding source to provide the basic computer enhancements and necessary support of the CURES system for real-time access for all potential users of the system.

Ensure laws are written to provide enhanced consumer protection.

1. Exclude 801.01, malpractice reports, from the up-front expert review, and send them directly to review and investigation.
2. Require the establishment, by regulation, of the knowledge, training, and ability a physician must possess to provide supervision of other health care providers and define "physician availability" in all clinical settings.
3. Require that health facilities with EHRs produce patient records within 15 days.
4. Require CDPH and other accrediting agencies to send reportable peer review, found during an inspection, or a report on the lack of peer review, directly to the Board.
5. Remove the requirement to eliminate the posting of Board actions that are over 10 years old.
6. Require the production of the respondent's expert report, setting deadlines for production of the report further from the hearing date, and defining a specific date for the commencement of the hearing.

Overall Program Enhancements

1. Consider the elimination of the Board approving specialty boards equivalent to the ABMS, grandfathering those that are currently recognized as approved for advertising purposes.
2. Consider transferring oversight of the RDO program to a to-be-determined appropriate agency or board. (See RDO Program Section 11, New Issues, Appendix III.)
3. Consider addressing the ongoing issues related to Midwifery, including supervision, access to medical devices and drugs necessary for the profession, and students/apprenticeships and assistants. (See Midwifery Program Section 11, New Issues, Appendix I.)

United States Medical Licensing Examination Step 3 Change

The U.S. and its territories have individual medical licensing authorities, commonly known as “state medical boards”, which set their own rules, regulations and requirements for passage of examinations to demonstrate an applicant’s qualifications for medical licensure. The Board receives examination results from the USMLE program, which is used to determine if an individual will be granted licensure to practice medicine in California.

The USMLE, although designed in the late-1980s, was not introduced until the early 1990s. The examination marked advancement to a single, uniform process for assessment of knowledge and skills related to the practice of medicine. The USMLE replaced two previous medical licensing examination programs and became the sole medical licensing examination entity.

The USMLE administers a three-step examination, which is sponsored by the FSMB and the NBME. The examination assesses the ability to apply knowledge, concepts and principles; to demonstrate fundamental patient-centered skills; and to determine the basis of safe and effective patient medical care. Each of the three steps is designed to complement each other, and none of the steps can stand alone in the assessment of an examinee’s readiness for medical licensure. Aggregated, the three steps are intended to certify to the respective medical board licensing authorities, that successful candidates have demonstrated the minimum knowledge and skills for initial licensure.

The examination consists of 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; and,
- Step 3: Focuses primarily on the knowledge and understanding of the biomedical and clinical science essential for the unsupervised, general practice of medicine.

The evolution of medical advancements as well as shifts in medical practice and education have required changes to the format delivery and content of the examinations. However, the original three-step concept remains intact. In 1999, a major change was made to the examination format delivery, which transitioned from paper-based delivery to computer delivery. In 2004, a standardized patient examination was introduced as a component of Step 2. The focus and overall structure of the step examinations have remained relatively unchanged.

The USMLE Composite Committee and its parent organizations, the FSMB and 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”. No timeline has been addressed for Steps 1 and 2 changes. 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. The new Step 3 examination is described as:

“The first exam is expected to focus on whether an examinee possesses the knowledge essential to the independent practice of medicine, including a comprehensive knowledge of both foundational science and clinical medicine. The second exam will assess an examinee’s ability to apply knowledge in the context of patient management, including demonstration of comprehensive knowledge of health and disease, and their impact on patients. The second exam will also require a demonstration of evidence-based medicine and quantitative reasoning skills important to patient care and to life-long learning.”

Although the proposed concept states an examinee must pass both of the Step 3 examinations to be considered for licensure, it is not yet known if there will be a prerequisite to pass the first day in order to take the second day.

Step 3 of the USMLE will remain known as Step 3; however, it will be a two-part examination as described herein. It is not known if there will be a designation such as Step 3A or Step 3 Day One. B&P Code section 2177 reads as follows and may require changes in subsection (c) through legislative action to ensure the new testing format is addressed.

B&P Code section 2177

(a) A passing score is required for an entire examination or for each part of an examination, as established by resolution of the board.

(b) Applicants may elect to take the written examinations conducted or accepted by the board in separate parts.

(c)(1) An applicant shall have obtained a passing score on Step 3 of the United States Medical Licensing Examination within not more than four attempts in order to be eligible for a physician's and surgeon's certificate.

(2) Notwithstanding paragraph (1), an applicant who obtains a passing score on Step 3 of the United States Medical Licensing Examination in more than four attempts and who meets the requirements of section 2135.5 shall be eligible to be considered for issuance of a physician's and surgeon's certificate.

CCR section 1328 may also require changes by the Board to ensure aspects of the new testing steps are addressed.

The Board recommends that the language of B&P Code section 2177 be written to accommodate two parts of the Step 3 examination, and any new evolving examination requirement.

Accelerated Track and Competency-Based Medical School Programs

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 (also known as family physicians, pediatricians, and family practitioners). National health care reform, known as the Affordable Care Act (ACA) contains provisions to relieve the projected shortage of primary care professionals. Combined with the Prevention and Public Health Fund and the American Recovery and Reinvestment Act, the ACA will provide for the training, development and placement of more than 16,000 primary care providers, including physicians, over the next five years.

A significant deterrent to become 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 approximately \$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 three-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.

Texas Tech University Health Sciences Center School of Medicine offers a Family Medicine Accelerated Track (F-MAT) curriculum which provides 10-12 medical students the opportunity to obtain a medical degree in three years with 149 contact weeks, as opposed to a traditional four-year program of 160 weeks. In addition, the F-MAT does not require the medical school student to pass USMLE Step 2CS prior to graduation, unlike most LCME accredited medical schools. However, the F-MAT students will be required to pass USMLE Step 2CS during their first year of postgraduate training. Normally, LCME accredited medical school graduates are required to pass USMLE Step 2CS as a graduation requirement and need to pass USMLE Step 3 during residency training.

The F-MAT also has an incentive program where students are given a scholarship in their first year. It is estimated that approximately \$50,000 can be saved by the student in an accelerated three-year program. This is a substantial economic incentive to a potential medical student.

In addition, other medical schools are proposing competency-based tracks for students that excel and can progress at a faster rate than the standard four-year program. Other programs may 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 Board is unable to determine if these accelerated programs meet the requirements pursuant to B&P Code sections 2089 – 2091.2.

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

Specifically:

- Section 2089(a) mandates *“a medical curriculum extending over a period of at least four academic years, or 32 months of actual instruction.....the total number of hours of all courses shall consist of a minimum of 4,000 hours. At least 80% of actual attendance shall be required”*.
- Section 2089.5(b) mandates *“instruction in the clinical courses shall total a minimum of 72 weeks in length”*.
- Section 2089.5(c) mandates *“instruction in the core clinical courses of surgery, medicine, family medicine, pediatrics, obstetrics and gynecology, and psychiatry shall total a minimum of 40 weeks in length, with a minimum of eight weeks in pediatrics, six weeks in obstetrics and gynecology, a minimum of four weeks in family medicine and four weeks in psychiatry”*.
- Section 2089.5(d) mandates *“of the instruction.....54 weeks shall be performed in a hospital that sponsors the instruction.....”*

With the immediate need for a significant increase in the number of primary care physicians, in addition to the driving force of accessible and affordable medical care that resulted in the ACA, it may be prudent to conduct a review of the aforementioned statutes to determine if increased Board discretion and flexibility is needed so that an LCME-accredited accelerated medical degree curriculum could satisfy the qualifications for licensure. There is recognition that these professional education programs would presumably boost primary care availability, and potentially increase medical care availability in the underserved areas of California, such as remote and rural communities.

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 be allowed to evolve with the practice.

The Board 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.

Maintenance of Licensure

For over a decade, the Board has been discussing the continuing competence and requalification of its licensees and the re-entry process for those who have not been practicing. To date, no viable resolution has been identified.

Past Efforts

The Board's Post-Licensure Assessment Committee (PLAC) began in early 1997 as the Committee on Physician Requalification, with initial plans for a decennial requalification process for all licensees. As the PLAC Members determined that requalification via examination was not a feasible reality, the name was changed to Post-Licensure Assessment to more accurately define the "new" purpose of the Committee.

In early discussions, it was recognized that while both the Physician Assessment and Clinical Education Program (PACE, in San Diego) and the Post-Licensure Assessment System (PLAS, in Denver) would be valuable assessment tools, it was too expensive to ask all physicians to participate in these programs as a requalification method. PLAS is a joint program of the FSMB and the NBME and was established in 1998. With all the efforts put forth in creating PLAS, there have not been any additional programs created offering other post-licensure assessment tools. (PLAS estimates the participation costs for a two and a half day assessment at a minimum to be \$7,500. Participation in the PACE program costs approximately \$8,500.)

Development of an examination was investigated by the Board's PLAC. With input from qualified psychometricians, it was determined that it would take five to seven years to develop a legally-defensible exam: the cost would be \$10 million just for exam development.

There was a split among the participants and interested parties on the appropriateness of a broad examination covering all aspects of medicine (since that is what the plenary physician's license covers) and the reality that specialists, many years after licensure, have developed specific skills that would not be tested by a general, undifferentiated medical examination. The Committee's efforts waned in mid-1999 with a lack of mutually-acceptable and fiscally-sound approaches having been identified.

Several years later, the issue arose again, and the former Division of Licensing (DOL) struggled with the problems associated with its role in oversight and the proper assessment of continuing competency for physicians. At the November 2001 DOL meeting, the Associate Dean for Continuing Medical Education, UCSD, and Chairperson for the Consortium of Continuing Medical Education Departments for the five UC schools, addressed the DOL regarding the issue of continuing medical education (CME). He stated that there has been a decline in the quality of CME that physicians are offered, partly due to the rate of information advanced in the profession and partly due to the fact that two-thirds of the CME offered is provided by private sector for-profit organizations.

At the February 2002 meeting a presentation was made by the Executive Vice President, ABMS, who is a California physician with prior associations at both UCLA and UCSD. He stated almost 90% of all licensed U.S. physicians are certified by a member board of the ABMS. In 1973, recertification was adopted as a way to guarantee continuing competency of physician specialists. By 1998, ABMS had

defined these recertification programs to include four integral components: 1) professional standing; 2) lifelong learning and self-assessment; 3) cognitive expertise; and 4) practice performance assessment. Additionally, ABMS, in concert with the ACGME and LCME, developed the following six general competencies deemed necessary and sufficient to assess continuing competency of physician specialists: 1) medical knowledge; 2) patient care; 3) interpersonal skills and communication; 4) professionalism; 5) practice-based learning and improvement; and, 6) systems-based practice. The goals of this process were to define and develop measures in each of these six areas that must be psychometrically reliable, clinically valid, and economically feasible for the venue in which they are evaluated.

During the 2002 meeting, it was argued there should be a tighter, more-collaborative relationship among the CME providers, the state licensing boards, and the certifying bodies. The Executive Vice President, ABMS, made several suggestions: the course content should be specialty-specific and decided upon by boards and specialty societies within that discipline; the courses should be accredited by organizations already in place; and, the ultimate indicator is a continuous maintenance of certification on a recurring, regular basis to ensure public protection. It was offered that the goal of more effective CME should be to ensure competency through an expansion and renewal of the skills and knowledge necessary to practice current medicine by assessment-driven, self-directed, specialty-specific learning.

The majority of speakers agreed that there was no evidence that didactic CME effectively improves practice patterns. The discussion ended with a determination that it be the intent of the DOL to pursue an objective assessment of the DOL's relicensure/recertification approach, including issues related to malpractice, CME, and physicians' practice as a whole, and that the DOL consider its role in changing the criteria for relicensure/requalification in California during the next decade, after ABMS Boards solidify their recertification process.

FSMB's Maintenance of Licensure (MOL) and ABMS' Maintenance of Certification (MOC)

This most-recent concept being advocated by the FSMB is the MOL, a system of continuous professional development for physicians that supports, as a condition for license renewal, a physician's commitment to lifelong learning that is relevant to the area of practice and contributes to improved health care. The FSMB, the non-profit organization that represents the nation's 70 state and territorial medical boards, is working with its member boards to develop a system over the next several years that is reasonable, logical, administratively feasible, and complementary to and not duplicative of the MOC now required of all ABMS board-certified physicians.

In 2004, the FSMB's House of Delegates adopted a policy statement that "*State medical boards have a responsibility to the public to ensure the ongoing competence of physicians seeking licensure.*" After seven years of careful study, which included input and guidance from physicians and health care organizations across the house of medicine, a framework for MOL was formally adopted by the FSMB's House of Delegates in 2010.

While MOL still is several years away from being adopted by a state medical board, the FSMB currently is working with 11 state boards to implement various pilot projects to help states prepare for MOL and to determine best practices. For physicians who were never specialty certified, or who have changed their practice specialty, the FSMB has offered to help state boards identify activities that

physicians already engage in, such as accredited CME (including Performance Improvement-CME), that could help them comply with the components envisioned in MOL.

Hand-in-hand with MOL is MOC, a similar concept advocated by ABMS. In 2000, the 24 ABMS boards agreed to evolve their recertification programs to one of continuous professional development, called MOC. MOC assures that the physician is committed to lifelong learning and competency in a specialty and/or subspecialty by requiring ongoing measurement of six core competencies adopted by ABMS and ACGME in 1999. Measurement of these competencies happens in a variety of ways, some of which vary according to the specialty. This is carried out by all member boards using a four-part process that is designed to keep certification continuous. In 2006, all member boards received approval of their ABMS MOC program plans. The individual boards are now in the process of implementation of these plans.

However, MOL and MOC face significant opposition. The Association of American Physicians and Surgeons warned that a doctor, after a decade of rigorous training and experience, may be driven out of practice by “a \$300 million industry that sells tests.” Similar to the arguments against CME, it is argued that there is no evidence that having to take still another test every few years makes doctors any better. It does, however, force them to take off weeks to study whatever the psychometricians believe should be tested, costing thousands of dollars to take the test and a loss of income during the period needed to study for the examination. Between testing periods, physicians may have to collect data about how they treat patients, and implement a plan to “improve” certain selected measures – that is to treat patients with a focus on one goal chosen by the authorities, without regard to adverse effects on individual patients.

Continuing Medical Education

Currently, California physicians are required to complete 50 hours of approved CME every two years as a condition of their license renewal. However, physicians are not required to pursue CME specific to their practice. Most physicians do, however, especially those who are certified by a specialty board.

The law places the responsibility with the Board to promulgate regulations to establish the specific requirements and approval of coursework. Also by Board regulation, physicians are required to self-certify that they have completed the minimum CME on their licensing renewal application. (Unless a physician is randomly chosen for audit, he/she is not required to provide documented proof of completion.)

In 2009, the Board discussed this issue and it was decided to create a task force under the auspices of the Education Committee. The charge of the task force was to determine what is most-effective and most-needed to ensure continued competence, improve the knowledge and skill of physicians, and thereby better protect patients. It was suggested the outcome would be a regulatory proposal to amend the requirements to be most meaningful and useful for physicians. The Board, more recently in discussions of its 2012 Strategic Plan, has determined that it will monitor the FSMB’s MOL process and evaluate the outcomes of the 11 state boards that are implementing pilot programs.

The Board recommends that it continue to track the pilot projects and bring recommendations for implementation of MOL back to the Legislature during the Board’s next Sunset Review.

Physician Re-entry Program

B&P Code section 2229 mandates protection of the public shall be the highest priority for the Board. This statute further specifies that, to the extent not inconsistent with public protection, disciplinary actions shall be calculated to aid in the rehabilitation of licensees. To implement the mandates of section 2229, the Board has adopted the *Manual of Model Disciplinary Orders and Disciplinary Guidelines* (guidelines), 11th Edition. Consistent with the mandates of section 2229, these guidelines set forth the framework for discipline the Board finds appropriate and necessary for the identified violations.

Per Condition 33, in the event respondent's period of non-practice while on probation exceeds 18 calendar months, the respondent shall successfully complete a clinical training program that meets the criteria of Condition 18 of the Board's guidelines prior to resuming the practice of medicine. This short timeframe (18 months) has been adopted because the licensee already is on probation for some previously-identified enforcement issue, 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 licensee who has let his/her license expire, B&P Code section 2456.3 states, in part, "...a license which has expired may be renewed at any time within five years after its expiration..." simply by submitting the renewal paperwork, CME verifications, and paying the fees and penalties. Hypothetically, this 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. This physician has not practiced for eight years, but can renew, pay fees, demonstrate that CME has been obtained, and go back into practice. (Licensure in another jurisdiction with documented practice would make this issue moot.) Although the Board is not aware that this hypothetical ever has happened, it is a potential scenario that could come to the Board's attention. In addition, the Board does not monitor whether a physician has any active clinical practice when he/she renews, thus the physician could be out of practice for years before returning to active practice.

There are physicians who have been out of practice for over five years (licensing standard) that apply for licensure in California. For public protection purposes, the Board asks for a clinical assessment or board certification prior to licensure. The clinical assessment criteria is applied differently for licensure than it is for enforcement. In order to protect consumers, it is important to set criteria when an assessment should occur.

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.

Mandatory Email Address for Licensees

The Board 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 Board 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. The Board sends some correspondence electronically instead of mailing the item to the physical address on record. This 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 that same day.

On rare occasions, the licensees' email addresses are used to notify them of important law changes, emergency regulations that are effective immediately, as well as, other urgent issues affecting licensees and public health. Executive and Board staff review and approve these rare, relatively infrequent emails that are distributed.

The Board regularly posts information on its Web site's Home Page 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 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. In August 2012, there were less than 4,000 subscribers for each topic.

The Board is proactive in its efforts to reduce paperwork and go green. It also understands that a clear message in the subject line will make it easy for the physician to select the email to read, delete, or save for later. The Board is moving to a new information technology (IT) system that will allow licensees to receive renewal notifications and other information via email. The new IT system will allow licensees the opportunity to choose the best method (i.e. electronically or U.S. Postal Service) of receiving information from the Board. SB 1575 Price (Statutes 2012, Chapter 799) amended B&P Code section 2424(a) to allow the Board to send email notifications for expired licenses. The Board wants to communicate with its licensees to provide the most current, meaningful, and important information in a 21st century manner, that is also respectful of the time that is taken going through email messages.

The Board is recommending 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.

Public Disclosure of Postgraduate Training

B&P Code section 803.1 states the Board shall disclose a physician's approved postgraduate training; section 2027 further states the Board's Web site should 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 Web site.

At the time applicants apply for a physician's license, most are participating in postgraduate training and usually are attending their first or second year of postgraduate training. 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. On average, individuals attend four years of postgraduate/fellowship training and some specialties require seven or more years to become eligible to take an ABMS certification examination. Therefore, at the time they apply for licensure, they may only have one or two years 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. In addition, licensees sometimes determine that they no longer want to pursue the course of study they originally planned. For example, an individual begins postgraduate training in pediatrics but determines that he/she no longer wishes to pursue this career, but wants to change to neurology. This individual may need to change training programs. If the individual had submitted his/her application prior to this decision and became licensed, the Board would not have this new postgraduate training program in its records. Thus, the information that is posted for the postgraduate training program would be outdated and incomplete.

Additionally, the Board does not currently request this additional postgraduate training information. 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. The Board lists this information in the physician survey section on the physician profile for those physicians who provide this information and also refers the public to the AMBS for more information. 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.

Physicians' Accredited Residency Training Programs and the Prohibition Against the Corporate Practice of Medicine

A question has been raised regarding the employment of residents and if this is a violation of the prohibition against the corporate practice of medicine.

B&P Code section 2052, provides:

"Any person who practices or attempts to practice, or who holds himself or herself out as practicing...[medicine] without having at the time of so doing a valid, unrevoked, or unsuspended certificate...is guilty of a public offense."

B&P Code section 2400 provides in pertinent part:

"Corporations and other artificial entities shall have no professional rights, privileges, or powers."

The policy expressed in B&P Code section 2400 against the corporate practice of medicine is intended to prevent unlicensed persons from interfering with or influencing the physician's professional judgment. The decisions described below are examples of some of the types of behaviors and subtle controls that the corporate practice doctrine is intended to prevent. From the Board's perspective, the following health care decisions should be made by a physician licensed in California and would constitute the unlicensed practice of medicine if performed by an unlicensed person:

- Determining what diagnostic tests are appropriate for a particular condition;
- Determining the need for referrals to, or consultation with, another physician/specialist;
- Responsibility for the ultimate overall care of the patient, including treatment options available to the patient; and/or
- Determining how many patients a physician must see in a given period of time or how many hours a physician must work.

In addition, certain "business" or "management" conditions, decisions, and activities result in control over the physician's practice of medicine and should be made by a licensed physician and not by an unlicensed person or entity. The following conditions suggest the corporate practice of medicine:

- Ownership or control of a patient's medical records, including determining the contents thereof (these should be retained by a California-licensed physician);
- Selection, hiring/firing (as it relates to clinical competency or proficiency) of physicians, allied health staff and medical assistants;
- Setting the parameters under which the physician will enter into contractual relationships with third-party payers;
- Decisions regarding coding and billing procedures for patient care services; and/or
- Approving of the selection of medical equipment and medical supplies for the medical practice.

The types of decisions and activities described above cannot be delegated to an unlicensed person, including (for example) management service organizations. While a physician may consult with

unlicensed persons in making the "business" or "management" decisions described above, the physician must retain the ultimate responsibility for, or approval of, those decisions.

The following types of medical practice ownership and operating structures also are prohibited:

- Non-physicians owning or operating a business that offers patient evaluation, diagnosis, care and/or treatment;
- Physician(s) operating a medical practice as a limited liability company, a limited liability partnership, or a general corporation;
- Management service organizations arranging for, advertising, or providing medical services rather than only providing administrative staff and services for a physician's medical practice (non-physician exercising controls over a physician's medical practice, even where physicians own and operate the business); and/or
- A physician acting as "medical director" when the physician does not own the practice. For example, a business offering spa treatments that include medical procedures such as Botox injections, laser hair removal, and medical microdermabrasion, that contracts with or hires a physician as its "medical director."

In the examples above, non-physicians would be engaged in the unlicensed practice of medicine, and the physician may be aiding and abetting the unlicensed practice of medicine.

The Board 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:

- New medical school graduates that are entering into an accredited residency program as PGY-1 have not yet taken and passed the USMLE Step 3 examination that is required for licensure;
- Physicians are not eligible to obtain licensure until they have satisfactorily met the minimum number of years that is required pursuant to B&P Code sections 2096, 2102 and 2103;
- US/CAN medical school graduates training in California may practice medicine in an accredited residency program for up to two years before requiring a license to continue in the residency program pursuant to B&P §2065;
- International medical school graduates training in California may practice medicine in an accredited residency program for up to three years pursuant to B&P §2066;
- All residents in an accredited residency program are given a one year contract for each of the PGY training years and the residents must meet the minimum training goals to proceed to the next training PGY training year;
- Residents do not practice medicine independently as the residents work under the supervision of the residency program director and the other teaching faculty;
- Residents are still required to meet specific training requirements for each specific year of PGY training even after the resident receives a California license;
- The funding to pay the residents comes from several resources, with a significant amount of the money coming from the Federal Government - Center for Medicare and Medicaid Services (CMS), the teaching hospitals, grants and other private sources; and

- The teaching hospital's accredited residency programs must meet the specific requirements as set forth by the ACGME.

The Board believes that the corporate practice of medicine issue regarding accredited residency programs and their residents should be clarified. The Board has determined that the corporate practice of medicine as it relates to accredited residency and fellowship programs should be addressed as a specific exemption. There is clearly an emerging need to remove any possible misinterpretations regarding the corporate practice of medicine for accredited residency programs. Resident physicians help to ensure that California will have new physicians to help address the physicians shortage in California. 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.

Coroner Reporting of Prescription Drug Overdose

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's 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.

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. They are afraid that notifying the Board will eliminate their drug supply. Some complaints regarding overprescribing come from anonymous tips, which usually do not have enough information to allow forwarding to the Board's district office for investigation as there is no patient to obtain records for or not enough information to open an investigation. Family members may make a complaint to the Board, however, the Board must have a patient release in order to obtain medical records or seek a subpoena. Sometimes it is difficult to obtain evidence to warrant a subpoena, or the family is not responsive.

B&P Code section 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. The initial report shall include the name of the decedent, attending physicians, date and place of death, and all other relevant information. This initial report must be followed, within 90 days, by copies of the coroner's report, autopsy protocol, and all other relevant information.

This section requires the coroner to make a determination that the death **may** be the result of a physician's gross negligence or incompetence. It could be that the decrease in coroners' reports is due to the fact the coroners have to make this determination. 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.

This increased workload would be offset by the benefit added to consumer protection. If only one physician was found to be overprescribing, this could save numerous lives.

The Board recommends that a section be added to B&P Code section 802.5 to require coroners to report all deaths related to prescription drug overdoses to the Board.

Controlled Substance Utilization Review and Evaluation System (CURES) and California Prescription Drug Monitoring Program (PDMP) Funding

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 five 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 five 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 healthcare 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 overdose 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 uses a Prescriber History report from CURES as a tool to assist in investigating complaints alleging excessive prescribing by a physician. For example, in 2009 a Burbank physician was accused of writing hundreds of fraudulent prescriptions to feed his patients' drug addictions. Seven of his patients died from prescription-drug overdoses. Following an investigation that included the CURES report of the prescriptions he had written, the physician faced criminal charges, lost his physician license and surrendered his permit to prescribe controlled substances. Criminal charges are currently pending for a number of physicians who have prescribed medications without a legitimate medical purpose. CURES reports have been a valuable tool used in these investigations.

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 Board recommends that legislation be considered to provide an adequate funding source (e.g. all individuals who prescribe or dispense medications, pharmaceutical companies, and the public). The prescribers/dispensers would include physicians, dentists, pharmacists, veterinarians, nurse practitioners, physician assistants, osteopathic physicians, optometrists, and podiatrists. This funding source would support the necessary enhancements to the computer system and provide for adequate staffing to run the system.

Medical Malpractice Cases -- No Upfront Review

B&P Code section 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. The rationale for the up-front specialty review makes sense. However, there have been some unintended consequences which adversely affect the time required to perform the initial review of new complaints and ultimately affects the amount of time required to review and investigate a complaint. As with the expert reviewer program, there are some practice specialties that are difficult to recruit for and complaints can wait more than 30 days for an expert to become available to review the file. There are also circumstances where the CCU is unable to obtain the information needed for the expert to review the complaint and will recommend referring the complaint to the field to obtain the missing information via subpoena. However, the AG's Office has expressed concern that the complaint is being referred to investigation without being properly vetted as required by section 2220.08. This statute currently contains some exceptions to the upfront specialty review, such as when a physician is the subject of a pending accusation or an ongoing investigation, or when the complaint is a result of a peer reviewed action filed pursuant to section 805. 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. The attorney for the plaintiff will typically secure an expert review to determine whether facts of the case merit the pursuit of a malpractice claim before the case is filed. Once a medical malpractice case is filed, the defendant's legal representative will also obtain an expert to review the care provided by the physician and opine as to whether the standard of care was met. If the malpractice case goes to trial, both sides need to present expert witnesses to interpret the standard of care and opine as to whether the physician was negligent.

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. The patient's medical records and any depositions gathered during litigation are provided to the Board along with the report relaying the outcome or resolution of the malpractice case. The medical records must then be referred to an upfront medical expert for the Board to perform another review to determine whether the facts of the malpractice case warrant investigation by the Board. Because the patient's medical records are provided by the insurance carrier, they are not certified medical records and cannot be introduced as evidence if the case is referred for a formal investigation. Instead, a Board Investigator must contact the patient, obtain a medical release and/or subpoena the patient's medical records in order to obtain a certified copy of the patient's medical records. There is little benefit to the Board 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.

Physician Availability – Knowledge And Training

At the July 2012 Board Meeting, the Committee on Physician Supervisory Responsibilities discussed and recommended regulatory language regarding the appropriate level of physician availability needed within clinics or other settings using lasers or intense pulse light devices for elective cosmetic procedures. In this discussion, the importance of applying physician availability standards across all areas, not just for elective cosmetic procedures, was expressed by both the Committee Members and members of the public. The importance of adequate training for the supervising physician and the health care practitioner performing the procedure, and having sufficient knowledge about the procedure being performed, was also expressed by both the Committee Members and members of the public.

The Committee voted to recommend that the Board suggest additional legislation to enhance consumer protection by applying the physician availability regulations in all clinical settings and by requiring specific training and/or certification for both the supervising physician and the health care practitioner performing the procedure. The Board approved the recommendation and voted to suggest additional legislation to enhance consumer protection.

The Board recommends that, in the interest of consumer protection, legislation should be written to require that regulations be adopted for physician availability in all clinical settings. Additionally, legislation should be written to establish by regulation the knowledge, training, and ability a physician must possess in order to supervise other health care providers.

Consistency in the Time to Provide Medical Records

B&P Code section 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, in the same code section, subsection (b), a facility is afforded 30 days to produce the certified records. This disparity may have been seen as appropriate prior to the implementation of Electronic Health Records (EHR).

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.

Peer Review Reporting Pursuant to B&P Code Section 805

Pursuant to B&P Code section 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; or
- 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. The following chart identifies the decline in reporting:

	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

In 2008, pursuant to a requirement in law, the Board had an outside entity perform a comprehensive review of the peer review process. Most of the recommendations required legislation for implementation. Legislation passed in 2010 provided some clarification to the peer review reporting process. The Board did see an increase in reports in FY 2011/2012, however, it is too early to tell if this was an anomaly, or actually due to the revised law.

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. 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 Board recommends an amendment to existing law to require CDPH and hospital accrediting agencies to send reportable peer review incidents found during an inspection of the facility to the Board. The Board would also recommend a requirement that these entities notify the Board if a hospital is not performing peer review.

Public Disclosure – Ten Year Posting Requirement

B&P Code section 2027 was amended effective January 1, 2003 to require the Board to remove certain public disclosure information from its Web site. Specifically, the amendment stated that “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 Web site. 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, which 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 B&P Code section 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 Web site 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 ten years from the date of restoration).

Although the statute requires the removal of the information from the Board's Web site, 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 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 Board 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 Web site, 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, 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 Web site. 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 Web site. This will result in additional calls, and

the workload associated with determining if there are documents available, making the copies, and either scanning/emailing the documents or mailing the documents (plus postage to mail).

While the Board understands this information has an impact on a physician, the Board 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 ten years from the date the Board obtains possession, custody, or control of the information. However, this is vague. The Board 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 ten years begins from the effective date of the decision as that would be when the information was in the Board's possession. If an individual were on probation for seven years, once probation was completed, the information would only be posted for those three additional years. The Board does not know if this was the Legislature's intention, or if the information should be posted for ten years from the date the probation was completed. For malpractice judgments, the Board interprets the law to mean the Board would keep this action on the Web site for ten years from the date the Board receives this information, not the date of the judgment. The Board may not receive the information timely, and the judgment may have been issued a significant amount of time prior to the Board's receipt.

The Board recommends elimination of the ten year posting requirement in order to ensure transparency to the public.

The Board 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 Board do that in regulations, when the ten years begins/ends for these cases.

Expert Reviewer Opinions

The Administrative Procedure Act (APA) includes limited discovery provisions that do not assist in discovering opposing expert information. In some instances, once the Board received this information, it has to amend the accusation and therefore increase the time frame 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).

The Board could try to amend and expand the discovery provisions under the APA, but it may be extremely difficult 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. As such, perhaps the best vehicle available is to expand the provisions of B&P Code section 2334.

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 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 to the Board, it does need improvement. The legislative history of section 2334 reveals that, during the legislative process, consideration was given to requiring both sides to exchange expert witnesses 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 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 legislatively defined. 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 as one superior court has construed this 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.

Specialty Board Advertising

The Law and History

In 1990, SB 2036 (McCorquodale), a bill 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 ABMS. It added B&P Code section 651(h), and prohibited physicians from advertising they are "board certified" or "board eligible" unless they are certified by:

- an ABMS approved specialty board;
- a board that has specialty training that is approved by the ACGME; or
- a board that has met requirements equivalent to ABMS and has been approved by the Board.

In summary, 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.

After four years of public meetings and hearings the regulations were adopted and enacted. The regulations 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 Board has reviewed a number of specialty board applications. The Board has approved four boards: the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine, and the American Board of Spine Surgery. The Board has also disapproved two boards: the American Academy of Pain Management and the 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 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.

For all of these reasons, the law prohibiting the advertising of board certification 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 of the administration of the program has been minimal of late, as there has only been one 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.

The processing of the application for the meeting of 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.)

When there is an application, 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 a minimum of 80 hours and as much as 160. 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.

The costs relating to processing of specialty board applications has not been the major expense in this program. As expected, denial of an application gives rise to litigation, and thereby legal costs.

Risk of Lawsuits and Potential Payouts

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

The Board and the law have prevailed in all litigation, but the cost was considerable. While the method of billing by the AG's Office makes it difficult to ascertain the exact cost of legal representation specific to the suits, it has conservatively been estimated to have cost the Board in excess of \$200,000.

Use of Medical Consultants and Experts

In 1990, when the original legislation was introduced, the Board Members opposed the bill. The opposition was not because the Members believed that physicians should be able to advertise credentials that they did not possess, but because they could see the tremendous problems in implementation. The ABMS is a well-established, huge organization with tremendous resources, both in revenue, infrastructure, and expertise, far beyond the Board's resources.

The law asks the Board to essentially perform most of the same tasks as the ABMS, the ACGME, and the specialty boards and their residency review committees – with a fraction of their resources. For an ABMS specialty board to become recognized, it takes years, developing model training standards for the specialty, establishing residency training programs at medical schools and medical facilities, operating training programs and obtaining accreditation, undergoing regular oversight by residency review committees, etc. All of the individuals within this system are experts in medical training and the specialty.

In contrast, the Board is comprised of appointed physicians and public Members. Physician Members may have no expertise in academic training or in the specialty over which they are being asked to consider. For that reason, the Board must use academic medical training experts to conduct reviews and provide recommendations to the Members. Unlike the ABMS process, the Board is not in any way 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?

There are basically three entities that have the expertise to review and evaluate the quality of medical specialty boards' training and certification criteria. The first would be the ABMS, the second would be the ACGME, and the third, to a lesser degree, would be medical schools that provide ABMS designed and ACGME accredited residency training programs. Unfortunately, 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 following should be considered:

1. The law was 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 Board has the legal tools to combat this practice.
2. As mentioned before, however, physicians may still legally advertise 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. This 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 Board 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 Board. In addition, the law could be amended to prevent the use of other misleading terms.

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 Applicant Review Committee
- Attachment I: B&P Code Section for Special Faculty Permit Review Committee
- Attachment J: B&P Code Sections for Special Programs Committee
- Attachment K: B&P Code Section for Midwifery Advisory Council
- Attachment L: B&P Code Section for Panel A and Panel B
- Attachment M: Performance Measures
- Attachment N: Revenue and Fee Schedule
- Attachment O: National Practitioner Databank Study by the Board
- Attachment P: United States Medical Licensing Examination (USMLE) Performance Data
- Attachment Q: Strategic Plan Objective 5.2 – 2012
- Attachment R: Attorney General’s Office Response to Medical Board of California’s Program Evaluation
- Attachment S: List of Acronyms



Attachment A

BOARD MEMBER ADMINISTRATIVE PROCEDURE MANUAL



State of California
State and Consumer Services Agency

MEDICAL BOARD OF CALIFORNIA
Board Member Administrative
Procedure Manual



2005 Evergreen Street, Suite 1200
Sacramento, CA 95815
(916) 263-2389
www.mbc.ca.gov

Board Member Administrative Procedure Manual

Updates to Manual – May 2009

Table of Contents

	Page
Chapter 1. Introduction	
Overview	1
Definitions	1
General Rules of Conduct	2
Chapter 2. Board Meeting Procedures	
Frequency of Meetings	3
Board Member Attendance at Board Meetings	3
Public Attendance at Board Meetings/Open Meetings Act	3
Quorum	3
Agenda Items	4
Notice of Meetings	4
Notice of Meetings to be Posted on Internet	4
Record of Meetings	4
Tape Recording	4
Meeting Rules	4
Public Comment	4
Chapter 3. Travel & Salary Policies & Procedures	
Travel Approval	6
Travel Arrangements	6
Out-of-State Travel	6
Travel Claims	6
Salary Per Diem	6
Chapter 4. Selection of Officers & Committees	
Officers of the Board	8
Election of Officers	8
Panel Members	8
Election of Panel Members	8
Officer Vacancies	8
Committee Appointments	8
Attendance at Committee Meetings	8

Chapter 5. Board Administration & Staff

Board Administration	9
Strategic Planning	9
Executive Director Evaluation	9
Board Staff	9
Business Cards	9

Chapter 6. Other Policies & Procedures

Board Member Disciplinary Actions	10
Removal of Board Members	10
Resignation of Board Members	10
Conflict of Interest	10
Gifts from Candidates	10
Communications with Interested Parties	11
Request for Records Access	11
<i>Ex Parte</i> Communications	11
Board Member Training Requirements	12

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 meeting day 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 which 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
(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.

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 complete a speaker request slip. 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.)

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 through Giselle's Travel but are encouraged to coordinate with the Executive Director's Executive 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 must be 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 Executive 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."

(Board Policy)

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. Where it is necessary for a Board Member to leave a meeting early, the Board President shall determine if the member has provided a substantial service during the meeting and, if so, shall authorize payment of salary per diem and reimbursement for travel-related expenses.

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 last meeting of the calendar year. Officers shall serve a term of one year beginning the next calendar year. 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. 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 first 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.)*

If a Board Member wishes to attend a meeting of a Committee of which he or she is not a member, that Board Member should notify the Committee chair and staff. 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.

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 17510)*

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.

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.

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.

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."

Occasionally, an applicant who is being formally denied licensure, or a licensee against whom a disciplinary action is being taken, will 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.

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 they 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.

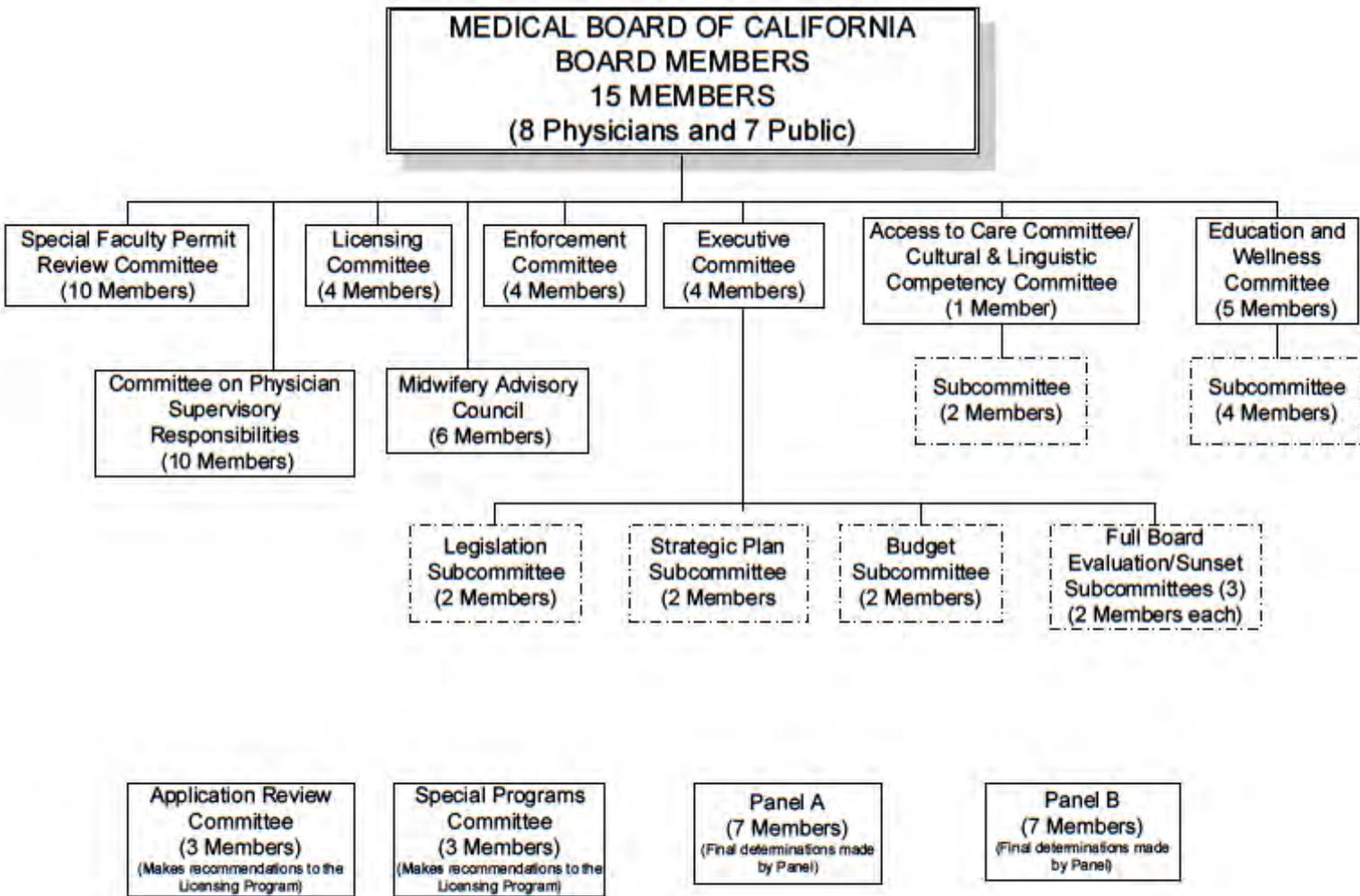
(Government Code section 12950.1)

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.

Attachment B

**CURRENT ORGANIZATIONAL CHART SHOWING
RELATIONSHIP OF COMMITTEES TO THE BOARD
AND MEMBERSHIP OF EACH COMMITTEE**





Attachment C

MAJOR STUDIES AND PUBLICATIONS

- Major Studies Conducted by the Board
 - *Report on Malpractice Insurance for Volunteer Physicians*
 - *Comprehensive Study of Peer Review in California: Final Report and Appendix*
 - *Physician Misconduct and Public Disclosure Practices at the Medical Board of California*
 - *Vertical Enforcement and Prosecution Model Report to the Legislature: 2007, 2009, and 2012*
 - *Medical Board of California - Program Evaluation: Volume I and II*
 - *Bureau of State Audits Report 2007-038*
 - *Medical Board of California Financial Status*
 - *Creating a Sustainable Licensing Program – Business Process Reengineering Study*
 - *Department of Consumer Affairs Risk Analysis*
 - *Senate Bill 376: Direct Employment of Physicians*
 - *California Physician Corps Loan Repayment Program – 2004 Report to the Legislature*
 - *Steven M. Thompson Physician Corps Loan Repayment Program – Supplement to the 2004 Report to the Legislature*

- Major Publications Prepared by the Board
 - *Board Newsletter - Fall 2012*
 - *Guide to Laws Governing the Practice of Medicine by Physicians and Surgeons*
 - *Strategic Plan: 2008 and 2012*
 - *Annual Report – 2011-2012*
 - *Disciplinary Guidelines*



Major Studies Conducted by the Board

Report on Malpractice Insurance for Volunteer Physicians

http://www.mbc.ca.gov/publications/malpractice_insurance.pdf

http://www.mbc.ca.gov/publications/malpractice_insurance_appendix.pdf

Comprehensive Study of Peer Review in California: Final Report

Report: http://www.mbc.ca.gov/publications/peer_review.pdf

Appendix: http://www.mbc.ca.gov/publications/peer_review_appendix.pdf

Physician Misconduct and Public Disclosure Practices at the Medical Board of California

<http://www.library.ca.gov/crb/08/08-015.pdf>

Vertical Enforcement and Prosecution Model Report to the Legislature

November 2007: http://www.mbc.ca.gov/publications/legislature_report.pdf

June 2009:

http://www.mbc.ca.gov/publications/vertical_enforcement_model_report_2009_06.pdf

March 2012: http://www.mbc.ca.gov/publications/vert_enf_model_report_2012_03.pdf

Medical Board of California - Program Evaluation

Volume I: http://www.mbc.ca.gov/publications/program_evaluation_vol-i.pdf

Volume II: http://www.mbc.ca.gov/publications/program_evaluation_vol-ii.pdf

Bureau of State Audits Report 2007-038

<http://www.bsa.ca.gov/pdfs/reports/2007-038.pdf>

Medical Board of California Financial Status

http://www.dof.ca.gov/osae/audit_reports/documents/FinalReportMedicalBoardofCaliforniaFinancialStatusWEB.pdf

Creating a Sustainable Licensing Program – Business Process Reengineering Study

http://www.mbc.ca.gov/di_VjWUjcbg/creating-sustainable-lic-prgm.pdf

Department of Consumer Affairs Risk Analysis

http://www.mbc.ca.gov/di_VjWUjcbg/risk-analysis-presentation.pdf

Senate Bill 376: Direct Employment of Physicians

http://www.mbc.ca.gov/divisions/cbg/sb376_report_legislature.pdf

California Physician Corps Loan Repayment Program – 2004 Report to the Legislature

http://www.mbc.ca.gov/licenseeg/loan_repay_2004_legislature_rept.pdf

Steven M. Thompson Physician Corps Loan Repayment Program – Supplement to the 2004 Report to the Legislature

http://www.mbc.ca.gov/licenseeg/loan_repay_2004_legislature_rept_sup.pdf

Major Publications Prepared by the Board

Board Newsletter

Newsletters: <http://www.mbc.ca.gov/publications/newsletters/Index.html>

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

2008: http://www.mbc.ca.gov/publications/strategic_plan/strategic_plan_2008.pdf

2012: http://www.mbc.ca.gov/publications/strategic_plan/strategic_plan_2012.pdf

Annual Report

Annual Reports: http://www.mbc.ca.gov/publications/annual_reports.html

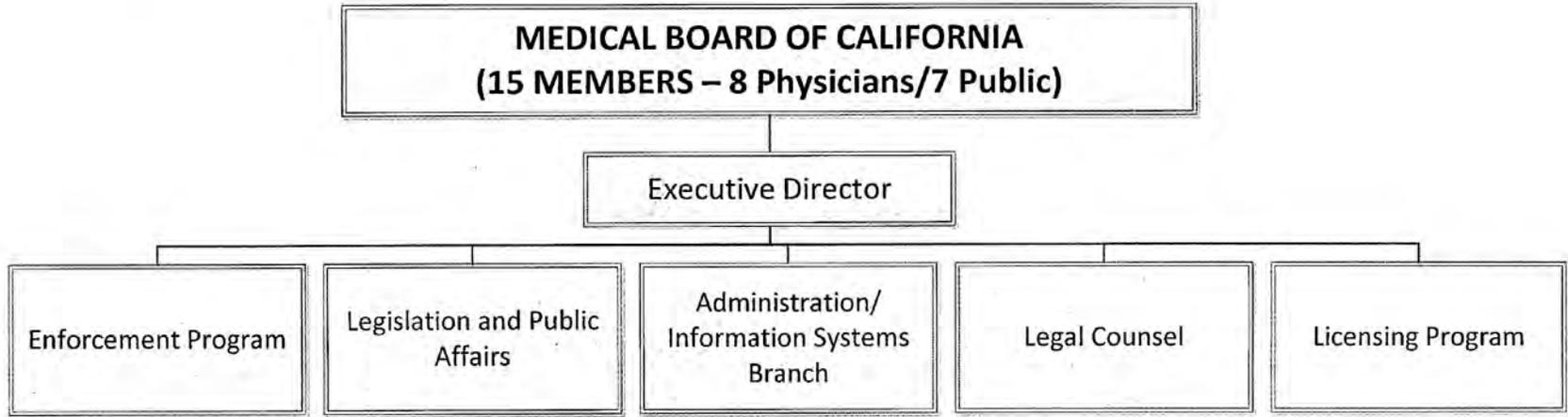
Disciplinary Guidelines

http://www.mbc.ca.gov/enforcement/disciplinary_guide.pdf

Attachment D

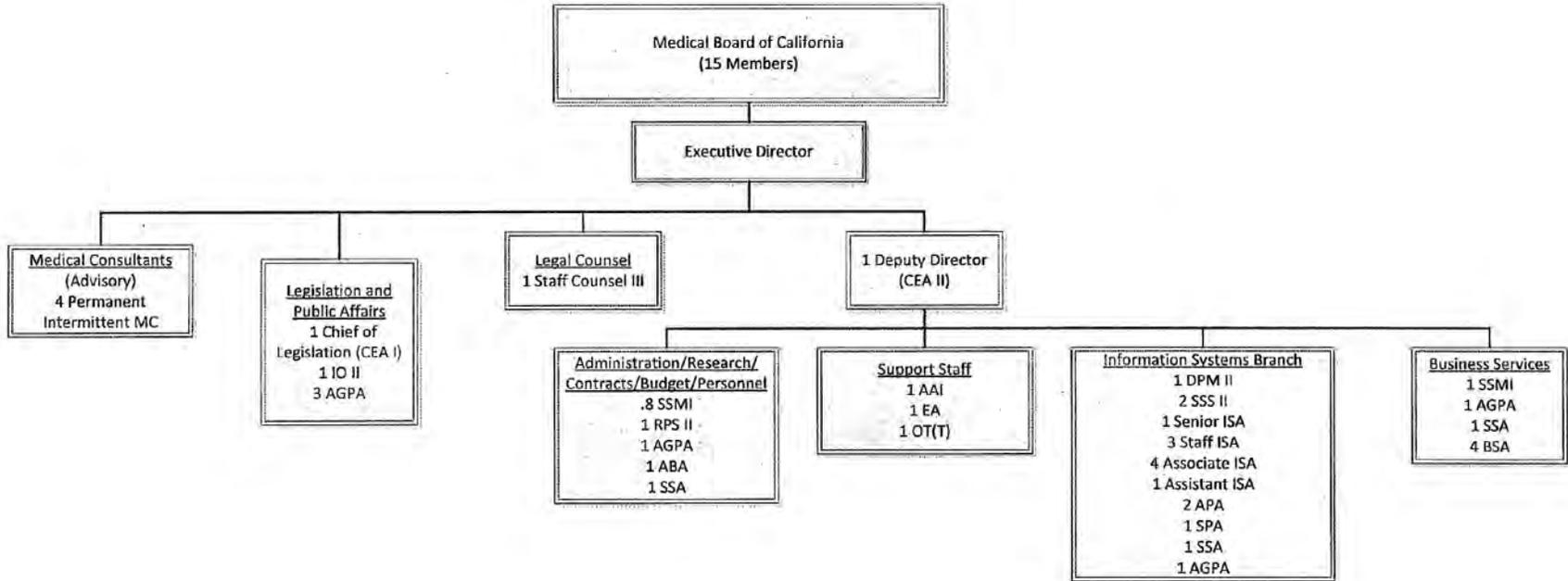
YEAR-END ORGANIZATIONAL CHARTS





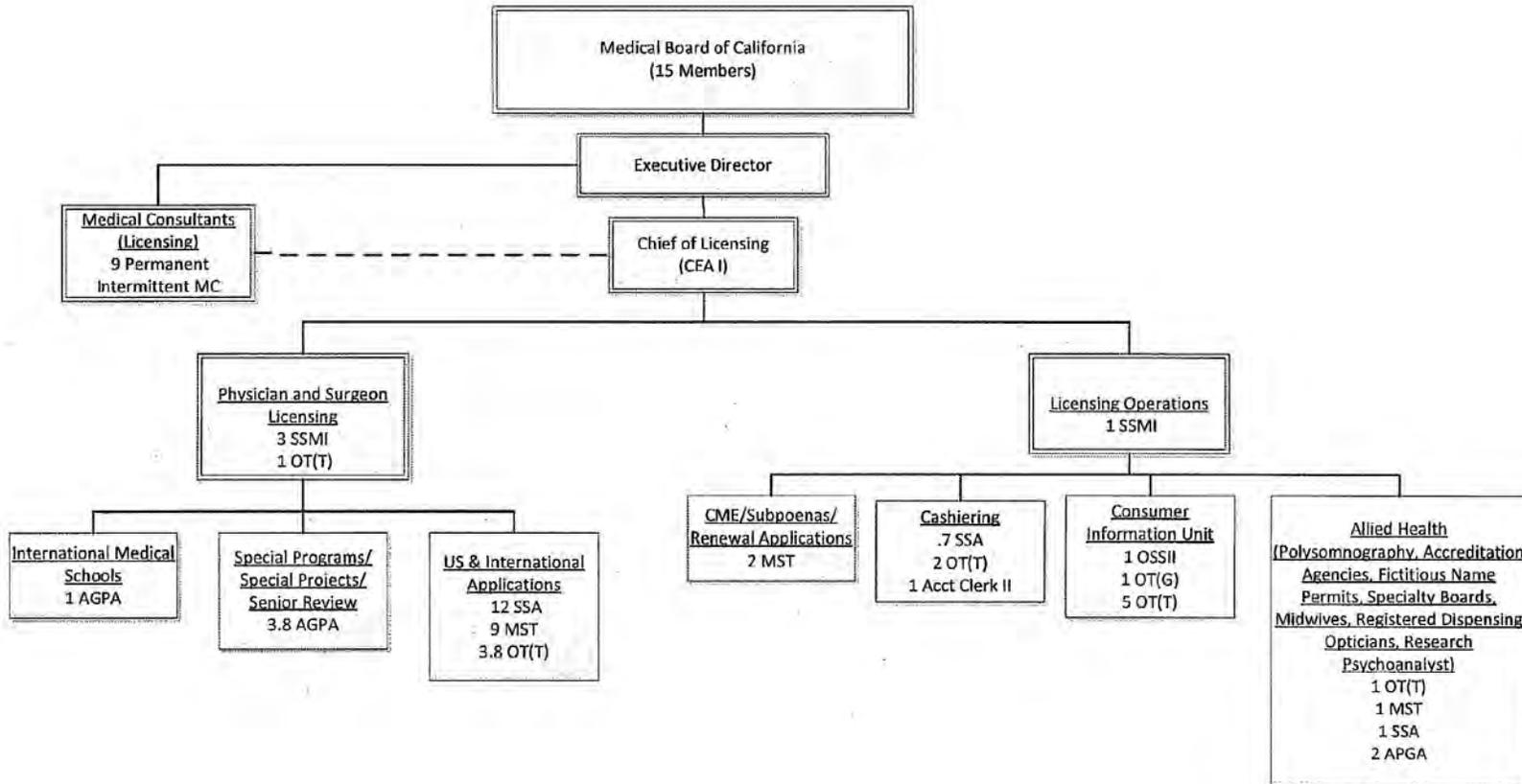
FY 2011/2012
283.2 PYs plus permanent intermittent

Medical Board of California
 Administrative and Executive Programs
 FY 2011/2012



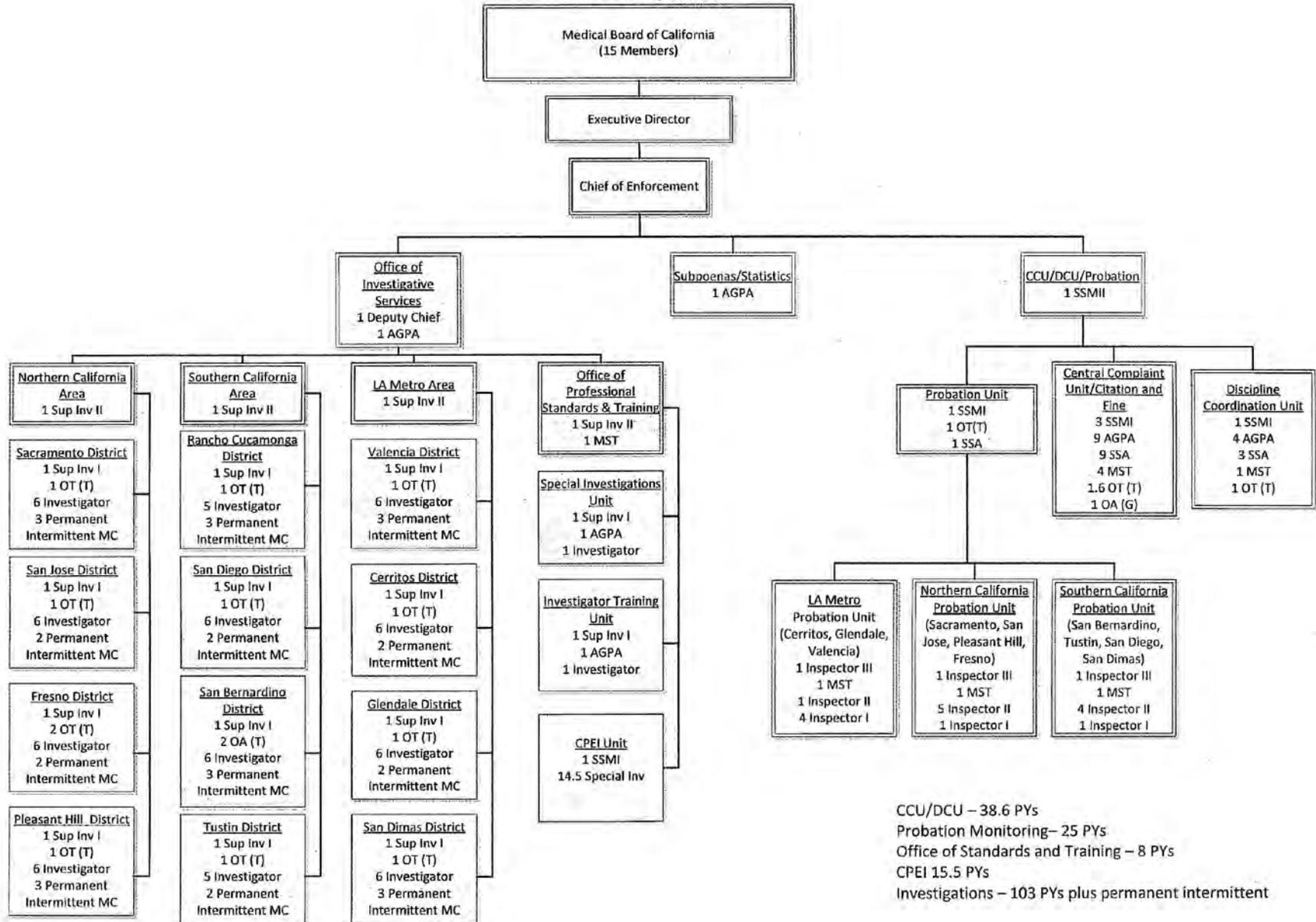
Administration – 11.8 PYs
 Executive – 11 PYs plus permanent intermittent
 Information Systems Branch – 17 PYs

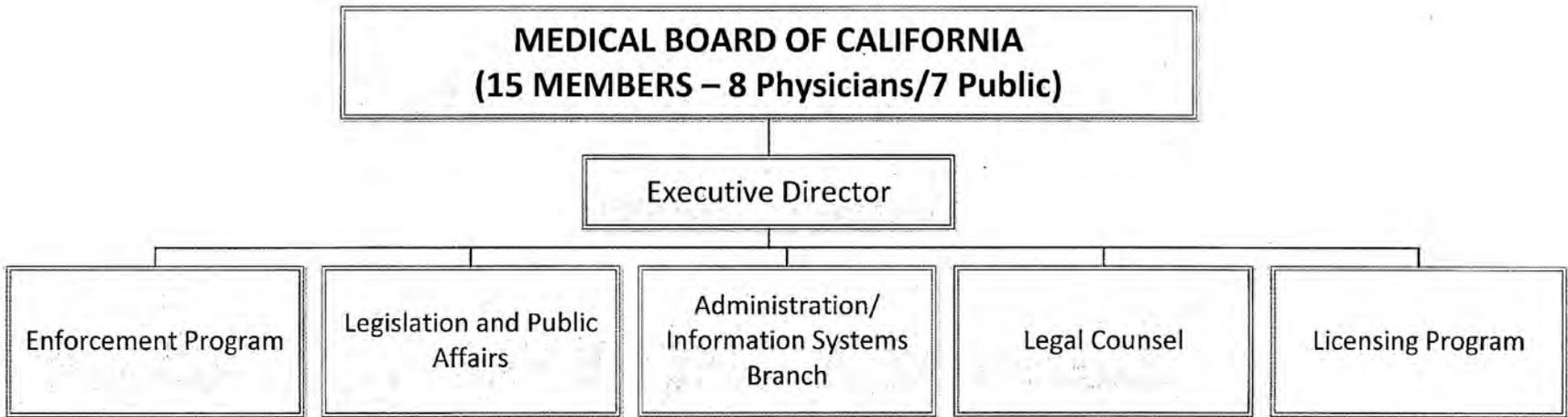
Medical Board of California
Licensing Program
FY 2011/2012



Licensing – 53.3 PYs plus permanent intermittent

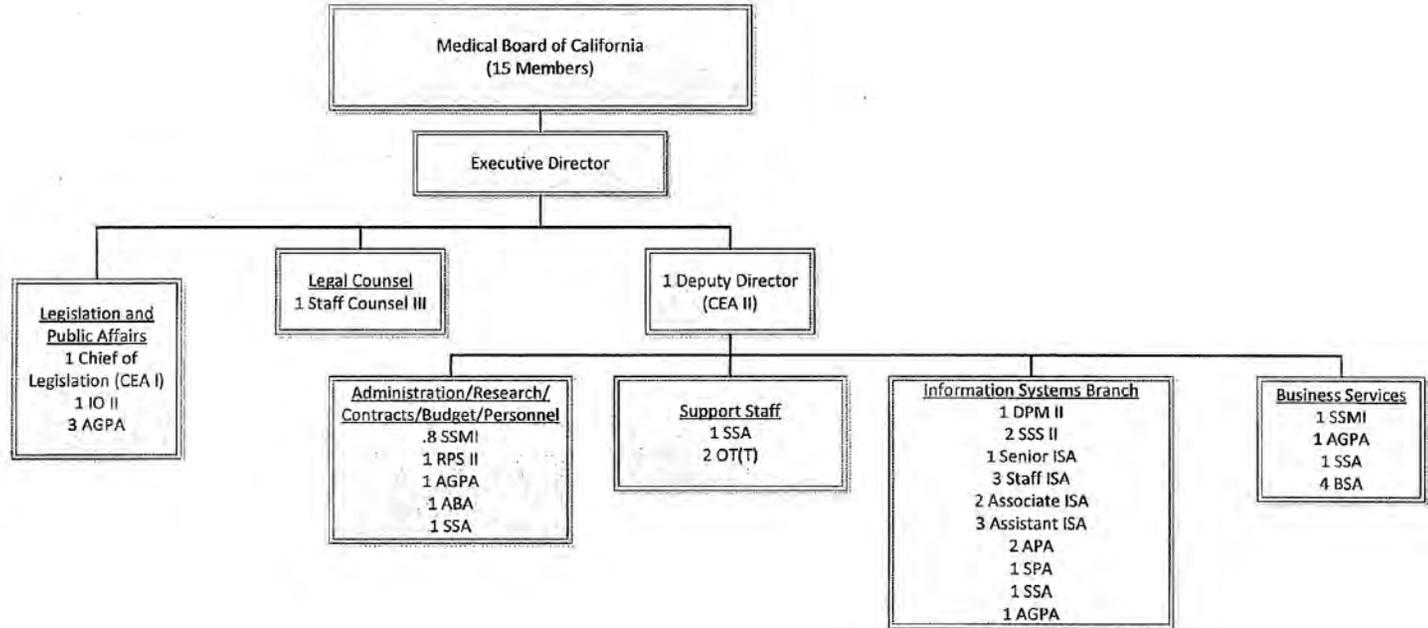
Medical Board of California
Enforcement Program
FY 2011/2012





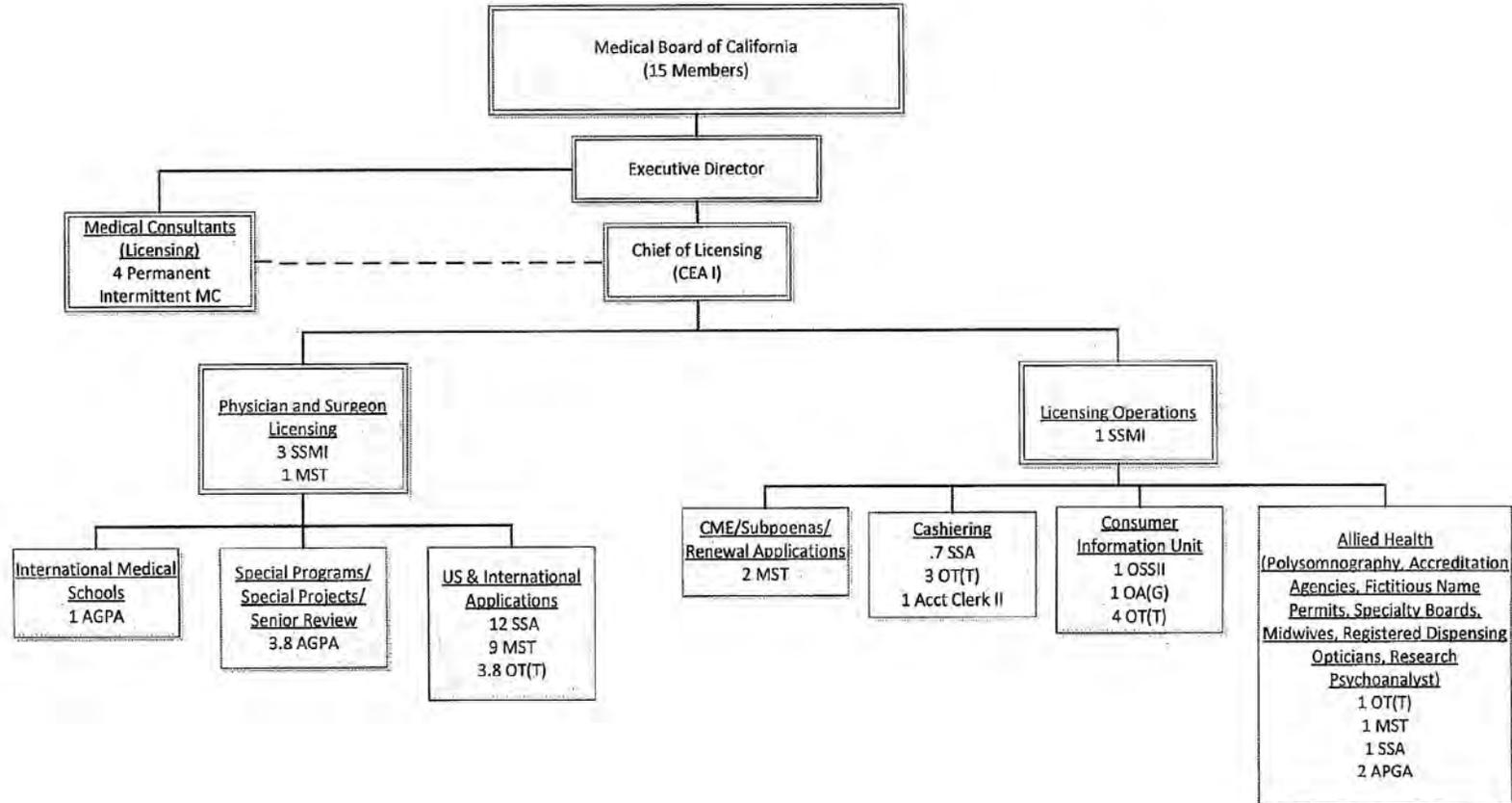
FY 2010/2011
289.1 PYs plus permanent intermittent

Medical Board of California
 Administrative and Executive Programs
 FY 2010/2011



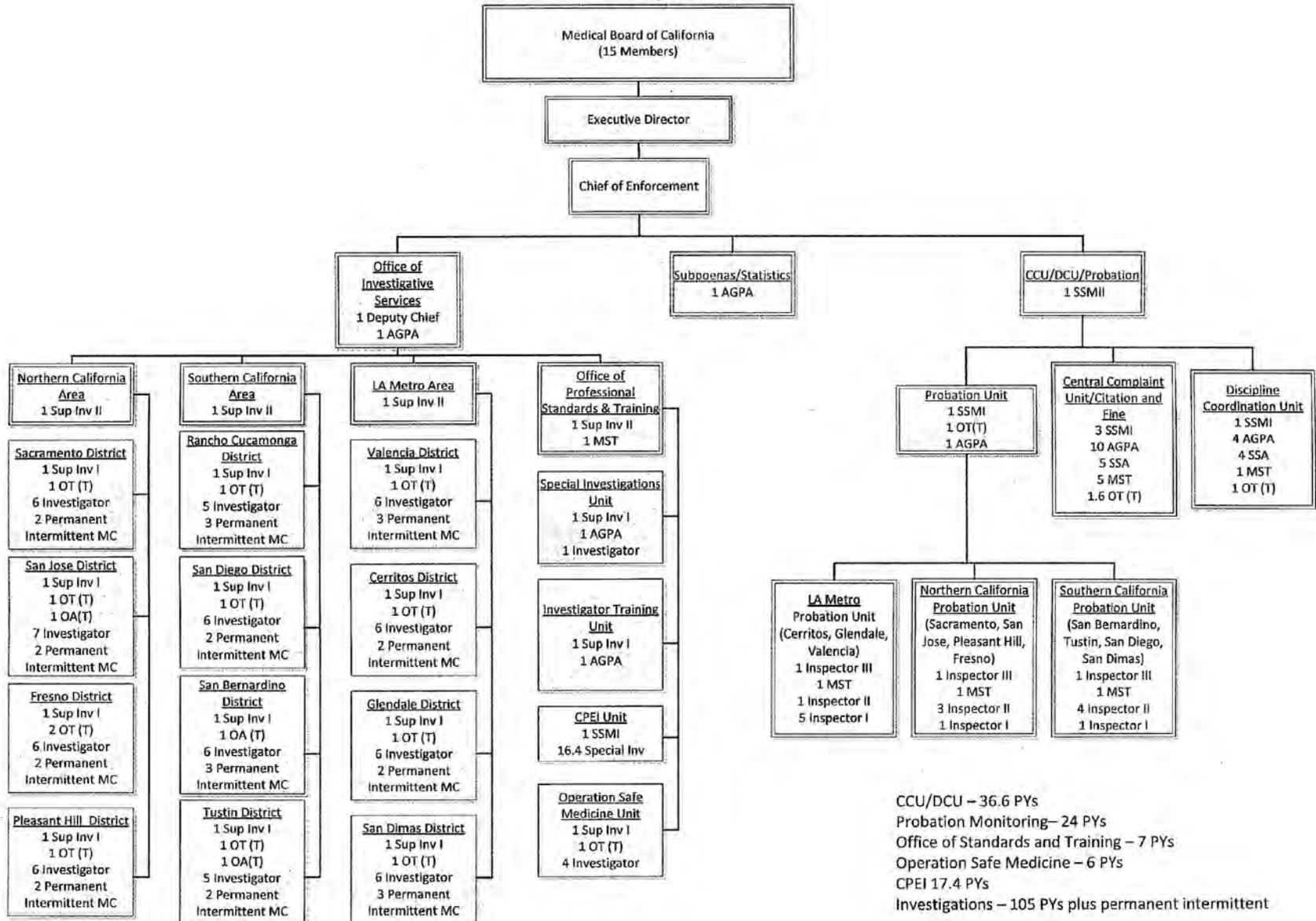
Administration – 11.8 PYs
 Executive – 11 PYs plus permanent intermittent
 Information Systems Branch – 17 PYs

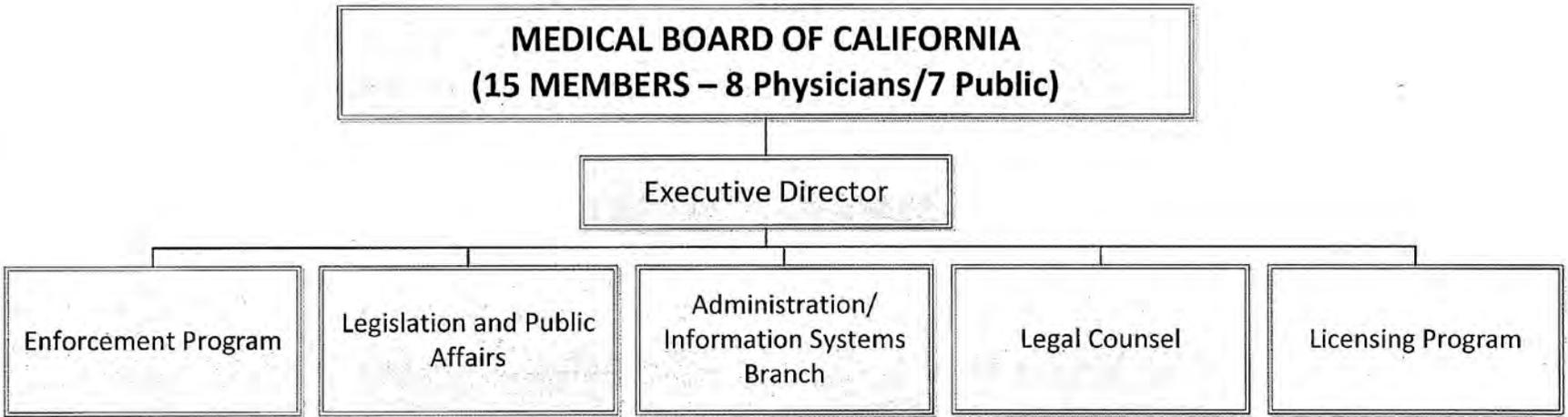
Medical Board of California
Licensing Program
FY 2010/2011



Licensing – 53.3 PYs plus permanent intermittent

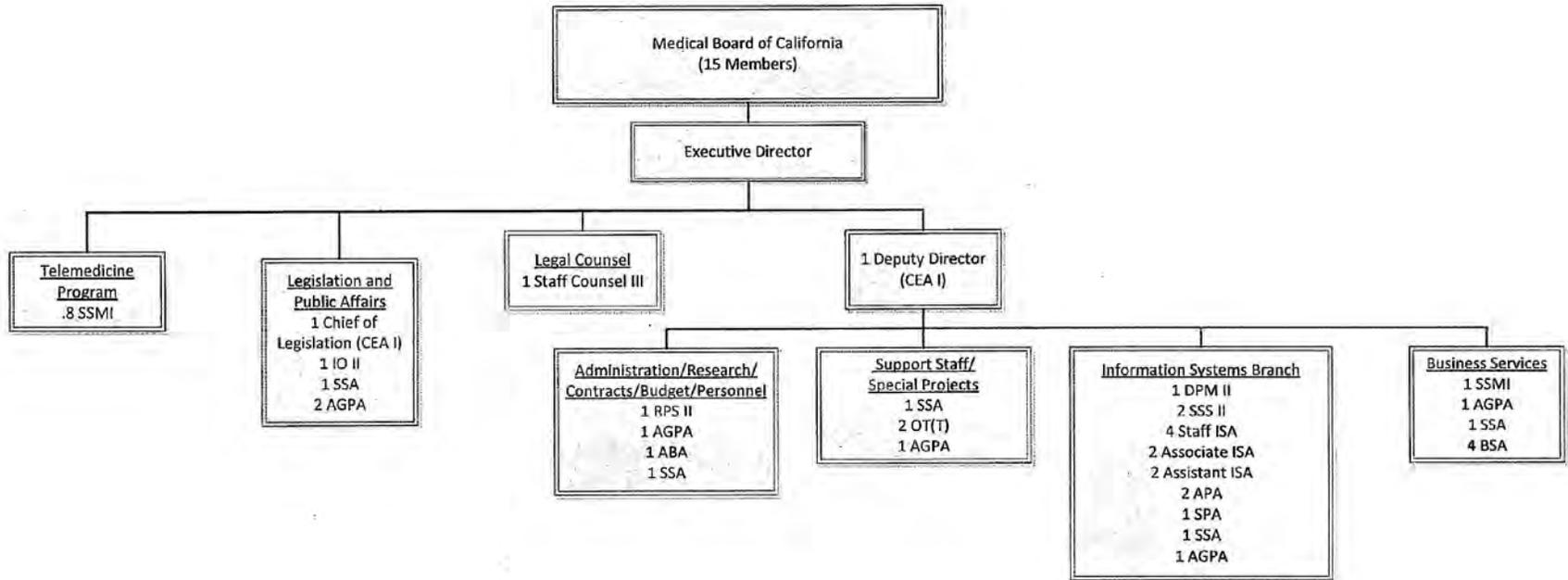
Medical Board of California
Enforcement Program
FY 2010/2011





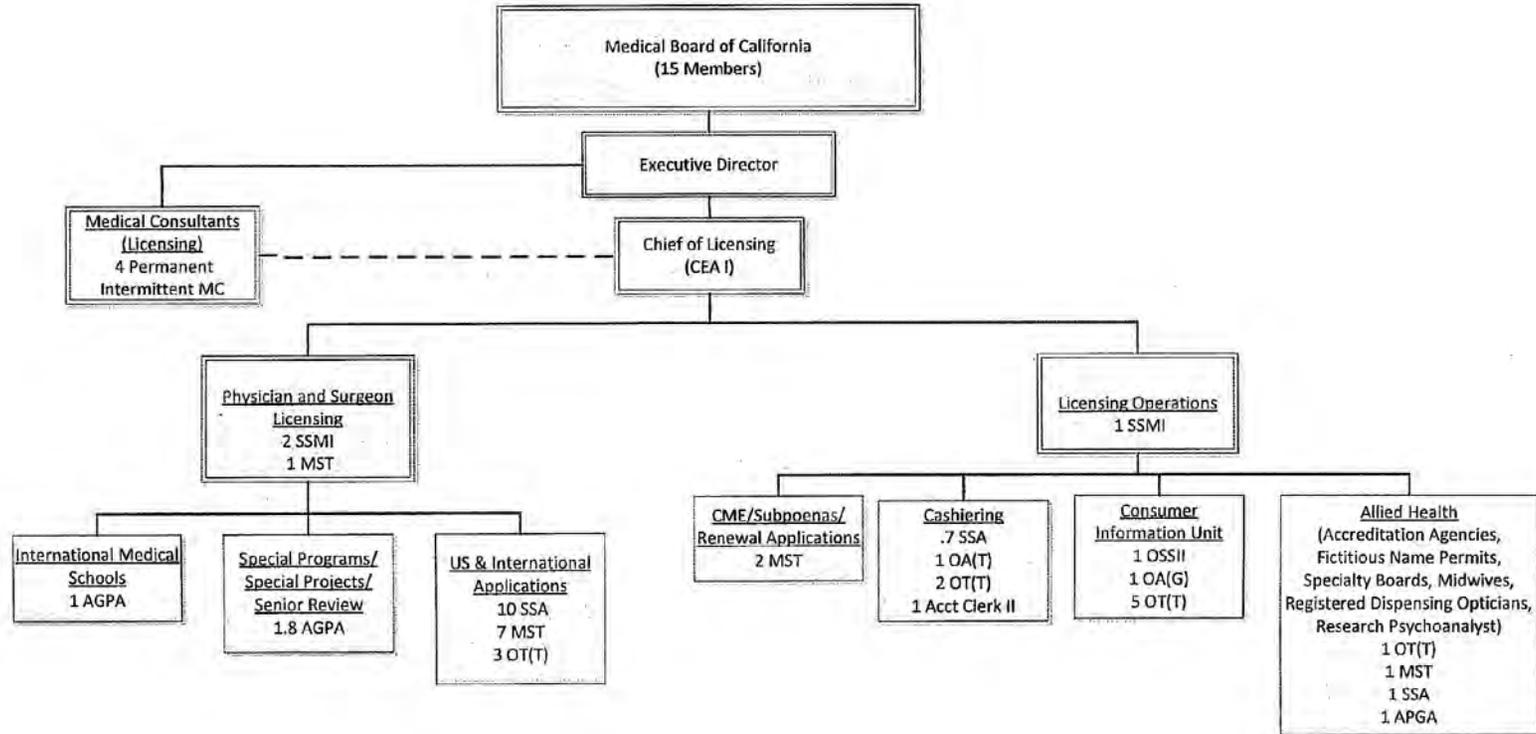
FY 2009/2010
262.9 PYs plus permanent intermittent

Medical Board of California
 Administrative and Executive Programs
 FY 2009/2010



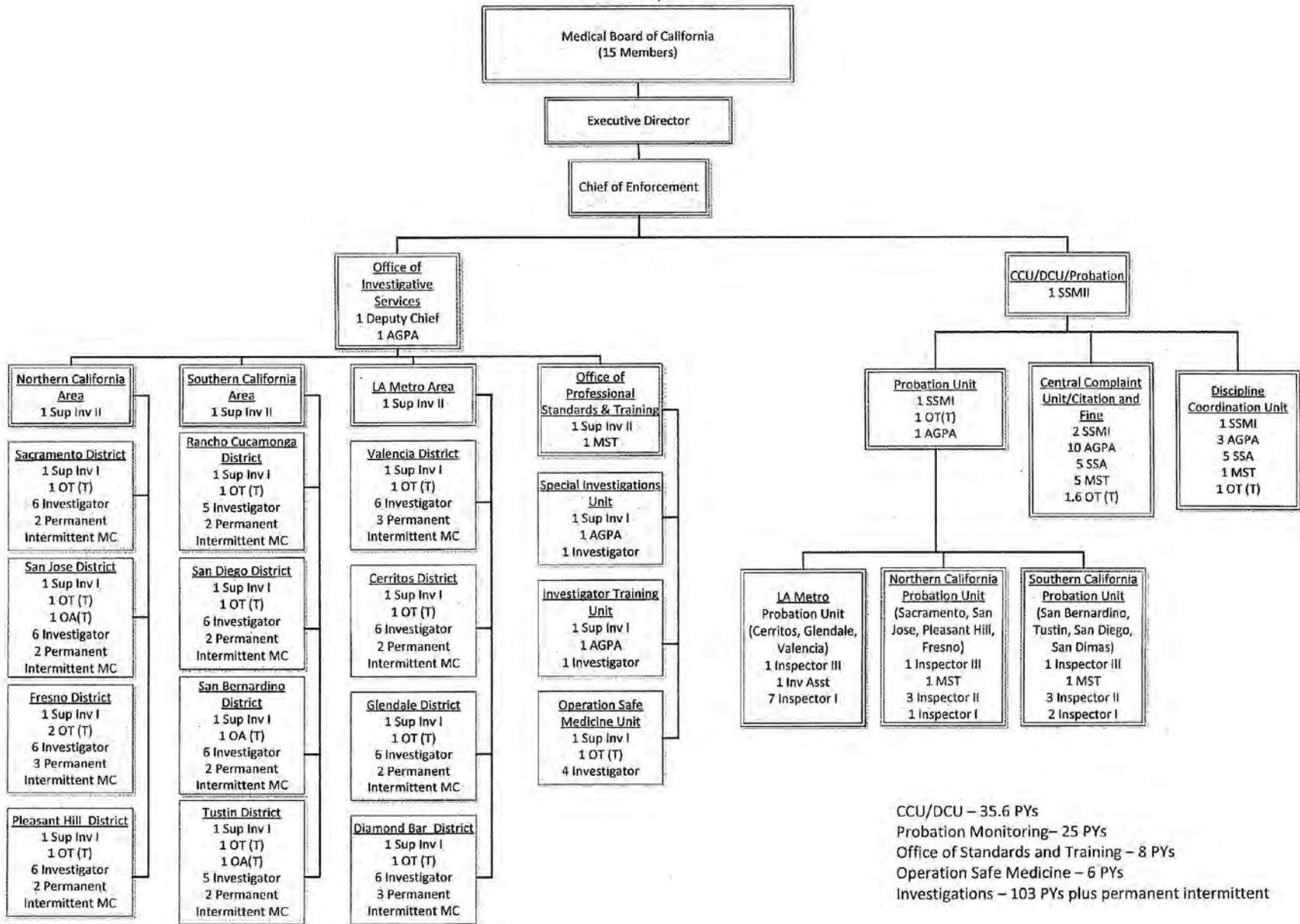
Administration – 11 PYs
 Executive – 12.8 PYs plus permanent intermittent
 Information Systems Branch – 16 PYs

Medical Board of California
Licensing Program
FY 2009/2010



Licensing – 45.5 PYs plus permanent intermittent

Medical Board of California
Enforcement Program
FY 2009/2010



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:
 - Internal changes (i.e., reorganization, relocation, change in leadership, strategic planning)

¹ The term "board" in this document refers to a board, bureau, commission, committee, department, division, program or agency, as applicable. Please change the term "board" throughout this document to appropriately refer to the entity being reviewed.

- All legislation sponsored by the board and affecting the board since the last sunset review.
 - All regulation changes approved by the board the last sunset review. Include the status of each regulatory change approved by the board.
4. Describe any major studies conducted by the board (cf. Section 12, Attachment C).
 5. List the status of all national associations to which the board belongs.
 - Does the board's membership include voting privileges?
 - List committees, workshops, working groups, task forces, etc., on which board participates.
 - How many meetings did board representative(s) attend? When and where?
 - If the board is using a national exam, how is the board involved in its development, scoring, analysis, and administration?

Section 2 – Performance Measures and Customer Satisfaction Surveys

6. Provide each quarterly and annual performance measure report as published on the DCA website
7. Provide results for each question in the customer satisfaction survey broken down by fiscal year. Discuss the results of the customer satisfaction surveys.

Section 3 – Fiscal and Staff

Fiscal Issues

8. Describe the board's current reserve level, spending, and if a statutory reserve level exists.
9. Describe if/when a deficit is projected to occur and if/when fee increase or reduction is anticipated. Describe the fee changes (increases or decreases) anticipated by the board.

Table 2. Fund Condition						
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2009/10	FY 2011/12	FY 2012/13	FY 2013/14
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						

- 10. Describe history of general fund loans. When were the loans made? When were payments made? What is the remaining balance?
- 11. Describe the amounts and percentages of expenditures by program component. Use *Table 3. Expenditures by Program Component* to provide a breakdown of the expenditures by the board in each program area. Expenditures by each component (except for pro rata) should be broken out by personnel expenditures and other expenditures.

Table 3. Expenditures by Program Component								
	FY 2008/09		FY 2009/10		FY 2010/11		FY 2011/12	
	Personnel Services	OE&E						
Enforcement								
Examination								
Licensing								
Administration *								
DCA Pro Rata								
Diversion (if applicable)								
TOTALS	\$	\$	\$	\$	\$	\$	\$	\$

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

- 12. Describe license renewal cycles and history of fee changes in the last 10 years. Give the fee authority (Business and Professions Code and California Code of Regulations citation) for each fee charged by the board.

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue

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

Table 5. Budget Change Proposals (BCPs)								
BCP ID #	Fiscal Year	Description of Purpose of BCP	Personnel Services				OE&E	
			# Staff Requested (include classification)	# Staff Approved (include classification)	\$ Requested	\$ Approved	\$ Requested	\$ Approved

Staffing Issues

- 14. Describe any staffing issues/challenges, i.e., vacancy rates, efforts to reclassify positions, staff turnover, recruitment and retention efforts, succession planning.
- 15. Describe the board's staff development efforts and how much is spent annually on staff development (cf., Section 12, Attachment D).

Section 4 – Licensing Program

- 16. What are the board's performance targets/expectations for its licensing² program? Is the board meeting those expectations? If not, what is the board doing to improve performance?
- 17. Describe any increase or decrease in 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 to address them? What are the performance barriers and what improvement plans are in place? What has the board done and what is the board going to do to address any performance issues, i.e., process efficiencies, regulations, BCP, legislation?
- 18. How many licenses or registrations does the board issue each year? How many renewals does the board issue each year?

Table 6. Licensee Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				
[Enter License Type]	Active				
	Out-of-State				
	Out-of-Country				
	Delinquent				

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

Table 7a. Licensing Data by Type											
Application Type	Received	Approved	Closed	Issued	Pending Applications			Cycle Times			
					Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out	
FY 2009/10	(Exam)				-	-	-	-	-	-	-
	(License)				-	-	-	-	-	-	-
	(Renewal)			n/a	-	-	-	-	-	-	-
FY 2010/11	(Exam)										
	(License)										
	(Renewal)			n/a							
FY 2011/12	(Exam)										
	(License)										
	(Renewal)			n/a							

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data			
	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License/Initial Exam Applications Received			
Initial License/Initial Exam Applications Approved			
Initial License/Initial Exam Applications Closed			
License Issued			
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)			
Pending Applications (outside of board control)*			
Pending Applications (within the board control)*			
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)			
Average Days to Application Approval (incomplete applications)*			
Average Days to Application Approval (complete applications)*			
License Renewal Data:			
License Renewed			

* Optional. List if tracked by the board.

19. How does the board verify information provided by the applicant?
- a. What process is used to check prior criminal history information, prior disciplinary actions, or other unlawful acts of the applicant?
 - b. Does the board fingerprint all applicants?
 - c. Have all current licensees been fingerprinted? If not, explain.

- d. Is there a national databank relating to disciplinary actions? Does the board check the national databank prior to issuing a license? Renewing a license?
 - e. Does the board require primary source documentation?
20. Describe the board's legal requirement and process for out-of-state and out-of-country applicants to obtain licensure.
21. 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 2008/09	# of 1 st Time Candidates		
	Pass %		
FY 2009/10	# of 1 st Time Candidates		
	Pass %		
FY 2010/11	# of 1 st Time Candidates		
	Pass %		
FY 2011/12	# 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 2008/09	# of 1 st Time Candidates		
	Pass %		
FY 2009/10	# of 1 st Time Candidates		
	Pass %		
FY 2010/11	# of 1 st Time Candidates		
	Pass %		
FY 2011/12	# of 1 st time Candidates		
	Pass %		
	Date of Last OA		
	Name of OA Developer		
	Target OA Date		

22. Describe the examinations required for licensure. Is a national examination used? Is a California specific examination required?

23. What are pass rates for first time vs. retakes in the past 4 fiscal years? (Refer to Table 8: Examination Data)
24. 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?
25. Are there existing statutes that hinder the efficient and effective processing of applications and/or examinations? If so, please describe.

School approvals

26. 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?
27. How many schools are approved by the board? How often are schools reviewed?
28. What are the board's legal requirements regarding approval of international schools?

Continuing Education/Competency Requirements

29. Describe the board's continuing education/competency requirements, if any. Describe any changes made by the board since the last review.
 - a. How does the board verify CE or other competency requirements?
 - b. Does the board conduct CE audits on its licensees? Describe the board's policy on CE audits.
 - c. What are consequences for failing a CE audit?
 - d. How many CE audits were conducted in the past four fiscal years? How many fails?
 - 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 licensees' continuing competence.

Section 5 – Enforcement Program

30. 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?
31. Explain trends in enforcement data and the board's efforts to address any increase in volume, timeframes, ratio of closure to pending, 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 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received			
Closed			
Referred to INV			
Average Time to Close	-		
Pending (close of FY)			
Source of Complaint (Use CAS Report 091)			
Public			
Licensee/Professional Groups			
Governmental Agencies			
Other			
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received			
CONV Closed			
Average Time to Close	-		
CONV Pending (close of FY)			
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
License Applications Denied			
SOIs Filed			
SOIs Withdrawn			
SOIs Dismissed			
SOIs Declined			
Average Days SOI	-		
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed			
Accusations Withdrawn			
Accusations Dismissed			
Accusations Declined			
Average Days Accusations	-		
Pending (close of FY)			

Table 9b. Enforcement Statistics (continued)			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions			
Stipulations			
Average Days to Complete			
AG Cases Initiated			
AG Cases Pending (close of FY)			
Disciplinary Outcomes (Use CAS Report 096)			
Revocation			
Voluntary Surrender			
Suspension			
Probation with Suspension			
Probation			
Probationary License Issued			
Other			
PROBATION			
New Probationers			
Probations Successfully Completed			
Probationers (close of FY)			
Petitions to Revoke Probation			
Probations Revoked			
Probations Modified			
Probations Extended			
Probationers Subject to Drug Testing			
Drug Tests Ordered			
Positive Drug Tests			
Petition for Reinstatement Granted			
DIVERSION			
New Participants			
Successful Completions			
Participants (close of FY)			
Terminations			
Terminations for Public Threat			
Drug Tests Ordered			
Positive Drug Tests			

Table 9c. Enforcement Statistics (continued)			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned			
Closed			
Average days to close	-		
Pending (close of FY)			
Desk Investigations (Use CAS Report EM 10)			
Closed	-		
Average days to close	-		
Pending (close of FY)	-		
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	-		
Average days to close	-		
Pending (close of FY)	-		
Sworn Investigation			
Closed (Use CAS Report EM 10)			
Average days to close	-		
Pending (close of FY)			
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued			
PC 23 Orders Requested			
Other Suspension Orders			
Public Letter of Reprimand			
Cease & Desist/Warning			
Referred for Diversion			
Compel Examination			
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued			
Average Days to Complete	-		
Amount of Fines Assessed			
Reduced, Withdrawn, Dismissed			
Amount Collected			
CRIMINAL ACTION			
Referred for Criminal Prosecution			

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	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						

32. What do overall statistics show as to increases or decreases in disciplinary action since last review.
33. 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.
34. Are there mandatory reporting requirements? For example, requiring local officials or organizations, or other professionals to report violations, or for civil courts to report actions taken against a licensee. Are there problems with receiving the required reports? If so, what could be done to correct the problems?
35. Does the board operate with a statute of limitations? If so, please describe and provide citation. If so, how many cases were lost due to statute of limitations? If not, what is the board's policy on statute of limitations?
36. Describe the board's efforts to address unlicensed activity and the underground economy.

Cite and Fine

37. Discuss the extent to which the board has used its cite and fine authority. Discuss any changes from last review and last time regulations were updated. Has the board increased its maximum fines to the \$5,000 statutory limit?
38. How is cite and fine used? What types of violations are the basis for citation and fine?
39. How many informal office conferences, Disciplinary Review Committees reviews and/or Administrative Procedure Act appeals in the last 4 fiscal years?
40. What are the 5 most common violations for which citations are issued?
41. What is average fine pre and post appeal?
42. Describe the board's use of Franchise Tax Board intercepts to collect outstanding fines.

Cost Recovery and Restitution

- 43. Describe the board's efforts to obtain cost recovery. Discuss any changes from the last review.
- 44. How many and how much is ordered for revocations, surrenders and probationers? How much do you believe is uncollectable? Explain.
- 45. Are there cases for which the board does not seek cost recovery? Why?
- 46. Describe the board's use of Franchise Tax Board intercepts to collect cost recovery.
- 47. 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				
	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
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				
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered				
Amount Collected				

Section 6 – Public Information Policies

- 48. 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 website? When are draft meeting minutes posted online? When does the board post final meeting minutes? How long do meeting minutes remain available online?
- 49. Does the board webcast its meetings? What is the board's plan to webcast future board and committee meetings?
- 50. Does the board establish an annual meeting calendar, and post it on the board's web site?
- 51. 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)?
- 52. What information does the board provide to the public regarding its licensees (i.e., education completed, awards, certificates, certification, specialty areas, disciplinary action, etc.)?

53. What methods are used by the board to provide consumer outreach and education?

Section 7 – Online Practice Issues

54. 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

55. What actions has the board taken in terms of workforce development?

56. Describe any assessment the board has conducted on the impact of licensing delays.

57. Describe the board's efforts to work with schools to inform potential licensees of the licensing requirements and licensing process.

58. Provide any workforce development data collected by the board, such as:

- a. Workforce shortages
- b. Successful training programs.

Section 9 – Current Issues

59. What is the status of the board's implementation of the Uniform Standards for Substance Abusing Licensees?

60. What is the status of the board's implementation of the Consumer Protection Enforcement Initiative (CPEI) regulations?

61. Describe how the board is participating in development of BreZE and any other secondary IT issues affecting the board.

Section 10 – Board Action and Response to Prior Sunset Issues

Include the following:

1. Background information concerning the issue as it pertains to the board.
2. Short discussion of recommendations made by the Committee/Joint Committee during prior sunset review.

3. What action the board took in response to the recommendation or findings made under prior sunset review.
4. Any recommendations the board has for dealing with the issue, if appropriate.

Section 11 – New Issues

This is the opportunity for the board to inform the Committee of solutions to issues identified by the board and by the Committee. 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., legislative changes, policy direction, budget 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 Committee.

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).

Attachment F

BOARD MEMBER ATTENDANCE



BOARD MEMBER ATTENDANCE

Table 1a. Attendance			
Michael Bishop, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes
Silvia Diego, M.D.			
Date Appointed: July 30, 2010			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	Yes
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Not a Member at this meeting
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes
Dev Gnanadev, M.D.			
Date Appointed: December 21, 2011			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes

Sharon Levine, M.D.			
Date Appointed: February 11, 2009			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	05/07/09 – 05/08/09	Burlingame, CA	Yes
Quarterly Board Meeting	07/23/09 – 07/24/09	Sacramento	Yes
Quarterly Board Meeting	10/29/09 – 10/30/09	San Diego	Yes
Quarterly Board Meeting	01/28/10 – 01/29/10	Burlingame, CA	Yes
Quarterly Board Meeting	04/29/10 – 04/30/10	Los Angeles, CA	Yes
Quarterly Board Meeting	07/29/10 – 07/30/10	Sacramento	Yes
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	No
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Yes
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	No
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes
Reginald Low, M.D.			
Date Appointed: August 10, 2006			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/02/06 – 11/03/06	El Segundo, CA	Yes
Quarterly Board Meeting	02/01/07 – 02/02/07	Los Angeles, CA	Yes
Quarterly Board Meeting	04/26/07 – 04/27/07	Sacramento, CA	Yes

Section 12

Attachment - F

Reginald Low, M.D. (cont.)			
Date Appointed: August 10, 2006			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	07/26/07 – 07/27/07	So San Francisco	Yes
Quarterly Board Meeting	11/01/07 – 11/02/07	San Diego	Yes
Quarterly Board Meeting	01/31/08 – 02/01/08	Los Angeles	Yes
Quarterly Board Meeting	04/24/08 – 04/25/08	Sacramento, CA	Yes
Quarterly Board Meeting	07/24/08 – 07/25/08	So San Francisco	Yes
Quarterly Board Meeting	11/06/08 – 11/07/08	San Diego	11/06 – No 11/07 – Yes
Quarterly Board Meeting	01/29/09 – 01/30/09	El Segundo, CA	Yes
Quarterly Board Meeting	05/07/09 – 05/08/09	Burlingame, CA	Yes
Quarterly Board Meeting	07/23/09 – 07/24/09	Sacramento	Yes
Quarterly Board Meeting	10/29/09 – 10/30/09	San Diego	Yes
Quarterly Board Meeting	01/28/10 – 01/29/10	Burlingame, CA	Yes
Quarterly Board Meeting	04/29/10 – 04/30/10	Los Angeles, CA	04/29 – No 04/30 – Yes
Quarterly Board Meeting	07/29/10 – 07/30/10	Sacramento	Yes
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	Yes
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Yes
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes

Section 12

Attachment - F

Denise Pines			
Date Appointed: August 29, 2012			
Meeting Type	Meeting Date	Meeting Location	Attended?
New to Board			
Janet Salomonson, M.D.			
Date Appointed:		August 10, 2006	
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/02/06 – 11/03/06	El Segundo, CA	No
Quarterly Board Meeting	02/01/07 – 02/02/07	Los Angeles, CA	No
Quarterly Board Meeting	04/26/07 – 04/27/07	Sacramento, CA	Yes
Quarterly Board Meeting	07/26/07 – 07/27/07	So San Francisco	Yes
Quarterly Board Meeting	11/01/07 – 11/02/07	San Diego	Yes
Quarterly Board Meeting	01/31/08 – 02/01/08	Los Angeles	Yes
Quarterly Board Meeting	04/24/08 – 04/25/08	Sacramento, CA	Yes
Quarterly Board Meeting	07/24/08 – 07/25/08	So San Francisco	Yes
Quarterly Board Meeting	11/06/08 – 11/07/08	San Diego	Yes
Quarterly Board Meeting	01/29/09 – 01/30/09	El Segundo, CA	Yes
Quarterly Board Meeting	05/07/09 – 05/08/09	Burlingame, CA	Yes
Quarterly Board Meeting	07/23/09 – 07/24/09	Sacramento	Yes
Quarterly Board Meeting	10/29/09 – 10/30/09	San Diego	Yes
Quarterly Board Meeting	01/28/10 – 01/29/10	Burlingame, CA	Yes
Quarterly Board Meeting	04/29/10 – 04/30/10	Los Angeles, CA	Yes
Quarterly Board Meeting	07/29/10 – 07/30/10	Sacramento	Yes
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	Yes
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes

Section 12

Attachment - F

Janet Salomonson, M.D. (cont.)			
Date Appointed: August 10, 2006			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Yes
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes
Gerrie Schipske, R.N.P., J.D.			
Date Appointed: June 12, 2007			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	07/26/07 – 07/27/07	So San Francisco	Yes
Quarterly Board Meeting	11/01/07 – 11/02/07	San Diego	Yes
Quarterly Board Meeting	01/31/08 – 02/01/08	Los Angeles	Yes
Quarterly Board Meeting	04/24/08 – 04/25/08	Sacramento, CA	Yes
Quarterly Board Meeting	07/24/08 – 07/25/08	So San Francisco	Yes
Quarterly Board Meeting	11/06/08 – 11/07/08	San Diego	Yes
Quarterly Board Meeting	01/29/09 – 01/30/09	El Segundo, CA	Yes
Quarterly Board Meeting	05/07/09 – 05/08/09	Burlingame, CA	Yes
Quarterly Board Meeting	07/23/09 – 07/24/09	Sacramento	No
Quarterly Board Meeting	10/29/09 – 10/30/09	San Diego	Yes
Quarterly Board Meeting	01/28/10 – 01/29/10	Burlingame, CA	No
Quarterly Board Meeting	04/29/10 – 04/30/10	Los Angeles, CA	Yes
Quarterly Board Meeting	07/29/10 – 07/30/10	Sacramento	Yes

Section 12

Attachment - F

Gerrie Schipske, R.N.P., J.D. (cont.)			
Date Appointed: June 12, 2007			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	Yes
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Yes
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	No
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes
David Serrano Sewell, J.D.			
Date Appointed: August 29, 2012			
Meeting Type	Meeting Date	Meeting Location	Attended?
New to Board			
Barbara Yaroslavsky			
Date Appointed: September 24, 2003			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/06/03 – 11/07/03	San Diego, CA	Yes
Quarterly Board Meeting	01/29/04 – 01/30/04	Sacramento, CA	Yes
Quarterly Board Meeting	05/06/04 – 05/07/04	Newport Beach, CA	Yes
Quarterly Board Meeting	07/29/04 – 07/30/04	Sacramento, CA	No
Quarterly Board Meeting	11/04/04 – 11/05/04	San Diego, CA	Yes
Quarterly Board Meeting	02/17/05 – 02/18/05	El Segundo, CA	Yes
Quarterly Board Meeting	05/05/05 – 05/06/05	Burlingame, CA	Yes
Quarterly Board Meeting	07/28/05 – 07/29/05	Sacramento	Yes

Barbara Yaroslavsky (cont.)			
Date Appointed: September 24, 2003			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	11/03/05 – 11/04/05	San Diego, CA	Yes
Quarterly Board Meeting	02/02/06 – 02/03/06	El Segundo, CA	Yes
Quarterly Board Meeting	05/11/06 – 05/12/06	Santa Ana, CA	Yes
Quarterly Board Meeting	07/27/06 – 07/28/06	Burlingame, CA	Yes
Quarterly Board Meeting	11/02/06 – 11/03/06	El Segundo, CA	Yes
Quarterly Board Meeting	02/01/07 – 02/02/07	Los Angeles, CA	Yes
Quarterly Board Meeting	04/26/07 – 04/27/07	Sacramento, CA	Yes
Quarterly Board Meeting	07/26/07 – 07/27/07	So San Francisco	Yes
Quarterly Board Meeting	11/01/07 – 11/02/07	San Diego	Yes
Quarterly Board Meeting	01/31/08 – 02/01/08	Los Angeles	Yes
Quarterly Board Meeting	04/24/08 – 04/25/08	Sacramento, CA	Yes
Quarterly Board Meeting	07/24/08 – 07/25/08	So San Francisco	Yes
Quarterly Board Meeting	11/06/08 – 11/07/08	San Diego	Yes
Quarterly Board Meeting	01/29/09 – 01/30/09	El Segundo, CA	Yes
Quarterly Board Meeting	05/07/09 – 05/08/09	Burlingame, CA	Yes
Quarterly Board Meeting	07/23/09 – 07/24/09	Sacramento	Yes
Quarterly Board Meeting	10/29/09 – 10/30/09	San Diego	Yes
Quarterly Board Meeting	01/28/10 – 01/29/10	Burlingame, CA	Yes
Quarterly Board Meeting	04/29/10 – 04/30/10	Los Angeles, CA	Yes
Quarterly Board Meeting	07/29/10 – 07/30/10	Sacramento	Yes
Quarterly Board Meeting	11/04/10 – 11/05/10	Long Beach, CA	Yes

Barbara Yaroslavsky (cont.)			
Date Appointed: September 24, 2003			
Meeting Type	Meeting Date	Meeting Location	Attended?
Quarterly Board Meeting	01/27/11 – 01/28/11	Burlingame, CA	Yes
Quarterly Board Meeting	05/05/11 – 05/06/11	Los Angeles, CA	Yes
Quarterly Board Meeting	07/28/11 – 07/29/11	Sacramento	Yes
Quarterly Board Meeting	10/27/11 – 10/28/11	San Diego, CA	Yes
Quarterly Board Meeting	02/02/12 – 02/03/12	Burlingame, CA	Yes
Quarterly Board Meeting	05/03/12 – 05/04/12	Torrance, CA	Yes
Quarterly Board Meeting	07/19/12 – 07/20/12	Sacramento	Yes

Attachment G

BOARD MEMBER COMMITTEE ROSTER



<p>Education Committee</p> <p>*****</p> <p>Subcommittee Members</p>	<p>Barbara Yaroslavsky, Chair Silvia Diego, M.D. Sharon Levine, M.D. Janet Salomonson, M.D. Gerrie Schipske, R.N.P., J.D.</p> <p>*****</p> <p>Daniel Giang, M.D. William Norcross, M.D. Laurie Gregg, M.D. Gary Nye, M.D.</p>
<p>Committee on Physician Supervisory Responsibilities</p>	<p>Gerrie Schipske, R.N.P., J.D. Chair Christopher Barnard, M.D. James Newman, M.D. Michael Bishop, M.D. Paul Phinney, M.D. Jack Bruner, M.D. Harrison Robbins, M.D. Beth Grivett, P.A. Janet Salomonson, M.D. Suzanne Kilmer, M.D.</p>
<p>Midwifery Advisory Council</p>	<p>Carrie Sparrevohn, L.M., Chair James Byrne, M.D. Karen Ehrlich, L.M. Faith Gibson, L.M. Monique Webster Barbara Yaroslavsky</p>
<p>Panel A</p>	<p>Barbara Yaroslavsky, Chair Janet Salomonson, M.D., Vice Chair Michael Bishop, M.D. Silvia Diego, M.D. David Serrano Sewell, J.D.</p>
<p>Panel B</p>	<p>Reginald Low, M.D., Chair Dev GnanaDev, M.D. Sharon Levine, M.D. Reginald Low, M.D. Denise Pines Gerrie Schipske, R.N.P., J.D.</p>

Revised: 10/26/12

Attachment H

B&P CODE SECTION AND CCR SECTION FOR APPLICANT REVIEW COMMITTEE

- B&P CODE SECTION 2099
- TITLE 16, CCR, SECTION 1301



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.

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(c)



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 SECTIONS FOR SPECIAL PROGRAMS COMMITTEE

- 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 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), are legally admitted to the United States, 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 but are legally admitted to the United States 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) Documentary evidence satisfactory to the division that the applicant is a United States citizen or is legally admitted to the United States.

(2) 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.

(3) 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.

(4) 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.

(5) 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 but are legally admitted to the United States 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.

Attachment K

B&P CODE SECTION FOR MIDWIFERY ADVISORY COUNCIL

- B&P CODE SECTION 2509



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 L

B&P CODE SECTION FOR PANEL A AND PANEL B

- B&P CODE SECTION 2008



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 M

PERFORMANCE MEASURES

- Annual Report (FY 2011/2012)
 - *Fourth Quarter Report (FY 2011/2012)*
 - *Third Quarter Report (FY 2011/2012)*
 - *Second Quarter Report (FY 2011/2012)*
 - *First Quarter Report (FY 2011/2012)*
- Annual Report (FY 2010/2011)
 - *Fourth Quarter Report (FY 2010/2011)*
 - *Third Quarter Report (FY 2010/2011)*
 - *Second Quarter Report (FY 2010/2011)*
 - *First Quarter Report (FY 2010/2011)*



Department of Consumer Affairs

Medical Board of California

Performance Measures Annual Report (2011 – 2012 Fiscal Year)

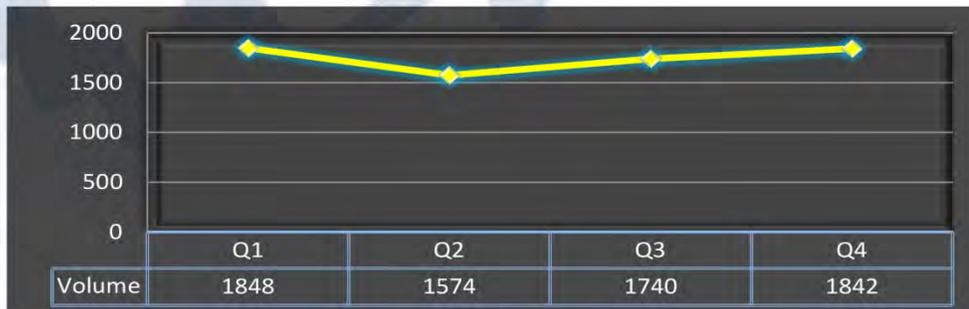
To ensure stakeholders can review the Board’s progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the four quarters worth of data.

Volume

Number of complaints and convictions received.

The Board had an annual total of 7,004 this fiscal year.



Intake

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

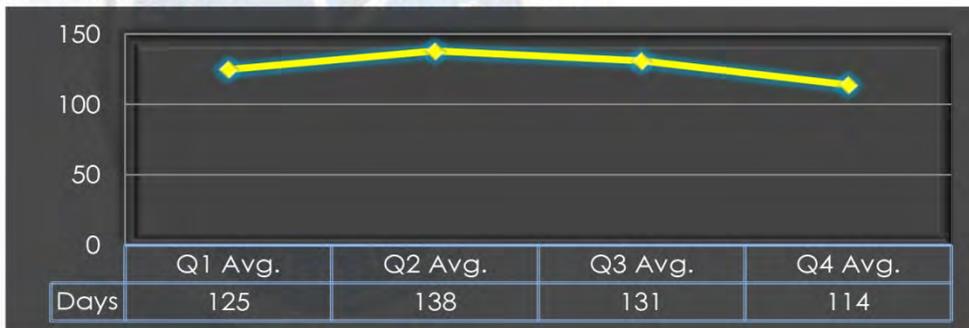
The Board has set a target of 9 days for this measure.



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.



Discipline

Average number of days to complete the enforcement process (intake, investigation, and formal discipline) for those cases closed at the discipline stage. Does not include withdrawals or dismissals.

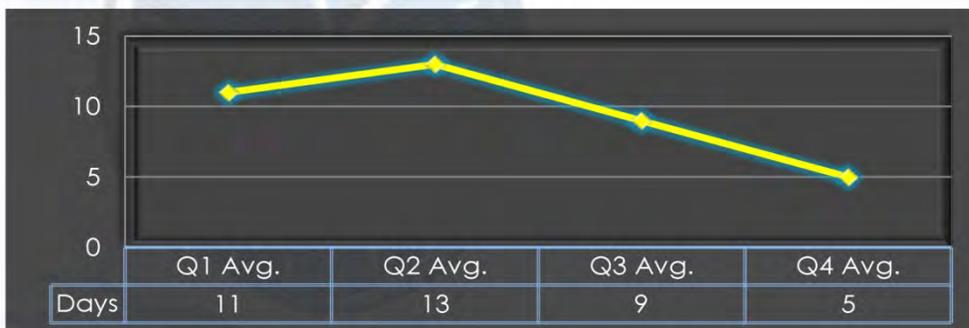
The Board has set a target of 540 days for this measure.



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.



Department of Consumer Affairs

Medical Board of California

Performance Measures

Q4 Report (April - June 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.

Q4 Total: 1,842

Complaints: 1,720 Convictions: 122

Q4 Monthly Average: 614



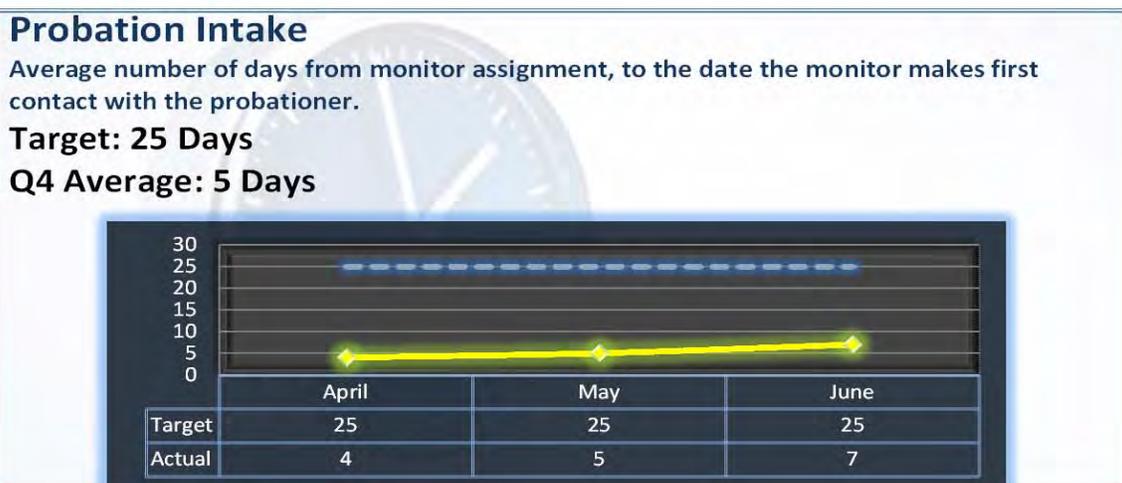
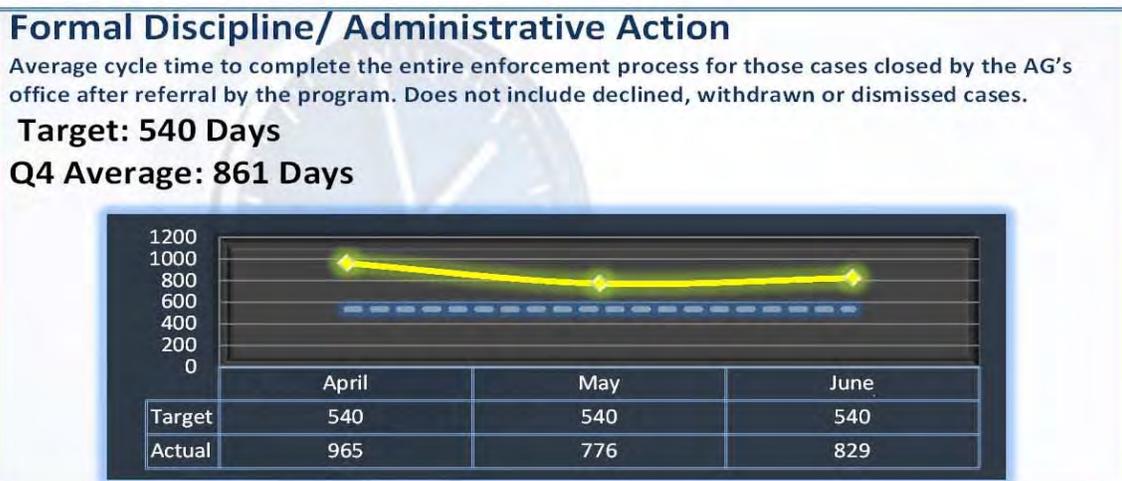
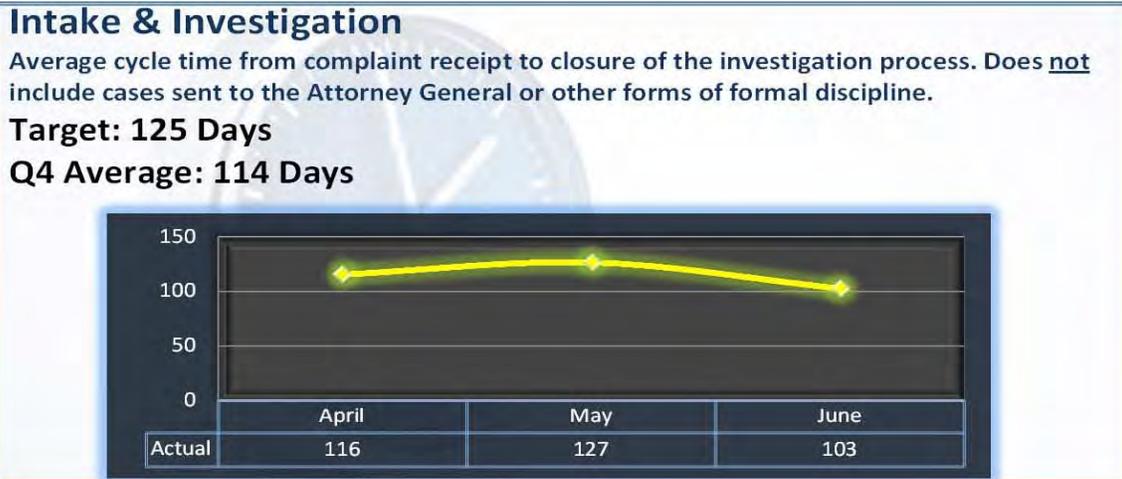
Intake

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

Target: 9 Days

Q4 Average: 10 Days





Department of Consumer Affairs

Medical Board of California

Performance Measures

Q3 Report (January - March 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.

Q3 Total: 1,740

Complaints: 1,560 Convictions: 180

Q3 Monthly Average: 580



Intake

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

Target: 9 Days

Q3 Average: 10 Days

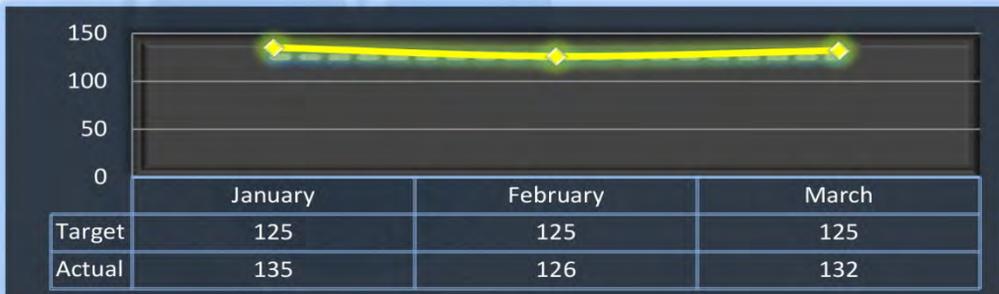


Intake & Investigation

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: 131 Days

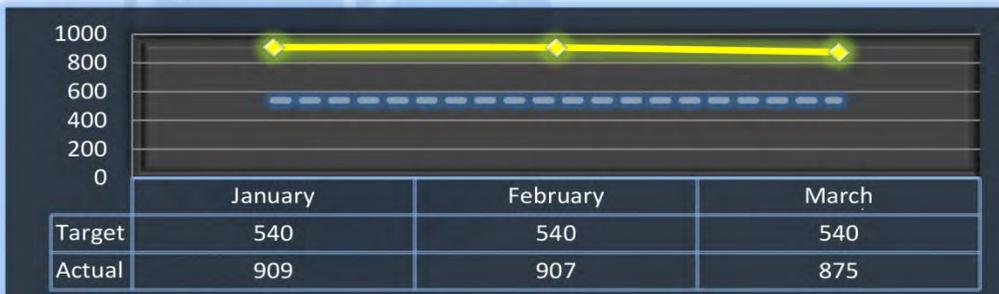


Formal Discipline/ Administrative Action

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: 895 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: 9 Days



Department of Consumer Affairs

Medical Board of California

Performance Measures

Q2 Report (October - December 2011)

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.

Q2 Total: 1,574

Complaints: 1,489 Convictions: 85

Q2 Monthly Average: 525



Intake

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

Target: 9 Days

Q2 Average: 17 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: 138 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: 856 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: 13 Days



Department of Consumer Affairs

Medical Board of California

Performance Measures

Q1 Report (July - September 2011)

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: 1,848

Complaints: 1,760 Convictions: 88

Q1 Monthly Average: 616



Intake

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

Target: 9 Days

Q1 Average: 12 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: 125 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: 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

Q1 Average: 11 Days



Department of Consumer Affairs
**Medical Board of
 California**

Performance Measures
Annual Report (2010 – 2011 Fiscal Year)

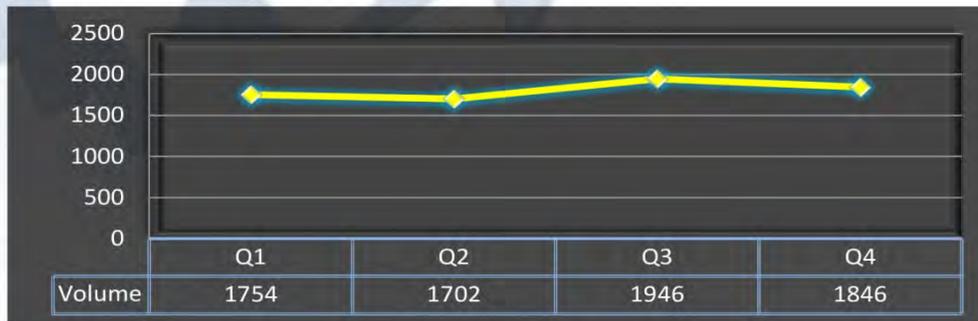
To ensure stakeholders can review the Board’s progress in meeting its enforcement goals and targets, we have developed a transparent system of performance measurement. These measures are posted publicly on a quarterly basis.

This annual report represents the culmination of the first four quarters worth of data.

Volume

Number of complaints and convictions received.

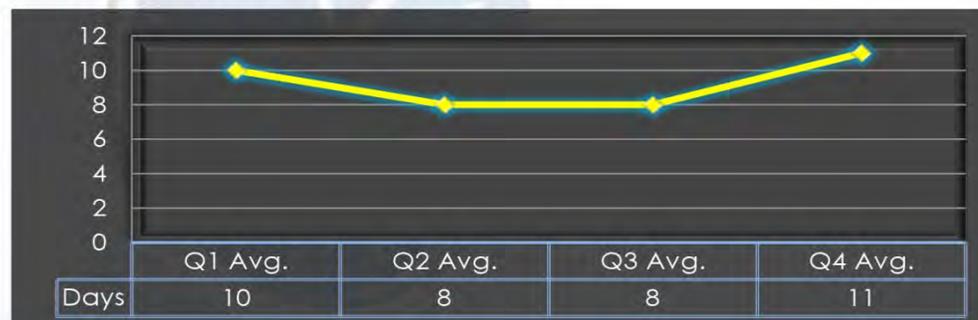
The Board had an annual total of 7,248 this fiscal year.



Intake

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

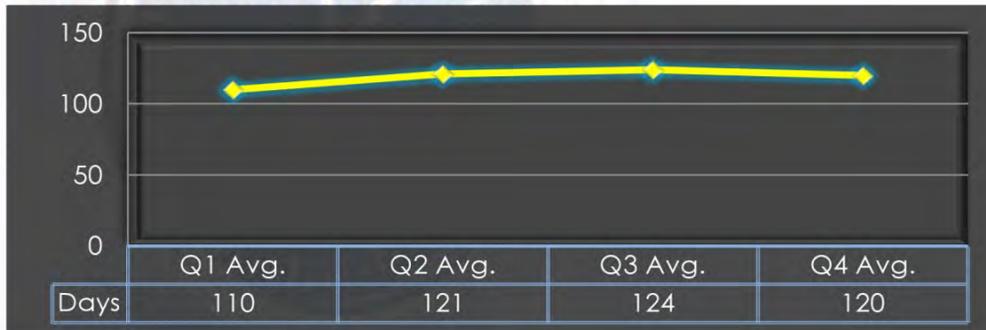
The Board has set a target of 9 days for this measure.



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.

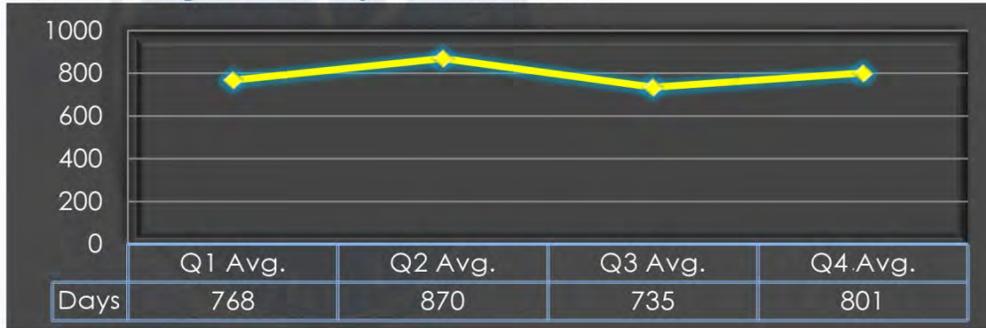
The Board has set a target of 125 days for this measure.



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.

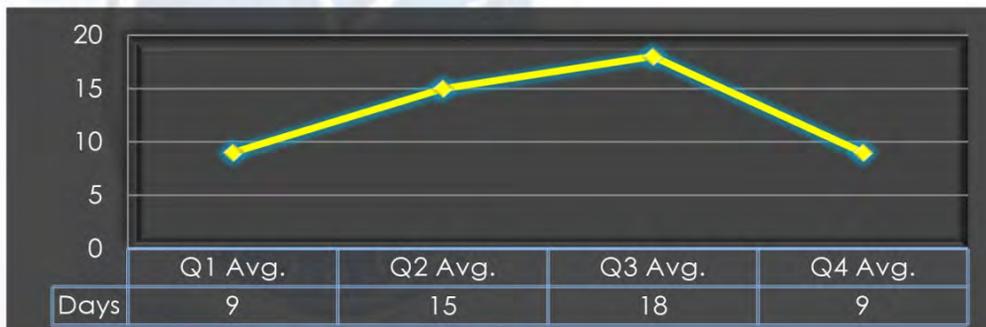
The Board has set a target of 540 days for this measure.



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.



Department of Consumer Affairs
**Medical Board of
 California**

Performance Measures

Q4 Report (April - June 2011)

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.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q4 Total: 1,846

Complaints: 1,756 Convictions: 90

Q4 Monthly Average: 615



Intake

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

Target: 9 Days

Q4 Average: 11 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: 120 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: 9 Days



Department of Consumer Affairs
**Medical Board of
 California**

Performance Measures

Q3 Report (January - March 2011)

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.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q3 Total: 1,946

Complaints: 1,860 Convictions: 86

Q3 Monthly Average: 649



Intake

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

Target: 9 Days

Q3 Average: 8 Days

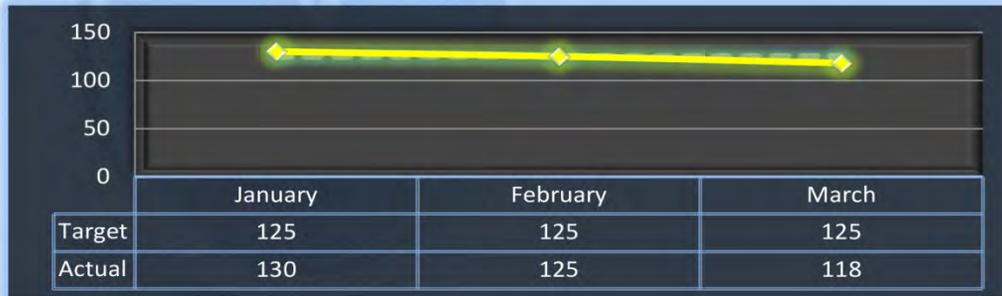


Intake & Investigation

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: 124 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: 735 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: 18 Days



Department of Consumer Affairs
**Medical Board of
 California**

Performance Measures

Q2 Report (October - December 2010)

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.

In future reports, the Department will request additional measures, such as consumer satisfaction. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints and convictions received.

Q2 Total: 1,702

Complaints: 1,601 Convictions: 101

Q2 Monthly Average: 567

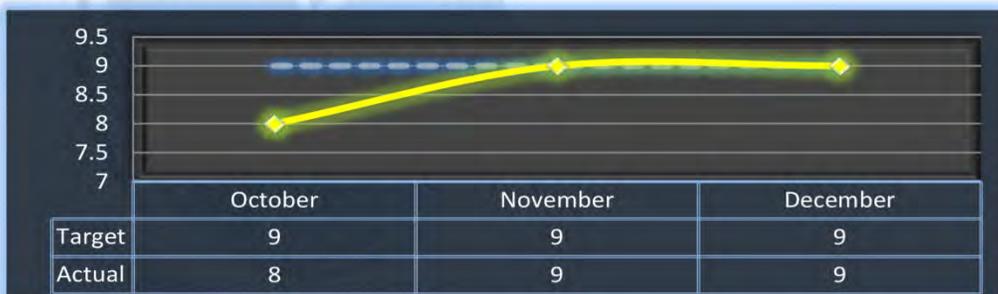


Intake

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

Target: 9 Days

Q2 Average: 8 Days

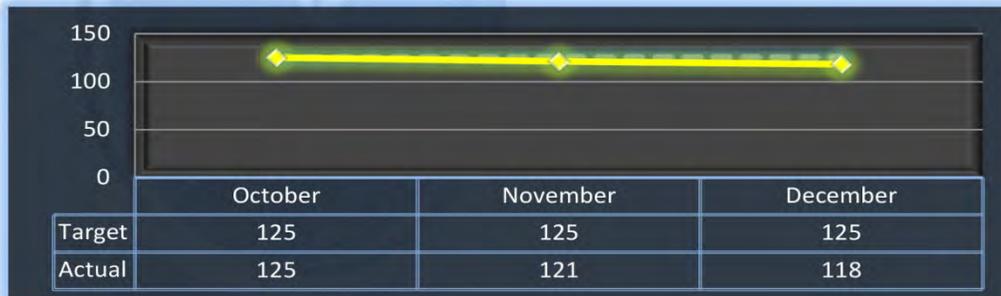


Intake & Investigation

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: 121 Days

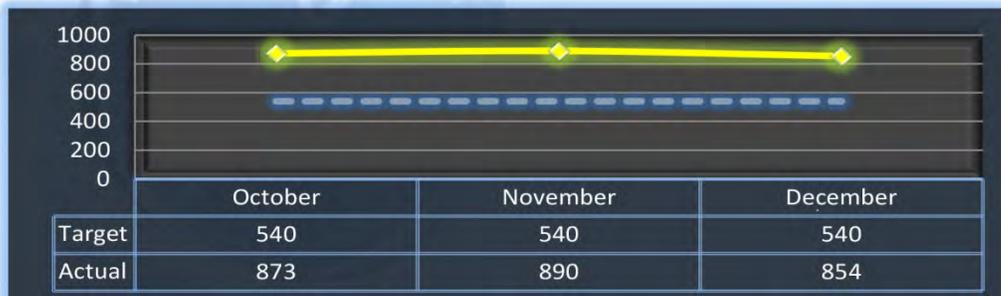


Formal Discipline / Administrative Action

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: 870 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: 15 Days



Department of Consumer Affairs

Medical Board of California

Performance Measures

Q1 Report (July - Sept 2010)

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. In future reports, additional measures, such as consumer satisfaction and complaint efficiency, will also be added. These additional measures are being collected internally at this time and will be released once sufficient data is available.

Volume

Number of complaints received.*

Q1 Total: 1,754 (Complaints: 1,659 Convictions: 95)

Q1 Monthly Average: 585



Intake

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

Target: 9 Days

Q1 Average: 10 Days



*“Complaints” in these measures include complaints, convictions, and arrest reports.

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: 110 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: 768 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: 9 Days



Attachment N

REVENUE AND FEE SCHEDULE



Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA							
Physician Application Fee (B&P 2435)	442.00	442.00	2,719,137	2,625,899	2,697,296	2,958,876	5.62%
Physician Initial License Fee (B&P 2435) (Title 16, CCR 1351.5)	783.00	790.00	1,512,442	1,285,555	1,408,668	1,492,531	2.84%
Physician Initial License Fee (Reduced – 1/2) (B&P 2435)	391.50	395.00	1,319,034	1,428,937	1,374,825	1,467,768	2.79%
Physician Biennial Renewal Fee (B&P 2435) (Title 16, CCR 1352)	783.00	790.00	44,478,782	44,455,854	43,570,578	46,047,490	87.51%
Physician Delinquency Fee (B&P 2435)	78.00	79.00	93,552	84,832	92,942	111,922	0.21%
Physician Penalty Fee (B&P 2424) (Title 16, CCR 1352.2)	391.50	391.50	128,423	102,798	108,575	134,409	0.26%
Physician Duplicate License Fee (B&P 2435)	10.00	10.00	610	750	720	510	0.00%
Physician Duplicate Certificate Fee (B&P 2435)	50.00	50.00	29,540	28,725	31,650	41,100	0.08%
Physician Letter of Good Standing (B&P 2435)	10.00	10.00	61,830	37,660	44,320	56,640	0.11%
Special Faculty Permit Application Fee (B&P 2168.4 & 2435)	442.00	442.00	442	442	442	--	--
Special Faculty Permit Initial License Fee (B&P 2435) (Title 16, CCR 1351.5)	783.00	790.00	1175	--	--	--	--
Special Faculty Permit Biennial Renewal Fee (B&P 2168.4 & 2435) (Title 16, CCR 1352.1)	783.00	790.00	1,610	3,959	783	2,349	0.00%
Special Faculty Permit Delinquency Fee (B&P 2168.4 & 2435)	78.00	79.00	--	--	--	--	--
Special Faculty Permit Penalty Fee (B&P 2168.4) (Title 16, CCR 1352.2)	391.50	391.50	--	805	--	--	--
Special Programs Initial Application Fee (B&P 21111 & 2113) (Title 16, CCR 1351.5)	86.00	86.00	6,020	3,784	4,902	4,386	0.01%
Special Programs Annual Renewal Fee (B&P 21111 & 2113) (Title 16, CCR 1351.1)	43.00	43.00	3,225	3,010	2,537	2,236	0.00%

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA							
Special Programs Delinquency Fee (B&P 163.5)	25.00	25.00	--	25	--	--	--
Fictitious Name Permit Application and Initial Permit Fee (B&P 2443)	50.00	50.00	71,240	64,780	69,500	71,200	0.14%
Fictitious Name Permit Biennial Renewal Fee (B&P 2443)	40.00	40.00	185,745	203,140	206,880	213,300	0.41%
Fictitious Name Permit Delinquency Fee (B&P 2443)	20.00	20.00	7,180	8,720	9,140	8,680	0.02%
Research Psychoanalyst Registration Fee (B&P 2529.5) (Title 16, CCR 1377)	100.00	100.00	500	600	700	500	0.00%
Research Psychoanalyst Reduced Registration Fee (B&P 2529.5) (Title 16, CCR 1377)	75.00	75.00	--	--	--	75	0.00%
Research Psychoanalyst Biennial Renewal Fee (B&P 2529.5) (Title 16, CCR 1377)	50.00	50.00	300	3,800	200	3,850	0.01%
Research Psychoanalyst Delinquency Fee (B&P 165.3)	25.00	25.00	50	150	--	50	0.00%
Polysomnography Trainee Application Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	3,700	0.01%
Polysomnography Trainee Registration Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	600	0.00%
Polysomnography Trainee Biennial Renewal Fee (B&P 3577) (Title 16, CCR 1379.78)	150.00	150.00	--	--	--	--	--
Polysomnography Trainee Delinquency Fee (B&P 163.5) (Title 16, CCR 1379.78)	75.00	75.00	--	--	--	--	--
Polysomnography Technician Application Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	--	--

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
CONTINGENT FUND OF THE MEDICAL BOARD OF CALIFORNIA							
Polysomnography Technician Registration Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	--	--
Polysomnography Technician Biennial Renewal Fee (B&P 3577) (Title 16, CCR 1379.78)	150.00	150.00	--	--	--	--	--
Polysomnography Technician Delinquency Fee (B&P 163.5) (Title 16, CCR 1379.78)	75.00	75.00	--	--	--	--	--
Polysomnography Technologist Application Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	--	--
Polysomnography Technologist Registration Fee (B&P 3577) (Title 16, CCR 1379.78)	100.00	100.00	--	--	--	--	--
Polysomnography Technologist Biennial Renewal Fee (B&P 3577) (Title 16, CCR 1379.78)	150.00	150.00	--	--	--	--	--
Polysomnography Technologist Delinquency Fee (B&P 163.5) (Title 16, CCR 1379.78)	75.00	75.00	--	--	--	--	--
Specialty Board Application Fee (B&P 651) (Title 16, CCR 1354)	4,030.00	4,030.00	--	--	--	--	--
Dishonored Check Fee (B&P 206)	25.00	25.00	--	--	--	--	--

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
OUTPATIENT SETTING FUND							
Accreditation Agency Approval Application Fee (Approval allows the agency to accredit Outpatient Surgery Settings) (B&P 2217) (H&S 1248.6) (Title 16, CCR 1313.6)	5,000.00	5,000.00	--	--	--	--	--
Accreditation Agency Approval Renewal Fee – every three years (Approval allows the agency to accredit Outpatient Surgery (B&P 2217) (H&S 1248.6) (Title 16, CCR 1313.6)	100.00 Per Outpatient Setting	100.00 Per Outpatient Setting	--	685	--	--	--

Attachment O

NATIONAL PRACTITIONER DATA BANK STUDY BY THE BOARD



MEDICAL BOARD STAFF REPORT

ATTENTION: Members, Medical Board of California
SUBJECT: National Practitioner Data Bank (NPDB) Information
STAFF CONTACT: Letitia Robinson, Research Specialist

RECOMMENDED ACTION

Staff requests the Board review the additional information provided and direct staff to implement the recommendations specified below as an alternative to querying the NPDB.

As reported at the May 2012 Board meeting (see attached agenda item memo), the Board has initiated and will continue, on an annual basis, to request from the NPDB reports filed from peer review bodies for California physicians. Board staff will review these reports to determine if the Board has received all of the reports and to pursue investigations if it has not received reports.

Staff recommends outreach activities to ensure mandated reporters are informed of their responsibility to report certain events to the Board. As suggested at the May 2012 Board meeting, an article regarding Peer review reporting has been placed in the Board's summer Newsletter, and more could be done via meetings with reporters.

BACKGROUND

At the February 3, 2012 Board Meeting, during "Public Comment on Items not on the Agenda" a suggestion was made to the Board. The suggestion encouraged the Board to look into the cost benefit analysis of querying the Data Bank every two years at the time of a physician's renewal.

Kimberly Kirchmeyer presented data on the feasibility of querying the NPDB for physician renewal candidates at the Board's May 4, 2012 meeting. The Board requested additional information including NPDB statistical data for review at the July 2012 Board meeting. The information below is in response to this request. (This item was deferred to the October Board meeting.)

ANALYSISPeer Review Reporting

An annual review is performed in order for the Board to conduct a periodic reconciliation of peer review reports made to NPDB versus reports made to the Board. The Board has, for the last two years and proposes to do on an annual basis, requested from the NPDB reports filed from peer review bodies for California physicians. Board staff will review these reports to determine if the Board has received all of the reports and pursue investigations if it has not received the reports.

Board staff has reviewed the 2010 and 2011 peer review actions for California physicians reported to the NPDB. In 2010, the Board received all peer review reports that were received by the NPDB. In 2011, there was one peer review report that was submitted to the NPDB but was not reported to the Board. Board staff has requested this report from the NPDB and will investigate the action taken against the licensee. Board staff will also investigate why the report was not made to the Board.

The 2010 and 2011 reports from NPDB did not include any physician peer review actions from other states where the physician was also licensed to practice medicine. The Board agrees that these actions are important to know about in order to protect California consumers. However, if the state for which the report was made did not take disciplinary action, it may not be worth the resources it would take for the Board to investigate. It is difficult to prosecute a case in another state, and if the other state did not take action, it would be much more difficult to attain the clear and convincing evidence standard.

For the Board to investigate such an action, it may require Board investigators to travel to other states. This is especially difficult with the requirement that all out-of-state travel be approved by the Governor’s Office. An out-of-state investigation may also require the Board to obtain out-of-state approval from the Governor’s Office and incur costs to bring witnesses to California. This is provided that the witness agrees to testify because the Board cannot compel a witness to come to California to testify. The Board’s subpoenas are not enforceable outside of California and obtaining witnesses and medical records may be problematic as the Board could not issue a subpoena. California consumers may be better served with having resources expended on physicians who are currently practicing in California.

The chart below shows the NPDB and MBC Peer Review reporting requirements. The biggest difference in the reporting requirements is the NPDB requires reporting actions that adversely affect privileges in excess of 30 days. The Board requires reporting of suspension in excess of 14 days and restrictions imposed for a cumulative total of 30 days or more for any 12-month period.

NPDB and MBC Peer Review Reporting Requirements

<i>NPDB</i>	<i>MBC</i>
Professional review action, based on reasons related to professional competence or conduct, adversely affecting clinical privileges for a period <u>longer than 30 days</u> including revocation, denial, non-renewal, and suspension. Voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation.	Peer Review actions, based on medical disciplinary cause or reason, when clinical privileges are denied or rejected; terminated or revoked; and when restrictions are imposed for a <u>cumulative total of 30 days or more</u> for any 12-month period. [B&P805(b)] Licensee resigns or take a leave of absence while under investigation; Licensee withdraws application or renewal of privileges while under investigation [B&P805(c)] Suspension in effect in excess of 14 days – [B&P805(e)]

The chart below shows the NPDB and MBC sanctions for failing to report Peer Review actions. The NPDB informed the Board that no sanctions have been levied against any entity in the last ten years. The Board has levied civil penalties for six cases of failure to report Peer Review actions within the past ten years. The

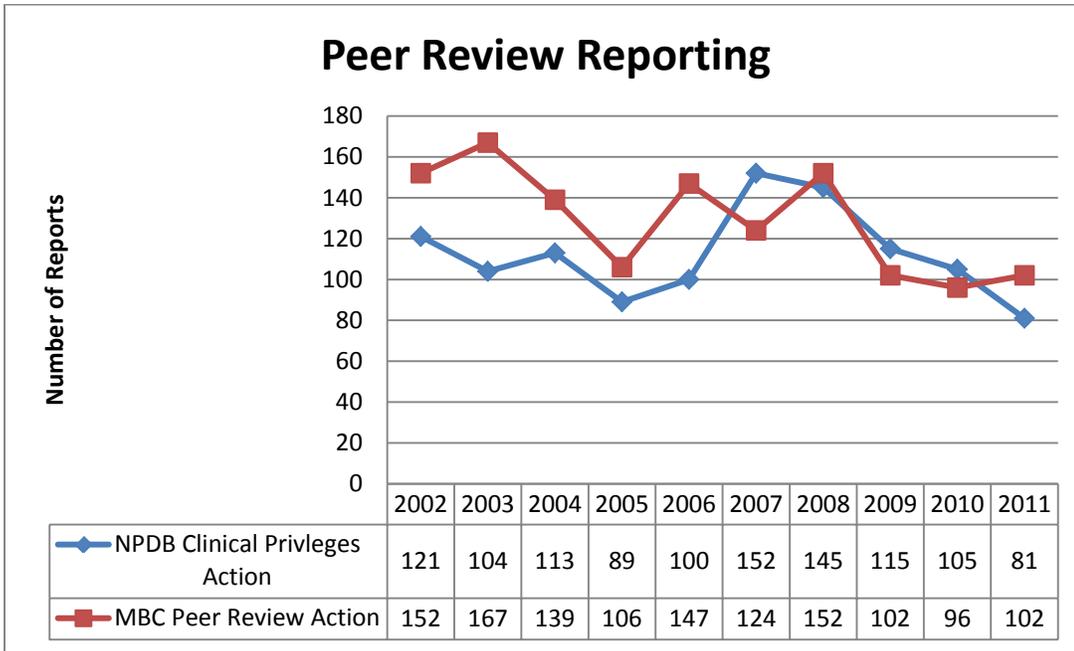
penalties in these cases ranged from \$5,000 to \$50,000 as some of these penalties were assessed prior to the increase in the amount of fines. SB 16 Figueroa (Statutes 2001, Chapter 614) increased the amount of the fine for a willful failure to report Peer Review actions from \$10,000 to \$100,000 and increased the amount of the fine for any failure to report from \$5,000 to \$50,000.

NPDB and MBC Sanctions for Failing to Report Peer Review Actions

<i>NPDB</i>	<i>Sanctions Issued in Years 2002-2011</i>	<i>MBC</i>	<i>Sanctions Issued in Years 2002-2011</i>
The entity will be published in the <i>Federal Register</i> and will lose immunity under the provisions of Title IV with respect to professional review activities for a period of 3 years.	None	<p>A willful failure to report: person designated to report may be fined up to \$100,000.</p> <p>[B&P 805(k)]</p> <p>Any failure to report: person designated to report may be fined up to \$50,000.</p> <p>[B&P 805(l)]</p>	Six

The following graph shows NPDB and MBC peer review reporting for the past 10 calendar years. The Board shows a higher number of reports than the NPDB in 7 of the 10 reporting years. Further, the NPDB peer review reports include reports of change in action of the reporting entity and restoration or reinstatement by the reporting entity as separate reports. The NPDB methodology of reporting is different than MBC reporting because MBC only counts the initial peer review report. The Board’s data does not include any supplemental reports it receives nor does it include any restoration/reinstatement in the data reporting.

For example in 2011, the NPDB reported receipt of 81 cases of Peer Review action against physicians in California. Of the 81 reports, seven were reports of restoration/reinstatement and nine were supplemental reports to an earlier 2011 report. These 16 reports would not be reflected in the Boards 2011 data because the Board only counts the report on its initial reporting. Therefore, only 65 of the 81 reports from the NPDB would be included in the MBC reports. However, in 2011 the Board reported 102 peer review reports. This is 37 more *initial* reports than what was reported to the NPDB.



Medical Malpractice Reporting

Assembly Bill 1070 Hill (Statutes 2009, Chapter 505) included amendments to Business and Professions Code § 801.01 – Report of Settlement or Arbitration Award. Previously, the law stated the failure of the licensee or his or her counsel to report the settlement or arbitration award was a public offense punishable by a fine from \$50 to \$500 and knowing and intentional failure to comply was punishable by a fine from \$5,000 to \$50,000. AB 1070 authorizes penalties for all reporters and states failure to substantially comply with the reporting requirements in B&P Code § 801.01 is a public offense punishable by a fine from \$500 to \$5,000. AB 1070 also added language to B&P Code § 801.01 (b)(3) to further clarify that the University of California System, as a self-insured agency, is required to report settlements and arbitration awards.

The charts below show the difference in NPDB and MBC Medical Malpractice reporting. The NPDB requires any and all payment claims in any amount be reported. The Board requires malpractice settlements over \$30,000, and judgments or arbitration awards of any amount be reported.

Difference in NPDB and MBC Medical Malpractice Reporting

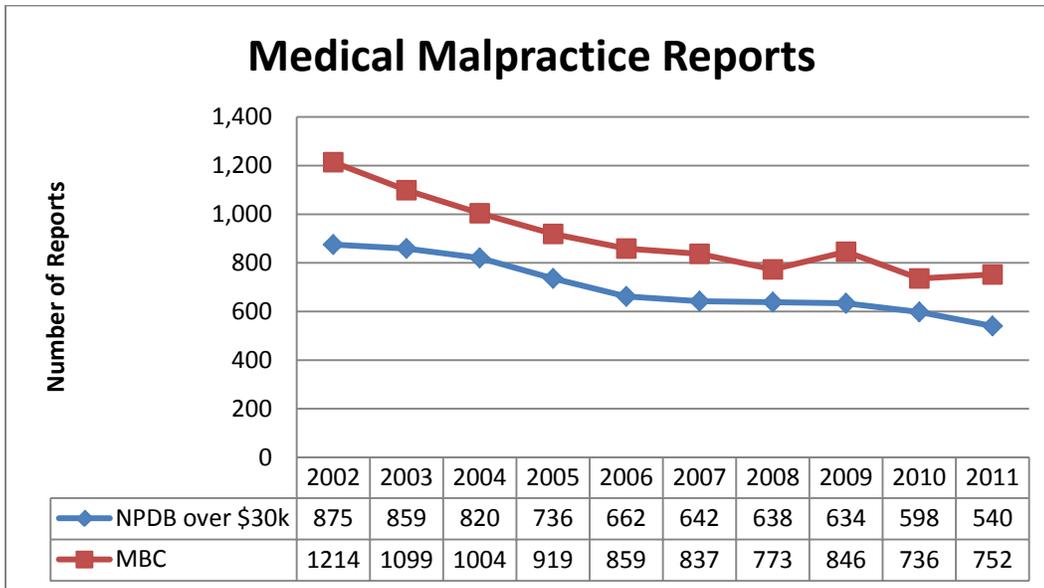
<i>NPDB</i>	<i>MBC</i>
Payment resulting from written claim or judgment.	Malpractice settlements over \$30,000; and judgments or arbitration awards of any amount. [B&P 801.01 (a)(1)(2)]

The charts below shows the sanctions imposed for failing to report medical malpractice payments to the NPDB and MBC. According to the NPDB, there has not been a penalty assessed in the last ten years for failure to report medical malpractice payments. The Board has also not levied any sanctions against any entity for failure to report medical malpractice payments.

Sanctions for Failing to Report Medical Malpractice Payments to the NPDB and MBC

<i>NPDB</i>	<i>Sanctions Issued 2001-2011</i>	<i>MBC</i>	<i>Sanctions Issued 2001-2011</i>
A civil money penalty up to \$11,000 for each payment involved.	None	Failure to substantially comply with the State’s reporting requirement is a public offense punishable by a fine ranging from \$500 to \$5,000. [B&P 801.01(f)]	None

The graph below shows NPDB and MBC medical malpractice payment reporting for the past 10 calendar years. The Board shows a higher number of reports than the NPDB in all 10 reporting years. The graph shows the decline of malpractice payment reports to the Board is similar to the decline of these reports to the NPDB. The Board requires malpractice settlements over \$30,000 and judgments/arbitration awards of any amount be reported to the Board. The graph below only shows the reports from the NPDB that are over \$30,000 to compare those of the same type of reports to the MBC.



Actions Reportable to the Healthcare Integrity and Protection Data Bank (HIPDB) and MBC

In addition to actions reported by the NPDB, HIPDB also receives reports. Below is a chart that shows the actions that are reported to HIPDB and MBC.

Reporting Organization	Reportable Action*	Are Reports Required?	
		To HIPDB	To MBC
Federal, State, and Local Prosecutors, Law Enforcement and Investigative Agencies	Criminal convictions, civil judgments (excluding those resulting from medical malpractice), injunctions, and <i>nolo contendere</i> /no contest pleas related to delivery of a health care item or service	Yes, must report	Yes, licensee must report: felony indictments; conviction of felony or misdemeanor. Fine up to \$5,000 for not reporting (B&P 802.1). District Attorney must report filing of felony charges; Clerk of the Court must report criminal convictions (B&P 803.5)
Federal and State Licensing or Certification Agencies	Final adverse actions related to the delivery of a health care item or service	Yes, must report	No report required
Federal and State Government Agencies	Exclusions from participating in Federal or State health care programs	Yes, must report	No report required (however, MBC obtains information from these entities)
Federal and State Government Agencies and Health Plans	Other adjudicated actions or decisions related to the delivery of a health care item or service	Yes, must report	No report required

* Subject of Report - Health Care Practitioners, Providers, and Suppliers

Update on NPDB Merger

Currently, when querying the NPBD there are two reports requested and there is a fee for each of the reports. These reports are the NPBD and the HIPDB. The data bank anticipates the NPBD and the HIPDB reports will be merged into the NPDB report by the end of 2012. The data bank could not confirm the fee for a query after the merger but stated it is probable that the current NPDB query fee would be increased.

MEDICAL BOARD STAFF REPORT

May 3, 2012

ATTENTION: Members, Medical Board of California
SUBJECT: Data Bank Query for Physicians Renewal Candidates
STAFF CONTACT: Letitia Robinson, Research Specialist

Recommended Action

Staff recommends the Board review the analysis and recommend that staff not pursue either a continuous query or a one-time query of the Data Bank for physician renewal candidates.

Background

At the February 3rd Board Meeting, during “Public Comment on Items not on the Agenda” a suggestion was made to the Board. The suggestion encouraged the Board to look into the cost benefit analysis of querying the Data Bank every two years at the time of a physician’s renewal.

This recommendation stemmed from a complaint made by Public Citizen, a Washington, D.C. consumer advocacy group, to the Governor of California. The complaint alleged the Board failed to take disciplinary action against 672 of its licensed physician and surgeons (alleged 710 physicians but 38 represent osteopathic physicians), all of whom were disciplined by California health care organizations, mainly hospitals. This information was based on an analysis of the Data Bank Public Use Data File from September 1990 through the end of 2009.

AnalysisData Bank Information

The Data Bank, consisting of the National Practitioner Data Bank (NPDB) and the Healthcare Integrity and Protection Data Bank (HIPDB), is a confidential information clearinghouse created by Congress to improve health care quality. The Data Bank does not disclose information on a specific practitioner to the general public. Authorized entities may query NPDB, HIPDB, or both.

The Data Bank offers two types of queries: one-time or continuous. For a one-time query, the name of the practitioner is provided to the Data Bank Web site and a query response is received within four hours. The report is available for about 45 days after the query. The current fee for each one-time query is \$4.75 per practitioner for each report per year. If both the NPDB and the HIPDB were queried, the cost would be \$9.50 per physician per year. For a continuous query, the initial query is processed; then continuous query automatically send alerts on any new reports or changes to reports on all enrolled practitioners for a 12-month period. The current fee for each continuous query is \$3.25 per practitioner for each report per year. If both the NPDB and the HIPDB were queried, the cost would be \$6.50 per physician per year.

Board’s current use of Data Bank reports

Currently, the Board only conducts queries to the Data Bank for some at the initial licensing process (those licensed in another state), in some cases during an enforcement investigation,

Data Bank Query for Physicians Renewal Candidates

May 3, 2012

and on all reinstatement cases. Most of the information that is provided by the Data Bank is already acquired by the Board through the fingerprinting process for criminal record query, Federation of State Medical Boards query, American Medical Association, and through reporting requirements by California law.

Existing California law, Business and Professions (B&P) Code §801.01, requires reporting to the Board of arbitration awards, civil judgments and settlements over \$30,000 when a claim or action is based on a licensee’s alleged negligence, error, or omission in rendering services. The Data Bank requires all such awards, judgments, or settlements of any amount be reported.

B&P Code §805 requires a peer review body to provide a written report (805 reports) to the Board when privileging actions have been taken against its licensees including terminations or revocations, suspensions for 15 days or more, restrictions on staff privileges for 30 days or more, etc. The Data Bank requires Health Care Entities to report privileging actions affecting clinical privileges for a period longer than 30 days. Board staff did a comparison of the Data Bank Public Use Data from September 1990 through the end of 2009 and found that approximately 20 reports of privileging actions were submitted to the Data Bank but an 805 report was not filed with the Board. This amounts to about one Data Bank report per year where an organization failed to provide the Board with an 805 report.

Board Options for Querying the Data Bank

The Board was encouraged to look into the cost benefit analysis of querying the Data Bank every two years at the time of a physician’s renewal. If the Board decides to query the Data Bank and increase physician’s renewal fee to cover the cost, this would require a change in law.

The Board processes approximately 61,735 physician renewals each year. If the Board decided to do a one-time query for both Data Bank reports (\$9.50) at the time of renewal, the fiscal impact would be:

Board Cost	FY 1	FY 2	Ongoing
Staff Services	\$190,207	\$180,207	\$180,207
Data Bank Reports	586,482	586,482	586,482
Supplies/Equipment	123,470	123,470	123,470
Total	\$900,159	\$890,159	\$890,159

FY 1 Staff Services is a higher amount because of the work involved in setting up the initial program. Staff would be required to request, print, and review each report. In reviewing the report, staff would determine if it is necessary to open an enforcement case. Reports would be filed and maintained according to an adopted retention schedule.

If the Board decided to conduct continuous query for both Data Bank reports (\$6.50), the fiscal impact would be:

Board Cost	FY 1	FY 2	Ongoing
Staff Services	\$ 360,414	\$ 60,069	\$ 60,069
Data Bank Reports	849,395	849,395	849,395
Supplies/Equipment	261,340	20,000	20,000
Total	\$1,471,149	\$929,464	\$929,464

In FY 1 Staff Services is a higher amount because of the work involved in setting up the initial program. Staff would be required to request, print, and review each report. In reviewing the report, staff would determine if it is necessary to open an enforcement case. Reports would be filed and maintained according to an adopted retention schedule. In FY 2 the cost would decline for staff services and supplies/equipment because the Board would only receive subsequent reports.

Based upon this initial analysis of the information provided by the Data Bank to the Board, the benefit for obtaining data at renewal or on a continuous basis may not be cost effective. An analysis of the data provided by the Data Bank pursuant to the Public Citizen report shows that less than five additional reports per year might be received, and these may not rise to the level of discipline. The cost effectiveness of this option is not supported.

As an alternative, staff has already initiated an annual request to the Data Bank of reports filed from peer review bodies to determine if the Board has received all of those reports and to pursue an investigation if it has not received the reports.

Attachment P

UNITED STATES MEDICAL LICENSING EXAMINATION (USMLE) PERFORMANCE DATA



Performance Data

2011 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2011

Step 1

Details on the numbers and overall performance of examinees taking USMLE in the past 2 years are provided below.

Step 1 Administrations

Examinees from US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	19,842	90%	19,810	93%
1st Takers	18,116	92%	18,312	94%
Repeaters**	1,726	61%	1,498	70%
DO Degree	2,039	80%	2,211	88%
1st Takers	1,964	82%	2,145	89%
Repeaters**	75	41%	66	65%
Total	21,881	89%	22,021	92%

Examinees from Non-US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	14,203	70%	14,855	73%
Repeaters**	4,656	33%	4,621	36%

* Represents data for examinees tested in 2011 and reported through February 8, 2012.
** 'Repeaters' represents examinations given, not number of examinees.

Examinees from Non-US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
Total	18,859	61%	19,476	64%

Performance Data

2011 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2011

Step 2 CK

Step 2 CK Administrations

Examinees from US/Canadian Schools	2009 - 2010*		2010 - 2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	18,218	96%	18,903	96%
1st Takers	17,493	97%	18,225	97%
Repeaters**	725	68%	678	68%
DO Degree	1,002	91%	1,092	93%
1st Takers	982	92%	1,071	93%
Repeaters**	20	70%	21	57%
Total	19,220	96%	19,995	96%

Examinees from Non-US/Canadian Schools	2009 - 2010*		2010 - 2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	11,422	83%	11,594	82%
Repeaters**	2,484	52%	2,304	50%
Total	13,906	78%	13,898	77%

United States Medical Licensing Examination | Performance Data

Page 2 of 2

* Data for Step 2 CK are provided for examinees tested during the period of July 1 to June 30.
** 'Repeaters' represents examinations given, not number of different examinees.

Performance Data

2011 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2011

Overview Step 1 Step 2 CK Step 2 CS Step 3

Step 2 CS

Step 2 CS Administrations

Examinees from US/Canadian Schools	2009 - 2010*		2010 - 2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	18,087	97%	18,294	98%
1st Takers	17,518	97%	17,852	98%
Repeaters**	569	92%	442	91%
DO Degree	40	90%	67	88%
1st Takers	38	89%	67	88%
Repeaters**	2	†	0	N/A
Total	18,127	97%	18,361	98%

Examinees from Non-US/Canadian Schools	2009 - 2010*		2010 - 2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	11,775	76%	11,899	79%
Repeaters**	3,428	65%	3,143	67%
Total	15,203	74%	15,042	77%

* Data for Step 2 CS are provided for examinees tested during the period of July 1 to June 30.
 *** 'Repeaters' represents examinations given, not number of different examinees.
 † Performance data not reported for categories containing fewer than 5 examinees.
 N/A - not applicable.

Examinees taking Step 2 CS must pass three separate subcomponents in order to record an overall pass on Step 2 CS. The three subcomponents are: Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). For the total US/Canadian and the total non-US/Canadian medical school groups separately, Table 4 provides first-taker passing rates on each of the CS subcomponents.

Step 2 CS Administrations* 2009 - 2011 First Taker Passing Rates for Subcomponents: Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), Spoken English Proficiency (SEP)**

	2009-2010			2010-2011		
	ICE	CIS	SEP	ICE	CIS	SEP
All US / Canadian Schools	98	99	> 99	98	99	> 99
All Non US / Canadian Schools	85	87	95	87	89	95

* Data for Step 2 CS are provided for examinees tested during the period of July 1 to June 30.
 ** '>99' is used to signify those passing rates that would otherwise round up to 100%.

Performance Data

2011 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2011

Step 3

Step 3 Administrations

Examinees from US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	18,448	95%	18,314	96%
1st Takers	17,332	96%	17,486	97%
Repeaters**	1,116	75%	828	74%
DO Degree	14	100%	18	94%
1st Takers	14	100%	18	94%
Repeaters**	0	N/A	0	N/A
Total	18,462	95%	18,332	96%

Examinees from Non- US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	9,182	83%	8,830	84%
Repeaters**	2,759	61%	2,244	60%

* Represents data for examinees tested in 2011 and reported through February 8, 2012.
 ** 'Repeaters' represents examinations given, not number of different examinees.
 † Performance data not reported for categories containing fewer than 5 examinees.

Examinees from Non-US/Canadian Schools	2010		2011*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
Total	11,941	78%	11,074	79%

Performance Data

2009 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2009

Overview | Step 1 | Step 2 CK | Step 2 CS | Step 3

Step 1

Details on the performance of examinees taking Step 1 in 2008 and 2009 are provided in the table below. Data for 2009 are based upon examinees whose results were reported through February 10, 2010. Approximately 17,500 and 18,000 first-time takers from US and Canadian medical schools that grant the MD degree were tested in 2008 and 2009, respectively. First-time takers from non-US/Canadian medical schools numbered 14,889 and 14,055 for the same years. The pass rates for first-time takers from MD-granting US and Canadian medical schools were 94% for both years. Because failing examinees generally retake Step 1, the ultimate passing rate across test administrations is expected to increase to approximately 99% for this same group.

Step 1 Administrations

Examinees from US/Canadian Schools	2008		2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	18,855	92%	19,499	92%
1st Takers	17,494	94%	18,003	94%
Repeaters**	1,361	61%	1,496	65%
DO Degree	1,661	80%	1,863	80%
1st Takers	1,605	81%	1,808	81%
Repeaters**	56	46%	55	49%
Total	20,516	91%	21,362	91%

* Represents data for examinees tested in 2009 and reported through February 10, 2010.

** 'Repeaters' represents examinations given, not number of different examinees.

Step 1 Standard Setting

Performance standards for Step 1 were reviewed in 2009. In addition to the survey described above, standard setting exercises were conducted using three panels of physicians. The 28 panelists were selected to represent a range of medical schools and medical specialties. In addition, panelists had a broad range of roles, such as course and clerkship directors, program directors, department chairs, and practitioners; a range of gender and ethnic groups were also included. Each panel met for two days. Panelists saw a subset of items appearing on the multiple-choice question (MCQ) component of the Step 1 exam while engaging in a modified version of the Angoff standard-setting procedure. As a result of their review, a tentative minimum passing performance level was identified, representing the opinion of the panelists on the required mastery of examination content for medical licensure purposes. The results were provided to the Step 1 Committee for consideration.

Examinees from Non- US/Canadian Schools	2008		2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	14,889	73%	14,055	73%
Repeaters**	5,534	37%	4,881	36%
Total	20,423	63%	18,936	63%

At its December 2009 meeting, the Step 1 Committee considered the results of the surveys and the standard setting exercises, as well as data on recent trends in examinee performance and on the relationship of score precision to the pass/fail decision. As a result of its review, the Committee decided to raise the 3-digit score recommended to pass Step 1 from 185 to 188. The new minimum passing score was applied to Step 1 examinations for which the first day of testing was on or after January 1, 2010.

Performance Data

2009 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2009

Step 2 CK

Details on the performance of examinees taking Step 2 CK in the 2007-2008 and 2008-2009 academic years are provided below. First-time takers from US and Canadian medical schools granting the MD degree numbered approximately 16,500 in the 2007-2008 academic year and 17,100 in 2008-2009. First-time takers from non-US/Canadian medical schools numbered 12,847 and 11,868, respectively. The pass rates for first-time takers from MD-granting US and Canadian medical schools were 96% and 97% for the academic years. As noted with Step 1, given the opportunity for this same group to repeat the examination, the ultimate Step 2 CK passing rate across test administrations is expected to increase to approximately 99% for this same group.

Step 2 CK Administrations

Examinees from US/Canadian Schools	2007 - 2008*		2008 - 2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	17,440	94%	17,842	96%
1st Takers	16,499	96%	17,060	97%
Repeaters**	941	69%	782	72%
DO Degree	701	87%	829	90%
1st Takers	672	87%	806	90%
Repeaters**	29	72%	23	78%
Total	18,141	94%	18,671	95%

* Data for Step 2 CK are provided for examinees tested during the period of July 1 to June 30.

** 'Repeaters' represents examinations given, not number of different examinees.

Examinees from Non- US/Canadian Schools	2007 - 2008*		2008 - 2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	12,847	81%	11,868	83%
Repeaters**	3,320	51%	2,865	54%
Total	16,167	74%	14,733	78%

Performance Data

2009 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2009

Overview Step 1 Step 2 CK Step 2 CS Step 3

Step 2 CS

Details on the numbers and overall performance of examinees taking Step 2 CS in the 2007-2008 and 2008-2009 academic years are provided in the Step 2 CS Administrations table (Number Tested and Percent Passing). First-time takers from US and Canadian medical schools granting the MD degree numbered 16,715 for 2007-2008 and 17,054 for 2008-2009, with passing rates of 97% for both years. First-time takers from non-US/Canadian medical schools numbered 13,787 and 13,181 during these two periods. The respective passing rates for this group were 72% and 73%.

Examinees taking Step 2 CS must pass three separate subcomponents in order to record an overall pass on Step 2 CS. The three sub-components are: Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), and Spoken English Proficiency (SEP). For the US/Canadian and the non-US/Canadian medical school groups separately, The Step 2 CS Administrations table (Passing Rates for ICE, CIS, and SEP) provides first-taker passing rates on each of the CS sub-components.

Step 2 CS Administrations

Examinees from	2007 - 2008*		2008 - 2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	17,302	97%	17,586	97%
1st Takers	16,715	97%	17,054	97%
Repeaters**	587	92%	532	89%
DO Degree	48	88%	51	88%
1st Takers	47	87%	47	92%
Repeaters**	1	†	4	†
Total	17,350	97%	17,637	97%

* Data for Step 2 CS are provided for examinees tested during the period of July 1 to June 30.
 ** 'Repeaters' represents examinations given, not number of different examinees.
 † Performance data not reported for categories containing fewer than 5 examinees.

Step 2 CS Administrations* (2007 - 2009 First Taker Passing Rates for Subcomponents: Integrated Clinical Encounter (ICE), Communication and Interpersonal Skills (CIS), Spoken English Proficiency (SEP))**

	Examinees from Non-US/Canadian Schools	2007 - 2008*		2008 - 2009*	
		Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers		13,787	72%	13,181	73%
Repeaters**		3,436	64%	3,836	64%
Total		17,223	70%	17,017	71%

	2007-2008			2008-2009		
	ICE	CIS	SEP	ICE	CIS	SEP
All US / Canadian Schools	98	99	> 99	98	99	> 99
All Non US / Canadian Schools	86	81	92	84	84	94

* Data for Step 2 CS are provided for examinees tested during the period of July 1 to June 30.
 ** '>99' is used to signify those passing rates that would otherwise round up to 100%.

Performance Data

2009 Performance Data

The National Board of Medical Examiners published USMLE performance data in its newsletter, the NBME Examiner, from 1993 to 2012 and publishes USMLE performance data in its annual reports. Most of the data presented here are excerpted from those publications with modification or as they appeared originally.

2009

Overview Step 1 Step 2 CK Step 2 CS Step 3

Step 3

Details on the performance of examinees taking Step 3 in 2008 and 2009 are provided in the table below. Data for 2009 are based upon examinees whose results were reported through February 10, 2010. First-time takers who were graduates of MD-granting schools in the US and Canada numbered 17,245 in 2008 and 17,170 in 2009. First-time takers who were graduates of non-US/Canadian medical schools numbered 9,376 and 9,117, respectively for the same years. The passing rates for first-time takers who were graduates of MD-granting US and Canadian medical schools were 95% in 2008 and 94% in 2009. Like Step 1 and Step 2 CK, the ultimate Step 3 passing rate, accounting for repeat attempts, is expected to increase to approximately 99% for this same group.

Examinees from US/Canadian Schools	2008		2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
MD Degree	18,241	94%	18,361	93%
1st Takers	17,245	95%	17,170	94%
Repeaters**	996	67%	1,191	72%
DO Degree	21	90%	25	96%
1st Takers	19	95%	23	100%
Repeaters**	2	†	2	†
Total	18,262	94%	18,386	93%

* Represents data for examinees tested in 2009 and reported through February 10, 2010.

** 'Repeaters' represents examinations given, not number of different examinees.

† Performance data not reported for categories containing fewer than 5 examinees.

Examinees from Non- US/Canadian Schools	2008		2009*	
	Number Tested	Percent Passing	Number Tested	Percent Passing
1st Takers	14,889	73%	14,055	73%
Repeaters**	5,534	37%	4,881	36%
Total	20,423	63%	18,936	63%

Attachment Q

STRATEGIC PLAN OBJECTIVE 5.2 - 2012



MEDICAL BOARD OF CALIFORNIA
Enforcement Processing Timeframes
2012 Strategic Plan Objective 5.2

Enforcement Process	2008/2009		2009/2010		2010/2011		2011/2012		2012/2013 Qtr 1	
	# Cases ¹	AVG ²	# Cases	AVG	# Cases	AVG	# Cases	AVG	# Cases	AVG
Complaint	6426	75	6563	76	7008	74	7217	83	1980	67
% of Complaints Below 50 days (Goal: 50-60%)	43%		41%		35%		42%		48%	
Investigation	1100	349	1290	328	1411	312	1545	264	406	267
Discipline										
AG Processing to Preparation of an Accusation	240	103	304	106	294	107	333	103	73	83
Other Stages of the Legal Process (e.g., after charges filed)	228	381	232	368	216	417	280	396	67	440

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

(Footnote applies to all years provided on report)

² Average time (calendar days) in processing complaints during the fiscal year, for all cases, from date of original receipt of the complaint, for each stage of discipline, through completion of judicial review. **(Footnote applies to all years provided on report)**

Attachment R

ATTORNEY GENERAL'S OFFICE RESPONSE TO
MEDICAL BOARD OF CALIFORNIA'S
PROGRAM EVALUATION



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October 12, 2010

Board Members
Medical Board of California
2005 Evergreen Street, Suite 1200
Sacramento, CA 95815

RE: Initial Response of the Health Quality Enforcement Section (HQE)
to the Medical Board Program Evaluation Conducted By Ben Frank
and HQE's Comprehensive Report to the Medical Board Regarding
Physician Discipline under the Vertical Enforcement Program

Dear Board Members:

Thank you for the opportunity to review the original Program Evaluation dated July 6, 2010, the draft Summary Report dated July 21, 2010, and the latest Summary Report dated August 2, 2010, prepared by Ben Frank, which document his findings, conclusions and recommendations following his review of the Medical Board's programs.¹

As you know, the Medical Board originally authorized its Executive Director "to undertake a comprehensive, independent evaluation of the Medical Board."² In this regard, the stated purpose of the evaluation was "to conduct an independent and unbiased review of the Medical Board's organizational structure and core programs to identify strengths and weaknesses of current operations and develop recommendations for improvements."³ That would soon change. Shortly after commencement of the evaluation, "it was jointly determined, in consultation with Medical Board management, that the primary focus of [the] assessment [would] be on (1) identifying and

¹ The original Program Evaluation dated July 6, 2010, will be referred to herein as "Frank Report I" followed by the page number. The draft Summary Report dated July 21, 2010, will be referred to herein as "Frank Report II" followed by the page number. Finally, the latest Summary Report dated August 2, 2010, will be referred to herein as "Frank Report III," followed by the page number. When referred to generally, all three reports will be referred to herein collectively as simply the "Frank Report."

² Frank Report I, at p. I-1; Frank Report II, at p. I-1; and Frank Report III, at p. I-1.

³ Frank Report I, at p. I-2; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

Board Members
October 4, 2010
Page 2

assessing the impacts of the VE Pilot Project⁴] on the Enforcement Program, (2) identifying and assessing the benefits provided from the increased expenditures for VE-related legal services, (3) identifying and assessing other factors contributing to deteriorating Enforcement Program performance, and (4) developing an *Enforcement Program Improvement Plan*.⁵

As a result of this joint determination, the *primary focus* of Mr. Frank's evaluation shifted away from the Medical Board's organizational structure and programs as specified in the original Request for Offers and, instead, centered on the Office of the Attorney General and, more specifically, on the Health Quality Enforcement Section (HQE). The joint determination of Mr. Frank and Medical Board management to conduct an evaluation of HQE, and its activities spanning over several years, was made without the knowledge, input or involvement of the Office of the Attorney General or HQE. Thereafter, Mr. Frank's evaluation of HQE was based on extremely limited information from HQE itself and, regrettably, the comprehensive, reliable statistical data provided by HQE to Mr. Frank at his request was virtually ignored. Additionally, notwithstanding representations that he would consult with me, as HQE's Senior Assistant Attorney General, at the conclusion of his evaluation, Mr. Frank did not do so. In short, the evaluation of HQE conducted by Mr. Frank was completed with little input from HQE, and reached the conclusion that the Medical Board's Enforcement Program is deteriorating largely for reasons attributed to HQE, with little or no assessment of the long-standing and unresolved problems within the Medical Board's Enforcement Program itself that continue to affect investigator performance and investigation completion timelines.⁶

The purpose of this response by HQE to the Frank Report is threefold. First, this response will identify and address some of the flaws in the Frank Report, demonstrating how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Had HQE been permitted to fully participate in the evaluation of its own activities, it is anticipated that these flaws could have been eliminated from the Frank Report before it was submitted to the Medical Board. Second, this response will present HQE's comprehensive report to the Medical Board, entitled "Physician Discipline under the Vertical Enforcement Program," based on the statistical data contained on the ProLaw database maintained by the Office of the Attorney General. As this report will demonstrate, while further improvement should definitely be pursued, the VE program has improved, and continues to improve, public protection of patients receiving medical services in California while, at the same time, protecting physicians from unwarranted or needlessly protracted investigations and prosecutions. Finally, this response will report on significant steps that HQE has already taken in its continuing efforts to further improve its own performance, and also present

⁴ "VE" refers to the "vertical enforcement and prosecution model" mandated by the Legislature in Government Code section 12529.6 which defines the manner in which allegations of unprofessional conduct by physicians and surgeons are to be investigated and, if warranted by the evidence, prosecuted by the Health Quality Enforcement Section. At this point, the VE program is not a "pilot program," having been repeatedly extended by the Legislature, nor is it referred to as such in Government Code section 12529.6.

⁵ Frank Report I, at p. I-3; italics original; footnote added; Frank Report II, at p. I-2; and Frank Report III, at p. I-2.

⁶ It should be noted that the Frank Report comes virtually on the heels of the Medical Board's Report to the Governor and the Legislature dated June 2009 (which was actually submitted later in 2009), wherein the Medical Board was statutorily required to "report and make recommendations . . . on the vertical enforcement and prosecution model created under Section 12529.6." (Gov. Code, § 12529.7.)

Board Members
 October 4, 2010
 Page 3

HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

Table of Contents

- I. Flaws in the Frank Report;
- II. Physician Discipline under the Vertical Enforcement Program; and
- III. Important Steps HQE Has Taken to Improve its Own Performance, and HQE's Recommendations on How the Medical Board's Enforcement Program Can Be Further Improved.

I. Flaws in the Frank Report

1. The Statistical Basis of the Frank Report is Unreliable

The Frank Report relies almost entirely on information obtained from the Medical Board's Case Tracking System ("CAS"), which is a management information system shared by other agencies in the Department of Consumer Affairs. However, information regarding Medical Board investigations and prosecutions contained in the CAS system has long been criticized and continues, at times, to be unreliable. For example, almost six years ago, in November 2004, the Medical Board's Enforcement Monitor⁷ noted that the CAS system "suffers from numerous inadequacies and problems impeding MBC's licensing and enforcement programs, and undermining its public disclosure program."⁸ Later, in her Final Report in November 2005, the Enforcement Monitor specifically recommended that the Medical Board and HQE upgrade their information management systems, noting that "MBC is studying [management information systems] improvements with [the Department of Consumer Affairs]; ProLaw is now in use at HQE . . ."⁹ While HQE has fully implemented its ProLaw case management system, over the last six years the Medical Board continues to utilize the CAS system.

Indeed, the Frank Report itself specifically notes some of the significant problems that demonstrate the unreliability of information maintained by the Medical Board in the CAS system. For example, "it appears that some updates to CAS are not always consistently posted by District Office staff for various interim investigation activities, including activities involving: Medical records requests[,] Complainant and Subject interviews[,] [and] Medical

⁷ Business and Professions Code section 2220.1 provided for the appointment of a "Medical Board Enforcement Program Monitor" to monitor and evaluate "the disciplinary system and procedures of the board, making as his or her highest priority the reform and reengineering of the board's enforcement program and operations and the improvement of the overall efficiency of the board's disciplinary system." (Added by Stats. 2002, c. 1085, (Sen. Bill No. 1950), § 18; repealed by Stats. 2004, c. 909 (Sen. Bill No. 136), § 3, operative Jan. 1, 2006.)

⁸ Initial Report, Executive Summary, at p. ES-12.

⁹ Final Report, Conclusions and Recommendations for the Future, at p. 203.

Board Members
 October 4, 2010
 Page 4

Consultant case reviews.”¹⁰ There are other problems as well.¹¹ “In some cases CAS is updated to show when the activity commenced (e.g., requested medical records, requested or scheduled a Complainant or Subject interview, or submitted records for review by the Medical Consultant or a Medical Expert, but CAS is not updated to show when the activity was completed). In other cases CAS is updated only when the activity is completed, or not updated to show either initiation or completion of the activity.”¹² Notwithstanding these significant problems, the Frank Report relies, almost entirely, on information obtained from the CAS system.

On or about March 3, 2010,¹³ Mr. Frank requested statistical information from HQE covering multiple aspects and stages of Medical Board investigations and prosecutions covering the period of 2005 through and including 2009.¹⁴ On June 20, 2010, after much effort, HQE provided Mr. Frank with a comprehensive response to his requests for case specific information for each of the calendar years of 2005 through 2009.¹⁵ In total, HQE provided detailed case specific information to Mr. Frank on a total of 1,899 cases.¹⁶ Finally, the requested information was provided to Mr. Frank first in .pdf format, and then in Excel spreadsheets.

The Frank Report virtually disregards the reliable statistical information obtained from the ProLaw database, admitting that “with some isolated exceptions, [it] was not used.”¹⁷ The justifications offered for disregarding the information provided by HQE

¹⁰ Frank Report I, at p. I-8; see also Frank Report II, at p. I-4; and Frank Report III, at p. I-3 and I-4.

¹¹ For example, the Frank Report notes that the statistical measures of the average time elapsed to complete interim investigation activities “may not be representative of actual performance” and, further, that “[t]he measures related to obtaining [m]edical [r]ecords are especially limited.” (Frank Report I, at p. I-9.) With respect to procuring medical records, the Frank Report also notes that “[t]he Medical Board’s measures count the records as received irrespective of the completeness or quality of the records provided, and do not account for supplemental submissions.” (Frank Report I, at I-9; Frank Report II, at p. I-4; and Frank Report III, at p. I-4.)

¹² Frank Report I, at pp. I-8 and I-9.

¹³ The Frank Report states that a revised data request was submitted to HQE on March 9, 2010, but later claims the date was March 7, 2010. (Frank Report I, at p. I-11; Frank Report II, at p. I-5.) The date of this request is changed yet again in Frank Report III, this time to April 22, 2010. (Frank Report III, at p. I-6.)

¹⁴ Frank Report I, at p. I-10; Frank Report II, at p. I-5; and Frank Report III, at p. I-5.

¹⁵ The information for each case that was provided to Mr. Frank included: (1) the ProLaw matter number; (2) matter description; (3) investigation number; (4) type of administrative matter; (5) the date the matter was opened; (6) the date the matter was accepted for prosecution; (7) the date the pleading was sent to the Medical Board for filing; (8) the number of days between the date the matter was accepted for prosecution and the date the pleading was sent to the Medical Board of filing; (9) the date the pleading was signed by the Executive Director; (10) the number of days between the date the pleading was sent to the Medical Board for filing and the date the pleading was signed by the Executive Director; (11) the number of days between the date the pleading was sent the Medical Board for filing and the date the stipulated settlement was sent to the Medical Board; (12) where applicable, the date the matter was rejected for prosecution; and (13) if the case was rejected, the date it was returned to the Medical Board.

¹⁶ The 1,899 total cases are broken down per year as follows: CY 2005 - 409 cases; CY 2006 - 387 cases, CY 2007 - 354 cases, CY 2008 - 355 cases, and CY 2009 - 394.

¹⁷ Frank Report II, cover letter, at p. 3; see also Frank Report II, cover letter, at p. 3.

Board Members
 October 4, 2010
 Page 5

vary.¹⁸ Unfortunately, this is not the first time that reliable statistical information provided by HQE has been disregarded.

Accordingly, relying on the admittedly incomplete information obtained from the CAS system while, at the same time, disregarding the statistical information provided by HQE from the ProLaw database, calls into question the accuracy of the findings, conclusions and recommendations contained in the Frank Report.¹⁹

2. The Frank Report Does Not Assess the Single Most Important Cause for Investigation Completion Delays – Continuing High Investigator Vacancy Rates and Turnovers

The Frank Report documents, but does not assess in any meaningful fashion, the most significant flaw in the Medical Board's Enforcement Program, namely, the inability of the Medical Board's Enforcement Program to recruit and retain experienced investigators.²⁰ This long-standing, problem, which has been fully documented many times over the past decade, continues to have a significant negative impact on both investigator performance and investigation completion timelines.

In her Initial Report back in 2004, the Enforcement Monitor correctly observed that:

“Recruitment and retention problems plague personnel management at the Medical Board. Supervisors and field investigators uniformly report that valuable, experienced investigators are lost and well-qualified applicants go elsewhere because of salary disparities between the pay of the MBC and other agencies hiring peace officers. MBC regularly loses in competition with other agencies over highly qualified investigative personnel.”²¹

Later, in her Final Report in 2005, the Enforcement Monitor again noted that:

“Compounding the loss of 19 sworn investigator positions during the 2001–04 hiring freeze, MBC continues to lose highly trained and experienced investigators and well-qualified applicants to other agencies because of disparities between MBC investigator salaries and those at other agencies

¹⁸ Originally, the reasons for this decision were reportedly that “much of the data provided by HQE was not provided until near the conclusion of the assessment,” and “much of the data provided was incomplete and of limited utility . . .” (Frank Report II, cover letter, at p. 3.) Those reasons were later revised to add that “much of the data was *unavailable*, incomplete and of limited utility.” (Frank Report III, cover letter, at p. 3; italics added.) It is unclear how the statistical information provided by HQE to Mr. Frank was “unavailable.”

¹⁹ While the Frank Report states that “[w]e filtered, compiled, summarized, and analyzed the data provided as needed for purposes of this study” (Frank Report II, at p. 1-3; Frank Report III, at p. 1-3), there is no description of the methodology that was used to compile the statistics presented in the report.

²⁰ Frank Report I, at pp. VI-44 and VI-45; Frank Report II, at p. VI-19; Frank Report III, at p. VI-19 and VI-20.

²¹ Initial Report, Executive Summary, at p. ES-24.

Board Members
 October 4, 2010
 Page 6

hiring peace officers. The Monitor urged MBC to continue its efforts to reinstate its lost enforcement program positions and to upgrade the salaries of its investigators commensurate with the competition.

“... ”

“The related problems of investigator recruitment and retention can ultimately be addressed by full implementation of the integrated vertical prosecution system envisioned in SB 231. Upon a showing of the success of the vertical prosecution system, and with the Legislature’s affirmative approval after review of the 2007 report, the transfer of the MBC investigators to HQE will eventually result in special agent status for MBC’s sworn personnel and a concomitant increase in pay and career recognition.^[22] Morale and productivity will be boosted, and MBC’s ability to recruit and retain highly qualified investigators will be dramatically improved.”²³

Very little has changed in the last five years. Simply stated, the Enforcement Monitor’s description of the inability of the Medical Board to successfully recruit and retain experienced investigators is as true today as it was in 2005.

The Enforcement Monitor’s Final Report in 2005 also clearly shows that the long-standing morale and productivity problems that have continually plagued the Medical Board Enforcement Program, and its inability to recruit and retain highly qualified investigators, unquestionably predate the January 1, 2006, implementation of the “vertical prosecution and enforcement model” mandated by the Legislature in Government Code section 12529.6. Less than one year ago, HQE identified the top three reasons for investigation completion delays as:

“Investigator vacancy rate of 14%.^[24] The absence of trained, experienced investigators appears to be the principal reason undermining the MBC’s ability to complete investigations on a timely basis.

“The constant turn-over of investigators at the MBC results in a significant loss of productivity as pending investigations are transferred from one investigator to another and, often, from one district office to another as well. This loss of productivity also continues for a considerable period of time as

²² At the last minute, Senate Bill 231 was changed to eliminate the contemplated transfer of Medical Board investigators to the Office of the Attorney General. As a result, the anticipated increase in pay and career recognition that would have accompanied the proposed transfer never happened.

²³ Final Report, Executive Summary, at p. ES-20; footnote added.

²⁴ As of late 2009, the investigator vacancy rate has now reportedly climbed to 16%. (Frank Report I, p. II-51; Frank Report II, at II-15; Frank Report III, at p. II-16.)

Board Members
 October 4, 2010
 Page 7

newly hired investigators go through the Academy and then complete their on-the-job training.

“Some of the most experienced and productive investigators have been reassigned to train new investigators, rather than having the Supervising Investigator I in each district office conduct this training for new hires. As a result, these experienced and productive investigators have carried a reduced investigation caseload, thus contributing to additional delays in the MBC’s timely completion of investigations.”²⁵

The vacancy rate of experienced investigators fluctuates but continues today. For example, two experienced and productive Medical Board investigators have recently indicated their intention to transfer to other state agency investigator positions in order to receive a promotion to the “senior investigator” classification. New investigators will ultimately have to be hired to fill those positions, then go through the Academy and finally complete their on-the-job training. Approximately one year after their hire date, they will become fully productive as Medical Board investigators, only to leave for desired promotions, or be recruited by other state agencies, which will start the process all over again.

The Frank Report correctly notes “[i]t is unlikely that Enforcement Program performance will improve unless Investigator workforce capability and competency levels are stabilized and, eventually restored to the levels that existed earlier in the decade.”²⁶ This is true, as it has been for almost a decade. At the same time, however, the Frank Report contains no statistical analysis of the continuing impact that the high investigator vacancy rate and turnover continues to have on investigator performance and investigation completion timelines.²⁷ To better assess the impact of investigator vacancy rates on the completion of investigations, on May 3, 2010, HQE requested from MBC substantially the same data MBC provided to Mr. Frank. MBC staff is currently working to produce this data.

Recognizing that some investigations were simply taking too long to complete, in July 2009, the Enforcement Program’s Executive Management created a new “Case Aging Council” whose tasks include, among other things, the review of aging investigations in order to identify and resolve the various reasons for investigation completion delays in those matters.

²⁵ Response of the Health Quality Enforcement Section to the Medical Board of California’s Report to the Governor and Legislature (Second Draft 6-7-09), at p. 3; footnotes added.

²⁶ Frank Report I, at p. VI-44; Frank Report II, at p. VI-19. In Frank Report III, this finding was significantly changed to read as follows: “It is unlikely that Enforcement Program performance will improve significantly unless *Investigator workforce capability levels are stabilized.*” (Frank Report III, at p. VI-19; italics added.)

²⁷ For example, the Frank Report contains no analysis of the impact of the constant reassignment of investigations from one investigator to another, or of the more recent development of investigations being transferred by Medical Board management from one District Office to another. This latter practice is particularly disruptive to the orderly and timely completion of investigations since it requires an investigator remotely located from the event or incident to familiarize him/herself with the case, and then to complete the investigation. Such transfers of investigations are also routinely ordered without any advance notification to, or input from, HQE, which, in turn, results in corresponding shifts in HQE caseloads that are often inconsistent with HQE staffing.

Board Members
October 4, 2010
Page 8

Greater efficiency and productivity by investigators will not, however, directly address the root cause for aging investigations, namely, the inability of the Medical Board to recruit and retain experienced investigators.

While only the Medical Board can solve the high investigator vacancy and turnover problems that have plagued its Enforcement Program for almost a decade, HQE has offered assistance in an effort to ameliorate the effects of these problems. Beginning in 2006 and continuing to 2009, HQE has offered to provide investigator services to the Medical Board in order to help reduce investigation completion delays. While HQE's offer has not been accepted, HQE recommends that the Medical Board consider this option, especially if no reasonable alternative presents itself.

3. The Frank Report Does Not Assess the "Chronic Weakness" in the Medical Board's Enforcement Program – its Expert Reviewer Program

The Frank Report mentions, but again fails to analyze in any meaningful fashion, the second most significant flaw in the Medical Board's Enforcement Program, namely, the "chronic weakness in the Medical Board's Expert Reviewer Program . . ." ²⁸ The continuing debilitating effect of this "chronic weakness" in the Medical Board's Enforcement Program simply cannot be overstated.

Both Frank Report I and Frank Report II correctly state that "in recent years little attention has been given to chronic weaknesses in the Medical Board's Expert Reviewer Program, except to authorize an increase in the billing rate for review services from \$100 to \$150 per hour." ²⁹ Those chronic weaknesses are identified as "deficiencies involving the insufficient availability of Medical Experts, particularly in specialized areas, the extended timeframes needed by the Medical Experts to complete their reviews, the quality of the Medical Expert's reports, and the effectiveness of the Medical Experts providing testimony as an Expert Witness at a hearing (when needed)." ³⁰ However, Frank Report III deletes these stated deficiencies in their entirety and, instead, simply recommends that the Board's policy restricting the use of experts to no more than three times per year be eliminated. ³¹ While elimination of this board-imposed restriction, which does not similarly restrict defense counsel, will make the most qualified experts more readily available, it will not, standing alone, sufficiently address all of the deficiencies correctly noted in Frank Reports I and II.

Expert opinions rendered by a Medical Board expert, following his/her review of the evidence gathered during the investigation, are the very heart of a quality-of-care case. The decision to recommend the filing of an accusation against a physician in a quality-of-care

²⁸ Frank Report I, at p. VI-44.

²⁹ Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

³⁰ Frank Report I, at p. VI-44; Frank Report II, at p. VI-18.

³¹ Frank Report III, at p. VI-19.

Board Members
October 4, 2010
Page 9

case rests, in large part, on the expert opinions provided to the assigned HQE deputy attorney general. And, as has often been demonstrated in the past, these cases will stand, or fall, based on the quality and soundness of those expert opinions.

It must be remembered that HQE has as strong an interest in protecting physicians against the unwarranted filing of disciplinary charges against their medical licenses as it does in the fair prosecution of those cases where, based on the evidence, disciplinary charges are warranted. It is for this reason that the quality and soundness of expert opinions submitted to HQE in quality-of-care cases are so very important.

When meeting with an expert witness to prepare her or him for the hearing, HQE deputy attorneys general are often informed that the expert witness has never testified before and that the upcoming hearing will be their first time doing so. Following such meetings, HQE deputy attorneys general occasionally return to the Attorney General's Office following such meetings with serious concerns regarding the expert's understanding the case, ability to articulate the basis for his/her expert opinions, or willingness to testify at the upcoming hearing.

HQE has brought up with Medical Board executive staff the continuing problems that exist within the Medical Board's Expert Review Program. Years ago, it was reportedly the practice of the Medical Board to meet with prospective experts to review their qualifications and to determine whether, in addition to meeting the minimum requirements,³² they were sufficiently qualified to serve as an expert in the Medical Board's Expert Reviewer Program. Unfortunately, that procedure was discontinued long ago. In late 2009, HQE recommended that the Medical Board reinstate this procedure as part of the selection process for Medical Board experts and, further, offered to have a Supervising Deputy Attorney General participate on the interview panel.³³ To date, HQE's recommendation and offer have not been accepted.³⁴

³² The minimum requirements for a physician to participate as an expert in the Medical Board's Expert Reviewer Program are: (1) possession of a current California medical license in good standing with no prior discipline, no Accusation pending, and no complaint history within the last three years; (2) Board certification in one of the 24 ABMS specialties (the American Board of Facial Plastic & Reconstructive Surgery, the American Board of Pain Medicine, the American Board of Sleep Medicine and the American Board of Spine Surgery are also recognized) with a minimum of three years of practice in the specialty area after obtaining Board certification; and (3) have an active practice (defined as at least 80 hours a month in direct patient care, clinical activity, or teaching, at least 40 hours of which is in direct patient care). (See http://www.mbc.ca.gov/licensee/expert_reviewer.html)

³³ In addition to careful selection of only those qualified to serve as experts, the Medical Board should seriously consider two additional improvements to the program as well. First, consideration should be given to increasing the compensation (currently set at \$150 per hour for case review/consultation and \$200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Second, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

³⁴ The Medical Board recently published an advertisement seeking applications from physicians who meet the minimum qualification and currently practice in California and are interested in providing expert reviewer services for the Board. (See Medical Board Newsletter, Vol. 115, July 2010, at p. 7.)

Board Members
 October 4, 2010
 Page 10

4. The Frank Report Does not Assess Another Leading Cause of Investigation Completion Delays – the Unavailability of Medical Consultants in the District Offices

The Frank Report mentions, but again fails to analyze in any meaningful fashion, another flaw in the Medical Board's Enforcement Program, namely, the unavailability of Medical Consultants in the District Offices.³⁵

In her Initial Report in 2004, the Enforcement Monitor observed that:

“Medical consultants play a vital and varied role in the Medical Board’s complaint handling and investigation process. The Monitor believes problems of medical consultant availability, training and proper use contribute significantly to lengthy investigations and inefficient operations.”³⁶

Unfortunately, as the Frank Report correctly notes, nothing has changed in the last six years. “Since publication of the Enforcement Monitor’s reports there has been very little change in the availability of Medical Consultants.”³⁷ The Frank Report also notes that “Needs in this area have not been emphasized.”³⁸ This leading cause for investigation completion delays simply must be addressed.

Medical consultants across the State continue to be unavailable in the District Office, often for the majority of the work week. Investigations are stalled, subject interviews delayed, medical records are unreviewed, medical consultant memorandums remain unwritten, and the whole process grinds to a halt as the entire VE team awaits the return of the Medical Consultant to the District Office. As noted by the Enforcement Monitor years ago, the unavailability of Medical Consultants contributes significantly to lengthy investigations and inefficient operations. Unfortunately, very little has changed in the last six years to correct this continuing cause of investigation completion delays.³⁹

³⁵ Frank Report I, at pp. VI-42 and VI-43; Frank Report II, at pp. VI-17 and VI-18; Frank Report III, at pp. VI-16 and VI-18.

³⁶ Initial Report, at p. 144; emphasis added.

³⁷ Frank Report I, at p. VII-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18. The Frank Report states that “no additional funding for Medical Consultants was included in th[e] package [that established the VE program or in the 2010/11 budget].” (Frank Report I, at VI-43; Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.) However, as far back as 2005, it was contemplated that a portion of the increased initial and biennial fees paid by licensees would be used for this purpose. Specifically, in her Final Report, the Enforcement Monitor noted that “SB 231 (Figueroa) increases initial and biennial renewal fees by 30%. MBC management staff plans to use some of these additional funds to increase medical consultant hours.” (Final Report, at p. 87.) It is unknown whether that was ever done.

³⁸ Frank Report II, at p. VI-18; Frank Report III, at p. VI-18.

³⁹ The Medical Board recently submitted a budget augmentation request to address this problem, but this request has not been approved.

Board Members
 October 4, 2010
 Page 11

5. The Frank Report Does Not Recognize HQE's Legislatively-Mandated Oversight Responsibility Over Investigations and Prosecutions of Medical Board Cases

HQE agrees that investigation completion delays continue to be a significant problem in the Medical Board's Enforcement Program. However, rather than analyzing the impact of the most significant reasons for those delays (i.e., the continuing high investigator vacancy rates and turnover, shortage of qualified experts, and unavailability of medical consultants), the Frank Report concludes that the higher level of involvement by HQE deputy attorneys general at the investigation stage, mandated by the Legislature in Government Code section 12529.6, is the real cause for these delays. Again, this is error.

At the outset it is important to recognize that the Legislature has created a partnership between the Medical Board's Enforcement Program and the HQE Section of the Office of the Attorney General. It is also important to recognize that HQE has a legislatively-mandated oversight responsibility over investigations and prosecution of Medical Board cases. Over the last two decades, the Legislature has increased HQE's oversight role, gradually shifting more and more responsibility to HQE in the process. In 1991, the Legislature created HQE within the Office of Attorney General and charged it with "primary responsibility" to prosecute administrative disciplinary proceedings before the Medical Board.⁴⁰ Later, in 2006, the Legislature expanded HQE's role by shifting primary responsibility for investigations of alleged misconduct by physicians and surgeons to HQE.⁴¹ At the same time, the Legislature also mandated that those investigations be conducted using the "vertical prosecution model"⁴² under which the assigned HQE deputy attorney general is required to direct⁴³ the investigator who is "responsible for obtaining the evidence required to permit the Attorney General to advise the board on legal matters such as whether the board should file a formal accusation, dismiss the complaint for a lack of evidence required to meet the applicable burden of proof, or take other appropriate legal action."⁴⁴

As part of its oversight responsibility, HQE is responsible for ensuring that no physician is charged with unprofessional conduct unless those charges are supported by clear and

⁴⁰ Gov. Code, § 12529, as added by Stats. 1990, c. 1597 (S.B. 2375).

⁴¹ Gov. Code, § 12529.5, as added by Stats. 2005, c. 674 (S.B. 231).

⁴² In 2008, the model was renamed the "vertical enforcement and prosecution model." (Gov. Code, § 12529.6, subd. (a), as amended by Stats. 2008, c. 33 (S.B. 797)).

⁴³ HQE has long taken the position that the direction authority conferred under Government Code section 12529.6 does not include supervision authority. Said another way, while the assigned HQE deputy attorney general is statutorily authorized and required to direct the assigned investigator in the accumulation of the required evidence, he or she does not actually supervise the investigator which, instead, is the responsibility of the supervising investigator in the District Office. Consistent with HQE's position, in 2008, Government Code section 12529.6 was amended to clarify that the investigator works under "the direction but not the supervision" of the assigned HQE deputy attorney general.

⁴⁴ Gov. Code, § 12529.6., subd. (a), as added by Stats. 2005, c. 674 (S.B. 231).

Board Members
 October 4, 2010
 Page 12

convincing evidence to a reasonable certainty.⁴⁵ In exercising that responsibility, whenever an HQE deputy attorney general concludes that an investigation has not produced clear and convincing evidence of any violation of the Medical Practice Act, he/she issues a memorandum declining to accept the case and directs that the investigation be closed. This cannot be a shared responsibility between the assigned investigator and the HQE deputy attorney general. Rather, it is a legal determination, made as part of the practice of law which only a member of the State Bar of California can make, and part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed. The prevention of unwarranted investigations and prosecutions is an important part of HQE's oversight role which is especially important today, since many of the Medical Board's new investigators lack significant experience in the investigation of Medical Board cases.

Apparently, without recognizing the foregoing, the Frank Report suggests that "the statutes governing Vertical Enforcement [be amended] to clarify the Medical Board's [investigators] sole authority to determine whether to continue an investigation."⁴⁶ The only manner by which that could be accomplished would be for the Legislature to overhaul the various statutes that currently govern the investigation and prosecution of Medical Board cases, and return the primary responsibility for investigations of allegations of misconduct by physicians and surgeons to the Medical Board investigators.

Additionally, the Frank Report also recommends that "independent panels [be established] to review all requests for supplemental investigations and all decline to file cases."⁴⁷ It is further recommended that the Chief of Enforcement and HQE Senior Assistant Attorney General be "advise[d] . . . as to the results of their review, including recommended disposition of the matter."⁴⁸ Again, this recommendation does not recognize that the legal determination that further evidence is required in order to properly evaluate a case, and the legal determination declining to file charges where not warranted by the evidence cannot be a shared responsibility between HQE and the Medical Board investigators. Rather, such legal determinations constitute the practice of law which only a member of the State Bar of California can make, and are a part of HQE's oversight role over Medical Board investigations to ensure that only meritorious cases are filed.

Finally, the Frank Report recommends the creation of a "new HQES Services Monitor" to, among other things, "continuously monitor and evaluate HQE's performance and costs, resolve conflicts that arise between the agencies, and prepare and provide regular reports to the Executive Management, the Medical Board, and oversight and control agencies."⁴⁹

⁴⁵ *Ettinger v. Board of Medical Quality Assurance* (1982) 135 Cal.App.3d 853, 856 [holding that "the proper standard of proof in an administrative hearing to revoke or suspend a doctor's license should be *clear and convincing proof to a reasonable certainty* and not a mere *preponderance of the evidence*." (Italics original)].

⁴⁶ Frank Report I, at p. X-7; Frank Report II, at p. X-2; Frank Report III, at p. X-2.

⁴⁷ Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

⁴⁸ Frank Report I, at ES-3; Frank Report II, at p. VII-17; Frank Report III, at p. VII-21.

⁴⁹ Frank Report I, at p. ES-4; Frank Report II, at p. X-5; Frank Report III, at p. X-5.

Board Members
October 4, 2010
Page 13

However, both HQE and the Medical Board have already developed policies and procedures for the timely resolution of any conflicts that may arise.⁵⁰ More importantly, as HQE's Senior Assistant Attorney General, it continues to be my responsibility within the Department of Justice to monitor and evaluate HQE's performance. Accordingly, issues, questions or concerns regarding the performance of any HQE deputy attorney general have been, and should continue to be, brought to my immediate attention for investigation and resolution.

6. The Frank Report Does Not Mention or Assess, the Significant Travel Burden Placed on HQE Deputy Attorneys General Under the VE Program

In 2005, Senate Bill 231 (Figueroa) originally contemplated the transfer of Medical Board investigators to Office of the Attorney General which would, in turn, would have brought about a consolidation of the investigators and HQE deputy attorneys general in the same offices in many parts of the state. However, the contemplated transfer of investigators to the Attorney General's Office never happened and, instead, both the Medical Board and HQE were left to implement the VE program with their respective personnel located in offices remotely located from each other.⁵¹

Originally, in late 2005/early 2006, it was agreed that both the Medical Board and HQE would share the travel burden created by the VE program. Under this agreement, investigators would travel to the Office of the Attorney General, as necessary, and HQE deputy attorneys general would travel to the District Office, as necessary. Unfortunately, since the very beginning of the program, the travel burden has fallen almost entirely on HQE deputy attorneys general who are required to travel to District Offices to meet with investigators, review evidence, participate in witness and subject interviews, and complete a myriad of other tasks and responsibilities.+

To illustrate the extent of the significant travel burden placed on HQE under the VE program, the following table lists the distance (in miles), driving time (in minutes), and cost per hour (based on a per hour cost of \$170.00) for travel by HQE deputy attorneys general from the Office of the Attorney General in Los Angeles to each of the five Medical Board District Offices within its geographical area of responsibility.⁵²

⁵⁰ See Vertical Prosecution Manual (Second Edition, November 2006) at Section XXII, page 12, entitled "Disagreements."

⁵¹ Recognizing the geographical obstacles, the Legislature has mandated that "[t]he Medical Board shall . . . [e]stablish an implement a plan to locate its enforcement staff and the staff of the Health Quality Enforcement Section in the same offices, as appropriate, in order to carry out the intent of the vertical enforcement and prosecution model." (Gov. Code, § 12529.6, subd. (c)(3).)

⁵² Distances and times are based on data obtained from <http://www.mapquest.com> on August 9, 2010. The cost per hour for attorney services set by the Department of Justice for the fiscal year 2009/10 is \$170.00. (DOJ Administrative Bulletin No. 09-25, issued June 26, 2009.)

Board Members
 October 4, 2010
 Page 14

Travel By Office of the Attorney General

Destination: MBC District Office	Round trip distance (miles)	Round trip driving time (minutes)	Cost of Attorney Time for One Round Trip
Valencia	77.8	90	\$255
Glendale	22.48	32	\$90.67
Diamond Bar	53.16	66	\$187
Cerritos	41.04	56	\$158.67
Tustin	71.7	88	\$249.33

In order to save attorney hours, improve efficiency, and significantly reduce travel costs to the Medical Board, HQE has previously proposed the following solution to the geographical obstacles created by the VE program. In HQE's response to the Medical Board's 2009 Report to the Governor and Legislature, we recommended:

"Video Conferencing: Under the VE Model, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's Offices and MBC district offices. As a result, DAGs spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. Implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, provide a convenient method for investigators and DAGs to readily confer when more than a simple telephone call is required and, from an environmental standpoint, would reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and MBC work together to implement a video conferencing network statewide to further improve the VE program."⁵³

To date, HQE's video conferencing recommendation has not been accepted by the Medical Board. HQE recommends that the Medical Board consider accepting this recommendation, especially if no reasonable alternative presents itself.

⁵³ Response of the Health Quality Enforcement Section to the Medical Board of California's Report to the Governor and Legislature (Second Draft 6-7-09), at p. 2.

Board Members
 October 4, 2010
 Page 15

7. The Frank Report's Allegation of "Potential Overcharges" by HQE is Unsupported by Evidence, and Raised Outside of the Established Procedure and Appropriate Forum for Addressing Such Questions, Concerns and Issues

The Frank Report claims to have "identified potential internal control issues involving HQES' billings to the Medical Board, and potential overcharges for HQES services."⁵⁴ The "evidence" for this serious allegation appears to be the Frank Report's identification of "two (2) cases in which HQE Attorneys appear to have misreported a significant portion of their time during 2008/09."⁵⁵ In both cases, the "evidence" consisted, in part, of a Medical Board supervising investigator expressing his/her opinion to Mr. Frank that "the time charges appeared to be significantly overstated."⁵⁶ It hardly seems necessary to state that the opinions of supervising investigators, one of whom has admitted "that she didn't have complete knowledge of other activities in which the Lead Prosecutor might have been involved during these periods," is not the type of evidence that responsible persons rely upon to make such a serious allegation. Also, in one of the two cases, an HQE Supervising Deputy Attorney General offered to research the issue for Mr. Frank "and provide additional information that would account for all the time charged."⁵⁷ However, Mr. Frank declined to ask for that research "because further investigation of this issue was outside of the scope of our assessment."⁵⁸

Notwithstanding the lack of evidence to support such a serious allegation, the Frank Report nevertheless states that "during 2008/09, and possibly in some prior years and subsequently, the Medical Board may have been charged for some time that was not spent on Medical Board matters."⁵⁹

Historically, any questions, concerns or inquiries regarding the billing of any HQE deputy attorney general has been brought to my attention by the Executive Director or Chief of Enforcement. The precise billing(s) that are under examination are identified and the matter is referred to the appropriate Supervising Deputy Attorney General to investigate the matter, review the case file, evaluate the billing, and report back to me. Once all the appropriate information has been gathered, and a determination has been made whether any adjustment is required, I contact the Executive Director or Chief of Enforcement to report my findings and the matter is appropriately resolved, with or without an adjustment to the identified

⁵⁴ Frank Report I, at p. III-1; Frank Report II, at p. III-4; Frank Report III, at p. III-4.

⁵⁵ Frank Report I, at p. III-8.

⁵⁶ Frank Report I, at p. III-9.

⁵⁷ Frank Report I, at p. III-9.

⁵⁸ Frank Report I, at p. III-9. It is difficult to understand how alleging potential overcharges to the Medical Board by HQE based on two cases is within the scope of the Frank Report's assessment but, at the same time, receiving additional information in one of those cases that would account for all the time charged is not.

⁵⁹ Frank Report I, at p. III-13.

Board Members
October 4, 2010
Page 16

billing. This process, which has been used successfully for years, continues to be the established procedure and the appropriate forum to address any billing questions, concerns or inquiries.⁶⁰ Indeed, the present executive director recently availed herself of this procedure to discuss and resolve a billing matter.

The speculation of “potential overcharges” by HQE contained in the Frank Report is both unfounded and inappropriately raised outside the established procedure and appropriate forum for addressing billing questions, concerns or inquiries. Accordingly, HQE requests that it be withdrawn from the Frank Report and, if there are any questions, concerns or inquires regarding any billing by any member of HQE, such matters should be brought to my immediate attention for investigation and resolution.

Lastly, it should be noted that, each month, the Case Management Section of the Division of Administrative Services of the Office of the Attorney General provides each HQE Supervising Deputy Attorney General with a report regarding the billing of each HQE deputy attorneys general under his or her supervision. Supervising Deputy Attorneys General are expected to review those billings in order to ensure appropriate billing. According to the Frank Report, surprisingly, HQE’s monthly billings to the Medical Board “are not reviewed by Medical Board staff, except at an aggregate level as needed for budget tracking purposes.”⁶¹ HQE urges Medical Board staff to review HQE’s monthly billing and, if there are any questions, concerns or inquiries regarding any of those billings, to bring the matter to my immediate attention in the appropriate forum for investigation and resolution.

In conclusion, in the section above, HQE identified and addressed some of the flaws in the Frank Report, explaining how some of its key findings, conclusions and recommendations are incorrect as a matter of fact, law or both. Turning now from the Frank Report, in the following section, HQE will present an accurate picture of “Physician Discipline under the Vertical Enforcement Program” for the years of 2005 through 2009, based on the reliable statistical information contained in the ProLaw database.

II. Physician Discipline under the Vertical Enforcement Program

In order to assess the actual state of physician discipline in California for the period of 2005 through 2009, it is important to first identify the key statistical measures that will provide the most accurate assessment, and then present those statistical measures in a format that the reader can quickly and easily review to obtain the necessary information. Accordingly, HQE’s report to the Medical Board on the state of physician discipline in California for the period of 2005 through 2009 will present statistical information on the following five key statistical measures:

⁶⁰ This is the same process utilized by Dave Thornton, in his capacity as Chief of Enforcement and Executive Director, to address billing questions.

⁶¹ Frank Report I, at p. III-13.

Board Members
 October 4, 2010
 Page 17

1. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution;
2. Average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing;
3. Average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation;
4. Average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision; and
5. Disciplinary outcomes under the VE Program.

The first key statistical measure is the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken for the Medical Board's Enforcement Program to complete investigations from the date the consumer complaint is first received at the District Office to the date the investigation is closed or accepted for prosecution for all Medical Board cases from 2005 to 2009.

Calendar Year	2006	2007	2008	2009
Statewide	430.55	419.12	392.66	259.60

This first key statistical measure shows that, since implementation of the VE program on January 1, 2006, to the end of the calendar year 2009, there has been an overall 39.7% statewide reduction in the average number of days from date of receipt of complaint at the Medical Board District Office to the date the investigation is closed, either for insufficiency of evidence, or because the case has been accepted for prosecution.⁶²

The second key statistical measure is the average number of days from the date the case is accepted by HQE for prosecution to the date the accusation is sent to the Medical Board for filing. This statistical measure allows the Medical Board to assess how long it has taken HQE, statewide, to prepare proposed accusations for the period of 2005 to 2009.

⁶² The methodology utilized for this first key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, average number of days was calculated from the date the consumer complaint was "Received at District Office" to the date "Matter Closed." "Matter Closed" included cases that were: (1) Closed: No Violation; (2) Closed: Insufficient Evidence; (3) Accepted for Prosecution; or (4) Citation or PLR issued. The following cases were omitted from the calculations above: (1) Closed: pending criminal resolution; (2) Closed: subject entered into Diversion; (3) Closed: unlicensed individual; (4) Closed: statute of limitations expired; and Non-MBC cases. Calculations were done using matters that had been resolved.

Board Members
 October 4, 2010
 Page 18

Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 Accusations Only

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	76.98	106.2	87.74	48.28	60.42
San Diego	97.3	89.4	59.67	72.63	50.55
Sacramento	64.53	82.77	56.64	89	104.5
San Francisco	39.53	35.44	27.91	44.71	36.48
Statewide	69.79	75.36	54.87	58.5	53.19

As the above chart shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, HQE has reduced its overall average filing time from 69.79 days to 53.19 days. This represents an overall 24% statewide reduction in filing times since implementation of the VE program.⁶³

When cases that involve a combined Accusation/Petition to Revoke Probation are reviewed for the period of 2005 through 2009, the statistical improvement is even greater.

Average Number of Days from “Accepted for Prosecution” to “Pleading Sent”
 Accusations/Petitions to Revoke Probation Only

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	120	88.5	68.5	55.33	69.43
San Diego	61.54	93.67	104.4	23	25
Sacramento	137	131.5	22	19	49.5
San Francisco	8	33	2	55.4	18.75
Statewide	88.44	95.07	68.5	40.93	42.63

When cases that involve Accusations only are combined with the cases involving Accusations/Petitions to Revoke Probation for the period of 2005 through 2009, the statistical improvement is likewise clearly shown.

⁶³ The methodology utilized for this second key statistical measure is as follows: Using the “Opened” date in Prolaw for each year, the average number of days was calculated from the date the case was “Accepted for Prosecution” to the date “Pleading Sent” to the Medical Board for filing. Administrative cases that were initially “Accepted for Prosecution,” only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The cases reflected in the chart include out-of-state discipline cases. Calculations were done using matters that had been resolved.

Board Members
October 4, 2010
Page 19

Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"
Accusations and Accusations/Petitions to Revoke Probation Combined

Calendar Year	2005	2006	2007	2008	2009
Statewide	71.54	76.51	55.47	57.5	52.45

Finally, when all of the various types of administrative cases are combined for the period of 2005 through 2009, the statistical improvement is again clearly shown.⁶⁴

Average Number of Days from "Accepted for Prosecution" to "Pleading Sent"
All Administrative Matters

Calendar Year	2005	2006	2007	2008	2009
Los Angeles	72.7	97.8	76.95	45.11	54
San Diego	87.5	85.83	65.92	63.52	47.27
Sacramento	65	73.75	46.65	80.15	88.56
San Francisco	39	33.39	26.81	45.65	35.46
Statewide	67.5	71.03	54.28	54.7	49.48

The following **third key statistical measure** is the average number of days from the date the case is accepted for prosecution by HQE to the date the case is ultimately resolved at the administrative level, either by way of a stipulated settlement or decision following litigation. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken HQE to complete the prosecution of physician discipline cases at the administrative level, statewide, from 2005 to 2009.

Average Number of Days from "Accepted for Prosecution" to "Decision Signed by Client"
Accusations and Accusations/Petitions to Revoke Probation

Calendar Year	2005	2006	2007	2008	2009
Statewide	496.82	455.22	403.61	341.51	263.90

As the above chart clearly shows, since implementation of the VE program on January 1, 2006, through the end of the calendar year 2009, there has been an overall 47% statewide reduction in the length of time it has taken to complete and entire investigation and, if warranted by the evidence, the entire administrative disciplinary process, for all Medical Board cases from 2005 to 2009.⁶⁵

⁶⁴ The administrative matters included in this calculation include the following: (1) Interim Order of Suspension cases; (2) Penal Code Section 23 appearances; (3) Business and Professions Code section 820 cases; (4) Petitions to Compel Competency Examination cases; (5) Accusation cases; (6) Accusation and Petition to Revoke Probation cases; (7) Petitions to Revoke Probation cases; and (8) Statement of Issues cases. Automatic suspension orders were not included in this calculation. Calculations were done using matters that had been resolved.

⁶⁵ The methodology utilized for this third key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, the average number of days was calculated from date the case was "Accepted for Prosecution" to the date "Decision Signed by Client." Every effort was made to delete duplicate cases and multiple administrative matters that were consolidated into one Decision signed by the client. In addition, administrative cases that were initially "Accepted

Board Members
October 4, 2010
Page 20

The fourth key statistical measure is average number of days from date of receipt of complaint at the Medical Board District Office to the date the case is ultimately resolved at the administrative level by stipulated settlement or decision. This statistical measure allows the Medical Board to accurately determine the overall length of time it has taken to complete the entire investigation and, if warranted by the evidence, the entire administrative disciplinary process for all Medical Board cases from 2006 to 2009.

Average Number of Days from "Received at District Office" to "Decision Signed by Client
Accusations and Accusations/Petitions to Revoke Probation

Calendar Year	2006	2007	2008	2009
Statewide	906.57	795.47	586.65	327.38

As this statistical measure demonstrates, since implementation of the VE program, there has been a 63.88% overall reduction in the overall length of time it has taken to complete the entire investigation and administrative disciplinary process for all Medical Board cases from 2006 to 2009.⁶⁶

Finally, any assessment of the state of physician discipline in California necessarily requires an examination of **disciplinary outcomes**. Under the Medical Practice Act, disciplinary outcomes range from the most severe – outright revocation or surrender of licensure – to revocation stayed with a period of probation – and finally to lowest level of post-accusation discipline, a public reprimand with or without educational courses. The following statistical measure allows the Medical Board to accurately determine the overall effectiveness of the VE program in obtaining the most severe disciplinary penalties, outright revocation, license surrenders, and revocation, stayed, with probation.

Accusations Resulting in "Serious Discipline"

Calendar Year	2006	2007	2008	2009
Los Angeles	65.6%	68.1%	72.7%	82.4%
Sacramento	61.0%	72.7%	64.0%	75.0%
San Francisco	65.4%	61.3%	54.5%	80.0%
San Diego	59.3%	50.9%	72.3%	64.3%
State total	62.7%	61.1%	67.1%	73.5%

for Prosecution," only to be reviewed and returned to the Medical Board District Office for additional investigation, have been calculated separately deleting the time period of investigation. The calculations for this statistical measure include out-of-state discipline cases. Calculations were done using matters that had been resolved.

⁶⁶ The methodology utilized for this fourth key statistical measure is as follows: Using the "Opened" date in Prolaw for each year, the average number of days was calculated from date the consumer complaint was "Received at District Office" to the date "Decision Signed by Client." For multiple investigation matters resulting in a single administrative matter (by amendment to the existing Accusation and/or Accusation/Petition to Revoke Probation), the earliest date "Received at District Office" was used. The calculations used for this statistical measure include matters investigated under the VE program. Calculations were done using matters that had been resolved.

Board Members
October 4, 2010
Page 21

Significantly, during the past two years, imposition of the most serious disciplinary action in cases handled by HQE – Los Angeles, where attorneys presently have greater involvement during the investigation stage, has increased 14.3%. This statistic, standing alone, undermines a central premise of the Frank Report, namely, that greater attorney involvement under the VE program has not translated into greater public protection. As this final statistical measure clearly demonstrates, since implementation of the VE program, imposition of the most severe disciplinary outcomes has increased 10.8% statewide from the pre-VE time period, with the resulting increase in public protection.⁶⁷

In conclusion, notwithstanding the problems that continue to plague the Medical Board's Enforcement Program, implementation of the VE program has resulted in overall improvements in the four key statistical measures that provide the most accurate picture of the state of physician discipline in California. Disciplinary outcomes over the same time period have significantly improved as well.

While the VE program continues to represent a vast improvement over the prior "Deputy-In-The-District-Office" Program, there is still nevertheless room for further improvement. In the next and final section of this response, HQE will report on the significant steps it has already taken in its continuing efforts to further improve its own performance, and also present its recommendations on important additional ways that the VE program can be further improved.

III. Important Steps HQE has taken to Improve its own Performance, and Recommendations on How the Medical Board's Enforcement Program Can be Further Improved

The staff of HQE – Los Angeles presently consists of twenty-two deputy attorneys general, one paralegal, and two supervising deputy attorneys general. It is by far the largest section in HQE statewide. In order to increase the efficiency and productivity of HQE – Los Angeles, and further improve the quality of legal services provided to the Medical Board by that office, a third supervising deputy attorney general position has been transferred from HQE – San Diego to HQE – Los Angeles. That new position has been advertised, applications have been accepted, and it is anticipated that interviews will be conducted in the near future.

HQE has also recently published its new "HQE Section Manual" for use by all staff in HQE statewide. While the manual will not be disseminated outside the Office of the Attorney General, in summary, it provides all HQE staff with a comprehensive set of policies and procedures that govern the legal work of the section, along with departmental policies and procedures, and will also be a valuable training resource for new deputy attorneys general who join the section in the future. It is anticipated that the new "HQE Section Manual" will also help to further promote uniformity in the handling of various legal issues by HQE staff statewide as well.

⁶⁷ The methodology utilized to calculate serious discipline is as follows: "Serious discipline" is defined as: (1) outright revocation of licensure; (2) surrender of licensure; and (3) revocation of licensure, stayed, with a period of probation of at least one year. Using the "Opened" date in ProLaw for each calendar year, "serious discipline" was calculated using the above definition. In calculating each outcome, cases that were "declined to prosecute" and cases that did not reach an administrative outcome (i.e., Accusations filed but waiting administrative hearing) were omitted from the calculations. Out-of-state discipline cases were also omitted from the calculations.

Board Members
October 4, 2010
Page 22

In addition to these important steps that HQE has taken to improve its own performance, the following are HQE's recommendations on important ways that the VE program can be further improved to address some of the long-standing, systemic problems within the Medical Board's Enforcement Program.

1. Consider Entering into an Interagency Contract for the Attorney General's Office to Provide the Medical Board with Investigative Services

The inability of the Medical Board to retain experienced investigators is a well-documented, longstanding problem that predates implementation of the VE program. As of 2009, the investigator vacancy rate was 16%. That unacceptably high vacancy rate, together with the high rate of investigator turnover, continues to seriously undermine the VE program. Permitting the Attorney General's Office to provide investigative services to the Medical Board would help to resolve the principal reason undermining the Medical Board's Enforcement Program's ability to complete investigations on a timely basis by providing trained, experienced investigators to compliment the job currently being performed by Medical Board investigators. For this reason, the HQE strongly recommends that the Medical Board consider entering into an interagency contract for the Attorney General's Office to provide investigative services to the Board, in addition to the legal services it currently provides. Funds that would otherwise be used by the Medical Board to pay the salaries of the currently vacant investigator positions could be used for this purpose.

2. Take Concrete Steps to Improve the Medical Board's Expert Reviewer Program

Earlier this year, the Medical Board established the Enforcement Committee and one of its goals is to enhance the expert reviewer training program. The committee should consider developing an outreach program to attract more qualified expert reviewers to participate in its Expert Reviewer Program. The committee should also consider reinstating its prior procedure under which prospective experts were actually interviewed to review their qualifications and to determine whether, in addition to meeting the minimum requirements, they are sufficiently qualified to serve as an expert in the Expert Reviewer Program. The Medical Board should also accept HQE's offer to have a Supervising Deputy Attorney General participate on the interview panel as well.

Consideration should also be given to increasing the compensation (currently set at \$150 per hour for case review/consultation and \$200 for providing expert testimony) in order to attract more qualified expert reviewers. Simply stated, a physician should not have to suffer an economic penalty for agreeing to participate as a Medical Board expert. Finally, before they are assigned to review any case, physicians accepted by the Medical Board's Expert Reviewer Program should be required to attend a comprehensive training conference to be conducted, in part, by HQE in order to ensure that they are adequately trained and prepared to fulfill their duties and responsibilities as an expert for the Medical Board.

Board Members
October 4, 2010
Page 23

3. Increase Medical Consultant Availability in the District Offices

The unavailability of medical consultants in the District Offices continues to be one of the leading causes for investigation completion delays. The Medical Board should take immediate steps to significantly increase medical consultant availability in the District Offices in order to reduce these continuing delays.

4. Utilize Video Conferencing to Reduce Required Travel Under the VE Program

Under the VE program, HQE has assumed the burden of the majority of required travel statewide between the various Attorney General's offices and Medical Board District Offices. As a result, HQE deputy attorneys general spend hundreds of hours a year traveling on California freeways in order to confer with investigators, review documents and attend interviews. This travel burden should be shared equally between HQE and the Medical Board's Enforcement Program, especially since the Board provides investigators with motor vehicles to use for all required travel. In addition, implementation of a video conferencing network statewide would eliminate the necessity of some of this required travel, reduce the number of attorney hours expended driving rather than performing legal work, and provide a convenient method for investigators and deputy attorneys general to readily confer when more than a simple telephone call is required. From an environmental standpoint, it would also reduce the negative impact such travel places on the environment overall. HQE recommends that HQE and the Medical Board work together to implement a video conferencing network statewide to further improve the VE program.

5. Foster an Environment of Cooperation and Support for the VE Program within the Medical Board's Enforcement Program

In some areas of the state, the VE program is working well, with HQE deputy attorneys general and Medical Board investigators working cooperatively and productively, and investigations and prosecutions being completed expeditiously. In other parts of the state, however, the program is not working as well as it could. However, the Frank Report's statement that "[t]here is a high level of conflict between Medical Board and HQE management and staff throughout much of the State" (Frank Report I, at p. X-6; Frank Report II, at p. X-1) is an overstatement of the occasional disagreements that have arisen under the VE program. In Frank Report III, this statement was revised to state that: "[c]onflicts have arisen among Board and HQES at all levels throughout the state, but particularly in the Los Angeles region. Conversely, in some offices, staff is respectful of each other's roles in the process and there is greater productivity." (Frank Report III, at p. X-1.) The importance of courtesy and cooperation which, in turn, fosters greater teamwork and productivity, has already been addressed and emphasized by both HQE and the Medical Board in the *Joint Vertical Enforcement Guidelines* (JVEG) (First Edition, April 2008). (See JVEG, Section 10, p. 8, entitled "Courtesy and Cooperation.")

Board Members
October 4, 2010
Page 24

It is important to recognize that at any given time there are over one thousand investigations or cases in which deputy attorneys general and Medical Board investigators are collaborating. It is also important to understand that only a handful of disputes arise each year and that all of these disputes are resolved either informally or by the dispute resolution process set forth in the *Vertical Enforcement Manual*. Indeed, over the twelve months, the number of conflicts requiring the formal dispute resolution process has almost been completely eliminated.

HQE and Medical Board's Enforcement Program should renew their efforts to achieve consistency and uniform implementation of the VE program in all of its District Offices statewide. By fostering an environment of cooperation and support for the VE program within the Medical Board's Enforcement Program, the Medical Board would send a strong signal that it supports the program and fully expects that all those within its Enforcement Program do the same.

In conclusion, thank you for the opportunity to review the Frank Report, as well as the opportunity for HQE to present its comprehensive report entitled "Physician Discipline Under the Vertical Enforcement Program." HQE looks forward to working with the Medical Board to further improve the VE program assist the Medical Board to reduce investigation completion delays, and implement much needed improvements to its Enforcement Program.

Sincerely,



CARLOS RAMIREZ
Senior Assistant Attorney General

For EDMUND G. BROWN JR.
Attorney General

cc: David C. Chaney
Chief Assistant Attorney General
Civil Law Division
Los Angeles

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Attachment S

LIST OF ACRONYMS



ACRONYMS

AAAHC	Accreditation Association for Ambulatory Health Care
AAASF	American Association for Accreditation of Ambulatory Surgery Facilities, Inc.
ABMS	American Board of Medical Specialties
ACA	Affordable Care Act
ACCME	Accreditation Council for Continuing Medical Education
ACGME	Accreditation Council for Graduate Medical Education
AG	Attorney General's Office
AIM	Administrators in Medicine
ALJ	Administrative Law Judge
AMA	American Medical Association
APA	Administrative Procedure Act
B&P	Business and Professions Code
BCP	Budget Change Proposal
Board	Medical Board of California
BPPE	Bureau for Private Postsecondary Education
BreEZe	Department of Consumer Affairs' pending computer project
BRN	Board of Registered Nursing
BSA	Bureau of State Audits
CAC	Citizen Advocacy Center

CAS	Consumer Affairs System (current computer system)
CCR	California Code of Regulations
CCU	Central Complaint Unit
CDPH	California Department of Public Health
CE	Continuing Education
CHCF	California HealthCare Foundation
CLD	Contact Lens Dispenser
CMA	California Medical Association
CME	Continuing Medical Education
CMS	Center for Medicare and Medicaid Services
COA	California Optometric Association
CPEI	Consumer Protection Enforcement Initiative
CPS	Cooperative Personnel Services
CRB	California Research Bureau of the California State Library
CRIMS	Complaint Resolution Information Management System
CURES	Controlled Substance Utilization Review and Evaluation System
DAC	Diversion Advisory Council
DAG	Deputy Attorney General
DCA	Department of Consumer Affairs
DMHC	Department of Managed Health Care
D.O.	Doctor of Osteopathic Medicine
DOF	Department of Finance

DOJ	Department of Justice
DOL	Division of Licensing
ECFMG	Educational Commission for Foreign Medical Graduates
EHR	Electronic Health Record
F-MAT	Family Medicine Accelerated Track
FAIMER	Foundation for the Advancement of International Medical Education and Research
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FNP	Fictitious Name Permit
FSMB	Federation of State Medical Boards
FTB	Franchise Tax Board
FTO	Field Training Officer
FY	Fiscal Year
GME	Graduate Medical Education
HPEF	Health Professions Education Foundation
HQES	Health Quality Enforcement Section
IAMRA	International Association of Medical Regulatory Authorities
IMED	International Medical Education Directory
IMG	International Medical Graduate
IMQ	Institute for Medical Quality
ISB	Information Systems Branch

ISO	Interim Suspension Order
IT	Information Technology
JC	The Joint Commission
LCME	Liaison Committee on Medical Education
LGS	Letter of Good Standing
MAC	Midwifery Advisory Council
MBC	Medical Board of California
M.D.	Medical Doctor
MICRA	Medical Injury Compensation Reform Act
MOC	Maintenance of Certification
MOL	Maintenance of Licensure
Monitor	Enforcement Program Monitor
NARM	North American Registry of Midwives
NASPER	National All Schedules Prescription Electronic Reporting
NBME	National Board of Medical Examiners
NCLS	Nonresident Contact Lens Seller
NLI	No Longer Interested
NPDB	National Practitioner Databank
OAH	Office of Administrative Hearings
OE&E	Operating Expenses and Equipment
OSHPD	Office of Statewide Health Planning and Development
OSM	Operation Safe Medicine

PACE	Physician Assessment and Clinical Education Program
PAR	Patient Activity Report
PDF	Portable Document Format
PDMP	Prescription Drug Monitoring Program
PGY	Postgraduate Training Year
PLAC	Post-Licensure Assessment Committee
PLAS	Post-Licensure Assessment System
POST	Peace Officer Standards and Training
PTAL	Postgraduate Training Authorization Letter
PY	Personnel Year
RCPSC	Royal College of Physicians and Surgeons of Canada
RDO	Registered Dispensing Optician
SACC	Substance Abuse Coordination Committee
SAR	Self-Assessment Report
SBO	State Board of Optometry
SDAG	Senior Deputy Attorney General
SFP	Special Faculty Permit
SLD	Spectacle Lens Dispenser
SLPAB	Speech-Language Pathology and Audiology and Hearing Aid Dispensers Board
STMSSP	Steven M. Thompson Medical School Scholarship Program
UC	University of California

UCLA	University of California at Los Angeles
UCSD	University California, San Diego
USMLE	United States Medical Licensing Examination
VE/P	Vertical Enforcement/Prosecution
VIP	Volunteer Insured Physicians
WHO	World Health Organization

Appendix I

Midwifery Program

- Background and Description of Midwifery Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments



Section 1 – Background and Description of Midwifery Program

History and Functions of the Midwifery Program

A licensed midwife is an individual who has been issued a license to practice midwifery by the Medical Board of California (Board). The Midwifery Practice Act was chaptered in 1993 and implemented in 1994 with the first direct entry midwives licensed in September 1995. The practice of midwifery authorizes the licensee, under the supervision of a licensed physician, in active practice, to attend cases of normal childbirth, in a home, birthing clinic, or hospital environment.

Pathways to licensure for midwives 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. This Council is made up of licensed midwives (pursuant to B&P Code section 2509 at least half of the Council shall be licensed midwives), a Board Member, a physician, and a member of the public (currently an individual who has used a licensed midwife). The Board specifies issues for the Council to discuss/resolve and the Council also identifies issues and requests approval from the Board to develop solutions to the various matters. Some items that have been discussed include physician supervision, challenge mechanisms, required reporting, and student midwives. The Midwifery Advisory Council Chair attends the Board meetings and provides an update on the issues and outcomes of the Council.

Major Legislation/Regulations Since the Last Sunset Review

Legislation

- *SB 1638 (Figueroa, Chapter 536, Statutes of 2006) Midwifery Advisory Council and Midwife Annual Report*

This bill required the Board to create and appoint a Midwifery Advisory Council. It required licensed midwives to make annual reports to OSHPD on specified information regarding birth outcomes, with the first report due in March 2008. This bill also required each licensed midwife who assists or supervises childbirth occurring in an out-of-hospital setting to annually report to OSHPD specified information regarding his or her practice for the previous year. This bill required the data to be consolidated by OSHPD and reported back to the Board for inclusion in the Board's annual report.

- *SB 1575 (B&P Comm., Chapter 799, Statutes of 2012) Omnibus*

This bill established a retired license status for licensed midwives.

Regulations➤ *Amend CCR section 1379.20*

This regulatory change in 2005 required a midwife, who does not carry liability insurance, to disclose this fact to the client in either written or oral form and note this disclosure in the patient's file.

➤ *Adopt CCR section 1379.19*

This new section added in 2006 defined the appropriate standard of care for licensed midwives and the level of supervision required for the practice of midwifery. The adoption of midwifery standards of care was necessary because midwifery is a distinct profession.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2012 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.

This fund currently does not have any approved budget appropriation. Now that the fund is solvent, the Board will be seeking an augmentation to establish an appropriation in FY 2013/2014 to fund the personnel needed to administer the Midwifery Program. Each year, the Board would request repayment 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.

The Licensed Midwives submit an application and initial license fee of \$300 and have a biennial renewal fee of \$200. The renewal fee comprises about 70% of the fees received in the Licensed Midwifery Fund.

Table 2. Fund Condition Midwifery					Proposed	Proposed
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	78	101	121	154	186	217
Revenues and Transfers*	24	27	33	34	33	33
Total Revenue	102	128	154	188	219	250
Budget Authority	--	--	--	--	--	--
Expenditures	1	7		2	2	2
Loans to General Fund	--	--	--	--	--	--
Accrued Interest, Loans to General Fund	--	--	--	--	--	--
Loans Repaid From General Fund	--	--	--	--	--	--
Fund Balance	101	121	154	186	217	252

Table 4. Fee Schedule and Revenue							
Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
LICENSED MIDWIFERY FUND							
Licensed Midwife Application and Initial License Fee (B&P 2520) (Title 16, CCR 1379.5)	300.00	300.00	5,700	5,400	12,300	9,900	29.60%
Licensed Midwife Biennial Renewal Fee (B&P 2520) (Title 16, CCR 1379.5)	200.00	200.00	16,400	21,200	19,400	23,400	69.95%
Licensed Midwife Delinquency Fee (B&P 2520) (Title 16, CCR 1379.5)	50.00	50.00	300	250	100	150	0.45%

For staffing issues, refer to Full 2012 Medical Board Sunset Report.

Section 4 – Licensing Program

Application Review

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 for the past four fiscal years 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 in the last few 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 Midwifery program are very small and those in a pending status are outside of the Board's control. The Board is continuously striving to review and approve applications within the set timeframes to ensure compliance with the law is met and has ensured that this occurs by reviewing policies and procedures within the program for best practices.

The tables below show the Midwifery Program licensee population, licenses issues and licenses renewed.

Table 6. Licensee Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Licensed Midwife	Active	199	219	252	270
	Out-of-State	21	22	21	20
	Out-of-Country	0	0	0	0
	Delinquent	21	18	19	28

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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	16	20	0	20	2	2	0	-	-	29
	(Renewal)	99	n/a	n/a	99	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	41	40	0	40	2	2	0	-	-	25
	(Renewal)	98	n/a	n/a	98	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	33	31	1	31	4	4	0	-	-	23
	(Renewal)	125	n/a	n/a	125	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data			
	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	16	41	33
Initial License/Initial Exam Applications Approved	20	40	31
Initial License/Initial Exam Applications Closed	0	0	1
License Issued	20	40	31
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	2	2	4
Pending Applications (outside of board control)*	2	2	4
Pending Applications (within the board control)*	0	0	0
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	29	25	23
Average Days to Application Approval (incomplete applications)*	-	-	-
Average Days to Application Approval (complete applications)*	-	-	-
License Renewal Data:			
License Renewed	99	98	125

* Optional. List if tracked by the board.

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 Letters of Good Standing 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, Letters of Good Standing, 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 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 license, 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 Letter of Good Standing (LGS) 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 LGS 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.

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 qualifications listed in B&P Code section 2512.5 (2) and CCR. 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 re-assessment process could be completed to ensure approved schools are maintaining compliance with B&P Code section 2512.5 (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 24 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 licensed midwife 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.

Each midwife is required to certify under penalty of perjury, upon renewal, that she has met the CE requirements. CCR section 1379.28 requires the Board to audit a random sample of midwives who have reported compliance with the continuing education requirements. The Board requires that each midwife retain records for a minimum of four years of all continuing education programs attended which may be needed in the event of an audit by the Board.

Due to limited staffing resources, the Board does not currently conduct CE audits on midwives. CCR section 1379.28 does require the Board to audit once every two years, a random sample of midwives who have reported compliance with the CE requirement. The Board is currently reviewing ways in which this process can be implemented.

If a midwife fails the audit by either not responding or failing to meet the requirements as set forth by section 1379.28 of CCR, the midwife will be allowed to renew her license one time following the audit to permit her 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 her compliance with the provisions of CCR, section 1379.28.

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. 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.

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 complaint is received. If an audit is made, course providers will be asked to submit to the Board documentation concerning each of the items described in section 1379.27 (a) of the CCR.

The Board is currently reviewing ways in which the CE policy is carried out and the procedures related to the certification and auditing of approved programs and courses of CE hours is being performed. The Board anticipates that the auditing function of the Board will be carried out in the current fiscal year to insure that all licensed midwives are in compliance with the current requirements.

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 5 disciplinary actions being filed over the past three fiscal years. Of the four disciplinary actions that have been adjudicated, all have been resolved with either a revocation or a license surrender. With this volume of activity it is difficult to identify trends or patterns.

The majority of the complaints received regarding licensed midwives relate to the care provided during labor and delivery which 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.

There are currently no mandatory reporting requirements for licensed midwives with the exception of statistical information that is collected by the Office of Statewide Health Planning.

The Midwifery Program does not have a statute of limitations established in statute but recognizes public protection as its highest priority and strives to investigate each complaint as quickly as possible.

The licensee population in this category is fairly small, however, there have been some complaints related to unlicensed practice. The Board utilizes its investigative resources to pursue and prosecute, if appropriate, individuals providing midwifery services without the proper credentials.

The Midwifery Program utilizes the Medical Board’s disciplinary guidelines as a model for disciplinary actions imposed on midwives.

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	7	9	22
Closed	0	0	0
Referred to INV	8	9	22
Average Time to Close	9	10	12
Pending (close of FY)	0	0	0
Source of Complaint (Use CAS Report 091)			
Public	4	5	16
Licensee/Professional Groups	2	3	4
Governmental Agencies	1	2	6
Other	0	0	0
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	0	1	4
CONV Closed	0	1	4
Average Time to Close	0	3	9
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
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 (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	0	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	0	2	3
Accusation Filed--Average Days from Case Referred to AG's Office to Accusation Filed	0	66	164
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	0	0	0
Pending-Accusation Filed (close of FY)	0	1	0
Pending-No Accusation Filed (close of FY)	1	1	3

Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	0	1	1
Stipulations	0	0	0
Average Days to Complete	0	874	878
AG Cases Initiated	1	2	2
AG Cases Pending (close of FY)	1	2	3
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	0	1	1
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	1
Probationers (close of FY)	1	1	0
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	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

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	8	10	26
Closed	8	11	25
Average days to close	212	269	210
Pending (close of FY)	7	6	7
Desk Investigations (Use CAS Report EM 10)			
Closed	5	7	19
Average days to close	48	116	78
Pending (close of FY)	1	0	3
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	0	4	0
Average days to close	0	537	0
Pending (close of FY)	0	6	0
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	1
Other Suspension Orders	0	0	1
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 (Use CAS Report EM 10 and 095)			
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	1	0	1

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	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	1	1	2	100%
4 Years	0	0	0	0	0	0%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	0	0	1	0	2	100%
Investigations (Average %)						
Closed Within:						
90 Days	8	4	3	11	26	47%
180 Days	2	1	4	6	13	24%
1 Year	0	0	1	2	3	6%
2 Years	1	3	1	4	9	16%
3 Years	0	0	2	2	4	7%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	11	8	11	25	55	100%

Cite and Fine

The Midwifery Program has not utilized its citation and fine authority primarily because there are no technical violations which would be appropriate to resolve through this administrative remedy.

Cost Recovery and Restitution

Two disciplinary actions were taken against licensees over the past 3 fiscal years which resulted in cost recovery. In both cases, the penalty imposed as a result of the disciplinary action was license revocation. The former licensees are continuing to make payments to the Board for the ordered costs.

The Board also has the ability to seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered and received for criminal investigations.

Fiscal Year	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Criminal Cost Recovery Ordered	\$0	\$0	\$0	\$18,356
Criminal Cost Recovery Received	\$0	\$0	\$0	\$1,620

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice can be referred by the Board to the local district attorney for prosecution. Restitution has been ordered by a judge as a part of the criminal case prosecuted by the district attorney. The restitution identified in Table 12 was ordered due to these unlicensed cases.

The Board is unable to identify how much is collected for the victim/patient because the court receives the funds and provides it to the victim/patient and the Board is not notified.

Table 11. Cost Recovery				
	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13**
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	1	1	0
Amount of Cost Recovery Ordered	\$0	\$11,565	\$12,530	\$0
Amount Collected	\$0	\$150	\$5,880	\$10,165
* "Potential Cases for Recovery" are those cases in which disciplinary action has been taken based on violation of the license practice act. **As of 9/30/12				

Table 12. Restitution				
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered	\$0	\$0	\$0	\$1,500
Amount Collected	\$0	\$0	\$0	\$0

Section 6 – Public Information Policies

Refer to Full 2012 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2012 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2012 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2012 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2012 Medical Board Sunset Report

Section 11 – New Issues

Physician Supervision

Section 2057 of the B&P Code 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. B&P Code section 2507(f) requires the Board *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 Board bifurcated this requirement and in 2006 adopted Standards of Care for Midwifery (CCR section 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 these companies if they 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. 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. For example, in New York, licensed midwives are required to establish and maintain a collaborative relationship with a physician. The midwife is required to maintain documentation of such collaborative relationships and make information about such collaborative relationships available to his or her patients. However, documentation of the collaborative relationship does not have to be submitted to the licensing authority.

In New Jersey, the licensed midwife is required to establish written clinical guidelines with the affiliated physician which outlines the licensee's scope of practice, circumstances under which consultation, collaborative management, referral and transfer of care of women between the licensee and the affiliated physician are to take place. These clinical guidelines must include provisions for periodic conferences with the affiliated physician for review of patient records and for quality improvements. The licensed midwife is required to provide this information to the licensing authority upon request. It is considered professional misconduct to practice without established clinical guidelines.

States such as Arkansas and South Carolina provide a very detailed list of situations where physician intervention or referral is required. Other states, such as Virginia and New Mexico, have laws requiring collaboration between a physician and a midwife, but limit physician liability, stating that any consultative relationship with a physician does not by itself provide the basis for finding a physician liable for any acts or omissions by a licensed midwife. New Mexico law requires that each woman

accepted for care must be referred at least once to a duly licensed physician within four (4) weeks of her initial midwifery visit. The referral must be documented in the chart.

The Board, 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. It appears the physician supervision requirement needs to be addressed through the legislative process.

Lab Orders and Obtaining Medical Supplies

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 section 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 Board, 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.

Midwife Students, Apprentices and Assistants

Section 2514 of the B&P Code 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 her 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 that midwife 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 Board and some members of the midwifery community regarding what constitutes a "bona fide student". However, 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 B&P Code section 2513(a) which allows an approved midwifery education program to offer the opportunity for students

to achieve credit by examination for previous clinical experience. This 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. This may have been included with the assumption that midwifery education programs would be created statewide for individuals seeking this career path. There is currently one approved education program in California. 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 B&P Code section 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.

A similar 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 Board 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. Some licensed midwives only use another licensed midwife as an assistant. Other licensed midwives use a midwife student who is enrolled in a recognized midwifery school and who has an official agreement with the student and midwifery school to provide clinical training to the student midwife. Other licensed midwives use someone who may or may not have formal midwifery training and/or someone that the licensed midwife has trained. The duties that a midwife assistant performs vary from midwife to midwife. Some midwife assistants only setup the birthing area prior to the baby being born and then cleanup the birthing area after the baby has been born. Some midwife assistants also hand supplies to the midwife during the delivery of the baby. Other midwife assistants (unlicensed individuals and not an official midwife student) actually assist the midwife with the birth of the baby. Current statute and regulations do 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.

Section 12 – Attachments

Refer to Full 2012 Medical Board Sunset Report

Appendix II

Polysomnographic Program

- Background and Description of Polysomnographic Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments



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, 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. Registration requirements include having a valid current credential as a Polysomnographic Technologist issued by the Board of Registered Polysomnographic Technologists; shall have graduated from a polysomnographic educational program that has been approved by the Board; and, shall have taken and passed the Board of Registered Polysomnographic Technologist examination given by the Board of Registered Polysomnographic Technologists. For this registration type, if the application is received on or before October 22, 2012, in lieu of these requirements, submission of documentation, under penalty of

perjury, from the supervising physician indicating the individual has engaged in the practice of polysomnography safely for five years, as verified by a supervising physician will be accepted.

The Board is in the process of reviewing applications to determine qualifications are being met by applicants and anticipates that registrations will begin to be issued within the next 30 days.

Major Legislation/Regulations Since the Last Sunset Review

Since the Polysomnographic Program is a new program, the only legislation introduced has been the initial statute referenced below .

➤ *SB 132 (Denham, Chapter 635, Statutes of 2009) Polysomnographic technologists*
This bill requires the Board to adopt regulations within one year after the effective date of this act relative to the qualifications for certified polysomnographic technologists, including requiring those technologists to be credentialed by a board-approved national accrediting agency, to have graduated from a board-approved educational program, and to have passed a board-approved national certifying examination, with a specified exception for that examination requirement for a 3-year period.

Further, the initial regulations for the Program were filed on January 19, 2012 and became operative on February 18, 2012. The regulations were established in the California Code of Regulations (CCR) section 1379.40-1379.78 entitled “Polysomnography” and includes the qualifications for certified polysomnographic technologists, technicians, and trainees, application and registration requirements, required education and examinations, and disciplinary actions.

➤ *Amend CCR section 1379.50*
This proposed amendment is in the review process, and is regarding the Polysomnography Program. The proposed amendment would remove the requirement that Basic Life Support certification can only be provided by the American Heart Association and would allow the requirement to also be met by certification issued by the American Health and Safety Institute. This revision will allow applicants for a Polysomnography Registration to have more options to choose from when obtaining the required Basic Life Support Certification. The Board will hold a regulatory hearing on this proposed amendment on October 26, 2012 at its Board Meeting in San Diego.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2012 Medical Board Sunset Report

Section 3 – Fiscal and Staff

Refer to Full 2012 Medical Board Sunset Report

Section 4 – Licensing Program

Application Review

Current law does not define the required time set to review an initial application for the polysomnography program; however, the program has set goals/expectations that all 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.

As the processes and procedures for this newly regulated program is still in process, the program is attempting to maintain the goals set by the Board and anticipates that the goals will be met in the future.

As the Polysomnographic Program was just implemented in April of this year, the Board is still in the process of creating policies and procedures for the program. The Board has received several applications since the implementation and is in the process of reviewing applications and supporting documentation to insure compliance with requirements are being met. The Board anticipates that the number of applications received per year will rise significantly over the next few years due to the newly mandated licensing requirements. Enhancements to the California Code of Regulations will need to be made to further define the requirements of this program and to insure requirements are clear and precise.

The tables below show the Polysomnographic Program data.

Table 6. Licensee Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Polysomnographic Trainee	Active	n/a	n/a	n/a	0
	Out-of-State	n/a	n/a	n/a	0
	Out-of-Country	n/a	n/a	n/a	0
	Delinquent	n/a	n/a	n/a	0
Polysomnographic Technician	Active	n/a	n/a	n/a	0
	Out-of-State	n/a	n/a	n/a	0
	Out-of-Country	n/a	n/a	n/a	0
	Delinquent	n/a	n/a	n/a	0
Polysomnographic Technologist	Active	n/a	n/a	n/a	0
	Out-of-State	n/a	n/a	n/a	0
	Out-of-Country	n/a	n/a	n/a	0
	Delinquent	n/a	n/a	n/a	0

Table 7a. Licensing 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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	0	0	0	0	-	-	-	-	-	-
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
* Optional. List if tracked by the board.											
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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	1	0	0	0	1	-	1	-	-	-
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
* Optional. List if tracked by the board.											

Table 7a. Licensing Data by Type (cont.)											
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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(License)	40	0	0	0	40	-	40	-	-	-
	(Renewal)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Licensing Data			
	FY 2009/10	FY 2010/11	FY 2011/12
Initial Licensing Data:			
Initial License/Initial Exam Applications Received	n/a	n/a	41
Initial License/Initial Exam Applications Approved	n/a	n/a	0
Initial License/Initial Exam Applications Closed	n/a	n/a	0
License Issued	n/a	n/a	0
Initial License/Initial Exam Pending Application Data:			
Pending Applications (total at close of FY)	n/a	n/a	41
Pending Applications (outside of board control)*	n/a	n/a	
Pending Applications (within the board control)*	n/a	n/a	41
Initial License/Initial Exam Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	n/a	n/a	n/a
Average Days to Application Approval (incomplete applications)*	n/a	n/a	n/a
Average Days to Application Approval (complete applications)*	n/a	n/a	n/a
License Renewal Data:			
License Renewed	n/a	n/a	n/a

* Optional. List if tracked by the board.

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 Letters of Good Standing 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, Letters of Good Standing, 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 a Letter of Good Standing (LGS) from each state or province to be sent directly to the Board verifying the applicants licensure information and whether any action has been taken against the license. If the LGS 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 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 administered by the Board of Registered Polysomnographic Technologist. This 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.

Section 5 – Enforcement Program

This Program is still in the development stages and the enforcement program is not yet fully functional. Eight complaints were filed in 2011 alleging unlicensed practice. However, the application and criteria for licensure were still being established at that point so no action was taken on these complaints.

Below are several tables that provide Polysomnographic Program enforcement statistical data including eight complaints that were received and closed over the past three fiscal years.

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	0	1	7
Closed	0	0	0
Referred to INV	0	1	7
Average Time to Close	0	1	1
Pending (close of FY)	0	0	0
Source of Complaint (Use CAS Report 091)			
Public	0	0	0
Licensee/Professional Groups	0	0	0
Governmental Agencies	0	1	7
Other	0	0	0
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	0	0	0
CONV Closed	0	0	0
Average Time to Close	0	0	0
CONV Pending (close of FY)	0	0	0
LICENSE DENIAL (Use CAS Reports EM 10 and 095)			
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 (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	0	0	0

Table 9a. Enforcement Statistics (cont.)			
	FY 2009/10	FY 2010/11	FY 2011/12
ACCUSATION	(Use CAS Report EM 10)		
Accusations Filed	0	0	0
Accusation Filed--Average Days from Case Referred to AG's Office to Accusation Filed	0	0	0
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	0	0	0
Pending-No Accusation Filed (close of FY)	0	0	0
Pending-Accusation Filed (close of FY)	0	0	0

Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE	(Use CAS Report EM 10)		
Disciplinary Actions			
Proposed/Default Decisions	0	0	0
Stipulations	0	0	0
Average Days to Complete	0	0	0
AG Cases Initiated	0	0	0
AG Cases Pending (close of FY)	0	0	0
Disciplinary Outcomes	(Use CAS Report 096)		
Revocation	0	0	0
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 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

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	0	1	7
Closed	0	1	7
Average days to close	0	1	1
Pending (close of FY)	0	0	0
Desk Investigations (Use CAS Report EM 10)			
Closed	0	1	7
Average days to close	0	1	1
Pending (close of FY)	0	0	0
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	0	0	0
Average days to close	0	0	0
Pending (close of FY)	0	0	0
COMPLIANCE ACTION (Use CAS Report 096)			
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 (Use CAS Report EM 10 and 095)			
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						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	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	0	1	7	8	100%
180 Days	0	0	0	0	0	0%
1 Year	0	0	0	0	0	0%
2 Years	0	0	0	0	0	0%
3 Years	0	0	0	0	0	0%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	0	0	1	7	8	100%

Table 11. Cost Recovery				
	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13
Potential Cases for Recovery *	0	0	0	0
Cases Recovery Ordered	0	0	0	0
Amount of Cost Recovery Ordered	\$0.00	\$0.00	\$0.00	\$0.00
Amount Collected	\$0.00	\$0.00	\$0.00	\$0.00
* "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				
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Amount Ordered	\$0.00	\$0.00	\$0.00	\$0.00
Amount Collected	\$0.00	\$0.00	\$0.00	\$0.00

Section 6 – Public Information Policies

Refer to Full 2012 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2012 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2012 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2012 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2012 Medical Board Sunset Report

Section 11 – New Issues

None

Section 12 – Attachments

Refer to Full 2012 Medical Board Sunset Report

Appendix III

Registered Dispensing Optician Program

- Background and Description of Registered Dispensing Optician Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments



Section 1 – Background and Description of the Registered Dispensing Optician Program

History and Functions of the Registered Dispensing Optician Program

The Legislature enacted the regulation of Dispensing Optician under the jurisdiction of the Board in 1939. Dispensing Opticians were defined as individuals and firms filling prescriptions of physicians licensed by the Board for ophthalmic lenses and kindred products. Individuals and firms were required to submit an application for registration as a Dispensing Optician for each place of business.

Contact Lens Dispenser registration began in 1983. This registration was required for individuals engaged in fitting and adjusting contact lenses at a registered dispensing optician business. Unregistered Individuals are allowed to perform these functions under the direct responsibility and supervision of a registered contact lens dispenser, who is present on the premises. A registered contact lens dispenser is allowed to supervisor no more than three contact lens dispenser trainees.

In 1986, legislation was enacted to require the registration of Spectacle Lens Dispensers. Business and Professions (B&P) Code section 2559.1 states that “on and after January 1, 1988, no individual may fit and adjust spectacle lenses” unless the individual is a registered as a spectacle lens dispenser and performing the functions at a registered dispensing optician business. Unregistered Individuals are allowed to fit and adjust spectacle lenses under the direct responsibility and supervision of a registered spectacle lens dispenser, whose certificate of registration is conspicuously and prominently displayed on the premises. A supervising registered dispenser shall be on the registered premises when services are being performed by an unregistered technician but allows for usual and customary absences of the registered dispenser.

The Board co-sponsored a bill with Lens Express to provide for clear state jurisdiction and minimum regulation over out-of-state contact lens sellers. SB 640 Craven (Statutes of 1995, Chapter 853) prohibited, commencing January 1, 1997, any person located outside of California from shipping, mailing, or delivering contact lenses to residents of California unless registered with the Board and provided that only replacement lenses may be shipped, mailed, or delivered to a patient. Registrants are referred to as Nonresident Contact Lens Sellers.

Currently, these four registrations make up the Registered Dispensing Optician (RDO) Program. They are repeated below with brief descriptions:

- [Registered Dispensing Optician](#): This registration is required for individuals, corporations, and firms engaged in the business of filling prescriptions of physicians licensed by the Medical Board of California or optometrists licensed by the Board of Optometry for prescription lenses.
- [Registered Spectacle Lens Dispenser](#): A registered spectacle lens dispenser is authorized to fit and adjust spectacle lenses at any place of business holding a Registered Dispensing Optician certificate provided that the certificate of the registered spectacle lens dispenser is displayed in a conspicuous place at the place of business where he or she is fitting and adjusting.

- [Registered Contact Lens Dispenser](#): A registered contact lens dispenser is authorized to fit and adjust contact lenses at any place of business holding a Registered Dispensing Optician certificate provided that the certificate of the registered contact lens dispenser is displayed in a conspicuous place at the place of business where he or she is fitting and adjusting.
- [Registered Nonresident Contact Lens Seller](#): This registration is required for individuals, partnerships, and corporations located outside California that ship, mail, or deliver in any manner, contact lenses at retail to a patient at a California address.

Major Legislation/Regulations Since the Last Sunset Review

There were no new or amended regulations to the RDO Program since the last Sunset Review. The RDO Program had the following legislative bills since 2005.

➤ *AB 1382 (Nakanishi, Chapter 148, Statutes of 2006) - Prescription lenses*

This bill makes it a deceptive marketing practice for any individual or entity who offers for sale plano contact lenses, as defined, to represent by any means that those lenses may be lawfully obtained without an eye examination or confirmation of a valid prescription, or may be dispensed or furnished to a purchaser without complying with prescribed requirements.

The California Optometric Association (COA) sponsored this bill. COA stated there was growing evidence that use of nonprescription (or 'plano') cosmetic contact lenses was creating a public health problem by causing injury to users. These lenses were being marketed as 'fashion accessories' and sold with no warnings about the necessity of being tested for compatibility or fitted properly to avoid irritation or injury. The Board supported this bill.

➤ *AB 2683 (Hernandez, Chapter 604, Statutes of 2010) – Optometry*

This bill (sponsored by the Board of Optometry) authorizes an assistant to fit prescription lenses and perform those additional duties in any setting where optometry or ophthalmology is practiced, under the direct responsibility and supervision of a physician, optometrist, or ophthalmologist, respectively.

➤ *SB 824 (Negrete McLeod, Chapter 389, Statutes of 2011) - Opticians: regulation*

This bill (sponsored by LensCrafters, Target Optical, and Sears Optical) requires a registered dispensing optician (RDO) assuming ownership of a business and the RDO selling or transferring the ownership of a business to both file a notice with the Board within 10 days of the completion of the transfer of ownership. The bill also makes the RDO selling or transferring the ownership interest responsible for complying with all laws relating to the place of business until the cancellation notice is received by the Board. The Board supported this bill.

➤ *AB 778 (Atkins, 2011, did not pass out of Legislature) - Health care service plans: vision care*

This bill (sponsored by Californians for Healthy Vision) 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 share 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 passed the Assembly. It was referred to Senate Business, Professions and Economic Development but the hearing was cancelled by the author.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2012 Medical Board Sunset Report

Section 3 – Fiscal and Staff

The fees collected for the RDO Program go into the Dispensing Opticians Fund. The Board performs the investigative and prosecution functions for this Program and then bills the Program for the costs to accomplish these services. In looking at the Program's reserve level, it appears the Program would need to seek a fee increase for FY 2013/2014. However, this Program has consistently underspent the budget appropriation over the last several years. Therefore, the Program should remain solvent in FY 2013/2014. The Board will continue to monitor both the revenue and the expenditures for this Program to determine if a fee increase is warranted in the future. There have been no General Fund loans from the Dispensing Opticians Fund.

The fees for this Program have not increased since its inception. The fund has remained solvent based upon these fees and therefore no increases have been necessary. The registrants under this Program pay an initial registration fee and then a biennial renewal fee. The majority of the Program's revenue is received from the Registered Spectacle Lens Dispenser renewal fees.

This Program has budget authority for one position to perform the functions of this Program. This position reports to one of the Board's Licensing Program Managers. For staffing issues, refer to the Board's Sunset Review Report, as the same challenges faced by the Board have been faced by this Program.

Table 2. Fund Condition RDO					Proposed	Proposed
(Dollars in Thousands)	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	FY 2012/13	FY 2013/14
Beginning Balance	330	346	374	361	345	173
Revenues and Transfers*	175	183	167	186	171	168
Total Revenue	505	529	541	547	516	341
Budget Authority	289	291	305	315	343	355
Expenditures	160	156	180	202	343	355
Loans to General Fund	--	--	--	--	--	--
Fund Balance	346	374	361	345	173	-14
Months in Reserve	14.3	14.7	13.8	12.2	5.9	-5

Table 3. Expenditures by Program Component RDO

(Dollars in Thousands)	FY 2008/09		FY 2009/10		FY 2010/11		FY 2011/12	
	Personnel Services	OE&E						
Enforcement		40		48		65		77
Examination	--	--	--	--	--	--	--	--
Licensing	45	15	30	18	39	18	40	17
Administration *	0	23		24		25	0	23
DCA Pro Rata and Statewide	0	34	0	29	0	33	0	42
Diversion (if applicable)	--	--	--	--	--	--	--	--
TOTALS	45	112	30	119	39	141	40	159

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

Table 4. Fee Schedule and Revenue

Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
Registered Dispensing Optician Initial Registration Fee (B&P 2565) (Title 16, CCR 1399.260)	75.00	100.00	7,350	14,325	6,375	5,175	2.75%
Registered Dispensing Optician Biennial Renewal Fee (B&P 2565) (Title 16, CCR 1399.260)	75.00	100.00	40,125	36,525	32,775	47,250	25.11%
Registered Dispensing Optician Delinquency Fee (B&P 2565)	25.00	25.00	2,700	1,100	1,000	3,525	1.87%
Registered Dispensing Optician Replacement Certificate Fee (B&P 2565)	\$25.00	25.00	50	300	175	275	.15%
Registered Contact Lens Dispenser Initial Registration Fee (B&P 2566) (Title 16, CCR 1399.261)	75.00	100.00	7,950	7,650	5,775	6,075	3.23%
Registered Contact Lens Dispenser Biennial Renewal Fee (B&P 2566) (Title 16, CCR 1399.261)	75.00	100.00	26,250	26,250	30,225	30,225	16.06%
Registered Contact Lens Dispenser Delinquency Fee (B&P 2566)	25.00	25.00	825	1,175	1,250	1,125	.60%

Table 4. Fee Schedule and Revenue (cont.)

Fee	Current Fee Amount	Statutory Limit	FY 2008/09 Revenue	FY 2009/10 Revenue	FY 2010/11 Revenue	FY 2011/12 Revenue	% of Total Revenue
Registered Contact Lens Dispenser Replacement Certificate Fee (B&P 2566)	25.00	25.00	25	25	150	25	.01%
Registered Spectacle Lens Dispenser Initial Registration Fee (B&P 2566.1) (Title 16, CCR 1399.263)	75.00	100.00	13,050	18,225	15,450	14,700	7.80%
Registered Spectacle Lens Dispenser Biennial Renewal Fee (B&P 2566.1) (Title 16, CCR 1399.263)	75.00	100.00	64,450	70,200	67,650	75,825	40.29%
Registered Spectacle Lens Dispenser Delinquency Fee (B&P 2566.1)	25.00	25.00	2,875	3,600	2,850	4,000	2.13%
Registered Spectacle Lens Dispenser Replacement Certificate Fee (B&P 2566.1)	25.00	25.00	50	200	150	25	5.88%
Nonresident Contact Lens Sellers Initial Registration Fee (B&P 2546.9)	100.00	100.00	200	200	--	--	0
Nonresident Contact Lens Sellers Biennial Renewal Fee (B&P 2546.9)	100.00	100.00	300	200	500	400	94.12%
Nonresident Contact Lens Sellers Delinquency Fee (B&P 2546.9)	25.00	25.00	--	--	25	--	0
Nonresident Contact Lens Sellers Replacement Certificate Fee (B&P 2546.9)	25.00	25.00	--	--	--	--	0

Section 4 – Licensing Program

Application Review

B&P Code section 2552 requires that the division promptly notify an applicant if, as of the 30th day following the submission of an application under Chapter 5.5 of the B&P Code, the application and

supporting documentation are not substantially complete and in the proper form. This applies to all registration types under the Registered Dispensing Optician program, including applications for Registered Dispensing Optician, Spectacle Lens Dispenser, Contact Lens Dispenser, and Non-Resident Contact Lens Dispenser. The RDO Program is meeting these requirements.

Due to the small amount of RDO applications received, processing times have neither decreased nor increased significantly in the last few 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 RDO program are very low and those in a pending status are outside of the Board's control.

The tables below show the RDO registration population, RDO registrations issues and RDO registrations renewed.

Table 6. Registration Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Registered Dispensing Optician	Active	1,165	1,146	1,161	1,170
	Out-of-State	0	0	0	0
	Out-of-Country	0	0	0	0
	Delinquent	205	210	205	190
Registered Contact Lens Dispenser	Active	827	874	902	948
	Out-of-State	7	9	9	8
	Out-of-Country	0	0	0	0
	Delinquent	239	255	253	256
Registered Spectacle Lens Dispenser	Active	2,045	2,130	2,182	2,258
	Out-of-State	35	32	29	36
	Out-of-Country	0	1	1	0
	Delinquent	832	818	802	770
Nonresident Contact Lens Sellers	Active	11	12	11	10
	Out-of-State	11	12	11	10
	Out-of-Country	0	0	0	0
	Delinquent	0	0	0	0

Table 7a. Registration Data by Type											
Registered Dispensing Optician		Received	Approved	Closed	Issued	Pending Applications ¹			Cycle Times ¹		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	149	142	n/a	142	30	-	-	n/a	n/a	n/a
	(Renewal)	485	n/a	n/a	485	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	74	69	n/a	69	17	-	-	n/a	n/a	n/a
	(Renewal)	421	n/a	n/a	421	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	66	49	n/a	49	39	-	-	n/a	n/a	n/a
	(Renewal)	582	n/a	n/a	582	n/a	n/a	n/a	n/a	n/a	n/a
Registered Contact Lens Dispenser		Received	Approved	Closed	Issued	Pending Applications ¹			Cycle Times ¹		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	96	98	n/a	98	7	-	-	n/a	n/a	n/a
	(Renewal)	366	n/a	n/a	366	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	70	73	n/a	73	22	-	-	n/a	n/a	n/a
	(Renewal)	384	n/a	n/a	384	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	92	85	n/a	85	21	-	-	n/a	n/a	n/a
	(Renewal)	420	n/a	n/a	420	n/a	n/a	n/a	n/a	n/a	n/a
* Optional. List if tracked by the board.											
Registered Spectacle Lens Dispenser		Received	Approved	Closed	Issued	Pending Applications ¹			Cycle Times ¹		
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out
FY 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	347	221	n/a	221	38	-	-	n/a	n/a	n/a
	(Renewal)	906	n/a	n/a	906	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	195	196	n/a	196	64	-	-	n/a	n/a	n/a
	(Renewal)	870	n/a	n/a	870	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	211	192	n/a	192	51	-	-	n/a	n/a	n/a
	(Renewal)	991	n/a	n/a	991	n/a	n/a	n/a	n/a	n/a	n/a

¹ The Board uses a data system that does not capture this information. This information will be available after the conversion to the new BreZe computer system.

Table 7a. Registration Data by Type												
	Nonresident Contact Lens Sellers	Received	Approved	Closed	Issued	Pending Applications ¹			Cycle Times ¹			
						Total (Close of FY)	Outside Board control*	Within Board control*	Complete Apps	Incomplete Apps	combined, IF unable to separate out	
FY 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	(Registration)	1	1	n/a	1	0	-	-	n/a	n/a	n/a	
	(Renewal)	3	n/a	n/a	3	n/a	n/a	n/a	n/a	n/a	n/a	
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	(Registration)	0	0	n/a	0	0	-	-	n/a	n/a	n/a	
	(Renewal)	5	n/a	n/a	5	n/a	n/a	n/a	n/a	n/a	n/a	
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	
	(Registration)	2	1	n/a	1	1	-	-	n/a	n/a	n/a	
	(Renewal)	3	n/a	n/a	3	n/a	n/a	n/a	n/a	n/a	n/a	
* Optional. List if tracked by the board.												
Table 7b. Total Registration Data												
								FY 2009/10	FY 2010/11	FY 2011/12		
Initial Registration Data:												
Initial Registration Applications Received								593	339	371		
Initial Registration Applications Approved								462	338	327		
Initial Registration Applications Closed								n/a	n/a	n/a		
Registration Issued								492	338	327		
Initial Registration Pending Application Data:												
Pending Applications (total at close of FY)								75	103	112		
Pending Applications (outside of board control)*								-	-	-		
Pending Applications (within the board control)*								-	-	-		
Initial Registration Cycle Time Data (WEIGHTED AVERAGE):												
Average Days to Application Approval (All - Complete/Incomplete)								n/a	n/a	n/a		
Average Days to Application Approval (incomplete applications)*								n/a	n/a	n/a		
Average Days to Application Approval (complete applications)*								n/a	n/a	n/a		
Table 7b. Total Registration Data (continued)												
								FY 2009/10	FY 2010/11	FY 2011/12		
Registration Renewal Data:												
Registration Renewed								1,760	1,680	1,996		
* Optional. List if tracked by the board.												

¹ The Board uses a data system that does not capture this information. This information will be available after the conversion to the new BreZe computer system.

Verification of Application Information

Spectacle Lens Dispenser (SLD) and Contact Lens Dispenser (CLD) applicants are required by law to disclose truthfully all questions asked on the application for registration. Failure to disclose information on the application may be grounds for denial. The application forms and Letters of Good Standing 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.

Pursuant to B&P Code section 2559.2(a), an individual applying as a SLD must have passed the registry examination of the American Board of Opticianry. Pursuant to B&P Code section 2561, an individual applying as a CLD must have passed the contact lens registry examination of the National Committee of Contact Lens Examiners. Results of these exams that were administered in California are provided to the Board. Applicant's test results are verified from this data for examinees in California. For exams administered outside of California, a verification letter, sent directly from the organization, indicating a passing score is required prior to approval of the application.

SLD and CLD applicants must disclose all current and/or previous registrations held and provide a Letter of Good Standing (LGS) from each state or province to be sent directly to the Board verifying the applicants registration information and whether any action has been taken against the registrant. If the LGS 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.

Individuals applying for SLD and CLD registrations 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 registration. Fingerprinting is not required for the Registered Dispensing Optician or Nonresident Contact Lens Seller registrations.

SLD and CLD applicants must disclose whether they have ever been convicted of or pled nolo contendere to a crime. This 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 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.

Registered Dispensing Optician (RDO) applicants are required by law to disclose truthfully all questions asked on the application for licensure. Failure to disclose information on the application may be grounds for denial. The application forms are valid for one year. After one year, an updated application must be submitted to ensure that correct and current information accurately reflects any changes.

RDO applicants must disclose the type of business that is being applied for such as individual, partnership, or corporation. For corporations, the applicant must provide a copy of the endorsed

Articles of Incorporation. A search of the Secretary of State's database for corporations is also performed to verify the current standing of the corporation.

Nonresident Contact Lens Seller (NCLS) applicants are required by law to disclose truthfully all questions asked on the application for licensure. Failure to disclose information on the application may be grounds for denial. The application forms are valid for one year. After one year, an updated application must be submitted to ensure that correct and current information accurately reflects any changes.

NCLS applicants must disclose the type of business that is being applied for such as individual, partnership, or corporation. For corporations, the applicant must provide a copy of the endorsed Articles of Incorporation. The Secretary of State's database in the state in which the articles have been filed is searched to verify the current standing of the corporation.

In order to be granted a NCLS registration, applicants must be in good standing and either registered or otherwise authorized in the state in which the selling facility is located and from which the contact lenses are sold. Applicants must provide a Letter of Good Standing (LGS) from the state in which they are registered, or a letter from the appropriate state level entity indicating that registration to sale contact lenses is not required in that state. Letters must be sent directly to the Board verifying the applicants registration information and whether any action has been taken against the registrant. If the LGS 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.

Further, NCLS applicants must provide a toll-free telephone number that consumers can call with questions and complaints. This number is included on the application which is then verified by Board staff. A copy of the invoice that will be provided to consumers must be submitted to the Board with the application and include the toll-free telephone number, facsimile number, and email address that are dedicated to prescribers and their authorized agents for the purposes of confirmation of contact lens prescriptions. The invoice must also include the mandated warning pursuant to B&P Code section 2546.5(e). Board staff reviews the information submitted to insure compliance with B&P Code section 2546.5 is being met.

If the NCLS registrant will be selling contact lenses through an Internet Web site, the site is also reviewed by staff to insure that the applicant is not publishing or causing to be published any advertisement or sales presentation relating to contact lenses representing that contact lenses may be obtained without confirmation of a valid prescription.

Section 5 – Enforcement Program

The number of disciplinary actions filed against registrants of the Registered Dispensing Optician (RDO) program is small and generally results from notification that the registrant has been convicted of a crime. In all but one of the disciplinary actions filed as a result of conviction of a crime in the past two fiscal years, the registrant has been revoked or surrendered as an outcome of the action filed. The majority of the complaints received regarding the RDO Program do not involve the inappropriate

dispensing or furnishing of eyeglasses or contact lenses. Instead, the complaints typically involve business issues such as employing or advertising the services of an optometrist or physician to examine or treat the eyes. Complaints dealing with technical violations of law are considered routine complaints which is consistent with DCA's guidelines. The Board also receives complaints regarding unregistered businesses or registered business which do not have registered dispensers on staff. These complaints are considered "urgent" complaints which is consistent with DCA's guidelines. Currently, there are no mandatory reporting requirements for the RDO Program.

The RDO Program does not have a statute of limitations established in statute but recognizes public protection as its highest priority and therefore strives to investigate each complaint as quickly as possible.

The RDO Program would utilize the Board's discipline guidelines as a model for any disciplinary actions imposed on registrants.

The Board utilizes its citation authority to address and resolve complaints related to an unregistered practice. The majority of the complaints involve either an unregistered employee working in a registered dispensing location or a business that is operating without being registered with the Board. The cases are resolved through an order of abatement requiring registration.

Below are several tables that provide RDO Program enforcement statistical data including complaints, accusations, disciplinary actions, and citations and fines issued.

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	31	96	24
Closed	0	0	0
Referred to INV	31	95	24
Average Time to Close	11	13	15
Pending (close of FY)	0	1	1
Source of Complaint (Use CAS Report 091)			
Public	19	79	22
Licensee/Professional Groups	4	6	3
Governmental Agencies	18	31	20
Other	0	0	0
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	10	20	21
CONV Closed	11	19	22
Average Time to Close	12	5	7
CONV Pending (close of FY)	0	1	0

Table 9a. Enforcement Statistics (cont.)			
	FY 2009/10	FY 2010/11	FY 2011/12
REGISTRATION DENIAL (Use CAS Reports EM 10 and 095)			
Registration Applications Denied	1	0	0
SOIs Filed	2	0	0
SOIs Withdrawn	0	0	0
SOIs Dismissed	0	0	0
SOIs Declined	0	0	0
Average Days SOI (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	361	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	2	5	0
Accusations Filed -- Average Days from Case Referred to AG's Office to Accusation Filed	54	100	0
Accusations Withdrawn	0	1	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	0	1,029	0
Pending-No Accusation Filed (close of FY)	1	0	1
Pending Accusation Filed (close of FY)	3	3	0

Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	1	4	2
Stipulations	1	0	1
Average Days to Complete	361	928	1,025
AG Cases Initiated	4	4	2
AG Cases Pending (close of FY)	4	3	1
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	0	4	1
Surrender	0	0	1
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	2	0	1
Probationary Registration Issued	0	0	0
Other	0	0	0
PROBATION			
New Probationers	2	0	1
Probations Successfully Completed	0	1	1
Probationers (close of FY)	4	3	3
Petitions to Revoke Probation	0	0	0
Probations Revoked	0	0	0
Probations Modified	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

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	42	115	46
Closed	30	105	54
Average days to close	149	153	177
Pending (close of FY)	24	34	26
Desk Investigations (Use CAS Report EM 10)			
Closed	20	71	42
Average days to close	89	124	141
Pending (close of FY)	7	27	9
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	10	34	12
Average days to close	269	214	302
Pending (close of FY)	17	7	17
COMPLIANCE ACTION (Use CAS Report 096)			
ISO & TRO Issued	0	0	0
PC 23 Orders Requested	0	0	1
Other Suspension Orders	0	0	1
Public Letter of Reprimand	0	0	0
Cease & Desist/Warning	1	1	0
Referred for Diversion	0	0	0
Compel Examination	0	0	0
CITATION AND FINE (Use CAS Report EM 10 and 095)			
Citations Issued	2	3	4
Average Days to Complete	269	393	434
Amount of Fines Assessed	\$5,000.00	\$7,500.00	\$10,500.00
Reduced, Withdrawn, Dismissed	\$0.00	\$5,000.00	\$4,500.00
Amount Collected	\$0.00	\$800.00	\$1,253.00
CRIMINAL ACTION			
Referred for Criminal Prosecution	0	10	1

Table 10. Enforcement Aging						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	Cases Closed	Average %
Attorney General Cases (Average %)						
Closed Within:						
1 Year	1	2	2	0	5	42%
2 Years	1	1	0	1	3	25%
3 Years	0	0	1	0	1	8%
4 Years	0	0	1	2	3	25%
Over 4 Years	0	0	0	0	0	0%
Total Cases Closed	2	3	34	3	12	100%
Investigations (Average %)						
Closed Within:						
90 Days	21	12	22	18	73	33%
180 Days	7	11	68	15	101	46%
1 Year	4	4	5	15	28	13%
2 Years	0	3	10	5	18	8%
3 Years	0	0	0	1	1	<1%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	32	30	105	54	221	100%

Cite and Fine

The RDO Program does utilize its citation and fine authority as a remedy to address any violation of law identified. The Board has not yet updated the regulation to reflect the maximum fine of \$5,000 now authorized.

A new trend developing in the past 1-2 years is the dispensing of glasses through the use of internet Web sites. The Board has utilized investigative staff to purchase glasses through these sites and confirm that registration is required. The typical citation in these cases results in the requirement to register with the Board along with a fine ranging from \$2,500 to \$3,000 for the unregistered practice violation.

Of the nine citations issued within the past three fiscal years, six informal conferences have been requested and held. No Administrative Procedure Act appeals have been filed.

The five most common violations for RDO Program citations issued are:

1. B&P Code section 2559 Unlicensed practice-Spectacle lens dispenser
2. B&P Code section 2550 Unlicensed practice – Dispensing Optician
3. B&P Code section 2551 Unlicensed business location
4. B&P Code section 2556 – General unlawful acts
5. B&P Code section 2546 – Unlicensed practice–nonresident contact lens seller

The Board utilizes its citation authority to gain compliance by compelling registration through an order of abatement to satisfy the citation. The data from three prior fiscal years indicates that in all but one

case, the citation was withdrawn once compliance was obtained. In one case the fine was reduced from \$2,500 to \$500 and compliance with the order of abatement satisfied the citation.

As indicated above, the citations issued by the RDO program generally relate to unregistered practice. In only one case, the Board was unable to collect the outstanding fine or obtain compliance on the citation. Because the individual was unregistered, the board had no access to social security information, which is required to utilize the Franchise Tax Board intercept program, and the citation was closed as “uncollectable”.

Cost Recovery and Restitution

The Board does not seek cost recovery in cases filed against registrants of the Registered Dispensing Opticians Program and did not seek any restitution.

The Board has the ability to seek cost recovery for investigations referred for criminal prosecution. The following chart identifies the costs ordered and received for criminal investigations.

Fiscal Year	FY 08/09	FY 09/10	FY 10/11	FY 11/12
Criminal Cost Recovery Ordered	\$750	\$0	\$500	\$0
Criminal Cost Recovery Received	\$0	\$0	\$0	\$0

The Board does not seek restitution from the licensee for individual consumers. However, cases involving unlicensed practice can be referred by the Board to the local district attorney for prosecution. Restitution has been ordered by a judge as a part of the criminal case prosecuted by the district attorney. The restitution identified in Table 12 was ordered due to these unlicensed cases. The Board is unable to identify how much is collected for the victim/patient because the court receives the funds and provides it to the victim/patient and the Board is not notified.

Section 6 – Public Information Policies

Refer to Full 2012 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2012 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2012 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2012 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2012 Medical Board Sunset Report

Section 11 – New Issues

Should the RDO Program be Transferred to Another State Agency?

The State Board of Optometry (SBO) has expressed interest in regulating the Registered Dispensing Optician (RDO) Program. SBO has informed the Board of its impending proposal, through its sunset review process, to transfer the RDO Program from the Board to the SBO. Board staff has been working with SBO staff in discussing the RDO Program and providing information about the administration of the Program.

SBO states its interest in regulating the RDO Program is to ensure more complete and efficient regulation of individuals and businesses that are registrants of the RDO Program, and to streamline the delivery of government services.

SBO reported that it receive 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 Board's 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. With regard to these types of complaints, SBO must refer all complaints related to the RDO Program to the Board, forcing both agencies to discipline their respective licensee/registrant separately. If the SBO had jurisdiction over the RDO Program, a more efficient, joint investigation of these type of complaints could be conducted by SBO. Further, many consumers do not understand that the functions of these two professions 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.

The Board believes that some of the consumer confusion may be due to the fact that an optometrist is often times located on or near the premises of an RDO business. This is the business set-up in at least 50% of the current RDO businesses. In FY 2011/2012 the Board reported 1,170 current RDO businesses. Over 600 of these RDO businesses are made up of large optical companies and department store companies that also provide optometric services in or near the RDO business premises.

What may lead to further confusion is that current law does not allow optometrists and RDO registrants to have commingling business relationships. B&P Code section 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 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 passed the Assembly and was referred to the Senate Business, Professions and Economic Development Committee. The hearing was cancelled by the author and therefore did not processed through the legislature for passage.

If the SBO were to regulate the RDO Program, it will 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.

Another option for the regulation of RDO is to transfer the program to the Department of Consumer Affairs as a program or bureau.

Section 12 – Attachments

Refer to Full 2012 Medical Board Sunset Report

Appendix IV

Research Psychoanalyst

- Background and Description of Research Psychoanalyst Program
- Performance Measures and Customer Satisfaction Surveys
- Fiscal and Staff Issues
- Licensing Program
- Enforcement Program
- Public Information Policies
- Online Practice Issues
- Workforce Development and Job Creation
- Current Issues
- Board Action and Response to Prior Sunset Issues
- New Issues
- Attachments



Section 1 – Background and Description of Research Psychoanalyst

History and Functions of the Research Psychoanalyst Program

The Legislature enacted the regulation of Research Psychoanalysts (RP) under the jurisdiction of the Board in 1977. A registered Research Psychoanalyst is an individual who has graduated from an approved psychoanalytic institution and is registered with the Medical Board of California (Board). Additionally, students who are currently enrolled in an approved psychoanalytic institution and are registered with the Board as a Student Research Psychoanalyst, 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 is required prior to registration.

An RP may engage in psychoanalysis as an adjunct to teaching, training or research. "Adjunct" means that the Research Psychoanalyst 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 Research Psychoanalyst. 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

Legislation

➤ *AB 139 Committee on Budget (Statutes 2005, Chapter 74) – Technical Changes to RP law*
This bill enacted the budget and eliminated continuous appropriation for various special funds within the Department of Consumer Affairs, including the Board. This bill made this conforming and technical change to B&P Code section 2529.5 relating to the research psychoanalysts.

➤ *AB 253 Eng (Statutes 2007, Chapter 678) – Technical Changes to RP law*

This bill reduced the membership of the Board and repealed the statutory requirement that the Board be divided into two divisions. This bill also made other related conforming and technical changes to B&P Codes 2529 and 2529.5 relating to research psychoanalysts.

Regulations

There were no new or amended regulations to the RP Program since the last Sunset Review.

Section 2 – Performance Measures and Customer Satisfaction Surveys

Refer to Full 2012 Medical Board Sunset Report

Section 3 – Fiscal and Staff

Refer to Full 2012 Medical Board Sunset Report

Section 4 – Licensing Program

Application Review

California Code of Regulations (CCR) section 1367.4 requires that the Board inform in writing an applicant for registration as a RP 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 RP Program is in compliance with this mandated timeframe.

Due to the low number of applications received, processing times have neither decreased nor increased significantly in the last few years. The Board has seen some increase in applications each year and anticipates that these numbers will remain the same over time. Pending applications for RPs are few and those in a pending status are outside of the Board’s control. The Board is continuously striving to review and approve applications within the set timeframes to ensure compliance with the law is met. This is accomplished by reviewing policies and procedures within the program for best practices.

The tables below show the RP registration population, registrations issued and registrations renewed.

Table 6. Registration Population					
		FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12
Research Psychoanalyst	Active	86	87	92	87
	Out-of-State	7	6	6	5
	Out-of-Country	0	1	1	1
	Delinquent	24	26	25	31

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 2009/10	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	5	3	0	3	2	2	0	-	-	95
	(Renewal)	79	n/a	n/a	79	n/a	n/a	n/a	n/a	n/a	n/a
FY 2010/11	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	9	8	0	8	3	3	0	-	-	36
	(Renewal)	4	n/a	n/a	4	n/a	n/a	n/a	n/a	n/a	n/a
FY 2011/12	(Exam)	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
	(Registration)	4	4	0	4	3	3	0	-	-	50
	(Renewal)	80	n/a	n/a	80	n/a	n/a	n/a	n/a	n/a	n/a

* Optional. List if tracked by the board.

Table 7b. Total Registration Data			
	FY 2009/10	FY 2010/11	FY 2011/12
Initial Registration Data:			
Initial Registration Applications Received	5	9	4
Initial Registration Applications Approved	3	8	4
Initial Registration Applications Closed	0	0	0
Registration Issued	3	8	4
Initial Registration Pending Application Data:			
Pending Applications (total at close of FY)	2	3	3
Pending Applications (outside of board control)*	2	3	3
Pending Applications (within the board control)*	0	0	0
Initial Registration Cycle Time Data (WEIGHTED AVERAGE):			
Average Days to Application Approval (All - Complete/Incomplete)	95	36	50
Average Days to Application Approval (incomplete applications)*	-	-	-
Average Days to Application Approval (complete applications)*	-	-	-
Registration Renewal Data:			
Registration Renewed	79	4	80

* Optional. List if tracked by the board.

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 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 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

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 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

No disciplinary actions have ever been filed or taken against registered research psychoanalysts. Over the past three fiscal years, the Board has received only four complaints regarding research psychoanalysts who provide services under the auspice of their training program as an adjunct to teaching, training or research. 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 Research Psychoanalysts.

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 Research Psychoanalyst Program enforcement statistical data including four complaints that were received and closed over the past three fiscal years.

Table 9a. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
COMPLAINT			
Intake (Use CAS Report EM 10)			
Received	1	0	3
Closed	0	0	0
Referred to INV	1	0	3
Average Time to Close	16	0	13
Pending (close of FY)	0	0	0
Source of Complaint (Use CAS Report 091)			
Public	1	0	3
Licensee/Professional Groups	0	0	0
Governmental Agencies	0	0	0
Other	0	0	0
Conviction / Arrest (Use CAS Report EM 10)			
CONV Received	0	0	0
CONV Closed	0	0	0
Average Time to Close	0	0	0
CONV Pending (close of FY)	0	0	0
REGISTRATION DENIAL(Use CAS Reports EM 10 and 095)			
Registration 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 (from case referred to AG's Office to one of outcomes above--withdrawn, dismissed, declined)	0	0	0
ACCUSATION (Use CAS Report EM 10)			
Accusations Filed	0	0	0
Accusation Filed--Average Days from Case Referred to AG's Office to Accusation Filed	0	0	0
Accusations Withdrawn	0	0	0
Accusations Dismissed	0	0	0
Accusations Declined	0	0	0
Average Days Accusations (from case referred to AG's Office to one of the outcomes above--withdrawn, dismissed, declined)	0	0	0
Pending-No Accusation Filed (close of FY)	0	0	0
Pending-Accusation Filed (close of FY)	0	0	0

Table 9b. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Actions (Use CAS Report EM 10)			
Proposed/Default Decisions	0	0	0
Stipulations	0	0	0
Average Days to Complete	0	0	0
AG Cases Initiated	0	0	0
AG Cases Pending (close of FY)	0	0	0
	FY 2009/10	FY 2010/11	FY 2011/12
DISCIPLINE			
Disciplinary Outcomes (Use CAS Report 096)			
Revocation	0	0	0
Surrender	0	0	0
Suspension	0	0	0
Probation with Suspension	0	0	0
Probation	0	0	0
Probationary Registration 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 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

Table 9c. Enforcement Statistics			
	FY 2009/10	FY 2010/11	FY 2011/12
INVESTIGATION			
All Investigations (Use CAS Report EM 10)			
First Assigned	1	0	3
Closed	1	0	3
Average days to close	29	0	61
Pending (close of FY)	0	0	0
Desk Investigations (Use CAS Report EM 10)			
Closed	1	0	3
Average days to close	29	0	61
Pending (close of FY)	0	0	0
Non-Sworn Investigation (Use CAS Report EM 10)			
Closed	n/a	n/a	n/a
Average days to close	n/a	n/a	n/a
Pending (close of FY)	n/a	n/a	n/a
Sworn Investigation			
Closed (Use CAS Report EM 10)	0	0	0
Average days to close	0	0	0
Pending (close of FY)	0	0	0
COMPLIANCE ACTION (Use CAS Report 096)			
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
	FY 2009/10	FY 2010/11	FY 2011/12
CITATION AND FINE (Use CAS Report EM 10 and 095)			
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						
	FY 2008/09	FY 2009/10	FY 2010/11	FY 2011/12	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	1	0	3	4	100%
180 Days	0	0	0	0	0	0%
1 Year	0	0	0	0	0	0%
2 Years	0	0	0	0	0	0%
3 Years	0	0	0	0	0	0%
Over 3 Years	0	0	0	0	0	0%
Total Cases Closed	0	1	0	3	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 this administrative remedy.

Cost Recovery and Restitution

The RP Program has the ability to order cost recovery and restitution, however no cases have proceeded to discipline and therefore no cost recovery or restitution have been ordered.

Section 6 – Public Information Policies

Refer to Full 2012 Medical Board Sunset Report

Section 7 – Online Practice Issues

Refer to Full 2012 Medical Board Sunset Report

Section 8 – Workforce Development and Job Creation

Refer to Full 2012 Medical Board Sunset Report

Section 9 – Current Issues

Refer to Full 2012 Medical Board Sunset Report

Section 10 – Board Action and Response to Prior Sunset Issues

Refer to Full 2012 Medical Board Sunset Report

Section 11 – New Issues

None

Section 12 – Attachments

Refer to Full 2012 Medical Board Sunset Report